Jongsma, A. E., Peterson, L. M., & Bruce, T. J. (2014). *[The complete adult psychotherapy treatment planner](https://ashford.instructure.com/courses/76122/external_tools/retrieve?display=borderless&url=https%3A%2F%2Flibrary.ashford.edu%2FAccount%2FLtiLogin.aspx%3Fcustom_redirectresource%3Dhttps%3A%2F%2Flibrary.ashford.edu%2Fezproxy.aspx%3Furl%3Dhttp%253A%2F%2Fsite.ebrary.com%2Flib%2Fashford%2Fdetail.action%3FdocID%3D10829266" \o "The complete adult psychotherapy treatment planner" \t "_blank)*(5th ed.). Hoboken, NJ: John Wiley & Sons.

* Cognitive Deficits (pp. 116-128)
* Eating Disorders and Obesity (pp.147-160)
* Impulse Control Disorder (pp. 209-219)

Cognitive Deficits

COGNITIVE DEFICITS 1 BEHAVIORAL DEFINITIONS 1. 2. 3. Client or client’s family expresses concern about memory, concentration, “thinking,” judgment, social behavior, or the ability to complete tasks. Client receives negative feedback about school or work performance, when performance has typically been satisfactory. Client makes frequent errors in everyday activities that were previously completed accurately. Noticeable deterioration in everyday tasks such as keeping appointments, paying bills on time, recalling recent conversations, and processing mail. Difficulty in recall of recent events. Inappropriate or embarrassing social behavior, with history of effective social functioning. Changes in driving safety not explained by visual problems. Marked change in client’s use of leisure time, with client reducing time spent on tasks requiring concentration (e.g., reading, woodworking, knitting, writing, puzzles, Internet searching). Client reports higher levels of stress than usual when working on cognitively difficult tasks (e.g., organizing income tax information, making financial decisions, completing occupational tasks).

COGNITIVE DEFICITS 117 LONG-TERM GOALS 1. 2. 3. Maintain effective functioning through the use of cognitive aids and strategies. Adjust activities and responsibilities to level of cognitive capacity, cooperating with others who provide assistance or oversight. Maintain physical and emotional health to maximize brain health and optimize cognitive performance. Experience satisfaction in life while managing cognitive symptoms and resulting lifestyle changes.

SHORT-TERM OBJECTIVES THERAPEUTIC INTERVENTIONS 1. Describe the history, nature, and severity of cognitive problems experienced. (1, 2, 3) 1. Ask the client and (with authorization) the client’s family/ support system, about the types and duration of the client’s cognitive problems, the temporal course (sudden, gradual, intermittent), and significant stressors occurring near the time of onset. 2. Ask the client and (with authorization) the client’s family/support system about the client’s use of prescribed and nonprescribed medications and substances (alcohol, street drugs, herbs). 3. Ask the client and (with authorization) the client’s family/support system, and/or physician(s) about the patient’s medical history, being attentive to conditions (e.g., hypothyroidism,

Participate in a brief psychometric assessment to quantify cognitive and emotional functioning, and to screen for alcohol abuse. (4, 5, 6) 3. Give the therapist permission to speak with others about the types and durations of cognitive problems, while developing a treatment plan. (7) 4. Cooperate with comprehensive evaluation procedures to assess diabetes, hypertension, strokes, etc.) that might impact cognitive functioning. 4. Administer tests to quantify patterns of cognitive performance (e.g., Repeatable Battery for the Assessment of Neuropsychological Status ) or to screen for dementia/ cognitive impairment (e.g., Mini Mental State Examination; Dementia Rating Scale-2 ; Memory Impairment Screen ), being attentive to the impact of age, educational level, and cultural background on the interpretation of scores. 5. Ask the client to complete inventories to assess depression (e.g., Beck Depression InventoryII; Geriatric Depression Scale ), anxiety (e.g., Beck Anxiety Inventory; State-Trait Anxiety Inventory ), posttraumatic stress disorder (e.g., Detailed Assessment of Posttraumatic Stress ), or general emotional status ( Symptom Checklist 90-R; Brief Symptom Inventory-18 ). 6. Administer tests to screen for alcohol abuse (e.g., CAGE or AUDIT ). 7. With the client’s authorization, talk with the client and family about initial impressions, and consult with the client’s physician regarding symptoms, history, assessment results, and agree on a plan of care for the cognitive problem. 8. Initiate or support referral to health care professionals skilled

COGNITIVE DEFICITS 119 cognition and factors impacting cognitive problems. (8) 5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a DSM diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (9, 10, 11, 12) in providing an in-depth assessment of cognitive disorders (e.g., neurologist, rehabilitation medicine physician, neuropsychologist, rehabilitation psychologist). 9. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change). 10. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident). 11. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior. 12. Assess for the severity of the level of impairment to the client’s functioning to determine 6. Client and/or family describe their understanding of the assessment results and recommendations. (13, 14) 7. Agree to treatment of emotional disorders and/or substance dependence/abuse that may impact cognitive functioning. (15) 8. Consistently use written records and/or alarms to remind self of commitments and planned activities. (16, 17) appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment). 13. Discuss evaluation results with the client and family members; provide them with education as the nature of the deficits found and treatment options. 14. Assess the degree of the client’s and family’s realistic appraisal of the client’s functioning by inquiring into their perception of the problem areas, the reason for the problems, and the typical clinical course; talk with the client and family about differences between their beliefs and what professionals are saying. 15. Develop and implement a treatment plan for depression, anxiety, and/ or substance abuse that might depress the client’s cognition (see the Unipolar Depression, Anxiety, or Substance Abuse chapters in this Planner ). 16. To address all levels of memory problems, recommend use of written, visible external aids (e.g., day planners, memory books, calendars, dry erase boards) and/or alarms to cue the client to commitments and COGNITIVE DEFICITS 121 9. Use computerized devices consistently to compensate for areas of cognitive weakness. (18, 19) 10. Use internal or covert cognitive strategies to increase effective task performance. (20, 21, 22, 23, 24) planned activities; teach the client to use these aids. 17. Inquire about the client’s use of written external memory aids, and reinforce consistent use. 18. Assist the client with the selection of computerized external aids (e.g., GPS navigation systems, PDAs, smart phones) that match his/her preferences, budget, and ability to learn to use them; teach the client to use these aids. 19. Inquire into the client’s use of computerized devices and reinforce use. 20. For clients having mild impairments, demonstrate the use of repetition and enriched imagery (e.g., learning a person’s name by repeating the name of the person during a conversation, and then associating their name with a physical feature (e.g., “Amy” has dark eyebrows that are “aiming” toward her nose). 21. For clients having mild impairments, demonstrate the use of clustering (e.g., organize grocery list items into groups: [4 fruits: bananas, blueberries, lemons, strawberries; 3 dairy items: butter, milk, yogurt; 2 bakery items: bagels, bread); remember these 3 groups, and then items within them, rather than trying to remember 9 random items) thereby focusing attention, enriching images, decreasing the cognitive load, and facilitating retrieval of information. 22. For clients having mild impairments, teach the peg word 11. Use a systematic approach to problem-solving. (25) 12. Link new recurring activities to existing recurring activities. (26) 13. Accept and implement environmental changes to enhance everyday performance. (27) rhyme (1 is a bun, 2 is a shoe, etc.; see How to Strengthen Memory by a New Process by Sambrook) and demonstrate how use of the peg word system coupled with exaggerated imagery, enhances recall of information (e.g., learn cell phone number by developing a mental picture based upon the rhyme. For example, 573-8821 becomes a huge bee hive (5) reaching to heaven (7), with a tree (3) forming a slide down from heaven. Next are two gates (8, 8) behind which are an ornate shoe (2) with a sticky bun (1) inside. 23. Recommend the client cue self silently (e.g., “Focus” “Stay on task”) to maintain concentration and facilitate persistence. 24. Inquire into the client’s use of covert aids and reinforce use. 25. Teach patient to use a systematic problem solving strategy (e.g., SOLVE: S = Situation specified; O = Options listed with pros and cons; L = Listen to others; V = Voice a choice, implement an option; E = evaluate the outcome) (see Overcoming Grief and Loss After Brain Injury by Niemeier and Karol). 26. Suggest the client use a behavioral chaining strategy to add a new recurring activity to existing recurring activity (e.g., instruct client to review day planner at the end of each meal). 27. Discuss ways to modify the client’s environment (e.g., reduce clutter, reduce distractions, maintain consistent placement COGNITIVE DEFICITS 123 14. Participate in cognitive rehabilitation sessions and perform homework exercises. (28) 15. Challenge self to accomplish cognitively difficult tasks that have been identified as “safe” by health care professionals. (29) 16. Implement actions to enhance physical health. (30) 17. Problem-solve with therapist around problems affecting adherence to treatment plan. (31) 18. Family members make adjustments to cope with the client’s cognitive deficits. (32) of regularly used items, label locations of commonly used objects, identify one purse/wallet that the client will consistently use) to enhance functioning. 28. Refer the client for cognitive rehabilitation services to address deficits and learn coping skills. 29. Work with the client to identify cognitively challenging, but reasonable activities (e.g., reading, puzzles, Mahjong, keeping up with sports) to build into the day. 30. Talk with the client about the positive impact of a healthy lifestyle (e.g., aerobic exercise, healthy diet, adequate sleep) on maintaining and perhaps improving cognition; inquire into implementation of these behaviors. 31. Support and periodically reinforce the client’s implementation of recommendations (e.g., adherence with medications, behavioral recommendations, participation in cognitive rehabilitation, use of strategies and aids, environmental modifications); problem-solve any obstacles to consistent treatment plan compliance. 32. Educate family members that the client’s cognitive changes are a family problem; talk about the most commonly encountered problems and ways to deal with them, work with family to identify coping resources, encourage caregivers to take

19. Client and family verbalize questions, anxiety, sadness, and other emotions triggered by this change in client’s functioning. (33) 20. Express hope for the ability to experience satisfaction, love, and pleasure while managing the cognitive deficit. (34) 21. Participate in an evaluation of driving skills, accepting results and recommendations. (35, 36, 37, 38) breaks, and recommend participation in recreational, social, and spiritual activities. 33. Assist the client and family members in working through grief, anger, and other emotions associated with the change in the client’s functioning and their expectations for the future. 34. Work with the client and family to create reasonable expectations about the client’s capacities and to bolster confidence in everyone’s ability to have a satisfying life as they manage this problem. 35. Talk with the client and family members about the potential impact of the cognitive deficit on the client’s driving safety. 36. Develop a plan with the client and family to informally assess the client’s driving skills (e.g., have client navigate through empty parking lot, observing the client’s ability to maintain appropriate speed, to keep vehicle within a lane, to pull car into a parking space, to observe posted signs). 37. Refer the client for an evaluation of driving skills administered by a professional trained to assess the impact of cognitive disorders on driving-related capacities. 38. Talk with the client and/or family about the state law governing responsibilities to report persons having medical conditions that affect driving skills; follow state laws and HIPAA in taking action (e.g., making a report directly to a

22. Utilize public transportation, or accept transportation with family and friends. (39) 23. Consider the advice of professionals and others in selecting “safe” activities in which to invest one’s time. (40) 24. Family and client implement restrictions in a way that preserves client’s experience of choice, while reducing confrontation. (41) 25. Family members respond with empathy to the client’s experience and allow the client to manage responsibilities and problems that are within his/her capacity. (42) state agency, discussing concerns about driving with the client’s physician); suggest the client voluntarily surrender his/her license and promise to not drive. 39. Assist the client in identifying alternate transportation resources (e.g., public transportation, handicappedaccessible public transportation, volunteer drivers, friends, extended family); if applicable, recommend supervision while the client learns to use these services. 40. Work with the health care team and family to identify which activities are safe and what restrictions are necessary; provide counsel to the client regarding deciding which activities one is free to engage in, which may require supervision or partial restrictions, and which must be abandoned. 41. When possible, offer safe options for daily activities (e.g., provide small amounts of spending money for client to carry in a wallet, provide credit card with a low spending limit, review checks written by the client prior to mailing them); create impediments to the client engaging in dangerous behavior (e.g., keeping the client’s car keys, disconnecting the car battery), if necessary. 42. Educate family members about the positive effect of empathic responding and emotional support; describe the negative impact on functioning if excessive instrumental support

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COGNITIVE DEFICITS 127 DIAGNOSTIC SUGGESTIONS Using DSM-IV/ICD-9-CM: Axis I: 294.9 294.10 294.11 290.40 290.41 290.42 290.43 294.1x \_\_\_\_\_\_ \_\_\_\_\_\_ Cognitive Disorder, NOS Dementia of the Alzheimer’s Type, Without Behavioral Disturbance Dementia of the Alzheimer’s Type, With Behavioral Disturbance Vascular Dementia Uncomplicated Vascular Dementia With Delirium Vascular Dementia With Delusions Vascular Dementia With Depressed Mood Dementia Due to (Axis III Disorder) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Axis II: 799.9 V71.09 \_\_\_\_\_\_ \_\_\_\_\_\_ Diagnosis Deferred No Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Using DSM-5/ICD-9-CM/ICD-10-CM: ICD-9-CM 799.59 294.11 294.10 ICD-10-CM R41.9 F02.81 331.9 331.83 F02.80 DSM-5 Disorder, Condition, or Problem Unspecified Neurocognitive Disorder Probable Major Neurocognitive Disorder Due to (specify disorder), With Behavioral Disturbance Probable Major Neurocognitive Disorder Due to (specify disorder), Without Behavioral Disturbance Possible Major Neurocognitive Disorder Due to (specify disorder) Mild Neurocognitive Disorder Due to (specify disorder) Probable Major Vascular Neurocognitive Disorder With Behavioral Disturbance Probable Major Vascular Neurocognitive Disorder Without Behavioral Disturbance Possible Major Vascular Neurocognitive Disorder Mild Vascular Neurocognitive Disorder Personality Change Due to Another Medical Condition Other Specified Mental Disorder Due to Another Medical Condition 290.40 G31.9 290.40 G31.84 331.9 F01.51 331.83 310.1 F01.50 294.8 G31.9 G31.84 F07.0 F06.8

128 THE COMPLETE ADULT PSYCHOTHERAPY TREATMENT PLANNER 294.10 294.11 F02.80 Major Neurocognitive Disorder Due to Another Medical Condition, Without Behavioral Disturbance Major Neurocognitive Disorder Due to Another Medical Condition, With Behavioral Disturbance Alcohol-Induced Major Neurocognitive Disorder, Nonamnestic-Confabulatory Type, With Moderate or Severe Alcohol Use Disorder Alcohol-Induced Major Neurocognitive Disorder, Amnestic-Confabulatory Type, With Moderate or Severe Alcohol Use Disorder Alcohol-Induced Mild Neurocognitive Disorder, With Moderate or Severe Use Disorder 291.2 F02.81 291.1 F10.27 291.89 F10.26 F10.288 Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9CM codes are associated with more than one ICD-10-CM and DSM-5 Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD9-CM codes are not listed in this table. See Diagnostic and Statistical Manual of Mental Disorders (2013) for details. indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

Eating Disorders and Obesity

EATING DISORDERS AND OBESITY BEHAVIORAL DEFINITIONS 1. 2. 3. 4. 5. 6. Refusal to maintain body weight at or above a minimally normal weight for age and height (i.e., body weight less than 85% of that expected). Intense fear of gaining weight or becoming fat, even though underweight. Persistent preoccupation with body image related to grossly inaccurate assessment of self as overweight. Undue influence of body weight or shape on self-evaluation. Strong denial of the seriousness of the current low body weight. In postmenarcheal females, amenorrhea (i.e., the absence of at least three consecutive menstrual cycles). Escalating fluid and electrolyte imbalance resulting from eating disorder. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise. Recurrent episodes of binge eating (a large amount of food is consumed in a relatively short period of time and there is a sense of lack of control over the eating behavior). Eating much more rapidly than normal. Eating until feeling uncomfortably full. Eating large amounts of food when not feeling physically hungry. Eating alone because of feeling embarrassed by how much one is eating. Feeling disgusted with oneself, depressed, or very guilty after eating too much. An excess of body weight, relative to height, that is attributed to an abnormally high proportion of body fat (Body Mass Index of 30 or more). 7. 8. 9. 10. 11. 12. 13. 14. 15.

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EATING DISORDERS AND OBESITY 149 2. Describe any regular use of unhealthy weight control behaviors. (5) 3. Complete psychological tests designed to assess and track eating patterns and unhealthy weight-loss practices. (6) 4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a DSM diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10) perceived personal and interpersonal triggers and personal goals. 3. Compare the client’s calorie consumption with an average adult rate of 1,900 (for women) to 2,500 (for men) calories per day to determine overor undereating. 4. Measure the client’s weight and assess for minimization and denial of the eating disorder behavior and related distorted thinking and self-perception of body image. 5. Assess for the presence of recurrent inappropriate purging and nonpurging compensatory behaviors such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise; monitor on an ongoing basis. 6. Administer psychological instruments to the client designed to objectively assess eating disorders (e.g., the Eating Inventory; Stirling Eating Disorder Scales ; or Eating Disorders Inventory-3 ); give the client feedback regarding the results of the assessment; readminister as indicated to assess treatment response. 7. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the problematic nature of the “described behavior,” agrees

150 THE COMPLETE ADULT PSYCHOTHERAPY TREATMENT PLANNER with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change). 8. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident). 9. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior. 10. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

EATING DISORDERS AND OBESITY 151 5. Cooperate with a complete medical evaluation. (11) 6. Cooperate with a nutritional evaluation. (12) 7. Cooperate with a dental exam. (13) 8. Cooperate with a psychotropic medication evaluation by a physician and, if indicated, take medications as prescribed. (14, 15) 9. Cooperate with admission to inpatient treatment, if indicated. (16) 10. Verbalize an accurate understanding of how eating disorders develop. (17) 11. Refer the client to a physician for a medical evaluation to assess negative consequences of failure to maintain adequate body weight and overuse of compensatory behaviors; stay in close consultation with the physician as to the client’s medical condition. 12. Refer the client to a nutritionist experienced in eating disorders for an assessment of nutritional rehabilitation; coordinate recommendations into the care plan. 13. Refer the client to a dentist for a dental exam to assess the possible damage to teeth from purging behaviors and/or poor nutrition. 14. Assess the client’s need for psychotropic medications (e.g., SSRIs); arrange for a physician to evaluate for and then prescribe psychotropic medications, if indicated. 15. Monitor the client for psychotropic medication prescription compliance, effectiveness, and side effects. 16. Refer the client for hospitalization, as necessary, if his/her weight loss becomes severe and physical health is jeopardized, or if he/she is a danger to self or others due to a severe psychiatric disorder (e.g., severely depressed and suicidal). 17. Teach the client a model of eating disorders development that includes concepts such as sociocultural pressures to be

152 THE COMPLETE ADULT PSYCHOTHERAPY TREATMENT PLANNER 11. Verbalize an understanding of the rationale for and goals of treatment. (18, 19) thin, overvaluation of body shape and size in determining selfimage, maladaptive eating habits (e.g., fasting, binging, overeating), maladaptive compensatory weight management behaviors (e.g., purging, exercise), and resultant feelings of low self-esteem (see Overcoming Binge Eating by Fairburn; The Eating Disorders Sourcebook: A Comprehensive Guide to the Causes, Treatments, and Prevention of Eating Disorders by Costin). 18. Discuss a rationale for treatment consistent with the model being used including how cognitive, behavioral, interpersonal, lifestyle, and/or nutritional factors can promote poor selfimage, uncontrolled eating, and unhealthy compensatory actions, and how changing them they can build physical and mental health-promoting eating practices. 19. Assign the client to read psychoeducational chapters of books or treatment manuals on the development and treatment of eating disorders or obesity that are consistent with the treatment model (e.g., Overcoming Binge Eating by Fairburn; Overcoming Your Eating Disorders: A CognitiveBehavioral Therapy Approach for Bulimia Nervosa and BingeEating Disorder-Workbook by Apple and Agras; The LEARN Program for Weight Management by Brownell for weight loss).

EATING DISORDERS AND OBESITY 153 12. Keep a journal of food consumption. (20) 13. Establish regular eating patterns by eating at regular intervals and consuming optimal daily calories. (21, 22, 23) 14. Attain and maintain balanced fluids and electrolytes, as well as resumption of reproductive functions. (24, 25) 15. Identify and develop a list of high-risk situations for unhealthy eating or weight loss practices. (26, 27) 20. Assign the client to self-monitor and record food intake (or assign “A Reality Journal: Food, Weight, Thoughts, and Feelings” in the Adult Psychotherapy Homework Planner by Jongsma); process the journal material to reinforce and facilitate motivation to change. 21. Establish an appropriate daily caloric intake for the client and assist him/her in meal planning. 22. Establish healthy weight goals for the client per the Body Mass Index (BMI), the Metropolitan Height and Weight Tables, or some other recognized standard. 23. Monitor the client’s weight (e.g., weekly) and give realistic feedback regarding body weight. 24. Monitor the client’s fluid intake and electrolyte balance; give realistic feedback regarding progress toward the goal of balance. 25. Refer the client back to the physician at regular intervals if fluids and electrolytes need monitoring due to poor eating patterns. 26. Assess the nature of any external cues (e.g., persons, objects, and situations) and internal cues (thoughts, images, and impulses) that precipitate the client’s uncontrolled eating and/or compensatory weight management behaviors. 27. Direct and assist the client in construction of a hierarchy of

154 THE COMPLETE ADULT PSYCHOTHERAPY TREATMENT PLANNER 16. Learn and implement skills for managing urges to engage in unhealthy eating or weight loss practices. (28) 17. Participate in exercises to build skills in managing urges to use maladaptive weight control practices. (29) 18. Identify, challenge, and replace self-talk and beliefs that promote the anorexia or bulimia. (30, 31, 32) high-risk internal and external triggers for uncontrolled eating and/or compensatory weight management behaviors. 28. Teach the client tailored skills to manage high-risk situations including distraction, positive self-talk, problem-solving, conflict resolution (e.g., empathy, active listening, “I messages,” respectful communication, assertiveness without aggression, compromise), or other social/ communication skills; use modeling, role-playing, and behavior rehearsal to work through several current situations. 29. Assign homework exercises that allow the client to practice and strengthen skills learned in therapy; select initial high-risk situations that have a high likelihood of being a successful coping experience for the client; prepare and rehearse a plan for managing the risk situation; review/process the real life implementation by the client, reinforcing success while providing corrective feedback toward improvement. 30. Conduct Phase One of Cognitive Behavioral Therapy (see Cognitive Behavior Therapy and Eating Disorders by Fairburn) to help the client understand the adverse effects of binging and purging; assigning selfmonitoring of weight and eating patterns and establishing a regular pattern of eating (use “A Reality Journal: Food, Weight,

EATING DISORDERS AND OBESITY 155 19. To begin to resolve bulimic behavior, identify important people in the past and present, and describe the quality, good and poor, of those relationships. (33) Thoughts, and Feelings” in the Adult Psychotherapy Homework Planner by Jongsma); process the journal material. 31. Conduct Phase Two of Cognitive Behavioral Therapy (CBT) to shift the focus to eliminating dieting, reducing weight and body image concerns, teaching problem-solving, and doing cognitive restructuring to identify, challenge, and replace negative cognitive messages that mediate feelings and actions leading to maladaptive eating and weight control practices (or assign “How Fears Control My Eating” from the Adult Psychotherapy Homework Planner by Jongsma). 32. Conduct Phase Three of CBT to assist the client in developing a maintenance and relapse prevention plan including selfmonitoring of eating and binge triggers, continued use of problem-solving and cognitive restructuring, and setting shortterm goals to stay on track. 33. Conduct Interpersonal Therapy (see “Interpersonal Psychotherapy for Bulimia Nervosa” by Fairburn) beginning with the assessment of the client’s “interpersonal inventory” of important past and present relationships, highlighting themes that may be supporting the eating disorder (e.g., interpersonal disputes, role transition conflict, unresolved grief, and/or interpersonal deficits).

156 THE COMPLETE ADULT PSYCHOTHERAPY TREATMENT PLANNER 20. Verbalize a resolution of current interpersonal problems and a resulting termination of bulimia. (34, 35, 36, 37) 21. Parents and adolescent with anorexia agree to participate in all three phases of family-based treatment of anorexia. (38, 39, 40) 34. For grief, facilitate mourning and gradually help client discover new activities and relationships to compensate for the loss. 35. For disputes, help the client explore the relationship, the nature of the dispute, whether it has reached an impasse, and available options to resolve it including learning and implementing conflict-resolution skills; if the relationship has reached an impasse, consider ways to change the impasse or to end the relationship. 36. For role transitions (e.g., beginning or ending a relationship or career, moving, promotion, retirement, graduation), help the client mourn the loss of the old role while recognizing positive and negative aspects of the new role and taking steps to gain mastery over the new role. 37. For interpersonal deficits, help the client develop new interpersonal skills and relationships. 38. Conduct Phase One (sessions 1– 10) of Family-Based Treatment (see Treatment Manual for Anorexia Nervosa: A FamilyBased Approach by Lock et al.) by confirming with the family their intent to participate and strictly adhere to the treatment plan, taking a history of the eating disorder, clarifying that the parents will be in charge of weight restoration of the client, establishing healthy weight

EATING DISORDERS AND OBESITY 157 22. State a basis for positive identity that is not based on weight and appearance but on character, traits, relationships, and intrinsic value. (41) 23. Follow through on implementing the five aspects of the LEARN program to achieve weight loss. (42, 43) goals, and asking the family to participate in the family meal in session; establish with the parents and a physician a minimum daily caloric intake for the client and focus them on meal planning; consult with a physician and/or nutritionist if fluids and electrolytes need monitoring due to poor nutritional habits. 39. Conduct Phase Two of FamilyBased Treatment (FBT) (sessions 11– 16) by continuing to closely monitor weight gain and physician/nutritionist reports regarding health status; gradually return control over eating decisions back to the adolescent as the acute starvation is resolved and portions consumed are nearing what is normally expected and weight gain in demonstrated. 40. Conduct Phase Three of FBT (sessions 17– 20) by reviewing and reinforcing progress and weight gain; focus on adolescent development issues; teach and rehearse problem-solving and relapse prevention skills. 41. Assist the client in identifying a basis for self-worth apart from body image by reviewing his/her talents, successes, positive traits, importance to others, and intrinsic spiritual value. 42. Assign the client to read the LEARN manual (see The LEARN Program for Weight Management by Brownell) and then review the five aspects of the program (i.e., Lifestyle,

158 THE COMPLETE ADULT PSYCHOTHERAPY TREATMENT PLANNER 24. Verbalize an understanding of relapse prevention and the distinction between a lapse and a relapse. (44, 45) 25. Implement relapse prevention strategies for managing possible future anxiety symptoms. (46, 47, 48) Exercise, Attitudes, Relationships, and Nutrition), that will be emphasized over the next 12 weeks. 43. In weekly sessions, systematically work through the five aspects of the LEARN program manual (Lifestyle, Exercise, Attitudes, Relationships, and Nutrition), applying each component to the client’s life to establish new behavioral patterns designed to achieve weight loss. 44. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of distress, urges, or to avoid, and relapse with the decision to return to the cycle of maladaptive thoughts and actions (e.g., feeling anxious, binging, then purging). 45. Identify with the client future situations or circumstances in which lapses could occur. 46. Instruct the client to routinely use strategies learned in therapy (e.g., continued exposure to previous external or internal cues that arise) to prevent relapse. 47. Develop a “maintenance plan” with the client that describes how the client plans to identify challenges, use knowledge and skills learned in therapy to manage them, and maintain positive changes gained in therapy. 48. Schedule periodic “maintenance” sessions to help the client maintain therapeutic gains and

EATING DISORDERS AND OBESITY 159 26. Attend an eating disorder group. (49) adjust to life without the eating disorder. 49. Refer the client to a support group for eating disorders. \_\_ . \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ . \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ . \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ . \_\_ . \_\_ . \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DIAGNOSTIC SUGGESTIONS Using DSM-IV/ICD-9-CM: Axis I: 307.1 307.51 307.50 xxx.xx 316 Anorexia Nervosa Bulimia Nervosa Eating Disorder NOS Binge Eating Disorder Psychological Symptoms Affecting Axis III Disorder (e.g., obesity) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Axis II: \_\_\_\_\_\_ \_\_\_\_\_\_ 301.6 799.9 V71.09 \_\_\_\_\_\_ \_\_\_\_\_\_ Dependent Personality Disorder Diagnosis Deferred No Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Using DSM-5/ICD-9-CM/ICD-10-CM: ICD-9-CM 307.1 307.1 307.51 278.00 307.50 307.59 ICD-10-CM F50.02 F50.01 F50.2 E66.9 F50.9 F50.8 DSM-5 Disorder, Condition, or Problem Anorexia Nervosa, Binge-Eating/Purging Type Anorexia Nervosa, Restricting Type Bulimia Nervosa Overweight or Obesity Unspecified Feeding or Eating Disorder Other Specified Feeding or Eating Disorder Dependent Personality Disorder 301.6 F60.7

Impulse Control Disorder

IMPULSE CONTROL DISORDER BEHAVIORAL DEFINITIONS 1. 2. 3. 4. 5. A tendency to act too quickly without careful deliberation, resulting in numerous negative consequences. Loss of control over aggressive impulses resulting in assault, selfdestructive behavior, or damage to property. Deliberate and purposeful fire-setting on more than one occasion. Persistent and recurrent maladaptive gambling behavior. Recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value. Recurrent pulling out of one’s hair resulting in noticeable hair loss. Desire to be satisfied almost immediately and a decreased ability to delay pleasure or gratification. A history of acting out in at least two areas that are potentially selfdamaging (e.g., spending money, sexual activity, reckless driving, addictive behavior). Overreactivity to mildly aversive or pleasure-oriented stimulation. A sense of tension or affective arousal before engaging in the impulsive behavior (e.g., kleptomania, pyromania). A sense of pleasure, gratification, or release at the time of committing the ego-dystonic, impulsive act. Difficulty waiting for things— that is, restless standing in line, talking out over others in a group, and the like. 6. 7. 8. 9. 10. 11. 12.

210 THE COMPLETE ADULT PSYCHOTHERAPY TREATMENT PLANNER LONG-TERM GOALS 1. 2. 3. \_\_. Reduce the frequency of impulsive behavior and increase the frequency of behavior that is carefully thought out. Reduce thoughts that trigger impulsive behavior and increase self-talk that controls behavior. Learn to stop, listen, and think before acting

SHORT-TERM OBJECTIVES THERAPEUTIC INTERVENTIONS 1. Identify the impulsive behaviors that have been engaged in over the last six months. (1) 2. List the reasons or rewards that lead to continuation of an impulsive pattern. (2, 3) 3. Disclose any history of substance use that may contribute to and complicate the treatment of Impulse Control Disorder. (4) 4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a DSM 1. Review the client’s behavior pattern to assist him/her in clearly identifying, without minimization, denial, or projection of blame, his/her pattern of impulsivity. 2. Explore whether the client’s impulsive behavior is triggered by anxiety and maintained by anxiety relief rewards; assess for bipolar manic disorder or ADHD. 3. Ask the client to make a list of the positive things he/she gets from impulsive actions and process it with the therapist. 4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this Planner ). 5. Assess the client’s level of insight (syntonic versus dystonic) toward the “presenting problems” (e.g., demonstrates good insight into the

IMPULSE CONTROL DISORDER 211 diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8) problematic nature of the “described behavior,” agrees with others’ concern, and is motivated to work on change; demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change). 6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident). 7. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior. 8. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

212 THE COMPLETE ADULT PSYCHOTHERAPY TREATMENT PLANNER 5. List the negative consequences that accrue to self and others as a result of impulsive behavior. (9, 10, 11) 6. Identify impulsive behavior’s antecedents, mediators, and consequences. (12, 13) 7. Participate in imaginal exposure sessions to decrease the urge to act impulsively. (14, 15) 9. Assign the client to write a list of the negative consequences that have occurred because of impulsivity (or assign “Recognizing the Negative Consequences of Impulsive Behavior” from the Adult Psychotherapy Homework Planner by Jongsma). 10. Assist the client in making connections between his/her impulsivity and the negative consequences for himself/herself and others. 11. Confront the client’s denial of responsibility for the impulsive behavior or the negative consequences (or assign “Accept Responsibility for Illegal Behavior” from the Adult Psychotherapy Homework Planner by Jongsma). 12. Ask the client to keep a log of impulsive acts (time, place, feelings, thoughts, what was going on prior to the act, and what was the result); process log content to discover triggers and reinforcers (or assign “Impulsive Behavior Journal” from the Adult Psychotherapy Homework Planner by Jongsma). 13. Explore the client’s past experiences to uncover his/her cognitive, emotional, and situational triggers to impulsive episodes. 14. Assist the client in composing a script describing a typical situation in which impulsive behavior occurs, the urge to act, physical symptoms, expected negative consequences, and, finally, resisting the urge.

IMPULSE CONTROL DISORDER 213 8. Participate in an in vivo exposure treatment procedure. (16, 17, 18, 19) 15. Use the client’s script in an imaginal exposure session in which the client is relaxed and the script is read repeatedly. 16. Direct and assist the client in construction of a hierarchy of feared internal and external impulsive behavior cues. 17. Assess the nature of any external cues (e.g., persons, objects, and situations) and internal cues (thoughts, images, and impulses) that precipitate the client’s impulsive actions. 18. Select initial exposures (imaginal or in vivo ) to the internal and/or external impulsive behavior cues that have a high likelihood of being a successful experience for the client; include response prevention and do cognitive restructuring within and after the exposure (see Mastery of Obsessive-Compulsive Disorder by Kozak and Foa; or Treatment of Obsessive-Compulsive Disorder by McGinn and Sanderson). 19. Assign the client a homework exercise in which he/she repeats the exposure to the internal and/or external impulsive behavior cues using response prevention and restructured cognitions between sessions and records responses (or assign “Reducing the Strength of Compulsive Behaviors” in the Adult Psychotherapy Homework Planner by Jongsma); review during next session, reinforcing success and providing corrective feedback toward improvement (see Mastery of Obsessive-Compulsive Disorder by Kozak and Foa).

9. Verbalize a clear connection

between impulsive behavior

and negative consequences to

self and others. (10, 20)

10. Assist the client in making

connections between his/her

impulsivity and the negative

consequences for himself/herself

and others.

20. Reinforce the client’s verbalized

acceptance of responsibility for

and connection between impulsive

behavior and negative

consequences.

10. Before acting on behavioral

decisions, frequently review

them with a trusted friend or

family member for feedback

regarding possible

consequences. (21, 22)

21. Conduct a session with the client

and his/her partner to develop a

contract for receiving feedback

prior to impulsive acts.

22. Brainstorm with the client who

he/she could rely on for trusted

feedback regarding action

decisions; use role-play and

modeling to teach how to ask

for and accept this help.

11. Utilize cognitive methods to

control trigger thoughts and

reduce impulsive reactions

to those trigger thoughts.

(13, 23, 24)

13. Explore the client’s past

experiences to uncover his/her

cognitive, emotional, and

situational triggers to impulsive

episodes.

23. Teach the client cognitive methods

(thought-stopping, thought

substitution, reframing, etc.) for

gaining and improving control

over impulsive urges and actions.

24. Use the cognitive restructuring

process (i.e., teaching the

connection between thoughts,

feelings, and actions; identifying

relevant automatic thoughts and

their underlying beliefs or biases;

challenging the biases; developing

alternative positive perspectives;

testing biased and alternative

beliefs through behavioral

experiments) to assist the client

in replacing negative automatic thoughts associated with education

and his/her ability to learn.

 12. Use relaxation exercises to

control anxiety, urges, and

reduce consequent impulsive

behavior. (25, 26, 27)

 25. Teach the client relaxation skills

(e.g., progressive muscle

relaxation, imagery, diaphragmatic

breathing, verbal cues for deep

relaxation), how to discriminate

better between relaxation and

tension, as well as how to apply

these skills to coping with

situations associated with

impulsive urges (e.g., see

Progressive Relaxation Training

by Bernstein and Borkovec).

26. Assign the client homework each

session in which he or she practices

relaxation exercises daily for at

least 15 minutes and applies the

technique to impulsive trigger

situations; review the exercises,

reinforcing success while providing

corrective feedback toward

improvement.

27. Assign the client to read about

progressive muscle relaxation and

other calming strategies in relevant

books or treatment manuals (e.g.,

The Relaxation and Stress Reduction

Workbook by Davis, RobbinsEshelman, and McKay; Mastery

of Your Anxiety and Worry—

Workbook by Craske and Barlow).

 13. Utilize behavioral strategies to

manage urges for impulsive

action. (28, 29, 30)

 28. Teach the use of positive

behavioral alternatives to cope

with impulsive urges (e.g., talking

to someone about the urge, taking

a time out to delay any reaction,

calling a friend or family member,

engaging in physical exercise,

leaving credit cards with a family

member, creating needed item

shopping lists to avoid impulsive

buying, avoiding use of police and

fire scanners, etc.).

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29. Review the client’s implementation

of behavioral coping strategies to

reduce urges and tension; reinforce

success and redirect for failure.

30. Teach the client covert sensitization

in which he/she imagines a negative

consequence (e.g., going to jail)

whenever the desire to act

impulsively appears (e.g., the desire

to steal); assign as homework;

review, reinforcing success and

problem-solving obstacles until

internalized by the client.

14. List instances where “stop,

listen, think, and act” has been

implemented, citing the

positive consequences. (31, 32)

31. Using modeling, role-playing, and

behavior rehearsal, teach the client

how to use “stop, listen, and think”

before acting in several current

situations.

32. Review and process the client’s use

of “stop, listen, think, and act” in

day-to-day living and identify the

positive consequences.

15. Describe any history of manic

or hypomanic behavior related

to a mood disorder. (33)

33. Assess the client for a mood

disorder that includes manic

episodes with a lack of judgment

over impulsive behavior and its

consequences (see the Bipolar

Disorder—Mania chapter in this

Planner).

16. Identify situations in which

there has been a loss of control

over aggressive impulses

resulting in destructive or

assaultive behavior. (34)

34. Explore the client’s history of

explosive anger management

problems; include this as

presenting problem if there have

been several such episodes of

aggressiveness grossly out of

proportion to any precipitating

psychosocial stressor (see the

Anger Control Problems chapter

in this Planner).

17. Comply with the recommendations from a physician

evaluation regarding the

35. Refer the client to a physician for

an evaluation for a psychotropic

medication prescription.

IMPULSE CONTROL DISORDER 217

necessity for psychopharmacological intervention. (35, 36)

36. Monitor the client for psychotropic

medication prescription

compliance, side effects, and

effectiveness; consult with the

prescribing physician at regular

intervals.

 18. Implement a reward system

for replacing impulsive

actions with reflection on

consequences and choosing

wise alternatives. (37, 38)

 37. Assist the client in identifying

rewards that would be effective

in reinforcing himself/herself for

suppressing impulsive behavior.

38. Assist the client and significant

others in developing and putting

into effect a reward system for

deterring the client’s impulsive

actions.

 19. Learn and implement problemsolving skills to reduce

impulsive behavior. (39, 40)

 39. Teach the client problemresolution skills (e.g., defining the

problem clearly, brainstorming

multiple solutions, listing the pros

and cons of each solution, seeking

input from others, selecting and

implementing a plan of action,

evaluating outcome, and

readjusting plan as necessary).

40. Use modeling and role-playing

with the client to apply the

problem-solving approach to

his/her urge for impulsive action

(or assign “Problem-Solving: An

Alternative to Impulsive Action”

from the Adult Psychotherapy

Homework Planner by Jongsma);

encourage implementation of

action plan, reinforcing success

and redirecting for failure.

 20. Read recommended material

on overcoming impulsive

behavior. (41)

 41. Recommend the client read

material on coping with impulsive

urges (e.g., Stop Me Because I

Can't Stop Myself: Taking Control

of Impulsive Behavior by Grant and

Fricchione; Overcoming Impulse