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**Arthur E. Jongsma, Jr., Series Editor**

# The Addiction Treatment Planner Sixth Edition

*Robert R. Perkinson*

*Arthur E. Jongsma, Jr*

*Timothy J. Bruce*

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To those who courageously overcome life-destroying addiction and to those who counsel them along the path to recovery.

—A.E.J.

To the angels of mental health.

—R.R.P.

To all those who struggle with addiction, and those who dedicate their lives in service to them.

—T.J.B.

# ABOUT THE COMPANION WEBSITE

This book is accompanied by a companion website.

www.wiley.com/go/jongsma/addictiontp6e

This website includes:

- Appendix G: References to Empirical Support for Evidence-Based Chapters in the Complete Addiction Treatment Planner, 6th Edition

Please note that corresponding homework assignments can be digitally downloaded through purchase of *The Addiction Homework Planner, 6th Edition.*

# CONTENTS


| | |
|---|---|
| Practice*Planners*® Series Preface | xi |
| Introduction | xv |
| Sample Treatment Plan | xxvii |
| Adult-Child-of-an-Alcoholic (ACA) Traits (Dimension 3) | 1 |
| Anger (Dimension 3) | 12 |
| Antisocial Behavior (Dimension 3) | 26 |
| Anxiety (Dimension 3) | 35 |
| Attention-Deficit/Hyperactivity Disorder (ADHD) – Adolescent (Dimension 3) | 48 |
| Attention-Deficit/Hyperactivity Disorder (ADHD) – Adult (Dimension 3) | 61 |
| Bipolar Disorder (Dimension 3) | 75 |
| Borderline Traits (Dimension 3) | 88 |
| Childhood Trauma (Dimension 3) | 101 |
| Chronic Pain (Dimension 2) | 111 |
| Conduct Disorder/Delinquency (Dimension 3) | 123 |
| Dangerousness/Lethality (Dimension 3) | 138 |
| Dependent Traits (Dimension 3) | 147 |
| Depression – Unipolar (Dimension 3) | 157 |
| Eating Disorders and Obesity (Dimension 3) | 171 |
| Family Conflicts (Dimension 3) | 185 |
| Gambling (Dimension 3) | 198 |
| Grief/Loss Unresolved (Dimension 3) | 209 |
| Impulsivity (Dimension 3) | 219 |
| Legal Problems (Dimension 3) | 228 |
| Living Environment Deficiency (Dimension 6) | 235 |
| Medical Issues (Dimension 2) | 243 |
| Narcissistic Traits (Dimension 3) | 255 |
| Nicotine Abuse/Dependence (Dimension 1) | 265 |
| Obsessive-Compulsive and Related Disorders (Dimension 3) | 276 |
| Occupational Problems (Dimension 6) | 287 |
| Opioid Use Disorder (Dimension 1) | 300 |
| Oppositional Defiant Behavior (Dimension 3) | 313 |

Panic Disorder/Agoraphobia (Dimension 3) 326
Parent–Child Relational Problem (Dimension 6) 338
Partner Relational Conflicts (Dimension 6) 351
Peer Group Negativity (Dimension 6) 362
Posttraumatic Stress Disorder (PTSD) (Dimension 3) 370
Psychosis (Dimension 3) 385
Readiness to Change (Dimension 4) 399
Relapse Proneness (Dimension 5) 407
Self-Care Deficits – Primary (Dimension 3) 419
Self-Care Deficits – Secondary (Dimension 3) 428
Self-Harm (Dimension 3) 438
Sexual Abuse (Dimension 3) 451
Sexual Promiscuity (Dimension 3) 460
Sleep Disturbance (Dimension 3) 469
Social Anxiety (Dimension 3) 479
Spiritual Confusion (Dimension 3) 492
Substance-Induced Disorders (Dimension 1) 500
Substance Intoxication/Withdrawal (Dimension 1) 508
Substance Use Disorders (Dimension 1) 516
Suicidal Ideation (Dimension 3) 531

Appendix A Bibliotherapy Suggestions 544
Appendix B References to Clinical Resources for Evidence-Based Chapters 576
Appendix C Recovery Model: Core Principles, Objectives, and Interventions 615
Appendix D Client Satisfaction Surveys: Resource Material 621
Appendix E ASAM Six Assessment Dimensions: A Checklist Example 623
Appendix F Alphabetical Index of Sources for Assessment Instruments and Clinical Interview Forms Cited in Interventions 630

# CONTENTS LISTED BY ASAM ASSESSMENT DIMENSIONS


**Dimension 1: Acute Intoxication and/or Withdrawal Potential**

Nicotine Abuse/Dependence 265
Opioid Use Disorder 300
Substance-Induced Disorders 500
Substance Intoxication/Withdrawal 508
Substance Use Disorders 516

**Dimension 2: Biomedical Conditions and Complications**

Chronic Pain 111
Medical Issues 243

**Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications**

Adult-Child-of-an-Alcoholic (ACA) Traits 1
Anger 12
Antisocial Behavior 26
Anxiety 35
Attention-Deficit/Hyperactivity Disorder (ADHD) – Adolescent 48
Attention-Deficit/Hyperactivity Disorder (ADHD) – Adult 61
Bipolar Disorder 75
Borderline Traits 88
Childhood Trauma 101
Conduct Disorder/Delinquency 123
Dangerousness/Lethality 138
Dependent Traits 147
Depression – Unipolar 157
Eating Disorders and Obesity 171
Family Conflicts 185
Gambling 198
Grief/Loss Unresolved 209
Impulsivity 219
Legal Problems 228
Narcissistic Traits 255

Obsessive-Compulsive and Related Disorders 276
Oppositional Defiant Behavior 313
Panic Disorder/Agoraphobia 326
Posttraumatic Stress Disorder (PTSD) 370
Psychosis 385
Self-Care Deficits – Primary 419
Self-Care Deficits – Secondary 428
Self-Harm 438
Sexual Abuse 451
Sexual Promiscuity 460
Sleep Disturbance 469
Social Anxiety 479
Spiritual Confusion 492
Suicidal Ideation 531

**Dimension 4: Readiness to Change**

Readiness to Change 399

**Dimension 5: Relapse, Continued Use, or Continued Problem Potential**

Relapse Proneness 407

**Dimension 6: Recovery/Living Environment**

Living Environment Deficiency 235
Occupational Problems 287
Parent–Child Relational Problem 338
Partner Relational Conflicts 351
Peer Group Negativity 362

# PRACTICE*PLANNERS*® SERIES PREFACE

Accountability is an important dimension of the practice of psychotherapy. Treatment programs, public agencies, clinics, and practitioners must justify and document their treatment plans to outside review entities in order to be reimbursed for services. The books in the Practice*Planners*® series are designed to help practitioners fulfill these documentation requirements efficiently and professionally.

- The Practice*Planners*® series includes a wide array of treatment planning books including not only the original *Complete Adult Psychotherapy Treatment Planner, Child Psychotherapy Treatment Planner, Adolescent Psychotherapy Treatment Planner*, and *Addictions Treatment Planner* all now in their sixth editions, but also Treatment Planners targeted to specialty areas of practice, including:
    - Co-occurring disorders
    - Integrated behavioral medicine
    - College students
    - Couples therapy
    - Crisis counseling
    - Early childhood education
    - Employee assistance
    - Family therapy
    - Gays and lesbians
    - Group therapy
    - Juvenile justice and residential care
    - Intellectual and developmental disability
    - Neuro rehabilitation
    - Older adults
    - Parenting skills
    - Pastoral counseling
    - Personality disorders
    - Probation and parole
    - Psychopharmacology

- School counseling and school social work
- Severe and persistent mental illness
- Sexual abuse victims and offenders
- Social work and human services
- Special education
- Speech-language pathology
- Suicide and homicide risk assessment
- Veterans and active military duty
- Women's issues

In addition, there are three branches of companion books that can be used in conjunction with the *Treatment Planners*, or on their own:

- ***Progress Notes Planners*** provide a menu of progress statements that elaborate on the client's symptom presentation and the provider's therapeutic intervention. Each *Progress Notes Planner* statement is directly integrated with the behavioral definitions and therapeutic interventions from its companion *Treatment Planner*.
- ***Homework Planners*** include homework assignments designed around each presenting problem (such as anxiety, depression, chemical dependence, anger management, eating disorders, or panic disorder) that is the focus of a chapter in its corresponding *Treatment Planner*.
- ***Client Education Handout Planners*** provide brochures and handouts to help educate and inform clients on presenting problems and mental health issues, as well as life skills techniques. The handouts are included on CD-ROMs for easy printing from your computer and are ideal for use in waiting rooms, at presentations, as newsletters, or as information for clients struggling with mental illness issues. The topics covered by these handouts correspond to the presenting problems in the *Treatment Planners*.

***The Series also includes:***

- ***Evidence-Based Psychotherapy Treatment Planning Video Series*** offers 12 sixty-minute programs that provide step-by-step guidance on how to use empirically supported treatments to inform the entire treatment planning process. In a viewer-friendly manner, Drs. Art Jongsma and Tim Bruce discuss the steps involved in integrating evidence-based (EBT) Objectives and Interventions into a treatment plan. The research support for the EBTs is summarized and selected aspects of the EBTs are demonstrated in role-played counseling scenarios.

***A companion Treatment Planning software product is also available:***

- ***TheraScribe®,*** the #1 selling treatment planning and clinical record-keeping software system for mental health professionals. TheraScribe® allows the user to import the data from any of the Treatment Planner,

Progress Notes Planner, or Homework Planner books into the software's expandable database to simply point and click to create a detailed, organized, individualized, and customized treatment plan along with optional integrated progress notes and homework assignments. TheraScribe® is available by calling 616-776-1745.

The goal of our series is to provide practitioners with the resources they need in order to provide high-quality care in the era of accountability. To put it simply: We seek to help you spend more time on patients and less time on paperwork.

Arthur E. Jongsma, Jr.
*Grand Rapids, Michigan*

# INTRODUCTION

## ABOUT PRACTICE*PLANNERS*® TREATMENT PLANNERS

Pressure from third-party payers, accrediting agencies, and other outside parties has increased the need for clinicians to quickly produce effective, high-quality treatment plans. *Treatment Planners* provide all the elements necessary to quickly and easily develop formal treatment plans that satisfy the needs of most third-party payers and state and federal review agencies.

**Each *Treatment Planner***

- Saves you hours of time-consuming paperwork.
- Offers the freedom to develop customized treatment plans.
- Includes over 1,000 clear statements describing the behavioral manifestations of each relational problem, and includes long-term goals, short-term objectives, and clinically tested treatment options.
- Has an easy-to-use reference format that helps locate treatment plan components by behavioral problem or psychiatric diagnosis.

As with the rest of the books in the Practice*Planners*® series, our aim is to clarify, simplify, and accelerate the treatment planning process so you spend less time on paperwork and more time with your clients.

## ABOUT *THE ADDICTION TREATMENT PLANNER*

The *Addiction Treatment Planner* has been written for individual, group, and family counselors and psychotherapists who are working with adults and adolescents who are struggling with addictions to mood-altering chemicals, gambling, abusive eating, nicotine, or sexual promiscuity. The problem list of chapter titles reflects those addictive behaviors and the emotional, behavioral, interpersonal, social, personality, legal, medical, and vocational issues associated with those addictions. Whereas the focus of the original *Chemical Dependence Treatment Planner* was limited exclusively to substance abuse and its associated problems, the focus of later editions has been expanded to include other common addictive behaviors as well as other behavioral problems and psychiatric conditions in which addictive behavior may occur.

This sixth edition of *The Addition Treatment Planner* has been improved in many ways:

- Updated with new and revised evidence-based objectives and interventions
- Addition at the outset of every chapter of an evidence-based Objective and two Therapeutic Interventions highlighting the importance of establishing a positive relationship with the client
- Revised, expanded, and updated References to Empirical Support for Evidence-based Chapters (Appendix G) are now listed online at www.wiley.com/go/jongsma/addictiontp6e
- Revised, expanded, and updated self-help book list in the Bibliotherapy Suggestions (Appendix A)
- More suggested homework assignments from *Homework Planners* integrated into the interventions
- Updated Appendix F, which provides an Alphabetical Index of Sources for the Assessment Instruments and Clinical Interview Forms Cited in Interventions
- New chapters on Opioid Use and Panic Disorder/Agoraphobia
- Renamed chapters for Depression – Unipolar (formerly Unipolar Depression) and Readiness for Change (formerly Treatment Resistance)
- Exclusive use of *DSM-5 (ICD-10-CM)* diagnostic labels and codes into the Diagnostic Suggestions section of each chapter

This edition of the *Planner* continues to give special attention to the Patient Placement Criteria (PPC) developed by the American Society of Addiction Medicine (ASAM). In the ASAM contents we have listed our presenting problem chapters under each of the six assessment dimensions:

| | |
|---|---|
| Dimension 1: | Acute intoxication and/or withdrawal potential |
| Dimension 2: | Biomedical conditions and complications |
| Dimension 3: | Emotional, behavioral, or cognitive conditions and complications |
| Dimension 4: | Readiness to change |
| Dimension 5: | Relapse, continued use, or continued problem potential |
| Dimension 6: | Recovery/living environment |

The *Addiction Treatment Planner* has treatment planning content applicable to problems discovered in all of the six assessment dimensions.

Also included (Appendix D) is a form that can be used to assess the client under the six ASAM dimensions. The checklist provides material for efficient evaluation of the client on each of the six dimensions. This form has been developed and is utilized by the staff at Keystone Treatment Center, Canton, South Dakota, where Dr. Perkinson is the clinical director. It is not copyrighted and may be used or adapted for use by our readers.

Interventions can be found in each chapter that reflect a 12-step recovery program approach, but you will also find interventions based on a broader

psychological and pharmacological model. Because addiction treatment is often done in a residential setting through a team approach, interventions have been created that can be assigned to staff members of various disciplines and modalities: nursing, medical, group counseling, family therapy, or individual therapy. We hope that we have provided a broad, eclectic menu of objectives and interventions from which you can select to meet your client's unique needs. Ideally, we have also provided a stimulus for you to create new objectives and interventions from your own clinical experience that have proven to be helpful to addictive clients.

Evidence-based practice (EBP) is steadily becoming the standard of care in mental health care as it has in medical health care. Professional organizations such as the American Psychological Association (APA), National Association of Social Workers, and the American Psychiatric Association, as well as consumer organizations such the National Alliance for the Mentally Ill (NAMI) have all endorsed the use of EBP. In some practice settings, EBP is becoming mandated. Some third-party payers are requiring use of EBP for reimbursement. It is clear that the call for evidence and accountability is being increasingly sounded. So, what is EBP and how is its use facilitated by this *Planner*?

Borrowing from the Institute of Medicine's definition (Institute of Medicine, 2001), the APA has defined EBP as, "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Presidential Task Force on EBP, 2006). Consistent with this definition, we have identified those psychological treatments with the best available supporting evidence, added Objectives and Interventions consistent with them in the pertinent chapters, and identified these with this symbol: EBP. As most practitioners know, research has shown that although these treatment methods may have demonstrated efficacy, factors such as the individual psychologist (e.g. Wampold, 2001), the treatment relationship (e.g. Norcross, 2019), and the patient (e.g. Bohart & Tallman, 1999) are also vital contributors to optimizing a client's response to psychotherapy. As noted by the APA, "Comprehensive evidence-based practice will consider all of these determinants and their optimal combinations." (APA, 2006, p. 275). For more information and instruction on constructing evidence-based psychotherapy treatment plans, see our 12 DVD-based training videos entitled *Evidence-based Psychotherapy Treatment Planning* (Jongsma & Bruce, 2010–2012).

The sources we used to identify the evidence-based treatments integrated into this *Planner* are multiple and, we believe, high quality. They include rigorous meta-analyses, current critical, expert reviews, as well as EBP guideline recommendations. Examples of specific sources include the Cochrane Collaboration reviews; the work of the Society of Clinical Psychology identifying research-supported psychological treatments; evidence-based treatment reviews (e.g. David, Lynn, & Montgomery, 2018; Nathan & Gorman, 2015), as well as critical analyses of the process through which EBP is defined

(e.g. Dimidjian, 2019; Norcross, Hogan, Koocher, & Maggio, 2017). EBP guidelines informing the selection process include those from the APA, American Psychiatric Association, the National Institute for Health and Clinical Excellence (NICE) in the United Kingdom, and the National Institute on Drug Abuse (NIDA) to name a few.

Although sources may vary slightly in the criteria they use for judging levels of empirical support, we favored those that use more rigorous criteria, typically requiring demonstration of efficacy through randomized controlled trials or clinical replication series, good experimental methodology, and independent replication. Our approach was to evaluate these various sources and include those treatments supported by the highest level of evidence and for which there was consensus across most of these sources. For any chapter in which EBP is indicated, references to the sources used to identify them can be found online at www.wiley.com/go/jongsma/addictiontp6e. In addition to these references to empirical support, we have also included a Professional Reference appendix listing references to Clinical Resources. Clinical Resources are books, manuals, and other resources for clinicians that describe the details of the application, or the "how to," of the treatment approaches described in a chapter.

We recognize that there is debate regarding EBP among mental health professionals, who are not always in agreement regarding the best treatment, what factors contribute to good outcomes, or even what constitutes "evidence." We also recognize that some practitioners are skeptical about changing their practice based on psychotherapy research. Our intent in this book is to accommodate these differences by providing a range of treatment plan options, including those consistent with the "best available research" (APA, 2006), those reflecting common clinical practices of experienced clinicians (that may have not been subjected to study), and some that reflect promising emerging approaches. Our intent is to allow users of this planner an array of options so that they can construct what they believe to be the best plan for their particular client.

More recently, psychotherapy research is moving toward trying to identify evidence-based principles of psychotherapeutic change that cut across the various individual psychotherapies that have largely been the focus of outcome research. An example of this call in seen in Goldfried (2019), in which he advances the following principles:

- Promoting client expectation and motivation that therapy can help,
- Establishing an optimal therapeutic alliance,
- Facilitating client awareness of the factors associated with his or her difficulties,
- Encouraging the client to engage in corrective experiences, and
- Emphasizing ongoing reality testing in the client's life.

Although many endorse this effort, at the time of this writing it is still in progress. Consequently, our approach to identifying objectives and interventions consistent with EBPs reflects what has been done from the "principles" approach as well as the research demonstrating the efficacy and effectiveness

of individual models. Perhaps the field will advance enough by the next edition of this planner to include only evidence-based principles of psychotherapeutic change. Until then, we believe that the approach we have taken reflects the current state of the science.

We would also like to note that for those selecting EBT objectives and interventions in their treatment, fidelity to the EBT as it was delivered in the studies demonstrating its efficacy or effectiveness offers the best chance for reproducing its results for your client. A demonstration of this point was witnessed in a recently published meta-analysis examining 12-Step Facilitation Therapy (TSF; Kelly, Humphreys, & Kelly, 2020). The review found that TSF manualized interventions intended to increase Alcoholics Anonymous (AA) participation during and following alcohol use disorder (AUD) treatment lead to enhanced abstinence outcomes compared to other well-established treatments over the next few months and for up to three years. Of note was that fidelity to the TSF treatment model was critical to this outcome as conveyed in this statement by the authors:

> . . . when different types of TSF interventions were tested against each other, the more intensive TSF interventions (e.g. those that include actively prescribing AA participation and ongoing monitoring of AA attendance and related experiences; personal linkages to existing AA members) often worked better at improving drinking-related outcomes than the "'treatment as usual (TAU) TSF"' intervention. This suggests that although many treatment professionals may believe that they "'already do 12-step"' (i.e. implement TSF strategies) because they hand out 12-step literature or mention 12-step groups to patients, this alone may not be sufficient to achieve a superior benefit (Kelly, Humphreys, & Yeterian, 2013). The types of TSF strategies used do matter, and the more intensive strategies, such as those evaluated herein, enhance participation rates and outcomes compared to the more routine 12-step-oriented TAU. Some of these strategies could be clinical linkage to existing members (e.g. Manning, et al. 2012; Timko, Debenedetti, & Billow, 2006), or active prescription of attendance versus leaving it to people to decide for themselves whether they want to attend AA (e.g. Walitzer, Dermen, & Barrick, 2009) (p. 33).

Throughout this *Planner* we cite references and include an appendix of clinical resources, including treatment manuals and books, which describe the how-to of delivering the EBT with high fidelity, and we recommend them for those who share the value of delivering treatment with the intent to maximize the client's outcome.

At the beginning of each chapter, as we launch into the process of offering ideas for treatment interventions for the presenting problem, we have listed one Client Objective along with two associated Therapeutic Interventions

that emphasize the critical nature of a therapeutic relationship. These options were derived from the research on empirically supported relationship factors (e.g. Norcross, 2002) and disseminated most recently in Norcross & Lambert (2018) and Norcoross & Wampold (2018). The relationship factors cited are as follows: *collaboration with the client* regarding the treatment process, agreement on the clear *goals and expectations* of therapy, demonstration of *consistent empathy* toward the client's feelings and struggles, verbalization of *positive regard* toward and *affirmation* of the client, and the collection and delivery of *client feedback* based on the client's appraisal of his/her progress in therapy (Norcross & Lambert, 2018; Norcross & Wampold, 2018). The body of research on relationship factors supports the conclusion that establishing a strong therapeutic relationship is necessary to optimize the treatment outcome. Accordingly, any of the other objectives and interventions that are selected to be included in a client's treatment plan should be integrated into and supported by an effective, foundational therapeutic relationship, and speaks to including this Client Objective and two associated Therapeutic Interventions in every treatment plan.

Each of the chapters in this edition has also been reviewed with the goal of integrating homework exercise options into the interventions. Many of the client homework exercise suggestions were taken from and can be found in the *Addiction Treatment Homework Planner* (Lenz, Finley, & Jongsma, 2014) and the *Adult Psychotherapy Homework Planner* (Jongsma & Bruce, 2014) along with a few from the *Adolescent Psychotherapy Homework Planner* (2014). You will find many more homework assignments suggested in this sixth edition of *The Addiction Treatment Planner* than in previous editions.

The bibliotherapy suggestions listed in Appendix A of this *Planner* have been significantly expanded and updated from previous editions. The appendix includes many recently published offerings as well as more recent editions of books cited in our earlier editions. All of the self-help books and client workbooks cited in the chapter interventions are listed in this appendix. There are also many additional books listed that are supportive of the treatment approaches described in the respective chapters. Each chapter has a list of self-help books consistent with it listed in this appendix.

In its final report entitled *Achieving the Promise: Transforming Mental Health Care in America*, the president's New Freedom Commission on Mental Health called for recovery to be the "common, recognized outcome of mental health services" (New Freedom Commission on Mental Health, 2003). To define recovery, SAMHSA within the US Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation (SAMHSA, 2004). Over 110 expert panelists participated, including mental health consumers, family members, providers, advocates, researchers, academicians, managed care representatives, accreditation bodies, state and local

public officials, and others. From these deliberations, the following consensus statement was derived:

Mental health recovery is a journey of healing and transformation for a person with a mental health problem to be able to live a meaningful life in a community of his or her choice while striving to achieve maximum human potential. Recovery is a multifaceted concept based on the following 10 fundamental elements and guiding principles:

- Self-direction
- Individualized and person-centered
- Empowerment
- Holistic
- Nonlinear
- Strengths-based
- Peer support
- Respect
- Responsibility
- Hope

These recovery model principles are defined in Appendix C. We have also created a set of Goal, Objective, and Intervention statements that reflect these 10 principles. The clinician who desires to insert into the client treatment plan specific statements reflecting a Recovery Model orientation may choose from this list.

In addition to this list, we believe that many of the Goal, Objective, and Intervention statements found in the chapters reflect a recovery orientation. For example, our assessment interventions are meant to identify how the problem affects this unique client and the strengths that the client brings to the treatment. In addition, an intervention statement such as, "Help the client to see the new hope that addiction treatment brings to the resolution of interpersonal conflicts" from the "Suicidal Ideation" chapter is evidence that recovery model content, such as the principle of hope, permeates items listed throughout our chapters. However, if the clinician desires a more focused set of statements directly related to each principle guiding the recovery model, they can be found in Appendix B.

We have done a bit of reorganizing of chapter content for this edition. We have renamed the "Unipolar Depression" chapter to become "Depression – Unipolar." A new chapter entitled "Opioid Use Disorder" is returned as a separate chapter due to the epidemic use of this drug that is sweeping the country. "Opioids were involved in 46,802 overdose deaths in 2018 (69.5% of all drug overdose deaths). Two out of three (67.0%) opioid-involved overdose deaths involve synthetic opioids." (Hedegaard, Miniño, & Warner, 2020; Wilson, Kariisa, Seth, Smith, & Davis, 2020). In recognition of the seriousness of this societal problem we have created a chapter to address this issue.

We have updated the Diagnostic Suggestions section at the end of each chapter by deleting all references to DSM-IV and ICD-9. Since the date for

mandatory use of *DSM-5 (ICD-10-CM)* codes and labels for billing purposes was October 2014, we have removed the transitional content of DSM-IV.

At the end of each chapter's list of objectives and interventions there is a reference to administration of a client satisfaction survey. Appendix D contains resource material for examples of various types of satisfaction assessment instruments.

Lastly, some clinicians have asked that the objective statements in this *Planner* be written such that the client's attainment of the objective can be measured. We have written our objectives in behavioral terms and many are measurable as written. For example, this objective from the "Anxiety" chapter is one that is measurable as written because it either can be done or it cannot: "Verbalize an understanding of the cognitive, physiological, and behavioral components of anxiety and its treatment." But at times the statements are too broad to be considered measurable. Consider, for example, this objective from the "Anxiety" chapter: "Identify, challenge, and replace biased, fearful self-talk with positive, realistic, and empowering self-talk." To make it quantifiable a clinician might modify it to read, "Give two examples of identifying, challenging, and replacing biased, fearful self-talk with positive, realistic, and empowering self-talk." Clearly, the use of two examples is arbitrary, but it does allow for a quantifiable measurement of the attainment of the objective. Or consider this example reflecting a behavioral activation objective: "Identify and engage in pleasant activities on a daily basis." To make it more measurable the clinician might simply add a desired target number of pleasant activities, thus: "Identify and report engagement in two pleasant activities on a daily basis." The exact target number that the client is to attain is subjective and should be selected by the individual clinician in consultation with the client. Once the exact target number is determined, then our content can be very easily modified to fit the specific treatment situation. For more information on psychotherapy treatment plan writing, see Jongsma (2005).

We hope you find these improvements to this sixth edition of the *Planner* useful to your treatment planning needs.

## HOW TO USE THIS TREATMENT PLANNER

Use this *Treatment Planner* to write treatment plans according to the following progression of six steps:

1. **Problem Selection.** Although the client may discuss a variety of issues during the assessment, the clinician must determine the most significant problems on which to focus the treatment process. Usually a primary problem will surface, and secondary problems may also be evident. Some other problems may have to be set aside as not urgent enough to require treatment at this time. An effective treatment plan can only deal with a few selected problems or treatment will lose its direction. Choose the

problem within this *Planner* that most accurately represents your client's presenting issues.

2. **Problem Definition.** Each client presents with unique nuances as to how a problem behaviorally reveals itself in his or her life. Therefore, each problem that is selected for treatment focus requires a specific definition about how it is evidenced in the particular client. The symptom pattern should be associated with diagnostic criteria and codes such as those found in the *DSM-IV-TR* or the International Classification of Diseases. This *Planner* offers such behaviorally specific definition statements to choose from or to serve as a model for your own personally crafted statements.
3. **Goal Development.** The next step in developing your treatment plan is to set broad goals for the resolution of the target problem. These statements need not be crafted in measurable terms but can be global, long-term goals that indicate a desired positive outcome to the treatment procedures. This *Planner* provides several possible goal statements for each problem, but one statement is all that is required in a treatment plan.
4. **Objective Construction.** In contrast to long-term goals, objectives must be stated in behaviorally measurable language so that it is clear to review agencies, health maintenance organizations, and managed care organizations when the client has achieved the established objectives. The objectives presented in this *Planner* are designed to meet this demand for accountability. Numerous alternatives are presented to allow construction of a variety of treatment plan possibilities for the same presenting problem.
5. **Intervention Creation.** Interventions are the actions of the clinician designed to help the client complete the objectives. There should be at least one intervention for every objective. If the client does not accomplish the objective after the initial intervention, new interventions should be added to the plan. Interventions should be selected on the basis of the client's needs and the treatment provider's full therapeutic repertoire. This *Planner* contains interventions from a broad range of therapeutic approaches, and we encourage the provider to write other interventions reflecting his or her own training and experience.

   Some suggested interventions listed in the *Planner* refer to specific books that can be assigned to the client for adjunctive bibliotherapy. Appendix A contains a full bibliographic reference list of these materials. Many references to homework interventions are found in each chapter. The sources for these assignments can be found in the books listed in the general references at the beginning of Appendix A. For further information about self-help books, mental health professionals may wish to consult *Self-Help That Works: Resources to Improve Emotional Health and Strengthen Relationships* (Norcross et al., 2013).
6. **Diagnosis Determination.** The determination of an appropriate diagnosis is based on an evaluation of the client's complete clinical presentation. The clinician must compare the behavioral, cognitive, emotional, and interpersonal symptoms that the client presents with the criteria for diagnosis of a

mental illness condition as described in *DSM-IV-TR*. Despite arguments made against diagnosing clients in this manner, diagnosis is a reality that exists in the world of mental health care, and it is a necessity for third-party reimbursement. It is the clinician's thorough knowledge of *DSM-IV-TR* criteria and a complete understanding of the client assessment data that contribute to the most reliable, valid diagnosis.

Congratulations! After completing these six steps, you should have a comprehensive and individualized treatment plan ready for immediate implementation and presentation to the client. A sample treatment plan for Substance Use is provided at the end of this introduction.

## A FINAL NOTE ON TAILORING THE TREATMENT PLAN TO THE CLIENT

One important aspect of effective treatment planning is that each plan should be tailored to the individual client's problems and needs. Treatment plans should not be mass-produced, even if clients have similar problems. The individual's strengths and weaknesses, unique stressors, social network, family circumstances, and symptom patterns must be considered in developing a treatment strategy. Drawing upon our own years of clinical experience, we have put together a variety of treatment choices. These statements can be combined in thousands of permutations to develop detailed treatment plans. Relying on their own good judgment, clinicians can easily select the statements that are appropriate for the individuals whom they are treating. In addition, we encourage readers to add their own definitions, goals, objectives, and interventions to the existing samples. As with all of the books in the *Treatment Planners* series, it is our hope that this book will help promote effective, creative treatment planning—a process that will ultimately benefit the client, clinicians, and mental health community.

## REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5). Author.

American Psychiatric Association. (2020) *American Psychiatric Association practice guidelines*. American Psychiatric Association [Online]. Available from http://psychiatryonline.org/guidelines.aspx.

American Psychological Association. (2020) *APA clinical practice guidelines*. American Psychological Association [Online]. Available from https://www.apa.org/about/offices/directorates/guidelines/clinical-practice.

American Psychological Association Division 12: Society of Clinical Psychology. (2016) American Psychological Association division 12 website on research-supported psychological treatments [Online]. Available from https://www.div12.org/treatments/.

American Psychological Association Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, 61(4), 271–185.

Bohart, A., & Tallman, K. (1999). *How clients make therapy work: The process of active self-healing*. American Psychological Association.

Cochrane Collaboration Reviews [Online]. Accessed on June 5, 2020. Available from http://www.cochrane.org.

David, D., Lynn, S. J., & Montgomery, G. H. (Eds.). (2018). *Evidence-based psychotherapy: The state of the science and practice*. Wiley.

Dimidjian, S. (Ed.) (2019). *Evidence-based practice in action*. Guilford Press.

Finley, J., & Lenz, B. (2014). *Addiction treatment homework planner*. Wiley.

Goldfried, M. R. (2019). Obtaining consensus in psychotherapy: What holds us back? *American Psychologist,* 74(4), 484–496.

Hedegaard, H., Miniño, A. M., & Warner, M. (2020). *Drug overdose deaths in the United States, 1999–2018*. National Center for Health Statistics.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. National Academies Press Available from http://www.iom.edu/Reports.aspx?sort=alpha&page=15

Jongsma, A. E. (2005). Psychotherapy treatment plan writing. In G. P. Koocher, J. C. Norcross, & S. S. Hill (Eds.), *Psychologists' desk reference* (2, pp. 232–236). Oxford University Press.

Jongsma, A. E. & Bruce, T. J. (2014). *Adult psychotherapy homework planner* (5). Wiley.

Jongsma, A. E., & Bruce, T. J. (2010–2012). *The evidence-based psychotherapy treatment planning* DVD-based series. Wiley. Available from http://www.Wiley.com/go/ebtdvds

Jongsma, A., Peterson, M., McInnis, W. P., & Bruce, T. J. (2014). *Adolescent psychotherapy homework planner*. Wiley.

Kelly J. F., Humphreys, K., & Ferri, M. (2020). Alcoholics anonymous and other 12-step programs for alcohol use disorder. *Cochrane Database of Systematic Reviews,* 3, CD012880.

Kelly, J. F., Humphreys, K., & Yeterian, J. (2013). Mutual-help groups. In M. Herie & W.J.W. Skinner (Eds.), *Fundamentals of addiction: A practical guide for counsellors* (pp. 321–348). Centre on Addiction and Mental Health, 2013: 321–48.

Manning, V., Best, D., Faulkner, N., Titherington, E., Morinan, A., Keaney, F., et al. (2012). Does active referral by a doctor or 12-step peer improve 12-step meeting attendance? Results from a pilot randomised control trial. *Drug and Alcohol Dependence,* 126, 131–137.

Nathan, P. E., & Gorman, J. M. (Eds.). (2015). *A guide to treatments that work* (4). Oxford University Press

New Freedom Commission on Mental Health. (2003). Achieving the promise: Transforming mental health care in America (Final report. DHHS Publication No. SMA-03-3832). Rockville, MD: Author. Available from http://govinfo.library.unt.edu/mentalhealthcommission/reports/reports.htm

National Institute on Drug Abuse [Online]. Accessed on June 5, 2020. Available from https://www.drugabuse.gov

National Institute for Health and Clinical Excellence (NICE) (2020) [Online]. Available from www.nice.org.uk.

Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patient needs*. New York, NY: Oxford University Press.

Norcross, J. C. (Ed.). (2019). *Psychotherapy relationships that work* (3). Oxford University Press.

Norcross, J., Campbell, L., Grohol, J., Santrock, J., Selegea, F., & Sommer, R. (2013). *Self-help that works: Resources to improve emotional health and strengthen relationships*. Oxford University Press.

Norcross, J. C., Hogan, T. P., & Koocher, G. P., & Maggio, L. A. (2017). *Clinician's guide to evidence-based practices: Behavioral health and the addictions*. Oxford University Press

Norcross, J. C. & Lambert, M. J. (2018). Psychotherapy relationships that work III. *Psychotherapy,* 55(4), 303–315. 10.1037/pst0000193

Norcross, J. C. & Wampold, B. E. (eds.) (2018). Psychotherapy relationships that work III. *Psychotherapy,* 55(4), 303–315. 10.1037/pst0000193

Substance Abuse and Mental Health Services Administration's (SAMHSA) National Mental Health Information Center: Center for Mental Health Services (2004). *National consensus statement on mental health recovery*. Author Available from http://www.westga.edu/~vickir/MentalHealth/MH01%20Intro-duction/10%20Fundamental%20Components.pdf

Timko, C., Debenedetti, A., & Billow, R. (2006). Intensive referral to 12step self-help groups and 6-month substance use disorder outcomes. *Addiction,* 101(5), 678–688.

Walitzer, K. S., Dermen, K. H., & Barrick, C. (2009). Facilitating involvement in alcoholics anonymous during out-patient treatment: A randomized clinical trial. *Addiction,* 104(3), 391–401.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Erlbaum.

Wilson, N., Kariisa, M., & Seth, P., Smith, H., & Davis, N. L. (2020). Drug and opioid-involved overdose deaths—United States, 2017-2018. *Morbidity and Mortality Weekly Review,* 69, 290–297.

# SAMPLE TREATMENT PLAN

## 1. SUBSTANCE USE DISORDER

**Definitions:**
Consistently uses alcohol or other mood-altering drugs until high, intoxicated, or passed out.
Unable to stop or cut down use of mood-altering drug once started, despite the verbalized desire to do so and the negative consequences continued use brings.
Denies that chemical dependence is a problem, despite feedback from significant others that the use of the substance is negatively affecting him/her/them and others.
Continues substance use despite knowledge of experiencing persistent physical, legal, financial, vocational, social, and/or relationship problems that are directly caused by the use of the substance.
Exhibits physical withdrawal symptoms (e.g. shaking, seizures, nausea, headaches, sweating, anxiety, insomnia, depression) when going without the substance for any length of time.
Suspends important social, recreational, or occupational activities because they interfere with using the mood-altering drug.

**Goals:**
Establish and maintain total abstinence, while increasing knowledge of the disease and the process of recovery.
Acquire the necessary 12-step skills and/or other skills to maintain long-term sobriety from all mood-altering substances and live a life free of substance abuse.

### OBJECTIVES

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allows. (1, 2)

### INTERVENTIONS

1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward he/she/they feeling safe to discuss his/her/their substance use and its impact on his/her/their life.

| | |
|---|---|
| | 2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: work *collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of his/her/their progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert & *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). |
| 2. Describe the type, amount, frequency, and history of substance abuse. (1) | 1. Gather a complete drug/alcohol history from the client, including the amount and pattern of his/her/their use, signs and symptoms of use, and negative life consequences (e.g. social, legal, familial, and vocational problems). |
| 3. Participate in a medical evaluation to assess medical health and the medical consequences of substance use. (1) | 1. Refer the client for a thorough physical examination to determine any physical/medical consequences of chemical dependence (include tests for HIV, hepatitis, and sexually transmitted diseases, if warranted). |
| 4. Explore and resolve ambivalence about entering treatment and changing substance use behavior. (1, 2, 3) | 1. Use the nondirective, client-centered, empathic style derived from motivational enhancement therapy (or supplement with "Assessing Readiness and Motivation" in the *Addiction Treatment Homework Planner* by Lenz, Finley, & Jongsma); explore the client's motivation for change and whether he/she/they are ready to take active steps or would benefit from continued motivational interviewing (see *Motivational Interviewing* by Miller & Rollnick; *Motivational Interviewing and Enhancement* by DiClemente, Van Orden, & Wright). |