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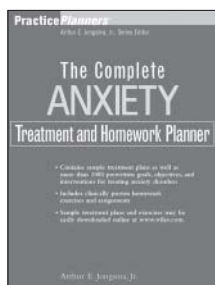
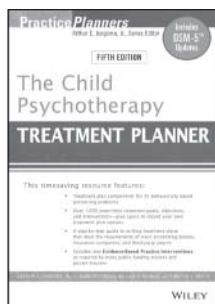
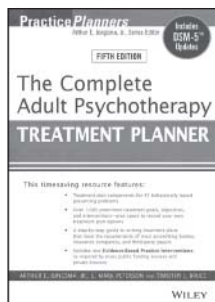
DEBORAH W. FRAZER, GREGORY A. HINRICHSSEN, AND ARTHUR E. JONGSMA, JR.

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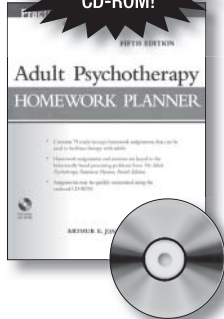
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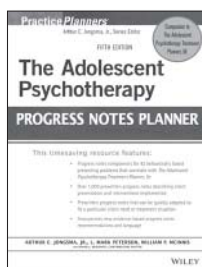
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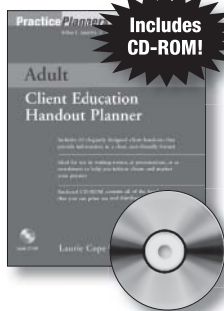
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Arthur E. Jongsma, Jr., Series Editor

The Older Adult
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with DSM-5 Updates
Second Edition

Deborah W. Frazer

Gregory A. Hinrichsen

Arthur E. Jongsma, Jr.

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Published by John Wiley & Sons, Inc., Hoboken, New Jersey.
Published simultaneously in Canada.

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Library of Congress Cataloging-in-Publication Data:

Frazer, Deborah W. (Deborah Willets), author.

The older adult psychotherapy treatment planner / by Deborah W. Frazer, Gregory A. Hinrichsen, Arthur E. Jongsma Jr.—Second Edition.

p. ; cm.—(PracticePlanners series)

Includes bibliographical references and index.

ISBN 978-1-119-06311-7 (pbk. : alk. paper)

ISBN 978-1-119-06415-2 (eMobi)

ISBN 978-1-119-06387-2 (ePub)

ISBN 978-1-119-06410-7 (ePDF)

1. Geriatric psychotherapy. 2. Psychotherapy for older people. 3. Mental illness—Treatment—Planning.
I. Hinrichsen, Gregory A., 1951—author. II. Jongsma, Arthur E., Jr., 1943—author. III. Title.
IV. Series: Practice planners.

[DNLM: 1. Geriatric Psychiatry—organization & administration. 2. Patient Care Planning. 3. Aged.
4. Mental Disorders—therapy. 5. Psychotherapy—methods. WT 150]

RC451.4.A5F755 2011

618.97689—dc22

2010048920

Printed in the United States of America

10 9 8 7 6 5 4 3 2 1

*In loving memory of my parents, Ann Willets Lapham Frazer
and Evan Wayne Frazer*

—D.W.F.

*To Dan, Sue, Mark, Mike, and C.J. —
We see Lake Ripley*

—G.A.H.

To the Older Adults who have given so much rich meaning to my life:
*Mom (Harmina), Dad (Arthur), Father-in-law (Frank),
and Mother-in-law (Evelyn)*

—A.E.J.

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^{EB} ▽ Indicates that selected Objective/Interventions are consistent with those found in evidence-based treatments.

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PRACTICEPLANNERS® 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 PracticePlanners® series are designed to help practitioners fulfill these documentation requirements efficiently and professionally.

The PracticePlanners® series includes a wide array of treatment planning books including not only the original *Complete Adult Psychotherapy Treatment Planner*, *Child Psychotherapy Treatment Planner*, and *Adolescent Psychotherapy Treatment Planner*, all now in their fifth editions, but also *Treatment Planners* targeted to specialty areas of practice, including:

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- College students
- Couples therapy
- Crisis counseling
- Early childhood education
- Employee assistance
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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, substance use, anger control problems, 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 adjunctive books, such as *The Psychotherapy Documentation Primer* and *The Clinical Documentation Sourcebook*, containing forms and resources to aid the clinician in mental health practice management.

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

ACKNOWLEDGMENTS

I want to thank the many individuals who were so important in the development and revision of this book. First, of course, are all the patients and staff who taught me so much through the years of our work together. Powell Lawton, mentor extraordinaire, provided a broad conceptual framework for all the disparate clinical experiences, as well as inspiration and warmth rarely found in the work world. Co-author and friend Greg Hinrichsen has provided breadth and depth to the original work with his cutting-edge revisions. My husband and son, Jack and Nicholas Malinowski, have been extremely supportive throughout my career, even when projects such as this meant precious time away from them.

—DEBORAH WILLETS FRAZER, PH.D.

I've been especially fortunate to have a professional career in clinical geropsychology that has yielded so many rewards. I've been privileged to share in the lives of older clients who have nourished my humanity. My geropsychology colleagues are some of the finest people I have met and with whom I've formed a professional community and many enduring friendships. Conducting research on older adults continues to pique my intellectual curiosity and deepen my appreciation of the diversity and complexity of older adulthood. Work in the public policy and aging arena has enhanced my understanding of how the welfare of all of America's citizens is interwoven across the generations.

My mother, Katherine Berndt Hinrichsen, was a model of how to live the later years with honesty about the challenges of aging and with delight in its unique blessings. She spent the last year of her life in a nursing home. In my view, the last year of her life was the best year of her life since in that nursing home she evidenced her finest qualities—compassion, intuition, and candor. After her death, my siblings—Dan, Sue, Mark, Mike, and C.J.—gathered at a favored place of our childhood, Lake Ripley in Wisconsin. During that gathering, we saw more clearly than ever how her life reflected in each of our lives and in those of our children.

—GREGORY A. HINRICHSEN, PH.D.

As we have launched into the empirically based treatment (EST) revision of many of our *Treatment Planner* books, I have had the privilege of working with several psychologists who epitomize the best of the Boulder model of clinician-scientist. Dr. Greg Hinrichsen is one of those rare folks who is a compassionate, expert clinician but also a well-informed researcher. He brings that expertise to bear on this new edition of the *Older Adult Psychotherapy Treatment Planner*. New evidence-based objectives and interventions have been added and existing items have also been highlighted in this new edition. We are indebted to Greg for his highly professional work, which has added value to this book. Deb Frazer created a very sound book in its original edition and now Dr. Hinrichsen has built upon that foundation to add new and highlight existing EST content throughout the manuscript. Thank you, Deb, for your quality original work and Greg for your expert scientist-clinician contribution.

I also want to recognize the thoroughly professional work done by Sue Rhoda, our manuscript manager. She is consistently alert to organizing the myriad details before a manuscript can be submitted to a publisher. Thank you, Sue!

Finally, our thanks to the great editorial, production, marketing and sales team at John Wiley & Sons, as they provide all the publishing skill one could want. You are the best!

—ARTHUR E. JONGSMA, JR., PH.D.

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INTRODUCTION

ABOUT PRACTICEPLANNERS® TREATMENT PLANNERS

Pressure from third-party payors, 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 payors 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 *DSM-5* diagnosis.

As with the rest of the books in the *PracticePlanners®* 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 OLDER ADULT PSYCHOTHERAPY TREATMENT PLANNER

This second edition of the *Older Adult Psychotherapy Treatment Planner* comes 12 years after publication of the first edition. This revision includes 30 chapters covering a range of problems often encountered in clinical practice with older adults. Notably, the book includes designation of select short-term objectives and therapeutic interventions which are evidence based. All chapters have been revised and updated and two new chapters have been added.

2 THE OLDER ADULT PSYCHOTHERAPY TREATMENT PLANNER

In the field of psychology, clinical geropsychology has grown slowly but steadily since 1981 when the first conference on training for applied geropsychology was convened in Boulder, Colorado (known as the “Older Boulder” conference; Santos & Vandenbos, 1982). Since that time there have been substantive professional developments: Psychologists were named as providers under Medicare; a Committee on Aging and its companion Office on Aging were established at the American Psychological Association (APA); APA’s Division 12, Section II (Society of Clinical Geropsychology) was founded and has flourished; Psychologists in Long-Term Care was formed; and most recently the Council of Professional Geropsychology Training Programs was established to promote high quality geropsychology training. There have been other notable developments. Two aging training conferences followed the Older Boulder Conference, the most recent of which was held in Colorado Springs, Colorado in 2006. From this gathering emerged the Pikes Peak Model for Geropsychology Training which offers a framework for acquiring attitudes, knowledge, and skills critical to the provision of psychological services to older adults (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009). APA adopted *Guidelines for Psychological Practice with Older Adults* in 2004 (APA, 2004), recognized Clinical Geropsychology as a proficiency in 1998, and in 2010 APA recognized Professional Geropsychology as a specialty. There have been parallel geriatric-relevant developments in the other core mental health disciplines of social work, nursing, and psychiatry.


In tandem with these professional developments has been the growth of the population of older adults, typically defined as individuals 65 years of age and older. The first members of the so-called “baby boom” generation will begin to turn 65 years of age in 2011, and by the year 2030 over 20% of the U.S. population will be older people (Federal Interagency Forum on Aging-Related Statistics, 2004). It is unfortunate that very few students are exposed to aging issues in graduate professional schools since many—if not most—of now emerging mental health professionals will be seeing older adults in clinical practice. In fact, a recent report from the Institute on Medicine raised serious concerns about how the physical health and mental health work forces will serve the needs of the soon to bloom population of older adults (Institute of Medicine, 2008). The reason older adults will be part of future clinical practice for many is their sheer numbers: There are 76 million members of the baby boom age cohort. Further, it is expected that older adults in the coming years will be more interested in accessing psychotherapeutic services than their parents’ generation when they were older people. But the future is upon us already. A survey of APA members found that over two-thirds of practicing psychologists already see at least a few older adults in clinical practice (Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002).

In view of these developments, we believe the *Older Adult Psychotherapy Treatment Planner* offers a practical, up-to-date, research informed set of behavioral definitions, long-term goals, short-term goals, therapeutic

interventions, and diagnostic considerations that will be helpful for the practitioner who is just beginning to see a few older clients in clinical practice as well as the mental health professional who has devoted his/her career to serving older adults. Readers of this book should also consider many excellent texts in the field of aging including those in gerontology, geriatric mental health, and psychotherapy with older adults. Other relevant resources include professional guidelines and consensus statements on mental health practice with older people.

INCORPORATING EVIDENCE-BASED TREATMENT INTO THE *TREATMENT PLANNER*

Evidence-based or empirically supported treatment (that is, treatment that has shown efficacy in research trials) is rapidly becoming of critical importance to the mental health community as the demand for quality and accountability increase. Indeed, identified empirically supported treatments (e.g., those of the APA Division 12 [Society of Clinical Psychology], the Substance Abuse and Mental Health Services Administration's [SAMHSA] National Registry of Evidence-based Programs and Practices [NREPP]) are being referenced by a number of local, state, and federal funding agencies, some of which are beginning to restrict reimbursement for these treatments, as are some managed care and insurance companies.

In this second edition of *The Older Adult Psychotherapy Treatment Planner*, we have made an effort to empirically inform many chapters by highlighting Short-Term Objectives (STOs) and Therapeutic Interventions (TIs) that are consistent with psychological treatments or therapeutic programs that have demonstrated some level of efficacy through empirical study. Watch for this icon () as an indication that an Objective/Intervention is consistent with those found in evidence-based treatments (EBT).

References to the empirical work supporting these interventions have been included in the reference section as Appendix B. For information related to the identification of evidence-based practices (EBPs), including the benefits and limitations of the effort, we suggest the APA Presidential Task Force on Evidence-Based Practice (2006); Bruce and Sanderson (2005); Chambless et al. (1996, 1998); Chambless and Ollendick (2001); Castonguay and Beutler (2006); Drake, Merrens, and Lynde (2005); Hofmann and Thompson (2002); and Nathan and Gorman (2007).

Criteria for Inclusion of Evidence-Based Therapies

The EBTs from which STOs and TIs were taken have different levels of empirical evidence supporting them. For example, some have been well

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established as efficacious for the problems that they target (e.g., exposure-based therapies for anxiety disorders). Others have less support, but nonetheless have demonstrated efficacy. We have included EBP the empirical support for which has either been well established or demonstrated at more than a preliminary level as defined by those authors who have undertaken the task of identifying them, such as the APA Division 12 (Society of Clinical Psychology); Drake and colleagues (2003, 2005); Chambless and colleagues (1996, 1998); and Nathan and Gorman (2007).

At minimum, efficacy needed to be demonstrated through a clinical trial or large clinical replication series with features reflecting good experimental design (e.g., random assignment, blind assignments, reliable and valid measurement, clear inclusion and exclusion criteria, state-of-the-art diagnostic methods, and adequate sample size or replications). Well-established EBTs typically have more than one of these types of studies demonstrating their efficacy, as well as other desirable features such as demonstration of efficacy by independent research groups and specification of client characteristics for which the treatment was effective.

Our designation of evidence-based STOs and TIs for this *Planner* was also informed by several bodies of work. First, we were guided by a series of evidenced-based reviews that were published recently by a group of geropsychologists who utilized Division 12 criteria for designation of evidence-based treatments for the most common problems encountered in clinical practice with older adults: anxiety, caregiver distress, depression, disruptive behaviors of dementia, and sleep disturbance (Yon & Scogin, 2007). The body of psychotherapy research on older adults is much smaller than that for studies of mixed-age adults, reflecting the relative youth of the field of psychotherapy and aging. Therefore, we had a smaller number of aging relevant problem areas for which there was solid evidence in psychotherapy studies that only included older adults compared to studies of mixed-aged adults. Nonetheless, most psychotherapeutic modalities developed for adults appear to be useful for older adults (APA Working Group on the Older Adults, 1998). Therefore, for other problem areas in this *Planner* we drew on the adult psychotherapy research literature to designate evidenced-based STOs and TIs that were likely effective in older adults. Some chapters were adapted from *The Complete Adult Psychotherapy Treatment Planner* (and are so footnoted). Over half of the chapters in this *Planner* contain evidence-based STOs and TIs.

Beyond references to the empirical studies supporting these interventions, we have provided some references to therapist- and client-oriented books and treatment manuals that describe the use of identified EBTs or treatments consistent with their objectives and interventions. Of course, recognizing that there are STOs and TIs that practicing clinicians have found useful but that have not yet received empirical scrutiny, we have included those that reflect common best practice among experienced clinicians. The goal is to provide a range of treatment plan options, some

studied empirically, others reflecting common clinical practice, so the user can construct what he or she believes to be the best plan for a particular client. Most of the STOs and TIs associated with the EBTs are described at a level of detail that permits flexibility and adaptability in their specific application. As with all *Planners* in this series, each chapter includes the option to add STOs and TIs at the therapist's discretion.

Lastly, all interventions, empirically supported or not, must be adapted to the particular client in light of his/her personal circumstances, cultural identity, strengths, and vulnerabilities. The STOs and TIs included in this *Planner* are written in a manner to suggest and allow for this adaptability.

Summary of Required and Preferred EBT Inclusion Criteria

Required

- Demonstration of efficacy through at least one randomized controlled trial with good experimental design, or
- Demonstration of efficacy through a large, well-designed clinical replication series.

Preferred

- Efficacy has been shown by more than one study.
- Efficacy has been demonstrated by independent research groups.
- Client characteristics for which the treatment was effective were specified.
- A clear description of the treatment was available.

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* which most accurately represents your client's presenting issues.

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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-5* 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. For further information about self-help books, mental health professionals may wish to consult *The Authoritative Guide to Self-Help Resources in Mental Health, Revised Edition* (2003) by Norcross et al. (available from Guilford Press, New York).

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-5*. 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-5* 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 anger management 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 older client's problems and needs. The gerontology research literature clearly underscores the great diversity among older adults. 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, objects, 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.

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SAMPLE TREATMENT PLAN

PRIMARY PROBLEM: DEPRESSION

- Definitions:
- Feeling sad, empty, or irritable much of the time.
Loss of interest or pleasure in many usual activities.
Vegetative symptoms including sleep disturbance, appetite disturbance, weight change, observable motor agitation, or retardation.
Poor concentration, indecisiveness, impaired memory, or other cognitive symptoms.
Fatigue or loss of energy.
Difficulty functioning in daily life such as not completing home-based tasks or not socially engaging with others.
- Goals:
- Reduce or eliminate vegetative symptoms of depression.
Increase ability to function in daily life and socially engage with others.
Increase feelings of vitality and zest.
Learn to identify the early warning signs of a depressed mood and the preventive actions to take.

OBJECTIVES

1. Consent to participate in evaluation and treatment.
2. Verbalize in detail depression-related concerns.
3. Complete a self-report assessment to evaluate the severity of depression.
4. Identify whether the symptoms of depression seem to be primarily related to interpersonal relationships, stressful life events

INTERVENTIONS

1. Obtain consent to evaluate and treat, including consent to discuss issues with physician(s) and family/staff, as needed.
1. Ask the client to identify specific problems with mood, behavior, thoughts/beliefs, life events, interpersonal issues, and physical health.
1. Administer the Geriatric Depression Scale (Yesavage et al., 1983), the CES-D (Radloff, 1977), or other measure of depression severity.
1. Assist the client with identifying the primary factors in his/her depression (e.g., disturbed interpersonal functioning, inadequate

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or circumstances, thoughts/
beliefs, or behaviors.

problem-solving of stressful life
events or circumstances,
distorted thoughts/beliefs, self-
defeating behaviors). ▽

▽ 5. Cooperate with evaluation and
treatment of medical causes of
depression.

1. Refer the client to a physician
or other medical provider for an
evaluation of his/her medical
condition and medications
(prescribed and over-the-counter)
that could be contributing to
his/her depression. ▽

▽ 6. Cooperate with psychiatric
evaluation and pharmacological
treatment if depression warrants
such intervention.

1. Refer the client to a medication
prescriber (preferably a geriatric
psychiatrist) for an evaluation
and pharmacological treatment
if his/her depression warrants
this. ▽









2. Discuss with the client the results
of the psychiatric evaluation by
the psychiatrist or other
prescriber; support and help
monitor the plan to treat the
client's depression
pharmacologically. ▽

▽ 7. Keep a daily record of mood
rating from 1 to 10, noting
associated behaviors, activities,
events, people, and thoughts.

1. Develop a chart and assign the
client to record daily mood
ratings (from 1 to 10), and
record the associated situations,
events, people, thoughts, and
behaviors (or assign "Journal of
Distorted, Negative Thoughts"
in the *Adult Psychotherapy
Homework Planner*, 2nd ed. by
Jongsma). ▽

▽ 8. Replace depression-promoting
thoughts with mood-elevating
thoughts.

1. Gently confront unrealistic
thinking by suggesting
alternative, logical, positive
thoughts; use role-playing,
modeling, and behavioral
rehearsal to have the client
practice formulating alternative
thoughts in hypothetical
situations. ▽

2. Instruct the client to make a list of all of his/her own negative, self-defeating thoughts; assist the client in replacing each thought with self-enhancing self-talk (see “Positive Self-Talk” in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma). 
-  9. Identify specific events/activities that elevate or depress mood.
-  10. Systematically increase pleasant events and decrease unpleasant events in daily life.
1. Help determine which current activities in daily life the client considers pleasant and which he/she considers unpleasant. 
2. Teach the client how behavior and mood are related: unpleasant events (or an absence of pleasant events) are associated with low mood; pleasant events are associated with better mood. 
1. Teach the client that his/her mood can be improved by increasing pleasant events and decreasing unpleasant events. 
2. Encourage the client to identify pleasant events that are desirable, but not currently part of a daily routine (see “Identify and Schedule Pleasant Activities” in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma). 
3. Develop a one-week daily schedule with the client that increases pleasant events and decreases unpleasant events, making sure to have at least one pleasant event every day. 
4. Monitor activities/events and mood through discussion of daily mood/behavior recordings; problem-solve and adjust as necessary. 