ALCOHOL ABUSE/DEPENDENCE

BEHAVIORAL DEFINITIONS

1. Consistent use of alcohol until high, intoxicated, or passed out.
2. Inability to stop or cut down use of alcohol once started, despite the verbalized desire to do so and the negative consequences continued use brings.
3. Blood work that reflects the results of a pattern of heavy alcohol use—for example, elevated liver enzymes.
4. Denial that alcohol use is a problem despite direct feedback from spouse, relatives, friends, and employers that the use of alcohol is negatively affecting them and others.
5. Occurrence of amnesiac blackouts when abusing alcohol.
6. Continued alcohol use despite experiencing persistent or recurring physical, legal, vocational, social, or relationship problems that are directly caused by the use of alcohol.
7. Increased tolerance for alcohol as there is the need to use more to become intoxicated or to attain the desired effect.
8. Physical symptoms—that is, shaking, seizures, nausea, headaches, sweating, anxiety, insomnia, and/or depression—when withdrawing from alcohol.
9. Suspension of important social, recreational, or occupational activities because they interfere with consuming alcohol.
10. Large time investment in activities to obtain alcohol, to use it, or to recover from its effects.
11. Consumption of alcohol in greater amounts and for longer periods than intended.
12. Continued use of alcohol after being told by a physician that it is causing health problems.
13. Expression of worry by loved ones that the client is drinking excessively.
14. Aggressive, abusive, or violent behavior when drinking alcohol.
15. Neglect of family obligations due to alcohol abuse.

16. Neglect of responsibilities at work or at school because of drinking alcohol.
17. Expression of fear of the client by loved ones when he/she is drinking excessively.
18. Poor health, low self-esteem, unemployment, broken relationships, and financial stress as a result of chronic alcohol dependence.
19. Homelessness, depression, and social isolation as a result of chronic alcohol dependence.

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LONG-TERM GOALS

1. Accept chemical dependence and begin to actively participate in a recovery program.
2. Withdraw from alcohol, stabilize physically and emotionally, and then establish a supportive recovery plan.
3. Improve quality of life by maintaining an ongoing abstinence from all mood-altering chemicals.
4. Reduce drinking to a level at which school or work are not negatively impacted.
5. Reduce drinking to a level at which loved ones are not negatively impacted.
6. Maintain alcohol consumption at an acceptable level.

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SHORT-TERM OBJECTIVES

1. Describe the details regarding the nature, extent, and frequency of alcohol consumption. (1)
2. Participate in medical examination to assess the consequences of alcohol abuse. (2)
3. Obtain ongoing recommended medical care. (3, 4)
4. Obtain information regarding negative nutritional consequences of chronic alcohol abuse and current nutritional rehabilitation needs. (5)
5. Describe the negative consequences of alcohol abuse to self and loved ones. (1, 6, 7)
6. Verbalize an increased understanding of the physical and psychological effects of alcohol abuse. (8, 9)
7. Accept referral for further assessment of alcohol abuse. (10)
8. Participate in alcohol counseling and treatment. (11)
9. Attend Alcoholics Anonymous (AA) meetings on a frequent and consistent basis. (12, 13)
10. List sources of stress and pressure that provide the impetus for escape into alcohol abuse. (14)

THERAPEUTIC INTERVENTIONS

1. Convey a warm, nonjudgmental approach when eliciting information from the client regarding his/her history of alcohol abuse.
2. Refer the client to a physician for examination of the medical consequences of the alcohol abuse.
3. Obtain written confidentiality release from the client to allow for contract with the evaluating professional to share information regarding the abuse and obtain the results and recommendations of the evaluation.
4. Facilitate and monitor the client's access to more medical services as recommended by the examining physician.
5. Refer the client for a nutritional assessment, education as to the effects of alcohol abuse on nutrition, and recommendations regarding nutritional rehabilitation.
6. Assist the client in listing the negative consequences of alcohol abuse (e.g., vocational, legal, familial, medical, social, and financial).
7. Confront the client when he/she minimizes his/her alcohol abuse or its negative impact.

11. Cooperate with a referral to resources for stress reduction. (15, 16)
12. Family members verbalize an increased understanding of alcohol abuse and treatment. (9, 17)
13. Family members accept a referral to support group. (18)
14. Utilize the services of a shelter for the homeless. (19)
15. Obtain vocational rehabilitation services as a step toward reemployment. (20)
16. Demonstrate compliance with the treatment plan. (21, 22, 23)

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8. Provide the client with specific information on the physical and psychological effects of alcohol abuse.
9. Refer the client and family to literature that explains the symptoms, consequences, and treatment of alcohol dependence (e.g., *I'll Quit Tomorrow* [Johnson] or *Many Roads, One Journey* [Kasl-Davis]).
10. Refer the client for a psychological evaluation for assessment of alcohol abuse and any related cognitive, emotional, and behavioral disorders.
11. Coordinate the client's obtaining ongoing treatment for alcohol dependence and psychological problems resulting from alcohol abuse; refer the client to an appropriate counseling provider.
12. Refer the client to Alcoholics Anonymous (AA); contact an AA member to accompany the client to a first-step meeting, if necessary.
13. Process the client's experience at AA and reinforce consistent attendance and participation.
14. Assist the client in identifying the sources of pain or stress that foster escape into alcohol abuse.
15. Refer the client to classes that teach stress management techniques.
16. Refer the client to a counseling resource for learning

stress-coping and stress-reduction approaches.

17. Provide family members with education regarding alcohol-abuse symptoms, prognosis, and treatment options.
18. Link family members to self-help groups in the community (e.g., Alanon, Alateen, and Tough Love).
19. Facilitate the client's admission to a facility or shelter for the homeless.
20. Refer the client to vocational rehabilitation counseling as a precursor to becoming employed.
21. Monitor the client's follow-through on linking with service providers.
22. Reinforce the importance of following through with linkages and treatment.
23. Monitor compliance by the client and family with the treatment plan.

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DIAGNOSTIC SUGGESTIONS:

ICD-9-CM	*ICD-10-CM*	*DSM-5* Disorder, Condition, or Problem
312.34	F63.81	Intermittent Explosive Disorder
309.81	F43.10	Posttraumatic Stress Disorder

301.7	F60.2	Antisocial Personality Disorder
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ASSAULTIVE BEHAVIOR

BEHAVIORAL DEFINITIONS

1. Episodes of loss of control of aggressive impulses out of proportion to the situation and resulting in assaultive acts and/or destruction of property.
2. Use of verbally abusive language intended to berate, intimidate, or hurt others.
3. Use of minimization, denial, and projection of responsibility in describing physical abuse of others.
4. Failure to conform with social norms with respect to the law, as shown by repeated performance of antisocial acts that may or may not have resulted in arrests.
5. Refusal to follow rules, with the attitude that they apply only to others.
6. History of criminal activity leading to numerous arrests and current court involvement.
7. Abuse of alcohol and/or drugs.

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LONG-TERM GOALS

1. Terminate physically and verbally aggressive acts.
2. Develop and demonstrate a healthy sense of respect for social norms, the rights of others, and the need for honesty.

3. Accept responsibility for own actions, including apologizing for hurts and not blaming others.
4. Come to an understanding and acceptance of the need for limits, rules, and boundaries on behavior.
5. Understand how substance abuse has contributed to assaultive behavior and accept the need for recovery.
6. Learn to stop, think, listen, and plan before acting.

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SHORT-TERM OBJECTIVES

1. Identify the physically and verbally aggressive acts that have been exhibited over the past year. (1)
2. List the reasons or rewards that have led to a pattern of aggressive behavior. (2)
3. List the negative consequences that accrue to self and others as a result of aggressive behaviors. (3, 4)
4. Admit to aggressive behavior that has trampled on the law and/or the rights and feelings of others. (1, 5)
5. Identify the thoughts and feelings that have triggered the aggressive behavior. (6)
6. List alternative coping responses to triggers to abusive behavior. (7)

THERAPEUTIC INTERVENTIONS

1. Explore and document instances of the client's aggressive behavior.
2. Help the client list the positive results he/she gets from aggressive actions and process the list.
3. Help the client list the negative consequences that have occurred because of his/her aggression.
4. Help the client make a connection between aggression and the negative outcomes experienced.
5. Confront the client's denial of responsibility for his/her aggressive behavior and the negative consequences.
6. Explore the client's thoughts and feelings that trigger his/her aggressive behavior.

7. Verbalize an understanding of the benefits for self and others of living within the laws and rules of society. (8, 9, 10)
8. List relationships that have been broken or damaged because of physical and verbal aggression. (11, 12)
9. List those who deserve an apology for hurtful behaviors. (11, 12, 13, 14)
10. Indicate steps that will be taken to make amends for hurt caused to others. (14, 15)
11. Describe the amount, frequency, and history of substance abuse. (16)
12. Identify the negative consequences of alcohol and/or drug abuse. (17, 18)
13. Cooperate with an alcohol and/or drug evaluation. (19)
14. Terminate substance abuse through participation in a recovery program. (20)
15. Accept a referral to individual counseling focused on terminating aggressive behavior. (21)
16. Consistently attend and participate in group therapy treatment. (22)
17. Family participates in family therapy. (23)
18. Fulfill the court requirements pertaining to sentencing for assault. (24, 25)

7. Teach the client cognitive and behavioral coping mechanisms for thoughts and feelings that have historically triggered physical abuse (e.g., time-out, deep breathing, physical exercise, escalation avoidance procedure, etc.).
8. Teach the client that the basis for social trust is lawfulness, which precludes anarchy in society.
9. Solicit a commitment to live a prosocial, law-abiding lifestyle.
10. Emphasize the reality of negative consequences for the client if continued lawlessness is practiced.
11. Review relationships that have been broken or damaged due to the client's antisocial attitudes and behaviors.
12. Confront the client's lack of sensitivity to the needs and feelings of others.
13. Assist the client in listing individuals who deserve amends for his/her hurtful behavior.
14. Teach the value of apologizing for hurt caused as a means of accepting responsibility for behavior.
15. Encourage a commitment by the client to take specific steps that will make amends for his/her actions.
16. Explore with the client his/her use of mood-altering substances.

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17. Assist the client in listing the negative consequences substance abuse has had on his/her life.
18. Help the client make the connection between his/her substance abuse and aggression.
19. Evaluate the client for chemical dependence or refer the client to an alcohol and drug counselor for evaluation.
20. Refer the client for chemical dependence treatment and to AA.
21. Facilitate a referral to individual counseling for the client.
22. Refer the client to group treatment for aggressive behavior.
23. Refer the family for family therapy.
24. Guide and monitor the client's cooperation with and fulfillment of the sentencing of the court resulting from arrest for assault.
25. Facilitate the family's or spouse's obtaining a court order restraining the client from close physical proximity to family members.

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DIAGNOSTIC SUGGESTIONS:

ICD-9-CM	*ICD-10-CM*	*DSM-5* Disorder, Condition, or Problem
312.34	F63.81	Intermittent Explosive Disorder
V71.01	Z72.811	Adult Antisocial Behavior
309.3	F43.24	Adjustment Disorder, With Disturbance of Conduct
312.89	F91.8	Other Specified Disruptive, Impulse Control, and Conduct Disorder
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
301.7	F60.2	Antisocial Personality Disorder
301.83	F60.3	Borderline Personality Disorder
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ASSAULT VICTIM

BEHAVIORAL DEFINITIONS

1. Self-report of verbal and physical assault.
2. Reports by family, friends, neighbors, or police that client was a victim of verbal and physical assault.
3. Evidence of physical assault: bruises, broken bones, and/or lacerations.
4. Intrusive, distressing thoughts, flashbacks, or images that recall the assault.
5. Inability to recall some aspects of the assault.
6. Physiological reactivity and intense distress when exposed to cues that symbolize the assault.
7. Avoidance of activity, people, or places associated with the assault.
8. Depressed affect, low energy, sleep disturbances, and tearful spells.
9. Alcohol and/or drug abuse.

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LONG-TERM GOALS

1. Reduce the negative impact that the assault has had on many aspects of life and return to pretrauma level of functioning.
2. Develop and implement effective coping skills in order to carry out normal responsibilities and participate constructively in relationships.

3. Recall the assault without becoming overwhelmed with negative emotions.
4. Terminate destructive behaviors and implement behaviors that promote healing, acceptance of assault, and responsible living.

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SHORT-TERM OBJECTIVES

1. Cooperate with a referral to a physician for a medical assessment. (1)
2. Describe the assault in as much detail as possible. (2, 3)
3. Express the feelings that were experienced at the time of the assault. (4)
4. Describe any fears regarding the perpetrator seeking revenge for being reported. (5)
5. Agree to and then make contact with legal authorities to seek protection for self. (6, 7, 8)
6. Cooperate with legal authorities under the guidance of an attorney. (7)
7. Verbalize an understanding of the legal process of police investigation and court proceedings. (8)
8. Verbalize that the responsibility for the assault belongs

THERAPEUTIC INTERVENTIONS

1. Refer the client to a physician to rule out any medical conditions that are in need of immediate treatment.
2. Built rapport with the client through consistent eye contact, unconditional positive regard, warm acceptance, soft voice, conversation about nonthreatening topics, and expressions of reassurance regarding the client's safety.
3. Slowly and gently explore the details of the assault without pressing the client beyond his/her ability to trust or cope with the emotional impact of the incident.
4. Explore the client's emotional reaction at the time of the assault.
5. Assess the client's safety from retaliation by the perpetrator of the assault; facilitate the client's finding a place of safety.

to the perpetrator, not self. (9, 10)

9. Accept a referral for individual counseling. (11)
10. Describe the amount, history, and frequency of substance abuse used to cope with trauma. (12)
11. Identify the negative consequences of substance abuse as a coping behavior. (13)
12. Accept a referral for drug and/or alcohol evaluation and treatment. (14)
13. Accept a referral to a support group for assault victims. (15)
14. Identify sources of support among family and friends. (16)
15. Increase the level of trust of others, as shown by more socialization. (17, 18)
16. Verbalize hopeful and positive statements regarding the future. (19, 20)

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6. Encourage the client to make contact with legal authorities to obtain protection from further assault.
7. Encourage and empower the client to assert his/her right to protection from the law by testifying against the perpet rator; refer him/her to a victim advocacy program.
8. Explain to the client the legal process that will ensue due to the assault.
9. Confront the client for excusing the perpetrator and reinforce all statements that place clear responsibility on the perpet rator of the assault.
10. Provide a more reality-based view of circumstances of the assault as the client tends to take on blame for the assault or excuse the perpetrator's actions.
11. Refer the client to individual counseling to assist him/her in overcoming the traumatic effects of the assault.
12. Gather data from the client regarding the amount, frequency, and history of his/her substance abuse as a means of coping with the feelings of anger and anxiety related to the assault.
13. Teach the client the negative consequences of abusing substances as a means of coping with fear, anger, and anxiety

(e.g., exacerbation of negative emotions; precipitation of chemical dependence; and precipitation of relational, vocational, and legal problems).

14. Refer the client to drug and/or alcohol counseling for an evaluation of substance abuse or dependence.
15. Refer the client to a support group for assault victims.
16. Assist the client in identifying people that he/she can turn to for understanding and support.
17. Teach the client the share-check method of building trust (i.e., sharing only a little of self and then checking to be sure that the shared data is treated respectfully, kindly, and confidentially; as proof of trustworthiness is verified, share more freely).
18. Encourage and reinforce the client's reaching out for social and emotional support rather than withdrawing into isolation.
19. Reinforce positive, reality-based messages that enhance self-confidence and increase adaptive action.
20. Assist the client in listing positive goals for his/her future rather than becoming fixated on the trauma of the past.

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DIAGNOSTIC SUGGESTIONS:

ICD-9-CM	*ICD-10-CM*	*DSM-5* Disorder, Condition, or Problem
309.81	F43.10	Posttraumatic Stress Disorder
309.0	F43.21	Adjustment Disorder, With Depressed Mood
308.3	F43.0	Acute Stress Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
300.00	F41.9	Unspecified Anxiety Disorder
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CHILD PHYSICAL/VERBAL ABUSE

BEHAVIORAL DEFINITIONS

1. Shoving, pushing, or scratching a child.
2. Pinching or biting a child.
3. Hitting, punching, or kicking a child.
4. Choking or strangling a child.
5. Violently shaking a child.
6. Using weapons or instruments to hurt a child.
7. Belittling or ridiculing a child in the family.
8. Insulting or shaming a child in front of others.
9. Yelling at or threatening a child.
10. Threatening another family member in front of a child.
11. Child observing physical violence between adults in a family.
12. Child observing verbal abuse between adults in a family.

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LONG-TERM GOALS

1. Eliminate physical abuse of the child.
2. Develop a safe physical environment for the child or place him/her in one.
3. Eliminate verbal abuse of the child.
4. Develop an adequate psychosocial environment for the child's development.

5. Reduce stress in the parental environment.
6. Increase marital compatibility and communication.
7. Develop adequate parenting skills.
8. Develop adequate negotiation skills.

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SHORT-TERM OBJECTIVES

1. Describe conditions of environment, eating habits, treatment, and supervision by caregivers. (1, 2)
2. Verbalize an understanding of the need to be moved to a safer environment. (1, 3, 4)
3. Accept placement in the home of a relative. (1, 5)
4. Accept placement in a temporary foster home. (6, 7, 8)
5. Accept placement in a residential facility. (6, 9, 10)
6. Verbalize acceptance of the adults who will serve as caregivers. (3, 11)
7. Parents express their feelings about their child being removed from their home. (12)
8. Parents verbalize an understanding of the criteria that must be met before the family can be reunited. (12, 13)

THERAPEUTIC INTERVENTIONS

1. Ascertain, through physical inspection of the premises and individual interviews with caregivers, neighbors, and the child or children, whether caregivers are able to provide a physically and emotionally safe environment for the child.
2. If it is determined that the child needs to be removed for his/her physical and emotional safety, move to terminate parental rights.
3. Meet with the child and explain the concern for his/her safety and his/her need for supervision, nurturance, and love, leading to the need for placement in a supportive environment.
4. Reassure the child of your interest in his/her safety and need for love; promise continued attempts to rectify the

9. Verbalize an acceptance of the schedule for continued contact with parents. (14)
10. Parents demonstrate reduced frequency and intensity of yelling, scolding, swearing, name-calling, and belittling directed at the children. (15, 16)
11. Parents verbalize reasonable expectations of the child commensurate with the child's level of psychosocial development. (17)
12. Parents implement relaxation strategies to cope with stress. (18)
13. Parents identify and implement pleasurable activities that reduce stress. (19)
14. Parents attend counseling to learn stress-reduction skills. (20, 21, 22)
15. Parents attend classes to learn effective parenting skills. (23)
16. Report adequate supervision, nurturant care, and absence of physical or verbal abuse. (24, 25)

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problems of the parental home and reunite the family.

5. Explore whether there are any other family members able to provide a safe, nurturing environment for the child or children on a temporary basis.
6. Make contact with the probate court to arrange for temporary court custody of the child.
7. Make arrangements to place the child in a temporary foster home.
8. Facilitate the transfer of the child to the foster home.
9. Arrange for the child's evaluation and admission at a residential treatment facility.
10. Facilitate the child's transfer to the residential facility.
11. Conduct a joint session with the child and new caregiver to introduce each to the other and give the child an opportunity to express his/her feelings and ask questions.
12. Meet with the neglectful or abusive parents to explain the need for the removal of the child from the home; reassure them regarding the process of treatment for them and regarding the return of the child to the home, contingent on their making environmental and behavioral changes.

13. Develop markers (e.g., complete a parenting class, pursue marital counseling, and demonstrate regular attendance at family therapy sessions and consistent responsibility in supervised visitation) that parents must satisfy before reunification of the family is possible.
14. Schedule visits between child and parents while child is temporarily removed from parents' custody.
15. Monitor and supervise parental visits to teach and reinforce calm, respectful child-management skills.
16. Alert the parents to focus on reducing negative physical (e.g., hitting, grabbing, spanking, and slapping) and verbal (e.g., yelling, swearing, name-calling, and scolding) contact, as well as threats, substituting positive parental communication skills instead.
17. Teach the parents reasonable expectations for each level of a child's psychosocial development.
18. Enroll the parents in classes that teach relaxation training (e.g., yoga and meditation).
19. Assist the parents in identifying pleasurable activities (e.g., hobbies, sports, music, dancing, hiking, and bike riding) that would enrich their

lives as well as reduce stress; structure times for implementation of these activities.

20. Assist the parents in identifying stressors (e.g., financial pressures, substance abuse, depression, social isolation, and extended family conflict) that increase frustration and exacerbate the likelihood of venting anger at the children.
21. Refer the parents for counseling to learn coping skills for stress.
22. Facilitate and monitor the parents' follow-through on obtaining counseling.
23. Refer the parents to a parenting-skills group.
24. Schedule regular contact with the child for interviews and assessment regarding the caregivers' provision of safe, nurturant, affirming care.
25. Maintain contact with the court to keep it informed of the child's welfare and the parents' progress in meeting the criteria for uniting the family.

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DIAGNOSTIC SUGGESTIONS:

ICD-9-CM	*ICD-10-CM*	*DSM-5* Disorder, Condition, or Problem
309.24	F43.22	Adjustment Disorder, With Anxiety
309.0	F43.21	Adjustment Disorder, With Depressed Mood
312.34	F63.81	Intermittent Explosive Disorder
995.53	T74.22XA	Child Sexual Abuse, Confirmed, Initial Encounter
995.53	T74.22XD	Child Sexual Abuse, Confirmed, Subsequent Encounter
301.82	F60.6	Avoidant Personality Disorder
301.7	F60.2	Antisocial Personality Disorder
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