

ADULT CHILDREN OF ALCOHOLICS

BEHAVIORAL DEFINITIONS

1. A history of being raised in an alcoholic home that resulted in having experienced emotional abandonment, role confusion, abuse, and a chaotic, unpredictable environment.
2. Inability to trust others, share feelings, or talk openly about self.
3. Overly concerned with the welfare of other people.
4. Passive-submissive to the wishes, wants, and needs of others; too eager to please others.
5. Chronically fearful of interpersonal abandonment and desperately clings to destructive relationships.
6. Tells other people what they want to hear rather than the truth.
7. Persistent feelings of worthlessness and a belief that being treated with disdain is normal and expected.
8. Strong feelings of panic and helplessness when faced with being alone as a close relationship ends.
9. Chooses partners and friends who are chemically dependent or have other serious problems.
10. Distrusts authority figures—trusts only peers.
11. Takes on the parental role in a relationship.
12. Chronic feelings of alienation from others.

LONG-TERM GOALS

1. Decrease dependence on relationships while beginning to meet own needs, build confidence, and practice assertiveness.
2. Demonstrate healthy communication that is honest, open, and self-disclosing.
3. Recognize adult child of an alcoholic traits and their detrimental effects on relationships.
4. Reduce the frequency of behaviors exclusively designed to please others.
5. Demonstrate the ability to recognize, accept, and meet the needs of self.
6. Replace negative, self-defeating thinking with self-enhancing messages to self.
7. Choose partners and friends who are responsible, respectful, and reliable.
8. Overcome fears of abandonment, loss, and neglect as the source of these feelings (i.e., being raised in an alcoholic home) becomes clear.
9. Reduce feelings of alienation and improve feelings of self-worth.

SHORT-TERM OBJECTIVES

1. Verbalize problems related to being an adult child of an alcoholic (ACOA) that have led to participating in the group. (1)
2. Verbalize an understanding of ACOA characteristics and their negative impact on life. (2, 3)
3. Describe own ACOA traits as experienced in daily interactions. (4)

THERAPEUTIC INTERVENTIONS

1. Ask each group member to describe life problems that precipitated joining the group.
2. Elicit group members' understanding of traits characteristic of adult children of alcoholics (ACOA).
3. Present additional material of ACOA traits if necessary to supplement members' knowledge, and teach an ac-

12 THE GROUP THERAPY TREATMENT PLANNER

4. List childhood family experiences that shape behavior, thoughts, and emotions into an ACOA pattern. (5)
 5. Verbalize feelings surrounding childhood family experiences of conflict. (6, 7, 8)
 6. Identify own role within family of origin. (9, 10)
 7. Describe how the role played in childhood family influences current relationships. (4, 11)
 8. Verbalize an understanding of the rules of "don't talk, don't trust, don't feel" that were learned in family of origin and cite examples of how they were implemented in own experience. (12, 13)
 9. List the negative impact on interpersonal relationships of the rules "don't talk, don't trust, don't feel." (4, 11, 13)
 10. Identify own alcohol problem and follow through with a referral for treatment. (14)
 11. Verbalize the difference between emotional needs and personal desires. (15)
 12. Identify own emotional needs and personal desires. (16)
 13. Practice the expression of own emotional needs and personal desires within the group first and then in daily life circumstances. (17, 18, 19)
 14. Ask someone outside the group for help in meeting
- curate understanding of this pattern of behavior. Assign reading of *It Will Never Happen to Me* (Black) or *Codependent No More* (Beattie).
4. Elicit from group members examples of their own behavior that corresponds to the typical ACOA characteristics.
 5. Teach group members how the lack of consistency, predictability, and safety, the secrecy and fear, combine to result in ACOA traits, soliciting from members examples of experiences that shaped their personality.
 6. Describe the family-sculpting exercise.
 7. Have each member sculpt a typical scene of turmoil in his or her family, using other group members as role players. The active member positions each person, explains who he or she represents in the family, and directs the verbal and physical interaction.
 8. After each sculpting exercise, process the group members' feelings arising from directing, role-playing, or witnessing the experience.
 9. Teach group members the four potential roles adopted by children of alcoholics as described in *It Will Never Happen to Me* (Black): the

ADULT CHILDREN OF ALCOHOLICS 13

- own emotional needs and personal desires. (18, 19)
15. Identify fears of not being in control of situations. (20, 21)
 16. Verbalize the link between growing up in an alcoholic family and the need to control. (22)
 17. Identify own attempts at controlling others' behaviors. (23)
 18. Describe what can reasonably be expected to be controlled and what situations cannot be controlled. (23, 24)
 19. Verbalize an understanding of the concept of a higher power and how a spiritual faith in this higher power can reduce the need to be in control. (25)
 20. Verbalize an understanding of the concept of compassionate detachment versus rejection. (26, 27)
 21. Report on the *in vivo* practice of compassionate detachment toward others' needs in order to reduce caretaking behavior. (28, 29, 30)
 22. Verbalize an understanding of where own responsibility for satisfying others' emotional needs begins and ends. (31, 32)
 23. Identify own feelings, and express them openly and assertively in group. (33, 34, 35, 36, 37)
- responsible one, the adjuster, the placater, and the acting-out child.
10. Facilitate group discussion of the four roles adopted by children of alcoholics and help members identify their own role within their family of origin.
 11. Encourage group sharing of how own role within family of origin affects current interpersonal relationships.
 12. Teach group members about the unspoken rule in alcoholic families that the alcoholism remain a secret (*don't talk*), about the chaos that requires children to rely only on themselves (*don't trust*), and about the denial of feelings that results from such a situation (*don't feel*). See *It Will Never Happen to Me* (Black).
 13. Facilitate group discussion about the *don't talk*, *don't trust*, *don't feel* rules that were learned in the family of origin, highlighting the negative impact of these rules on all interpersonal relationships.
 14. Evaluate each member's current alcohol and substance use and make an appropriate referral where necessary.
 15. Clarify the differences between emotional needs (e.g., to be loved, to be accepted) and personal desires (e.g., to go to the movies, to get a

ADULT CHILDREN OF ALCOHOLICS 15

25. Encourage group discussion of the concept of a higher power that runs the universe and how acceptance of this concept helps with letting go of control and turning concerns over to the higher power. Encourage members to share their own ideas (or alternative) of this concept.
26. Teach group members the relationship between letting go of control and the concept of compassionate detachment (i.e., caring for another person but maintaining boundaries of responsibility for behavior and decisions).
27. Have group members discuss the distinction between detachment and rejection and relate it to their own lives.
28. In small groups, have members develop strategies for handling situations at home with detachment (i.e., maintaining boundaries of responsibility).
29. Assign group members to try using at least one of their detachment strategies with significant others during the week.
30. Review members' experiences in applying detachment strategies during the week, reinforcing successes and further strategizing for failures.

16 THE GROUP THERAPY TREATMENT PLANNER

31. Teach group members the differences between enmeshed relationships and those with healthy boundaries.
32. Have group members sculpt examples of enmeshed relationships and those with healthy boundaries.
33. Assist group members in identifying own feelings (i.e., using “I” statements: “I feel _____ when you _____ because _____”; “I would like _____”) as they pertain to material raised in the group.
34. Teach active listening skills (e.g., listen with full attention, listen for the feelings, ask clarifying questions, acknowledge by paraphrasing) as an alternative to solution-finding responses; confront any inappropriate ownership of responsibility.
35. Reinforce the appropriate expression of feelings in the group.
36. Facilitate group discussion of the idea that the honest, open expression of feelings is a healthy alternative to controlling, ACOA behavior.
37. Teach group members how expressing feelings and needs honestly and openly is most critical when situations stir up feelings of shame, worthlessness, fear, and alienation.

ADULT CHILDREN OF ALCOHOLICS 17

38. Elicit group members' fears of expressing anger, including their fear of being abandoned by those they love if they express anger toward them.
39. Encourage group members to write out their angry feelings before expressing them in "I" statements.
40. Facilitate the development of feeling statements for each group member about people they care about. Assign members to use at least one of their feeling statements during the week.
41. Review members' success using feeling statements with significant others.
42. Elicit group members' examples of own behavior that was congruent with their feelings and thoughts, as well as examples of incongruent behavior.
43. Demonstrate and encourage group members to provide empathic confrontation of incongruity in any members' behavior.
44. Facilitate group brainstorming of self-nurturing behavior (e.g., taking a walk, listening to music, taking a bath), and assign members to practice at least one self-nurturing behavior each day.

18 THE GROUP THERAPY TREATMENT PLANNER

45. Assist group members in identifying negative, distorted cognitions that fuel and maintain ACOA behaviors.
46. Teach group members thought-stopping techniques (e.g., mentally shouting “Stop,” snapping a rubber band around the wrist), and encourage them to practice *in vivo*.
47. Teach group members how to challenge the negative, distorted cognitions using Socratic questioning.
48. Facilitate the development of reality-based, self-affirming cognitions to replace the distorted cognitions, and demonstrate the link between positive, realistic thoughts and calm feelings of self-esteem.
49. Encourage group discussion of the characteristics that are necessary for building trust between two people (honesty, self-disclosure, acceptance, etc.).
50. Assign pairs of group members to go on a “trust walk,” where one member leads another “blind” member (eyes closed or blindfolded) on a walk around the room. Each sighted leader helps the “blind” person explore the surroundings using touch, sound, and smell. Process the blind members’

ADULT CHILDREN OF ALCOHOLICS 19

difficulty in letting go of control and trusting the partner.

—

—

—

DIAGNOSTIC SUGGESTIONS

Axis I:	311	Depressive Disorder NOS
	300.00	Anxiety Disorder NOS
	309.81	Posttraumatic Stress Disorder
	300.4	Dysthymic Disorder
	_____	_____
	_____	_____
Axis II:	301.82	Avoidant Personality Disorder
	301.6	Dependent Personality Disorder
	301.9	Personality Disorder NOS
	_____	_____
	_____	_____

AGORAPHOBIA/PANIC

BEHAVIORAL DEFINITIONS

1. Unexpected, sudden, and repeated panic symptoms (shallow breathing, sweating, heart racing or pounding, dizziness, depersonalization or derealization, trembling, chest tightness, fear of dying or losing control, nausea).
2. Fear of having another panic attack in situations where escape is perceived to be difficult.
3. Avoidance of those situations where panic attacks have previously occurred or where they may occur.
4. Dependence on the company of a support person, including spouse or partner, on ventures outside the home.
5. Mild depression in the face of a decreasing range of possible activities.
6. Prevalence of negative, anxiety-producing self-talk.
7. Sensitivity to environmental stimuli (temperature, light, sounds, smells).
8. Sensitivity to other people and their feelings.
9. Tendency to please others over own needs and desires.
10. Very rich and vivid imagination.
11. High degree of emotional reactivity.
12. Tendency toward perfectionism.

LONG-TERM GOALS

1. Reduce incidence of panic attacks.
2. Reduce fear so that he/she can independently and freely leave home and comfortably be in public environments.
3. Reduce panic symptoms and the fear that they will recur without the ability to cope with and control them.
4. Replace anxiety-provoking cognitions with reality-based, self-affirming cognitions.
5. Increase feelings of self-esteem while reducing feelings of inadequacy, insecurity, and shame.
6. Reduce experience of general social anxiety.

SHORT-TERM OBJECTIVES

1. Get to know another person in a social context. (1)
2. Verbalize an understanding and acceptance of the ground rules of the group. (2, 3)
3. Agree to do homework consistently. (2, 3)
4. Describe the history of panic attacks. (4)
5. Verbalize an understanding of the development of agoraphobia and relate it to own experience. (5)
6. Identify a safe person (or place) on which dependence exists. (6)

THERAPEUTIC INTERVENTIONS

1. Have members introduce each other in dyads (paired with a stranger) and then introduce their partner to the group.
2. Explain and discuss the ground rules, including necessity of doing homework, asking permission to leave the room to calm down if feeling anxious (and returning if at all possible), sharing weekly progress without discussing specific anxiety symptoms, and avoiding unnecessary anxiety-provoking situations until

22 THE GROUP THERAPY TREATMENT PLANNER

7. Verbalize an understanding of how depression often stems from the shrinking from daily opportunities for activity. (7)
8. Identify within self the characteristic personality traits of the agoraphobic person. (8)
9. Give support to and accept support from other group members. (9)
10. Verbalize an understanding of the long-term, predisposing factors that lead to agoraphobia and relate them to own experience. (10, 11)
11. Identify own level of cumulative stress and its relationship to a vulnerability to panic attacks. (12, 13)
12. Describe first panic attack and its triggering event or situation. (14)
13. Identify those elements that maintain own agoraphobia. (15)
14. Practice abdominal breathing and progressive relaxation to reduce stress level. (16, 17, 19)
15. Implement visualization of a peaceful scene to reduce stress. (18, 19)
16. Exercise aerobically at least four times per week for at least 20 to 30 minutes. (20, 21)
17. Verbalize an understanding of the panic cycle. (22)
3. Teach group members that fears must be addressed on a daily basis in order for recovery to proceed and that relaxation, exercise, desensitization, and cognitive restructuring must be practiced consistently to achieve this.
4. Elicit from group members their history of panic attacks, including circumstantial triggers, severity, symptom pattern, chronicity, and attempts at coping or resolution.
5. Teach group members how agoraphobia can develop as a complication in a person suffering from panic attacks if one develops a pattern of avoidance, not just of the situation in which the attack occurred, but of the possibility of another panic attack in any remotely similar situation.
6. Facilitate group discussion of the dependence on a safe person and/or safe place that resulted from (or contributed to) their agoraphobia.
7. Explore with group members the hopelessness and helplessness they experience as a result of their avoidance.
8. Assist group members in identifying within themselves the characteristic appropriate skills have been learned.

18. Verbalize an accurate understanding of the nature of panic attacks. (23)
 19. Report success at accepting, observing, and floating with the feelings of panic when they occur rather than fighting them. (24, 25)
 20. Articulate the distinction between first and second fear. (26)
 21. Use coping statements to facilitate an attitude of calm acceptance toward panic attacks and to float with the waves of panic. (27)
 22. Use personal anxiety scale to identify early stages of panic. (28, 29)
 23. Temporarily withdraw from a situation when anxiety of level 4 is reached and return to it when anxiety is reduced. (30, 31, 32)
 24. Report success in using diversion techniques to reduce panic. (33, 34)
 25. Report success using abdominal breathing. (16, 17, 35)
 26. Report success using coping statements along with relaxation skills to reduce panic. (16, 17, 27, 36)
 27. Keep a journal of panic attack symptoms, environmental circumstance, severity rating, and coping strategies used. (37, 38)
 28. Make appropriate decision regarding the need for medication.
- personality traits of the agoraphobic person (e.g., sensitivity to environmental stimuli, sensitivity to other people's feelings and needs, a "people pleaser," creative and intelligent, rich and vivid imagination, high emotional reactivity, prevalence of negative thinking, tendency toward perfectionism, tendency to avoid by procrastination, shame and secrecy about the problem).
9. Foster group cohesiveness by distributing, after permission has been privately obtained, a list of the names and phone numbers of all members. Ask each member to call one other (different) member each week to talk for at least a few minutes to get further acquainted or to share a success achieved during the week.
 10. Teach group members the predisposing causes of agoraphobia that occur in childhood, which can include parents who communicate an overly cautious view of the world, are overly critical, set excessively high standards, or are emotionally abusive, as well as traumatic experiences that lead to tremendous insecurity. Stress to members that agoraphobic responses are learned and therefore can be unlearned, regardless of predisposition.

24 THE GROUP THERAPY TREATMENT PLANNER

- ication to reduce panic symptoms. (39)
29. Verbalize an understanding of the concepts of sensitization and desensitization. (40)
 30. Complete successful desensitization protocol using imagery. (41, 42, 43, 44)
 31. Confront own resistance to undertaking exposure to a fear-inducing situation or tolerating anxiety in those situations. (45)
 32. Verbalize an understanding of difference between avoidance and temporary retreat. (45)
 33. Complete successful *in vivo* desensitization. (46, 47)
 34. Reward self for small successes that demonstrate any progress at all. (48)
 35. Identify negative, anxiety-provoking cognitions. (49)
 36. Develop reality-based, self-affirming cognitions to challenge and replace the negative, anxiety-provoking cognitions. (50, 51, 52)
 37. Identify the mistaken beliefs that fuel the anxiety-provoking cognitions, and counter with positive affirmations. (53, 54, 55)
 38. Express feelings, including anger, openly and honestly in group and then with significant others. (56, 57)
 39. Verbalize the difference between behaviors that are
 11. Have group members share those predisposing factors that pertain to their own experiences.
 12. Facilitate group discussion of the way stress accumulates when it is not dealt with and how it can lead to psychophysiological illnesses, including panic attacks. Encourage members to identify their cumulative levels of stress.
 13. Assign group members to fill out a Holmes and Rahe stress chart to identify recent stressors that could be contributing to their agoraphobia.
 14. Elicit from group members the stories of their first panic attack and the situations that triggered them.
 15. Describe the factors that contribute to the maintenance of agoraphobia (e.g., phobic avoidance; self-talk that fosters anxiety; inability to assertively express feelings, needs, and wants; inadequate self-nurturing skills; a high-stress lifestyle; and a lack of meaning or purpose in life). Encourage group members to identify those factors with which they identify.
 16. Teach deep-breathing technique, instructing group members to inhale slowly and deeply, pause, and exhale slowly and completely.

- passive, aggressive, and assertive, and then demonstrate assertive expression of feelings in group and with significant others. (58, 59)
40. Increase the implementation of self-nurturing behaviors. (60, 61, 62)
 41. Decrease consumption of caffeine and refined sugar and focus on good nutrition. (63)
 42. Verbalize a commitment to relapse-prevention program. (64)
-
-
-
-
-
17. Lead members through progressive relaxation protocol, where each muscle group is first tightened and then relaxed. Stress the need for daily practice.
 18. Guide members through a visualization of a peaceful scene, eliciting as many details of the scene as possible. Encourage members to practice visualization daily after relaxation protocol.
 19. Review members' success using progressive relaxation and visualization during the week.
 20. Describe to group members the anxiety-reducing effects of aerobic exercise, and elicit a commitment from each member to incorporate exercise into their daily routine at least four times a week for at least 20 to 30 minutes. Recommend reading *Exercising Your Way to Better Mental Health* (Leith.)
 21. Have members report back to the group on their progress in meeting their exercise commitment.
 22. Teach the concept of the panic cycle, where a physical or emotional trigger leads to body symptoms of panic (heart palpitations, shortness of breath, sweating, dizziness, trembling, tightness in the chest, etc.). The negative thoughts that immediately follow the be-

26 THE GROUP THERAPY TREATMENT PLANNER

ginning of body symptoms lead to intensified body symptoms, which in turn lead to more negative, catastrophic thoughts and result finally in a full-blown panic attack. Elicit group members' experiences that conform to the panic cycle.

23. Present accurate information (e.g., that panic attacks are simply the fight-or-flight response occurring out of context; that they are not dangerous and will not result in heart attack, fainting, dizziness, or going crazy) that counters the myths regarding the nature of panic attacks.
24. Introduce the concept of accepting and observing rather than fighting the panic attack. Discuss floating with the "wave" of panic, and explain that the physiological concomitants of the fight-or-flight response are time-limited and will end of their own accord.
25. Assign group members to practice observing the pattern of their panic attacks and to try floating with the panic rather than fighting it. Have members report back to the group on their success.
26. Describe to the group the distinction between the first fear (i.e., the actual physiological reactions underlying panic) and second fear (i.e.,

AGORAPHOBIA 27

the one elicited by the negative, frightening self-statements made in response to first fear).

27. Provide group members with a list of coping statements (e.g., "I can be anxious and still deal with this situation"; "This is just anxiety, it won't kill me"; "I've survived this before and I'll survive it now") to encourage acceptance and a willingness to float with the panic rather than fighting it.
28. Help group members develop a personal anxiety scale from 0 (calm and relaxed) to 10 (terror, major panic attack), using 4 (marked anxiety) as the point between tolerable anxiety and out-of-control panic. Have members identify specific personal physiological signs that indicate a potential panic attack.
29. Ask group members to use personal anxiety scale to identify early stages of panic (4 or below), when intervention is still possible.
30. Explain to group members the concept of being sensitized to a situation by staying in it while experiencing increased anxiety. Describe how a phobia to that situation could be developed or, if already in existence, reinforced.

28 THE GROUP THERAPY TREATMENT PLANNER

31. Teach group members the strategy of withdrawing temporarily from situations where anxiety level of 4 is reached, and then returning after anxiety is reduced.
32. Ask group members to use the withdrawal strategy during the week, and then have them report back to the group on their success.
33. Assign the practice of diversion strategies (talking to someone; engaging in physical activity; doing something that requires intense concentration; practicing thought-stopping techniques, etc.) to help abort a panic attack before anxiety reaches levels higher than 4.
34. Review members' use of diversion strategies, reinforcing successes and redirecting failures.
35. Assign group members to use abdominal breathing and relaxation during the week to abort panic attacks in which anxiety levels are at 4 or below. Have members report back to the group on their success.
36. Assign group members to choose three or four coping statements and practice them with abdominal breathing and relaxation, first in group and then *in vivo* during the week.
37. Have group members keep a log of their panic attacks

during the week, noting when and where the attack occurred, what triggers might have precipitated the attack, the maximum intensity of the attack based on their personal anxiety scale, and the coping strategies they used to abort or limit the attack.

38. Have members share with the group insights gained from the log.
39. Help group members evaluate their need for medication in handling severe attacks, and make appropriate referrals to a physician.
40. Teach group members the concepts of sensitization and desensitization using both imagery and *in vivo* experiences.
41. Help group members construct an appropriate desensitization hierarchy for a phobic situation, from least to most anxiety-provoking stimuli. Encourage members to include reality-based details of each step of the hierarchy.
42. Lead group members through the steps of systematic desensitization, repeating the scene until it no longer has the capacity to raise anxiety levels above level 1 on the personal anxiety scale before progressing to the next scene in hierarchy.

30 THE GROUP THERAPY TREATMENT PLANNER

43. Assign group members to continue working on desensitization protocol every day for 20 minutes. Ask members to develop hierarchies for three other phobic situations.
44. Review members' success in working on desensitization hierarchies.
45. Facilitate group discussion of possible resistance to the discomfort and hard work of *in vivo* desensitization, emphasizing the difference between avoidance and temporary retreat. Teach that sometimes anxiety gets worse before it gets better.
46. Assign group members to begin *in vivo* desensitization with their safe person. Stress the exposure-retreat-recover-return cycle that is a part of systematic desensitization *in vivo*.
47. Review members' success with *in vivo* desensitization.
48. Help group members develop a reward system for reinforcing small steps toward recovery.
49. Clarify distinction between thoughts and feelings. Help group members identify the distorted, negative thoughts that trigger fear and anxiety.
50. Help members develop (using the Socratic method of questioning), reality-based, self-affirming cogni-

tions to challenge and replace anxiety-provoking cognitions.

51. Assign group members to practice *in vivo* challenging and replacing their negative, anxiety-provoking cognitions with realistic, self-affirming thoughts.
52. Review members' experience with cognitive restructuring, reinforcing success and redirecting failure.
53. Explore with group members the underlying mistaken beliefs that fuel anxiety-provoking cognitions (e.g., "People won't like me if they see who I really am"; "I don't deserve to be happy and successful"; "It's terrible to fail"; "I should (never) be _____").
54. Challenge members' beliefs using the Socratic method of questioning, and help them develop affirmations to counter the mistaken beliefs.
55. Assign group members to use their affirmations during the week to challenge mistaken beliefs, and report on their success.
56. Explore with group members their fears about expressing anger, including fears of losing control or of alienating their safe person.
57. Help members write out their angry feelings before communicating them to another person.

32 THE GROUP THERAPY TREATMENT PLANNER

58. Clarify the distinction between passive, aggressive, and assertive behaviors. Then role-play situations where members make assertive requests of their dyad partners.
59. Encourage honest, assertive expression of feelings within the group and then with significant others.
60. Introduce the concept of the inner child who carries the pain of childhood trauma.
61. Help members develop a list of self-nurturing behaviors to heal feelings of neglect or abuse, and assign daily completion of at least one item from the list.
62. Have members report to the group their success in self-nurturing.
63. Explore with group members their use of caffeine and refined sugar and the influence of these chemicals on anxiety and depression via hypoglycemia. Discuss the importance of decreasing the use of both, as well as focusing on good nutrition and vitamin/mineral balance to increase stress resistance.
64. Elicit commitment from group members to a relapse-prevention program consisting of daily relaxation, physical exercise, good nutrition, and cognitive restructuring. Include

AGORAPHOBIA 33

twice-weekly sessions of imagery and *in vivo* desensitization around specific fears.

—

—

—

DIAGNOSTIC SUGGESTIONS

- Axis I:** 300.21 Panic Disorder With Agoraphobia
300.22 Agoraphobia Without History of Panic Disorder
300.01 Panic Disorder Without Agoraphobia

- Axis II:** 301.6 Dependent Personality Disorder

ANGER CONTROL PROBLEMS

BEHAVIORAL DEFINITIONS

1. Overreaction of hostility to insignificant irritants.
2. Swift and harsh judgments made to or about others.
3. Body language of tense muscles (e.g., clenched fist or jaw, glaring looks, or refusal to make eye contact).
4. Use of passive-aggressive patterns (social withdrawal due to anger, lack of complete or timely compliance in following directions or rules, complaining about authority figures behind their backs, or refusal to meet expected behavioral norms).
5. Consistent pattern of challenging or disrespectful treatment of authority figures.
6. Use of verbally abusive language.
7. Recognition and admission of negative consequences of poor anger control (in terms of relationships, health, work life, etc.).
8. No history of physical violence against either persons or property.
9. No current abuse of drugs or alcohol.

—

—

—

LONG-TERM GOALS

1. Decrease overall intensity and frequency of angry feelings in provocative situations.

2. Learn effective coping behaviors to stop escalation and resolve conflicts.
3. Express anger in a controlled, respectful manner with reasonable judgment regarding time and place.

SHORT-TERM OBJECTIVES

1. State reason for participating in group. (1)
2. Verbalize an understanding of goals and ground rules of the group therapy experience. (2)
3. Keep a log of circumstances surrounding the experience of anger. (3, 4)
4. Verbalize an understanding of the two-step model of anger. (5, 6)
5. Verbalize an awareness of the futility of ventilation as an anger-control tool. (7)
6. Verbalize the distinction between anger and aggressive behavior. (8, 9)
7. Articulate a commitment to coping with pain rather than blaming with anger. (10)
8. Demonstrate mastery of progressive muscle relax-

THERAPEUTIC INTERVENTIONS

1. Ask members to introduce themselves to the rest of the group and explain why they are seeking help.
2. Clarify goals of the group therapy experience and ground rules, emphasizing importance of homework.
3. Assign group members to keep anger log to facilitate self-observation. Entries include date, time, the situation, anger-triggering thoughts, emotional arousal (on a 1 to 10 scale), and aggressive behavior (on a 1 to 10 scale).
4. Review members' anger logs and have members share with the group insights gained.
5. Teach that anger is a two-step process, requiring both (1) experience of pain (physical or emotional) and (2)

36 THE GROUP THERAPY TREATMENT PLANNER

- ation and relaxation without tension. (11, 12, 13, 14)
9. Demonstrate mastery of visualization of a safe place. (15, 17, 18)
 10. Demonstrate quick reflexive use of safe place visualization in group and *in vivo* stressful situations. (16)
 11. Demonstrate use of cue word coupled with deep, abdominal breathing. (19, 20)
 12. Implement the combined use of deep-muscle relaxation, safe place visualization, and slow abdominal breathing. (21, 22)
 13. Verbalize an understanding of Ellis's ABC model of explaining how thoughts lead to emotion. (23, 24)
 14. Verbalize an increased awareness of trigger thoughts that generate anger. (25)
 15. Identify own common trigger thoughts for anger. (26)
 16. List coping self-talk statements for use in response to trigger thoughts. (27)
 17. Demonstrate use in imagery of the coping skills of relaxation and positive self-talk in low-anger situations. (28, 29, 30)
 18. Monitor effects of relaxation and coping self-talk in anger log. (31, 32)
 19. Use imagery to practice coping skills in medium-anger situations. (33, 34, 35, 36, 37, 38)
 20. Use of trigger thoughts (attributions that blame others for the painful experience) to discharge arousal.
 6. Facilitate group discussion about anger's self-perpetuating cycle of anger: anger-trigger thoughts—more anger. Encourage members to share their own experiences with this cycle.
 7. Elicit group members' beliefs about the value of venting anger; then correct misperceptions by teaching that ventilation increases rather than dissipates anger.
 8. Clarify the distinction between anger as an emotion and aggression as a behavior. Emphasize that they can occur independently.
 9. Elicit examples from group members of the independent occurrence of anger and aggressive behavior.
 10. Encourage group discussion about the choice between developing coping strategies to deal with the painful experience versus blaming others for the pain, emphasizing the advantages of the former alternative.
 11. Teach progressive muscle relaxation, tensing and then relaxing each muscle group in the body.
 12. Teach muscle relaxation of each muscle group without

ANGER CONTROL PROBLEMS 37

20. Use imagery to practice coping skills in high-anger situations. (30, 40, 41)
 21. Verbalize an understanding of active and passive Response Choice Rehearsal (RCR). (42, 43)
 22. Demonstrate memorization of six RCR responses. (44)
 23. Verbalize own need statements, negotiating statements, and self-care solutions assertively, not aggressively. (45, 51)
 24. Verbalize an understanding of the ways in which RCR responses can be used. (46, 47)
 25. Demonstrate flexible use of the six RCR responses in role-play situations. (48, 49, 50, 51)
 26. Report success on leaving anger-arousing situations if withdrawal statement is ignored. (52)
 27. Demonstrate flexible use *in vivo* of the six RCR responses in low-, medium-, and high-anger situations. (53, 54, 55)
-
-
-
-
13. Assign members to practice progressive muscle relaxation daily, with and without using intentional muscle tension.
 14. Have members report back to the group on their success in using progressive muscle relaxation.
 15. Lead group members in a detailed visualization of a personal “safe place” where they feel relaxed and safe.
 16. Have members practice visualizing their safe place quickly, then returning to the group. Tell them to stay one minute in each place, cycling back and forth to achieve reflexive use of this technique in stressful situations.
 17. Assign members to practice safe place visualization daily after progressive muscle relaxation, as well as in any situation that has potential to provoke or disturb.
 18. Review members’ success in avoiding provocation using safe place visualization.
 19. Teach group members deep, abdominal breathing, helping members push out their bellies with each breath.
 20. Have group members select a cue word (e.g., *relax*, *peace*, *blue*) to use with deep abdominal breathing to cue relaxation. Instruct mem-

38 THE GROUP THERAPY TREATMENT PLANNER

bers to say cue word on each exhalation.

21. Lead group members through entire combined relaxation program: progressive muscle relaxation (without tension), followed by safe place visualization, and finally deep abdominal breathing using cue words.
22. Assign members to practice the entire sequence daily during the week, and report on their progress the following week.
23. Teach Ellis's ABC model of emotion: A = activating event; B = belief (thought, interpretation, assumption); and C = consequence (emotion).
24. Encourage sharing of personal examples that fit the ABC model.
25. Give group members a list describing major trigger thoughts, including three types of shoulds: *entitlement* ("I want it so much, I should be able to have it"); *fairness* ("It's fair so it should happen"); and *change* ("If I insist enough, she should do it my way"); and three types of blamers: *assumed intent* ("He's doing that deliberately to upset me"); *magnification* ("This is so awful, she's always doing it"); and *global labeling* ("He's so lazy [stupid, selfish, etc.]").
26. Elicit from group members personal examples of the

ANGER CONTROL PROBLEMS 39

use of each type of trigger thought and the resulting anger.

27. Facilitate development of a list of coping self-talk statements for each category of trigger thought and a list of general coping statements (“I can stay calm and relaxed,” “Getting mad won’t help”), and make copies for each group member.
28. Ask group members to select responses from each list that seem most useful to them.
29. Facilitate group discussion about coping statements that work the best. Help members who have problems generating effective coping statements.
30. Lead group members through several rehearsals in imagery of coping skills used with low-anger situations: (1) induce relaxation (progressive relaxation, visualization, breathing, and cue-controlled relaxation); (2) visualize in detail a low-anger scene (3 or 4 on a scale of 10) and use trigger thoughts to arouse anger; (3) erase scene, using relaxation skills and coping self-talk statements to become relaxed again.
31. Assign group members to include coping efforts in anger log, and note if emotional arousal or aggressive behavior decreases as a result.

40 THE GROUP THERAPY TREATMENT PLANNER

32. Review members' progress in using positive self-talk and relaxation as indicated in anger logs, noting changes in frequency, intensity or duration of anger.
33. Assign group members to identify two midrange anger scenes (5 or 6 on scale of 10).
34. Lead members through several imagery coping skills rehearsals of midrange-anger scenes.
35. Have members share with the rest of the group their experiences with coping-skills rehearsal and effective coping self-statements.
36. Focus on particular trigger words and thoughts that members report difficulty coping with, and facilitate development of appropriate responses.
37. Lead group members through several coping-skills rehearsals of medium-anger (7 or 8 on scale of 10) scenes. Have members stay in the scene and practice relaxation and coping self-talk statements.
38. Encourage members to share their successes with the rest of the group in coping with high- to midrange-anger scenes.
39. Assign group members to identify two high-anger scenes (9 or 10 on scale of 10).

ANGER CONTROL PROBLEMS 41

40. Lead group members through several coping-skills rehearsals using high-anger scenes (9 or 10 on scale of 10), staying in the scenes using relaxation and positive self-statements to reduce anger arousal.
41. Celebrate with members their successes in coping with high-anger scenes.
42. Teach three *active* (when client is feeling anger) Response Choice Rehearsal (RCR) opening statements (McKay and Rogers): (1) Ask for what you need/want (“I’m feeling _____, and what I think I need/want in this situation is _____”). (2) Negotiate (“What would you propose to solve this problem?”). (3) Use self-care (“If this continues, I’ll have to _____ in order to take care of myself”).
43. Teach three *passive* (when other person is feeling anger) RCR opening statements (McKay and Rogers): (1) Get information (“What do you need in this situation?” “What concerns you?” “What’s bothering you in this situation?”). (2) Acknowledge (“So what you want is _____”; “So what concerns/bothers you is _____”). (3) Withdraw (“It feels like we’re starting to get upset”; “I want to stop and cool off for awhile”).

42 THE GROUP THERAPY TREATMENT PLANNER

44. Emphasize the need for memorization of statements for the benefits of de-escalation to accrue. Assign group members to memorize RCR opening statements.
45. Help group members develop appropriate, assertive need/want statements, negotiating statements, and self-care solutions. Emphasize positive voice control (no sarcasm or anger).
46. Teach group members how to start with one RCR statement and switch if anger continues or if met with resistance. Switching can continue until success is achieved.
47. Teach members to switch, if stuck, from active to passive responses or from passive to active.
48. Have triads of group members role-play low-, medium-, and high-anger scenes (with one person the provocateur, one practicing the RCR responses, and the third coaching).
49. Facilitate group discussion about role-play experiences.
50. Coach group members in developing appropriate negotiation and compromise statements to use in role plays.
51. Confront members' statements that focus on revenge rather than on negotiating or self-care.

ANGER CONTROL PROBLEMS 43

- 52. Encourage group members to leave a situation if their withdrawal statement is ignored.
- 53. Assign members to practice *in vivo* RCR with a low-risk person with whom they've had conflict. Have them plan ahead their need/want statement, a fallback position, and a self-care solution.
- 54. Have members report back to the rest of the group their success with *in vivo* RCR situations.
- 55. Assign members to practice *in vivo* RCR in medium- and high-anger situations and report back to the group.

—

—

—

—

—

DIAGNOSTIC SUGGESTIONS

Axis I: 312.81 Conduct Disorder/Childhood Onset Type
 312.82 Conduct Disorder/Adolescent Onset Type
 296.xx Bipolar I Disorder
 312.34 Intermittent Explosive Disorder

Axis II: 301.83 Borderline Personality Disorder
 301.7 Antisocial Personality Disorder

ANXIETY

BEHAVIORAL DEFINITIONS

1. Excessive daily anxiety and worry, without factual or logical basis, about several life circumstances.
2. Symptoms of motor tension, such as restlessness, tiredness, shakiness, or muscle tension.
3. Symptoms of autonomic hyperactivity, such as palpitations, shortness of breath, dizziness, dry mouth, trouble swallowing, nausea, or diarrhea.
4. Symptoms of hypervigilance, such as feeling constantly on edge, concentration difficulties, startling easily, trouble falling or staying asleep, and general state of irritability.
5. Prevalence of negative, anxiety-provoking self-talk.
6. A high degree of sensitivity to other people and their feelings.
7. Excessive tendency to please others over own needs and desires.
8. Tendency to perfectionism.

—

—

—

LONG-TERM GOALS

1. Reduce overall level, frequency, and intensity of the anxiety so that daily functioning is not impaired.
2. Stabilize anxiety level while increasing ability to function on a daily basis.

3. Replace anxiety-provoking cognitions with reality-based, self-affirming cognitions.
4. Increase feelings of self-esteem while reducing feelings of inadequacy and insecurity regarding acceptance from others.

SHORT-TERM OBJECTIVES

1. Each member describe own anxiety symptoms that led to participating in anxiety group. (1)
2. Describe the history of feelings of anxiety and the impact on daily living. (2)
3. Verbalize an understanding of the long-term, predisposing causes of anxiety and relate them to own experience. (3, 4)
4. Identify own level of cumulative stress and its relationship to anxiety. (5, 6)
5. Identify the emotional, cognitive, and behavioral elements that maintain own anxiety. (7, 8)
6. Practice abdominal breathing and progressive muscle relaxation to reduce anxiety. (9)
7. Implement visualization of a peaceful scene to reduce stress. (10)

THERAPEUTIC INTERVENTIONS

1. Ask each member to describe his/her symptoms of anxiety and the incident that precipitated joining the anxiety group.
2. Have members describe their personal histories of anxiety, including the negative impact on their social and vocational functioning.
3. Teach group members the long-term, predisposing causes of anxiety (e.g., genetic predisposition; growing up in family where parents fostered overcautiousness, perfectionism, emotional insecurity, and dependence, or where parents suppressed assertiveness).
4. Have group members share the long-term, predisposing causes of anxiety that pertain to their own experiences.

46 THE GROUP THERAPY TREATMENT PLANNER

8. Report on the degree of success in reducing anxiety when using abdominal breathing, progressive muscle relaxation, and visualization techniques. (11)
9. Exercise aerobically at least four times per week for at least 20 to 30 minutes. (12, 13, 14)
10. Identify own negative, anxiety-provoking self-talk. (15)
11. Verbalize the major types of cognitive distortions. (16)
12. Develop and implement reality-based, self-affirming cognitions to counter cognitive distortions and anxiety-provoking self-talk. (17, 18, 19)
13. Identify the mistaken beliefs that fuel anxiety-provoking cognitions. (20)
14. Report success in using positive affirmations to replace distorted, negative beliefs. (21, 22)
15. Report increased ability to identify and describe suppressed feelings. (23, 24, 25)
16. Express feelings, including anger, openly, honestly, and assertively in group and then with significant others. (26, 27, 28, 29)
17. Verbalize the difference between behaviors that are aggressive, passive, and assertive. (28)
5. Facilitate group discussion of the way stress accumulates when it is not dealt with and how it can lead to psychophysiological illnesses. Encourage members to identify their own cumulative levels of stress.
6. Assign group members to fill out a Holmes and Rahe stress chart to identify recent stressors that could be contributing to their anxiety.
7. Teach group members the emotional, cognitive, and behavioral elements that maintain anxiety (e.g., anxious self-talk, mistaken beliefs, withheld feelings, lack of assertiveness, muscle tension).
8. Encourage members to identify the elements that maintain their own anxiety.
9. Teach group members abdominal breathing and progressive muscle relaxation techniques.
10. Lead group members through detailed visualization of safe, peaceful place, and encourage daily use of this imagery following progressive muscle relaxation.
11. Assign members to practice abdominal breathing, progressive muscle relaxation, and safe place visualization daily and report back to group on their experience.
12. Describe to group members the physiological and psy-

48 THE GROUP THERAPY TREATMENT PLANNER

can't believe I messed up so badly"); *emotional reasoning* ("I feel overwhelmed, therefore I must not be competent to do the job"); *should statements* ("I should be able to do this without a single mistake"). Encourage members to share the distortions that trigger their own anxiety. Recommend *Ten Days to Self-Esteem* (Burns).

17. Help members, using the Socratic method of questioning, to develop reality-based, self-affirming cognitions to challenge and replace distorted, anxiety-provoking cognitions.
18. Assign group members to practice *in vivo* challenging and replacing their distorted, negative, anxiety-provoking cognitions with realistic, self-affirming ones.
19. Review members' experiences with cognitive restructuring, reinforcing success and redirecting strategies that fail.
20. Explore with group members the underlying mistaken beliefs that fuel anxiety-provoking cognitions (e.g., "People won't like me if they see who I really am"; "I don't deserve to be happy and successful"; "It's terrible to fail"; "I should (never) be _____").
21. Challenge members' distorted, negative beliefs re-

garding self by using the Socratic method of questioning, and help them develop self-affirmations to counter the mistaken beliefs.

22. Assign group members to use their self-affirmations during the week to challenge mistaken beliefs, and report on their success.
23. Help group members identify the symptoms of suppressed feelings that each experiences (e.g., free-floating anxiety, depression, psychosomatic symptoms such as headaches or ulcers, or muscle tension).
24. Give group members a handout listing a large number of feelings for use as personal reference in learning to label and talk about their feelings.
25. Teach group members steps to “tune in” to their bodies to identify their feelings (e.g., relax; pay attention to where in the body there are physical sensations; wait and listen to whatever arises; use the feelings list to clarify).
26. Explore with group members their fears about expressing anger, including fears of losing control or of alienating significant people.
27. Help members write out their angry feelings before communicating them to another person.

50 THE GROUP THERAPY TREATMENT PLANNER

28. Clarify the distinction between passive, aggressive, and assertive behavior. Then role-play situations where members make assertive requests of their dyad partners.
29. Encourage honest, assertive expression of feelings in group and then with significant others.
30. Teach group members the five steps to assertive problem solving (i.e., identifying problem, brainstorming all possible options, evaluating each option, implementing course of action, and evaluating results), and role-play their application to everyday life conflicts.
31. Teach group members four techniques of responding to manipulation: *broken record technique* (repeating a request in calm, direct manner, such as “I would like to return this backpack and get a refund” to an uncooperative store clerk); *fogging* (agreeing to a possibly accurate part of a criticism, such as “You could be right that I’d look better if I made those changes”); *content-to-process shift* (changing the focus of discussion from the content to a description of what’s going on between you, such as “You’re making a joke, but it doesn’t change my request”); *assertive inquiry* (used when an as-

sertive request is met with criticism, such as “Why is it a problem for you to let me leave on time today?”).

32. Using the four assertiveness techniques to avoid manipulation, have small groups role-play life situations, and encourage members to implement the techniques during the week.
33. Review group members’ experiences in responding to efforts to manipulate them, reinforcing successes and redirecting unsuccessful attempts.
34. Help members develop a list of self-nurturing behaviors (e.g., soak in a bath, read a book, listen to music), and assign daily completion of at least one item from the list.
35. Have members report to the group their success in self-nurturing.
36. Assign group members to participate in one social activity per day and report to the group on their experiences.
37. Explore with group members their use of caffeine and refined sugar and the influence of these chemicals on anxiety and depression via hypoglycemia. Discuss the importance of decreasing the use of both, as well as focusing on good nutrition and vitamin/mineral

52 THE GROUP THERAPY TREATMENT PLANNER

balance to increase stress resistance.

- 38. Help group members evaluate their need for medication in handling their anxiety, and make appropriate referrals to a physician.
- 39. Elicit commitment from group members to a relapse-prevention program consisting of daily relaxation, physical exercise, good nutrition, and cognitive restructuring.

DIAGNOSTIC SUGGESTIONS

Axis I:	300.02	Generalized Anxiety Disorder
	300.00	Anxiety Disorder NOS
	309.24	Adjustment Disorder With Anxiety
	_____	_____
	_____	_____