PracticePlanners®

Arthur E. Jongsma, Jr., Series Editor

Companion to *The Complete Adult Psychotherapy Treatment Planner, Fifth Edition*

FIFTH EDITION

The Adult Psychotherapy

This timesaving resource features:

- Progress notes components for 43 behaviorally based presenting problems that correlate with *The Complete Adult Psychotherapy Treatment Planner, Fifth Edition*
- Over 1,000 prewritten progress notes describing client presentation and interventions implemented
- Prewritten progress notes that can be quickly adapted to fit a particular client need or treatment situation
- Incorporates new progress notes language consistent with **Evidence-Based Treatment Interventions**

ARTHUR E. JONGSMA, JR. AND DAVID J. BERGHUIS

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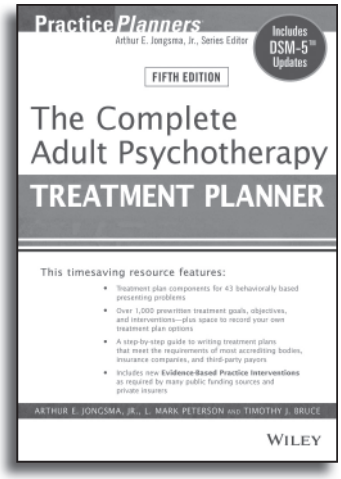
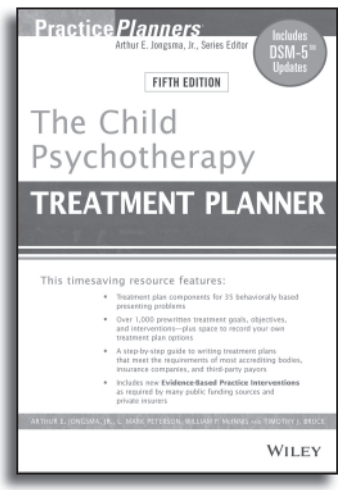
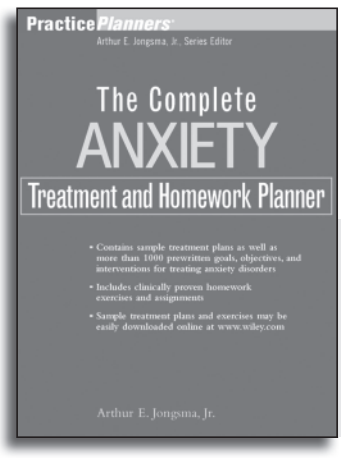
Arthur E. Jongsma, Jr., Series Editor

Helping therapists help their clients . . .







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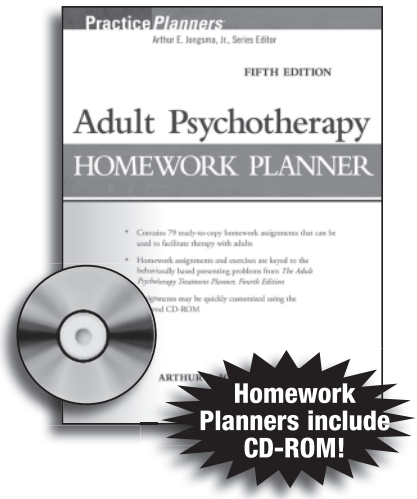

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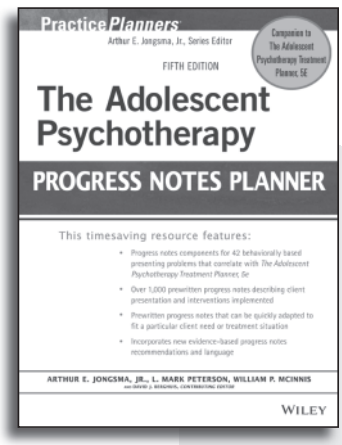

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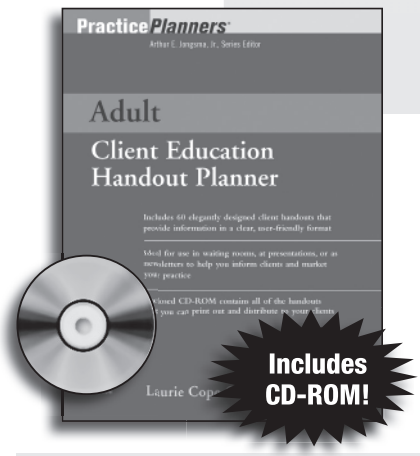

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The Adult Psychotherapy Progress Notes Planner

Fifth Edition

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The Adult Psychotherapy Progress Notes Planner

Fifth Edition

Arthur E. Jongsma, Jr.

David J. Berghuis

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To my manuscript manager, Sue Rhoda, who has brought to the task wonderful organizational skills and a genuine warmth and pleasantness.

Arthur E. Jongsma, Jr.

To my wife, Barbara, with all my love.

David J. Berghuis

CONTENTS

PRACTICE*PLANNERS*® SERIES PREFACE

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

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

- Addictions
- Co-occurring disorders
- Behavioral medicine
- College students
- Couples therapy
- Crisis counseling
- Early childhood education
- Employee assistance
- Family therapy
- Gays and lesbians
- Group therapy
- Juvenile justice and residential care
- Mental retardation and developmental disability
- Neuropsychology
- Older adults
- Parenting skills
- Pastoral counseling
- Personality disorders
- Probation and parole
- Psychopharmacology
- Rehabilitation psychology
- School counseling and school social work
- Severe and persistent mental illness
- Sexual abuse victims and offenders
- Social work and human services
- Special education
- Speech-language pathology
- Suicide and homicide risk assessment

- Veterans and active military duty
- Women's issues

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

- ***Progress Notes Planners*** provide a menu of progress statements that elaborate on the client's symptom presentation and the provider's therapeutic intervention. Each *Progress Notes Planner* statement is directly integrated with the behavioral definitions and therapeutic interventions from its companion *Treatment Planner*.

- ***Homework Planners*** include homework assignments designed around each presenting problem (such as anxiety, depression, chemical dependence, anger management, eating disorders, or panic disorder) that is the focus of a chapter in its corresponding *Treatment Planner*.

- ***Client Education Handout Planners*** provide brochures and handouts to help educate and inform clients on presenting problems and mental health issues, as well as life skills techniques. The handouts are included on CD-ROMs for easy printing from your computer and are ideal for use in waiting rooms, at presentations, as newsletters, or as information for clients struggling with mental illness issues. The topics covered by these handouts correspond to the presenting problems in the *Treatment Planners*.

Adjunctive books, such as *The Psychotherapy Documentation Primer* and *The Clinical Documentation Sourcebook*, contain 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

Again, I am deeply indebted to David Berghuis, who managed the project of updating this fifth edition of *The Adult Psychotherapy Progress Notes Planner*. He is responsible for modifying the evidence-based chapters to make them coordinate exactly with the new fifth edition of *The Complete Adult Psychotherapy Treatment Planner*. Thank you, Dave, for your fine work.

A.E.J.

The Adult Psychotherapy Progress Notes Planner

Fifth Edition

PROGRESS NOTES INTRODUCTION

ABOUT PRACTICE*PLANNERS*® PROGRESS NOTES

Progress notes are not only the primary source for documenting the therapeutic process, but also one of the main factors in determining the client's eligibility for reimbursable treatment. The purpose of the *Progress Notes Planner* series is to assist the practitioner in easily and quickly constructing progress notes that are thoroughly unified with the client's treatment plan.

Each *Progress Notes Planner*:

- Saves you hours of time-consuming paperwork.
- Offers the freedom to develop customized progress notes.
- Features over 1,000 prewritten progress notes summarizing patient presentation and treatment delivered.
- Provides an array of treatment approaches that correspond with the behavioral problems and *DSM-IV* and *DSM-5* diagnostic categories in the corresponding companion *Treatment Planner*.
- Offers sample progress notes that conform to the requirements of most third-party payors and accrediting agencies, including JCAHO, COA, CARF, and NCQA.

HOW TO USE THIS *PROGRESS NOTES PLANNER*

This *Progress Notes Planner* provides a menu of sentences that can be selected for constructing progress notes based on the behavioral definitions (or client's symptom presentation) and therapeutic interventions from its companion *Treatment Planner*. All progress notes must be tied to the patient's treatment plan—session notes should elaborate on the problems, symptoms, and interventions contained in the plan.

Each chapter title is a reflection of the client's potential presenting problem. The first section of the chapter, "Client Presentation," provides a detailed menu of statements that may describe how that presenting problem manifested itself in behavioral signs and symptoms. The numbers in parentheses within the Client Presentation section correspond to the numbers of the Behavioral Definitions from the *Treatment Planner*.

The second section of each chapter, "Interventions Implemented," provides a menu of statements related to the action that was taken within the session to assist the client in making progress. The numbering of the items in the Interventions Implemented section follows exactly the numbering of Therapeutic Intervention items in the corresponding *Treatment Planner*.

All item lists begin with a few keywords. These words are meant to convey the theme or content of the sentences that are contained in that listing. The clinician may peruse the list of keywords to find content that matches the client's presentation and the clinician's intervention.

It is expected that the clinician may modify the prewritten statements contained in this book to fit the exact circumstances of the client's presentation and treatment. To maintain complete client records, in addition to progress note statements that may be selected and individualized from this book, the date, time, and length of a session; those present within the session; the provider; the provider's credentials; and a signature must be entered in the client's record.

A FINAL NOTE ABOUT PROGRESS NOTES AND HIPAA

Federal regulations under the Health Insurance Portability and Accountability Act (HIPAA) govern the privacy of a client's psychotherapy notes, as well as other protected health information (PHI). PHI and psychotherapy notes must be kept secure and the client must sign a specific authorization to release this confidential information to anyone beyond the client's therapist or treatment team. Further, psychotherapy notes receive other special treatment under HIPAA; for example, they may not be altered after they are initially drafted. Instead, the clinician must create and file formal amendments to the notes if he or she wishes to expand, delete, or otherwise change them.

Does the information contained in this book, when entered into a client's record as a progress note, qualify as a "psychotherapy note" and therefore merit confidential protection under HIPAA regulations? If the progress note that is created by selecting sentences from the database contained in this book is kept in a location separate from the client's PHI data, then the note could qualify as psychotherapy note data that is more protected than general PHI. However, because the sentences contained in this book convey generic information regarding the client's progress, the clinician may decide to keep the notes mixed in with the client's PHI and not consider it psychotherapy note data. In short, how you treat the information (separated from or integrated with PHI) can determine if this progress note planner data is psychotherapy note information. If you modify or edit these generic sentences to reflect more personal information about the client or you add sentences that contain confidential information, the argument for keeping these notes separate from PHI and treating them as psychotherapy notes becomes stronger. For some therapists, our sentences alone reflect enough personal information to qualify as psychotherapy notes and they will keep these notes separate from the client's PHI and require specific authorization from the client to share them with a clearly identified recipient for a clearly identified purpose.

ANGER CONTROL PROBLEMS

CLIENT PRESENTATION

1. Episodic Excessive Anger (1)*

A. The client described a history of loss of temper in response to specific situations.
B. The client described a history of loss of temper that dates back many years, including verbal outbursts and property destruction, typically related to specific emotional themes.
C. As treatment has progressed, the client has reported increased control of his/her situational episodic excessive anger.
D. The client has had no recent incidents of episodic excessive anger.

2. General Excessive Anger (2)

A. The client shows a pattern of general, excessive anger across many situations.
B. The client does not appear to be experiencing anger in response to specific issues, but as a general pattern.
C. As treatment has progressed, the client has verbalized insight into his/her pattern of excessive anger.
D. The client has made progress in controlling his/her pattern of excessive anger.

3. Cognitive Biases Toward Anger (3)

A. The client shows a pattern of cognitive biases commonly associated with anger.
B. The client makes demanding expectations of others.
C. The client tends to generalize labeling the targets of his/her anger.
D. The client tends to have anger in reaction to perceived slights.
E. As treatment has progressed, the subject displays decreased patterns of cognitive biases associated with anger.

4. Evidence of Physiological Arousal (4)

A. The client displayed direct evidence of physiological arousal in relation to his/her feelings of anger.
B. The client displays indirect evidence of physiological arousal related to his/her feelings of anger.
C. As treatment has progressed, the subject's level of physiological arousal has decreased as anger has become more managed.

5. Explosive, Destructive Outbursts (5)

A. The client described a history of loss of temper in which he/she has destroyed property during fits of rage.

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* The numbers in parentheses correlate to the number of the Behavioral Definition statement in the companion chapter with the same title in *The Complete Adult Psychotherapy Treatment Planner,* Fifth Edition, by Jongsma, Peterson, and Bruce (Hoboken, NJ: Wiley, 2014).

B. The client described a history of loss of temper that dates back to childhood, involving verbal outbursts as well as property destruction.
C. As therapy has progressed, the client has reported increased control over his/her temper and a significant reduction in incidents of poor anger management.
D. The client has had no recent incidents of explosive outbursts that have resulted in destruction of property or intimidating verbal assaults.

6. Explosive, Assaultive Outbursts (5)

A. The client described a history of loss of anger control to the point of physical assault on others who were the target of his/her anger.
B. The client has been arrested for assaultive attacks on others when he/she has lost control of his/her temper.
C. The client has used assaultive acts as well as threats and intimidation to control others.
D. The client has made a commitment to control his/her temper and terminate all assaultive behavior.
E. There have been no recent incidents of assaultive attacks on anyone, in spite of the client having experienced periods of anger.

7. Overreactive Irritability (6)

A. The client described a history of reacting too angrily to rather insignificant irritants in his/her daily life.
B. The client indicated that he/she recognizes that he/she becomes too angry in the face of rather minor frustrations and irritants.
C. Minor irritants have resulted in explosive, angry outbursts that have led to destruction of property and/or striking out physically at others.
D. The client has made significant progress at increasing frustration tolerance and reducing explosive overreactivity to minor irritants.

8. Physical/Emotional Abuse (7)

A. The client reported physical encounters that have injured others or have threatened serious injury to others.
B. The client showed little or no remorse for causing pain to others.
C. The client projected blame for his/her aggressive encounters onto others.
D. The client has a violent history and continues to interact with others in a very intimidating, aggressive style.
E. The client has shown progress in controlling his/her aggressive patterns and seems to be trying to interact with more assertiveness rather than aggression.

9. Harsh Judgment Statements (8)

A. The client exhibited frequent incidents of being harshly critical of others.
B. The client's family members reported that he/she reacts very quickly with angry, critical, and demeaning language toward them.
C. The client reported that he/she has been more successful at controlling critical and intimidating statements made to or about others.

D. The client reported that there have been no recent incidents of harsh, critical, and intimidating statements made to or about others.

10. Angry/Tense Body Language (9)

A. The client presented with verbalizations of anger as well as tense, rigid muscles and glaring facial expressions.
B. The client expressed his/her anger with bodily signs of muscle tension, clenched fists, and refusal to make eye contact.
C. The client appeared more relaxed, less angry, and did not exhibit physical signs of aggression.
D. The client's family reported that he/she has been more relaxed within the home setting and has not shown glaring looks or pounded his/her fist on the table.

11. Passive-Aggressive Behavior (10)

A. The client described a history of passive-aggressive behavior in which he/she would not comply with directions, would complain about authority figures behind their backs, and would not meet expected behavioral norms.
B. The client's family confirmed a pattern of the client's passive-aggressive behavior in which he/she would make promises of doing something, but not follow through.
C. The client acknowledged that he/she tends to express anger indirectly through social withdrawal or uncooperative behavior, rather than using assertiveness to express feelings directly.
D. The client has reported an increase in assertively expressing thoughts and feelings and terminating passive-aggressive behavior patterns.

12. Time Bomb (11)

A. The client tends to passively withhold feelings, and then explodes in a rage.
B. The client seems to be "adding up" slights and irritations, waiting until enough have been "banked" and then explodes into a rage.
C. The client appears to have rageful feelings under the surface, but presents in a passive manner.
D. As treatment has progressed, the client has improved in regard to being able to express his/her feelings appropriately, and has decreased the reactive rage episodes.

13. Overreaction to Perceived Negative Circumstances (12)

A. The client seems to overreact to perceived disapproval, rejection, or criticism.
B. The client can become angry even when no disapproval, rejection, or criticism exists.
C. The client tends to have a bias toward his/her experience of disapproval, rejection, or criticism.
D. As treatment has progressed, the client has decreased his/her pattern of overreaction to disapproval, rejection, or criticism.
E. The client has decreased his/her angry overreaction to perceived disapproval, rejection, or criticism.

14. Verbal Abuse (13)

A. The client acknowledged that he/she frequently engages in verbal abuse of others as a means of expressing anger or frustration with them.
B. Significant others in the client's family have indicated that they have been hurt by his/her frequent verbal abuse toward them.
C. The client has shown little empathy toward others for the pain that he/she has caused because of his/her verbal abuse of them.
D. The client has become more aware of his/her pattern of verbal abuse of others and is becoming more sensitive to the negative impact of this behavior on them.
E. There have been no recent incidents of verbal abuse of others by the client.

15. Rationalization and Blaming (14)

A. The client has a history of projecting blame for his/her angry outbursts or aggressive behaviors onto other people or outside circumstances.
B. The client did not accept responsibility for his/her recent angry outbursts or aggressive behaviors.
C. The client has begun to accept greater responsibility for his/her anger control problems and blame others less often for his/her angry outbursts or aggressive behaviors.
D. The client verbalized an acceptance of responsibility for the poor control of his/her anger or aggressive impulses.
E. The client expressed guilt about his/her anger control problems and apologized to significant others for his/her loss of control of anger.

16. Aggression to Achieve Power and Control (15)

A. The client appears to use aggression as a means to achieve power and control over others.
B. The client uses veiled threats of aggression as a way to intimidate others.
C. As treatment has progressed, the client has decreased aggression as mean of achieving power and control over others.

INTERVENTIONS IMPLEMENTED

1. Build Trust (1)*

A. Consistent eye contact, active listening, unconditional positive regard, and warm acceptance were used to help build trust with the client.
B. The client was urged to feel safe in expressing his/her anger symptoms.
C. The client began to express feelings more freely as rapport and trust level have increased.
D. The client has continued to experience difficulty being open and direct about his/her expression of painful feelings; he/she was encouraged to use the safe haven of therapy to express these difficult issues.

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* The numbers in parentheses correlate to the number of the Therapeutic Intervention statement in the companion chapter with the same title in *The Complete Adult Psychotherapy Treatment Planner,* Fifth Edition, by Jongsma, Peterson, and Bruce (Hoboken, NJ: Wiley, 2014).

2. Assess Anger Dynamics (2)

A. The client was assessed for various stimuli that have triggered his/her anger.
B. The client was assisted in identifying situations, people, and thoughts that have triggered his/her anger.
C. The client was assisted in identifying the thoughts, feelings, and actions that have characterized his/her anger responses.

3. Administer Psychological Testing (3)

A. The client was administered psychometric instruments designed to objectively assess anger expression.
B. The client was assessed with the *Anger, Irritability, and Assault Questionnaire (AIAQ)*.
C. The client was assessed with the Buss-Durkee Hostility Inventory (BDHI).
D. The client was assessed with the *State-Trait Anger Expression Inventory (STAXI)*.
E. The client was given feedback about the results of the assessment.

4. Refer for Physical Examination (4)

A. The client was referred to a physician for a complete physical examination to rule out organic contributors (e.g., brain damage, tumor, elevated testosterone levels) to his/her anger.
B. The client has complied with the physical examination and the results were shared with him/her.
C. The physical examination has identified organic contributors to poor anger control and treatment was suggested.
D. The physical examiner has not identified any organic contributors to poor anger control and this was reflected to the client.
E. The client has not complied with the physical examination to assess organic contributors and was redirected to do so.

5. Assess Level of Insight (5)

A. The client's level of insight toward the presenting problems was assessed.
B. The client was assessed in regard to the syntonic vs. dystonic nature of his/her insight about the presenting problems.
C. The client was noted to demonstrate good insight into the problematic nature of the behavior and symptoms.
D. The client was noted to be in agreement with others' concerns and is motivated to work on change.
E. The client was noted to be ambivalent regarding the problems described and is reluctant to address the issues as a concern.
F. The client was noted to be resistant regarding acknowledgment of the problem areas, is not concerned about them, and has no motivation to make changes.

6. Assess for Correlated Disorders (6)

A. The client was assessed for evidence of research-based correlated disorders.
B. The client was assessed in regard to his/her level of vulnerability to suicide.

C. The client was identified as having a comorbid disorder, and treatment was adjusted to account for these concerns.
D. The client has been assessed for any correlated disorders, but none were found.

7. Assess for Culturally Based Confounding Issues (7)

A. The client was assessed for age-related issues that could help to better understand his/her clinical presentation.
B. The client was assessed for gender-related issues that could help to better understand his/her clinical presentation.
C. The client was assessed for cultural syndromes, cultural idioms of distress, or culturally based perceived causes that could help to better understand his/her clinical presentation.
D. Alternative factors have been identified as contributing to the client's currently defined "problem behavior," and these were taken into account in regard to his/her treatment.
E. Culturally based factors that could help to account for the client's currently defined "problem behavior" were investigated, but no significant factors were identified.

8. Assess Severity of Impairment (8)

A. The severity of the client's impairment was assessed to determine the appropriate level of care.
B. The client was assessed in regard to his/her impairment in social, relational, vocational, and occupational endeavors.
C. It was reflected to the client that his/her impairment appears to create mild to moderate effects on the client's functioning.
D. It was reflected to the client that his/her impairment appears to create severe to very severe effects on the client's functioning.
E. The client was continuously assessed for the severity of impairment, as well as the efficacy and appropriateness of treatment.

9. Refer for Medication Evaluation (9)

A. The client was referred to a physician to evaluate him/her for psychotropic medication to reduce anger symptoms.
B. The client has completed an evaluation by the physician and has begun taking medications.
C. The client has resisted the referral to a physician and does not want to take any medication to reduce anger symptoms; his/her concerns were processed.

10. Monitor Medication Compliance (10)

A. The client's compliance with the physician's prescription for psychotropic medication was monitored for the medication's effectiveness and side effects.
B. The client reported that the medication has been beneficial to him/her in reducing his/her experience of anger symptoms; the benefits of this progress were reviewed.
C. The client reported that the medication does not seem to be helpful in reducing anger symptoms; this was reflected to the prescribing clinician.
D. The therapist conferred with the physician to discuss the client's reaction to the psychotropic medication and adjustments were made to the prescription by the physician.

11. Assign Anger Journal (11)

A. The client was assigned to keep a daily journal in which he/she will document persons or situations that cause anger, irritation, or disappointment.
B. The client was assigned "Anger Journal" in the *Adult Psychotherapy Homework Planner* (Jongsma).
C. The client has kept a journal of anger-producing situations and this material was processed within the session.
D. The client has become more aware of the causes for and targets of his/her anger as a result of journaling these experiences on a daily basis; the benefits of this insight were reflected to him/her.
E. The client has not kept an anger journal and was redirected to do so.

12. List Targets of/Causes for Anger (12)

A. The client was assigned to list as many of the causes for and targets of his/her anger that he/she is aware of.
B. The client's list of targets of and causes for anger was processed in order to increase his/her awareness of anger management issues.
C. The client has indicated a greater sensitivity to his/her angry feelings and the causes for them as a result of the focus on these issues.
D. The client has not been able to develop a comprehensive list of causes for and targets of anger and was gently offered examples in this area.

13. Reconceptualize Anger (13)

A. The client was assisted in reconceptualizing anger as involving different components that go through predictable phases.
B. The client was taught about the different components of anger, including cognitive, physiological, affective, and behavioral components.
C. The client was taught how to better discriminate between relaxation and tension.
D. The client was taught about the predictable phases of anger, including demanding expectations that are not met, leading to increased arousal and anger, which leads to acting out.
E. The client displayed a clear understanding of the ways to conceptualize anger and was provided with positive reinforcement.
F. The client has struggled to understand the ways to conceptualize anger and was provided with remedial feedback in this area.

14. Process Anger Triggers (14)

A. The client was assisted in processing the list of anger triggers and other relevant journal information.
B. The client was assisted in understanding how cognitive, physiological, and effective factors interplay to produce anger.
C. The client was reinforced for his/her insight into anger triggers and the cognitive, physiological, and effective factors.

D. The client struggled to connect his/her anger triggers with cognitive, physiological, and effective factors, and was provided with remedial information in this area.

15. List Negative Anger Impact (15)

A. The client was assisted in listing ways that his/her explosive expression of anger has negatively impacted his/her life.
B. The client was supported as he/she identified many negative consequences that have resulted from his/her poor anger management.
C. It was reflected to the client that his/her denial about the negative impact of his/her anger has decreased and he/she has verbalized an increased awareness of the negative impact of his/her behavior.
D. The client has been guarded about identifying the negative impact of his/her anger and was provided with specific examples of how his/her anger has negatively impacted his/her life and relationships (e.g., injuring others or self, legal conflicts, loss of respect from self or others, destruction of property).

16. Identify Positive Consequences of Anger Management (16)

A. The client was asked to identify the positive consequences he/she has experienced in managing his/her anger.
B. The client was assigned the homework exercise "Alternatives to Destructive Anger" from the *Adult Psychotherapy Homework Planner* (Jongsma).
C. The client was assisted in identifying positive consequences of managing anger (e.g., respect from others and self, cooperation from others, improved physical health).
D. The client was asked to agree to learn new ways to conceptualize and manage anger.

17. Use Motivational Interviewing (17)

A. Motivational interviewing techniques were used to help the client clarify his/her stage of motivation to change.
B. Motivational interviewing techniques were used to help move the client to the action stage in which he/she agrees to learn new ways to conceptualize and manage anger.
C. The client was assisted in identifying his/her dissatisfaction with the status quo and the benefits of making changes.
D. The client was assisted in identifying his/her level of optimism for making changes.

18. Discuss Rationale for Treatment (18)

A. The client was engaged in a discussion about the rationale for treatment.
B. Emphasis was placed on how functioning can be improved through change in various dimensions of anger management.
C. The concept of rationale for treatment and how functioning can be improved through change in the various dimensions of anger management was revisited.

19. Assign Reading Material (19)

A. The client was assigned to read material that educates him/her about anger and its management.

B. The client was directed to read *Overcoming Situational and General Anger: Client Manual* (Deffenbacher and McKay).
C. The client was directed to read *Of Course You're Angry* (Rosselini and Worden).
D. The client was directed to read *The Anger Control Workbook* (McKay).
E. The client was assigned to read *Anger Management for Everyone* (Kassinove and Tafrate).
F. The client has read the assigned material on anger management and key concepts were reviewed.
G. The client has not read the assigned material on anger management and was redirected to do so.

20. Teach Calming Techniques (20)

A. The client was taught deep-muscle relaxation, rhythmic breathing, and positive imagery as ways to reduce muscle tension when feelings of anger are experienced.
B. The client has implemented the relaxation techniques and reported decreased reactivity when experiencing anger; the benefits of these techniques were underscored.
C. The client has not implemented the relaxation techniques and continues to feel quite stressed in the face of anger; he/she was encouraged to use the techniques.

21. Explore Self-Talk (21)

A. The client's self-talk that mediates his/her angry feelings was explored.
B. The client was assessed for self-talk, such as demanding expectations reflected in "should," "must," or "have to" statements.
C. The client was assisted in identifying and challenging his/her biases and in generating alternative self-talk that correct for the biases.
D. The client was taught about how to use correcting self-talk to facilitate a more flexible and temperate response to frustration.

22. Assign Self-Talk Homework (22)

A. The client was assigned a homework exercise in which he/she identifies angry self-talk and generates alternatives that help moderate angry reactions.
B. The client's use of self-talk alternatives was reviewed within the session.
C. The client was reinforced for his/her success in changing angry self-talk to more moderate alternatives.
D. The client was provided with corrective feedback to help improve his/her use of alternative self-talk to moderate his/her angry reactions.

23. Role-Play Relaxation and Cognitive Coping (23)

A. The client was assisted in visualizing anger-provoking scenes, then using relaxation and cognitive coping skills.
B. The client engaged in role-plays regarding the use of relaxation and cognitive coping in anger-provoking scenes.
C. The client was gradually moved from low to high anger-inducing scenes.

D. The client was assigned to implement calming techniques in his/her daily life and when facing anger-triggering situations.
E. The client's experience of using relaxation and cognitive coping in his/her daily life was processed, with reinforcement for success and problem solving for obstacles identified.

24. Assign Thought-Stopping Technique (24)

A. The client was directed to implement a thought-stopping technique on a daily basis between sessions.
B. The client was assigned "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner* (Jongsma).
C. The client's use of the thought-stopping technique was reviewed.
D. The client was provided with positive feedback for his/her helpful use of the thought-stopping technique.
E. The client was provided with corrective feedback to help improve his/her use of the thought-stopping technique.

25. Teach Assertive Communication (25)

A. The client was taught about assertive communication through instruction, modeling, and role-playing.
B. The client was referred to an assertiveness training class.
C. The client displayed increased assertiveness and was provided with positive feedback in this area.
D. The client has not increased his/her level of assertiveness and was provided with additional feedback in this area.

26. Teach Problem-Solving Skills (26)

A. The client was taught problem-solving skills.
B. The client was taught about defining the problem clearly, brainstorming multiple solutions, listing the pros and cons of each solution, seeking input from others, selecting and implementing a plan of action, and evaluating and readjusting the outcome.
C. The client displayed a clear understanding of the use of the problem-solving skills, and displayed this through examples.
D. The client struggled to understand the use of problem-solving skills and was provided with remedial feedback in this area.

27. Teach Conflict Resolution Skills (27)

A. The client was taught conflict resolution skills through modeling, role-playing, and behavioral rehearsal.
B. The client was taught about empathy and active listening.
C. The client was taught about "I messages," respectful communication, assertiveness without aggression, and compromise.
D. The client was reinforced for his/her clear understanding of the conflict resolution skills.
E. The client displayed a poor understanding of the conflict resolution skills and was provided with remedial feedback.