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ARTHUR E. JONGSMA, JR., L. MARK PETERSON, WILLIAM P. McINNIS, AND TIMOTHY J. BRUCE

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

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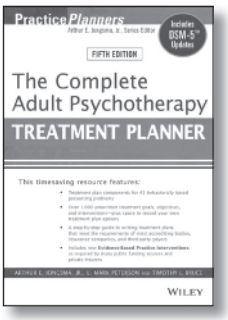


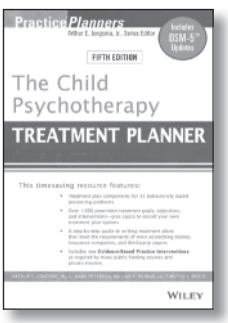


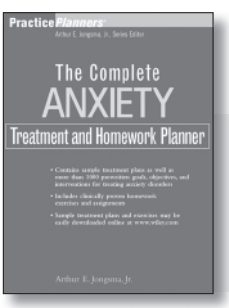


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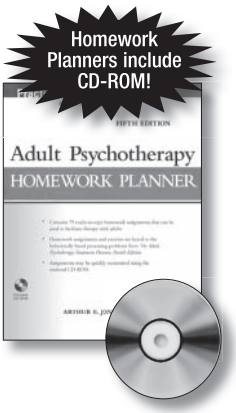


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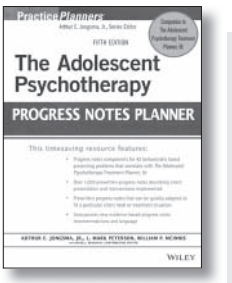


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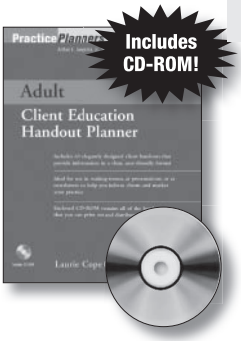


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**Arthur E. Jongsma, Jr., Series Editor**

# The Adolescent Psychotherapy Treatment Planner, Fifth Edition

*Arthur E. Jongsma, Jr.*

*L. Mark Peterson*

*William P. McInnis*

*Timothy J. Bruce*

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This book is printed on acid-free paper. ♾



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To our wives:

Judy, Cherry, Lynn, and Lori

We reach our long-term goals only due to your faithful interventions
of love and encouragement.

# 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 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, substance use, anger control problems, eating disorders, or panic disorder) that is the focus of a chapter in its corresponding *Treatment Planner*.
- ***Client Education Handout Planners*** provide brochures and handouts to help educate and inform clients on presenting problems and mental health issues, as well as life skills techniques. The handouts are included on CD-ROMs for easy printing from your computer and are ideal for use in waiting rooms, at presentations, as newsletters, or as information for clients struggling with mental illness issues. The topics covered by these handouts correspond to the presenting problems in the *Treatment Planners*.

The series also includes adjunctive books, such as *The Psychotherapy Documentation Primer* and *The Clinical Documentation Sourcebook*, 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

Since 2005 we have turned to research evidence to inform the treatment Objectives and Interventions in our latest editions of the *Psychotherapy Treatment Planner* books. While much of the content of our *Planners* was "best practice" and also from the mainstream of sound psychological procedure, we have benefited significantly from a thorough review that looked through the lens of evidence-based practice. The later editions of the *Planners* now stand as content not just based on "best practice" but based on reliable research results. Although several of my coauthors have contributed to this recertification of our content, Timothy J. Bruce has been the main guiding force behind this effort. I am very proud of the highly professional content provided by so many coauthors who are leaders in their respective subspecialties in the field of psychology such as addiction, family therapy, couples therapy, personality disorder treatment, group treatment, women's issues, military personnel treatment, older adult treatment, and many others. Added to this expertise over the past 9 years has been the contribution of Dr. Tim Bruce who has used his depth of knowledge regarding evidence-supported treatment to shape and inform the content of the last two editions of *Adult*, *Adolescent*, *Child*, and *Addiction Psychotherapy Treatment Planners*. I welcome Tim aboard as an author for these books and consider it an honor to have him as a friend, colleague, and coauthor.

I must also add my acknowledgment of the supportive professionalism of the Wiley staff, especially that of my editor, Marquita Flemming. Wiley has been a trusted partner in this series for almost 20 years now and I am blessed to be published by such a highly respected company. Thank you to all my friends at Wiley!

And then there is our manuscript manager, Sue Rhoda, who knows just what to do to make a document presentable, right up to the standards required by a publisher. Thank you, Sue.

Finally, I tip my hat to my coauthors, Mark Peterson and Bill McInnis, who launched this *Child Psychotherapy Treatment Planner* with their original

content contributions many years ago and have supported all the efforts to keep it fresh and evidence-based.

AEJ

I am fortunate to have been invited some 7 years ago by Dr. Art Jongsma to work with him on his well-known and highly regarded *Psychotherapy Treatment Planner* series and now to be welcomed as one of his coauthors on this *Planner* along with Mark Peterson and Bill McInnis. As readers know, Art's treatment planners are highly regarded as works of enormous value to practicing clinicians as well as terrific educational tools for "students" of our profession. That Art's brainchild would have this type of value to our field is no surprise when you work with him. He is the consummate psychologist, with enormous breadth and depth of experience, a profound intellect, and a Rogerian capacity for empathy and understanding—all of which he would modestly deny. When you work with Art, you not only get to know him, you get to know his family, colleagues, and friends. In doing so, you get to know his values. If you are like me, you have relationships that you prize because they are with people whom you know to be, simply stated, good. Well, to use an expression I grew up with, Art is good people. And it is my honor to have him as a friend, colleague, and coauthor. Thank you, Art!

I also would like thank Marquita Flemming and the staff at Wiley for their immeasurable support, guidance, and professionalism. It is just my opinion, but I think Marquita should publish her own book on author relations.

I would also like to extend a big thank-you to our manuscript manager, Sue Rhoda, for her exacting work and (needed) patience. In fact, I am sure Sue will take it in stride when we ask to do one more edit of this acknowledgment section after it has been "finalized."

Lastly, I would like thank my wife, Lori, and our children, Logan and Madeline, for all they do. They're good people, too.

TJB

# INTRODUCTION

## ABOUT PRACTICE*PLANNERS*® TREATMENT PLANNERS

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

Each *Treatment Planner*:

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

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

## ABOUT THIS FIFTH EDITION *ADOLESCENT PSYCHOTHERAPY TREATMENT PLANNER*

This fifth edition of the *Adolescent Psychotherapy Treatment Planner* has been improved in many ways:

- Updated with new and revised evidence-based Objectives and Interventions
- Revised, expanded, and updated Appendix B: Professional References

- Many more suggested homework assignments from the companion book, *The Adolescent Psychotherapy Homework Planner*, have been integrated into the Interventions
- Extensively expanded and updated self-help book list in Appendix A: Bibliotherapy Suggestions
- Appendix C: New Recovery Model listing Goals, Objectives, and Interventions allowing for the integration of a recovery model orientation into treatment plans
- Addition of a chapter on Overweight/Obesity
- Renamed chapter titles including the changing of Mental Retardation to Intellectual Development Disorder, Mania/Hypomania to Bipolar Disorder, Depression to Unipolar Depression, Sexual Acting Out to Sexual Promiscuity, Autism/Pervasive Developmental Disorder to Autism Spectrum Disorder, Anger Management to Anger Control Problems, Social Phobia/Shyness to Social Anxiety, and Chemical Dependence to Substance Use
- Integrated *DSM-5* diagnostic labels and codes into the Diagnostic Suggestions section of each chapter
- A new Appendix D presenting location and availability information in an alphabetical index of objective assessment instruments and structured clinical interviews cited in interventions

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

Borrowing from the Institute of Medicine's definition (Institute of Medicine, 2001), the American Psychological Association (APA) has defined EBP as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Presidential Task Force on Evidence-Based Practice, 2006). Consistent with this definition, we have identified those psychological treatments with the best available supporting evidence, added Objectives and Interventions consistent with them in the pertinent chapters, and identified these with this symbol: EBP. As most practitioners know, research has shown that although these treatment methods have demonstrated efficacy (e.g., Nathan & Gorman, 2007), the individual psychologist (e.g., Wampold, 2001), the treatment relationship (e.g., Norcross, 2002), and the patient (e.g., Bohart & Tallman, 1999) are also vital contributors to the success of psychotherapy. As noted by the APA, "Comprehensive evidence-based practice will consider

all of these determinants and their optimal combinations" (APA, 2006, p. 275). For more information and instruction on constructing evidence-based psychotherapy treatment plans, see our DVD-based training series entitled *Evidence-Based Psychotherapy Treatment Planning* (Jongsma & Bruce, 2010–2012).

The sources listed in Appendix B: Professional References and used to identify the evidence-based treatments integrated into this *Planner* are many. They include supportive studies from the psychotherapy outcome literature; current expert individual, group, and organizational reviews; as well as evidence-based practice guideline recommendations. Examples of specific sources used include the Cochrane Collaboration reviews, the work of the Society of Clinical Psychology (Division 12 of the American Psychological Association) and the Society of Clinical Child and Adolescent Psychology (Division 53 of the American Psychological Association) identifying research-supported psychological treatments, evidence-based treatment reviews such as those in Nathan and Gorman's *A Guide to Treatments That Work* (2007), and Weisz and Kazdin's *Evidence-Based Psychotherapies for Children and Adolescents* (2010), as well as evidence-based practice guidelines from professional organizations such as the American Psychiatric Association, the American Academy of Child & Adolescent Psychiatry, the National Institute for Health and Clinical Excellence in Great Britain, the National Institute on Drug Abuse (NIDA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Agency for Healthcare Research and Quality (AHRQ), to name a few.

Although each of these sources uses its own criteria for judging levels of empirical support for any given treatment, we favored those that use more rigorous criteria typically requiring demonstration of efficacy through randomized controlled trials or clinical replication series, good experimental design, and independent replication. Our approach was to evaluate these various sources and include those treatments supported by the highest level of evidence and for which there was consensus in conclusions/recommendations. For any chapter in which EBP is identified, references to the sources used are listed in Appendix B: Professional References and can be consulted by those interested in further information regarding criteria and conclusions. In addition to these references, this appendix also includes references to Clinical Resources. Clinical Resources are books, manuals, and other resources for clinicians that describe the details of the application, or "how to" of the treatment approaches described in a chapter.

There is debate regarding evidence-based practice among mental health professionals who are not always in agreement regarding the best treatment or how to weigh the factors that contribute to good outcomes. Some practitioners are skeptical about changing their practice on the basis of research evidence, and their reluctance is fueled by the methodological challenges and problems inherent in psychotherapy research. Our intent in this book is to accommodate these differences by providing a range of

treatment plan options, some supported by the evidence-based value of "best available research," others reflecting common clinical practices of experienced clinicians, and still others representing emerging approaches so the user can construct what they believe to be the best plan for their particular client.

Each of the chapters in this edition has also been reviewed with the goal of integrating homework exercise options into the Interventions. Many (but not all) of the client homework exercise suggestions were taken from and can be found in the *Adolescent Psychotherapy Homework Planner* (Jongsma, Peterson, & McInnis, 2014). You will find many more homework assignments suggested for your consideration as part of the Intervention process in this fifth edition of the *Adolescent Psychotherapy Treatment Planner* than in previous editions.

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

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

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

- Self-direction
- Individualized and person-centered
- Empowerment
- Holistic

- Nonlinear
- Strengths-based
- Peer support
- Respect
- Responsibility
- Hope

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

In addition to this list, we believe that many of the Goal, Objective, and Intervention statements found in the chapters reflect a recovery orientation. For example, our assessment interventions are meant to identify how the problem affects this unique client and the strengths that the client brings to the treatment. Additionally, an intervention statement such as, "Develop with the client a list of positive affirmations about himself/herself, and ask that it be read three times daily" from the Low Self-Esteem chapter is evidence that recovery model content permeates items listed throughout our chapters. However, if the clinician desires a more focused set of statements directly related to each principle guiding the recovery model they can be found in Appendix D.

The topic of our children (and adults, too) becoming seriously overweight or obese is getting increasing media and professional attention in recent years. Because obesity predisposes individuals to an increased risk of several diseases and medical conditions, it is included in the *International Classification of Diseases* (or *ICD*) as a general medical condition. It does not appear in the *DSM* because it is not consistently associated with a psychological or behavioral syndrome. It is, however, a highly prevalent medical issue, influenced by psychological and behavioral factors, and has proven to be responsive to psychological treatment. Therefore, we have added a chapter on Overweight/Obesity to provide evidence-based guidance in developing a treatment plan for this problem. We hope you find this addition helpful.

We have made a few title changes in this edition of the *Adolescent Psychotherapy Treatment Planner* that we would like to highlight. One is for the chapter previously entitled Mental Retardation. Even though the term mental retardation was selected about 50 years ago to replace what was seen as overly general terminology (e.g., mental deficiency) or pejorative labels (e.g., idiocy), in recent years the term mental retardation has been seen similarly. Instead, we replaced the title Mental Retardation with the title Intellectual Development Disorder to improve specificity and bring our title in line with the latest classification system terminology. We have also changed the titles of previous chapters entitled Depression and Mania/Hypomania to Unipolar Depression and Bipolar Disorder, respectively.

These changes were made in large part because the treatments demonstrating efficacy for unipolar and bipolar depression differ in several respects. We have changed the previous title Sexual Acting Out to Sexual Promiscuity so as not to suggest a theoretical interpretation of the behavior. Although we recognize that the word promiscuity may have negative connotative meanings, we use it here with the intent that it be read as a nonjudgmental description of behavior. Autism/Pervasive Developmental Disorder changed to Autism Spectrum Disorder, Social Phobia/Shyness changed to Social Anxiety, and Chemical Dependence changed to Substance Use, all in accord with the nomenclature used by *DSM-5*. Finally, Anger Management has been changed to Anger Control Problems as that is the convention most used today.

With the publication of the *DSM-5* (American Psychiatric Association [APA], 2013) we have updated the Diagnostic Suggestions listed at the end of each chapter. The *DSM-IV-TR* (APA, 2000) was used in previous editions of this *Planner*. Although many of the diagnostic labels and codes remain the same, several have changed with the publication of the *DSM-5* and are reflected in this *Planner*. We have continued to list *DSM-IV* (*ICD-9-CM*) codes and diagnostic labels while adding a section of *DSM-5* (*ICD-10-CM*) codes and labels describing the disorder, condition, or problem. The date currently set for mandatory use of *DSM-5* (*ICD-10-CM*) codes and labels for billing purposes is October, 2014.

Lastly, some clinicians have asked that the Objective statements in this *Planner* be written such that the client's attainment of the Objective can be measured. We have written our Objectives in behavioral terms and many are measurable as written. For example, this Objective from the Anxiety chapter is one that is measurable as written because it either is done or it is not: "Participate in live, or imaginal then live, exposure exercises in which worries and fears are gradually faced." But at times the statements are too broad to be considered measurable. Consider, for example, this Objective from the Anxiety chapter: "Identify, challenge, and replace biased, fearful self-talk with positive, realistic, and empowering self-talk." To make it quantifiable a clinician might modify it to read, "Give two examples of identifying, challenging, and replacing biased, fearful self-talk with positive, realistic, and empowering self-talk." Clearly, the use of two examples is arbitrary, but it does allow for a quantifiable measurement of the attainment of the Objective. Or consider this example prescribing an increase in potentially rewarding activities: "Identify and engage in pleasant activities on a daily basis." To make it more measurable the clinician might simply add a desired target number of pleasant activities, thus: "Identify and report engagement in two pleasant activities on a daily basis." The exact target number that the client is to attain is subjective and should be selected by the individual clinician in consultation with the client. Once the exact target number is determined, then our content can be very easily modified to fit the specific

treatment situation. For more information on psychotherapy treatment plan writing, see Jongsma (2005).

We hope you find these improvements to this fifth edition of the *Adolescent Psychotherapy Treatment Planner* useful to your treatment planning needs.

## HOW TO USE THIS *TREATMENT PLANNER*

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

1. **Problem Selection.** Although the client may discuss a variety of issues during the assessment, the clinician must determine the most significant problems on which to focus the treatment process. Usually a primary problem will surface, and secondary problems may also be evident. Some other problems may have to be set aside as not urgent enough to require treatment at this time. An effective treatment plan can only deal with a few selected problems or treatment will lose its direction. Choose the problem within this *Planner* that most accurately represents your client's presenting issues.
2. **Problem Definition.** Each client presents with unique nuances as to how a problem behaviorally reveals itself in his or her life. Therefore, each problem that is selected for treatment focus requires a specific definition about how it is evidenced in the particular client. The symptom pattern should be associated with diagnostic criteria and codes such as those found in the *DSM-5* or the *International Classification of Diseases*. This *Planner* offers such behaviorally specific definition statements to choose from or to serve as a model for your own personally crafted statements.
3. **Goal Development.** The next step in developing your treatment plan is to set broad goals for the resolution of the target problem. These statements need not be crafted in measurable terms but can be global, long-term goals that indicate a desired positive outcome to the treatment procedures. This *Planner* provides several possible goal statements for each problem, but one statement is all that is required in a treatment plan.
4. **Objective Construction.** In contrast to long-term goals, objectives must be stated in behaviorally measurable language so that it is clear to review agencies, health maintenance organizations, and managed care organizations when the client has achieved the established objectives. The objectives presented in this *Planner* are designed to meet this demand for accountability. Numerous alternatives are presented to allow construction of a variety of treatment plan possibilities for the same presenting problem.

5. **Intervention Creation.** Interventions are the actions of the clinician designed to help the client complete the objectives. There should be at least one intervention for every objective. If the client does not accomplish the objective after the initial intervention, new interventions should be added to the plan. Interventions should be selected on the basis of the client's needs and the treatment provider's full therapeutic repertoire. This *Planner* contains interventions from a broad range of therapeutic approaches, and we encourage the provider to write other interventions reflecting his or her own training and experience.

   Some suggested interventions listed in the *Planner* refer to specific books that can be assigned to the client for adjunctive bibliotherapy. Appendix A contains a full bibliographic reference list of these materials. For further information about self-help books, mental health professionals may wish to consult the *Authoritative Guide to Self-Help Resources in Mental Health, Revised Edition* (Norcross et al., 2003).
6. **Diagnosis Determination.** The determination of an appropriate diagnosis is based on an evaluation of the client's complete clinical presentation. The clinician must compare the behavioral, cognitive, emotional, and interpersonal symptoms that the client presents with the criteria for diagnosis of a mental illness condition as described in *DSM-5*. Despite arguments made against diagnosing clients in this manner, diagnosis is a reality that exists in the world of mental health care, and it is a necessity for third-party reimbursement. It is the clinician's thorough knowledge of *DSM-5* criteria and a complete understanding of the client assessment data that contribute to the most reliable, valid diagnosis.

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

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

One important aspect of effective treatment planning is that each plan should be tailored to the individual client's problems and needs. Treatment plans should not be mass-produced, even if clients have similar problems. The individual's strengths and weaknesses, unique stressors, social network, family circumstances, and symptom patterns must be considered in developing a treatment strategy. Drawing upon our own years of clinical experience and the best available research, we have put together a variety of treatment choices. These statements can be combined in thousands of permutations to develop detailed treatment plans. Relying on their own

good judgment, clinicians can easily select the statements that are appropriate for the individuals whom they are treating. In addition, we encourage readers to add their own definitions, goals, objectives, and interventions to the existing samples. As with all of the books in the *Treatment Planners* series, it is our hope that this book will help promote effective, creative treatment planning—a process that will ultimately benefit the client, clinician, and mental health community.

## REFERENCES

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

American Psychological Association Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271–285.

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

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

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

Jongsma, A. E., & Bruce, T. J. (2010–2012). *Evidence-based psychotherapy treatment planning* [DVD-based series]. Hoboken, NJ: Wiley. Available from Jongsma, A. E., & Bruce, T. J. (2010-2012). *Evidence-based psychotherapy treatment planning* [DVD-based series]. Hoboken, NJ: Wiley [Online]. Available from www.Wiley.com/go/ebtdvds

Jongsma, A. E., Peterson, L. M., & McInnis, W. P. (2014). *Adolescent psychotherapy homework planner*. Hoboken, NJ: Wiley.

Nathan, P. E., & Gorman, J. M. (Eds.) (2007). *A guide to treatments that work* (3rd ed.). New York, NY: Oxford University Press.

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

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

Norcross, J. C., Santrock, J. W., Campbell, L. F., Smith, T. P., Sommer, R., & Zuckerman, E. L. (2003). *Authoritative guide to self-help resources in mental health, revised edition*. New York, NY: Guilford Press.

Substance Abuse and Mental Health Services Administration's (SAMHSA) National Mental Health Information Center: Center for Mental Health Services (2004). *National consensus statement on mental health recovery.* Washington, DC: Author. Available from http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/

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

Weisz, J., & Kazdin, K. (Eds.) (2010). *Evidence-based psychotherapies for children and adolescents.* New York, NY: Guilford Press.

## SAMPLE TREATMENT PLAN

## OBSESSIVE-COMPULSIVE DISORDER (OCD)

**Definitions:** Recurrent and persistent ideas, thoughts, or impulses that are viewed as intrusive, senseless, and time-consuming, or that interfere with the client's daily routine, school performance, or social relationships.

Failed attempts to ignore or control these recurrent thoughts or impulses or neutralize them with other thoughts and actions.

Recognition that obsessive thoughts are a product of his/her own mind.

Recognition of repetitive behaviors as excessive and unreasonable.

Cleaning and washing compulsions (e.g., excessive hand washing, bathing, showering, cleaning of household products).

Repetitive and excessive behavior that is done to neutralize or prevent discomfort or some dreadful situation; however, that behavior is not connected in any realistic way with what it is designed to neutralize or prevent.

**Goals:** Significantly reduce frequency of compulsive or ritualistic behaviors.

Function daily at a consistent level with minimal interference from obsessions and compulsions.

### OBJECTIVES

1. Describe the nature, history, and severity of obsessive thoughts and/or compulsive behavior.

### INTERVENTIONS

1. Establish rapport and a working alliance with the child and parents using appropriate process skills (e.g., active listening, reflective empathy, support, and instillation of hope).
2. Assess the nature, severity, and history of the client's obsessions and compulsions using clinical interview with the client and the parents.

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| 2. Verbalize an understanding of OCD and the rationale for its treatment. | 1. Provide the client and parents with initial and ongoing psychoeducation about OCD, a cognitive behavioral conceptualization of OCD, biopsychosocial factors influencing its development, how fear and avoidance serve to maintain the disorder, and other information relevant to therapeutic goals. |
| 3. Participate in imaginal exposure to feared external and/or internal triggers of obsessions without use of compulsive rituals. | 1. Assess the nature of any external cues (e.g., persons, objects, situations) and internal cues (thoughts, images, and impulses) that precipitate the client's obsessions and compulsions.<br>2. Direct and assist the client in construction of a hierarchy of feared internal and external fear cues (or assign "Gradual Exposure to Fear" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).<br>3. Select initial imaginal exposures to the internal and/or external OCD cues that have a high likelihood of being a successful experience for the client; do cognitive restructuring during and after the exposure. |
| 4. Participate in live (*in vivo*) exposure to feared external and/or internal triggers of obsessions without use of compulsive rituals. | 1. Teach the client to use coping strategies (e.g., constructive self-talk, distraction, distancing) to resist engaging in compulsive behaviors invoked to reduce the obsession-triggered distress; ask client to record attempts to resist compulsions (or assign *Treating Your OCD with Exposure and Response (Ritual) Prevention: Workbook* by Yadin, Foa, and Lichner; or "Refocus Attention |

Away from Obsessions and Compulsions" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review during next session, reinforcing success and providing corrective feedback toward improvement.

2. Design a reward system for the parents to reinforce the client for attempts to complete exposures while resisting the urge to engage in compulsive behavior.

3. Assign an exposure homework exercise in which the client gradually reduces time given per day to obsessions and/or compulsions encouraging him/her to use coping strategies and the parents to use reinforcement of the child's success (or assign "Ritual Exposure and Response Prevention" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

5. Parents participate in therapy to provide appropriate support, facilitate the client's advancement in therapy, and help manage stresses encountered in the process.

1. Include family in sessions to identify specific, positive ways that the parents can help the client manage his/her obsessions or compulsions (see *FOCUS* by Barrett).

2. Teach parents how to remain calm, patient, and supportive when faced with the client's obsessions or compulsions, discouraging parents from reacting strongly with anger or frustration.

3. Teach family members their appropriate role in helping the client adhere to treatment; assist

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| | them in identifying and changing tendencies to reinforce the client's OCD (recommend *Freeing Your Child from Obsessive-Compulsive Disorder: Powerful, Practical Solutions to Overcome Your Child's Fears, Worries, and Phobias* by Chansky; *Helping Your Child with OCD* by Fitzgibbons and Pedrick).  |
| | 4. Teach family members stress management techniques (e.g., calming, problem-solving and communication skills) to manage stress and resolve problems encountered through therapy (or assign "Progressive Muscle Relaxation" or "Problem-Solving Exercise" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).  |
|  6. Implement relapse prevention strategies to help maintain gain achieved through therapy. | 1. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of symptoms, fear, or urges to avoid and relapse with the decision to return to fearful and avoidant patterns.  |
| | 2. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.  |
| | 3. Instruct the client to routinely use strategies learned in therapy (e.g., continued exposure to previously feared external or internal cues that arise) to prevent relapse into obsessive-compulsive patterns.  |

4. Schedule periodic "maintenance" sessions to help the client maintain therapeutic gains and adjust to life without OCD (see *A Relapse Prevention Program for Treatment of Obsessive-Compulsive Disorder* by Hiss, Foa, and Kozak for a description of relapse prevention strategies for OCD).

## DIAGNOSIS

| *ICD-9-CM* | *ICD-10-CM* |
|---|---|
| 300.3 | F42 Obsessive-Compulsive Disorder |

# ACADEMIC UNDERACHIEVEMENT

## BEHAVIORAL DEFINITIONS

1. History of academic performance that is below the expected level, given the client's measured intelligence or performance on standardized achievement tests.
2. Repeated failure to complete homework assignments on time.
3. Poor organization or study skills.
4. Frequent tendency to postpone doing homework assignments in favor of engaging in recreational and leisure activities.
5. Positive family history of members having academic problems, failures, or disinterest.
6. Feelings of depression, insecurity, and low self-esteem that interfere with learning and academic progress.
7. Recurrent pattern of engaging in acting-out, disruptive, and negative attention-seeking behaviors when encountering frustration in learning.
8. Heightened anxiety that interferes with performance during tests.
9. Parents place excessive or unrealistic pressure on the client to such a degree that it negatively affects the client's academic performance.
10. Decline in academic performance that occurs in response to environmental stress (e.g., parents' divorce, death of loved one, relocation move).

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## LONG-TERM GOALS

1. Attain and maintain a level of academic performance that is commensurate with intellectual ability.
2. Complete school and homework assignments on a regular and consistent basis.
3. Achieve and maintain a healthy balance between accomplishing academic goals and meeting social and emotional needs.
4. Stabilize mood and build self-esteem sufficiently to cope effectively with the frustration associated with academic pursuits.
5. Eliminate pattern of engaging in acting-out, disruptive, or negative attention-seeking behaviors when confronted with frustration in learning.
6. Significantly reduce the level of anxiety related to taking tests.
7. Parents establish realistic expectations of the client's learning abilities.
8. Parents implement effective intervention strategies at home to help the client achieve academic goals.
9. Remove emotional impediments or resolve family conflicts and environmental stressors to allow for improved academic performance.

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| SHORT-TERM OBJECTIVES | THERAPEUTIC INTERVENTIONS |
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| 1. Complete a psychoeducational evaluation. (1) | 1. Arrange for psychoeducational testing to evaluate the presence of a learning disability and to determine whether the client is eligible to receive special education services; provide feedback to the client, his/her family, and school officials regarding the psychoeducational evaluation. |
| 2. Complete psychological testing. (2) | 2. Arrange for psychological testing to assess whether it is possible that Attention-Deficit/ |

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| | Hyperactivity Disorder (ADHD) or emotional factors are interfering with the client's academic performance; provide feedback to the client, his/her family, and school officials regarding the psychological evaluation. |
| 3. Parents and client provide psychosocial history information. (3) | 3. Gather psychosocial history information that includes key developmental milestones and a family history of educational achievements and failures. |
| 4. Cooperate with a hearing, vision, or medical examination. (4) | 4. Refer the client for a hearing, vision, or medical examination to rule out possible hearing, visual, or health problems that are interfering with school performance. |
| 5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a DSM diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8, 9) | 5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change). |
| | 6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if |

appropriate (e.g., increased suicide risk when comorbid depression is evident).

7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
9. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).
6. Comply with the recommendations made by the multidisciplinary evaluation team at school regarding educational interventions. (10)
10. Attend an individualized educational planning committee (IEPC) meeting with the parents, teachers, and school officials to determine the client's eligibility for special education services, design educational interventions, and establish education goals.

7. Parents and teachers implement educational strategies that maximize the client's learning strengths and compensate for learning weaknesses. (11, 12)

11. Based on the IEPC goals and recommendations, move the client to an appropriate classroom setting to maximize his/her learning.

12. Consult with the client, parents, and school officials about designing effective learning programs or intervention strategies that build on the client's strengths and compensate for his/her weaknesses.

8. Participate in outside tutoring to increase knowledge and skills in the area of academic weakness. (13, 14, 15)

13. Recommend that the parents seek privately contracted tutoring for the client after school to boost his/her skills in the area of his/her academic weakness (i.e., reading, mathematics, written expression).

14. Refer the client to a private learning center for extra tutoring in the areas of academic weakness and assistance in improving study and test-taking skills.

15. Help the client to identify specific academic goals and steps needed to accomplish goals.

9. Implement effective study skills that increase the frequency of completion of school assignments and improve academic performance. (16, 17)

16. Teach the client more effective study skills (e.g., remove distractions, study in quiet places, develop outlines, highlight important details, schedule breaks).

17. Consult with teachers and parents about using a peer tutor to assist the client in his/her area of academic weakness and help improve study skills.

10. Implement effective test-taking strategies that decrease anxiety and improve test performance. (18, 19)

18. Teach the client more effective test-taking strategies (e.g., study in small segments over an extended period of time, review material regularly, read

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| | directions twice, recheck work); assess the application of these strategies on current assignments (or assign "Good Grade/Bad Grade Incident Reports" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 19. Train the client in the use of guided imagery or relaxation techniques to reduce anxiety before or during the taking of tests (or assign "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 11. Parents maintain regular communication (i.e., daily to weekly) with teachers. (20) | 20. Encourage the parents to maintain regular (daily or weekly) communication with teachers to help the client remain organized and keep up with school assignments. |
| 12. Use self-monitoring checklists, planners, or calendars to remain organized and help complete school assignments. (21, 22, 23) | 21. Encourage the client to use self-monitoring checklists to increase completion of school assignments and improve academic performance. |
| | 22. Direct the client to use planners or calendars to record school or homework assignments and plan ahead for long-term projects. |
| | 23. Utilize the "Break It Down Into Small Steps" program in the *Adolescent Psychotherapy Homework Planner* (Jongsma, Peterson, and McInnis) to help the client complete projects or long-term assignments on time. |
| 13. Establish a regular routine that allows time to engage in leisure or recreational activities, spend quality time with the family, and | 24. Assist the client and his/her parents in developing a routine daily schedule at home that allows him/her to achieve a |

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| complete homework assignments. (24) | healthy balance of completing school/homework assignments, engaging in leisure activities, and spending quality time with family and peers. |
| 14. Parents and teachers increase praise and positive reinforcement toward the client for improved school performance. (25, 26, 27) | 25. Encourage the parents and teachers to give frequent praise and positive reinforcement for the client's effort and accomplishment on academic tasks.<br>26. Assign the parents to observe and record responsible behaviors by the client between therapy sessions that pertain to schoolwork. Reinforce responsible behaviors to encourage the client to continue to engage in those behaviors in the future.<br>27. Help the client identify what rewards would increase his/her motivation to improve academic performance and then make these reinforcers contingent on academic success. |
| 15. Identify and remove all emotional or family conflicts that may be a hindrance to learning. (28, 29) | 28. Conduct family sessions to identify any family or marital conflicts that may be inhibiting the client's academic performance; assist the family in resolving conflicts.<br>29. Conduct individual therapy sessions to help the client work through and resolve painful emotions, core conflicts, or stressors that impede academic performance. |
| 16. Parents increase time spent involved with the client's homework. (30, 31, 32) | 30. Encourage the parents to demonstrate and/or maintain regular interest and involvement in the client's homework (i.e., attend school functions, review planners or calendars to see if |

the client is staying caught up with schoolwork).

31. Design and implement a reward system and/or contingency contract to help the parents reinforce the client's responsible behaviors, completion of school assignments, and academic success.

32. Assign the parents to observe and record responsible behaviors by the client between therapy sessions that pertain to schoolwork; urge them to reinforce responsible behaviors to encourage the client to continue to engage in those behaviors in the future.

17. Parents decrease the frequency and intensity of arguments with the client over issues related to school performance and homework. (33, 34)

33. Conduct family therapy sessions to assess whether the parents have developed unrealistic expectations or are placing excessive pressure on the client to perform; confront and challenge the parents about placing excessive pressure on the client (suggest the parents read *Overcoming Underachieving: A Simple Plan to Boost Your Kids' Grades and End the Homework Hassles* by Peters).

34. Encourage the parents to set firm, consistent limits and utilize natural, logical consequences for the client's noncompliance or refusal to do homework; instruct the parents to avoid unhealthy power struggles or lengthy arguments over the client's homework each night (or assign "Attitudes About Homework" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

18. Parents verbally recognize that their pattern of over-protectiveness interferes with the client's academic growth and assumption of responsibility. (35, 36)

35. Assess the parent-child relationship to help determine whether the parents' overprotectiveness and/or overindulgence of the client contributes to his/her academic underachievement; assist the parents in developing realistic expectations of the client's learning potential.

36. Encourage the parents not to protect the client from the natural consequences of poor academic performance (e.g., loss of credits, detention, delayed graduation, inability to take driver training, higher cost of car insurance) and allow him/her to learn from mistakes or failures.

19. Increase the frequency of on-task behaviors at school, completing school assignments without expressing the desire to give up. (37)

37. Consult with school officials about ways to improve the client's on-task behaviors (e.g., sit the client toward the front of the class or near positive peer role models, call on the client often, provide frequent feedback, break larger assignments into a series of small steps); discuss with the client how to apply these strategies to his situation (or recommend *How to Do Homework Without Throwing Up* by Romain).

20. Increase the frequency of positive statements about school experiences and about confidence in the ability to succeed academically. (38, 39, 40)

38. Reinforce the client's successful school experiences and positive statements about school and confront the client's self-disparaging remarks and expressed desire to give up on school assignments.

39. Consult with the teachers to assign the client a task at school (e.g., giving announcements over the intercom, tutoring another

student in his/her area of interest or strength) to demonstrate confidence in his/her ability to act responsibly.

40. Assign the client the task of making one positive statement daily to himself/herself about school and his/her ability and recording it in a journal or writing it on a sticky note and posting it in the bedroom or kitchen.

21. Decrease the frequency and severity of acting-out behaviors when encountering frustration with school assignments. (41)

41. Teach the client positive coping strategies (e.g., deep breathing and relaxation skills, positive self-talk, "stop, listen, think, and act") to inhibit the impulse to act out or engage in negative attention-seeking behaviors when he/she encounters frustration with schoolwork.

22. Identify and verbalize how specific responsible actions lead to improvements in academic performance. (42, 43, 44)

42. Explore for periods of time when the client completed schoolwork regularly and achieved academic success; identify and encourage him/her to use similar strategies to improve his/her current academic functioning.

43. Examine coping strategies that the client has used to solve other problems; encourage him/her to use similar coping strategies to overcome his/her problems associated with learning.

44. Give the client a homework assignment of identifying three to five role models and listing reasons he/she admires each role model. Explore in the next session the factors that contributed to each role model's success; encourage the client to take similar positive steps to achieve academic success.

23. Develop a list of resource people within the school setting who can be turned to for support, assistance, or instruction for learning problems. (45)

45. Identify a list of individuals within the school to whom the client can turn for support, assistance, or instruction when he/she encounters difficulty or frustration with learning.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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|---|---|---|
| **Axis I:** | 315.00 | Reading Disorder |
| | 315.1 | Mathematics Disorder |
| | 315.2 | Disorder of Written Expression |
| | V62.3 | Academic Problem |
| | 314.01 | Attention-Deficit/Hyperactivity Disorder, Combined Type |
| | 314.00 | Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type |
| | 300.4 | Dysthymic Disorder |
| | 313.81 | Oppositional Defiant Disorder |
| | 312.9 | Disruptive Behavior Disorder NOS |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | 317 | Mild Mental Retardation |
| | V62.89 | Borderline Intellectual Functioning |
| | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 315.00 | F81.0 | Specific Learning Disorder With Impairment in Reading |
| 315.1 | F81.2 | Specific Learning Disorder With Impairment in Mathematics |
| 315.2 | F81.2 | Specific Learning Disorder With Impairment in Written Expression |
| V62.3 | Z55.9 | Academic or Educational Problem |
| 314.01 | F90.2 | Attention-Deficit/Hyperactivity Disorder, Combined Presentation |
| 314.00 | F90.0 | Attention-Deficit/Hyperactivity Disorder, Predominately Inattentive Presentation |
| 314.01 | F90.1 | Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive /Impulsive Presentation |
| 300.4 | F34.1 | Persistent Depressive Disorder |
| 313.81 | F91.3 | Oppositional Defiant Disorder |
| 312.9 | F91.9 | Unspecified Disruptive, Impulse Control, and Conduct Disorder |
| 312.89 | F91.8 | Other Specified Disruptive, Impulse Control, and Conduct Disorder |
| 317 | F70 | Intellectual Disability, Mild |
| V62.89 | R41.83 | Borderline Intellectual Functioning |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# ADOPTION

## BEHAVIORAL DEFINITIONS

1. Questions are arising regarding family of origin or biological parents.
2. Confusion regarding identity linked to adoption.
3. Statements that reflect a feeling of not being a part of the family (e.g., "I don't fit here," "I'm different").
4. Asking to make a search to get additional information about or make contact with biological parents.
5. Marked shift in interests, dress, and peer group, all of which are contrary to the adoptive family's standards.
6. Exhibiting excessive clingy and helpless behavior that is inappropriate for developmental level.
7. Extreme testing of all limits (e.g., lying, breaking rules, academic underachievement, truancy, stealing, drug and alcohol experimentation/use, verbal abuse of parents and other authority, promiscuity).
8. Adoptive parents express anxiety and fearfulness because the child wants to meet his/her biological parents.
9. The adoption of an older child with special needs.
10. Parents express frustration with the adopted child's development and level of achievement.

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## LONG-TERM GOALS

1. Termination of self-defeating, acting-out behaviors and acceptance of self as loved and lovable within an adopted family.
2. The weaving of an acceptable self-identify that includes self, biological parents, and adoptive parents.
3. Resolution of the loss of a potential relationship with the biological parents.
4. Completion of the search process that results in reconnection with the biological parent(s).
5. Successful working through of all unresolved issues connected with being adopted.
6. Resolution of the question, "Who am I?"

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## SHORT-TERM OBJECTIVES

1. Develop a trusting relationship with the therapist in which feelings and thoughts can be openly communicated. (1)

2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of

## THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with the client in individual and family sessions through consistent eye contact, active listening, and unconditional acceptance to increase his/her ability to express thoughts and feelings regarding his/her adoption (consider assigning "Questions and Concerns About Being Adopted" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

2. Assess the client's level of in-sight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the

treatment, and the nature of the therapy relationship. (2, 3, 4, 5, 6)

"described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

3. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with Attention-Deficit/Hyperactivity Disorder (ADHD), depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
4. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
5. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now

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| | is causing mild or moderate impairment).<br>6. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment or other grossly inept parenting). |
| 3. Family members commit to attending and actively participating in family sessions that address issues related to adoption. (7, 8, 9) | 7. Solicit a commitment from all family members to regularly attend and participate in family therapy sessions.<br>8. Create a genogram in a family session, listing all family members and what is known about each. Ask the child and the parents what they know or have been told about the biological parents and their families.<br>9. Ask the client to verbalize thoughts about himself/herself that have been unexpressed until now and may help the adoptive parents better understand what struggles are occurring under the surface (or assign "Some Things I'd Like You to Know" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 4. Verbally identify all the losses related to being adopted. (10) | 10. Ask the client to identify losses connected to being adopted and to process them with the therapist. |
| 5. Express feelings of grief connected to the losses associated with being adopted. (11, 12) | 11. Assist, guide, and support the client in working through the process of grieving each identified loss associated with being adopted. |

12. Assign the client to read *Common Threads of Teenage Grief* (Tyson) and to process the key concepts he/she gains from the reading with the therapist.

6. Report decreased feelings of guilt, shame, abandonment, and rejection. (13, 14, 15, 16)

13. Help the client identify and verbally express feelings connected to issues of rejection or abandonment.

14. Assign the client to read *Why Didn't She Keep Me?* (Burlingham-Brown) to help him/her resolve feelings of rejection, abandonment, and guilt/shame.

15. Ask the client to read *How It Feels to Be Adopted* (Krementz) and list the key items from each vignette that he/she identifies with; process completed list.

16. Assist the client in identifying irrational thoughts and beliefs (e.g., "I must have been bad for Mom to have released me for adoption," "I must have been a burden") that contribute to his/her feelings of shame and guilt; assist him/her in replacing the irrational thoughts and beliefs with healthy, rational ones.

7. Attend an adoption support group. (17)

17. Refer the client and/or parents to an adoption support group.

8. Identify positive aspects of self. (18, 19)

18. Explore with the client what aspects of himself/herself he/she likes and those he/she would like to change (or assign "Recognizing Your Abilities, Traits, and Accomplishments" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); develop an action plan to achieve those goals (or assign the exercise

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| | "Three Ways to Change Yourself" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 19. Assign a self-esteem-building exercise from *SEALS & Plus* (Korb-Khalsa, Azok, and Leutenberg) to help the client develop self-knowledge, acceptance, and confidence. |
| 9. Verbalize a decrease in confusion regarding self-identity. (20, 21) | 20. Provide education to the client about his/her "true and false self or artificial and forbidden self" (see *Adopted: The Ultimate Teen Guide* by Slade) to give him/her direction and permission to pursue exploring who he/she is. |
| | 21. Assign the client the task of creating a list that responds to the question, "Who am I?" Ask him/her to add daily to the list and to share the list with the therapist each week for processing. |
| 10. Parents verbalize an understanding of the dynamics of the struggle with adoption status by adolescents who are searching for identity developmentally. (22, 23) | 22. Encourage the parents to read material to increase their knowledge and understanding of the adopted child in adolescence (e.g., *The Whole Life Adoption Book* by Schooler and Atwood; *Making Sense of Adoption* by Melina). |
| | 23. Teach the parents about the developmental task of adolescence that is focused on searching for an independent identity and how this is complicated for an adopted adolescent (recommend *Parenting Adopted Adolescents: Understanding and Appreciating Their Journeys* by Keck). |

11. Parents report reduced level of fear of the client's interest in and search for information and possible contact with biological parents. (24)

12. Parents verbalize support for the client's search for biological parents. (25)

13. Parents verbalize refusal to support a search for the biological parents and insist it be postponed until the client is 18 or older. (26)

14. Verbalize an acceptance of the need to delay the search for the biological parents until age 18. (27)

15. Verbalize anxieties associated with the search for the biological parents. (28, 29, 30)

24. Conduct a session with the adoptive parents in which their fears and concerns are discussed regarding the client searching for and possibly meeting the biological parents. Confirm the parents' rights and empower them to support, curtail, or postpone the client's search.

25. Hold a family session in which the client's desire to search for his/her biological parents is the issue. If the parents give support to the search, ask them to state verbally their encouragement in going forward. Then elicit from the client a commitment to keep his/her parents informed about the search at a mutually agreed-upon level.

26. Hold a family session in which the client's desire to search for his/her biological parents is the issue. If the parents are opposed, support their right, since the child is a minor, and ask them to state their rationale; affirm the client's right to search after he/she is 18 if he/she still desires to.

27. Affirm the parents' right to refuse to support a search for the client's biological parents at present, and assist the client in working to a feeling of acceptance of this decision.

28. Locate an adult who is adopted and who would agree to meet with the client and the therapist to tell of his/her search experience and answer any questions that the client has.

29. Prepare the client for the search by probing and affirming

his/her fears, hopes, and concerns; develop a list of questions about the biological parents that he/she would like to have answered (or assign "Considering a Search for Birth Parents" or "Beginning a Search for Birth Parents" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

30. Ask the client and the parents to read material on the process of searching for birthparents (e.g., *Lost and Found: The Adoption Experience* by Lifton; *Birthright: The Guide to Search and Reunion for Adoptees, Birthparents, and Adoptive Parents* by Strauss) to expand their knowledge and understanding of the search process (or assign "My Child's Search for Birth Parents" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

16. Create an album of life experiences that could be shared with the biological parents. (31)

31. Have the client review his/her "life book" filled with pictures and mementos; if he/she does not have one, help him/her construct one to add to the search/reunion process.

17. Begin the search for the biological parents. (32)

32. Refer the client to the agency that did his/her adoption or to an adoption agency that has postadoption services to begin the search process.

18. Share any increased knowledge of the biological parents and their backgrounds that is attained from the search. (33)

33. Debrief the client on the information he/she receives from the search; identify and support his/her feelings around what is revealed.

19. Verbalize and resolve feelings associated with not being able to contact the biological parents. (34)

20. Inform the adoptive parents of information discovered about the biological parents and feelings about it. (35)

21. Make a decision to pursue or not pursue a reunion with the biological parents. (36)

22. Identify and express expectations and feelings around impending reunion with the biological parents. (37, 38)

23. Attend and participate in a meeting with the biological parents. (39)

24. Verbalize feelings regarding first contact with the biological parents and expectations regarding the future of the relationship. (40)

25. Reassure the adoptive parents of love and loyalty to them that is not compromised by contact with the biological parents. (41)

34. Assist the client in working through his/her feelings of disappointment, anger, or loss connected to a dead end regarding possible contact with the biological parents.

35. Monitor the client's communication to the adoptive parents of information regarding the search to make sure it is occurring at the agreed-upon level.

36. Help the client reach a decision to pursue or postpone contact or reunion with the biological parents, reviewing the pros and cons of each alternative.

37. Prepare the client to have contact with the biological parents by examining his/her expectations to make them as realistic as possible and to send and reinforce the message to let the relationship build slowly.

38. Role-play with the client a first meeting with the biological parents and process the experience.

39. Arrange for and conduct a meeting with the client and the biological parents facilitating a complete expression of feelings by all family members; explore with all parties the next possible steps.

40. Process with the client his/her first contact with the biological parents and explore the next step he/she would like to take in terms of a future relationship.

41. Assist the client in creating a plan for further developing his/her new relationship with the biological parents, with emphasis

on taking things slowly, keeping expectations realistic, and being sensitive to the feelings of the adoptive parents who have provided consistent love and nurturing.

26. Verbalize to adoptive parents a realistic plan for a future relationship with the biological parents. (42)

42. Conduct a family session with the client and the adoptive parents to update them on the meeting with the biological parents and the next possible steps. Offer appropriate affirmation and explore how the new family arrangement might work.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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|---|---|---|
| **Axis I:** | 309.0 | Adjustment Disorder With Depressed Mood |
| | 309.4 | Adjustment Disorder With Mixed Disturbance of Emotions and Conduct |
| | 303.90 | Alcohol Dependence |
| | 300.4 | Dysthymic Disorder |
| | 312.81 | Conduct Disorder, Childhood–Onset Type |
| | 312.82 | Conduct Disorder, Adolescent–Onset Type |
| | 313.81 | Oppositional Defiant Disorder |
| | 314.01 | Attention-Deficit/Hyperactivity Disorder, Combined Type |
| | _____ | _____ |
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| **Axis II:** | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
| | _____ | _____ |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.4 | F43.25 | Adjustment Disorder, With Mixed Disturbance of Emotions and Conduct |
| 303.90 | F10.20 | Alcohol Use Disorder, Moderate or Severe |
| 300.4 | F34.1 | Persistent Depressive Disorder |
| 312.81 | F91.1 | Conduct Disorder, Childhood-Onset Type |
| 312.82 | F91.2 | Conduct Disorder, Adolescent-Onset Type |
| 313.81 | F91.3 | Oppositional Defiant Disorder |
| 314.01 | F90.2 | Attention-Deficit/Hyperactivity Disorder, Combined Presentation |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# ANGER CONTROL PROBLEMS

## BEHAVIORAL DEFINITIONS

1. Shows a pattern of episodic excessive anger in response to specific situations or situational themes.
2. Shows cognitive biases associated with anger (e.g., demanding expectations of others, overly generalized labeling of the targets of anger, anger in response to perceived "slights").
3. Describes experiencing direct or indirect evidence of physiological arousal related to anger.
4. Displays body language suggesting anger, including tense muscles (e.g., clenched fist or jaw), glaring looks, or refusal to make eye contact.
5. Demonstrates an angry overreaction to perceived disapproval, rejection, or criticism.
6. Rationalizes and blames others for aggressive and abusive behavior.
7. Repeated angry outbursts that are out of proportion to the precipitating event.
8. Excessive yelling, swearing, crying, or use of verbally abusive language when efforts to meet desires are frustrated or limits are placed on behavior.
9. Frequent fighting, intimidation of others, and acts of cruelty or violence toward people or animals.
10. Verbal threats of harm to parents, adult authority figures, siblings, or peers.
11. Persistent pattern of destroying property or throwing objects when angry.
12. Consistent failure to accept responsibility for anger control problems accompanied by repeated pattern of blaming others for anger control problems.
13. Repeated history of engaging in passive-aggressive behaviors (e.g., forgetting, pretending not to listen, dawdling, procrastinating) to frustrate or annoy others.
14. Strained interpersonal relationships with peers due to aggressiveness and anger control problems.

15. Underlying feelings of depression, anxiety, or insecurity that contribute to angry outbursts and aggressive behaviors.

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## LONG-TERM GOALS

1. Learn and implement anger management skills that reduce irritability, anger, and aggressive behavior.
2. Significantly reduce the frequency and intensity of temper outbursts.
3. Terminate all acts of aggression including destruction of property, physical aggression, and acts of violence or cruelty toward people or animals.
4. Interact consistently with adults and peers in a mutually respectful manner.
5. Markedly reduce frequency of passive-aggressive behaviors by expressing anger and frustration through controlled, respectful, and direct verbalizations.
6. Parents learn and implement consistent, effective parenting practices.

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## SHORT-TERM OBJECTIVES

1. Identify situations, thoughts, or feelings that trigger anger, angry verbal and/or behavioral actions and the targets of those actions. (1, 2)

## THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with the client through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help increase his/her ability to identify and express feelings.

2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (3, 4, 5, 6, 7)

2. Ask the client and the parents to recall the various stimuli (e.g., situations, people, thoughts) that have triggered the client's anger and the thoughts, feelings, and actions that have characterized his/her anger responses (or assign "Anger Checklist" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
3. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
4. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior withADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
5. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better

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| | understanding of the client's behavior. |
| | 6. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment). |
| | 7. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment or other grossly inept parenting). |
| 3. Identify major concerns regarding the child's angry behavior and the associated parenting approaches that have been tried. (8) | 8. Assess how the parents have attempted to respond to the child's anger and what the triggers and reinforcements there may be contributing to its expression. |
| 4. Describe any conflicts that result from the different approaches to parenting that each partner has. (9) | 9. Assess the parents' approach and consistency in addressing their child's anger control problem and any conflicts between them resulting from parenting practices. |
| 5. Complete psychological testing. (10) | 10. Conduct or arrange for psychological testing to |

supplement assessment of the anger control problem, including possible clinical syndromes and comorbid conditions (e.g., anxiety, depression, ADHD; follow up accordingly with client and parents regarding treatment options.

6. Complete a substance abuse evaluation and comply with the recommendations offered by the evaluation findings. (11)

11. Arrange for a substance abuse evaluation and/or treatment for the client.

7. Cooperate with the recommendations or requirements mandated by the criminal justice system. (12, 13, 14)

12. Consult with criminal justice officials about the appropriate consequences for the client's destructive or aggressive behaviors (e.g., pay restitution, community service, probation, intensive surveillance).

13. Consult with parents, school officials, and criminal justice officials about the need to place the client in an alternative setting (e.g., foster home, group home, residential program, or juvenile detention facility).

14. Encourage and challenge the parents not to protect the client from the natural or legal consequences of his/her destructive or aggressive behaviors.

8. Cooperate with a physician who can evaluate the client for possible treatment with psychotropic medications to assist in anger control and take medications consistently, if prescribed. (15)

15. Assess the client for the need for psychotropic medication to assist in control of anger; refer him/her to a physician for an evaluation and prescription of medication, if needed; monitor for prescription compliance, effectiveness, and side effects; provide feedback to the prescribing physician.

9. Increase the number of statements that reflect an acceptance of responsibility for the consequences of angry and/or aggressive behavior. (16, 17)

16. Use a motivational interviewing approach involving active listening, clarifying questions, exploration of possible contributors to the client's pattern of blaming others (e.g., harsh punishment experiences, family pattern of blaming others), and the examination of consequences toward the client's acceptance of responsibility and willingness to change anger control problems.

17. Therapeutically challenge statements in which the client lies and/or blames others for his/her misbehaviors and fails to accept responsibility for his/her actions toward the client's acceptance of responsibility and willingness to change anger control problems.

10. Parents verbalize a willingness to learn and implement consistent parenting practices to increase anger control in the client. (18)

18. Explore the parents' willingness to learn and implement new parenting techniques designed to manage their child's anger control problem; confirm their commitment.

11. Parents verbalize an understanding of Parent Management Training, its rationale, and techniques. (19, 20)

19. Use a Parent Management Training approach to conveying how parent and child behavioral interactions can encourage or discourage positive or negative behavior and that changing key elements of those interactions (e.g., prompting and reinforcing positive behaviors) can be used to promote positive change (e.g., see *The Kazdin Method for Parenting the Defiant Child* by Kazdin; or *Parents and Adolescents Living Together: Part 1, The Basics* by Patterson and Forgatch).

20. Ask the parents to read parent training books or manuals (e.g.,

*Parenting Your Out-of-Control Child* by Kapalka).

12. Parents implement Parent Management Training skills to recognize and manage problem behavior of the client. (21, 22, 23)

21. Teach the parents how to specifically define and identify problem behaviors, identify their reactions to the behavior, determine whether the reaction encourages or discourages the behavior, and generate alternatives to the problem behavior.

22. Teach parents how to implement key parenting practices consistently, including establishing realistic age-appropriate rules for acceptable and unacceptable behavior, prompting of positive behavior in the environment, use of positive reinforcement to encourage behavior (e.g., praise), use of clear and direct instruction, time-out, and other loss-of-privilege practices for problem behavior.

23. Assign the parents home exercises in which they implement and record results of implementation exercises (or assign "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review in session, providing corrective feedback toward improved, appropriate, and consistent use of skills.

13. Participate in either individual or group therapy for anger management. (24)

24. Conduct an anger management group (closed enrollment, with peers), or a directive individual therapy with the client focused on anger management (see *Cognitive-Behavioral Therapy for*

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| | *Anger and Aggression in Children* by Sukhodolsky and Scahill). |
| 14. Keep a daily journal of persons, situations, and other triggers of anger, recording thoughts, feelings, and actions taken. (25) | 25. Ask the client to self-monitor by keeping a daily journal in which he/she documents persons, situations, and other triggers of anger, irritation, or disappointment (or assign "Anger Journal" in the *Adult Psychotherapy Homework Planner* by Jongsma); routinely process the journal toward helping the client understand contributions to generating his/her anger. |
| 15. Verbalize increased awareness of anger expression patterns. (26) | 26. Review journal information to help the client understand how cognitive appraisals of people, situations and circumstances can lead to angry feelings and actions toward increasing the client's understanding of his/her anger expression patterns. |
| 16. Agree to learn alternative ways to think about and manage anger. (27, 28) | 27. Using approaches from Anger Control Training (see *Helping Schoolchildren Cope with Anger* by Larson and Lochman), assist the client in adopting a reconceptualization of frustration and anger involving different domains of response (cognitive, physiological, affective, and behavioral) that go through predictable sequences (e.g., demanding expectations not being met leading to increased arousal and anger leading to acting out), and that can be managed by intervening within the domains. |
| | 28. Assist the client in identifying the positive consequences of managing frustration and anger (e.g., respect from others and |

self, cooperation from others, improved physical health); ask the client to agree to learn new ways to conceptualize and manage anger and misbehavior (or assign "Anger Control" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). EBT

17. Learn and implement calming strategies as part of a new way to manage reactions to frustration. (29, 30) EBT

29. Using behavioral skills-building techniques such as instruction, modeling, corrective feedback, and reinforcement to teach the client calming techniques (e.g., muscle relaxation, paced breathing, calming imagery) as part of a tailored strategy for responding appropriately to angry feelings when they occur (or assign "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). EBT

30. Assign the client to implement and strengthen use of calming techniques in his/her daily life when facing anger-trigger situations; process the results, reinforcing success and redirecting failure. EBT

18. Identify, challenge, and replace anger-inducing self-talk with self-talk that facilitates a less angry reaction. (31, 32) EBT

31. Using cognitive therapy techniques, explore the client's self-talk that mediates his/her angry feelings and actions (e.g., demanding expectations reflected in *should, must,* or *have to* statements); identify and challenge biases, assisting him/her in generating appraisals and self-talk that corrects for the biases and facilitates a more flexible and temperate response to frustration.

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| | 32. Assign the client a homework exercise in which he/she identifies angry self-talk and generates alternatives that help moderate angry reactions; review; reinforce success, providing corrective feedback toward improvement (or assign "Anger Control" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 19. Learn and implement thought-stopping to manage intrusive unwanted thoughts that trigger anger. (33) | 33. Teach the client the thought-stopping technique as part of his/her new anger management skill set and assign implementation on a daily basis between sessions; review implementation, reinforcing success and providing corrective feedback toward improvement (or assign the parents to assist the child in working through "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner* by Jongsma). |
| 20. Verbalize feelings of frustration, disagreement, and anger in a controlled, assertive way. (34) | 34. Use behavioral skills-building techniques such as instruction, modeling, and/or role-playing to teach the client assertive communication (or assign "Becoming Assertive" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); if indicated, refer him/her to an assertiveness training class/group for further instruction. |
| 21. Learn and implement problem-solving and/or conflict resolution skills to manage personal and interpersonal problems constructively. (35, 36) | 35. Teach the client conflict resolution skills (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise); use modeling, role- |

playing, and behavior rehearsal to work through several current conflicts.

36. Instruct the client to practice assertion, problem-solving, and/or conflict resolution skills with group members or otherwise significant others.

22. Practice using new calming, communication, conflict resolution, and thinking skills. (37, 38)

37. Assist the client in consolidating his/her new anger management skill set that combines any of the somatic, cognitive, communication, problem-solving, and/or conflict resolution skills relevant to his/her needs.

38. Use any of several techniques (e.g., relaxation, imagery, behavioral rehearsal, modeling, role-playing, feedback of videotaped practice) in session using increasingly challenging situations to help the client consolidate the use of his/her new anger management skills.

23. Practice using new anger management skills in between session homework exercises. (39)

39. Assign the client homework exercises to help him/her practice newly learned calming, assertion, conflict resolution, or cognitive restructuring skills as needed; review and refine toward the goal of consolidation.

24. Decrease the number, intensity, and duration of angry outbursts, while increasing the use of new skills for managing anger. (40)

40. Monitor the client's reports of angry outbursts toward the goal of decreasing their frequency, intensity, and duration through the client's use of new anger management skills (or assign "Anger Control" or "Anger Checklist" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review progress, reinforcing success and

providing corrective feedback toward improvement.

25. Identify social supports that will help facilitate the implementation of anger management skills. (41)

26. Implement relapse prevention strategies for managing possible future anger-provoking situations. (42, 43, 44, 45)

27. Read a book or treatment manual that supplements the therapy by improving understanding of anger and anger management. (46)

41. Encourage the client to discuss his/her anger management goals with trusted persons who are likely to support his/her change.

42. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible angry outburst and relapse with the choice to return routinely to the old pattern of anger.

43. Identify and rehearse with the client the management of future situations or circumstances in which lapses back to anger could occur; instruct the client to routinely use the new anger management strategies learned in therapy (e.g., calming, adaptive self-talk, assertion, conflict resolution) to prevent anger management problems.

44. Develop a "coping card" or other reminder on which new anger management skills and other important information (e.g., "Calm yourself," "Be flexible in your expectations of others," "Voice your opinion calmly," "Respect other's point of view") are recorded for the client's later use.

45. Schedule periodic "maintenance sessions" to help the client maintain therapeutic gains.

46. Assign the client to read material that educates him/her about anger and its management (e.g., *Overcoming Situational and General Anger: Client Manual* by

Deffenbacher and McKay; *The Anger Control Workbook* by McKay; suggest parents read *The Angry Child* by Murphy).

28. Parents verbalize appropriate boundaries for discipline to prevent further occurrences of abuse and to ensure the safety of the client and his/her siblings. (47, 48)

47. Explore the client's family background for a history of neglect and physical or sexual abuse that may contribute to his/her behavioral problems; confront the client's parents to cease physically abusive or overly punitive methods of discipline.

48. Implement the steps necessary to protect the client or siblings from further abuse (e.g., report abuse to the appropriate agencies; remove the client or perpetrator from the home).

29. Increase the frequency of civil, respectful interactions with parents/adults. (49)

49. Establish with the client the basics of treating others respectfully. Teach the principle of reciprocity, asking him/her to agree to treat everyone in a respectful manner for a 1-week period to see if others will reciprocate by treating him/her with more respect (or assign "Stop Yelling" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

30. Increase the frequency of responsible and positive social behaviors. (50, 51)

50. Direct the client to engage in three altruistic or benevolent acts (e.g., read to a developmentally disabled student, mow grandmother's lawn) before the next session to increase his/her empathy and sensitivity to the needs of others.

51. Place the client in charge of tasks at home (e.g., preparing and cooking a special dish for a

family get-together, building shelves in the garage, changing oil in the car) to demonstrate confidence in his/her ability to act responsibly.

31. Parents participate in marital therapy. (52)

52. Assess the marital dyad for possible substance abuse, conflict, or triangulation that shifts the focus from marriage issues to the client's acting-out behaviors; refer for appropriate treatment, if needed.

32. Participate in family therapy to explore and change family dynamics that contribute to the emergence of anger control problems. (53)

53. Conduct Functional Family Therapy (see fftinc.com/index.html) or Brief Strategic Family Therapy (see bsft.org) to assess and intervene within the family system toward reducing its contributions to the client's anger control problems.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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|---|---|---|
| **Axis I:** | 312.34 | Intermittent Explosive Disorder |
| | 296.xx | Bipolar I Disorder |
| | 296.89 | Bipolar II Disorder |
| | 312.8 | Conduct Disorder |
| | 310.1 | Personality Change Due to Axis III Disorder |
| | 309.81 | Posttraumatic Stress Disorder |
| | _____ | _____ |
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| **Axis II:** | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 312.34 | F63.81 | Intermittent Explosive Disorder |
| 296.xx | F31.xx | Bipolar I Disorder |
| 296.89 | F31.81 | Bipolar II Disorder |
| 312.8 | F91.x | Conduct Disorder |
| 310.1 | F07.0 | Personality Change Due to Another Medical Condition |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

# ANXIETY

## BEHAVIORAL DEFINITIONS

1. Excessive anxiety, worry, or fear that markedly exceeds the normal level for the client's stage of development.
2. High level of motor tension, such as restlessness, tiredness, shakiness, or muscle tension.
3. Autonomic hyperactivity (e.g., rapid heartbeat, shortness of breath, dizziness, dry mouth, nausea, diarrhea).
4. Hypervigilance, such as feeling constantly on edge, concentration difficulties, trouble falling or staying asleep, and a general state of irritability.
5. A specific fear that has become generalized to cover a wide area and has reached the point where it significantly interferes with the client and his/her family's daily life.
6. Excessive anxiety or worry due to parent's threat of abandonment, overuse of guilt, denial of autonomy and status, friction between parents, or interference with physical activity.

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## LONG-TERM GOALS

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

4. Enhance ability to effectively cope with the full variety of life's anxieties.
5. Parents effectively manage child's anxious thoughts, feelings, and behaviors.
6. Family members function effectively without undue anxiety.

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## SHORT-TERM OBJECTIVES

1. Describe current and past experiences with specific fears, prominent worries, and anxiety symptoms, including their impact on functioning and attempts to resolve them. (1, 2)

2. Complete questionnaires designed to assess fear, worry, and anxiety symptoms. (3)

## THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with the client through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help increase his/her ability to identify and express concerns.

2. Assess the focus, excessiveness, and uncontrollability of the client's fears and worries, and the type, frequency, intensity, and duration of his/her anxiety symptoms (e.g., use *The Anxiety Disorders Interview Schedule—Parent Version* or *Child Version*; consider assigning "Finding and Losing Your Anxiety" and/or "What Makes Me Anxious" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

3. Administer a patient and/or parent-report measure to help assess the nature and degree of the client's fears, worries, and anxiety symptoms (e.g., *Revised Children's Manifest Anxiety*

*Scale*; *Multidimensional Anxiety Scale for Children*); repeat administration as desired to assess therapeutic progress.

3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (4, 5, 6, 7, 8)

4. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

5. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

6. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.

7. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care

(e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

8. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment or other grossly inept parenting).

4. Cooperate with an evaluation by a physician for antianxiety medication. (9, 10)

9. Refer the client to a physician for a psychotropic medication consultation.

10. Monitor the client's psychotropic medication compliance, side effects, and effectiveness; confer regularly with the physician.

5. Verbalize an understanding of how thoughts, physical feelings, and behavioral actions contribute to anxiety and its treatment. (11, 12, 13)

11. Educate the client about the interrelated physiological, cognitive, emotional, and behavioral components of anxiety, including how fears and worries typically involve excessive concern about unrealistic threats, various bodily expressions of tension, overarousal, hypervigilance, and avoidance of what is threatening, which interact to maintain problematic anxiety (e.g., see *The*

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| | *C.A.T. Project Manual for the Cognitive Behavioral Treatment of Anxious Adolescents* by Kendall et al.; *Helping Your Anxious Child* by Rapee et al.). EBT |
| | 12. Discuss how treatment targets the interrelated components of anxiety to help the client identify and manage thoughts, overarousal, and effectively overcoming unnecessary avoidance. EBT |
| | 13. Assign the client and/or parents to read psychoeducational sections of books or treatment manuals to emphasize key therapy concepts (e.g., *The C.A.T. Project Workbook for the Cognitive Behavioral Treatment of Anxious Adolescents* by Kendall et al.; *Helping Your Anxious Child* by Rapee et al.). EBT |
| EBT 6. Learn and implement calming skills to reduce overall anxiety and manage anxiety symptoms. (14, 15, 16, 17) | 14. Teach the client calming skills (e.g., progressive muscle relaxation, guided imagery, slow diaphragmatic breathing) and how to discriminate better between relaxation and tension; teach the client how to apply these skills to his/her daily life. EBT |
| | 15. Assign the client homework each session in which he/she practices calming daily (or assign "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review and reinforce success while providing corrective feedback toward improvement. EBT |
| | 16. Assign the client and/or parents to read and discuss progressive muscle relaxation and other |

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| | calming strategies in relevant books or treatment manuals (e.g., *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay; *The Relaxation and Stress Reduction Workbook for Kids* by Shapiro and Sprague). EBP |
| | 17. Use biofeedback techniques to facilitate the client's success at learning calming skills. EBP |
| EBP 7. Verbalize an understanding of the role that fearful thinking plays in creating fears, excessive worry, and persistent anxiety symptoms. (18, 19, 20) | 18. Discuss examples demonstrating that unrealistic fear or worry typically overestimates the probability of threats and underestimates the client's ability to manage realistic demands. EBP |
| | 19. Assist the client in challenging his/her fear or worry by examining the actual probability of the negative expectation occurring, the real consequences of it occurring, his/her ability to manage the likely outcome, the worst possible outcome, and his/her ability to accept it. EBP |
| | 20. Help the client gain insight into the notion that fear and worry involve a form of avoidance of the problem, that this creates anxious arousal, and precludes resolution. EBP |
| EBP 8. Identify, challenge, and replace fearful self-talk with positive, realistic, and empowering self-talk. (21, 22, 23, 24) | 21. Explore the client's schema and self-talk that mediate his/her fear response; challenge the biases; assist him/her in replacing the distorted messages with reality-based alternatives and positive self-talk that will increase his/her self-confidence in coping with irrational fears or worries. EBP |
| | 22. Assign the client a homework exercise in which he/she identifies |

fearful self-talk and creates reality-based alternatives (or assign "Tools for Anxiety" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review and reinforce success, providing corrective feedback toward improvement.

23. Teach the client to implement a thought-stopping technique (thinking of a STOP sign and then a pleasant scene) for fears or worries that have been addressed but persist (or assign "Making Use of the Thought-Stopping Technique" in the *Adult Psychotherapy Homework Planner* by Jongsma); monitor and encourage the client's use of the technique in daily life between sessions.

24. Assign parents to read and discuss with the client cognitive restructuring of fears or worries in relevant books or treatment manuals (e.g., *The C.A.T. Project Workbook for the Cognitive Behavioral Treatment of Anxious Adolescents by* Kendall et al.; *Helping Your Anxious Child* by Rapee et al.).

9. Learn and implement a stimulus control strategy to limit the association between various environmental settings and worry, delaying the worry until a designated "worry time." (25, 26)

25. Explain how using "worry time" limits the association between worrying and environmental stimuli; agree upon setting a worry time and place with the client and implement.

26. Teach the client to recognize and postpone worry to the agreed-upon worry time and place using skills such as thought stopping, relaxation, and redirecting attention (or assign "Worry

Time" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis to assist skill development); encourage use in daily life, reviewing and reinforcing success while providing corrective feedback toward improvement.

10. Participate in live, or imaginal then live, exposure exercises in which worries and fears are gradually faced. (27, 28, 29, 30 )

27. Direct and assist the client in constructing a hierarchy around two to three spheres of worry for use in exposure (e.g., fears of school failure, worries about relationship problems).

28. Select initial exposures that have a high likelihood of being a success experience for the client; develop a coping plan for managing the negative effect engendered by exposure; mentally rehearse the procedure.

29. Ask the client to vividly imagine conducting the exposure, or conduct it live until anxiety associated with it weakens and a sense of safety and/or confidence strengthens; process the experience.

30. Assign the client a homework exercise in which he/she does gradual exposure to identified fears and records responses; review, reinforce success, and provide corrective feedback toward improvement (or assign "Gradual Exposure to Fear" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

11. Learn and implement new strategies for realistically addressing fears or worries. (31, 32)

31. Ask the client to develop a list of key conflicts that trigger fear or worry and process this list toward resolution using

problem-solving, assertiveness, acceptance, and/or cognitive restructuring (consider assigning "Problem-Solving Exercise" or "Becoming Assertive" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

32. Assign the client a homework exercise in which he/she works on solving a current problem using skills learned in therapy (see "Tools for Anxiety" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review, repeat, reinforce success, and provide corrective feedback toward effective use of skills.

12. Increase participation in daily social and academic activities. (33)

33. Encourage the client to increase daily social and academic activities and other potentially rewarding experiences to strengthen his/her new nonavoidant approach and build self-confidence.

13. Parents verbalize an understanding of the client's treatment plan and a willingness to participate in it with the client. (34)

34. If acceptable to the client and if possible, involve the client's parents in the treatment, having them participate in selective activities.

14. Participate in a cognitive behavioral group treatment for anxiety to learn about anxiety, develop skills for managing it, and use the skills effectively in everyday life. (35)

35. Conduct cognitive behavioral group therapy (e.g., *Cognitive Behavioral Therapy for Anxious Children: Therapist Manual for Group Treatment* by Flannery-Schroeder and Kendall; the *FRIENDS Program for Youth* series by Barrett et al.) in which participant youth are taught about the cognitive, behavioral, and emotional components of anxiety, learn and implement skills for coping with anxiety,

and then practice their new skills in several anxiety-provoking situations toward consistent effective use.

15. Participate in cognitive behavioral family therapy to learn about anxiety, develop skills for managing it, and use the skills effectively in everyday life, while parents learn and implement constructive ways to respond to the client's fear and avoidance. (36, 37, 38)

36. Conduct cognitive behavioral family therapy (e.g., *Cognitive Behavioral Family Therapy for Anxious Children* by Howard et al.; the *FRIENDS Program for Youth* series by Barrett et al.) in which family members are taught about the cognitive, behavioral, and emotional components of anxiety, learn and implement skills for coping with anxiety, practice their new skills, and parents learn parenting skills to facilitate therapeutic progress.

37. Teach parents constructive skills for managing their child's anxious behavior, including how to prompt and reward courageous behavior, empathetically ignore excessive complaining and other avoidant behaviors, manage their own anxieties, and model the behavior being taught in session.

38. Teach family members anxiety management, problem-solving, and communication skills to reduce family conflict and assist the client's progress through therapy.

16. Learn and implement relapse prevention strategies for managing possible future fears or worries. (39, 40, 41, 42)

39. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of a fear, worry, anxiety symptom, or urges to avoid and relapse with the decision to return to a fearful and avoidant manner

of dealing with the fear or worry.

40. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.

41. Instruct the client to routinely use his/her newly learned skills in relaxation, cognitive restructuring, exposure, and problem-solving exposures as needed to address emergent fears or worries, building them into his/her life as much as possible.

42. Develop a "coping card" or other reminder on which coping strategies and other important information (e.g., "Breathe deeply and relax," "Challenge unrealistic worries," "Use problem-solving") are recorded for the client's or parent's later use.

17. Parents learn and implement constructive ways to respond to the client's fear and avoidance. (43)

43. Teach the parents skills in effectively responding to the client's fears and anxieties with calm reassurance and reward for successes and with calm persistence in prompting coping skills when needed; frame the family as an expert team.

18. Parents learn and implement problem-solving strategies, assertive communication, and other constructive ways to respond to their own anxieties. (44)

44. Teach and encourage parents to use the same nonavoidant skills the client is learning to manage and approach their own fears and worries, including problem-solving conflicts and assertive communication (e.g., *Keys to Parenting Your Anxious Child* by Manassis or *Face Your Fears* by Tolin).

19. Learn to accept limitations in life and commit to tolerating, rather than avoiding, unpleasant emotions while accomplishing meaningful goals. (45)

20. Explore a connection, symbolic or not, between present anxiety and past experiences. (46)

45. Use an Acceptance and Commitment Therapy approach to help client accept uncomfortable realities such as lack of complete control, imperfections, and uncertainty and tolerate unpleasant emotions and thoughts while accomplishing value-consistent goals.

46. Explore with the client the influence of past experiences with loss, abandonment, or other anxiety-related developmental themes on current fears or worries; process toward resolution.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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|---|---|---|
| **Axis I:** | 300.02 | Generalized Anxiety Disorder |
| | 300.00 | Anxiety Disorder NOS |
| | 314.01 | Attention-Deficit/Hyperactivity Disorder, Combined Type |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | V71.09 | No Diagnosis |
| | _____ | _____ |
| | _____ | _____ |

*Using DSM-5/ICD-9-CM/ICD-10-CM*:

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 300.09 | F41.8 | Other Specified Anxiety Disorder |
| 300.00 | F41.9 | Unspecified Anxiety Disorder |
| 314.01 | F90.2 | Attention-Deficit/Hyperactivity Disorder, Combined Presentation |
| 309.24 | F43.22 | Adjustment Disorder, With Anxiety |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

# ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)

## BEHAVIORAL DEFINITIONS

1. Short attention span; difficulty sustaining attention on a consistent basis.
2. Susceptibility to distraction by extraneous stimuli and internal thoughts.
3. Gives impression that he/she is not listening well.
4. Repeated failure to follow through on instructions or complete school assignments or chores in a timely manner.
5. Poor organizational skills as demonstrated by forgetfulness, inattention to details, and losing things necessary for tasks.
6. Hyperactivity as evidenced by a high energy level, restlessness, difficulty sitting still, or loud or excessive talking.
7. Impulsivity as evidenced by difficulty awaiting turn in group situations, blurting out answers to questions before the questions have been completed, and frequent intrusions into others' personal business.
8. Frequent disruptive, aggressive, or negative attention-seeking behaviors.
9. Tendency to engage in carelessness or potentially dangerous activities.
10. Difficulty accepting responsibility for actions, projecting blame for problems onto others, and failing to learn from experience.
11. Low self-esteem and poor social skills.

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## LONG-TERM GOALS

1. Sustain attention and concentration for consistently longer periods of time and increase the frequency of on-task behaviors.
2. Demonstrate marked improvement in impulse control.
3. Regularly take medication as prescribed to decrease impulsivity, hyperactivity, and distractibility.
4. Parents and/or teachers successfully utilize a reward system, contingency contract, or token economy to reinforce positive behaviors and deter negative behaviors.
5. Parents set firm, consistent limits and maintain appropriate parent-child boundaries.

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## SHORT-TERM OBJECTIVES

1. Client and parents describe the nature of the ADHD including specific behaviors, triggers, and consequences. (1, 2, 3)

## THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with the client and parents through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help increase his/her ability to identify and express feelings.
2. Thoroughly assess the various stimuli (e.g., situations, people, thoughts) that have triggered the client's ADHD behavior; the thoughts, feelings, and actions that have characterized his/her responses; and the consequences of the behavior (e.g., reinforcements, punishments) toward identifying

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| | target behaviors, antecedents, consequences, and the appropriate placement of interventions (e.g., school-based, home-based, peer-based).<br>3. Rule out alternative conditions/causes of inattention, hyperactivity, and impulsivity (e.g., other behavioral, physical, emotional problems, or normal developmental behavior). |
| 2. Complete psychological testing to measure the nature and extent of ADHD and/or rule out other possible contributors. (4) | 4. Arrange for psychological testing and/or objectives measures to assess the features of ADHD (e.g., *Disruptive Behavior Rating Scale*; *ADHD Rating Scale–IV*) rule out emotional problems that may be contributing to the client's inattentiveness, impulsivity, and hyperactivity; and/or measure the behavior and stimuli associated with its appearance; give feedback to the client and his/her parents regarding the testing results. |
| 3. Provide behavioral, emotional and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8, 9) | 5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change). |

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
9. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

4. Take prescribed medication as directed by the physician. (10, 11)

5. Parents and the client demonstrate increased knowledge about ADHD and its treatment. (12, 13, 14, 15)

10. Arrange for the client to have an evaluation by a physician to assess the appropriateness of prescribing ADHD medication.

11. Monitor the client for psychotropic medication prescription compliance, side effects, and effectiveness; consult with the prescribing physician at regular intervals (consider assigning "Evaluating Medication Effects" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

12. Educate the client and/or client's parents about the signs and symptoms of ADHD.

13. Discuss with the client and/or parents the various treatment options for ADHD (e.g., behavioral parent training, classroom-based behavioral management programs, peer-based programs, medication), discussing risks and benefits to fully inform the parents' decision-making.

14. Assign the parents readings to increase their knowledge of ADHD (e.g., *Taking Charge of ADHD* by Barkley; *Parenting Children With ADHD: 10 Lessons That Medicine Cannot Teach* by Monastra; *The Family ADHD Solution: A Scientific Approach to Maximizing Your Child's Attention and Minimizing Parental Stress* by Bertin).

15. Assign the client readings to increase his/her knowledge about ADHD and ways to manage related behavior (e.g., *The*

*ADHD Workbook for Teens: Activities to Help You Gain Motivation and Confidence* by Honos-Webb; *Take Control of ADHD: The Ultimate Guide for Teens with ADHD* by Spodak and Stephano; *ADHD—A Teenager's Guide* by Crist).

6. Parents learn and implement Parent Management Training to increase prosocial behavior and decrease disruptive behavior of their adolescent child/children. (16, 17, 18, 19, 20)

16. Explain how parent and child behavioral interactions can reduce the frequency of impulsive, disruptive, and negative attention-seeking behaviors and increase desired prosocial behavior through prompting and reinforcing positive behaviors as well as use of clear instruction, time out, and other loss-of-privilege practices for problem behavior (recommend *The Kazdin Method for Parenting the Defiant Child* by Kazdin; *Parents and Adolescents Living Together: Part 1, The Basics* by Patterson and Forgatch).

17. Teach the parents how to specifically define and identify problem behaviors, identify their reactions to the behavior, determine whether the reaction encourages or discourages the behavior, and generate alternatives to the problem behavior (assign "Switching from Defense to Offense" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

18. Teach parents about the possible functions of the ADHD behavior (e.g., avoidance, attention, to gain a desired object/activity, regulate sensory stimulation); how to test

which function(s) is being served by the behavior, and how to use parent training methods to manage the behavior.

19. Assign the parents home exercises in which they implement and record results of reinforcing prosocial behavior (or assign "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review in session, providing corrective feedback toward improved, appropriate, and consistent use of skills.

20. Refer parents to a Parent Management Training Course.

7. Parents work with therapist and school to implement a behavioral classroom management program. (21, 22)

21. Consult with the client's teachers to implement age-appropriate strategies to improve school performance, such as sitting in the front row during class, using a prearranged signal to redirect the client back to task, scheduling breaks from tasks, providing frequent feedback, calling on the client often, arranging for a listening buddy, and implementing a daily behavioral report card.

22. Consult with parents and pertinent school personnel to implement an age-appropriate Behavioral Classroom Management Intervention (see *ADHD in the Schools* by DuPaul and Stoner, or *Homework Success for Children with ADHD: A Family-School Intervention Program* by Power, Karustis, and Habboushe) that reinforces appropriate behavior at school

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| | and at home, uses time-out for undesirable behavior, and uses a daily behavioral report card to monitor progress. EB |
| EB 8. Complete a peer-based treatment program focused on improving social interaction skills. (23) | 23. Conduct or refer the client to a Behavioral Peer Intervention (e.g., Summer Treatment Program or after-school/weekend version) that involves brief social skills training followed by coached group play in recreational activities guided by contingency management systems (e.g., point system, time-out) and utilizing objective observations, frequency counts, and adult ratings of social behaviors as outcome measures (see *Children's Summer Treatment Program Manual for ADHD* by Pelham, Greiner, and Gnagy). EB |
| 9. Parents develop and utilize an organized system to keep track of the client's school assignments, chores, and household responsibilities. (24, 25) | 24. Assist the parents in developing and implementing an organizational system to increase the client's on-task behaviors and completion of school assignments, chores, or household responsibilities through the use of calendars, charts, notebooks, and class syllabi (see "Getting It Done" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 25. Assist the parents in developing a routine schedule to increase the client's compliance with school, household, or work-related responsibilities. |
| 10. Utilize effective study and test-taking skills on a regular basis to improve academic performance. (26, 27, 28) | 26. Teach the client more effective study skills (e.g., clearing away distractions, studying in quiet places, and scheduling breaks in studying). |

27. Teach the client more effective test-taking strategies (e.g., reviewing material regularly, reading directions twice, and rechecking work).
28. Assign the client to read *13 Steps to Better Grades* (Silverman) to improve organizational and study skills; process the material read and identify ways to implement new practices.

11. Increase frequency of completion of school assignments, chores, and household responsibilities. (29)

29. Assist the parents in developing a routine schedule to increase the client's compliance with school, household, or work-related responsibilities (or employ the "Getting It Done" program in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

12. Delay instant gratification in favor of achieving meaningful long-term goals. (30, 31)

30. Teach the client mediational and self-control strategies (e.g., "stop, look, listen, and think") to delay the need for instant gratification and inhibit impulses to achieve more meaningful, longer-term goals (or assign "Action Minus Thought Equals Painful Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
31. Assist the parents in increasing structure to help the client learn to delay gratification for longer-term goals (e.g., completing homework or chores before playing).

13. Learn and implement social skills to reduce anxiety and build confidence in social interactions. (32, 33)

32. Use instruction, modeling, and role-playing to build the client's general and developmentally appropriate social and/or communication skills.

33. Assign the client to read about general social and/or communication skills in books or treatment manuals on building social skills (e.g., or assign the "Social Skills Exercise" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

14. Identify and implement effective problem-solving strategies. (34, 35)

34. Teach older clients effective problem-solving skills through identifying the problem, brainstorming alternative solution options, listing pros and cons of each solution option, selecting an option, implementing a course of action, and evaluating the outcome (or assign the "Problem-Solving Exercise" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

35. Utilize role-playing and modeling to teach the older child how to implement effective problem-solving techniques in his/her daily life.

15. Increase the frequency of positive interactions with parents. (36, 37, 38)

36. Explore for periods of time when the client demonstrated good impulse control and engaged in fewer disruptive behaviors; process his/her responses and reinforce positive coping mechanisms that he/she used to deter impulsive or disruptive behaviors.

37. Instruct the parents to observe and record three to five positive behaviors by the client in between therapy sessions; reinforce positive behaviors and encourage him/her to continue to exhibit these behaviors.

38. Encourage the parents to spend 10 to 15 minutes daily of one-on-one time with the client to create a closer parent-child bond. Allow the client to take the lead in selecting the activity or task.

16. Increase the frequency of socially appropriate behaviors with siblings and peers. (39, 40)

39. Give homework assignments where the client identifies 5 to 10 strengths or interests; review the list in the following session and encourage him/her to utilize strengths or interests to establish friendships (consider assigning "Show Your Strengths" or "Recognizing Your Abilities, Traits, and Accomplishments" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

40. Assign the client the task of showing empathy, kindness, or sensitivity to the needs of others (e.g., allowing sibling or peer to take first turn in a video game, helping with a school fundraiser).

17. Increase verbalizations of acceptance of responsibility for misbehavior. (41, 42)

41. Firmly confront the client's impulsive behaviors, pointing out consequences for him/her and others.

42. Confront statements in which the client blames others for his/her annoying or impulsive behaviors and fails to accept responsibility for his/her actions.

18. Identify stressors or painful emotions that trigger an increase in hyperactivity and impulsivity. (43, 44, 45)

43. Explore and identify stressful events or factors that contribute to an increase in impulsivity, hyperactivity, and distractibility.

44. Explore possible stressors, roadblocks, or hurdles that might cause impulsive and acting-out behaviors to increase in the future.

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| | 45. Identify coping strategies (e.g., "stop, look, listen, and think," guided imagery, utilizing "I messages" to communicate needs) that the client and his/her family can use to cope with or overcome stressors, roadblocks, or hurdles. |
| 19. Parents and the client regularly attend and actively participate in group therapy. (46) | 46. Encourage the client's parents to participate in an ADHD support group. |
| 20. Complete a course of biofeedback to improve concentration and attention. (47) | 47. Conduct or refer the client to a trial of EEG biofeedback (neurotherapy) for ADHD. |
| 21. Identify and list constructive ways to utilize energy. (48) | 48. Give a homework assignment where the client lists the positive and negative aspects of his/her high energy level; review the list in the following session and encourage him/her to channel energy into healthy physical outlets and positive social activities (or assign "Channel Your Energy in a Positive Direction" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 22. Express feelings through artwork. (49) | 49. Instruct the client to draw a picture reflecting what it feels like to have ADHD; process content of the drawing with the therapist. |
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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 314.01 | Attention-Deficit/Hyperactivity Disorder, Combined Type |
| | 314.00 | Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type |
| | 314.01 | Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type |
| | 314.9 | Attention-Deficit/Hyperactivity Disorder NOS |
| | 312.81 | Conduct Disorder, Childhood-Onset Type |
| | 313.81 | Oppositional Defiant Disorder |
| | 312.9 | Disruptive Behavior Disorder NOS |
| | 296.xx | Bipolar I Disorder |
| | _____ | _____ |
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| **Axis II:** | V71.09 | No Diagnosis |
| | _____ | _____ |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 314.01 | F90.2 | Attention-Deficit/Hyperactivity Disorder, Combined Presentation |
| 314.00 | F90.0 | Attention-Deficit/Hyperactivity Disorder, Predominately Inattentive Presentation |
| 314.01 | F90.1 | Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive /Impulsive Presentation |
| 314.01 | F90.9 | Unspecified Attention-Deficit/ Hyperactivity Disorder |
| 314.01 | F90.8 | Other Specified Attention-Deficit/ Hyperactivity Disorder |
| 312.81 | F91.1 | Conduct Disorder, Childhood-Onset Type |
| 312.82 | F91.2 | Conduct Disorder, Adolescent-Onset Type |
| 313.81 | F91.3 | Oppositional Defiant Disorder |
| 312.9 | F91.9 | Unspecified Disruptive, Impulse Control, and Conduct Disorder |

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| 312.89 | F91.8 | Other Specified Disruptive, Impulse Control, and Conduct Disorder |
| 296.xx | F31.xx | Bipolar I Disorder |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# AUTISM SPECTRUM DISORDER

## BEHAVIORAL DEFINITIONS

1. Pervasive lack of interest in or responsiveness to other people.
2. Chronic failure to develop social relationships appropriate to the developmental level.
3. Lack of spontaneity and emotional or social reciprocity.
4. Significant delays in or total lack of spoken language development.
5. Impairment in sustaining or initiating conversation.
6. Oddities in speech and language as manifested by echolalia, pronominal reversal, or metaphorical language.
7. Inflexible adherence to repetition of nonfunctional rituals or stereotyped motor mannerisms.
8. Persistent preoccupation with objects, parts of objects, or restricted areas of interest.
9. Marked impairment or extreme variability in intellectual and cognitive functioning.
10. Extreme resistance or overreaction to minor changes in routines or environment.
11. Emotional constriction or blunted affect.
12. Recurrent pattern of self-abusive behaviors (e.g., head banging, biting, or burning self).

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## LONG-TERM GOALS

1. Develop basic language skills and the ability to communicate simply with others.
2. Establish and maintain a basic emotional bond with primary attachment figures.
3. Achieve the educational, behavioral, and social goals identified on the individualized educational plan (IEP).
4. Family members develop acceptance of the client's overall capabilities and place realistic expectations on his/her behavior.
5. Engage in reciprocal and cooperative interactions with others on a regular basis.
6. Stabilize mood and tolerate changes in routine or environment.
7. Eliminate all self-abusive behaviors.
8. Attain and maintain the highest realistic level of independent functioning.

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## SHORT-TERM OBJECTIVES

1. Cooperate with and complete all recommended evaluations and testing. (1, 2, 3, 4)

## THERAPEUTIC INTERVENTIONS

1. Arrange for an intellectual and cognitive assessment to gain greater insights into the client's strengths and weaknesses; provide feedback to the parents.
2. Refer the client for a speech/language evaluation; consult with the speech/language pathologist about the evaluation findings.
3. Arrange for a neurological evaluation or neuropsychological testing of the client to rule out organic factors.

2. Provide behavioral, emotional and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8, 9)

4. Arrange for a psychiatric evaluation of the client.
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivatedto work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resis tance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe

impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

9. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

3. Comply fully with the recommendations offered by the assessment(s) and individualized educational planning committee (IEPC). (10)

10. Attend an individualized educational planning committee (IEPC) review to establish the client's eligibility for special education services, to update and revise educational interventions, and to establish new behavioral and educational goals.

4. Comply with the move to an appropriate classroom setting. (11)

11. Consult with the parents, teachers, and other appropriate school officials about designing effective learning programs, classroom assignments, or interventions that build on the client's strengths and compensate for weaknesses.

5. Comply with the move to an appropriate alternative residential placement setting. (12)

12. Consult with the parents, school officials, and mental health professionals about the need to place the client in an alternative residential setting (e.g., foster care, group home, residential program).

6. Attend speech and language therapy sessions. (13)

7. Increase the frequency of appropriate, spontaneous verbalizations toward the therapist, family members, and others. (14, 15, 16)

8. Decrease oddities or peculiarities in speech and language. (17)

9. Decrease the frequency and severity of temper outbursts and aggressive and self-abusive behaviors. (18, 19, 20, 21, 22)

13. Refer the client to a speech/language pathologist for ongoing services to improve his/her speech and language abilities.

14. Actively build the level of trust with the client through consistent eye contact, frequent attention and interest, unconditional positive regard, and warm acceptance to facilitate increased communication.

15. Employ frequent use of praise and positive reinforcement to increase the client's initiation of verbalizations as well as acknowledgment of and responsiveness to others' verbalizations.

16. Provide the parents with encouragement, support, and reinforcement or modeling methods to foster the client's language development.

17. In conjunction with the speech therapist, design and implement a response-shaping program using positive reinforcement principles to facilitate the client's language development and decrease oddities or peculiarities in speech and language.

18. Teach the parents behavior management techniques (e.g., time-out, response cost, overcorrection, removal of privileges) to decrease the client's idiosyncratic speech, excessive self-stimulation temper outbursts, and self-abusive behaviors (or assign "Managing the Meltdowns" in the

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| | *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 19. Design a token economy for use in the home, classroom, or residential program to improve the client's social skills, anger management, impulse control, and speech/language abilities. |
| | 20. Develop a reward system or contingency contract to improve the client's social skills and anger control. |
| | 21. Teach the proper use of aversive therapy techniques to stop or limit the client's self-abusive or self-stimulating behaviors. |
| | 22. Counsel the parents to develop interventions to manage the client's self-abusive behaviors, including positive reinforcement, response cost, and, if necessary, physical restraint. |
| 10. Parents verbalize increased knowledge and understanding of autism spectrum disorders. (23) | 23. Educate the client's parents and family members about the maturation process in individuals with autism spectrum disorders and the challenges that this process presents. |
| 11. Parents increase social support network. (24, 25) | 24. Direct the parents to join the Autism Society of America to expand their social network, to gain additional knowledge of the disorder, and to give them support and encouragement. |
| | 25. Refer the client's parents to a support group for parents of autistic children. |
| 12. Parents utilize respite care to reduce stress related to being caregiver(s). (26) | 26. Refer the parents to, and encourage them to use, respite care for the client on a periodic basis. |

13. Demonstrate essential self-care and independent living skills. (27, 28, 29)

27. Counsel the parents about teaching the client essential self-care skills (e.g., combing hair, bathing, brushing teeth).

28. Monitor and provide frequent feedback to the client regarding his/her progress toward developing self-care skills (or assign "Progress Survey" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

29. Use operant conditioning principles and response-shaping techniques to help the client develop self-help skills (e.g., dressing self, making bed, fixing sandwich) and improve personal hygiene.

14. Parents and siblings report feeling a closer bond with the client. (30, 31)

30. Conduct family therapy sessions to provide the parents and siblings with the opportunity to share and work through their feelings pertaining to the client's autism spectrum disorder.

31. Assign the client and his/her parents a task (e.g., swimming, riding a bike) that will help build trust and mutual dependence (or assign "Interaction as a Family" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

15. Increase the frequency of positive interactions with parents and siblings. (32, 33)

32. Encourage the family members to regularly include the client in structured work or play activities for 20 minutes each day.

33. Encourage detached parents to increase their involvement in the client's daily life, leisure activities, or schoolwork.

16. Channel strengths or areas of interest into a positive, constructive activity. (34, 35)

34. Redirect the client's preoccupation with a single object or restricted area of interest to turn it into a productive activity (e.g., learning to tune instruments, using interest with numbers to learn how to budget allowance money).

35. Employ applied behavior analysis in home, school, or residential setting to alter maladaptive behaviors. First, define and operationalize target behaviors. Next, select antecedents and consequences for specific behaviors. Then, observe and record the client's response to reinforcement interventions. Finally, analyze data to assess treatment effectiveness (or assign "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

17. Increase the frequency of social contacts with peers. (36, 37)

36. Consult with the client's parents and teachers about increasing the frequency of the client's social contacts with his/her peers (see *Social Skills Picture Book for High School and Beyond* by Baker) such as working with a student aide in class, attending Sunday School, or participating in Special Olympics (or assign "Greeting Peers," "Developing Conversational Skills," or "Observe Positive Social Behaviors" in the *Adolescent Psychotherapy Homework*

*Planner* by Jongsma, Peterson, and McInnis).

37. Refer the client to a summer camp program to foster social contacts.

18. Attend vocational training sessions. (38, 39)

38. Refer the client to a sheltered workshop or vocational training program to develop basic job skills.

39. Help the family to arrange an interview for the client's possible placement in a school-based vocational training program.

19. Attend a program to build skills for independent activities of daily living. (40)

40. Refer the client to a life or daily skills program that builds competency in budgeting, cooking, shopping, and other skills required to maintain an independent living arrangement.

20. Parents verbalize their fears regarding the client living independent of them. (41)

41. Help the parents and family process their concerns and fears about the client living independently from them (or assign "Progress: Past, Present, and Future" or "Progress Survey" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

21. Parents develop and implement a step program for moving the client toward establishing independent status. (42, 43, 44)

42. Work with the family and parents to develop a step program that will move the client toward working and living independently (or assign "Moving Toward Independence" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

43. Coach and monitor the parents and the client in implementing a plan for the client to live independently.

44. Assist the family in finding a group home or supervised living program (e.g., an apartment with an on-site manager) for the client to establish his/her independence from the family.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 299.00 | Autistic Disorder |
| | 299.80 | Pervasive Developmental Disorder NOS |
| | 299.80 | Rett's Disorder |
| | 299.10 | Childhood Disintegrative Disorder |
| | 299.80 | Asperger's Disorder |
| | 307.3 | Stereotypic Movement Disorder |
| | 295.xx | Schizophrenia |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | 317 | Mild Mental Retardation |
| | 319 | Mental Retardation, Severity Unspecified |
| | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
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| 299.00 | F84 | Autistic Spectrum Disorder |
| 315.9 | F89 | Unspecified Neurodevelopmental Disorder |
| 315.8 | F88 | Other Specified Neurodevelopmental Disorder |

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| 313.89 | F94.1 | Reactive Attachment Disorder |
| 295.xx | F20.9 | Schizophrenia |
| 317 | F70 | Intellectual Disability, Mild |
| 319 | F79 | Unspecified Intellectual Disability |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# BIPOLAR DISORDER

## BEHAVIORAL DEFINITIONS

1. Exhibits an abnormally and persistently elevated, expansive, or irritable mood with at least three additional symptoms of mania.
2. Demonstrates loquaciousness or pressured speech.
3. Reports flight of ideas or thoughts racing.
4. Verbalizes grandiose ideas, inflated self-esteem, and/or persecutory beliefs.
5. Exhibits increased motor activity or psychomotor agitation.
6. Loss of normal inhibition leads to impulsive and excessive pleasure-oriented, high-risk behavior without regard for painful consequences.
7. Depressed or irritable mood.
8. Diminished interest in or enjoyment of activities.
9. Lack of energy.
10. Poor concentration and indecisiveness.
11. Social withdrawal.
12. Suicidal thoughts and/or gestures.
13. Mood-related hallucinations or delusions.
14. History of at least one hypomanic, manic, or mixed-mood episode.

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## LONG-TERM GOALS

1. Alleviate bipolar symptoms and return to previous level of effective functioning.

2. Stabilize energy level and return to usual activities, good judgment, stable mood, more realistic expectations, and goal-directed behavior.
3. Reduce agitation, impulsivity, and pressured speech while achieving sensitivity to the consequences of behavior and having more realistic expectations.
4. Renew typical interest in academic achievement, social involvement, and eating patterns as well as occasional expressions of joy and zest for life.
5. Elevate mood and show evidence of usual energy, activities, and socialization level.
6. Achieve controlled behavior, moderated mood, more deliberative speech and thought process, and a stable daily activity pattern.
7. Develop healthy interpersonal relationships that lead to the alleviation and help prevent the relapse of mania and depression.
8. Talk about underlying feelings of low self-esteem or guilt and fears of rejection, dependency, and abandonment.

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## SHORT-TERM OBJECTIVES

1. Describe mood state, energy level, amount of control over thoughts, and sleeping pattern. (1, 2)

## THERAPEUTIC INTERVENTIONS

1. Encourage the client to share his/her thoughts and feelings; express empathy and build rapport while assessing primary cognitive, behavioral, interpersonal, or other symptoms of the mood disorder.
2. Assess presence, severity, and impact of past and present mood episodes on social, occupational, and interpersonal functioning; supplement with semi-structured inventory, if desired (e.g., *Montgomery-Asberg Depression Rating Scale; Inventory to Diagnose Depression*).

2. Complete psychological testing to assess the nature and impact of mood problems. (3)

3. Arrange for the administration of an objective instrument(s) for evaluating relevant features of the bipolar disorder such as symptoms, communication patterns with family/significant others, or expressed emotion (e.g., *Beck Depression Inventory–II* and/or *Beck Hopelessness Scale*; *Perceived Criticism Measure*); evaluate results and process feedback with the client or client and family; re-administer as indicated to assess treatment response.

3. Disclose any history of substance use that may contribute to and complicate the treatment of social anxiety. (4)

4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it.

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8, 9)

5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgement of the "problem described," is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with attention-deficit/hyperactivity disorder (ADHD), depression secondary to an anxiety disorder) including

vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
9. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

5. Verbalize any history of past and present suicidal thoughts and actions. (10)

10. Assess the client's history of suicidality and current state of suicide risk (see the Suicidal Ideation chapter in this *Planner* if suicide risk is present).

6. State no longer having thoughts of self-harm. (11, 12)

7. Cooperate with a medical/psychiatric evaluation for medication needs to stabilize symptoms. (13)

8. Take prescribed medications as directed. (14)

9. Achieve a level of symptom stability that allows for meaningful participation in psychotherapy. (15)

10. Verbalize an understanding of the causes for, symptoms of, and treatment of bipolar mood episodes and the rationale for treatment. (16, 17, 18, 19)

11. Continuously assess and monitor the client's suicide risk.

12. Arrange for or continue hospitalization if the client is judged to be potentially harmful to self or others, unable to care for his/her own basic needs, or symptom severity warrants it.

13. Arrange for an evaluation with a psychiatrist to determine appropriate pharmacotherapy (e.g., Lithium Carbonate, Depakote, Lamictil).

14. Monitor the client for psychotropic medication prescription compliance, side effects, and effectiveness.

15. Monitor the client's symptom improvement toward stabilization sufficient to allow participation in psychotherapy.

16. Provide psychoeducation to the client and family, using all modalities necessary, including reviewing the signs, symptoms, and phasic relapsing nature of the client's mood episodes (supplement with "Mood Disorders Symptom List" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); destigmatize and normalize (recommend reading *The Bipolar Teen: What You Can Do to Help Your Child and Your Family* by Miklowitz and George).

17. Teach the client a stress diathesis model of bipolar disorder that emphasizes the strong role of a biological predisposition to mood episodes that is vulnerable to personal and interpersonal

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| | stresses, that medication helps moderate and skills help manage. |
| | 18. Provide the client with a rationale for treatment involving on-going medication and psychosocial treatment to recognize, manage, and reduce biological and psychological vulnerabilities that could precipitate relapse. |
| | 19. Ask the client to read a book on bipolar disorder to reinforce psychoeducation done in session (e.g., *The Bipolar Disorder Survival Guide* by Miklowitz; *Bipolar 101: A Practical Guide to Identifying Triggers, Managing Medications, Coping with Symptoms, and More* by White and Preston); review and process concepts learned through the reading. |
| 11. Verbalize acceptance of the need to take psychotropic medication and commit to prescription compliance with blood level monitoring. (20, 21) | 20. Educate the client about the importance of medication compliance; teach him/her the risk for relapse when medication is discontinued and work toward a commitment to prescription adherence. |
| | 21. Assess factors (e.g., thoughts, feelings, stressors) that have precipitated the client's prescription noncompliance; develop a plan for recognizing and addressing them (supplement with the exercise "Medication Resistance" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 12. Client and family members participate in a family-based | 22. Conduct or refer to Family-Focused Treatment with the |

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| therapy emphasizing education about bipolar disorder, personal and interpersonal skills building, and relapse prevention. (22) | client and significant others emphasizing psychoeducation emphasizing the biological nature of bipolar disorder, the need for medication and medication adherence, personal and interpersonal skills building (e.g., communication enhancement, problem-solving), and relapse prevention and early episode intervention planning (see *Bipolar Disorder: A Family-Focused Treatment Approach* by Miklowitz; and *Family Treatment for Bipolar Disorder and Substance Abuse in Late Adolescence* by Miklowitz). |
| 13. Commit to active and consistent participation in Dialectical Behavior Therapy. (23) | 23. Conduct or refer to Dialectical Behavior Therapy adapted for adolescents with bipolar disorder (recommend *The Bipolar Workbook for Teens: DBT Skills to Help You Control Mood Swings* by Van Dijk and Guidon) using individual and group interventions designed to improve knowledge of bipolar disorder, client's personal and interpersonal skills (e.g., mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness), and parent's skills (see *Dialectical Behavior Therapy for Adolescents with Bipolar Disorder* by Goldstein et al. for their adaptation of *Dialectical Behavior Therapy for Suicidal Adolescents* by Miller, Rathus, and Linehan). |
| 14. Attend group psychoeducational and skills building sessions designed to inform members of the nature, causes, and treatment of bipolar disorder. (24, 25) | 24. Conduct or refer the client to a group psychoeducation program that teaches clients the psychological, biological, and social influences in development |

of bipolar disorder, its biological and psychological treatment (see *Dialectical Behavior Therapy for Adolescents with Bipolar Disorder* by Goldstein et al.; the *Psychoeducation Manual for Bipolar Disorder* by Colom and Vieta).

25. Teach the group members illness management skills (e.g., early warning signs, common triggers, coping strategies), problem-solving focused on life goals, and a personal care plan that emphasizes a regular sleep routine, the need to comply with medication, and ways to minimize relapse through stress regulation.

15. Family members learn and implement skills that help manage the client's bipolar disorder and improve the quality of life of the family and its members. (26, 27, 28, 29, 30)

26. Assess and educate the client and family about the role of aversive communication (e.g., high expressed emotion) in family distress and risk for the client's relapse; teach them to reduce aversive communication and replace it with a more controlled, calm, and less critical approach.

27. Use behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach family members communication skills, including: offering positive feedback, active listening, making positive requests of others for behavior change, complimenting and giving constructive feedback in an honest and respectful manner while reducing negative expressed emotion (supplement with "Social Skills Exercise" in

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| | the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). EB |
| | 28. Assist the client and family in identifying conflicts that can be addressed with problem-solving techniques. EB |
| | 29. Use behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach the client and family problem-solving skills, including: defining the problem constructively and specifically, brainstorming solution options, listing pros and cons of the options, choosing and implementing a solution, evaluating the results, and adjusting the plan (or assign "Problem-Solving Exercise" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). EB |
| | 30. Assign the client and family homework exercises to use and record use of newly learned communication and problem-solving skills; process results in session toward effective use; problem-solve obstacles; (consider assigning "Action Minus Thought Equals Painful Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); process results in session. EB |
| EB 16. Develop a "relapse drill" in which roles, responsibilities, and a course of action is agreed upon in the event that signs of relapse emerge. (31) | 31. Help the client and family draw up a "relapse drill" detailing roles and responsibilities (e.g., who will call a meeting of the family to problem-solve |

potential relapse; who will call the client's physician, schedule a blood lithium serum level to be taken, or contact emergency services, if needed); problem-solve obstacles and work toward a commitment to adherence with the plan.

17. Identify and replace thoughts and behaviors that trigger manic or depressive symptoms. (32, 33, 34)

32. Use cognitive therapy techniques to explore and educate the client's about cognitive biases that trigger his/her elevated or depressive mood (see *Cognitive Therapy for Bipolar Disorder* by Lam et al.; and consider assigning "Bad Thoughts Lead to Depressed Feelings" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

33. Assign the client a homework exercise in which he/she identifies self-talk reflective of mania, biases in the self-talk, alternatives (see "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback toward improvement (recommend reading *Thoughts and Feelings: Taking Control of Your Moods and Your Life* by McKay, Davis, and Fanning).

34. Teach the client cognitive-behavioral coping and relapse prevention skills including delaying impulsive actions, structured scheduling of daily activities, keeping a regular sleep routine, avoiding unrealistic goal striving, using relaxation

procedures, identifying and avoiding episode triggers such as stimulant drug use, alcohol consumption, breaking sleep routine, or high stress (see *Cognitive Therapy for Bipolar Disorder* by Lam et al.).

18. Maintain a pattern of regular rhythm to daily activities. (35, 36, 37, 38)

35. Conduct Interpersonal and Social Rhythm Therapy adapted to adolescents beginning with the assessment of the client's daily activities using an interview and the Social Rhythm Metric (see *Adapting Interpersonal and Social Rhythm Therapy to the Developmental Needs of Adolescents with Bipolar Disorder* by Hlastala and Frank; and *Treating Bipolar Disorder* by Frank).

36. Assist the client in establishing a more routine pattern of daily activities such as sleeping, eating, solitary and social activities, and exercise; use and review a form to schedule, assess, and modify these activities so that they occur in a predictable rhythm every day (supplement with the exercise "Keeping a Daily Rhythm" in the *Adult Psychotherapy Homework Planner* by Jongsma).

37. Teach the client about the importance of good sleep hygiene (see "Sleep Pattern Record" in the *Adult Psychotherapy Homework Planner* by Jongsma); assess and intervene accordingly (see the Sleep Disturbance chapter in this *Planner*).

38. Engage the client in a balanced schedule of "behavioral activation" by scheduling

rewarding activities while not over stimulating; (see "Home, School, and Community Activities I Enjoyed" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); use activity and mood monitoring to facilitate an optimal balance of activity; reinforce success.

19. Discuss and resolve troubling personal and interpersonal issues. (39, 40, 41)

39. Conduct the interpersonal component of Interpersonal and Social Rhythm Therapy beginning with the assessment the client's current and past significant relationships; assess for themes related to grief, interpersonal role disputes, interpersonal role transitions, and interpersonal skills deficits (see *Adapting Interpersonal and Social Rhythm Therapy to the Developmental Needs of Adolescents with Bipolar Disorder* by Hlastala and Frank; and *Treating Bipolar Disorder* by Frank).

40. Use interpersonal therapy techniques to explore and resolve issues surrounding grief, role disputes, role transitions, and social skills deficits; provide support and strategies for resolving identified interpersonal issues.

41. Establish a "rescue protocol" with the client and significant others, consistent with Interpersonal and Social Rhythm Therapy, to identify and manage clinical deterioration; include medication use, sleep pattern restoration, maintaining a daily routine, and conflict-free social support.

20. Parents adjust parenting style to that of proven effective techniques. (42)

42. Assist the parents to be firm but reasonable in setting clear behavioral expectations for the client and to use positive reinforcement when rules are kept (supplement with "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis; and recommend *Parents and Adolescents Living Together* by Patterson and Forgatch).

21. Participate in periodic "maintenance" sessions. (43)

43. Hold periodic "maintenance" sessions within the first few months after therapy to facilitate the client's positive changes; problem-solve obstacles to improvement.

22. Use mindfulness and acceptance strategies to reduce experiential and cognitive avoidance and increase value-based behavior. (44)

44. Conduct Acceptance and Commitment Therapy (see *ACT for Depression* by Zettle) including mindfulness strategies to help the client decrease experiential avoidance, disconnect thoughts from actions, accept one's experience rather than change or control symptoms, and behave according to his/her broader life values; assist the client in clarifying his/her goals and values and commit to behaving accordingly).

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 296.xx | Bipolar I Disorder |
| | 296.89 | Bipolar II Disorder |
| | 301.13 | Cyclothymic Disorder |
| | 295.70 | Schizoaffective Disorder |
| | 296.80 | Bipolar Disorder NOS |
| | 310.1 | Personality Change Due to Axis III Disorder |
| | _____ | _____ |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
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| 296.xx | F31.xx | Bipolar I Disorder |
| 296.89 | F31.81 | Bipolar II Disorder |
| 301.13 | F34.0 | Cyclothymic Disorder |
| 295.70 | F25.0 | Schizoaffective Disorder, Bipolar Type |
| 296.80 | F31.9 | Unspecified Bipolar and Related Disorder |
| 310.1 | F07.0 | Personality Change Due to Another Medical Condition |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# BLENDED FAMILY

## BEHAVIORAL DEFINITIONS

1. Children from a previous union of respective parents are brought into a single family unit, resulting in interpersonal conflict, anger, and frustration.
2. Resistance and defiance on the part of a child toward his/her new stepparent.
3. Open conflict between siblings with different parents now residing as siblings in the same family system.
4. Overt or covert defiance of the stepparent by one or several siblings.
5. Verbal threats to the biological parent of going to live with the other parent, report abuse, and so on.
6. Interference from ex-spouse in the daily life of the new family system.
7. Anxiety and concern by both new partners regarding bringing their two families together.
8. No clear lines of communication or responsibilities assigned within the blended family, making for confusion, frustration, and unhappiness.
9. Internal conflicts regarding loyalty to the noncustodial parent result in distance from the stepparent.

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## LONG-TERM GOALS

1. Achieve a reasonable level of family connectedness and harmony whereby members support, help, and are concerned for each other.

2. Become an integrated blended family system that is functional and in which members are bonded to each other.
3. Attain a level of peaceful coexistence where daily issues can be negotiated without becoming ongoing conflicts.
4. Accept the stepparent and/or stepsiblings and treat them with respect, kindness, and cordiality.
5. Establish a new family identity in which each member feels he/she belongs and is valued.
6. Accept the new blended family system as not inferior to the nuclear family, just different.
7. Establish a strong bond between the couple as a parenting team that is free from triangulation and is able to bring stabilization to the family.

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## SHORT-TERM OBJECTIVES

1. Each family member openly shares thoughts and feelings regarding the blended family. (1, 2)

## THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with each family member within family therapy sessions through consistent eye contact, active listening, unconditional positive regard, and acceptance to allow each family member to identify and express openly his/her thoughts and feelings regarding the blended family.
2. Explore with each family member their perception of the family unit and the sources of pain and conflict that affect him/her adversely (or assign each family member to complete "Assessing the Family—Present and Future" or "A Few Things About Me" in the *Adolescent*

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| | *Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); identify any diagnosable behavioral, emotional, or cognitive conditions in any family member. |
| 2. Disclose any history of substance use that may contribute to and complicate the treatment of blended family issues. (3) | 3. If indicated, arrange for or perform a substance abuse evaluation and refer the client for treatment if the evaluation recommends it. |
| 3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (4, 5, 6, 7, 8) | 4. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).<br>5. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).<br>6. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better |

understanding of the client's behavior.

7. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
8. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

4. Attend and actively take part in family or sibling group sessions. (9, 10)

9. Conduct family, sibling, and marital sessions to address the issues of loss, conflict negotiation, parenting, stepfamily psychoeducation, joining, rituals, and relationship building.
10. Utilize an exercise with a set of markers and a large sheet of drawing paper in a family session. The therapist indicates that everyone is going to make a drawing and begins by making a scribble line on the paper, then has each family member add to the line using a colored marker of his/her choice. When the

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| | drawing is complete, the family is given the chance to either interpret the drawing individually or develop a mutual story based on the drawing (see *Scribble Art* by Lowe). |
| 5. Family members verbalize realistic expectations and rejection of myths regarding stepfamilies. (11, 12, 13) | 11. Within a family session, ask each member to list his/her expectations for the new family or assign "Stepparent and Sibling Questionnaire" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); ask members to share and process their lists with the whole family and the therapist. |
| | 12. Remind family members that "instant love" of new family members is a myth. It is unrealistic to expect children to immediately like (and certainly to love) the partner who is serving in the new parent role. |
| | 13. Help family members accept the position that siblings from different biological families need not like or love one another, but that they should be mutually respectful and kind. |
| 6. Family members identify losses/changes in each of their lives. (14) | 14. Assign siblings to complete a list of losses and changes each has experienced for the last year and then for all years. Give empathetic confirmation while they share their lists in session and help them see the similarity in their experiences to those of the other siblings. |
| 7. Family members demonstrate increased skills in recognizing and expressing feelings. (15, 16, 17) | 15. Have the family or siblings play The Ungame (Zakich; available from The Ungame Company) or The Talking, Feeling, and Doing |

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| | Game (Gardner; available from Childswork/Childsplay) to promote family members' awareness of self and their feelings. |
| | 16. Provide education to the family on identifying, labeling, and expressing feelings appropriately. |
| | 17. Help the family practice identifying and expressing feelings by doing a feelings exercise (e.g., "I feel sad when _____," "I feel excited when _____") in a family session. The therapist models affirming and acknowledging each member as he/she shares during the exercise. |
| 8. Family members verbalize expanded knowledge of stepfamilies. (18, 19) | 18. Suggest that the parents and teen read material to expand their knowledge of stepfamilies and their development (e.g., *Blended Family Advice: A Step-by-Step Guide to Help Blended Families Become Stronger and Successful* by Dudley; *Strengthening Your Stepfamily* by Einstein and Albert; or *Stepchildren Speak: 10 Grown-Up Stepchildren Teach Us How to Build Healthy Stepfamilies* by Philips). |
| | 19. Refer parents to the Stepfamily Association of America (1-800-735-0329) to obtain additional information and resources on stepfamilies. |
| 9. Family members demonstrate increased negotiating skills. (20, 21) | 20. Train family members in building problem-solving skills (e.g., problem identification, brainstorming solutions, evaluating pros and cons, compromising, agreeing on a selected solution, making and |

implementing a plan); have them practice these skills on issues that present in family sessions (or assign "Problem-Solving Exercise" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

21. Ask siblings to specify their conflicts and suggest solutions (or assign the exercise "Negotiating a Peace Treaty" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

10. Family members report a reduced level of tension among all members. (22, 23, 24)

22. Inject humor whenever appropriate in family or sibling sessions to decrease tensions and conflict and to model balance and perspective; give positive feedback to members who create appropriate humor.

23. Hold a family sibling session in which each child lists and verbalizes an appreciation of each sibling's unique traits or abilities (or assign the exercise "Cloning the Perfect Sibling" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

24. Utilize a brief solution-focused intervention of reframing or normalizing the conflictual situation as a stage that the family needs to get through. Identify the next stage as the coming together stage, and talk about when they might be ready to move there and how they could start to head there (see *A Guide to Possibility Land* by O'Hanlon and Beadle).

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| 11. Each parent takes primary role of discipline with own children. (25) | 25. Encourage each parent to take the primary role in disciplining his/her own children and refrain from all negative references to ex-spouses. |
| 12. The parents attend a step-parenting didactic group to increase parenting skills. (26) | 26. Refer the parents to a parenting group for stepparents. |
| 13. Family members attend weekly family meeting in the home to express feelings and voice issues. (27) | 27. Assist the parents in implementing a once-a-week family meeting in which issues can be raised and resolved and where members are encouraged to share their thoughts, complaints, and compliments. |
| 14. The parents create and institute new family rituals. (28, 29, 30) | 28. Encourage the parents to create and implement daily rituals (e.g., mealtimes, bedtime stories, household chores, time alone with parents, time together) in order to give structure and connection to the system. |
| | 29. Conduct a family session where rituals from both former families are examined. Then work with the family to retain the rituals that are appropriate and will work in the new system and create the necessary new ones to fill in any gaps. |
| | 30. Give the family the assignment to create birthday rituals for their new blended unit in a family session. |
| 15. The parents identify and eliminate triangulation within the system. (31) | 31. Provide education to the parents on patterns of interactions within families, focusing on the pattern of triangulation and its dysfunctional aspects. |
| 16. The parents report a strengthening of their marital bond. (32, 33, 34, 35) | 32. Refer the couple to skills-based marital therapy based on strengthening avenues of |

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| | responsibilities, communication, and conflict resolution (see *PREP—Fighting for Your Marriage* by Markman, Stanley, and Blumberg). |
| | 33. Work with the parents in conjoint sessions to deal with issues of time away alone, privacy, and individual space; develop specific ways for these things to regularly occur. |
| | 34. Hold conjoint sessions with the parents to process the issue of showing affection toward each other. Help the parents develop appropriate boundaries and ways of showing affection that do not give rise to unnecessary anger in their children. |
| | 35. Assign the parents to read material on marriage within a stepfamily (e.g., *Stepcoupling: Creating and Sustaining a Strong Marriage in Today's Blended Family* by Wisdom and Green); process the key concepts they gather from the reading. |
| 17. The parents spend one-on-one time with each child. (36) | 36. Work with the parents to build into each of their schedules one-on-one time with each child and stepchild in order to give each child undivided attention and to build and maintain relationships (consider assigning "One-on-One" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 18. Family members report a slow development of bonds between each member. (37, 38, 39) | 37. Refer the family members to an initiatives camp weekend to increase their skills in working cooperatively, conflict resolution, and their sense of |

trust; process the experience with the family in the next family session.

38. Complete and process with the siblings a cost-benefit analysis (see *Ten Days to Self-Esteem* by Burns) to evaluate the pluses and minuses of becoming a family or resisting; use a positive outcome to move beyond resistance to begin the process of joining.

39. Emphasize and model in family, sibling, and couple sessions the need for family members to build their new relationships slowly, allowing everyone time and space to adjust and develop a level of trust with each other.

19. Family members report an increased sense of loyalty and connectedness. (40, 41)

40. Conduct family sessions in which a genogram is developed for the entire new family system to show everyone how they are connected.

41. Ask each family member to suggest an enjoyable activity the family should engage in to promote connectedness (or assign "Interaction as a Family" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 309.0 | Adjustment Disorder With Depressed Mood |
| | 309.3 | Adjustment Disorder With Disturbance of Conduct |
| | 309.24 | Adjustment Disorder With Anxiety |
| | 309.81 | Posttraumatic Stress Disorder |
| | 300.4 | Dysthymic Disorder |
| | V62.81 | Relational Problem NOS |
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| **Axis II:** | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
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| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.3 | F43.24 | Adjustment Disorder, With Disturbance of Conduct |
| 309.24 | F43.22 | Adjustment Disorder, With Anxiety |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
| 300.4 | F34.1 | Persistent Depressive Disorder |
| V62.29 | Z62.898 | Child Affected by Parental Relationship Distress |
| V61.8 | Z62.891 | Sibling Relational Problem |
| V61.10 | Z63.0 | Relationship Distress with Spouse or Intimate Partner |
| V61.20 | Z62.820 | Parent-Child Relational Problem |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# CONDUCT DISORDER/DELINQUENCY

## BEHAVIORAL DEFINITIONS

1. Persistent refusal to comply with rules or expectations in the home, school, or community.
2. Excessive fighting, intimidation of others, cruelty or violence toward people or animals, and destruction of property.
3. History of stealing at home, at school, or in the community.
4. School adjustment characterized by disrespectful attitude toward authority figures, frequent disruptive behaviors, and detentions or suspensions for misbehavior.
5. Repeated conflict with authority figures at home, at school, or in the community.
6. Impulsivity as manifested by poor judgment, taking inappropriate risks, and failing to stop and think about consequences of actions.
7. Numerous attempts to deceive others through lying, conning, or manipulating.
8. Consistent failure to accept responsibility for misbehavior accompanied by a pattern of blaming others.
9. Little or no remorse for misbehavior.
10. Lack of sensitivity to the thoughts, feelings, and needs of other people.
11. Multiple sexual partners, lack of emotional commitment, and engaging in unsafe sexual practices.
12. Use of mood-altering substances on a regular basis.
13. Participation in gang membership and activities.

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## LONG-TERM GOALS

1. Comply with rules and expectations in the home, school, and community consistently.
2. Eliminate all illegal and antisocial behavior.
3. Terminate all acts of violence or cruelty toward people or animals and the destruction of property.
4. Express anger in a controlled, respectful manner on a consistent basis.
5. Parents establish and maintain appropriate parent-child boundaries, setting firm, consistent limits when the client acts out in an aggressive or rebellious manner.
6. Parents learn and implement good child behavioral management skills.
7. Demonstrate empathy, concern, and sensitivity for the thoughts, feelings, and needs of others on a regular basis.

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## SHORT-TERM OBJECTIVES

1. Identify situations, thoughts, and feelings that trigger angry feelings, antisocial behaviors, and the targets of those actions. (1, 2)

## THERAPEUTIC INTERVENTIONS

1. Using relevant verbal response modes (e.g., questioning, active listening, clarification, reflection, empathy), build rapport toward creating trust and a good working therapeutic alliance with the client.
2. Conduct clinical interviews with the client and parents focused on specifying the nature, severity, and history of the adolescent's misbehavior; thoroughly assess the various stimuli (e.g., situations, people, thoughts) that have triggered the client's anger and the thoughts, feelings, and actions that have characterized his/her antisocial responses;

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| | consult others (e.g., family members, teachers) and/or use parent/teacher rating scales (e.g., *Child Behavior Checklist*; *Eyberg Child Behavior Inventory*) to supplement the assessment as necessary. |
| 2. Parents identify major concerns regarding the child's misbehavior and the associated parenting approaches that have been tried. (3) | 3. Assess how the parents have attempted to respond to the child's misbehavior, what triggers and reinforcements there may be contributing to the behavior, the parents' consistency in their approach to the child, and whether they have experienced conflicts between themselves over how to react to the child. |
| 3. Parents and child cooperate with psychological assessment to further delineate the nature of the presenting problem. (4) | 4. Administer psychological instruments designed to assess whether a comorbid condition(s) (e.g., bipolar disorder, depression, ADHD) is contributing to disruptive behavior problems and/or objectively assess parent-child relational conflict (e.g., the *Parent-Child Relationship Inventory*); follow up accordingly with client and parents regarding treatment options; re-administer as needed to assess treatment outcome. |
| 4. Complete a substance abuse evaluation and comply with the recommendations offered by the evaluation findings. (5) | 5. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it. |
| 5. Provide behavioral, emotional and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9, 10) | 6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is |

motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

10. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

6. Cooperate with the recommendations or requirements mandated by the criminal justice system. (11, 12, 13)

11. Assess the child's illegal behavior patterns and consult with criminal justice officials about the appropriate consequences for the client's destructive or aggressive behaviors (e.g., pay restitution, community service, probation, intensive surveillance).

12. Consult with parents, school officials, and criminal justice officials about the need to place the client in an alternative setting (e.g., foster home, group home, residential program, juvenile detention facility).

13. Encourage and challenge the parents not to protect the client from the natural or legal consequences of his/her destructive or aggressive behaviors.

7. Cooperate with a physician's evaluation for possible treatment with psychotropic medications to assist in anger and behavioral control and take medications consistently, if prescribed. (14)

14. Assess the client for the need for psychotropic medication to assist in control of anger; refer him/her to a physician for an evaluation for prescription medication; monitor prescription compliance, effectiveness, and side effects; and provide feedback to the prescribing physician.

8. Increase the number of statements that reflect the acceptance of responsibility for misbehavior. (15, 16, 17, 18)

15. Use techniques derived from motivational interviewing to move the client away from externalizing and blaming toward accepting responsibility for his/her actions and motivation to change.

16. Therapeutically confront statements regarding the client's antisocial behavior and attitude, pointing out consequences for himself/herself and others (or assign "How My Behavior Hurts Others" or "Patterns of Stealing" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

17. Therapeutically confront statements in which the client lies and/or blames others for his/her misbehaviors and fails to accept responsibility for his/her actions; explore and process the factors that contribute to the client's pattern of blaming others (e.g., harsh punishment experiences, family pattern of blaming others).

18. Assist the client in identifying the positive consequences of managing anger and misbehavior (e.g., respect from others and self, cooperation from others, improved physical health); ask the client to agree to learn new ways to conceptualize and manage anger and misbehavior.

9. Agree to learn alternative ways to think about and manage anger and misbehavior. (19, 20)

19. Assist the client in making a connection between his/her feelings and reactive behaviors (or assign "Surface Behavior/Inner Feelings" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

20. Assist the client in conceptualizing his/her disruptive behavior as involving different components (cognitive, physiological, affective, and behavioral) that go through predictable phases that can be managed (e.g., demanding expectations not being met leading to increased arousal and anger which leads to acting out).

10. Learn and implement calming strategies as part of a new way to manage reactions to frustration. (21)

21. Teach the client calming techniques (e.g., muscle relaxation, paced breathing, calming imagery) as part of a tailored strategy for responding appropriately to angry feelings when they occur (or assign "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

11. Identify, challenge, and replace self-talk that leads to anger and misbehavior with self-talk that facilitates a more constructive reaction. (22)

22. Explore the client's self-talk and beliefs that mediate his/her angry feelings and actions (e.g., demanding expectations reflected in *should*, *must*, or *have to* statements); identify and challenge biases, assisting him/her in generating appraisals and self-talk that corrects for the biases and facilitates a more flexible and temperate response to frustration (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma).

12. Learn and implement thought-stopping to manage intrusive unwanted thoughts that trigger anger and acting out. (23)

23. Assign the client to implement a thought-stopping technique on a daily basis between sessions (or assign "Thought-Stopping" in the *Adolescent Psychotherapy*

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| | *Homework Planner* by Jongsma, Peterson, and McInnis); review implementation; reinforce success, providing corrective feedback toward improvement. EBT |
| 13. Verbalize feelings of frustration, disagreement, and anger in a controlled, assertive way. (24) EB | 24. Use instruction, modeling, and/or role-playing to teach the client assertive communication; if indicated, refer him/her to an assertiveness training class/group for further instruction (see *Anger Control Training for Aggressive Youths* by Lochman et al.). EBT |
| 14. Learn and implement problem-solving and/or conflict resolution skills to manage interpersonal problems constructively. (25) EB | 25. Teach the client conflict resolution skills (e.g., empathy, problem-solving, active listening, "I messages," respectful communication, assertiveness without aggression, compromise); use modeling, role-playing, and behavior rehearsal to work through several current conflicts (consider assigning "Becoming Assertive" or "Problem-Solving Exercise" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). EBT |
| 15. Practice using new calming, communication, conflict resolution, and thinking skills in session with the therapist and during homework exercises. (26, 27) EB | 26. Assist the client in constructing and consolidating a client-tailored strategy for managing anger that combines any of the somatic, cognitive, communication, problem-solving, and/or conflict resolution skills relevant to his/her needs. EBT |
| | 27. Use any of several techniques, including relaxation, imagery, behavioral rehearsal, modeling, role-playing, or feedback of videotaped practice in increasingly challenging |

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| | situations to help the client consolidate the use of his/her new anger management skills (see *Problem-Solving Skills Training and Parent Management Training for Conduct Disorder* by Kazdin). |
| 16. Practice using new calming, communication, conflict resolution, and thinking skills in homework exercises. (28) | 28. Assign the client homework exercises to help them practice newly learned calming, assertion, conflict resolution, or cognitive restructuring skills as needed (or assign "Anger Control" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review and process toward the goal of consolidation. |
| 17. Decrease the number, intensity, and duration of angry outbursts, while increasing the use of new skills for managing anger. (29) | 29. Monitor the client's reports of angry outbursts with the goal of decreasing their frequency, intensity, and duration through the client's use of new anger management skills (or assign "Alternatives to Destructive Anger" in the *Adult Psychotherapy Homework Planner* by Jongsma); review progress, reinforcing success and providing corrective feedback toward improvement. |
| 18. Increase verbalizations of empathy and concern for other people. (30) | 30. Use role-playing and role-reversal techniques to help the client develop sensitivity to the feelings of others in reaction to his/her antisocial behaviors. |
| 19. Identify social supports that will help facilitate the implementation of new skills. (31) | 31. Encourage the client to discuss and/or use his/her new anger and conduct management skills with trusted peers, family, or otherwise significant others who are likely to support his/her change. |

20. Increase the frequency of responsible and positive social behaviors. (32, 33, 34)

32. Direct the client to engage in three altruistic or benevolent acts (e.g., read to a developmentally disabled student, mow grandmother's lawn) before the next session to increase his/her empathy and sensitivity to the needs of others.

33. Assign homework designed to increase the client's empathy and sensitivity toward the thoughts, feelings, and needs of others (e.g., "Headed in the Right Direction" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

34. Place the client in charge of tasks at home (e.g., preparing and cooking a special dish for a family get-together, building shelves in the garage, changing oil in the car) to demonstrate confidence in his/her ability to act responsibly.

21. Parents learn and implement Parent Management Training skills to recognize and manage problem behavior of the client. (35, 36, 37, 38, 39)

35. Use a Parent Management Training approach beginning with teaching the parents how parent and child behavioral interactions can encourage or discourage positive or negative behavior and that changing key elements of those interactions (e.g., prompting and reinforcing positive behaviors) can be used to promote positive change (e.g., *Parents and Adolescents Living Together: Part 1, The Basics* by Patterson and Forgatch; *Parents and Adolescents Living Together: Part 2, Family Problem Solving* by Patterson and Forgatch).

36. Ask the parents to read material consistent with a parent training approach to managing disruptive behavior (e.g., *The Kazdin Method for Parenting the Defiant Child* by Kazdin; *Parents and Adolescents Living Together: Part 1, The Basics* by Patterson and Forgatch).
37. Teach the parents how to specifically define and identify problem behaviors, identify their reactions to the behavior, determine whether the reaction encourages or discourages the behavior, and generate alternatives to the problem behavior.
38. Teach parents how to implement key parenting practices consistently, including establishing realistic age-appropriate rules for acceptable and unacceptable behavior, prompting of positive behavior in the environment, use of positive reinforcement to encourage behavior (e.g., praise), use of clear direct instruction, time-out, and other loss-of-privilege practices for problem behavior.
39. Assign the parents home exercises in which they implement and record results of implementation exercises (or assign "Clear Rules, Positive Reinforcement, Appropriate Consequences" or "Catch Your Teen Being Responsible" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review in session, providing corrective

feedback toward improved, appropriate, and consistent use of skills.

22. Increase compliance with rules at home and school. (40)

40. Design a reward system and/or contingency contract for the client and meet with school officials to reinforce identified positive behaviors at home and school and deter impulsive or rebellious behaviors.

23. Client and family participate in family therapy. (41)

41. Refer family to an evidence-based family therapy such as Functional Family Therapy (see www.fftinc.com) or Brief Strategic Family Therapy (see *Brief Strategic Family Therapy for Hispanic Youth* by Robbins et al.) in which problematic interactions within the family system are assessed and changed through the use of family systems and social learning interventions to support more adaptive communication and functioning.

24. Client and family participate in a Multisystemic Therapy program. (42)

42. Refer client with severe conduct problems to a Multisystemic Therapy program with cognitive behavioral and family interventions to target factors that are contributing to his/her antisocial behavior and/or substance use in an effort to improve caregiver discipline practices, enhance family affective relations, decrease youth association with deviant peers and increase youth association with prosocial peers, improve youth school or vocational performance, engage youth in prosocial recreational outlets, and develop an indigenous support network (see

*Multisystemic Therapy for Antisocial Behavior in Children and Adolescents* by Henggeler et al.).

25. Verbalize an understanding of the difference between a lapse and relapse. (43, 44)

43. Provide a rationale for relapse prevention that discusses the risk and introduces strategies for preventing it.

44. Discuss with the parent/child the distinction between a lapse and relapse, associating a lapse with a temporary setback and relapse with a return to a sustained pattern thinking, feeling, and behaving that is characteristic of conduct disorder.

26. Implement strategies learned in therapy to counter lapses and prevent relapse. (45, 46, 47, 48)

45. Identify and rehearse with the parent/child the management of future situations or circumstances in which lapses could occur.

46. Instruct the parent/child to routinely use strategies learned in therapy (e.g., parent training techniques, problem-solving, anger management), building them into his/her life as much as possible.

47. Develop a "coping card" on which coping strategies and other important information can be kept (e.g., steps in problem-solving, positive coping statements, reminders that were helpful to the client during therapy).

48. Schedule periodic maintenance or "booster" sessions to help the parent/child maintain therapeutic gains and problem-solve challenges.

27. Parents verbalize appropriate boundaries for discipline to prevent further occurrences of abuse and to ensure the safety of the client and his/her siblings. (49)

28. Identify and verbally express feelings associated with past neglect, abuse, separation, or abandonment. (50)

29. Establish and maintain steady employment. (51, 52)

30. Identify and verbalize the risks involved in sexually promiscuous behavior. (53)

49. Explore the client's family background for a history of neglect and physical or sexual abuse that may contribute to his/her behavioral problems; confront the client's parents to cease physically abusive or overly punitive methods of discipline; implement the steps necessary to protect the client or siblings from further abuse (e.g., report abuse to the appropriate agencies; remove the client or perpetrator from the home).

50. Encourage and support the client in expressing feelings associated with neglect, abuse, separation, or abandonment (consider assigning "Letter to Absent or Uninvolved Parent" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

51. Refer the client to vocational training to develop basic job skills and find employment.

52. Encourage and reinforce the client's acceptance of the responsibility of a job, the authority of a supervisor, and the employer's rules.

53. Provide the client with sex education; discuss the risks involved with sexually promiscuous behaviors; and explore the client's feelings, irrational beliefs, and unmet needs that contribute to the emergence of sexually promiscuous behaviors (or assign "Connecting Sexual Behavior With Needs" or "Looking Closer at My Sexual Behavior" in the *Adolescent*

*Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

31. Parents participate in marital therapy. (54)

54. Assess the marital dyad for possible substance abuse, conflict, or triangulation that shifts the focus from marriage issues to the client's acting-out behaviors; refer for appropriate treatment, if needed.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 312.81 | Conduct Disorder, Childhood-Onset Type |
| | 312.82 | Conduct Disorder, Adolescent-Onset Type |
| | 313.81 | Oppositional Defiant Disorder |
| | 312.9 | Disruptive Behavior Disorder NOS |
| | 314.01 | Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type |
| | 314.9 | Attention-Deficit/Hyperactivity Disorder NOS |
| | 312.34 | Intermittent Explosive Disorder |
| | V71.02 | Child or Adolescent Antisocial Behavior |
| | V61.20 | Parent-Child Relational Problem |
| | _____ | _____ |
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| **Axis II:** | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
| | _____ | _____ |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
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| 312.81 | F91.1 | Conduct Disorder, Childhood-Onset Type |
| 312.82 | F91.2 | Conduct Disorder, Adolescent-Onset Type |
| 313.81 | F91.3 | Oppositional Defiant Disorder |
| 312.9 | F91.9 | Unspecified Disruptive, Impulse Control, and Conduct Disorder |
| 312.9 | F91.8 | Other Specified Disruptive, Impulse Control, and Conduct Disorder |
| 314.01 | F90.1 | Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive/Impulsive Presentation |
| 314.01 | F90.9 | Unspecified Attention-Deficit/Hyperactivity Disorder |
| 314.01 | F90.8 | Other Specified Attention-Deficit/Hyperactivity Disorder |
| 312.34 | F63.81 | Intermittent Explosive Disorder |
| V71.02 | Z72.810 | Child or Adolescent Antisocial Behavior |
| V61.20 | Z62.820 | Parent-Child Relational Problem |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

# DIVORCE REACTION

## BEHAVIORAL DEFINITIONS

1. Infrequent contact or loss of contact with a parental figure due to separation or divorce.
2. Intense emotional outbursts (e.g., crying, yelling, swearing) and sudden shifts in mood due to significant change in the family system.
3. Excessive use of alcohol and drugs as a maladaptive coping mechanism to ward off painful emotions surrounding separation or divorce.
4. Strong feelings of grief and sadness combined with feelings of low self-worth, lack of confidence, social withdrawal, and loss of interest in activities that normally bring pleasure.
5. Feelings of guilt accompanied by the unreasonable belief of having behaved in some manner to cause the parents' divorce and/or failing to prevent the divorce from occurring.
6. Marked increase in frequency and severity of acting-out, oppositional, and aggressive behaviors since the onset of the parents' marital problems, separation, or divorce.
7. Significant decline in school performance and lack of interest or motivation in school-related activities.
8. Pattern of engaging in sexually promiscuous or seductive behaviors to compensate for the loss of security or support within the family system.
9. Pseudomaturity as manifested by denying or suppressing painful emotions about divorce and often assuming parental roles or responsibilities.
10. Numerous psychosomatic complaints in response to anticipated separations, stress, or frustration.
11. Loss of contact with a positive support network due to a geographic move.

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## LONG-TERM GOALS

1. Accept the parents' separation or divorce with understanding and control of feelings and behavior.
2. Eliminate feelings of guilt and statements that reflect self-blame for the parents' divorce.
3. Cease the pattern of engaging in maladaptive and self-destructive behaviors to meet needs for affection, affiliation, and acceptance.
4. Create a strong, supportive social network outside of the immediate family to offset the loss of affection, approval, or support from within the family.
5. Parents establish and maintain a consistent, yet flexible, visitation arrangement that meets the client's emotional needs.
6. Parents establish and maintain appropriate parent-child boundaries in discipline and assignment of responsibilities.
7. Parents consistently demonstrate mutual respect for one another, especially in front of the children.

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## SHORT-TERM OBJECTIVES

1. Tell the story of the parents' separation or divorce. (1)

## THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with the client through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to improve his/her ability to tell the story of the parents' separation or divorce.

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| 2. Identify and express feelings related to the parents' separation or divorce. (2, 3, 4) | 2. Explore, encourage, and support the client in verbally expressing and clarifying his/her feelings associated with the separation or divorce (or assign "Initial Reaction to Parents' Separation" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).<br>3. Use the empty-chair technique to help the client express mixed emotions he/she feels toward both parents about the separation or divorce.<br>4. Ask the client to keep a journal in which he/she records experiences or situations that evoke strong emotions pertaining to the divorce; review the journal in therapy sessions. |
| 3. Describe how the parents' separation or divorce has impacted personal and family life. (5) | 5. Develop a timeline where the client records significant developments that have positively or negatively impacted his/her personal and family life, both before and after the divorce. Allow the client to verbalize his/her feelings about the divorce and subsequent changes in the family system (or assign "Impact of Parents' Separation/Divorce" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 4. Complete a substance abuse evaluation and comply with the recommendations offered by the evaluation findings. (6, 7, 8) | 6. Arrange for or conduct a substance abuse evaluation and refer the client for treatment if indicated (see the Substance Use chapter in this *Planner*).<br>7. Explore the client's underlying feelings of depression, insecurity, |

and rejection that led him/her to escape into substance abuse.

8. Assist the client in constructing and signing an agreement to refrain from using substances.

5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (9, 10, 11, 12, 13)

9. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

10. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

11. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.

12. Assess for the severity of the level of impairment to the client's functioning to determine

appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

13. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

6. Express thoughts and feelings within the family system regarding parental separation or divorce. (14, 15, 16)

14. Assist the client in developing a list of questions about the parents' divorce, then suggest ways he/she could find possible answers for each question (e.g., asking parents directly, writing parents a letter).

15. Hold family therapy sessions to allow the client and siblings to express feelings about the separation or divorce in the presence of the parents (or assign the client to complete and share "My Thoughts, Feelings, and Beliefs About Divorce" from the *Adolescent Psychotherapy Homework planner* by Jongsma, Peterson, and McInnis).

16. Encourage the parents to provide opportunities (e.g., family meetings) at home to

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| | allow the client and siblings to express feelings about separation/divorce and subsequent changes in family system. |
| 7. Recognize and affirm self as not being responsible for the parents' separation or divorce. (17, 18) | 17. Explore the factors contributing to the client's feelings of guilt and self-blame about parents' separation or divorce; assist him/her in realizing that his/her negative behaviors did not cause parents' divorce to occur (recommend *Now What Do I Do?: A Guide to Help Teenagers With Their Parents' Separation or Divorce* by Cassella-Kapusinski; or *The Divorce Workbook for Teens: Activities to Help You Move Beyond the Breakup* by Schab). |
| | 18. Assist the client in realizing that he/she does not have the power or control to bring the parents back together. |
| 8. Parents verbalize an acceptance of responsibility for the dissolution of the marriage. (19, 20) | 19. Conduct family therapy sessions where parents affirm the client and siblings as not being responsible for separation or divorce. |
| | 20. Challenge and confront statements by parents that place blame or responsibility for separation or divorce on the children. |
| 9. Identify positive and negative aspects of the parents' separation or divorce. (21) | 21. Give a homework assignment in which the client lists both positive and negative aspects of parents' divorce; process the list in the next session and allow him/her to express different emotions. |
| 10. Identify and verbalize unmet needs to the parents. (22, 23) | 22. Give the parents the directive of spending 10 to 15 minutes of |

one-on-one time with the client and siblings on a regular or daily basis to identify and meet the children's needs (consider assigning "One-on-One" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

23. Assign the client homework in the middle stages of therapy to help him/her list unmet needs and identify steps he/she can take to meet those needs (or assign the "Unmet Emotional Needs—Identification and Satisfaction" exercise from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

11. Reduce the frequency and severity of acting-out, oppositional, and aggressive behaviors. (24, 25)

24. Empower the client by reinforcing his/her ability to cope with the divorce and make healthy adjustments.

25. Assist the client in making a connection between underlying painful emotions about divorce and angry outbursts or aggressive behaviors (or assign "Surface Behavior/Inner Feelings" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

12. Express feelings of anger about the parents' separation or divorce through controlled, respectful verbalizations and healthy physical outlets. (26, 27)

26. Assist the client in identifying appropriate and inappropriate ways for the client to express anger about parents' separation or divorce.

27. Teach relaxation and/or guided imagery techniques to help the client learn to control anger more effectively (or assign "Progressive Muscle Relaxation"

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| | from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 13. Parents verbally recognize how their guilt and failure to follow through with limits contributes to the client's acting-out or aggressive behaviors. (28, 29) | 28. Encourage and challenge the parents not to allow guilt feelings about the divorce to interfere with the need to impose consequences for oppositional-defiant behaviors. |
| | 29. Assist the parents in establishing clearly defined rules, boundaries, and consequences for acting-out, oppositional, or aggressive behaviors (or assign "Clear Rules, Positive Reinforcement, Appropriate Consequences" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 14. Complete school homework assignments on a regular basis. (30, 31) | 30. Assist the parents in establishing a new study routine to help the client complete homework assignments (or assign "Break It Down Into Small Steps" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 31. Design and implement a reward system and/or contingency contract to reinforce completion of school and homework assignments or good academic performance. |
| 15. Decrease the frequency of somatic complaints. (32) | 32. Refocus the client's discussion from physical complaints to emotional conflicts and the expression of feelings. |
| 16. Noncustodial parent verbally recognizes his/her pattern of overindulgence and begins to set limits on money and/or time | 33. Explore the noncustodial parent's pattern of trying to win the favor of his/her child; encourage the noncustodial |

spent in leisure or recreational activities. (33)

parent to set limits on the client's misbehavior and refrain from overindulging the client during visits.

17. Noncustodial parent assigns household responsibilities and/or requires the client to complete homework during visits. (34)

34. Encourage the noncustodial parent to assign a chore or have the client complete homework assignments during visits to reinforce the supervisory role of the parent.

18. Reduce the frequency of immature and irresponsible behaviors. (35, 36)

35. Teach how enmeshed or overly protective parents reinforce the client's immature or irresponsible behaviors by failing to set necessary limits.

36. Have the client and parents identify age-appropriate ways for the client to meet his/her needs for affiliation, acceptance, and approval. Process the list and encourage the client to engage in age-appropriate behaviors.

19. Parents cease making unnecessary, hostile, or overly critical remarks about the other parent in the presence of the children. (37)

37. Confront and challenge the parents to cease making unnecessary hostile or overly critical remarks about the other biological parent in the presence of the client (or assign the client to complete and share "Stop the Fighting" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

20. Parents recognize and agree to cease the pattern of soliciting information about and/or sending messages to the other parent through the children. (38, 39)

38. Counsel the parents about not placing the client in the middle by soliciting information about the other parent or sending messages about adult matters through the client to the other parent (recommend *The Co-Parenting Survival Guide: Letting Go of Conflict After a Difficult*

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| | *Divorce* by Thayer and Zimmerman or *New Beginnings for Divorcing Parents: Co-Parenting Divorce Workbook* by Turner). |
| | 39. Challenge and confront the client about playing one parent against the other to meet needs, obtain material goods, or avoid responsibility. |
| 21. Disengaged or uninvolved parent follows through with recommendations to spend greater quality time with the client. (40, 41) | 40. Hold individual and/or family therapy session to challenge and encourage the noncustodial parent to maintain regular visitation and involvement in the client's life. |
| | 41. Give a directive to the disengaged or distant parent to spend more time or perform a specific task with the client (e.g., go on an outing to the mall, assist the client with homework, work on a project around the home). |
| 12. Identify and express feelings through artwork and music. (42, 43) | 42. Ask the client to draw a variety of pictures that reflect his/her feelings about the divorce, family move, or change in schools. |
| | 43. Instruct the client to sing a song or play a musical instrument that reflects his/her feelings about separation or divorce, then have the client verbalize times when he/she experienced those feelings. |
| 23. Increase participation in positive peer group, extracurricular, or school-related activities. (44) | 44. Encourage the client to participate in school, extracurricular, or positive peer group activities to offset the loss of time spent with the parents. |
| 24. Attend a support group for children of divorce. (45) | 45. Refer the client to group therapy to help him/her share and work through feelings with other |

adolescents whose parents are divorcing.

25. Increase contacts with adults and build a support network outside the family. (46)

26. Identify and verbalize the feelings, irrational beliefs, stressors, and needs that contribute to sexually promiscuous or seductive behaviors. (47, 48)

46. Identify a list of adult individuals (e.g., school counselor, neighbor, uncle or aunt, Big Brother or Big Sister, clergyperson) outside the family who the client can turn to for support and guidance to help cope with the divorce.

47. Provide sex education and discuss the risks involved with sexually promiscuous or seductive behaviors.

48. Explore the client's feelings, irrational beliefs, stressors, and unmet needs that contribute to the emergence of sexually promiscuous or seductive behaviors (or assign "Connecting Sexual Behavior with Needs" and/or "Looking Closer at My Sexual Behavior" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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|---|---|---|
| **Axis I:** | 309.0 | Adjustment Disorder With Depressed Mood |
| | 309.24 | Adjustment Disorder With Anxiety |
| | 309.28 | Adjustment Disorder With Mixed Anxiety and Depressed Mood |

| | | |
|---|---|---|
| | 309.3 | Adjustment Disorder With Disturbance of Conduct |
| | 309.4 | Adjustment Disorder With Mixed Disturbance of Emotions and Conduct |
| | 300.4 | Dysthymic Disorder |
| | 300.02 | Generalized Anxiety Disorder |
| | 309.21 | Separation Anxiety Disorder |
| | 313.81 | Oppositional Defiant Disorder |
| | 300.81 | Undifferentiated Somatoform Disorder |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
| | _____ | _____ |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.24 | F43.22 | Adjustment Disorder, With Anxiety |
| 309.28 | F43.23 | Adjustment Disorder, With Mixed Anxiety and Depressed Mood |
| 309.3 | F43.24 | Adjustment Disorder, With Disturbance of Conduct |
| 309.4 | F43.25 | Adjustment Disorder, With Mixed Disturbance of Emotions and Conduct |
| 300.4 | F34.1 | Persistent Depressive Disorder |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 309.21 | F93.0 | Separation Anxiety Disorder |
| 313.81 | F91.3 | Oppositional Defiant Disorder |
| 300.81 | F45.1 | Somatic Symptom Disorder |
| V61.03 | Z63.5 | Disruption of Family by Separation or Divorce |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# EATING DISORDER

## BEHAVIORAL DEFINITIONS

1. Refusal to maintain body weight at or above a minimally normal weight for age and height (i.e., body weight less than 85% of that expected).
2. Intense fear of gaining weight or becoming fat, even though underweight.
3. Persistent preoccupation with body image related to grossly inaccurate assessment of self as overweight.
4. Undue influence of body weight or shape on self-evaluation.
5. Strong denial of the seriousness of the current low body weight.
6. In post-monarchal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles.
7. Escalating fluid and electrolyte imbalance resulting from eating disorder.
8. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
9. Recurrent episodes of binge eating (a large amount of food is consumed in a relatively short period of time and there is a sense of lack of control over the eating behavior).
10. Eating much more rapidly than normal.
11. Eating until feeling uncomfortably full.
12. Eating large amounts of food when not feeling physically hungry.
13. Eating alone because of feeling embarrassed by how much one is eating.
14. Feeling disgusted with oneself, depressed, or very guilty after eating too much.

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## LONG-TERM GOALS

1. Restore normal eating patterns, healthy weight maintenance, and a realistic appraisal of body size.
2. Stabilize medical condition with balanced fluid and electrolytes, resuming patterns of food intake that will sustain life and gain weight to a normal level.
3. Terminate the pattern of binge eating and purging behavior with a return to eating normal amounts of nutritious foods.
4. Terminate overeating and implement lifestyle changes that lead to weight loss and improved health.
5. Develop healthy cognitive patterns and beliefs about self that lead to positive identity and prevent a relapse of the eating disorder.
6. Develop healthy interpersonal relationships that lead to alleviation and help prevent the relapse of the eating disorder.
7. Develop coping strategies (e.g., feeling identification, problem-solving, assertiveness) to address emotional issues that could lead to relapse of the eating disorder.

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## SHORT-TERM OBJECTIVES

1. Honestly describe the pattern of eating including types, amounts, and frequency of food consumed or hoarded. (1, 2, 3, 4)

## THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a therapeutic alliance.
2. Assess the historical course of the disorder including the amount, type, and pattern of the client's food intake (e.g., too little food, too much food, binge eating, or hoarding food), as well as perceived personal and interpersonal triggers and personal goals.

3. Compare the client's calorie consumption with an average rate of 1,900 (for women) to 2,500 (for men) calories per day to determine over- or undereating.
4. Measure the client's weight and assess for minimization and denial of the eating disorder behavior and related distorted thinking and self-perception of body image.

2. Describe any regular use of unhealthy weight control behaviors. (5)

5. Assess for the presence of recurrent inappropriate purging and nonpurging compensatory behaviors such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise; monitor on an ongoing basis.

3. Disclose any history of substance use that may contribute to and complicate the treatment of the eating disorder. (6)

6. Arrange for a thorough substance abuse evaluation and refer the client for treatment focused on that issue if the evaluation results recommend it.

4. Provide behavioral, emotional and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10, 11)

7. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

8. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
9. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
10. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
11. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

5. Complete psychological tests designed to assess and track eating patterns and unhealthy weight loss practices. (12)

12. Administer psychological instruments to the client designed to objectively assess eating disorders (e.g., the *Eating Disorders Diagnostic Scale*; *Eating Disorders Inventory-3*; *The Body Shape Questionnaire);* give the client feedback regarding the results of the assessment; readminister as indicated to assess treatment response.

6. Cooperate with a complete medical evaluation. (13)

13. Refer the client to a physician for a medical evaluation to assess negative consequences of failure to maintain adequate body weight and overuse of compensatory behaviors; stay in close consultation with the physician as to the client's medical condition.

7. Cooperate with a nutritional evaluation. (14)

14. Refer the client to a nutritionist experienced in eating disorders for an assessment of nutritional rehabilitation; coordinate recommendations into the care plan.

8. Cooperate with a dental exam. (15)

15. Refer the client to a dentist for a dental exam to assess the possible damage to teeth from purging behaviors and/or poor nutrition.

9. Cooperate with a psychotropic medication evaluation by a physician and, if indicated, take medications as prescribed. (16, 17)

16. Assess the client's need for psychotropic medications (e.g., selective serotonin reuptake inhibitors [SSRIs]); arrange for a physician to evaluate for and then prescribe psychotropic medications, if indicated.

17. Monitor the client for psychotropic medication prescription compliance, effectiveness, and side effects.

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| 10. Cooperate with admission to inpatient treatment, if indicated. (18) | 18. Refer the client for hospitalization, as necessary, if his/her weight loss becomes severe and physical health is jeopardized, or if he/she is a danger to self or others due to a severe psychiatric disorder (e.g., severely depressed and suicidal). |
| 11. Verbalize an accurate understanding of how eating disorders develop. (19) | 19. Teach the client a biopsychosocial model of eating disorder development that includes concepts such as the biological need nourishment, genetic determinates of body size and shape, sociocultural pressures to be thin, overvaluation of body shape and size in determining self-image, maladaptive eating habits (e.g., fasting, binging, overeating), maladaptive compensatory weight management behaviors (e.g., purging, exercise), and resultant feelings of low self-esteem (see *Overcoming Binge Eating* by Fairburn; *Eating Disorders in Children and Adolescents* by le Grange and Lock). |
| 12. Explore motivation for change and commit to a plan of action. (20) | 20. Use motivational techniques to help the client explore ambivalence, weigh pros and cons, and clarify wants toward developing motivation to change and committing to therapy. |
| 13. Verbalize an understanding of the rationale for and goals of treatment. (21) | 21. Discuss a rationale for treatment consistent with the model being used including how cognitive, behavioral, interpersonal/family, lifestyle, and/or nutritional factors can promote poor self-image, uncontrolled eating, and unhealthy compensatory actions, |

and how changing them can build physical and mental health-promoting eating practices.

14. Participate in therapist-guided self-care for bulimia or binge-eating disorder. (22, 23)

22. Guide the client through use of a workbook for the treatment of bulimia or binge-eating disorder that focuses on building motivation to change, gaining information about how symptoms are maintained, use of self-monitoring of thoughts, feelings, and behaviors, learning and implementing problem-solving skills through the use of behavioral experiments and goal setting to breaking the client's vicious cycles of bulimic or binge-eating behavior (e.g., *Getting Better Bit(e) by Bit(e): A Treatment Manual for Sufferers of Bulimia Nervosa* by Schmidt and Treasure; *The Binge Eating and Compulsive Overeating Workbook: An Integrated Approach to Overcoming Disordered Eating* by Ross; *Overcoming Your Eating Disorders: A Cognitive-Behavioral Therapy Approach for Bulimia Nervosa and Binge-Eating Disorder—Workbook* by Apple and Agras).

23. Conduct follow-up sessions focused on relapse prevention; counsel significant others regarding how to help the patient, as needed.

15. Client and/or parents read educational materials on eating disorders and overcoming them. (24)

24. Assign the client and/or parents to read psychoeducational chapters of books or treatment manuals on the development and treatment of eating disorders or obesity that are consistent with

the treatment model (e.g., *Unlocking the Mysteries of Eating Disorders: A Life-Saving Guide to Your Child's Treatment and Recovery* by Herzog, Franko, and Cable; *Help Your Teenager Beat an Eating Disorder* by Lock and le Grange; *Overcoming Your Eating Disorders: A Cognitive-Behavioral Therapy Approach for Bulimia Nervosa and Binge-Eating Disorder—Workbook* by Apple and Agras).

16. Keep a journal of food consumption. (25)

25. Assign the client to self-monitor and record food intake (or assign "Reality: Food, Weight, Thoughts, and Feelings" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); process the journal material to reinforce and facilitate motivation to change.

17. Establish regular eating patterns by eating at regular intervals and consuming optimal daily calories. (26, 27, 28)

26. Establish an appropriate daily caloric intake for the client and assist him/her in meal planning (or assign "Plan and Eat a Meal" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

27. Establish healthy weight goals for the client per the Body Mass Index (BMI), the Metropolitan Height and Weight Tables, or some other recognized standard.

28. Monitor the client's weight (e.g., weekly) and give realistic feedback regarding body weight (or assign "Body Image" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

18. Attain and maintain balanced fluids and electrolytes, as well as resumption of reproductive functions. (29, 30)

29. Monitor the client's fluid intake and electrolyte balance; give realistic feedback regarding progress toward the goal of balance.

30. Refer the client back to the physician at regular intervals if fluids and electrolytes need monitoring due to poor eating patterns.

19. Identify and develop a list of high-risk situations for unhealthy eating or weight loss practices. (31, 32)

31. Assess the nature of any external cues (e.g., persons, objects, and situations) and internal cues (thoughts, images, and impulses) that precipitate the client's uncontrolled eating and/or compensatory weight management behaviors.

32. Direct and assist the client in construction of a hierarchy of high-risk internal and external triggers for uncontrolled eating and/or compensatory weight management behaviors.

20. Learn and implement skills for managing urges to engage in unhealthy eating or weight-loss practices. (33)

33. Teach the client tailored skills to manage high-risk situations including distraction, positive self-talk, relaxation, problem-solving, conflict resolution (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise), thought-stopping, or other stress reduction and social/communication skills; use modeling, role-playing, and behavior rehearsal to work through several current situations (or consider assigning "Problem-Solving Exercise," "Becoming Assertive," "Thought-Stopping," or "Progressive Muscle Relaxation"

in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

21. Participate in exercises to build skills in managing urges to use maladaptive weight control practices. (34)

34. Assign homework exercises that allow the client to practice and strengthen skills learned in therapy; select initial high-risk situations that have a high likelihood of being a successful coping experience for the client; prepare and rehearse a plan for managing the risk situation; review/process the real life implementation by the client, reinforcing success while providing corrective feedback toward improvement.

22. Identify, challenge, and replace self-talk and beliefs that promote the eating disorder. (35, 36, 37)

35. Conduct Phase One of Cognitive Behavioral Therapy (CBT) (see *Cognitive Behavior Therapy and Eating Disorders* by Fairburn) to help the client understand the adverse effects of binging and purging; assigning self-monitoring of weight and eating patterns and establishing a regular pattern of eating (use "Reality: Food, Weight, Thoughts, and Feelings" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis; or "Daily Record of Dysfunctional Thoughts" in *Cognitive Therapy of Depression* by Beck et al.); process the journal material.

36. Conduct Phase Two of CBT to shift the focus to eliminating dieting, reducing weight and body image concerns, teaching problem-solving, and doing cognitive restructuring to identify, challenge, and replace negative cognitive messages that

mediate feelings and actions leading to maladaptive eating and weight control practices (or assign "Fears Beneath the Eating Disorder" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

37. Conduct Phase Three of CBT to assist the client in developing a maintenance and relapse prevention plan including self-monitoring of eating and binge triggers, continued use of problem-solving and cognitive restructuring, and setting short-term goals to stay on track.

23. Parents and adolescent agree to participate in all three phases of family-based treatment for the eating disorder. (38, 39, 40)

38. Conduct Phase One (sessions 1–10) of Family-Based Treatment (see *Treatment Manual for Anorexia Nervosa: A Family-Based Approach* by Lock and le Grange; *Treating Bulimia in Adolescents: A Family-Based Approach* by le Grange and Lock), confirming intent to participate and adhere to the treatment plan; taking a history of the eating disorder; placing parents in charge of weight restoration, patterns of eating, and compensatory behavior of the client; and establishing healthy weight goals. Establish with physician a minimum daily caloric intake for the client; implement meal planning; consult with physician if fluids and electrolytes need monitoring due to poor nutritional habits; provide suggested reading to parents to support the client's progress in therapy (see *Help Your Teenager Beat an Eating*

*Disorder* by Lock and le Grange).

39. Conduct Phase Two of Family-Based Treatment (sessions 11–16) by continuing to closely monitor weight gain and physician/nutritionist reports regarding health status; gradually return control over eating decisions back to the adolescent as the acute starvation is resolved, portions consumed are nearing what is normally expected, and weight gain in demonstrated in anorexia or control over binging and purging is demonstrated in bulimia.

40. Conduct Phase Three of Family-Based Treatment (sessions 17–20) by reviewing and reinforcing progress and weight gain; focus on adolescent development issues; teach and rehearse problem-solving and relapse prevention skills.

24. State a basis for positive identity that is not based on weight and appearance but on character, traits, relationships, and intrinsic value. (41)

41. Assist the client in identifying a basis for self-worth apart from body image by reviewing his/her talents, successes, positive traits, importance to others, and intrinsic and/or spiritual value.

25. Identify important people in the past and present, and describe the quality, good and poor, of those relationships. (42)

42. Conduct Interpersonal Therapy (see *Interpersonal Psychotherapy for Bulimia Nervosa* by Fairburn) beginning with the assessment of the client's "interpersonal inventory" of important past and present relationships, highlighting themes that may be supporting the eating disorder (e.g., interpersonal disputes, role transition conflict, unresolved grief, and/or interpersonal deficits).

26. Verbalize a resolution of current interpersonal problems and a resulting termination of binge eating and bulimia. (43, 44, 45, 46)

43. For grief, facilitate mourning and gradually help the client discover new activities and relationships to compensate for the loss and return to healthy eating behavior.

44. For disputes, help the client explore the relationship, the nature of the dispute, whether it has reached an impasse, and available options to resolve it including learning and implementing conflict resolution skills; if the relationship has reached an impasse, consider ways to change the impasse or to end the relationship.

45. For role transitions (e.g., beginning or ending a relationship, moving, graduation), help the youth mourn the loss of the old role while recognizing positive and negative aspects of the new role, and taking steps to gain mastery over the new role.

46. For interpersonal deficits, help the youth develop new interpersonal skills and relationships.

27. Verbalize an understanding of relapse prevention and the distinction between a lapse and a relapse. (47, 48)

47. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of distress, urges, or to avoid and relapse with the decision to return to the cycle of maladaptive thoughts and actions (e.g., feeling anxious, binging, then purging).

48. Identify with the client future situations or circumstances in which lapses could occur.

28. Implement relapse prevention strategies for managing possible future anxiety symptoms. (49, 50, 51)

29. Attend an eating disorder group. (52)

49. Instruct the client to routinely use strategies learned in therapy (e.g., continued exposure to previous external or internal cues that arise) to prevent relapse.

50. Develop a "maintenance plan" with the client that describes how the client plans to identify challenges, use knowledge and skills learned in therapy to manage them, and maintain positive changes gained in therapy.

51. Schedule periodic "maintenance" sessions to help the client maintain therapeutic gains and adjust to life without the eating disorder.

52. Refer the client to a support group for eating disorders.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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|---|---|---|
| **Axis I:** | 307.1 | Anorexia Nervosa |
| | 307.51 | Bulimia Nervosa |
| | 307.50 | Eating Disorder NOS |
| | 316 | Psychological Factor Affecting Medical Condition (e.g., obesity) |
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| **Axis II:** | 301.6 | Dependent Personality Disorder |
| | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 307.1 | F50.02 | Anorexia Nervosa, Binge-Eating/Purging Type |
| 307.1 | F50.01 | Anorexia Nervosa, Restricting Type |
| 307.51 | F50.2 | Bulimia Nervosa |
| 307.50 | F50.9 | Unspecified Feeding or Eating Disorder |
| 316 | F54 | Psychological Factors Affecting Other Medical Conditions |
| 307.51 | F50.8 | Binge-Eating Disorder |
| 307.59 | F50.8 | Other Specified Feeding or Eating Disorder |
| 301.6 | F60.7 | Dependent Personality Disorder |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

# GRIEF/LOSS UNRESOLVED

## BEHAVIORAL DEFINITIONS

1. Loss of contact with a parent due to the parent's death.
2. Loss of contact with a parent figure due to termination of parental rights.
3. Loss of contact with a parent due to the parent's incarceration.
4. Loss of contact with a positive support network due to a geographic move.
5. Loss of meaningful contact with a parent figure due to the parent's emotional abandonment.
6. Strong emotional response experienced when the loss is mentioned.
7. Lack of appetite, nightmares, restlessness, inability to concentrate, irritability, tearfulness, or social withdrawal that began subsequent to a loss.
8. Marked drop in school grades, and an increase in angry outbursts, hyperactivity, or clinginess when separating from parents.
9. Feelings of guilt associated with the unreasonable belief in having done something to cause the loss or not having prevented it.
10. Avoidance of talking at length or in any depth about the loss.

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## LONG-TERM GOALS

1. Begin a healthy grieving process around the loss.
2. Complete the process of letting go of the lost significant other.

3. Work through the grieving and letting-go process and reach the point of emotionally reinvesting in life.
4. Successfully grieve the loss within a supportive emotional environment.
5. Resolve the loss and begin reinvesting in relationships with others and in age-appropriate activities.
6. Resolve feelings of guilt, depression, or anger associated with loss and return to previous level of functioning.

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## SHORT-TERM OBJECTIVES

1. Develop a trusting relationship with the therapist as evidenced by the open communication of feelings and thoughts associated with the loss. (1, 2)

2. Verbalize and experience feelings connected with the loss. (3, 4, 5)

## THERAPEUTIC INTERVENTIONS

1. Actively build level of trust with the client through consistent eye contact, active listening, unconditional positive regard, and warm acceptance while asking him/her to describe the loss and to identify and express feelings associated with the loss.
2. Ask the client to tell the story of the loss through drawing pictures of his/her experience.
3. Ask the client to write a letter to the lost person describing his/her feelings and read this letter to the therapist (or assign "Grief Letter" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
4. Assign the client to journal his/her daily thoughts and feelings regarding the loss (recommend *The Healing Your*

*Grieving Heart Journal for Teens* by Wolfelt); process the journal material within sessions.

5. Ask the client to collect and bring to a session various photos and other memorabilia related to the lost loved one (or assign the "Create a Memory Album" exercise from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

3. Provide behavioral, emotional and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9, 10)

6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and

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| | factors that could offer a better understanding of the client's behavior. |
| | 9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment). |
| | 10. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting). |
| 4. Participate in a therapy focused on addressing and resolving depression. (11) | 11. Conduct an evidence-based therapy for cases in which the client's loss has resulted in clinical depression (see the Unipolar Depression chapter in this *Planner*). |
| 5. Verbalize an understanding of the process or journey of grief that is unique for each individual. (12, 13, 14) | 12. Have the client read sections or the entirety of the books on teen grieving (e.g., *Common Threads of Teenage Grief* by Tyson) or *Straight Talk about Death for Teenagers* by Grollman) and select three to five key ideas from the reading to discuss with the therapist. |

13. Educate the client and his/her parents about the grieving process and assist the parents in how to answer any of the client's questions.
14. Ask the client to watch a film that focuses on loss and grieving (e.g., *Terms of Endearment, Ordinary People, My Girl*); discuss how various characters coped with the loss and expressed their grief.

6. Attend a grief support group. (15)

15. Refer the client to a support group for adolescents grieving death or divorce in the family.

7. Identify those activities that have contributed to the avoidance of feelings connected to the loss. (16, 17)

16. Ask the client to list how he/she has avoided the pain of grieving and how that has negatively impacted his/her life.
17. Explore the client's use of mood-altering substances as a means of grief avoidance (see the Substance Use chapter in this *Planner*).

8. Terminate the use of alcohol and illicit drugs. (18)

18. Make a contract with the client to abstain from all mood-altering substances; monitor for compliance by checking with the client and parents and make a referral for a substance abuse evaluation if he/she is unable to keep the contract.

9. Verbalize questions about the loss and work to obtain answers for each. (19, 20, 21)

19. Assist the client in developing a list of questions about a specific loss, then try to direct him/her to resources (e.g., books, clergy, parent, counselor) for possible answers for each question.
20. Expand the client's understanding of death by reading *Lifetimes* (Mellonie and Ingpen) to him/ her and

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| | discussing all questions that arise from the reading. |
| | 21. Assist the client in identifying a peer or an adult who has experienced a loss similar to the client's and has successfully worked his/her way through it. Work with the client to develop a list of questions that he/she would like to ask this person (e.g., "What was the experience like for you? What was the most difficult part? What did you find the most helpful?"). |
| 10. Verbalize an increase in understanding the process of grieving and letting go. (22, 23) | 22. Assign the client to ask questions about grieving to a peer or adult who has successfully resolved a loss, or arrange a conjoint session to ask the questions; process the experience. |
| | 23. Assign the client to interview a member of the clergy about death and to interview an adult who has experienced and successfully worked through the death of a loved one. |
| 11. Identify positive things about the deceased loved one and/or the lost relationship and how these things may be remembered. (24) | 24. Ask the client to list positive things about the deceased, why these things were memorable, and how he/she plans to remember each one; process the list. |
| 12. Decrease the expression of feelings of guilt and blame for the loss. (25, 26) | 25. Explore the client's thoughts and feelings of guilt and blame surrounding the loss, replacing irrational thoughts with realistic thoughts. |
| | 26. Help the client lift the self-imposed curse he/she believes to be the cause for the loss by asking the person who is perceived as having imposed the curse to take it back or by |

role-playing a phone conversation for the client to apologize for the behavior he/she believes is the cause for the curse.

13. Verbalize and resolve feelings of anger or guilt focused on self, God, or the deceased loved one that block the grief process. (27, 28, 29)

27. Suggest an absolution ritual (e.g., dedicate time to a charity that the deceased loved one supported) for the client to implement to relieve the guilt or blame for the loss; monitor the results and adjust as necessary.

28. Encourage and support the client in sessions to look angry, then act angry, and finally put words to the anger.

29. Assign the client to complete an exercise related to an apology or forgiveness (e.g., writing a letter asking for forgiveness from the deceased, using the empty-chair technique to apologize) and to process it with the therapist.

14. Say goodbye to the lost loved one. (30, 31)

30. Assign the client to write a goodbye letter to the deceased (or assign the "Grief Letter" exercise in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

31. Suggest the client visit the grave of the loved one with an adult to communicate feelings and say goodbye, perhaps by leaving the goodbye letter or drawing; process the experience.

15. List how life will demonstrate that the loss is being resolved. (32)

32. Assist the client in developing a list of indicators that the loss is beginning to be resolved such as sleeping undisturbed, feeling less irritable and tearful, experiencing more happy times, recalling the loss with good memories instead of just

heartache, and reinvesting in life interests (or assign "Moving Closer to Resolution" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

16. Parents verbalize an increase in their understanding of how to be supportive during the grief process. (33, 34)

33. Train the parents in specific ways they can provide comfort, consolation, love, companionship, and support to the client in grief (e.g., bring up the loss occasionally for discussion, encourage the client to talk freely of the loss, encourage photographs of the loved one to be displayed, spend one-on-one time with the client in quiet activities that may foster sharing of feelings, spend time with the client in diversion activities).

34. Assign the parents to read a book to help them become familiar with the grieving process (e.g., *The Grieving Teen* by Fitzgerald; *Caring for Your Grieving Child: A Parent's Guide* by Wakenshaw; or *Teen Grief Relief: Parenting with Understanding, Support, and Guidance* by Horsley and Horsley).

17. Parents increase their verbal openness about the loss. (35, 36, 37)

35. Refer the parents to a grief/loss support group; process the experience within sessions.

36. Conduct family sessions where each member of the client's family talks about his/her experience related to the loss.

37. Assign the client and parents to play The Good Mourning Game (Bisenius and Norris), first in a family session and then later at

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| | home by themselves. Follow up the assignment by processing with the family members, focusing on what each learned about themselves and about others in the grieving process. |
| 18. Parents facilitate the client's participation in grief healing rituals. (38, 39) | 38. Assist the family in the development of new rituals to fill the void created by the loss. |
| | 39. Encourage the parents to allow the client to participate in the rituals and customs of grieving if the client is willing to be involved. |
| 19. Participate in memorial services, funeral services, or other grieving rituals. (40) | 40. Encourage the parents to allow the client to participate in a memorial service, funeral service, or other grieving rituals. |
| 20. Verbalize an understanding of the grief anniversary reaction and state a plan to cope with it. (41) | 41. Educate the client and parents in the area of anniversary dates, focusing on what to expect and ways to handle the feelings such as reminisce about the loss with significant others, visit the grave site, or celebrate the good memories with a dinner out (or assign "Honoring the Anniversary of the Loss" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 21. Parents who are losing custody verbally say goodbye to the client. (42) | 42. Conduct a session with the parents who are losing custody of the client to prepare them to say goodbye to the client in a healthy, affirmative way. |
| 22. Attend and participate in a formal session to say goodbye to the parents whose parental rights are being terminated. (43) | 43. Facilitate a goodbye session with the client and the parents who are losing custody, for the purpose of giving the client permission to move on with his/her life. If the parents who are losing custody or the current |

parents are not available, ask them to write a letter that can be read at the session, or conduct a role-play in which the client says goodbye to each parent.

23. Verbalize positive memories of the past and hopeful statements about the future. (44)

44. Ask the client to make a record of his/her life in a book format, using pictures and other memorabilia, to help visualize his/her past, present, and future life (or assign the "Create a Memory Album" or "Memorial Collage" exercise from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 296.2x | Major Depressive Disorder, Single Episode |
| | 296.3x | Major Depressive Disorder, Recurrent |
| | V62.82 | Bereavement |
| | 309.0 | Adjustment Disorder With Depressed Mood |
| | 309.4 | Adjustment Disorder With Mixed Disturbance of Emotions and Conduct |
| | 300.4 | Dysthymic Disorder |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 296.2x | F32.x | Major Depressive Disorder, Single Episode |
| 296.3x | F33.x | Major Depressive Disorder, Recurrent Episode |
| V62.82 | Z63.4 | Uncomplicated Bereavement |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.4 | F43.25 | Adjustment Disorder, With Mixed Disturbance of Emotions and Conduct |
| 300.4 | F34.1 | Persistent Depressive Disorder |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# INTELLECTUAL DEVELOPMENT DISORDER

## BEHAVIORAL DEFINITIONS

1. Significantly subaverage intellectual functioning as demonstrated by an IQ score of approximately 70 or below on an individually administered intelligence test.
2. Significant impairments in academic functioning, communication, self-care, home living, social skills, and leisure activities.
3. Difficulty understanding and following complex directions in home, school, or community settings.
4. Short- and long-term memory impairment.
5. Concrete thinking or impaired abstract reasoning abilities.
6. Impoverished social skills as manifested by frequent use of poor judgment, limited understanding of the antecedents and consequences of social actions, and lack of reciprocity in peer interactions.
7. Lack of insight and repeated failure to learn from experience or past mistakes.
8. Low self-esteem as evidenced by frequent self-derogatory remarks (e.g., "I'm so stupid").
9. Recurrent pattern of acting out or engaging in disruptive behaviors without considering the consequences of the actions.

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## LONG-TERM GOALS

1. Achieve all academic goals identified on the client's individualized educational plan (IEP).
2. Function at an appropriate level of independence in home, residential, educational, or community settings.
3. Develop an awareness and acceptance of intellectual and cognitive limitations but consistently verbalize feelings of self-worth.
4. Parents and/or caregivers develop an awareness and acceptance of the client's intellectual and cognitive capabilities so that they place appropriate expectations on his/her functioning.
5. Consistently comply and follow through with simple directions in a daily routine at home, in school, or in a residential setting.
6. Significantly reduce the frequency and severity of socially inappropriate or acting-out behaviors.

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| SHORT-TERM OBJECTIVES | THERAPEUTIC INTERVENTIONS |
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| 1. Complete a comprehensive intellectual and cognitive assessment. (1) | 1. Arrange for a comprehensive intellectual and cognitive assessment (e.g., *Wechsler Adult Intelligence Scale* or *Wechsler Intelligence Scale for Children*) to determine the presence of an intellectual development disorder and gain greater insight into the client's learning strengths and weaknesses; provide feedback to the client, parents, and school officials. |
| 2. Complete psychological testing. (2) | 2. Arrange for psychological testing to assess whether emotional factors or ADHD are interfering |

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| | with the client's intellectual and academic functioning; provide feedback to the client and parents. |
| 3. Complete neuropsychological testing. (3) | 3. Arrange for a neurological examination or neuropsychological testing to rule out possible organic factors that may be contributing to the client's intellectual or cognitive deficits. |
| 4. Complete an evaluation by physical and occupational therapists. (4) | 4. Refer the client to physical and occupational therapists to assess perceptual or sensory-motor deficits and determine the need for ongoing physical and/or occupational therapy. |
| 5. Complete a speech/language evaluation. (5) | 5. Refer the client to a speech/language pathologist to assess deficits and determine the need for appropriate therapy. |
| 6. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9, 10) | 6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change). |
| | 7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional |

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| | defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident). |
| | 8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior. |
| | 9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment). |
| | 10. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting). |
| 7. The client and his/her parents comply with recommendations made by a multidisciplinary evaluation team at school | 11. Attend an individualized educational planning committee (IEPC) meeting with the client's parents, teachers, and other |

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| regarding educational interventions. (11, 12) | appropriate professionals to determine his/her eligibility for special education services, design educational interventions, and establish goals. |
| | 12. Consult with the client, his/her parents, teachers, and other appropriate school officials about designing effective learning programs or interventions that build on the client's strengths and compensate for weaknesses. |
| 8. Move to an appropriate residential setting. (13) | 13. Consult with the client's parents, school officials, or mental health professionals about the client's need for placement in a foster home, group home, or residential program. |
| 9. Attend a program focused on teaching basic job skills. (14) | 14. Refer the client to a sheltered workshop or educational rehabilitation center to develop basic job skills. |
| 10. Parents maintain regular communication with the client's teachers and other appropriate school officials. (15) | 15. Encourage the parents to maintain regular communication with the client's teacher or school officials to monitor his/her academic, behavioral, emotional, and social progress. |
| 11. Parents, teachers, and caregivers implement a token economy in the classroom or placement setting. (16) | 16. Design a token economy for the classroom or residential program to reinforce on-task behaviors, completion of school assignments, good impulse control, and positive social skills. |
| 12. Parents increase praise and other positive reinforcement toward the client regarding his/her academic performance or social behaviors. (17, 18) | 17. Encourage the parents to provide frequent praise and other reinforcement for the client's positive social behaviors and academic performance. |
| | 18. Design a reward system or contingency contract to reinforce |

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| | the client's adaptive or prosocial behaviors. |
| 13. Parents and family cease verbalizations of denial about the client's intellectual and cognitive deficits. (19, 20) | 19. Educate the parents about the symptoms and characteristics of intellectual developmental disorder (recommend *Intellectual Disability: A Guide for Families and Professionals* by Harris). |
| | 20. Confront and challenge the parents' denial surrounding their child's intellectual deficits so they cooperate with recommendations regarding placement and educational interventions (or assign "Hopes and Dreams for Your Child" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 14. Parents recognize and verbally acknowledge their unrealistic expectations of, or excessive pressure on, the client. (21, 22) | 21. Conduct family therapy sessions to assess whether the parents are placing excessive pressure on the client to function at a level that he/she is not capable of achieving. |
| | 22. Confront and challenge the parents about placing excessive pressure on the client. |
| 15. Parents recognize and verbally acknowledge that their pattern of overprotectiveness interferes with the client's intellectual, emotional, and social development. (23, 24) | 23. Observe parent-child interactions to assess whether the parents' overprotectiveness or infantilization of the client interferes with his/her intellectual, emotional, or social development. |
| | 24. Assist the parents or caregivers in developing realistic expectations of the client's intellectual capabilities and level of adaptive functioning (recommend *Steps to Independence: Teaching Everyday* |

*Skills to Children with Special Needs* by Baker and Brightman).

16. Increase participation in family activities or outings. (25, 26, 27, 28, 29)

25. Encourage the parents and family members to regularly include the client in outings or activities (e.g., attending sporting events, going ice skating, visiting a children's museum).

26. Instruct family members to observe positive behaviors by the client between therapy sessions; reinforce positive behaviors and encourage the client to continue to exhibit these behaviors.

27. Assign the client a task in the family (e.g., cooking a simple meal, gardening) that is appropriate for his/her level of functioning and provides him/her with a sense of responsibility or belonging.

28. Place the client in charge of a routine or basic task at home to increase his/her self-esteem and feelings of self-worth in the family.

29. Assign homework designed to promote the client's feelings of acceptance and a sense of belonging in the family system, school setting, or community (or assign the "A Sense of Belonging" exercise from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

17. Increase the frequency of responsible behaviors at school or residential program. (30)

30. Consult with school officials or residential staff about the client performing a job (e.g., raising the flag, helping to run video equipment) to build self-esteem and provide him/her with a sense of responsibility.

18. Parents agree to and implement an allowance program that helps the client learn to manage money more effectively. (31)

19. Take a bath or shower, dress self independently, comb hair, wash hands before meals, and brush teeth on a daily basis. (32)

20. Parents consistently implement behavior management techniques to reduce the frequency and severity of temper outbursts or disruptive and aggressive behaviors. (33, 34)

21. Decrease frequency of impulsive, disruptive, or aggressive behaviors. (35, 36)

31. Counsel the parents about setting up an allowance plan to increase the client's responsibilities and help him/her learn simple money management skills.

32. Design and implement a reward system to reinforce desired self-care behaviors, such as combing hair, washing dishes, or cleaning bedroom (or assign the parents to use the "Activities of Daily Living" program from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

33. Teach the parents effective behavior management techniques such as time-outs or removal of privileges to decrease the frequency and severity of the client's temper outbursts, acting-out, and aggressive behaviors (or assign the parents to complete the exercise "Clear Rules, Positive Reinforcement, Appropriate Consequences" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

34. Encourage the parents to utilize natural, logical consequences for the client's inappropriate social or maladaptive behaviors.

35. Teach the client basic mediational and self-control strategies (e.g., "stop, listen, think, and act") to delay gratification and inhibit impulses.

36. Train the client in the use of guided imagery or relaxation techniques to calm himself/herself down and develop greater control of anger

(or assign "Progressive Muscle Relaxation" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

22. Recognize and verbally identify appropriate and inappropriate social behaviors. (37)

37. Utilize role-playing and modeling in individual sessions to teach the client positive social skills. Reinforce new or emerging prosocial behaviors.

23. Increase the ability to identify and express feelings. (38, 39, 40)

38. Educate the client about how to identify and label different emotions.

39. Tell the client to draw faces of basic emotions, then have him/her share times when he/she experienced the different emotions.

40. Teach the client effective communication skills (i.e., proper listening, good eye contact, "I statements") to improve his/her ability to express thoughts, feelings, and needs more clearly.

24. Express feelings of sadness, anxiety, and insecurity that are related to cognitive and intellectual limitations. (41, 42)

41. Assist the client in coming to an understanding and acceptance of the limitations surrounding his/her intellectual deficits and adaptive functioning.

42. Explore the client's feelings of depression, anxiety, and insecurity that are related to cognitive or intellectual limitations; provide encouragement and support for the client.

25. Increase the frequency of positive self-statements. (43, 44)

43. Encourage the client to participate in the Special Olympics to build self-esteem.

44. Explore times when the client achieved success or

accomplished a goal (or complete this exercise with the client: "Recognizing Your Abilities, Traits, and Accomplishments" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); reinforce positive steps that the client took to successfully accomplish goals.

26. Identify when it is appropriate to seek help with a task and when it is not. (45)

45. Assist the client in identifying appropriate and inappropriate times to ask for help; identify a list of acceptable resource people to whom the client can turn for support, help, and supervision when necessary.

27. Recognize and verbally identify appropriate and inappropriate sexual behaviors. (46)

46. Provide sex education to help the client identify and verbally recognize appropriate and inappropriate sexual urges and behaviors.

28. Parents review community support services that have been beneficial and which would be helpful now. (47)

47. Explore with the parents supportive services that they have used in the past and what they wish for now; educate them as to what might be available but has not been accessed as yet (or assign "Supportive Services for Your Child" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 299.00 | Autistic Disorder |
| | 299.80 | Rett's Disorder |
| | 299.80 | Asperger's Disorder |
| | 299.10 | Childhood Disintegrative Disorder |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | 317 | Mild Mental Retardation |
| | 318.0 | Moderate Mental Retardation |
| | 318.1 | Severe Mental Retardation |
| | 318.2 | Profound Mental Retardation |
| | 319 | Mental Retardation, Severity Unspecified |
| | V62.89 | Borderline Intellectual Functioning |
| | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
| | _____ | _____ |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
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| 299.00 | F84 | Autistic Spectrum Disorder |
| 317 | F70 | Intellectual Disability, Mild |
| 318.0 | F71 | Intellectual Disability, Moderate |
| 318.1 | F72 | Intellectual Disability, Severe |
| 318.2 | F73 | Intellectual Disability, Profound |
| 319 | F79 | Unspecified Intellectual Disability |
| V62.89 | R41.83 | Borderline Intellectual Functioning |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# LOW SELF-ESTEEM

## BEHAVIORAL DEFINITIONS

1. Verbalizes self-disparaging remarks, seeing self as unattractive, worthless, stupid, a loser, a burden, unimportant.
2. Takes blame easily.
3. Inability to accept compliments.
4. Refuses to take risks associated with new experiences, as she/he expects failure.
5. Avoids social contact with adults and peers.
6. Seeks excessively to please or receive attention/praise of adults and/or peers.
7. Unable to identify or accept positive traits or talents about self.
8. Fears rejection from others, especially peer group.
9. Acts out in negative, attention-seeking ways.
10. Difficulty saying no to others; fears not being liked by others.

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## LONG-TERM GOALS

1. Elevate self-esteem.
2. Increase social interaction, assertiveness, confidence in self, and reasonable risk-taking.
3. Build a consistently positive self-image.

4. Demonstrate improved self-esteem by accepting compliments, by identifying positive characteristics about self, by being able to say no to others, and by eliminating self-disparaging remarks.
5. See self as lovable and capable.
6. Increase social skill level.

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| SHORT-TERM OBJECTIVES | THERAPEUTIC INTERVENTIONS |
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| 1. Describe self as perceived by self and others. (1) | 1. Ask the client to describe how he/she perceives himself/herself including strengths and weaknesses, traits, accomplishments, and how he/she believes others see him/her. |
| 2. Cooperate with psychological testing. (2) | 2. Administer to the client a self-esteem questionnaire (e.g., *Rosenberg Self-Esteem Scale*) and/or a more general test of emotional status (e.g., *Minnesota Multiphasic Personality Inventory-Adolescent [MMPI-A], Millon Adolescent Clinical Inventory [MAPI], Beck Youth Inventories*) to assess self-concept and more serious mental health issues (see the Social Anxiety and Unipolar Depression chapters in this *Planner* if necessary). |
| 3. Verbalize an increased awareness of self-disparaging statements. (3, 4) | 3. Assist the client in becoming aware of how he/she expresses or acts out (e.g., lack of eye contact, social withdrawal, and expectation of failure or rejection) negative feelings about self. |

4. Disclose any history of substance use that may contribute to and complicate the treatment of low self-esteem. (5)
5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9, 10)

4. Confront and reframe the client's self-disparaging comments.
5. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it.
6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates

mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

10. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

6. Decrease frequency of negative self-statements. (11, 12, 13)

11. Refer the client to group therapy that is focused on ways to build self-esteem.

12. Ask the client to read a book on self-esteem (e.g., *The Self-Esteem Workbook for Teens: Activities to Help You Build Confidence and Achieve Your Goals* by Schab; *Self-Esteem: A Proven Program of Cognitive Techniques for Assessing, Improving, and Maintaining Your Self-Esteem* by McKay and Fanning; *10 Simple Solutions for Building Self-Esteem* by Schiraldi); ask him/her to note 5 to 10 key points to discuss with the therapist.

13. Assign the client to read *Why Am I Afraid to Tell You Who I Am?* (Powell) and choose 5 to 10 key points to discuss with the therapist.

7. Decrease verbalized fear of rejection while increasing statements of self-acceptance. (14, 15, 16)

14. Ask the client to make one positive statement about himself/herself daily and record it on a chart or in a journal (see *The Power of Positive Talk* by Block).
15. Assist the client in developing positive self-talk as a way of boosting his/her confidence and positive self-image (or assign "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma).
16. Probe the parents' interactions with the client in family sessions and redirect or rechannel any patterns of interaction or methods of discipline that are negative or critical of the client.

8. Identify positive traits and talents about self. (17, 18, 19)

17. Reinforce verbally the client's use of positive statements of confidence or identification of positive attributes about himself/herself.
18. Develop with the client a list of positive affirmations about himself/herself and ask that it be read three times daily (or assign "Recognizing Your Abilities, Traits, and Accomplishments" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
19. Assign a mirror exercise in which the client looks daily into a mirror and then records all that he/she sees there. Repeat the exercise a second week, increasing the daily time to 4 minutes, and have the client look for and record only the positive things he/she sees. Have the client process what he/she

records and what the experience was like with the therapist.

9. Identify and verbalize feelings. (20, 21, 22)

20. Have the client complete the exercise "Self-Esteem—What Is It—How Do I Get It?" from *Ten Days to Self-Esteem* (Burns) and then process the completed exercise with the therapist.

21. Use a therapeutic game (e.g., The Talking, Feeling, and Doing Game by Gardner, available from Creative Therapeutics; Let's See About Me, available from Childswork/Childsplay; or The Ungame by Zakich, available from The Ungame Company) to promote the client becoming more aware of self and his/her feelings.

22. Educate the client in the basics of identifying and labeling feelings, and assist him/her in the beginning to identify what he/she is feeling.

10. Increase eye contact with others. (23, 24)

23. Focus attention on the client's lack of eye contact; encourage and reinforce increased eye contact within sessions.

24. Ask the client to increase eye contact with teachers, parents, and other adults; review and process reports of attempts and the feelings associated with them.

11. Identify actions that can be taken to improve self-image. (25, 26)

25. Ask the client to draw representations of the changes he/she desires for himself/herself or his/her life situation; help the client develop a plan of implementation for the changes (or assign "Three Wishes Game," "Three Ways to Change Yourself," or "Maintaining Your Self-Esteem" from the

*Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

26. Utilize a brief solution-focused approach (O'Hanlon and Beadle) such as externalizing the problem by framing the difficulty as a stage or something that the client might grow out of or get over in order to depathologize the issue and open up new hopes and possibilities for action that might improve the client's self-esteem.

12. Identify and verbalize needs. (27, 28)

27. Assist the client in identifying and verbalizing his/her emotional needs; brainstorm ways to increase the chances of his/her needs being met (or assign "Unmet Emotional Needs—Identification and Satisfaction" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

28. Conduct a family session in which the client expresses his/her needs to family and vice versa.

13. Identify instances of emotional, physical, or sexual abuse that have damaged self-esteem. (29)

29. Explore for incidents of abuse (emotional, physical, or sexual) and how they have impacted feelings about self (see the "Sexual Abuse Victim and/or Physical/Emotional Abuse Victim chapters in this *Planner*).

14. Identify negative automatic thoughts and replace them with positive self-talk messages to build self-esteem. (30, 31)

30. Help the client identify his/her distorted negative beliefs about self and the world.

31. Help the client identify, and reinforce the use of, more realistic, positive messages about self and life events (or assign

"Bad Thoughts Lead to Depressed Feelings" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

15. Take responsibility for daily self-care and household tasks that are developmentally age-appropriate. (32)

32. Help the client find and implement daily self-care and household or academic responsibilities that are age-appropriate. Monitor follow-through and give positive feedback when warranted.

16. Positively acknowledge and verbally accept praise or compliments from others. (33, 34)

33. Use neurolinguistic programming or reframing techniques in which messages about self are changed to assist the client in accepting compliments from others.

34. Ask the client to obtain three letters of recommendation from adults he/she knows but is not related to. The letters are to be sent directly to the therapist (the therapist provides three addressed, stamped envelopes) and then opened and read in session.

17. Parents identify specific activities for the client that will facilitate development of positive self-esteem. (35, 36)

35. Provide the parents with or have them purchase the book *Full Esteem Ahead!: 100 Ways to Build Self-Esteem in Children and Adults* (Loomans and Loomans); have them look over the book and then select two to three ideas to implement; have the parents process the results with the therapist.

36. Ask the parents to involve the client in esteem-building activities (Scouting, experiential camps, music, sports, youth groups, enrichment programs, etc.).

18. Parents verbalize realistic expectations and discipline methods for the client. (37, 38)

19. Parents attend a didactic series on positive parenting. (39)

20. Increase the frequency of speaking up with confidence in social situations. (40, 41, 42, 43)

37. Explore parents' expectations of the client; assist, if necessary, in making them more realistic.

38. Train the parents in the 3 Rs (related, respectful, and reasonable) of discipline techniques (see *Raising Self-Reliant Children in a Self-Indulgent World* by Glenn and Nelson) in order to eliminate discipline that results in rebellion, revenge, or reduced self-esteem. Assist in implementation, and coach the parents as they develop and improve their skills using this method.

39. Ask the parents to attend a didactic series on positive parenting, afterward processing how they can begin to implement some of these techniques (see *Positive Discipline for Teenagers* by Nelsen and Lott; or *Parents and Adolescents Living Together* by Patterson and Forgatch).

40. Encourage the client to use the technique "Pretending to Know How" (see Theiss in *101 Favorite Play Therapy Techniques*) or "The Therapist on the Inside" (see Grigoryev in *101 Favorite Play Therapy Techniques*) on one identified task or problem area in the next week. Follow up by processing the experience and results, and then have the client use the technique again on two new situations or problems, and so on.

41. Ask the client to read *How to Say No and Keep Your Friends* (Scott) and to process with the therapist how saying no can

boost self-confidence and self-esteem.

42. Use role-playing and behavioral rehearsal to improve the client's assertiveness and social skills (or assign "Becoming Assertive," "Developing Conversational Skills," or "Greeting Peers" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

43. Encourage the client to attend an alternative camp or weekend experience to promote his/her personal growth in the areas of trust, self-confidence, and cooperation and in developing relationships with others.

21. Parents verbally reinforce the client's active attempts to build positive self-esteem. (44)

44. Encourage the parents to seek out opportunities to praise, reinforce, and recognize the client's minor or major accomplishments.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

| | | |
|---|---|---|
| **Axis I:** | 300.4 | Dysthymic Disorder |
| | 314.01 | Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type |
| | 300.23 | Social Anxiety Disorder (Social Phobia) |
| | 296.xx | Major Depressive Disorder |
| | 307.1 | Anorexia Nervosa |

| | | |
|---|---|---|
| | 309.21 | Separation Anxiety Disorder |
| | 300.02 | Generalized Anxiety Disorder |
| | 995.54 | Physical Abuse of Child (Victim) |
| | 995.53 | Sexual Abuse of Child (Victim) |
| | 995.52 | Neglect of Child (Victim) |
| | 303.90 | Alcohol Dependence |
| | 304.30 | Cannabis Dependence |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
| | _____ | _____ |
| | _____ | _____ |

*Using DSM-5/ICD-9-CM/ICD-10-CM*:

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 300.4 | F34.1 | Persistent Depressive Disorder |
| 314.01 | F90.1 | Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive /Impulsive Presentation |
| 300.23 | F40.10 | Social Anxiety Disorder (Social Phobia) |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 296.xx | F33.x | Major Depressive Disorder, Recurrent Episode |
| 307.1 | F50.02 | Anorexia Nervosa, Binge-Eating/Purging Type |
| 307.1 | F50.01 | Anorexia Nervosa, Restricting Type |
| 309.21 | F93.0 | Separation Anxiety Disorder |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 995.54 | T74.12XA | Child Physical Abuse, Confirmed, Initial Encounter |
| 995.54 | T74.12XD | Child Physical Abuse, Confirmed, Subsequent Encounter |
| V61.22 | Z69.011 | Encounter for Mental Health Services for Perpetrator of Parental Child Sexual Abuse |
| V62.83 | Z69.021 | Encounter for Mental Health Services for Perpetrator of Nonparental Child Sexual Abuse |
| V61.22 | Z69.011 | Encounter for Mental Health Services for Perpetrator of Parental Child Neglect |
| 995.52 | T74.02XA | Child Neglect, Confirmed, Initial Encounter |
| 995.52 | T74.02XD | Child Neglect, Confirmed, Subsequent Encounter |

| | | |
|---|---|---|
| 995.53 | T74.22XA | Child Sexual Abuse, Confirmed, Initial Encounter |
| 995.53 | T74.22XD | Child Sexual Abuse, Confirmed, Subsequent Encounter |
| 303.90 | F10.20 | Alcohol Use Disorder, Moderate or Severe |
| 304.30 | F12.20 | Cannabis Use Disorder, Moderate or Severe |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# MEDICAL CONDITION

## BEHAVIORAL DEFINITIONS

1. A diagnosis of a chronic illness that is not life-threatening but necessitates changes in living.
2. A diagnosis of an acute, serious illness that is life-threatening.
3. A diagnosis of a chronic illness that eventually will lead to an early death.
4. Sad affect, social withdrawal, anxiety, loss of interest in activities, and low energy.
5. Suicidal ideation.
6. Denial of the seriousness of the medical condition.
7. Refusal to cooperate with recommended medical treatments.

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## LONG-TERM GOALS

1. Accept the illness and adapt life to necessary changes.
2. Resolve emotional crisis and face terminal illness's implications.
3. Work through the grieving process and face the reality of own death with peace.
4. Accept emotional support from those who care without pushing them away in anger.
5. Resolve depression, fear, and anxiety, finding peace of mind despite the illness.

6. Live life to the fullest extent possible even though time may be limited.
7. Cooperate with the medical treatment regimen without passive-aggressive or active resistance.

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## SHORT-TERM OBJECTIVES

1. Describe history, symptoms, and treatment of the medical condition. (1, 2, 3)

2. Disclose any history of substance use that may contribute to and complicate the treatment of the medical condition. (4)

## THERAPEUTIC INTERVENTIONS

1. Establish rapport and a working alliance with the client and parents using appropriate process skills (e.g., active listening, reflective empathy, support, and instillation of hope).
2. Gather a history of the facts regarding the client's medical condition, including symptoms, treatment, and prognosis; assess the emotional, cognitive, and behavioral impact of the medical condition.
3. With informed consent and appropriate releases, contact the treating physician and family members for additional medical information regarding the client's diagnosis, treatment, and prognosis.
4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it.

3. Provide behavioral, emotional and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8, 9)

5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess

this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

9. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

4. Verbalize an understanding of the medical condition, its consequences, and effective cognitive behavioral coping. (10)

10. Encourage and facilitate the client and parents in learning about the medical condition, cognitive behavioral factors that facilitate or interfere with effective coping and symptom reduction, the realistic course of the illness, pain management options, and chance for recovery (see *Chronic Illness in Children and Adolescents* by Brown, Daly, and Rickel; *Psychological Interventions in Childhood Chronic Illness* by Drotar).

5. Comply with the medication regimen and necessary medical procedures, reporting any side effects or problems to physicians or therapists. (11, 12, 13)

11. Monitor and reinforce the client's compliance with the medical treatment regimen.

12. Explore and address the client's misconceptions, fears, and situational factors that interfere with medical treatment compliance (or assign "Attitudes About Medication or Medical Treatment" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

13. Therapeutically confront any manipulation, passive-aggressive, and denial mechanisms that interfere with the client's compliance with the medical treatment regimen.

6. Adjust sleep hours to those typical of the developmental stage. (14)

14. Assess and monitor the client's sleep patterns and sleep hygiene; intervene accordingly to promote good sleep hygiene and sleep cycle (or assign "Sleep Pattern Record" in the *Adult Psychotherapy Homework Planner* by Jongsma).

7. Eat nutritional meals regularly. (15)

15. Assess the teen's eating habits and intervene accordingly to plan and establish a well-balanced and nutritious eating schedule.

8. Share feelings triggered by the knowledge of the medical condition and its consequences. (16)

16. Assist the client in identifying, sorting through, and verbalizing the various feelings and stresses generated by his/her medical condition (or assign "Coping With Your Illness" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

9. Verbalize acceptance of the reality of the medical condition and its consequences while decreasing denial. (17, 18)

17. Gently confront the client's denial of the seriousness of his/her condition and of the need for compliance with medical treatment procedures.

18. Reinforce the client's acceptance of his/her medical condition.

10. Share fearful or depressed feelings regarding the medical condition and develop a plan for addressing them. (19, 20, 21)

19. Explore and process the client's fears associated with deterioration of physical health, death, and dying.

20. Normalize the client's feelings of grief, sadness, or anxiety associated with his/her medical

condition; encourage verbal expression of these emotions.

21. Assess the client for and treat his/her depression and anxiety using relevant cognitive, physiological, and/or behavioral aspects of treatments for those conditions (see the Unipolar Depression and Anxiety chapters in this *Planner*).

11. Family members share with each other the feelings that are triggered by the client's medical condition. (22)

22. Meet with family members to facilitate their clarifying and sharing possible feelings of guilt, anger, helplessness, and/or sibling attention jealousy associated with the client's medical condition (or assign "Coping With a Sibling's Health Problems" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

12. Family members share any conflicts that have developed between them. (23, 24, 25)

23. Explore how each parent is dealing with the stress related to the client's illness and whether conflicts have developed between the parents because of differing response styles.

24. Assess family conflicts using a conflict resolution approach to addressing them.

25. Facilitate a spirit of tolerance for individual difference in each person's internal resources and response styles in the face of threat.

13. Family members verbalize an understanding of the power of one's own personal positive presence with the sick child. (26)

26. Stress the healing power in the family's constant presence with the ill child and emphasize that there is strong healing potential in creating a warm, caring, supportive, positive environment for the child.

14. Identify and grieve the losses or limitations that have been experienced due to the medical condition. (27, 28, 29, 30)

27. Ask the client to list his/her perception of changes, losses, or limitations that have resulted from the medical condition (or assign "Coping With Your Illness" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

28. Educate the client on the stages of the grieving process and answer any questions (or suggest that the teen read *Good Grief* by Westberg).

29. Suggest that the client's parents read a book on grief and loss (e.g., *Good Grief* by Westberg; *How Can It Be All Right When Everything Is All Wrong?* by Smedes; *When Bad Things Happen to Good People* by Kushner; or *Teen Grief Relief: Parenting with Understanding, Support, and Guidance* by Horsley and Horsley) to help them understand and support their teenager in the grieving process.

30. Assign the client to keep a daily grief journal to be shared in therapy sessions.

15. Parents implement consistent positive parenting practices to facilitate adaptive responding of child to the medical condition. (31)

31. Assess the parents' understanding and use of positive reinforcement principles in child-rearing practices; if necessary, teach the parents operant-based child management techniques (see the Parenting chapter in this *Planner*).

16. Identify and replace negative self-talk and catastrophizing that is associated with the medical condition. (32, 33)

32. Assist the client in identifying the cognitive distortions and negative automatic thoughts that contribute to his/her negative

attitude and hopeless feelings associated with the medical condition (or assign "Bad Thoughts Lead to Depressed Feelings" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

33. Generate with the client a list of positive, realistic self-talk that can replace cognitive distortions and catastrophizing regarding his/her medical condition and its treatment (or assign "Replacing Fears With Positive Messages" in the *Adult Psychotherapy Homework Planner* by Jongsma).

17. Decrease time spent focused on the negative aspects of the medical condition. (34, 35)

34. Suggest that the client set aside a specific time-limited period each day to focus on mourning the medical condition; after the time period is up, have the client resume regular daily activities with agreement to put off thoughts until next scheduled time (or assign "Worry Time" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

35. Challenge the client to focus his/her thoughts on the positive aspects of his/her life and time remaining, rather than on the losses associated with his/her medical condition; reinforce instances of such a positive focus.

18. Learn and implement calming skills to reduce overall tension and moments of increased anxiety, tension, or arousal. (36, 37, 38)

36. Teach the client cognitive and somatic calming skills (e.g., calming breathing; cognitive distancing, decatastrophizing, distraction; progressive muscle relaxation; guided imagery); rehearse with the client how to

apply these skills to his/her daily life (or assign "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review and reinforce success while providing corrective feedback toward consistent implementation.

37. Utilize electromyography (EMG) biofeedback to monitor, increase, and reinforce the client's depth of relaxation.

38. Assign the client and/or parents to read and discuss progressive muscle relaxation and other anxiety coping strategies in relevant books or treatment manuals (e.g., *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay; or *The C.A.T. Project Workbook for the Cognitive Behavioral Treatment of Anxious Adolescents* by Kendall et al.).

19. Parents and child learn and implement personal and interpersonal skills for resolving conflicts effectively. (39)

39. Teach the client and parents tailored, age-appropriate personal and interpersonal skills including problem-solving skills (e.g., specifying problem, generating options, listing pros and cons of each option, selecting an option, implementation, and refining), and conflict resolution skills (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise) to improve personal and interpersonal functioning; use behavioral skills-building

techniques (e.g., modeling, role-playing, and behavior rehearsal, corrective feedback) to develop skills and work through several current conflicts.

20. Engage in social, productive, and recreational activities that are possible despite the medical condition. (40, 41, 42, 43)

40. Sort out with the client activities that can still be enjoyed alone and with others.

41. Assess the effects of the medical condition on the client's social network; facilitate the social support available through the client's family and friends.

42. Solicit a commitment from the client to increase his/her activity level by engaging in enjoyable and challenging activities (or assign "Show Your Strengths" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); reinforce such engagement.

43. Engage the client in "behavioral activation" by scheduling activities that have a high likelihood for pleasure and mastery, are worthwhile to the client, and/or make him/her feel good about self; use behavioral techniques (e.g., modeling, role-playing, role reversal, rehearsal, and corrective feedback) as needed, to assist adoption in the client's daily life (or assign "Home, School, and Community Activities I Enjoyed" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); reinforce advances.

21. Establish a regular exercise schedule. (44)

44. Develop and encourage a routine of physical exercise for the client.

22. Learn and implement relapse prevention skills. (45)

23. Attend a support group of others diagnosed with a similar illness, if desired. (46)

24. Parents and family members attend a support group, if desired. (47)

25. Client and family identify the sources of emotional support that have been beneficial and additional sources that could be sought. (48, 49)

26. Implement faith-based activities as a source of comfort and hope. (50, 51)

45. Build the client's relapse prevention skills by helping him/her identify early warning signs of relapse into negative thoughts, feelings, and actions; reviewing skills learned during therapy; and developing a plan for managing challenges.

46. Refer the client to a support group of others living with a similar medical condition.

47. Refer family members to a community-based support group associated with the client's medical condition.

48. Probe and evaluate the client's, siblings', and parents' sources of emotional support.

49. Encourage the parents and siblings to reach out for support from each other, church leaders, extended family, hospital social services, community support groups, and personal religious beliefs.

50. Draw out the parents' unspoken fears about the client's possible death; empathize with their panic, helplessness, frustration, and anxiety; reassure them of their God's presence as the giver and supporter of life.

51. Encourage the client to rely upon his/her spiritual faith promises, activities (e.g., prayer, meditation, worship, music), and fellowship as sources of support and peace of mind.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

| | | |
|---|---|---|
| **Axis I:** | 316 | Psychological Symptoms Affecting (Axis III Disorder) |
| | 309.0 | Adjustment Disorder With Depressed Mood |
| | 309.24 | Adjustment Disorder With Anxiety |
| | 309.28 | Adjustment Disorder With Mixed Anxiety and Depressed Mood |
| | 309.3 | Adjustment Disorder With Disturbance of Conduct |
| | 309.4 | Adjustment Disorder With Mixed Disturbance of Emotions and Conduct |
| | 296.xx | Major Depressive Disorder |
| | 311 | Depressive Disorder NOS |
| | 300.02 | Generalized Anxiety Disorder |
| | 300.00 | Anxiety Disorder NOS |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | V71.09 | No Diagnosis |
| | _____ | _____ |
| | _____ | _____ |

*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 316 | F54 | Psychological Factors Affecting Other Medical Conditions |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 309.24 | F43.22 | Adjustment Disorder, With Anxiety |
| 309.28 | F43.23 | Adjustment Disorder, With Mixed Anxiety and Depressed Mood |
| 309.3 | F43.24 | Adjustment Disorder, With Disturbance of Conduct |

| | | |
|---|---|---|
| 309.4 | F43.25 | Adjustment Disorder, With Mixed Disturbance of Emotions and Conduct |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 296.xx | F33.x | Major Depressive Disorder, Recurrent Episode |
| 311 | F32.9 | Unspecified Depressive Disorder |
| 311 | F32.8 | Other Specified Depressive Disorder |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 300.09 | F41.8 | Other Specified Anxiety Disorder |
| 300.00 | F41.9 | Unspecified Anxiety Disorder |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# NEGATIVE PEER INFLUENCES

## BEHAVIORAL DEFINITIONS

1. Strong susceptibility to negative peer influences that contribute to problems with authority figures at home, at school, and in the community; sexual promiscuity; or substance abuse problems.
2. Recurrent pattern of engaging in disruptive, negative attention-seeking behaviors at school or in the community to elicit attention, approval, or support from peers.
3. Excessive willingness to follow the lead of others in order to win approval or acceptance.
4. Propensity for taking ill-advised risks or engaging in thrill-seeking behavior in peer group settings.
5. Identification with negative peer group as a means to gain acceptance or elevate status and self-esteem.
6. Affiliation with negative peer groups or gangs to protect self from harm, danger, or perceived threats in the environment.
7. Tendency to gravitate toward negative peer groups because of underlying feelings of low self-esteem and insecurity.
8. Verbal report of being ostracized, teased, or mocked by peers at school or in the community.
9. History of rejection experiences within family system or peer group that contribute to the desire to seek out negative peer groups for belonging.
10. Social immaturity and pronounced deficits in the area of social skills.
11. Participation in substance abuse and other acting-out behaviors to gain group acceptance.

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## LONG-TERM GOALS

1. Establish positive self-image and feelings of self-worth separate from affiliating with negative peer groups.
2. Achieve a sense of belonging and acceptance within the family and within positive peer groups by consistently engaging in socially appropriate behaviors.
3. Develop positive social skills necessary to establish and maintain positive, meaningful, and lasting peer friendships.
4. Resist negative peer group influences on a regular, consistent basis.
5. Terminate involvement with negative peer groups or gangs.
6. Eliminate all acting-out behavior and delinquent acts.
7. Resolve the core conflicts that contribute to susceptibility to negative peer group influences.

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## SHORT-TERM OBJECTIVES

1. Describe the nature of peer relationships. (1, 2)

## THERAPEUTIC INTERVENTIONS

1. Explore the client's perception of the nature of his/her peer relationships as well as any areas of conflict; encourage and support him/her in expressing thoughts and feelings about peer relationships.
2. Gather a detailed psychosocial history of the client's development, family environment, and interpersonal relationships to gain insight into the factors contributing to his/her desire to affiliate with negative peer groups.

2. Disclose any history of substance use that may contribute to and complicate the treatment of negative peer influences. (3)

3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (4, 5, 6, 7, 8)

3. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).

4. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

5. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior deficit/hyper-activity disorder ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

6. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.

7. Assess for the severity of the level of impairment to the client's functioning to determine

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| | appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment). |
| | 8. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting). |
| 4. Record positive and negative experiences with peers and share with the therapist along with the feelings associated with these experiences. (9) | 9. Instruct the client to keep a daily journal in which he/she records both positive and negative experiences with peers that evoked strong emotions. Process excerpts from this journal in follow-up sessions to uncover factors that contribute to the desire to affiliate with negative peer groups, as well as to identify strengths that the client can use to build positive peer relationships. |
| 5. Identify and verbalize needs that are met through involvement in negative peer groups. (10) | 10. Assist the client in identifying the social-emotional needs that he/she attempts to meet through his/her involvement with negative peer groups such as achieve a sense of belonging and acceptance, elevate status, obtain material goods, or seek protection (or assign "Reasons |

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| | for Negative Peer Group Involvement" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 6. Parents establish clearly defined rules and provide structure or boundaries to deter client from being highly susceptible to negative peer influences. (11, 12, 13) | 11. Assist the parents in establishing clearly defined rules and boundaries, as well as providing greater structure, to deter the client from being highly susceptible to negative peer influences (recommend *How to Keep Your Teenager Out of Trouble and What to Do If You Can't* by Bernstein). |
| | 12. Encourage the parents to maintain regular communication with school officials to monitor the client's relationships with peers; encourage parents and teachers to follow through with firm, consistent limits if the client engages in acting-out, disruptive, or aggressive behavior with peers at school. |
| | 13. Establish a contingency contract that identifies specific consequences that the client will receive if he/she engages in disruptive, acting-out, or antisocial behaviors with peers. Have the client repeat terms of contract to demonstrate understanding (or assign to the parents "Clear Rules, Positive Reinforcement, Appropriate Consequences" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 7. Parents and/or teachers implement a reward system to reinforce desired social behaviors. (14) | 14. Design a reward system for parents and/or teachers to reinforce the client for engaging in specific, positive social |

behaviors and deter the need to affiliate with negative peer groups (e.g., introduce self to other individuals in positive peer group, display kindness, help another peer with academic or social problems).

8. Identify the negative consequences on self and others of participation with negative peer groups. (15, 16)

15. Have the client list between 5 and 10 negative consequences that his/her participation with negative peer groups has had on himself/herself and others.

16. Firmly confront the client about the impact of his/her involvement with negative peer groups, pointing out consequences for himself/herself and others.

9. Increase the number of statements that reflect acceptance of responsibility for negative social behavior. (17, 18, 19)

17. Challenge and confront statements by the client that minimize the impact that his/her involvement with negative peer groups has on his/her behavior.

18. Redirect statements in which the client blames other peers for his/her acting-out, disruptive, or antisocial behaviors and fails to accept responsibility for his/her actions.

19. Challenge the parents to cease blaming the client's misbehavior on his/her peers; instead, encourage parents to focus on the client and set limits for his/her negative social behaviors that occur while affiliating with peers.

10. Implement effective coping strategies to help resist negative peer influences. (20, 21, 22, 23)

20. Teach mediational and self-control techniques (e.g., "stop, listen, think, and act"; count to 10; walk away) to help the client successfully resist negative peer influences (or assign "Action

Minus Thought Equals Painful Consequences" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

21. Utilize role-playing, modeling, or behavioral rehearsal techniques to teach the client more effective ways to resist negative peer influences, meet his/her social needs, or establish lasting, meaningful friendships such as walk away, change the subject, say "no," initiate conversations with positive peers, or demonstrate empathy (or assign "Becoming Assertive" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
22. Assign the client to read material to teach him/her effective ways to resist negative peer influences and maintain friendships (e.g., *How to Say No and Keep Your Friends by Scott*; or *The Complete Idiot's Guide to Surviving Peer Pressure for Teens* by Cherniss and Sluke); process reading with the client.
23. Explore times when the client was able to successfully resist negative peer influences and not engage in acting-out, disruptive, or antisocial behaviors. Process the experiences and encourage him/her to use similar coping strategies to resist negative peer influences at present or in future.

11. Increase assertive behavior to deal more effectively with negative peer pressure. (24)

24. Teach the client effective communication and assertiveness skills (e.g., "I have to leave now"; "I can't afford to get into any more trouble") to help

him/her successfully resist negative peer pressure (or assign "Becoming Assertive" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

12. Attend and regularly participate in group therapy sessions that focus on developing positive social skills. (25, 26)

25. Refer the client for group therapy to improve social skills and learn ways to successfully resist negative peer pressure; direct client to self-disclose at least two times in each group therapy session about his/her peer relationships.

26. Refer the client to a behavioral contracting group where he/she and other group members develop contracts each week to increase the frequency of positive peer interactions; review progress with the contracts each week and praise the client for achieving goals regarding peer interactions.

13. Identify and implement positive social skills that will help to improve peer relationships and establish friendships. (27, 28)

27. Teach positive social skills (e.g., introducing self to others, active listening, verbalizing empathy and concern for others, ignoring teasing) to improve peer relationships and increase chances of developing meaningful friendships (or use *Skillstreaming the Adolescent: Student Manual* by Goldstein and McGinnis).

28. Give the client a homework assignment of practicing newly learned positive social skills at least once each day between therapy sessions (or assign "Developing Conversational Skills," "Greeting Peers," or "Observe Positive Social Behaviors" from the *Adolescent*

*Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review implementation, reinforcing success and redirecting for failure.

14. Increase involvement in positive social activities or community organizations. (29, 30)

29. Encourage the client to become involved in positive peer groups or community activities where he/she can gain acceptance and status (e.g., church or synagogue youth groups, YWCA or YMCA functions, school clubs, Boys Clubs or Girls Clubs).

30. Consult with school officials about ways to increase the client's socialization with positive peer groups at school (e.g., join school choir or newspaper staff, participate in student government, become involved in school fundraiser).

15. Increase frequency of positive interactions with peers. (31, 32, 33, 34)

31. Assign the client the task of initiating one social contact per day with other peers who are identified as being responsible, dependable, friendly, or well-liked (or assign "Choice of Friends Survey" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

32. Direct the client to initiate three phone contacts per week to different individuals outside of the identified negative peer group.

33. Give the client a directive to invite a peer or friend (outside of negative peer group) for an overnight visit and/or set up an overnight visit at the other peer's or friend's home; process the experience in follow-up session.

34. Give the client a homework assignment of engaging in three altruistic or benevolent acts with peers before the next therapy session (or assign "Headed in the Right Direction" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); process how others respond to acts of kindness, and encourage the client to engage in similar behavior in the future.

16. Identify and implement positive ways to meet needs other than through participation in negative peer group activities or gang involvement. (35, 36)

35. Brainstorm with the client more adaptive ways for him/her to meet needs for recognition/status, acceptance, material goods, and excitement other than through his/her involvement with negative peer groups or gangs such as attend or participate in sporting events, secure employment, or visit amusement park with community or church youth group (or assign "Unmet Emotional Needs—Identification and Satisfaction" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

36. Assign the client to view the video entitled *Handling Peer Pressure and Gangs* (part of the Peace Talks series available through Wellness Reproductions & Publishing) to help the client resist negative peer influences or pressure to join a gang.

17. Identify and list resource people to whom the client can turn for support, comfort, and guidance. (37)

37. Help the client to identify a list of resource people, both peers and adults, at school or in the community to whom he/she can

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| | turn for support, comfort, or guidance when he/she is experiencing negative peer pressure and/or feels rejected by peers. |
| 18. Identify and express feelings associated with past rejection experiences. (38, 39) | 38. Explore the client's background in peer relationships to assess whether he/she feels rejected, ostracized, or unaccepted by many peers; assist the client in identifying possible causes of rejection or alienation (e.g., hypersensitivity to teasing, target of scapegoating, poor social skills). |
| | 39. Use the empty-chair technique to help the client express his/her feelings of anger, hurt, and sadness toward individuals by whom he/she has felt rejected or alienated in the past. |
| 19. Verbalize recognition of how underlying feelings of low self-esteem and insecurity are related to involvement with negative peer groups. (40, 41, 42, 43) | 40. Assist the client in making a connection between underlying feelings of low self-esteem and insecurity and his/her gravitation toward negative peer groups to achieve a sense of belonging and acceptance. |
| | 41. Assist the client in identifying more constructive ways to build self-esteem and win approval other than affiliating with negative peer groups that influence him/her to act out and engage in antisocial behavior (e.g., try out for school play, attend a school dance, participate in sporting or recreational activities). |
| | 42. Instruct the client to identify 5 to 10 strengths or interests; review the list in follow-up session and encourage the client |

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| | to utilize his/her strengths to build self-esteem and increase positive peer interactions (or assign the "Show Your Strengths" exercise from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 43. Help the client to identify healthy risks that he/she can take in the near future to improve his/her self-esteem (e.g., try out for sports team, attend new social functions or gatherings, initiate conversations with unfamiliar people outside of negative peer group); challenge the client to take three healthy risks before the next therapy session. |
| 20. Overly rigid parents recognize how their strict or harsh enforcement of rules and boundaries contributes to the client's gravitation toward negative peer groups. (44, 45) | 44. Explore whether the parents are overly rigid or strict in their establishment of rules and boundaries to the point where the client has little opportunity to socialize with peers and rebels by engaging in acting-out behaviors with negative peer groups. |
| | 45. Encourage and challenge the overly rigid parents to loosen rules and boundaries to allow the client increased opportunities to engage in socially appropriate activities or positive peer group activities. |
| 21. Parents recognize how their lack of supervision and failure to follow through with limits contributes to the client's affiliation with negative peer groups. (46) | 46. Conduct family therapy session to explore whether the parents' lack of supervision and inability to establish appropriate parent-child boundaries contribute to the client's gravitation toward negative peer group influences. |

22. Describe traits of a positive role model. (47)

47. Assist the client in listing traits and characteristics that he/she would like to see in a positive role model (or assign "I Want to Be Like . . ." from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 313.81 | Oppositional Defiant Disorder |
| | 312.82 | Conduct Disorder, Adolescent-Onset Type |
| | 312.9 | Disruptive Behavior Disorder NOS |
| | 314.01 | Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type |
| | 314.9 | Attention-Deficit/Hyperactivity Disorder NOS |
| | V71.02 | Adolescent Antisocial Behavior |
| | V62.81 | Relational Problem NOS |
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| **Axis II:** | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
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| 313.81 | F91.3 | Oppositional Defiant Disorder |
| 312.82 | F91.2 | Conduct Disorder, Adolescent-Onset Type |
| 312.9 | F91.9 | Unspecified Disruptive, Impulse Control, and Conduct Disorder |
| 312.89 | F91.8 | Other Specified Disruptive, Impulse Control, and Conduct Disorder |
| 314.01 | F90.1 | Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive/Impulsive Presentation |
| 314.01 | F90.9 | Unspecified Attention-Deficit/Hyperactivity Disorder |
| 314.01 | F90.8 | Other Specified Attention-Deficit/Hyperactivity Disorder |
| 305.00 | F10.10 | Alcohol Use Disorder, Mild |
| 303.90 | F10.20 | Alcohol Use Disorder, Moderate or Severe |
| 305.20 | F12.10 | Cannabis Use Disorder, Mild |
| 304.30 | F12.20 | Cannabis Use Disorder, Moderate or Severe |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# OBSESSIVE-COMPULSIVE DISORDER (OCD)

## BEHAVIORAL DEFINITIONS

1. Recurrent and persistent ideas, thoughts, or impulses that are viewed as intrusive, senseless, and time-consuming, or that interfere with the client's daily routine, school performance, or social relationships.
2. Failed attempts to ignore or control these recurrent thoughts or impulses or neutralize them with other thoughts and actions.
3. Recognition that obsessive thoughts are a product of his/her own mind.
4. Excessive concerns about dirt or unfounded fears of contracting a dreadful disease or illness.
5. Obsessions related to troubling aggressive or sexual thoughts, urges, or images.
6. Persistent and troubling thoughts about religious issues; excessive concern about morality and right or wrong.
7. Repetitive and intentional behaviors and/or mental acts that are done in response to obsessive thoughts or increased feelings of anxiety or fearfulness.
8. Repetitive and excessive behaviors and/or mental acts that are done to neutralize or prevent discomfort or some dreaded event; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.
9. Recognition of repetitive behaviors and/or mental acts as excessive and unreasonable.
10. Cleaning and washing compulsions (e.g., excessive hand washing, bathing, showering, cleaning of household items).
11. Hoarding or collecting compulsions.
12. Checking compulsions (e.g., repeatedly checking to see if door is locked, rechecking homework to make sure it is done correctly, checking to make sure that no one has been harmed).

13. Compulsions about having to arrange objects or things in proper order (e.g., stacking coins in certain order, laying out clothes each evening at same time, wearing only certain clothes on certain days).

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## LONG-TERM GOALS

1. Significantly reduce time involved with or interference from obsessions.
2. Significantly reduce frequency of compulsive or ritualistic behaviors.
3. Function daily at a consistent level with minimal interference from obsessions and compulsions.
4. Resolve key life conflicts and the emotional stress that fuels obsessive-compulsive behavior patterns.
5. Let go of key thoughts, beliefs, and past life events in order to maximize time free from obsessions and compulsions.

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## SHORT-TERM OBJECTIVES

1. Describe the nature, history, and severity of obsessive thoughts and/or compulsive behavior. (1, 2)

## THERAPEUTIC INTERVENTIONS

1. Establish rapport and a working alliance with the client and parents using appropriate process skills (e.g., active listening, reflective empathy, support, and instillation of hope).

2. Disclose any history of substance use that may contribute to and complicate the treatment of the OCD. (3)
3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (4, 5, 6, 7, 8)

2. Assess the nature, severity, and history of the client's obsessions and compulsions using clinical interview with the client and the parents.
3. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it.
4. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
5. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
6. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.

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| | 7. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment). |
| | 8. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting). |
| 4. Comply with psychological testing evaluation to assess the nature and severity of the obsessive-compulsive problem. (9) | 9. Arrange for psychological testing or use objective measures to further evaluate the nature and severity of the client's obsessive-compulsive problem (e.g., *Children's Yale-Brown Obsessive Compulsive Scale*). |
| 5. Cooperate with an evaluation by a physician for psychotropic medication. (10, 11) | 10. Arrange for an evaluation for a prescription of psychotropic medications (e.g., serotonergic medications). |
| | 11. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with the prescribing physician at regular intervals. |

6. Verbalize an understanding of OCD and the rationale for its treatment. (12, 13, 14)

12. Provide the client and parents with initial and ongoing psychoeducation about OCD, a cognitive behavioral conceptualization of OCD, biopsychosocial factors influencing its development, how fear and avoidance serve to maintain the disorder, and other information relevant to therapeutic goals.

13. Discuss a rationale in which treatment serves as an arena to desensitize learned fear, reality-test obsessive fears and underlying beliefs (e.g., seeing obsessive fears as "false alarms"), and build confidence in managing fears without compulsions (see *Cognitive Behavioral Treatment of Childhood OCD: It's Only a False Alarm—Therapist Guide* by Piacentini, Langley, and Roblek).

14. Prescribe reading or other sources of information (e.g., CDs, DVDs) on OCD and exposure and ritual prevention therapy to facilitate psychoeducation done in session (e.g., *Treating Your OCD with Exposure and Response (Ritual) Prevention: Workbook* by Yadin, Foa, and Lichner; *Brain Lock: Free Yourself from Obsessive-Compulsive Behavior* by Schwartz; *Obsessive-Compulsive Disorder: Help for Children and Adolescents* by Waltz).

7. Express a commitment to participate in Cognitive Behavioral Therapy for OCD. (15)

15. Confirm the client's motivation to participate in treatment; use motivational interviewing techniques, a pros-cons analysis,

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| | and/or other motivational interventions to help move the client toward committed engagement in therapy. |
| 8. Complete a daily journal of obsessions and compulsions as guided by the therapist. (16) | 16. Instruct and ask the client to self-monitor and record obsessions and compulsions including triggers, specific fears, and mental and/or behavioral compulsions; involve parents if needed; review to facilitate psychoeducation and/or assess response to treatment. |
| 9. Identify and replace biased, fearful self-talk and beliefs. (17) | 17. Explore the client's biased cognitive self-talk, beliefs, and underlying assumptions that mediate his/her obsessive fears and compulsive behavior (e.g., distorted risk appraisals, inflated sense of responsibility for harm, excessive self-doubt, thought-action fusion-thinking of a harmful act is the same as actually doing it); assist him/her in generating thoughts/beliefs that correct for the biases (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma). |
| 10. Learn cognitive coping strategies to manage obsessions therapeutically. (18) | 18. Teach cognitive skills such as constructive self-talk, "bossing back" obsessions, distancing and nonattachment (letting obsessive thoughts images and/or impulses come and go) to improve the client's personal efficacy in managing obsessions (supplement with "Thought-Stopping" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |

11. Participate in exposure and ritual prevention therapy for obsessions and compulsions in individual or small group format, with or without family. (19)

12. Participate in imaginal exposure to feared external and/or internal triggers of obsessions without use of compulsive rituals. (20, 21, 22)

13. Participate in live (*in vivo*) exposure to feared external and/or internal triggers of obsessions without use of compulsive rituals. (23, 24, 25)

19. Enroll the client in exposure and (response) ritual prevention therapy for obsessions and compulsions in an intensive (e.g., daily) or non-intensive (e.g., weekly) level of care; individual (preferred) or small (closed enrollment) group; with or without family involvement (e.g., see *Treatment of OCD in Children and Adolescents* by Wagner; *OCD in Children and Adolescents* by March and Mulle; *Cognitive Behavioral Treatment of Childhood OCD: It's Only a False Alarm—Therapist Guide* by Piacentini, Langley, and Roblek; *FOCUS* by Barrett).

20. Assess the nature of any external cues (e.g., persons, objects, situations) and internal cues (thoughts, images, and impulses) that precipitate the client's obsessions and compulsions.

21. Direct and assist the client in construction of a hierarchy of feared internal and external fear cues (or assign "Gradual Exposure to Fear" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

22. Select initial imaginal exposures to the internal and/or external OCD cues that have a high likelihood of being a successful experience for the client; do cognitive restructuring during and after the exposure.

23. Teach the client to use coping strategies (e.g., constructive self-talk, distraction, distancing) to resist engaging in compulsive behaviors invoked to reduce the

obsession-triggered distress; ask the client to record attempts to resist compulsions (or assign *Treating Your OCD with Exposure and Response (Ritual) Prevention: Workbook* by Yadin, Foa, and Lichner; or "Refocus Attention Away From Obsessions and Compulsions" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review during next session, reinforcing success and providing corrective feedback toward improvement.

24. Design a reward system for the parents to reinforce the client for attempts to complete exposures while resisting the urge to engage in compulsive behavior.

25. Assign an exposure homework exercise in which the client gradually reduces time given per day to obsessions and/or compulsions, encouraging him/her to use coping strategies and the parents to use reinforcement of the child's success (or assign "Ritual Exposure and Response Prevention" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

14. Parents participate in therapy to provide appropriate support, facilitate the client's advancement in therapy, and help manage stresses encountered in the process. (26, 27, 28, 29)

26. Include family in sessions to identify specific, positive ways that the parents can help the client manage his/her obsessions or compulsions (see *FOCUS* by Barrett).

27. Teach parents how to remain calm, patient, and supportive when faced with the client's obsessions or compulsions,

discouraging parents from reacting strongly with anger or frustration.

28. Teach family members their appropriate role in helping the client adhere to treatment; assist them in identifying and changing tendencies to reinforce the client's OCD (recommend *Freeing Your Child from Obsessive-Compulsive Disorder: Powerful, Practical Solutions to Overcome Your Child's Fears, Worries, and Phobias* by Chansky; *Helping Your Child with OCD* by Fitzgibbons and Pedrick).

29. Teach family members stress management techniques (e.g., calming, problem-solving, and communication skills) to manage stress and resolve problems encountered through therapy (or assign "Progressive Muscle Relaxation" or "Problem-Solving Exercise" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

15. Implement relapse prevention strategies to help maintain gain achieved through therapy. (30, 31, 32, 33)

30. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of symptoms, fear, or urges to avoid and relapse with the decision to return to fearful and avoidant patterns.

31. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.

32. Instruct the client to routinely use strategies learned in therapy (e.g., continued exposure to

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| | previously feared external or internal cues that arise) to prevent relapse into obsessive-compulsive patterns. EBP |
| | 33. Schedule periodic "maintenance" sessions to help the client maintain therapeutic gains and adjust to life without OCD (see *A Relapse Prevention Program for Treatment of Obsessive Compulsive Disorder* by Hiss, Foa, and Kozak for a description of relapse prevention strategies for OCD). EBP |
| 16. Identify support persons or resources that can help the client manage obsessions/ compulsions. (34, 35) | 34. Encourage and instruct the client to involve support person(s) or a "coach" who can help him/her adhere to therapeutic recommendations in managing OCD. |
| | 35. Refer the client and parents to support group(s) to help maintain and support the gains made in therapy. |
| 17. Participate in an Acceptance and Commitment Therapy for OCD. (36) | 36. Use an acceptance and commitment-based approach (see *Acceptance and Mindfulness Treatments for Children and Adolescents* by Greco and Hayes) to help the client change from experiential avoidance of obsessions and compulsions to a more psychologically flexible approach of acceptance of thoughts, images, and/or impulses and commitment to valued action (recommend *The Mindful Way Through Anxiety: Break Free from Chronic Worry and Reclaim Your Life* by Orsillo and Roemer; or *The Stress Reduction Workbook for Teens: Mindfulness Skills to Help You Deal with Stress* by Biegel). |

18. Verbalize and clarify feelings connected to key life concepts. (37)

19. Participate in an Ericksonian task that involves facing the OCD. (38)

20. Engage in a strategic ordeal to overcome OCD impulses. (39)

21. Participate in family therapy addressing family dynamics that contribute to the emergence, maintenance, or exacerbation of OCD symptoms. (40, 41)

37. Encourage, support, and assist the client in identifying and expressing feelings related to key unresolved life issues (or assign "Surface Behavior/Inner Feelings" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

38. Develop and design an Ericksonian task (e.g., if obsessed with a loss, give the client the task to visit, send a card, or bring flowers to someone who has lost someone) for the client that is centered on facing the obsession or compulsion and process the results with the client (see *Uncommon Therapy: The Psychiatric Techniques of Milton H. Erickson, M.D.* by Haley).

39. Create and promote a strategic ordeal that offers a guaranteed cure to help the client with the obsession or compulsion (e.g., instruct client to perform an aversive chore each time an obsessive thought or compulsive behavior occurs). Note that Haley emphasizes that the "cure" offers an intervention to achieve a goal and is not a promise to cure the client in beginning of therapy (see *Ordeal Therapy* by Haley).

40. Obtain detailed family history of important past and present interpersonal relationships and experiences; identify dynamics that may contribute to the emergence, maintenance, or exacerbation of OCD symptoms.

41. Conduct family therapy sessions to address past and/or present conflicts, as well as the dynamics contributing to the emergence, maintenance, or exacerbation of OCD symptoms.

22. Remove unneeded, hoarded items from area of possessions. (42)

42. Encourage the client to use cognitive and behavioral coping strategies (e.g., calming skills, cognitive restructuring, distraction, ritual prevention, etc.) while reducing hoarded items from possession (or assign "Decreasing What You Save and Collect" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 300.3 | Obsessive-Compulsive Disorder |
| | 300.00 | Anxiety Disorder NOS |
| | 300.02 | Generalized Anxiety Disorder |
| | 296.xx | Major Depressive Disorder |
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| **Axis II:** | V71.09 | No Diagnosis |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
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| 300.3 | F42 | Obsessive-Compulsive Disorder |
| 300.09 | F41.8 | Other Specified Anxiety Disorder |
| 300.00 | F41.9 | Unspecified Anxiety Disorder |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 296.xx | F33.x | Major Depressive Disorder, Recurrent Episode |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

# OPPOSITIONAL DEFIANT DISORDER

## BEHAVIORAL DEFINITIONS

1. Displays a pattern of negativistic, hostile, and defiant behavior toward most adults.
2. Often acts as if parents, teachers, and other authority figures are the "enemy."
3. Erupts in temper tantrums (e.g., screaming, crying, throwing objects, thrashing on ground, refusing to move) in defiance of direction from an adult caregiver.
4. Consistently argues with adults.
5. Often defies or refuses to comply with requests and rules, even when they are reasonable.
6. Deliberately annoys people and is easily annoyed by others.
7. Often blames others for own mistakes or misbehavior.
8. Consistently is angry and resentful.
9. Often is spiteful or vindictive.
10. Has experienced significant impairment in social or academic functioning.

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## LONG-TERM GOALS

1. Display a marked reduction in the intensity and frequency of hostile and defiant behaviors toward adults.

2. Terminate temper tantrums and replace with controlled, respectful compliance with directions from authority figures.
3. Replace hostile, defiant behaviors toward adults with those of respect and cooperation.
4. Resolution of the conflict that underlies the anger, hostility, and defiance.
5. Reach a level of reduced tension, increased satisfaction, and improved communication with family and/or other authority figures.
6. Parents learn and implement good child behavioral management skills.

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## SHORT-TERM OBJECTIVES

1. Parents, client, and others identify situations, thoughts, and feelings that trigger angry feelings, problem behaviors, and the targets of those actions. (1, 2)

## THERAPEUTIC INTERVENTIONS

1. Using relevant process techniques (e.g., questioning, active listening, clarification, reflection, empathy), build rapport toward creating trust and a good working therapeutic alliance with the client.
2. Thoroughly assess the various stimuli (e.g., situations, people, thoughts) that have triggered the client's anger and the thoughts, feelings, and actions that have characterized his/her anger responses; consult others (e.g., family members, teachers) and/or use parent/teacher rating scales (e.g., *Child Behavior Checklist; Eyberg Child Behavior Inventory; Sutter-Eyberg Student Behavior Inventory–Revised*) to supplement assessment as necessary.

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| 2. Parents and client cooperate with psychological assessment to further delineate the nature of the presenting problem. (3) | 3. Administer psychological instruments designed to assess whether a comorbid condition(s) (e.g., bipolar disorder, depression, ADHD) is contributing to disruptive behavior problems and/or objectively assess parent-child relational conflict (e.g., the *Parent-Child Relationship Inventory*); follow up accordingly with client and parents regarding treatment options; readminister as needed to assess treatment outcome. |
| 3. Complete a substance abuse evaluation and comply with the recommendations offered by the evaluation findings.(4) | 4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it. |
| 4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8, 9) | 5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).<br>6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if |

appropriate (e.g., increased suicide risk when comorbid depression is evident).

7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
9. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

5. Cooperate with a physician evaluation for possible treatment with psychotropic medications and take medications consistently, if prescribed. (10, 11)

10. Assess the client for the need for psychotropic medication to assist in anger and behavioral control, referring him/her, if indicated, to a physician for an evaluation for prescription medication.

11. Monitor the client's prescription compliance, effectiveness, and side effects; provide feedback to the prescribing physician.

6. Agree to learn alternative ways to think about and manage anger and oppositional behavior. (12)

12. Assist the client in identifying the positive consequences of managing anger and misbehavior (e.g., respect from others and self, improved relationships, less stress, more freedom); ask the client to agree to learn new ways to conceptualize and manage anger and oppositional behavior.

7. Verbalize alternative ways to think about and manage anger and misbehavior. (13, 14)

13. In individual or group format, use a cognitive-behavioral skill-building approach to treating oppositional behavior beginning with conveying a conceptualization of oppositional behavior involving different components (cognitive, physiological, affective, and behavioral) that go through predictable phases that can be managed (e.g., demanding expectations not being met leading to increased arousal and anger which leads to acting out).

14. Discuss a rationale for treatment explaining how changes in the different factors contributing to oppositional behavior (e.g., cognitive, physiological, affective, and behavioral) can change interactions with others that minimize negative consequences and increase positive ones.

8. Learn and implement calming strategies as part of a new way to manage reactions to frustration. (15)

15. Teach the client calming techniques (e.g., muscle relaxation, paced breathing, calming imagery) as part of a

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| | more comprehensive, tailored skill set for responding appropriately to angry feelings when they occur (supplement with "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 9. Identify, challenge, and replace self-talk that leads to anger and misbehavior with self-talk that facilitates more constructive reactions. (16) | 16. Explore the client's self-talk that mediates his/her angry feelings and actions (e.g., demanding expectations reflected in *should, must, or have to* statements); identify and challenge biases, assisting him/her in generating appraisals and self-talk that corrects for the biases and facilitates a more flexible and temperate response to frustration (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma). |
| 10. Learn and implement thought-stopping to manage intrusive unwanted thoughts that trigger anger and acting out. (17) | 17. Teach the client the thought-stopping technique and assign implementation on a daily basis between sessions; review implementation, reinforcing success and providing corrective feedback toward improvement (or assign "Thought-Stopping" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 11. Verbalize feelings of frustration, disagreement, and anger in a controlled, assertive way. (18) | 18. Use instruction, videotaped or live modeling, and/or role-playing to help develop the client's anger control and assertiveness skills, such as calming, self-statements, assertion skills; if indicated, refer him/her to an anger control or assertiveness group for further |

instruction (see *Anger Control Training for Aggressive Youths* by Lochman et al.).

12. Implement problem-solving and/or conflict resolution skills to manage interpersonal problems constructively. (19)

19. Teach the client conflict resolution skills (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise; problem-solving steps) and recommend the client and parents read *Cool, Calm, and Confident: A Workbook to Help Kids Learn Assertiveness Skills* by Schab; use modeling, role-playing, and behavior rehearsal to work through several current conflicts (or assign "Problem-Solving Exercise" or "Becoming Assertive" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

13. Practice using new calming, communication, conflict resolution, and thinking skills in group or individual therapy. (20, 21)

20. Assist the client in constructing and consolidating a client-tailored strategy for managing anger that combines any of the somatic, cognitive, communication, problem-solving, and/or conflict resolution skills relevant to his/her needs.

21. Use any of several techniques (e.g., relaxation, imagery, behavioral rehearsal, modeling, role-playing, feedback of videotaped practice) in increasingly challenging situations to teach the client to consolidate the use of his/her new anger management skills; encourage the client to practice these skills *in vivo* (see *Problem-Solving Skills Training and*

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| | *Parent Management Training for Conduct Disorder* by Kazdin). |
| 14. Identify social supports that will help facilitate the implementation of new skills. (22) | 22. Encourage the client to discuss and/or use his/her new anger and conduct management skills with trusted peers, family, or otherwise significant others who are likely to support his/her change. |
| 15. Decrease the number, intensity, and duration of angry outbursts, while increasing the use of new skills for managing anger. (23) | 23. Monitor the client's reports of angry outbursts toward the goal of decreasing their frequency, intensity, and duration through the client's use of new anger management skills (or assign "Anger Control" or "Child Anger Checklist" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review progress, reinforcing success and providing corrective feedback toward improvement. |
| 16. Increase the frequency of civil, respectful interactions with parents/adults using new calming, communication, and conflict resolution skills. (24) | 24. Ask the client to try to increase respectful interactions using his/her new personal and interpersonal skills; monitor interactions, reinforce success, and problem-solve obstacles toward increasing respectful interactions. |
| 17. Parents learn and implement Parent Management Training skills to recognize and manage problem behavior of the client. (25, 26, 27, 28, 29) | 25. Use an age-appropriate Parent Management Training approach beginning with teaching the parents how parent and teen behavioral interactions can encourage or discourage positive or negative behavior and that changing key elements of those interactions (e.g., prompting and reinforcing positive behaviors) can be used to promote positive change (e.g., *Parents and* |

*Adolescents Living Together* by Patterson and Forgatch).

26. Ask the parents to read material consistent with a parent training approach to managing disruptive behavior (e.g., *The Kazdin Method for Parenting the Defiant Child* by Kazdin; *Parents and Adolescents Living Together* by Patterson and Forgatch).
27. Teach the parents how to specifically define and identify problem behaviors, identify their reactions to the behavior, determine whether the reaction encourages or discourages the behavior, and generate alternatives to the problem behavior.
28. Teach parents how to implement key parenting practices consistently, including establishing realistic age-appropriate rules for acceptable and unacceptable behavior, prompting of positive behavior in the environment, use of positive reinforcement to encourage behavior (e.g., praise), use of clear direct instruction, time-out, and other loss-of-privilege practices for problem behavior (supplement with "Switching from Defense to Offense" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
29. Assign the parents home exercises in which they implement and record results of behavior reinforcement (or assign "Clear Rules, Positive Reinforcement, Appropriate

Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review in session, providing corrective feedback toward improved, appropriate, and consistent use of skills.

18. Increase compliance with rules at home and school. (30)

30. Design a reward system and/or contingency contract for the client and meet with school officials to reinforce identified positive behaviors at home and school and deter impulsive or rebellious behaviors (or assign "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

19. Parents and child identify and work toward preferred relational patterns between family members. (31, 32, 33, 34)

31. Use a family-system approach in individual sessions to assist the client in seeing the family from a different perspective and in moving toward disengaging from dysfunction.

32. Conduct family sessions during which the family system and its interactions are analyzed; develop and implement a strategic/structural/experiential intervention.

33. Facilitate a family session in which the family is sculpted (see *Peoplemaking* by Satir); process the experience with the family; then sculpt them as they would like to be.

34. Conduct family sessions in which all members express their thoughts and feelings respectfully and openly followed by offering suggestions for

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| | reasonable resolution of the complaints (or assign "Filing a Complaint" or "If I Could Run My Family" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); monitor progress, giving feedback, support, and praise as appropriate. |
| 20. Increase the frequency of responsible and positive social behaviors. (35, 36) | 35. Direct the client to engage in three altruistic or benevolent acts (e.g., read to a developmentally disabled student, mow grandmother's lawn) before the next session to increase his/her empathy and sensitivity to the needs of others (or assign "Cooperative Activity" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 36. Place the client in charge of tasks at home (e.g., preparing and cooking a special dish for a family get-together, building shelves in the garage, changing oil in the car) to demonstrate confidence in his/her ability to act responsibly. |
| 21. Identify and verbally express feelings associated with past neglect, abuse, separation, or abandonment. (37) | 37. Encourage and support the client in expressing feelings associated with neglect, abuse, separation, or abandonment and help process (e.g., assign the task of writing a letter to an absent parent, use the empty-chair technique). |
| 22. Parents verbalize appropriate boundaries for discipline to prevent further occurrences of abuse and to ensure the safety of the client and his/her siblings. (38, 39) | 38. Explore the client's family background for a history of neglect and physical or sexual abuse that may contribute to his/her behavioral problems; confront the client's parents to cease physically abusive or |

overly punitive methods of discipline.

39. Implement the steps necessary to protect the client and siblings from further abuse (e.g., report abuse to the appropriate agencies; remove the client or perpetrator from the home).

23. Parents participate in marital therapy. (40)

40. Assess the marital dyad for possible substance abuse, conflict, or triangulation that shifts the focus from marriage issues to the client's acting out behaviors; refer for appropriate treatment, if needed.

24. Verbalize an understanding of the difference between a lapse and relapse. (41, 42)

41. Provide a rationale for relapse prevention that discusses the risk and introduces strategies for preventing it.

42. Discuss with the parent/client the distinction between a lapse and relapse, associating a lapse with a temporary setback and relapse with a return to a sustained pattern of thinking, feeling, and behaving that is characteristic of ODD.

25. Implement strategies learned in therapy to counter lapses and prevent relapse. (43, 44, 45, 46)

43. Identify and rehearse with the parent/client the management of future situations or circumstances in which lapses could occur.

44. Instruct the parent/client to routinely use strategies learned in therapy (e.g., parent training techniques, problem-solving, anger management), building them into his/her life as much as possible.

45. Develop a "coping card" on which coping strategies and other important information can

be kept (e.g., steps in problem-solving, positive coping statements, reminders that were helpful to the client during therapy).

46. Schedule periodic maintenance or "booster" sessions to help the parent/client maintain therapeutic gains and problem-solve challenges.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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|---|---|---|
| **Axis I:** | 312.81 | Conduct Disorder, Childhood-Onset Type |
| | 312.82 | Conduct Disorder, Adolescent-Onset Type |
| | 313.81 | Oppositional Defiant Disorder |
| | 312.9 | Disruptive Behavior Disorder NOS |
| | 314.01 | Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type |
| | 314.9 | Attention-Deficit/Hyperactivity Disorder NOS |
| | 312.34 | Intermittent Explosive Disorder |
| | V71.02 | Child Antisocial Behavior |
| | V61.20 | Parent-Child Relational Problem |
| | _____ | _____ |
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| **Axis II:** | V71.09 | No Diagnosis |
| | _____ | _____ |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
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| 312.81 | F91.1 | Conduct Disorder, Childhood-Onset Type |
| 312.82 | F91.2 | Conduct Disorder, Adolescent-Onset Type |
| 313.81 | F91.3 | Oppositional Defiant Disorder |
| 312.9 | F91.9 | Unspecified Disruptive, Impulse Control, and Conduct Disorder |
| 312.89 | F91.8 | Other Specified Disruptive, Impulse Control, and Conduct Disorder |
| 314.01 | F90.1 | Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive/Impulsive Presentation |
| 314.01 | F90.9 | Unspecified Attention-Deficit/Hyperactivity Disorder |
| 314.01 | F90.8 | Other Specified Attention-Deficit/Hyperactivity Disorder |
| 312.34 | F63.81 | Intermittent Explosive Disorder |
| V71.02 | Z72.810 | Child or Adolescent Antisocial Behavior |
| V61.20 | Z62.820 | Parent-Child Relational Problem |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

# OVERWEIGHT/OBESITY

## BEHAVIORAL DEFINITIONS

1. An excess of body weight, relative to height, that is attributed to an abnormally high proportion of body fat (Body Mass Index of 30 or more).
2. Episodes of binge eating (a large amount of food is consumed in a relatively short period of time and there is a sense of lack of control over the eating behavior).
3. Eating to manage troubling emotions.
4. Eating much more rapidly than normal.
5. Eating until feeling uncomfortably full.
6. Eating large amounts of food when not feeling physically hungry.
7. Eating alone because of feeling embarrassed by how much one is eating.
8. Feeling disgusted with oneself, depressed, or very guilty after eating too much.

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## LONG-TERM GOALS

1. Terminate overeating and implement lifestyle changes (e.g., more exercise, eat more vegetables and fruits, eat healthy snacks) that lead to weight loss and improved health.

2. Develop healthy cognitive patterns and beliefs about self that lead to positive identity and prevent a relapse into unhealthy eating patterns.
3. Develop effective skills for managing personal and interpersonal stresses without resorting to overeating or emotional eating.
4. Gain insight into past painful emotional experiences contributing to present overeating.

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## SHORT-TERM OBJECTIVES

1. Honestly describe the pattern of eating including types, amounts, frequency of food restricted and consumed; thoughts and feeling associated with food, lifestyle, as well as family and peer relationships. (1, 2)

2. Client and parents discuss any other personal, marital, or family problems. (3)

## THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client and parents toward building a therapeutic alliance.

2. Conduct a comprehensive assessment of factors potentially influencing obesity toward identifying targets for change including: personal and family eating habits and patterns; thoughts, attitudes, and beliefs about food and diet; emotional status; lifestyle; exercise; and relationships.

3. Assess for the presence of problems/psychopathology in the parents, child, or both that may be contributing to over-eating (e.g., child's depression, anxiety disorder, parent's marital conflict) or otherwise warrant treatment attention; treat accordingly if evident (see relevant chapters in this *Planner*).

3. Disclose any history of substance use that may contribute to and complicate the treatment of the eating disorder. (4)
4. Complete psychological testing or objective questionnaires. (5)
5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9, 10)

4. Arrange for a substance abuse evaluation and refer the client for treatment for if the evaluation recommends it.
5. Refer or conduct psychological testing to inform the overall assessment (e.g., confirm or rule out psychopathology); give the client feedback regarding the results of the assessment; readminister as needed to assess treatment outcome.
6. Assess the client's level of insight (syntonic vs. dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and

factors that could offer a better understanding of the client's behavior.

9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
10. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

6. Cooperate with a complete medical evaluation. (11)

11. Refer the client to a physician for a medical evaluation to assess possible negative consequences of obesity that may influence treatment planning (e.g., medical conditions secondary to obesity, approved types and amount of exercise, foods to avoid for health purposes) and to assess cholesterol level and blood sugar or hormone imbalances that could be contributing to weight problem.

7. Cooperate with an evaluation by a physician for psychotropic medication and, if indicated, take medications as prescribed. (12, 13)

8. Verbalize an understanding of the relative risks and benefits of obesity. (14)

9. Client and parents discuss motivation to participate in weight management treatment. (15)

10. Keep a journal documenting food consumption and related factors. (16)

12. Refer the client for a medication evaluation if warranted (e.g., presence of depression, anxiety).

13. Monitor the client's psychotropic medication prescription compliance, effectiveness, and side effects; stay in contact with prescriber as needed.

14. Discuss with the client and parents how the seeming (short-term) rewards of overeating increase the risk for more serious medical consequences (e.g., hypertension, heart disease, and the like); discuss the health benefits of good weight management practices.

15. Assess the client's and parents' motivation and readiness for change and intervene accordingly (e.g., defer treatment or conduct motivational interventions with the unmotivated, obtain consent for treatment with the motivated).

16. Ask the client and/or parents to monitor and record the child's exercise activity and food consumption including types, amounts, time of day, setting, and any other relevant factors such as associated emotions, and thoughts (or assign "My Eating and Exercise Journal" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review using data to reinforce psychoeducational objectives as needed (e.g., increased exercise, portion sizes, high and low calorie food, nutrition, food as stress management).

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| 11. Verbalize an accurate understanding of factors influencing eating, health, overweight, and obesity. (17) | 17. Conduct a Behavioral Weight Management approach to treatment beginning with discussion of obesity, factors influencing it; attend to the roles of lifestyle, exercise, attitudes or cognition/beliefs, relationships, and nutrition (see *The LEARN Program for Weight Management* by Brownell). |
| 12. Read recommended material to supplement information learned in therapy. (18) | 18. Assign the client and parents to read psychoeducational material about obesity, factors influencing it, and the rationale and various emphases in treatment as they are introduced throughout therapy (e.g., *The LEARN Program for Weight Management* by Brownell). |
| 13. Verbalize an understanding of the rationale of treatment. (19) | 19. Review the primary emphases of the treatment program, confirming that the client understands and agrees with the rationale and approach. |
| 14. Agree to reasonable weight goals and realistic expectations about how they can be achieved through the therapy. (20, 21, 22) | 20. Discuss with the client and parents realistic expectations for what the therapy will entail, the challenges and benefits; emphasize the importance of adherence; instill hope for success and realistic expectations for the challenges. |
| | 21. Establish short-term (weekly), medium-term (monthly), and long-term (6 months to a year) goals; evaluate and update on a regular basis. |
| | 22. Discuss a flexible goal-setting strategy recognizing that lapses occur in behavior change and that a problem-solving approach is taken should a lapse occur (e.g., forgive self, identify triggers, |

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| | generate and evaluate options for addressing risks, implement plan, get back on track with the established goals). EBP |
| EBP 15. Track and chart weight on a routine interval throughout therapy. (23) | 23. Routinely measure the client's weight and chart/graph to assess changes during treatment (e.g., weekly). EBP |
| EBP 16. Learn and implement healthy nutritional practices. (24, 25) | 24. Teach healthy nutritional practices involving concepts of balance and variety in obtaining necessary nutrients (recommend *Good Enough to Eat: A Kid's Guide to Food and Nutrition* by Rockwell); outline a healthy food diet consistent with good nutritional practices and aimed at attaining the client's weight goals (or assign "Developing and Implementing a Healthier Diet" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). EBP |
| | 25. Refer the client to a nutritionist to develop an appropriate diet aimed at attaining the client's weight goals. EBP |
| EBP 17. Learn and implement the principles of moderation and variety in food choices and diet. (26) | 26. Work with client and parents to develop an individualized diet that includes the child's preferred food choices while encouraging variety and allowing choice; teach the client and/or parents the principle of portion control for managing total caloric intake; emphasize that a family approach to healthy eating is most beneficial, that no food is prohibited, and that moderation of intake is a key to maintaining a healthy weight (or assign "Developing and Implementing a Healthier Diet" in the *Adolescent Psychotherapy* |

*Homework Planner* by Jongsma, Peterson, and McInnis).

18. As a lifestyle change take steps to avoid and/or manage triggers of spontaneous food buying or eating. (27)

19. Make changes in the environment and in one's approach to eating that facilitate adherence to moderation and portion size goals. (28)

20. Identify changes in daily lifestyle activity conducive to improved health and good weight management. (29, 30, 31)

27. Use stimulus control techniques that reduce exposure to triggers of spontaneous food buying/selection/eating and other poor eating practices (e.g., avoiding buying and eating high calorie snacks after school; eat before shopping for food or going to a place where unhealthy food is readily available; shop for food from a list; no non-nutritional snack foods openly available in the home; prepare foods from a preplanned menu).

28. Use stimulus control techniques such as serving on smaller plates, eating slowly, and creating a pleasant mealtime ambience to create an eating routine conducive to pleasurable, moderated eating.

29. Work with the parents and client to identify small, doable changes in activities consistent with therapeutic exercise goals such as parking further away to promote walking, taking stairs, walking to school, staying active during recess, and avoiding electronic games that are sedentary (or assign "Increasing My Physical Activity" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); monitor and record physical activity.

30. Encourage parents and child to play games that require physical movement (e.g., running/throwing games, interactive computer games).

31. Encourage participation in organized physical activities (e.g., physical education/gym at school, swimming, youth club sports).

21. Identify, challenge, and replace negative self-talk with positive, realistic, and empowering self-talk. (32, 33, 34)

32. Explore the client's self-talk and beliefs that mediate his/her nontherapeutic eating habits (e.g., overeating, eating to manage emotions, poor self-concept); teach him/her how to challenge the biases; assist him/her in replacing the biased messages with reality-based, positive alternatives (e.g., eating for health, using character/values rather than weight in defining self).

33. Assign the client a homework exercise in which he/she identifies self-talk and creates reality-based alternatives (consider assigning "Bad Thoughts Lead to Depressed Feelings" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review and reinforce success, providing corrective feedback for failure.

34. Use behavioral techniques (e.g., modeling, corrective feedback, imaginal rehearsal, social reinforcement) to teach the client positive self-talk and self-reward to facilitate the child's new behavior change efforts (or assign "Positive Self-Talk" from the *Adult Psychotherapy Homework Planner* by Jongsma).

22. Learn and implement skills for managing stress and effectively solving daily relationship problems previously managed through eating. (35, 36, 37, 38, 39)

35. Use behavioral skill-building techniques (e.g., modeling, role-playing, and behavior rehearsal, corrective feedback) to teach the client tailored, age-appropriate cognitive and somatic calming

skills (recommend *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay; or assign "Progressive Muscle Relaxation" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

36. Use behavioral skill-building techniques (e.g., modeling, role-playing, behavior rehearsal, and corrective feedback) to teach the client tailored, age-appropriate problem-solving skills (e.g., pinpointing the problem, generating options, listing pros and cons of each option, selecting an option, implementing an option, and refining); assign homework to practice these skills (consider assigning "Problem-Solving Exercise" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

37. Use behavioral skill-building techniques (e.g., modeling, role-playing, and behavior rehearsal, corrective feedback) to teach the client tailored, age-appropriate conflict resolution skills such as empathy, active listening, and "I messages" (or assign "Negotiating a Peace Treaty" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

38. Use behavioral skill-building techniques (e.g., modeling, role-playing, and behavior rehearsal, corrective feedback) to

teach the client tailored, age-appropriate respectful communication; assertiveness without aggression, compromise; and to develop skills and work through several current conflicts (or assign "Becoming Assertive" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

39. Teach all family members stress management skills (e.g., calming, problem-solving, communication, conflict resolution) to manage stress and facilitate the client's progress in treatment.

23. Family members demonstrate support for the client as he/she participates in treatment. (40, 41, 42)

40. Teach parents how to prompt and reward treatment-consistent behavior, empathetically ignore excessive complaining, and model the behavior being prescribed to the child.

41. Assist the family in overcoming the tendency to reinforce the client's poor eating habits and/or misplaced motivations (e.g., eating to manage emotions); teach them constructive ways to reward the client's progress.

42. Encourage and assist the parents in arranging ongoing support for weight management effort of the child (e.g., email messages, phone calls, website communication, and postal mail notes from significant others) that provide maintenance support and encouragement.

24. Implement strategies for preventing relapse. (43, 44, 45, 46)

43. Discuss with the client the distinction between a lapse and relapse, associating a lapse with

a temporary and reversible return to prior habits and relapse with the decision to repeatedly return to the pattern of behavior associated with overweight or obesity.

44. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.

45. Instruct the client to routinely use strategies learned in therapy (e.g., calming, cognitive restructuring, stimulus control), building them into his/her life as much as possible.

46. Develop a "coping card" on which coping strategies and other important information (e.g., "One step at a time," "Eat healthy," "Distract yourself from urges," "Keep portions small," "You can manage it") are written for the client's later use.

25. Attend a group behavioral weight-loss program. (47)

47. Refer the client and parents to a group behavioral weight-loss program (e.g., programs that emphasize changes in lifestyle, exercise, attitudes, relationships, and nutrition).

26. Verbalize the feelings associated with a past emotionally painful situation connected with eating or food deprivation. (48, 49)

48. Using sensitive questioning, active listening and unconditional regard, probe, discuss, and interpret the possible emotional neglect, abuse, and/or unmet emotional needs being met through eating.

49. Reinforce the client's insight into the past emotional pain and its connection to present overeating.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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|---|---|---|
| **Axis I:** | 307.50 | Eating Disorder NOS |
| | 316 | Personality Traits or Coping Style Affecting Obesity |
| | V61.20 | Parent-Child Relational Problem |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | V71.09 | No Diagnosis |
| | _____ | _____ |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 278.00 | E66.9 | Overweight or Obesity |
| 309.0 | F43.21 | Adjustment Disorder, With Depressed Mood |
| 307.59 | F50.8 | Other Specified Feeding or Eating Disorder |
| 316 | F54 | Psychological Factors Affecting Other Medical Conditions, Obesity |
| V61.20 | Z62.820 | Parent-Child Relational Problem |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# PANIC/AGORAPHOBIA

## BEHAVIORAL DEFINITIONS

1. Complains of unexpected, sudden, debilitating panic symptoms (e.g., shallow breathing, sweating, heart racing or pounding, dizziness, depersonalization or derealization, trembling, chest tightness, fear of dying or losing control, nausea) that have occurred repeatedly, resulting in persisting concern about having additional attacks.
2. Demonstrates marked avoidance of activities or environments due to fear of triggering intense panic symptoms, resulting in interference with normal routine.
3. Acknowledges a persistence of fear in spite of the recognition that the fear is unreasonable.
4. Increasingly isolates self due to fear of traveling or leaving a "safe environment" such as home.
5. Avoids public places or environments with large groups of people such as malls or big stores.

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## LONG-TERM GOALS

1. Reduce the frequency, intensity, and duration of panic attacks.
2. Reduce the fear that panic symptoms will recur without the ability to manage them.

3. Reduce the fear of triggering panic and eliminate avoidance of activities and environments thought to trigger panic.
4. Increase comfort in freely leaving home and being in a public environment.
5. Learn to accept occasional panic symptoms and fearful thoughts without their affecting actions.

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## SHORT-TERM OBJECTIVES

1. Describe the history and nature of the panic symptoms and any avoidant behaviors. (1, 2, 3)

2. Disclose any history of substance use that may contribute to and complicate the treatment of the panic disorder. (4)

## THERAPEUTIC INTERVENTIONS

1. Establish rapport and a working alliance with the client and parents using appropriate process skills (e.g., active listening, reflective empathy, support, and instillation of hope).
2. Assess the client's frequency, intensity, duration, and history of panic symptoms, fear, and avoidance (e.g., *Anxiety Disorders Interview Schedule for Children—Parent Version or Child Version*; "Panic Survey" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
3. Assess the nature of any stimulus, thoughts, or situations that precipitate the client's panic and avoidance.
4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it.

3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8, 9)

5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder), including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.

8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess

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| | this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment). |
| | 9. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting). |
| 4. Complete psychological tests designed to supplement the clinical interview. (10) | 10. Administer psychological testing or objective measures to further assess features of panic disorder (e.g., the *Anxiety Sensitivity Index*), agoraphobia (e.g., *The Mobility Inventory for Agoraphobia*), or other psychopathology (e.g., *Minnesota Multiphasic Personality Inventory* or *Millon Adolescent Clinical Inventory*); repeat as needed to assess response to treatment. |
| 5. Cooperate with an evaluation by a physician for psychotropic medication. (11, 12) | 11. Arrange for an evaluation for a prescription of psychotropic medications to alleviate the client's symptoms. |
| | 12. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with the prescribing physician at regular intervals. |
| 6. Verbalize an accurate understanding of panic attacks and agoraphobia. (13, 14) | 13. Use a cognitive-behavioral approach based on Panic Control Therapy beginning with a discussion of how panic attacks |

represent "false alarms" of danger, are not medically dangerous, are not a sign of weakness or craziness, and are common, but often lead to unnecessary avoidance (see *Mastery of Anxiety and Panic for Adolescents* by Pincus, Ehrenreich, and Mattis; *Phobic and Anxiety Disorders in Children and Adolescents* by Grills-Taquechel and Ollendick).

14. Assign the client to read psychoeducational chapters of workbooks on panic disorders and agoraphobia (see *Riding the Wave Workbook* by Pincus, Ehrenreich, and Spiegel).

7. Verbalize an understanding of the rationale for treatment of panic. (15, 16)

15. Discuss how exposure serves as an arena to desensitize learned fear, build confidence, and feel safer by building a new history of success experiences.

16. Assign the client to read about exposure-based therapy in chapters of workbooks or treatment manuals on panic disorder and agoraphobia (e.g., *Riding the Wave Workbook* by Pincus, Ehrenreich, and Spiegel).

8. Learn and implement calming and coping strategies to reduce overall anxiety and to manage panic symptoms. (17, 18, 19)

17. Teach the client progressive muscle relaxation as a daily exercise for general relaxation and train him/her in the use of coping strategies (e.g., staying focused on behavioral goals, muscular relaxation, evenly paced diaphragmatic breathing, positive self-talk) to manage symptom attacks (or assign "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

18. Teach the client to keep focus on external stimuli and behavioral responsibilities during panic rather than being preoccupied with internal focus on physiological changes. EB

19. Assign the client to read about progressive muscle relaxation and paced diaphragmatic breathing in books or treatment manuals on panic disorder and agoraphobia (e.g., *The Relaxation and Stress Reduction Workbook for Kids* by Shapiro and Sprague; *10 Simple Solutions to Panic* by Antony and McCabe; *The Anxiety and Phobia Workbook* by Bourne; *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay). EB

EB 9. Identify, challenge, and replace fearful self-talk and beliefs with reality-based, positive self-talk and beliefs. (20, 21, 22, 23)

20. Explore the client's schema and self-talk that mediate his/her fear response; challenge the biases; assist him/her in replacing the distorted messages with self-talk that neither overestimates the likelihood of catastrophic outcomes nor underestimates the ability to cope with panic symptoms. EB

21. Use modeling and behavioral rehearsal to train the client in positive self-talk that reassures him/her of the ability to endure anxiety symptoms without serious consequences (or assign "Panic Attack Rating Form" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). EB

22. Assign the client to read about cognitive restructuring in books or treatment manuals on panic disorder and agoraphobia

(e.g., *Riding the Wave Workbook* by Pincus, Ehrenreich, and Spiegel; *The Cognitive Behavioral Workbook for Anxiety: A Step-by-Step Program* by Knaus; or *Mastery of Your Anxiety and Panic: Workbook* by Barlow and Craske).

23. Assign the client a behavioral experiment homework exercise in which he/she identifies fearful self-talk, creates reality-based alternatives, and tests the validity of each through selected exercises; review; reinforce success, problem-solve obstacles toward mastery (see *Mastery of Anxiety and Panic for Adolescents* by Pincus, Ehrenreich, and Mattis; *Phobic and Anxiety Disorders in Children and Adolescents* by Grills-Taquechel and Ollendick; supplement with "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma).

10. Participate in gradual repeated exposure to feared physical sensations until they are no longer frightening to experience. (24, 25, 26)

24. Teach the client a sensation exposure technique in which he/she generates feared physical sensations through exercise (e.g., breathes rapidly until slightly lightheaded, spins in chair briefly until slightly dizzy), then uses coping strategies (e.g., staying focused on behavioral goals, muscular relaxation, evenly paced diaphragmatic breathing, positive self-talk) to calm himself/herself down; repeat exercise until anxiety wanes (see *Mastery of Anxiety and Panic for Adolescents* by Pincus, Ehrenreich, and Mattis).

25. Assign the client to read about overcoming fears or sensations associated with panic in workbooks or treatment manuals on panic disorder and agoraphobia (e.g., *Riding the Wave Workbook* by Pincus, Ehrenreich, and Spiegel).

26. Assign the client a homework exercise in which he/she does sensation exposures and records the experience; review, reinforcing success and problem-solving obstacles toward mastery.

11. Participate in gradual repeated exposure to feared or avoided situations in which a symptom attack and its negative consequences are feared. (27, 28, 29, 30)

27. Direct and assist the client in construction of a hierarchy of anxiety-producing activities associated with the agoraphobic response.

28. Select initial exposures that have a high likelihood of being a successful experience for the client; develop a plan for managing the symptoms, and rehearse the plan in imagination.

29. Assign the client to read about situational (exteroceptive) exposure in workbooks or treatment manuals on panic disorder and agoraphobia (e.g., *Riding the Wave Workbook* by Pincus, Ehrenreich, and Spiegel).

30. Assign the client a homework exercise in which he/she does situational exposures and records responses (e.g., "Gradually Facing a Phobic Fear" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson,

and McInnis); review, reinforcing success and problem-solving obstacles toward mastery.

12. Learn and implement relapse prevention strategies for managing possible future anxiety symptoms. (31, 32, 33, 34)

31. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of symptoms, fear, or urges to avoid and relapse with the decision to return to fearful and avoidant patterns.

32. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.

33. Instruct the client to routinely use strategies learned in therapy (e.g., cognitive restructuring, exposure), building them into his/her life as much as possible.

34. Develop a "coping card" on which coping strategies and other important information (e.g., "Pace your breathing," "Focus on the task at hand," "You can manage it," "It will go away") are written for the client's later use.

13. Learn to accept limitations in life and commit to tolerating, rather than avoiding, unpleasant emotions while accomplishing meaningful goals. (35)

35. Use an Acceptance and Commitment Therapy approach to help client accept uncomfortable realities such as lack of complete control, imperfections, and uncertainty and tolerate unpleasant emotions and thoughts while accomplishing value-consistent goals.

14. Discuss the emotional significance of panic symptoms toward gaining insight into their role in current relationships. (36, 37, 38, 39)

36. Use a panic-focused psychodynamic approach focusing on transference as the therapeutic agent promoting change.

37. Encourage the client to confront the emotional significance of his/her panic symptoms.

38. Make the connection between panic symptoms and current personal and/or interpersonal conflicts with the aim of promoting greater autonomy, symptom relief, and improved functioning.

39. Support the client's efforts to resolve or accept personal and/or interpersonal issues arising from the therapeutic discussion.

15. Verbalize the costs and benefits of remaining fearful and avoidant. (40)

40. Probe for the presence of secondary gain that reinforces the client's panic symptoms through escape or avoidance mechanisms; challenge the client to remain in feared situations and to use coping skills to endure.

16. Verbalize the separate realities of the irrationally feared object or situation and the emotionally painful experience from the past that has been evoked by the phobic stimulus. (41, 42)

41. Clarify and differentiate between the client's current irrational fear and past emotional pain.

42. Encourage the client's sharing of feelings associated with past traumas through active listening, positive regard, and questioning.

17. Return for a follow-up session. (43)

43. Schedule a "maintenance session" for the client for one to three months after therapy ends to track progress, reinforce gains, and problem-solve barriers.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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|---|---|---|
| **Axis I:** | 300.01 | Panic Disorder Without Agoraphobia |
| | 300.21 | Panic Disorder With Agoraphobia |
| | 300.22 | Agoraphobia Without History of Panic Disorder |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
| | _____ | _____ |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 300.01 | F41.0 | Panic Disorder |
| 300.22 | F40.00 | Agoraphobia |
| 300.02 | F41.1 | Generalized Anxiety Disorder |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

# PARENTING

## BEHAVIORAL DEFINITIONS

1. Expresses feelings of inadequacy in setting effective limits with his/her adolescent child.
2. Reports difficulty in managing the challenging problem behavior of an adolescent child.
3. Frequently struggles to control his/her emotional reactions to an adolescent child's misbehavior.
4. Exhibits increasing conflict between spouses over how to parent/discipline their adolescent child.
5. Displays deficits in parenting knowledge and skills.
6. Displays inconsistent parenting styles.
7. Demonstrates a pattern of lax supervision and inadequate limit-setting.
8. Regularly overindulges the adolescent child's wishes and demands.
9. Displays a pattern of harsh, rigid, and demeaning behavior toward the adolescent child.
10. Shows a pattern of physically and emotionally abusive parenting.
11. Lacks knowledge regarding reasonable expectations for an adolescent child's behavior at a given developmental level.
12. Has exhausted his/her ideas and resources in attempting to deal with the adolescent child's behavior.

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## LONG-TERM GOALS

1. Achieve a level of competent, effective parenting.
2. Effectively manage challenging problem behavior of the adolescent child.
3. Reach a realistic view and approach to parenting, given the adolescent child's developmental level.
4. Terminate ineffective and/or abusive parenting and implement positive, effective techniques.
5. Strengthen the parental team by resolving marital conflicts.
6. Achieve a greater level of family connectedness.

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## SHORT-TERM OBJECTIVES

1. Identify major concerns regarding the adolescent child's misbehavior and the associated parenting approaches that have been tried. (1)

2. Describe any conflicts that result from the different approaches to parenting that each partner has. (2)

3. Parents and client cooperate with psychological testing designed to enhance understanding of the family. (3, 4)

## THERAPEUTIC INTERVENTIONS

1. Using empathy and normalization of the parents' struggles, conduct a clinical interview focused on pinpointing the nature and severity of the child's misbehavior; assess parenting styles used to respond to the child's misbehavior, and what triggers and reinforcements may be contributing to the behavior.

2. Assess the parents' consistency in their approach to the child and whether they have experienced conflicts between them over how to react to the child.

3. Administer psychological instruments designed to objectively assess parent-child relational conflict (e.g., the *Parenting Stress Index*,

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| | *Parent-Child Relationship Inventory*), or traits of oppositional defiance or conduct disorder (e.g., *Adolescent Psychopathology Scale–Short Form* or the *Millon Adolescent Clinical Inventory*); discuss results with clients toward increasing understanding of the problems and engage in treatment; readminister as indicated to assess treatment progress. |
| | 4. Conduct or arrange for psychological testing to help in assessing for comorbid conditions (e.g., depression, ADHD) contributing to disruptive behavior problems; follow up accordingly with the client and his/her parents regarding treatment options; readminister as indicated to assess treatment progress. |
| 4. Disclose any history of substance use that may contribute to and complicate the treatment of the panic disorder. (5) | 5. Arrange for a substance abuse evaluation and refer the client for treatment focused on this issue if the evaluation results recommend it. |
| 5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9, 10) | 6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem |

described," is not concerned, and has no motivation to change).

7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder), including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
10. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable

attachments, persistent harsh punishment, or other grossly inept parenting).

6. Accept feedback and referral for individual treatment, if warranted. (11)

11. Analyze the testing and interview data received from the parents about their mental status, relationship, and parenting; establish or rule out the presence of superseding marital conflicts or serious individual mental health issues; provide feedback.

7. Identify specific marital conflicts and work toward their resolution. (12)

12. Conduct or refer the parents to marital/relationship therapy to resolve the conflicts that are preventing them from being effective parents).

8. Cooperate with an evaluation for possible treatment with psychotropic medications to assist in anger and behavioral control and take medications consistently, if prescribed. (13)

13. Assess the client for the need for psychotropic medication to assist in control of anger and other misbehaviors; refer him/her to a physician for an evaluation for prescription medication; monitor prescription compliance, effectiveness, and side effects; provide feedback to the prescribing physician.

9. Freely express feelings of frustration, helplessness, and inadequacy that each experiences in the parenting role. (14, 15, 16)

14. Create a compassionate, empathetic environment where the parents become comfortable enough to let their guard down and express the frustrations of parenting.

15. Educate the parents on the full scope of parenting an adolescent; use humor and normalization as needed.

16. Help the parents reduce their unrealistic expectations of their parenting performance, identify parental strengths, and begin to build the confidence and effectiveness level of the parental team.

10. Verbalize a commitment to learning and using alternative ways to think about and manage anger. (17, 18)

11. Verbalize an understanding of the numerous key differences between boys and girls at different levels of development and adjust expectations and parenting practices accordingly. (19)

12. Verbalize an increased awareness and understanding of the unique issues and trials of parenting adolescents. (20, 21, 22)

17. Assist the parent in reconceptualizing anger as involving different components (cognitive, physiological, affective, and behavioral) that go through predictable phases (e.g., demanding expectations not being met, leading to increased arousal and anger, leading to acting out) that can be managed.

18. Assist the parent in identifying the positive consequences of managing anger and misbehavior (e.g., respect from others and self, cooperation from others, improved physical health, etc.); ask the client to agree to learn new ways to conceptualize and manage anger and misbehavior (recommend *Everything You Need to Know About Anger* by Licata; *The Anger Control Workbook* by McKay and Rogers).

19. Educate the parents on key developmental differences between adolescent boys and girls, such as rate of development, perspectives, impulse control, temperament, and how these influence the parenting process.

20. Educate the parents about the various biopsychosocial influences on adolescent behavior, including biological changes, peer influences, self-concept, identity, and parenting styles (or supplement with "Transitioning from Parenting a Child to Parenting a Teen" in the *Adolescent Psychotherapy Homework Planner* by

Jongsma, Peterson, and McInnis).

21. Teach the parents the concept that adolescence is a time in which the parents need to "ride the adolescent rapids" until both survive (see *Positive Discipline for Teenagers: Empowering Your Teens and Yourself Through Kind and Firm Parenting* by Nelsen and Lott; *Parenting Teens with Love and Logic* by Cline and Fay; *Surviving Your Adolescents* by Phelan; *How to Talk So Kids Will Listen and Listen So Kids Will Talk* by Faber and Mazlish).

22. Assist the parents in coping with the issues and reducing their fears regarding negative peer groups, negative peer influences, and losing their influence to these groups.

13. Verbalize an understanding of the impact of their reaction on their child's behavior. (23, 24)

23. Use a Parent Management Training approach beginning with teaching the parents how parent and child behavioral interactions can encourage or discourage positive or negative behavior and that changing key elements of those interactions (e.g., prompting and reinforcing positive behaviors) can be used to promote positive change (e.g., *Parents and Adolescents Living Together* by Patterson and Forgatch).

24. Assign the parents to implement key parenting practices consistently, including establishing realistic age-appropriate rules for acceptable and unacceptable behavior, prompting of positive behavior

in the environment, use of positive reinforcement to encourage behavior (e.g., praise and clearly established rewards), use of calm, clear, direct instruction, time-out and other loss-of-privilege practices for problem behavior.

14. Learn and implement parenting practices that have demonstrated effectiveness. (25, 26, 27)

25. Teach the parents how to implement key parenting practices consistently, including establishing realistic age-appropriate rules for acceptable and unacceptable behavior, prompting of positive behavior in the environment, use of positive reinforcement to encourage behavior (e.g., praise), use of clear, direct instruction, time-out and other loss-of-privilege practices for problem behavior, negotiation, and renegotiation—usually with older children and adolescents (see *Defiant Teens: A Clinician's Manual for Assessment and Family Intervention* by Barkley, Edwards, and Robin).

26. Assign the parents home exercises in which they implement parenting skills and record results of implementation (or assign "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review in session, providing corrective feedback toward improved, appropriate, and consistent use of skills.

27. Ask the parents to read parent training manuals consistent with

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| | the therapy (e.g., *Parents and Adolescents Living Together: Part 1, The Basics* by Patterson and Forgatch; *Parents and Adolescents Living Together: Part 2, Family Problem Solving* by Forgatch and Patterson; *The Kazdin Method for Parenting the Defiant Child* by Kazdin). |
| 15. Verbalize a sense of increased skill, effectiveness, and confidence in parenting. (28) | 28. Support, empower, monitor, and encourage the parents in implementing new strategies for parenting their child; reinforce successes; problem-solve obstacles toward consolidating a coordinated, consistent, and effective parenting style. |
| 16. Adolescent client learns and implements skills for managing self and interactions with others. (29, 30) | 29. Use a Cognitive-Behavioral Therapy approach with older children and adolescents using several techniques such as instruction, modeling, role-playing, feedback, and practice to teach the child how to manage his/her emotional reactions, manage interpersonal interactions, and resolve problem-solving conflicts (see *Don't Let Your Emotions Run Your Life for Teens* by Van Dijk; *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay; *The Stress Reduction Workbook for Teens* by Biegel). |
| | 30. Use structured tasks involving role-plays in session to develop personal and interpersonal skills; then carry them into real-life situations through homework exercises (consider utilizing "Becoming Assertive," "Problem-Solving Exercise," or "Developing Conversational |

Skills" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review; reinforce successes; problem-solve obstacles toward integration into the client's life.

17. Develop skills to talk openly and effectively with the children. (31, 32)

31. Use instruction, modeling, and role-play to teach the parents how to communicate effectively with their child, including use of open-ended questions, active listening, and respectful, assertive communication that encourages openness, sharing, and ongoing dialogue.

32. Ask the parents to read material supportive of their efforts to improve parent-child communication skills (e.g., *How to Talk So Kids Will Listen and Listen So Kids Will Talk* by Faber and Mazlish; *Parenting Teens with Love and Logic* by Cline and Fay); help them to implement the new communication style in daily dialogue with their children and to see the positive responses each child had to it.

18. Parents expand repertoire of parenting options. (33, 34, 35)

33. Expand the parents' repertoire of intervention options by having them read material on parenting difficult children (e.g., *The Explosive Child* by Greene; *The Kazdin Method for Parenting the Defiant Child* by Kazdin); review, process, and integrate into therapy.

34. Refer parents to an evidence-based parent training program that teaches positive child management practices and stress management techniques (e.g.,

The Teen Triple P—Positive Parenting Program).

35. Support, empower, monitor, and encourage the parents in implementing new strategies for parenting their child, giving feedback and redirection as needed.

19. Partners express verbal support of each other in the parenting process. (36, 37)

36. Assist the parental team in identifying areas of parenting strengths and weaknesses; help the parents improve their skills and boost their confidence and follow-through (consider supplementing with "Parent Report Card" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

37. Help the parents identify and implement specific ways they can support each other as parents and in realizing the ways children work to keep the parents from cooperating in order to get their way (or assign "Evaluating the Strength of Your Parenting Team" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

20. Decrease outside pressures, demands, and distractions that drain energy and time from the family. (38, 39)

38. Give the parents permission to not involve their child and themselves in too many activities, organizations, or sports.

39. Ask the parents to provide a weekly schedule of their entire family's activities and then evaluate the schedule with them, looking for which activities are valuable and which can possibly be eliminated to create a more

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| | focused and relaxed time to parent. |
| 21. Identify unresolved childhood issues that affect parenting and work toward their resolution. (40, 41) | 40. Explore each parent's story of his/her childhood to identify any unresolved issues that are present (e.g., abusive or neglectful parents, substance abuse by parents, etc.) and to identify how these issues are now affecting the ability to effectively parent. |
| | 41. Assist the parents in working through issues from their own childhood that are unresolved. |
| 22. Increase the gradual letting go of their adolescent in constructive, affirmative ways. (42) | 42. Guide the parents in identifying and implementing constructive, affirmative ways they can allow and support the healthy separation of their adolescent (or assign "Transitioning From Parenting a Child to Parenting a Teen" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 23. Parents and child report an increased feeling of connectedness between them. (43, 44) | 43. Assist the parents in removing and resolving any barriers that prevent or limit connectedness between family members and in identifying activities that will promote connectedness such as games or one-to-one time (or assign "One-on-One" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 44. Encourage the parents to see that just "hanging out at home" or being around/available is quality time. |
| 24. Verbalize an understanding of relapse prevention and the | 45. Provide a rationale for relapse prevention that discusses the risk |

difference between a lapse and a relapse. (45, 46, 47)

and introduces strategies for preventing it.

46. Discuss with the parent/child the distinction between a lapse and relapse, associating a lapse with a temporary setback and relapse with a return to a sustained pattern of conflict.

47. Identify and rehearse with the parent/child the management of future situations or circumstances in which lapses could occur.

25. Learn and implement strategies to prevent relapse of disruptive behavior. (48, 49, 50)

48. Instruct the parent/child to routinely use strategies learned in therapy (e.g., parent training techniques, problem-solving, anger management), building them into his/her life as much as possible.

49. Develop a "coping card" or other record on which coping strategies and other important information can be kept (e.g., steps in problem-solving, positive coping statements, reminders that were helpful to the client during therapy).

50. Schedule periodic maintenance or "booster" sessions to help the parent/child maintain therapeutic gains and problem-solve challenges.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 309.3 | Adjustment Disorder With Disturbance of Conduct |
| | 309.4 | Adjustment Disorder With Mixed Disturbances of Emotions and Conduct |
| | V61.21 | Neglect of Child |
| | V61.20 | Parent-Child Relational Problem |
| | V61.10 | Partner Relational Problem |
| | V61.21 | Physical Abuse of Child |
| | V61.21 | Sexual Abuse of Child |
| | 313.81 | Oppositional Defiant Disorder |
| | 312.9 | Disruptive Behavior Disorder NOS |
| | 312.8 | Conduct Disorder, Adolescent-Onset Type |
| | 314.01 | Attention-Deficit/Hyperactivity Disorder, Combined Type |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | 301.7 | Antisocial Personality Disorder |
| | 301.6 | Dependent Personality Disorder |
| | 301.81 | Narcissistic Personality Disorder |
| | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis on Axis II |
| | _____ | _____ |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 309.3 | F43.24 | Adjustment Disorder With Disturbance of Conduct |
| 309.4 | F43.25 | Adjustment Disorder With Mixed Disturbance of Emotions and Conduct |
| V61.22 | Z69.011 | Encounter for Mental Health Services for Perpetrator of Parental Child Neglect |
| V61.20 | Z62.820 | Parent-Child Relational Problem |
| V61.10 | Z63.0 | Relationship Distress With Spouse or Intimate Partner |
| V61.22 | Z69.011 | Encounter for Mental Health Services for Perpetrator of Parental Child Abuse |
| V61.22 | Z69.011 | Encounter for Mental Health Services for Perpetrator of Parental Child Sexual Abuse |
| 313.81 | F91.3 | Oppositional Defiant Disorder |

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| 312.9 | F91.9 | Unspecified Disruptive, Impulse Control, and Conduct Disorder |
| 312.89 | F91.8 | Other Specified Disruptive, Impulse Control, and Conduct Disorder |
| 312.82 | F91.2 | Conduct Disorder, Adolescent-Onset Type |
| | F91.1 | Conduct Disorder, Childhood-Onset Type |
| 314.01 | F90.2 | Attention-Deficit/Hyperactivity Disorder, Combined Presentation |
| 301.7 | F60.2 | Antisocial Personality Disorder |
| 301.6 | F60.7 | Dependent Personality Disorder |
| 301.81 | F60.81 | Narcissistic Personality Disorder |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

# PEER/SIBLING CONFLICT

## BEHAVIORAL DEFINITIONS

1. Engages in frequent, overt, intense fighting (verbal and/or physical) with peers and/or siblings.
2. Projects responsibility for conflicts onto others.
3. Believes that he/she is treated unfairly and/or that parents favor sibling(s) over himself/herself.
4. Peer and/or sibling relationships are characterized by bullying, defiance, revenge, taunting, and incessant teasing.
5. Has virtually no friends, or a few who exhibit similar socially disapproved behavior.
6. Exhibits a general pattern of behavior that is impulsive, intimidating, and unmalleable.
7. Behaviors toward peers are aggressive and lack discernible empathy for others.
8. Parents are hostile toward the client, demonstrating a familial pattern of rejection, quarreling, and lack of respect or affection.

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## LONG-TERM GOALS

1. Form respectful, trusting peer and sibling relationships.
2. Develop healthy mechanisms for handling anxiety, tension, frustration, and anger.

3. Obtain the skills required to build positive peer relationships.
4. Terminate aggressive behavior and replace with assertiveness and empathy.
5. Compete, cooperate, and resolve conflict appropriately with peers and siblings.
6. Parents acquire the necessary parenting skills to model respect, empathy, nurturance, and lack of aggression.

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## SHORT-TERM OBJECTIVES

1. Describe relationship with siblings and friends. (1, 2)

2. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (3, 4, 5, 6, 7)

## THERAPEUTIC INTERVENTIONS

1. Actively build a level of trust with client through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help increase the client's ability to identify and express feelings.
2. Explore the client's perception of the nature of his/her relationships with siblings and peers; assess the degree of denial regarding conflict and projection of the responsibility for conflict onto others.
3. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior,"agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is

reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

4. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder), including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
5. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
6. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
7. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for

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| | the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting). |
| 3. Decrease the frequency and intensity of aggressive actions toward peers or siblings. (8, 9) | 8. Instruct the parents and teachers in behavior therapy techniques of ignoring the client's aggressive acts, except when there is danger of physical injury, while making a concerted effort to attend to and praise all nonaggressive, cooperative, and peaceful behavior (or assign the parents "Clear Rules, Positive Reinforcement, Appropriate Consequences" or "How Parents Respond to Sibling Rivalry" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 9. Use The Anger Control Game (Berg) or a similar game to expose the client to new, constructive ways to manage aggressive feelings (see the Anger Control Problems chapter in this *Planner*). |
| 4. Identify verbally and in writing how he/she would like to be treated by others. (10, 11, 12, 13) | 10. Play with the client and/or family The Helping, Sharing, Caring Game (Gardner) to develop and expand feelings of respect for self and others. |
| | 11. Play with the client The Social Conflict Game (Berg) to assist him/her in developing social skills to decrease interpersonal conflict with others. |
| | 12. Ask the client to list the problems that he/she has with |

siblings and to suggest concrete solutions (or assign the client and parents the exercise "Negotiating a Peace Treaty" or "Why I Fight With My Peers" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

13. Educate the client about feelings, concentrating on how others feel when they are the focus of aggressive actions and then asking how the client would like to be treated by others (or assign "How My Behavior Hurts Others" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

5. Recognize and verbalize own feelings as well as feelings of others. (14, 15)

14. Refer the client to a peer therapy group whose objectives are to increase social sensitivity and behavioral flexibility through the use of group exercises (strength bombardment, trusting, walking, expressing negative feelings, etc.).

15. Use The Talking, Feeling, and Doing Game (Gardner; available from Creative Therapeutics) to increase the client's awareness of self and others.

6. Increase socially appropriate behavior with peers and siblings. (16)

16. Conduct or refer the client to a behavioral contracting group therapy in which contracts for positive peer interaction are developed each week and reviewed. Positive reinforcers are verbal feedback and small concrete rewards.

7. Participate in peer group activities in a cooperative manner. (17, 18)

17. Direct the parents to involve the client in cooperative activities (e.g., sports, Scouting).

18. Refer the client to an alternative summer camp that focuses on self-esteem and cooperation with peers.

8. Identify feelings associated with the perception that parent(s) have special feelings of favoritism toward a sibling. (19)

19. Help the client work through his/her perception that his/her parents have more affectionate feelings for a sibling rather than the client.

9. Respond positively to praise and encouragement as evidenced by smiling and expressing gratitude. (20, 21)

20. Use role-playing, modeling, and behavior rehearsal to teach the client to become open and responsive to praise and encouragement.

21. Assist the parents in developing their ability to verbalize affection and appropriate praise to the client in family sessions.

10. Family members decrease the frequency of quarreling and messages of rejection. (22, 23, 24)

22. Work with the parents in family sessions to reduce parental aggression, messages of rejection, and quarreling within the family.

23. Assign the client to read material on resolving relationship conflict (e.g., *Siblings: You're Stuck with Each Other, So Stick Together* by Crist and Verdick or *Teen Relationship Workbook* by Moles); process the reading, identifying key changes in personal interactions that will need to occur to decrease the level of rivalry.

24. Assign the parents to read *Siblings Without Rivalry* (Faber and Mazlish) and process key concepts with the therapist; ask the parents to choose two suggestions from the reading and implement them with their children.

11. Verbalize an understanding of the pain that underlies the anger. (25)
12. Implement a brief solution to sibling conflict that has had success in the past. (26, 27)
13. Parents attend a didactic series on positive parenting. (28)
14. Parents implement a behavior modification plan designed to increase the frequency of cooperative social behaviors. (29, 30, 31)

25. Probe for rejection experiences with family and friends as the causes for the client's anger.
26. Reframe the family members' rivalry as a stage that they will get through with support, or (if appropriate) normalize the issue of the rivalry as something that occurs in all families to varying degrees (see *A Guide to Possibility Land* by O'Hanlon and Beadle).
27. Probe the client and parents to find "time without the problem," "exceptions," or "the ending or stopping pattern" (see *A Guide to Possibility Land* by O'Hanlon and Beadle).
28. Refer the parents to a positive parenting class.
29. Assist the parents in developing and implementing a behavior modification plan in which the client's positive interaction with peers and siblings is reinforced immediately with tokens that can be exchanged for preestablished rewards; monitor and give feedback as indicated.
30. Conduct weekly contract sessions with the client and the parents in which the past week's behavior modification contract is reviewed and revised for the following week; give feedback and model positive encouragement when appropriate.
31. Institute with the client's parents and teachers a system of positive consequences (see *Solution-Focused Therapy with Children* by Selekman) for the client's

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| | misbehavior in order to promote prosocial behaviors (e.g., writing a card to a relative, mowing a neighbor's lawn, doing two good deeds for elderly neighbors, assisting a parent for a day with household projects). |
| 15. Family members engage in conflict resolution in a respectful manner. (32, 33) | 32. Teach family members problem-solving skills (i.e., pinpoint the problem precisely, brainstorm alternative solutions, list the pros and cons of each solution, select one solution for implementation, enact the solution, evaluate satisfaction of all parties, and adjust if indicated) to apply to current conflicts (or assign "Problem-Solving Exercise" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 33. Confront disrespectful expression of feelings in family sessions and use modeling, role-playing, and behavior rehearsal to teach cooperation, respect, and peaceful resolution of conflict. |
| 16. Parents terminate alliances with children that foster sibling conflict. (34, 35, 36) | 34. Assist the parents in identifying specific things they could do within their home (e.g., creating separate rooms, eating at the dinner table) or to alter the family procedures (e.g., not putting one child in charge of the other) to reduce sibling conflict. Help the parents identify and make all changes and monitor their effectiveness after implementation. |
| | 35. Ask the parents to read *How to End the Sibling Wars* (Bieniek) and coach them on implementing |

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| | several of the suggestions; follow up by monitoring, encouraging, and redirecting as needed. |
| | 36. Hold family therapy sessions to assess dynamics and alliances that may underlie peer or sibling conflict. |
| 17. Family members verbalize increased cooperation and respect for one another. (37, 38) | 37. Refer the family to an experiential or alternative weekend program (i.e., ropes course, cooperative problem-solving, trust activities). Afterward, process the experience with the family members, focusing on two to three specific things gained in terms of cooperation, respect, and trust. |
| | 38. Explore with the siblings to find an appropriate common point they would like to change in the family (e.g., amount of allowance, later bedtime/curfew) and then conduct a family session in which the siblings work together to negotiate the issue with the parents. Coach both sides in negotiating and move the parents to accept this point on a specific condition of decreased conflict between siblings. |
| 18. Verbalize an acceptance of differences between siblings rather than being critical of each person's uniqueness. (39) | 39. Hold a family sibling session in which each child lists and verbalizes an appreciation of each sibling's unique traits or abilities (or assign the exercise "Cloning the Perfect Sibling" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 19. Complete the recommended psychiatric or psychological testing/evaluation. (40) | 40. Assess and refer the client for a psychiatric or psychological evaluation. |

20. Comply with the recommendations of the mental health evaluations. (41)

41. Facilitate and monitor client and the parents in implementing the recommendations of the evaluations.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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|---|---|---|
| **Axis I:** | 313.81 | Oppositional Defiant Disorder |
| | 312.81 | Conduct Disorder, Childhood-Onset Type |
| | 312.82 | Conduct Disorder, Adolescent-Onset Type |
| | 312.9 | Disruptive Behavior Disorder NOS |
| | 314.01 | Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type |
| | 314.9 | Attention-Deficit/Hyperactivity Disorder NOS |
| | V62.81 | Relational Problem NOS |
| | V71.02 | Child or Adolescent Antisocial Behavior |
| | 315.00 | Reading Disorder |
| | 315.9 | Learning Disorder NOS |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 313.81 | F91.3 | Oppositional Defiant Disorder |
| 312.81 | F91.1 | Conduct Disorder, Childhood-Onset Type |
| 312.82 | F91.2 | Conduct Disorder, Adolescent-Onset Type |

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| 312.9 | F91.9 | Unspecified Disruptive, Impulse Control, and Conduct Disorder |
| 312.89 | F91.8 | Other Specified Disruptive, Impulse Control, and Conduct Disorder |
| 314.01 | F90.1 | Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive/Impulsive Presentation |
| 314.01 | F90.9 | Unspecified Attention-Deficit/Hyperactivity Disorder |
| 314.01 | F90.8 | Other Specified Attention-Deficit/ Hyperactivity Disorder |
| V62.81 | Z62.891 | Sibling Relational Problem |
| V61.20 | Z62.820 | Parent-Child Relational Problem |
| V71.02 | Z72.810 | Child or Adolescent Antisocial Behavior |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# PHYSICAL/EMOTIONAL ABUSE VICTIM

## BEHAVIORAL DEFINITIONS

1. Confirmed self-report or account by others of having been assaulted (e.g., hit, burned, kicked, slapped, tortured) by an older person.
2. Bruises or wounds as evidence of victimization.
3. Self-reports of being injured by a supposed caregiver coupled with feelings of fear and social withdrawal.
4. Significant increase in the frequency and severity of aggressive behaviors toward peers or adults.
5. Recurrent and intrusive distressing recollections of the abuse.
6. Feelings of anger, rage, or fear when in contact with the perpetrator.
7. Frequent and prolonged periods of depression, irritability, anxiety, and/or apathetic withdrawal.
8. Sleep disturbances (e.g., difficulty falling asleep, night terrors, recurrent distressing nightmares).
9. Running away from home to avoid further physical assaults.

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## LONG-TERM GOALS

1. Terminate the physical abuse.
2. Escape from the environment where the abuse is occurring and move to a safe haven.

3 Rebuild sense of self-worth and overcome the overwhelming sense of fear, shame, and sadness.
4. Resolve feelings of fear and depression while improving communication and the boundaries of respect within the family.
5. Increased self-esteem and a sense of empowerment as manifested by an increased number of positive self-descriptive statements and greater participation in extracurricular activities.

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## SHORT-TERM OBJECTIVES

1. Tell the entire account of the most recent abuse. (1, 2, 3)

2. Client and abusive caregiver disclose the history, frequency, amount, and type of substance use. (4)

## THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with the client through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help him/her increase the ability to identify and express facts and feelings about the abuse.
2. Explore, encourage, and support the client in verbally expressing and clarifying the facts associated with the abuse.
3. Assign the client to complete the "Take the First Step" exercise from the *Adolescent Psychotherapy Homework Planner* (Jongsma, Peterson, and McInnis) in which he/she can read a story of a teenager who was abused and shared it with a trusted adult.
4. Assess the abusive caregiver and client's use and abuse of alcohol or illicit drugs or refer him/her for a thorough substance abuse

evaluation and treatment if indicated (see the Substance Use chapter in this *Planner*).

3. Cooperate with psychological testing. (5)

5. Administer to the client/victim a self-esteem questionnaire (e.g., *Rosenberg Self-Esteem Scale*) and/or a more general test of emotional status (e.g., *MMPI-A*, *MAPI*, *Beck Youth Inventories*, *Child PTSD Symptom Scale*) to assess self-concept and more serious mental health issues (see the Posttraumatic Stress Disorder and/or Unipolar Depression chapters in this *Planner* if necessary).

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9, 10)

6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder), including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
10. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

5. Verbalize an understanding that physical abuse of a minor must be reported to authorities. (11, 12)

11. Report physical abuse to the appropriate child protection agency, criminal justice officials, or medical professionals.
12. Consult with the family, a physician, criminal justice officials, or child protection case managers to assess the veracity of the physical abuse charges.

6. Agree to actions taken to protect self and provide boundaries against any future abuse or retaliation. (13, 14, 15)

13. Assess whether the perpetrator or the client should be removed from the client's home.

14. Implement the necessary steps (e.g., removal of the client from the home, removal of the perpetrator from the home) to protect the client and other children in the home from further physical abuse.

15. Reassure the client repeatedly of concern and caring on the part of the therapist and others who will protect him/her from any further abuse.

7. Identify and express the feelings connected to the abuse. (16)

16. Explore, encourage, and support the client in expressing and clarifying his/her feelings toward the perpetrator and himself/herself (or assign the homework exercise "My Thoughts and Feelings" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

8. Terminate verbalizations of denial or making excuses for the perpetrator. (17, 18, 19)

17. Actively confront and challenge denial by the perpetrator and within the entire family system.

18. Confront the client about making excuses for the perpetrator's abuse and accepting blame for it.

19. Reassure the client that he/she did not deserve the abuse but that he/she deserves respect and a controlled response even in punishment situations.

9. Perpetrator takes responsibility for the abuse. (20, 21)

20. Reinforce any and all client statements that put responsibility clearly on the perpetrator for the abuse, regardless of any misbehavior by the client (or

supplement with "Identify the Nature of the Abuse" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

21. Hold a family therapy session in which the client and/or therapist confronts the perpetrator with the abuse.

10. Perpetrator asks for forgiveness and pledges respect for disciplinary boundaries. (22)

22. Conduct a family therapy session in which the perpetrator apologizes to the client and/or other family member(s) for the abuse (or assign the perpetrator "Perpetrator Apology to the Victim" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

11. Perpetrator agrees to seek treatment. (23, 24, 25)

23. Require the perpetrator to participate in a child abusers' psychotherapy group.

24. Refer the perpetrator for a psychological evaluation and treatment.

25. Evaluate the possibility of substance abuse with the perpetrator or within the family; refer the perpetrator and/or family member(s) for substance abuse treatment, if indicated.

12. Parents and caregivers verbalize the establishment of appropriate disciplinary boundaries to ensure protection of the client. (26, 27)

26. Counsel the client's family about appropriate disciplinary boundaries.

27. Ask the parents/caregivers to list appropriate means of discipline or correction; reinforce reasonable actions and appropriate boundaries that reflect respect for the rights and feelings of the child.

13. Family members identify the stressors or other factors that may trigger violence. (28, 29)

28. Construct a multigenerational family genogram that identifies physical abuse within the extended family to help the perpetrator recognize the cycle of violence.

29. Assess the client's family dynamics and explore for the stress factors or precipitating events that contributed to the emergence of the abuse.

14. Nonabusive parent and other key family members verbalize support and acceptance of the client. (30)

30. Elicit and reinforce support and nurturance of the client from the nonabusive parent and other key family members.

15. Reduce the expressions of rage and aggressiveness that stem from feelings of helplessness related to physical abuse. (31, 32)

31. Assign the client to write a letter expressing feelings of hurt, fear, and anger to the perpetrator; process the letter.

32. Interpret the client's generalized expressions of anger and aggression as triggered by feelings toward the perpetrator.

16. Decrease the statements of being a victim while increasing the statements that reflect personal empowerment. (33, 34)

33. Empower the client by identifying sources of help against abuse (e.g., phone numbers to call, a safe place to run to, asking for temporary alternate protective placement).

34. Assist the client in writing his/her thoughts and feelings regarding the abuse (or assign the exercise "Letter of Empowerment" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

17. Identify negative automatic thoughts and replace them with positive self-talk messages to build self-esteem. (35, 36)

35. Help the client identify his/her distorted negative beliefs about self and the world.

36. Help the client identify, and reinforce the use of, more realistic, positive messages about

self and life events (or assign "Bad Thoughts Lead to Depressed Feelings" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

18. Increase the frequency of positive self-descriptive statements. (37, 38)

37. Assist the client in identifying a basis for self-worth by reviewing his/her talents, importance to others, and intrinsic spiritual value (supplement with "Recognizing Your Abilities, Traits, and Accomplishments" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

38. Reinforce positive statements that the client has made about himself/herself and the future (or assign "Positive Self-Talk" from the *Adult Psychotherapy Homework Planner* by Jongsma).

19. Express forgiveness of the perpetrator and others connected with the abuse while insisting on respect for own right to safety in the future. (39, 40)

39. Ask the client to write a forgiveness letter and/or complete a forgiveness exercise in which he/she verbalizes forgiveness to the perpetrator and/or significant family member(s) while asserting the right to safety. Process this letter in individual session before any decision is made to share it with the perpetrator.

40. Assign the client a letting-go exercise in which a symbol of the abuse is disposed of or destroyed; process this experience.

20. Increase socialization with peers and family. (41, 42, 43)

41. Encourage the client to make plans for the future that involve engaging in pleasurable activities with his/her peers and family

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| | (supplement with "Home, School, and Community Activities I Enjoyed" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 42. Encourage the client to participate in positive peer groups or extracurricular activities. |
| | 43. Refer the client to a victim support group with other children to assist him/her in realizing that he/she is not alone in this experience. |
| 21. Increase the level of trust of others as shown by increased socialization and a greater number of friendships. (44, 45, 46) | 44. Facilitate the client expressing loss of trust in adults and relate this loss to the perpetrator's abusive behavior and the lack of protection provided. |
| | 45. Assist the client in making discriminating judgments that allow for trust of some people rather than distrust of all. |
| | 46. Teach the client the share-check method of building trust, in which a degree of shared information is related to a proven level of trustworthiness. |
| 22. Verbalize how the abuse has affected feelings toward self. (47, 48) | 47. Assign the client to describe his/her feelings about himself/herself before, during, and after being abused. |
| | 48. Ask the client to draw pictures of his/her own face that represent how he/she felt about himself/herself before, during, and after the abuse occurred (or utilize the exercise "Self-Esteem Before, During, and After Abuse" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |

23. Verbalize instances of aggressive behavior toward peers and/or authority figures. (49)

24. Recognize how aggressive behavior impacts other people's feelings. (50)

25. Acknowledge the use of alcohol and/or drugs as an escape from the pain and anger resulting from abuse. (51)

49. Assess the client for adopting the aggressive manner that he/she has been exposed to in the home (see the Anger Control Problems chapter in this *Planner*).

50. Use role-playing and role reversal techniques to sensitize the client to the feelings of the target of his/her anger.

51. Interpret the client's substance abuse as a maladaptive coping behavior for his/her feelings related to abuse.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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|---|---|---|
| **Axis I:** | 309.81 | Posttraumatic Stress Disorder |
| | 308.3 | Acute Stress Disorder |
| | 995.54 | Physical Abuse of Child (Victim) |
| | 300.4 | Dysthymic Disorder |
| | 296.xx | Major Depressive Disorder |
| | 300.02 | Generalized Anxiety Disorder |
| | 307.47 | Nightmare Disorder |
| | 313.81 | Oppositional Defiant Disorder |
| | 312.81 | Conduct Disorder, Childhood-Onset Type |
| | 300.6 | Depersonalization Disorder |
| | 300.15 | Dissociative Disorder NOS |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
| | _____ | _____ |
| | _____ | _____ |

*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
| 308.3 | F43.0 | Acute Stress Disorder |
| 995.54 | T74.12XA | Child Physical Abuse, Confirmed, Initial Encounter |
| 995.54 | T74.12XD | Child Physical Abuse, Confirmed, Subsequent Encounter |
| 995.51 | T74.32XA | Child Psychological Abuse, Confirmed, Initial Encounter |
| 995.51 | T74.32XD | Child Psychological Abuse, Confirmed, Subsequent Encounter |
| 300.4 | F34.1 | Persistent Depressive Disorder |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 296.xx | F33.x | Major Depressive Disorder, Recurrent Episode |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 307.47 | F51.5 | Nightmare Disorder |
| 313.81 | F91.3 | Oppositional Defiant Disorder |
| 312.81 | F91.1 | Conduct Disorder, Childhood-Onset Type |
| 312.32 | F91.2 | Conduct Disorder, Adolescent-Onset Type |
| 300.6 | F48.1 | Depersonalization/Derealization Disorder |
| 300.15 | F44.89 | Other Specified Dissociative Disorder |
| 300.15 | F44.9 | Unspecified Dissociative Disorder |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# POSTTRAUMATIC STRESS DISORDER (PTSD)

## BEHAVIORAL DEFINITIONS

1. Exposure to threats of death or serious injury, or subjection to actual injury, that resulted in an intense emotional response of fear, helplessness, or horror.
2. Intrusive, distressing thoughts or images that recall the traumatic event.
3. Disturbing dreams associated with the traumatic event.
4. A sense that the event is recurring, as in illusions or flashbacks.
5. Intense distress when exposed to reminders of the traumatic event.
6. Physiological reactivity when exposed to internal or external cues that symbolize the traumatic event.
7. Avoidance of thoughts, feelings, or conversations about the traumatic event.
8. Avoidance of activities, places, or people associated with the traumatic event.
9. Inability to recall some important aspect of the traumatic event.
10. Lack of interest and participation in formerly meaningful activities.
11. A sense of detachment from others.
12. Inability to experience the full range of emotions, including love.
13. A pessimistic, fatalistic attitude regarding the future.
14. Sleep disturbance.
15. Irritability or angry outbursts.
16. Lack of concentration.
17. Hypervigilance.
18. Exaggerated startle response.
19. Symptoms have been present for more than 1 month.
20. Sad or guilty affect and other signs of depression.
21. Verbally and/or physically violent threats or behavior.

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## LONG-TERM GOALS

1. Recall the traumatic event without becoming overwhelmed with negative emotions.
2. Interact normally with friends and family without irrational fears or intrusive thoughts that control behavior.
3. Return to pretrauma level of functioning without avoiding people, places, thoughts, or feelings associated with the traumatic event.
4. Display a full range of emotions without experiencing loss of control.
5. Develop and implement effective coping skills that allow for carrying out normal responsibilities and participating in relationships and social activities.

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## SHORT-TERM OBJECTIVES

1. Describe the traumatic event in as much detail as possible without being emotionally overwhelmed. (1, 2)

## THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client and parents toward building a working therapeutic alliance.
2. Gently and sensitively explore the client's recollection of the facts of the traumatic incident and his/her emotional reactions at the time; begin with descriptions of neutral events

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| | and then progress to a description of the trauma, if needed (consider utilizing "Describe the Trauma and Your Feelings" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 2. Describe the history and nature of the posttraumatic stress disorder (PTSD) and any other reactions to the trauma. (3) | 3. Conduct an assessment of the client's PTSD symptoms, other psychopathology/behavior problems, and their impact on functioning (supplement with "Describe Your PTSD Symptoms" and "Impact of Frightening or Dangerous Event" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis; or see *The Anxiety Disorders Interview Schedule for Children—Parent Version* or *Child Version*). |
| 3. Complete psychological tests designed to assess and/or track the nature and severity of PTSD symptoms. (4) | 4. Administer or refer the client for psychological testing or objective measurement of PTSD and other relevant symptoms (e.g., *The Child PTSD Symptom Scale*; *Child Posttraumatic Stress Reaction Index*; *Clinician-Administered PTSD Scale for Children and Adolescents*). |
| 4. Discuss any feelings of depression, including any suicidal thoughts. (5) | 5. Assess the client's depth of depression and suicide potential and treat appropriately, taking the necessary safety precautions as indicated (see the Unipolar Depression chapter in this *Planner*). |
| 5. Disclose any history of substance use that may contribute to and complicate the treatment of the panic disorder. (6) | 6. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it. |

6. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10, 11)
7. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
8. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder), including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
9. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
10. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess

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| | this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment). |
| | 11. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting). |
| 7. Participate in an evaluation by a physician for psychotropic medication. (12, 13) | 12. Assess the client's need for medication (e.g., selective serotonin reuptake inhibitors) and arrange for prescription if appropriate. |
| | 13. Monitor and evaluate the client's psychotropic medication prescription compliance and the effectiveness of the medication on his/her level of functioning. |
| 8. Participate, with or without parents, in individual or group therapy sessions focused on PTSD. (14) | 14. Conduct group or individual therapy sessions consistent with Trauma-Focused Cognitive-Behavioral Therapy; include parents as needed and if helpful (see *Trauma-Focused CBT for Children and Adolescents* by Cohen, Mannarino, and Deblinger; *Treating Trauma and Traumatic Grief in Children and Adolescents* by Cohen, Mannarino, and Deblinger). |
| 9. Client and parents verbalize an accurate understanding of PTSD and how it develops. (15, 16) | 15. Discuss with the client and parents a biopsychosocial model of PTSD, including that it results from exposure to trauma and |

results in intrusive recollection, unwarranted fears, anxiety, and a vulnerability to other negative emotions such as shame, anger, and guilt; normalize the client's experiences.

16. Assign the client and/or client's parents to read psychoeducational chapters of workbooks or treatment manuals on Posttraumatic Stress Disorder (PTSD) that explain its features and development (e.g., *Prolonged Exposure Therapy for PTSD—Teen Workbook* by Chrestman, Gilboa-Schechtman, and Foa; *The Post-Traumatic Stress Disorder Sourcebook: A Guide to Healing, Recovery, and Growth* by Schiraldi).

10. Verbalize an understanding of the rationale for treatment of PTSD. (17, 18)

17. Discuss how coping skills, cognitive restructuring, and exposure help build confidence, desensitize and overcome fears, and enable one to see one's self, others, and the world in a less fearful and/or depressing way.

18. Assign the client and/or client's parents to read about anxiety management, stress inoculation, cognitive restructuring, and/or exposure-based therapy in chapters of books or treatment manuals on PTSD (e.g., *Prolonged Exposure Therapy for PTSD—Teen Workbook* by Chrestman, Gilboa-Schechtman, and Foa; *My Anxious Mind: A Teen's Guide to Managing Anxiety and Panic* by Tompkins and Martinez; *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay; *The Cognitive*

*Behavioral Workbook for Anxiety: A Step-by-Step Program* by Knaus).

11. Parents learn and implement Parent Management Training skills to recognize and manage any problem behavior of the client. (19, 20, 21, 22, 23)

19. Use a Parent Management Training approach beginning with teaching the parents how parent and child behavioral interactions can encourage or discourage positive or negative behavior and that changing key elements of those interactions (e.g., prompting and reinforcing positive behaviors) can be used to promote positive change (see *Trauma-Focused CBT for Children with Co-Occurring Trauma and Behavior Problems* by Cohen, Berliner, and Mannarino; *Defiant Children* by Barkley).

20. Ask the parents to read material consistent with a parent training approach to managing disruptive behavior (e.g., *The Kazdin Method for Parenting the Defiant Child* by Kazdin; *Parents and Adolescents Living Together* by Patterson and Forgatch).

21. Teach the parents how to specifically define and identify problem behaviors, identify their reactions to the behavior, determine whether the reaction encourages or discourages the behavior, and generate alternatives to the problem behavior.

22. Teach parents how to implement key parenting practices consistently, including establishing realistic age-appropriate rules for acceptable and unacceptable behavior, prompting positive behavior in the environment, use

of positive reinforcement to encourage behavior (e.g., praise), and use of clear direct instruction, time-out, and other loss-of-privilege practices for problem behavior.

23. Assign the parents home exercises in which they implement and record results of implementation exercises (or assign "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review in session, providing corrective feedback toward improved, appropriate, and consistent use of skills.

12. Learn and implement personal self-management skills to manage emotional reactions related to trauma and other stressors. (24)

24. While building rapport, teach the client skills needed to progress in therapy, including the identification, labeling, and management of emotions such as anxiety, anger, and shame; use skill-building and emotional regulation techniques (e.g., from Anxiety Management Training, Stress Inoculation Training, Dialectical Behavior Therapy) such as emotion labeling, calming skills (e.g., relaxation, breathing control), coping skills (e.g., coping self-statements, covert modeling or imagining the successful use of the strategies), and/or role-playing (i.e., with therapist or trusted other) toward effective use of relevant skills (see relevant chapters such as Anxiety or Anger Control Problems in this *Planner*).

13. Learn and implement interpersonal skills for managing self and relationships with friends, family, and others. (25)

25. Teach the client interpersonal skills such as assertive communication, problem-solving, and conflict resolution skills for mitigating and managing interpersonal conflicts and resuming negatively impacted developmental competencies (or assign "Problem-Solving Exercise" or "Becoming Assertive" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); use behavioral skills training methods such as instruction, modeling, and rehearsal to develop skills; practice, review, and use reinforcement and supportive corrective feedback for refining and consolidating use.

14. Identify, challenge, and replace fearful self-talk with reality-based, positive self-talk. (26, 27)

26. Teach the client how to identify and explore the schema and self-talk that mediate his/her trauma-related fears; identify and challenge biases; assist him/her in generating appraisals that correct for the biases and build confidence.

27. Assign the client a homework exercise in which he/she identifies fearful self-talk and creates reality-based alternatives (consider using "Bad Thoughts Lead to Depressed Feelings" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review and reinforce success, providing corrective feedback for failure.

15. Participate in imaginal and *in vivo* exposure to trauma-related memories until talking or thinking about the trauma does not cause marked distress. (28, 29, 30)

28. Assist the client in constructing a detailed narrative description of the trauma(s) for imaginal exposure in which cognitive distortions are corrected and the experiences are placed in the context of the child's entire life (supplement with "Gradual Exposure to Fear" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); construct a fear and avoidance hierarchy of feared and avoided trauma-related stimuli for *in vivo* exposure.

29. Assist the client in undergoing imaginal exposure to the trauma by having him/her describe a traumatic experience at an increasing but client-chosen level of detail; use narrative, drawing, or other imaginal methods as needed; repeat exposure until associated anxiety reduces and stabilizes, recording the session for use in cognitive restructuring and further exposure in and/or between sessions (see *Trauma-Focused CBT for Children and Adolescents* by Cohen, Mannarino, and Deblinger); review and reinforce progress, problem-solve obstacles.

30. Assign the client homework exercises in which he/she repeats the narrative exposure and does *in vivo* exposure to reminders of the trauma as rehearsed in therapy; ask him/her to record responses; review, problem-solve obstacles, and reinforce progress toward mastery.

16. Discuss feelings of grief/loss associated with the trauma. (31)

31. Assess the extent that traumatic grief is a consequence of the trauma experience, encouraging expression and working toward acceptance and resolution (see *Treating Trauma and Traumatic Grief in Children and Adolescents* by Cohen, Mannarino, and Deblinger).

17. Implement relapse prevention strategies for managing possible future trauma-related lapses and to enhance the gains made in therapy. (32, 33, 34, 35)

32. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of symptoms, fear, or urges to avoid and relapse with the decision to return to fearful and avoidant patterns.

33. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.

34. Instruct the client to routinely use strategies learned in therapy (e.g., cognitive restructuring, social skills, exposure) while building social interactions and relationships.

35. Develop a "coping card" or other reminder on which coping strategies and other important information (e.g., "Pace your breathing," "Focus on the task at hand," "You can manage it," "It will go away") are recorded for the client's later use.

18. Family members learn skills that strengthen and support the client's positive behavior change. (36, 37, 38)

36. Involve the family in the treatment of the client, teaching them developmentally appropriate treatment goals, how to give support as the client faces his/her fears, and how to prevent reinforcing the client's fear and avoidance; offer

encouragement, support, and redirection as required (recommend *Children and Trauma: A Parent's Guide to Helping Children Heal* by Monahon).

37. Assist the family members in recognizing and managing their own difficult emotional reactions to the client's experience of trauma.

38. Encourage the family to model constructive skills they have learned, and model and praise the therapeutic skills the client is learning (e.g., calming, cognitive restructuring, nonavoidance of unrealistic fears).

19. Client and parents participate in conjoint sessions to review and enhance progress made in therapy. (39)

39. Lead conjoint client-parent sessions to review shared therapeutic activities; facilitate open communication; model and encourage positive reinforcement of advancements; provide psychoeducation as needed.

20. Engage in activities that allow one to experience pleasure, feel one is doing something worthwhile, and/or feel good about oneself. (40, 41)

40. Teach and engage the client in "behavioral activation" by scheduling activities that have a high likelihood for pleasure and mastery, are worthwhile to the client, and/or make him/her feel good about self; use behavioral techniques (e.g., modeling, role-playing, role reversal, rehearsal, and corrective feedback) as needed to assist adoption in the client's daily life toward re-establishing a normal developmental trajectory (supplement with "Home, School, and Community Activities I Enjoyed" in the *Adolescent Psychotherapy*

*Homework Planner* by Jongsma, Peterson, and McInnis); reinforce advances.

41. Develop and reinforce a routine of physical exercise for the client; supplement intervention with prescribed reading (e.g., *Exercising Your Way to Better Mental Health* by Leith).

21. Cooperate with eye movement desensitization and reprocessing (EMDR) technique to reduce emotional reaction to the traumatic event. (42)

42. Utilize the EMDR technique to reduce the client's emotional reactivity to the traumatic event (see *Through the Eyes of a Child: EMDR with Children* by Tinker and Wilson; *Eye Movement Desensitization and Reprocessing (EMDR) in Child and Adolescent Psychotherapy* by Greenwald).

22. Participate in group support therapy sessions focused on sustaining recovery from Posttraumatic Stress Disorder (PTSD). (43)

43. Refer the client to or conduct group therapy sessions where the focus is on sharing experiences with overcoming traumatic events with other PTSD survivors.

23. Sleep without being disturbed by dreams of the trauma. (44)

44. Monitor the client's sleep pattern and encourage use of relaxation, positive imagery, and sleep hygiene as aids to sleep.

24. Verbalize hopeful and positive statements regarding the future. (45)

45. Reinforce the client's positive, reality-based cognitive messages that enhance self-confidence and increase adaptive action.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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|---|---|---|
| **Axis I:** | 309.81 | Posttraumatic Stress Disorder |
| | 309.xx | Adjustment Disorder |
| | 995.54 | Physical Abuse of Child (Victim) |
| | 995.53 | Sexual Abuse of Child (Victim) |
| | 308.3 | Acute Stress Disorder |
| | 296.xx | Major Depressive Disorder |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | V71.09 | No Diagnosis |
| | _____ | _____ |
| | _____ | _____ |

*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
| 309.xx | F43.xx | Adjustment Disorder |
| 995.54 | T74.12XA | Child Physical Abuse, Confirmed, Initial Encounter |
| 995.54 | T74.12XD | Child Physical Abuse, Confirmed, Subsequent Encounter |
| 995.53 | T74.22XA | Child Sexual Abuse, Confirmed, Initial Encounter |
| 995.53 | T74.22XD | Child Sexual Abuse, Confirmed, Subsequent Encounter |
| 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 |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

# PSYCHOTICISM

## BEHAVIORAL DEFINITIONS

1. Bizarre thought content (delusions of grandeur, persecution, reference, influence, control, somatic sensations, or infidelity).
2. Illogical form of thought or speech (loose association of ideas in speech; incoherence; illogical thinking; vague, abstract, or repetitive speech; neologisms; perseverations; clanging).
3. Perception disturbance (hallucinations, primarily auditory but occasionally visual or olfactory).
4. Disturbed affect (blunted, none, flattened, or inappropriate).
5. Lost sense of self (loss of ego boundaries, lack of identity, blatant confusion).
6. Diminished volition (inadequate interest, drive, or ability to follow a course of action to its logical conclusion; pronounced ambivalence or cessation of goal-directed activity).
7. Relationship withdrawal (withdrawal from involvement with the external world and preoccupation with egocentric ideas and fantasies; alienation feelings).
8. Poor social skills (misinterpretation of the actions or motives of others; maintaining emotional distance from others; feeling awkward and threatened in most social situations; embarrassment of others by failure to recognize the impact of own behavior).
9. Inadequate control over sexual, aggressive, or frightening thoughts, feelings, or impulses (blatantly sexual or aggressive fantasies; fears of impending doom; acting out sexual or aggressive impulses in an unpredictable and unusual manner, often directed toward family and friends).
10. Psychomotor abnormalities (a marked decrease in reactivity to the environment; various catatonic patterns such as stupor, rigidity, excitement, posturing, or negativism; unusual mannerisms or grimacing).

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## LONG-TERM GOALS

1. Control or eliminate active psychotic symptoms such that supervised functioning is positive and medication is taken consistently.
2. Significantly reduce or eliminate hallucinations and/or delusions.
3. Eliminate acute, reactive psychotic symptoms and return to normal functioning in affect, thinking, and relating.
4. Interact appropriately in social situations and improve the reality-based understanding of and reaction to the behaviors and motives of others.
5. Attain control over disturbing thoughts, feelings, and impulses.

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## SHORT-TERM OBJECTIVES

1. Describe thoughts about self and others; history, content, nature, and frequency of hallucinations or delusions; fantasies and fears. (1, 2)

2. Establish trust and therapeutic alliance to begin to express feelings and discuss the nature of psychotic symptoms. (3)

## THERAPEUTIC INTERVENTIONS

1. Assess the pervasiveness of the client's thought disorder through a clinical interview.

2. Determine if the client's psychosis is of a brief, reactive nature or long-term with prodromal and reactive elements.

3. Provide supportive therapy characterized by genuine warmth, understanding, and acceptance to reduce the client's distrust, alleviate fears, and promote openness regarding his/her psychotic symptoms and

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| | the feelings surrounding them (or assist the client in completing "Describe Your Hallucinations" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 3. Cooperate with psychological testing to assess severity and type of psychosis. (4) | 4. Administer or arrange for psychological testing (e.g., *Minnesota Multiphasic Personality Inventory-Adolescent* or *Millon Adolescent Clinical Inventory*) to assess the client's severity and type of psychosis; provide feedback to the client and parents. |
| 4. Family members and client provide psychosocial history of the client and the extended family. (5) | 5. Explore the client's personal and family history for serious mental illness and significant traumas or stressors. |
| 5. Disclose any history of substance use that may contribute to and complicate the treatment of the psychosis. (6) | 6. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it. |
| 6. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10, 11) | 7. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change). |
| | 8. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with |

ADHD, depression secondary to an anxiety disorder), including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

9. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
10. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
11. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

7. Accept and understand that the distressing thought disorder symptoms are due to mental illness. (12)

12. Explain to the client and parents the nature of the psychotic process, its biochemical component, and the confusing effect on rational thought.

8. Take antipsychotic medications consistently with or without supervision. (13, 14)

13. Arrange for the administration of appropriate antipsychotic medications to the client.

14. Monitor the client for medication compliance and redirect if he/she is noncompliant.

9. Move to appropriate hospital or residential setting. (15)

15. Arrange for an appropriate level of residential or hospital care if the client may be harmful to self or others or unable to care for his/her own basic needs.

10. Verbally identify the stressors that contributed to the reactive psychosis. (16, 17, 18, 19)

16. Probe the external or internal stressors that may account for the client's reactive psychosis.

17. Explore the client's feelings about the stressors that triggered the psychotic episodes.

18. Assist the client in identifying threats in the environment and develop a plan with the family to reduce these stressors.

19. Explore the client's history for significant separations, losses, or traumas.

11. Family members verbalize increased understanding of and knowledge about the client's illness and treatment. (20)

20. Arrange for family therapy sessions to educate the family regarding the client's illness, treatment, and prognosis; provide reading recommendations for learning about serious mental illness (e.g., *The Complete Family Guide to Schizophrenia: Helping Your Loved One Get the Most Out of Life* by Mueser and Gingerich; or *Surviving Schizophrenia: A Family Manual* by Torrey).

12. Family members increase positive support of the client to reduce the chances of acute exacerbation of the psychotic episode. (21, 22)

21. Encourage the parents to involve the client in here-and-now based social and recreational activities (e.g., intramural sports, after-school enrichment programs, YMCA structured programs).

22. Encourage the parents to look for opportunities to praise and reinforce the client for engaging in responsible, adaptive, and prosocial behaviors.

13. Parents increase frequency of communicating to the client with direct eye contact, clear language, and complete thoughts. (23, 24)

23. Assist the family in avoiding double-bind messages that are inconsistent and contradictory, resulting in increased anxiety, confusion, and psychotic symptoms in the client.

24. Confront the parents in family therapy when their communication is indirect and disjointed, leaving the client confused and anxious.

14. Parents terminate hostile, critical responses to the client and increase their statements of praise, optimism, and affirmation. (25, 26)

25. Hold family therapy sessions to reduce the atmosphere of criticism and hostility toward the client and promote an understanding of the client and his/her illness.

26. Support the parents in setting firm limits without hostility on the client's inappropriate aggressive or sexual behavior.

15. Family members share their feelings of guilt, frustration, and fear associated with the client's mental illness. (27)

27. Encourage the family members to share their feelings of frustration, guilt, fear, or depression surrounding the client's mental illness and behavior patterns.

16. Stay current with schoolwork, completing assignments and interacting appropriately with peers and teachers. (28, 29)

28. Arrange for and/or encourage ongoing academic training while the client is receiving psychological treatment.

29. Contact school personnel (having obtained the necessary confidentiality releases) to educate them regarding the client's unusual behavior and his/her need for an accepting, supportive environment.

17. Verbalize an understanding of the underlying needs, conflicts, and emotions that support the irrational beliefs. (30)

18. Think more clearly as demonstrated by logical, coherent speech. (31, 32)

19. Report a diminishing or absence of hallucinations and/or delusions. (33, 34, 35)

20. Demonstrate control over inappropriate thoughts, feelings, and impulses by verbalizing a reduced frequency of occurrence. (36, 37)

30. Probe the client's underlying needs and feelings (e.g., inadequacy, rejection, anxiety, guilt) that contribute to internal conflict and irrational beliefs.

31. Gently confront the client's illogical thoughts and speech to refocus disordered thinking (or assist the client in completing "My Irrational Thoughts" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

32. Assist in restructuring the client's irrational beliefs by reviewing reality-based evidence and misinterpretation.

33. Encourage the client to focus on the reality of the external world as opposed to distorted fantasy.

34. Differentiate for the client between the sources of stimuli from self-generated messages and the reality of the external world.

35. Interpret the client's inaccurate perceptions or bizarre associations as reflective of unspoken fears of rejection or losing control.

36. Set firm limits on the client's inappropriate aggressive or sexual behavior that emanates from a lack of impulse control or a misperception of reality.

37. Monitor the client's daily level of functioning (i.e., reality orientation, personal hygiene, social interactions, affect appropriateness) and give feedback that either redirects or reinforces the behavior.

21. Begin to show limited social functioning by responding appropriately to friendly encounters. (38, 39)

22. Family members accept a referral to a support group. (40)

23. Develop a plan to contact a mental health clinician when early warning signs of psychosis appear. (41)

38. Use role-playing and behavioral rehearsal of social situations to explore and teach the client alternative positive social interactions with family and friends.

39. Reinforce socially and emotionally appropriate responses to others (or assign "Developing Conversational Skills" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

40. Refer family members to a community-based support group designed for the families of psychotic clients.

41. Review with the client signs that the psychotic symptoms are starting to reassert themselves and he/she should contact a mental health clinician for help (or assign "Recognizing Early Warning Signs" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); write out a plan for who can be contacted and how.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 297.1 | Delusional Disorder |
| | 298.8 | Brief Psychotic Disorder |
| | 295.xx | Schizophrenia |

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|---|---|---|
| | 295.30 | Schizophrenia, Paranoid Type |
| | 295.70 | Schizoaffective Disorder |
| | 295.40 | Schizophreniform Disorder |
| | 296.xx | Bipolar I Disorder |
| | 296.89 | Bipolar II Disorder |
| | 296.24 | Major Depressive Disorder, Single Episode With Psychotic Features |
| | 296.34 | Major Depressive Disorder, Recurrent With Psychotic Features |
| | 310.1 | Personality Change Due to Axis III Disorder |
| | _____ | _____ |
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| **Axis II:** | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 297.1 | F22 | Delusional Disorder |
| 298.8 | F23 | Brief Psychotic Disorder |
| 295.30 | F20.9 | Schizophrenia |
| 295.70 | F25.0 | Schizoaffective Disorder, Bipolar Type |
| 295.70 | F25.1 | Schizoaffective Disorder, Depressive Type |
| 295.40 | F20.40 | Schizophreniform Disorder |
| 296.xx | F31.2 | Bipolar I Disorder, With Psychotic Features |
| 296.89 | F31.81 | Bipolar II Disorder |
| 296.xx | F32.3 | Major Depressive Disorder, Single Episode, With Psychotic Features |
| 296.xx | F33.3 | Major Depressive Disorder, Recurrent Episode, With Psychotic Features |
| 310.1 | F07.0 | Personality Change Due to Another Medical Condition |
| 298.8 | F28 | Other Specified Schizophrenia Spectrum and Other Psychotic Disorder |
| 298.9 | F29 | Unspecified Schizophrenia Spectrum and Other Psychotic Disorder |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# RUNAWAY

## BEHAVIORAL DEFINITIONS

1. Running away from home for a day or more without parental permission.
2. Pattern of running to the noncustodial parent, relative, or friend when conflicts arise with the custodial parent or guardian.
3. Running away from home and crossing state lines.
4. Running away from home overnight at least twice.
5. Running away at least one time without returning within 48 hours.
6. Poor self-image and feelings of worthlessness and inadequacy.
7. Chaotic, violent, or abusive home environment.
8. Severe conflict with parents.
9. Victim of physical, sexual, or emotional abuse.

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## LONG-TERM GOALS

1. Develop a closer, more caring relationship with the parents.
2. Reduce the level, frequency, and degree of family conflicts.
3. Attain the necessary skills to cope with family stress without resorting to the flight response.
4. Caregivers terminate any abuse of the client and establish a nurturing family environment with appropriate boundaries.
5. Eliminate the runaway behavior.
6. Begin the process of healthy separation from the family.

7. Parents demonstrate acceptance and respect for the client.

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## SHORT-TERM OBJECTIVES

1. Verbalize the emotions causing a need to escape from the home environment. (1, 2, 3)

2. Complete psychiatric evaluations. (4)

## THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with the client in individual sessions through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help him/her increase the ability to identify and express feelings.

2. Gather a history of the client's runaway behavior, precipitating events, any accomplices or facilitators, living conditions during runaway time, any substance abuse or sexual acting out, illegal behavior, emotional state, and so on. (or assign "Describe Life on the Run" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

3. Facilitate the client's expression of emotions that prompt the runaway behavior.

4. Refer the client for an evaluation for ADHD, affective disorder, or psychotic processes that could benefit from psychotropic medications.

3. Comply with all recommendations of the psychiatric evaluation. (5)
4. Disclose any history of substance use that may contribute to and complicate the treatment of the runaway problem. (6)
5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10, 11)

5. Monitor the client's and the family's compliance with the evaluation recommendations.
6. Arrange for a thorough substance abuse evaluation and refer the client for treatment if the evaluation results would recommend it.
7. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
8. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder), including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
9. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
10. Assess for the severity of the level of impairment to the

client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

11. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

6. Identify and implement alternative reactions to conflictual situations. (12, 13)

12. Ask the client to list all possible constructive ways of handling conflictual situations and process the list with the therapist.

13. Train the client in alternative ways of handling conflictual situations (e.g., being assertive with his/her wishes or plans, staying out of conflicts that are parents' issues), and assist him/her in implementing them into his/her daily life.

7. Increase communication with and the expressed level of understanding of the parents. (14, 15)

14. Conduct family therapy sessions with the client and his/her parents to facilitate healthy, positive communications.

15. Teach the client and parents problem-solving skills (i.e., pinpoint the precise problem,

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| | brainstorm possible solutions, list the pros and cons of each solution, select and implement a solution, evaluate the action taken for mutual satisfaction, adjust solution if necessary); use role-play and modeling to apply these steps to a current issue (or assign "Problem-Solving Exercise" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 8. Parents and client each express acceptance of and responsibility for his/her share of the conflicts between them. (16) | 16. Assist the parents and the client in each accepting responsibility for his/her share of the conflicts in the home. |
| 9. Parents terminate physical and/or sexual abuse of the client. (17, 18) | 17. Explore for the occurrence of physical or sexual abuse to the client with the client and his/her family (or assign "My Story" or "Identify the Nature of the Abuse" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 18. Arrange for the client to be placed in respite care or in another secure setting, if necessary, while the family works in family therapy to resolve conflicts that have led to abuse or neglect of the client. |
| 10. Parents acknowledge substance abuse problem and accept referral for treatment. (19) | 19. Evaluate the parents for substance abuse and its effect on the client; refer parents for treatment, if necessary. |
| 11. Parents identify unresolved issues with their parents and begin to move toward resolving each issue. (20, 21) | 20. Hold a family session in which a detailed genogram is developed with a particular emphasis on unresolved issues between the client's parents and their own parents. Then assist the client's |

parents in coming to see the importance of resolving these issues before change can possibly occur in their own family system (or assign the parents "Parents Understand the Roots of Their Parenting Methods" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

21. Facilitate sessions with the client's parents to assist in working through past unresolved issues with their own parents.

12. Parents decrease messages of rejection. (22)

22. Help the client's parents identify and alter parenting techniques, interactions, or other messages that communicate rejection to the client.

13. Parents attend a didactic group focused on teaching positive parenting skills. (23)

23. Refer the parents to a class that teaches positive and effective parenting skills.

14. Parents identify and implement ways they can make the client feel valued and cherished within the family. (24, 25)

24. Assign the parents to read books on parenting (e.g., *Parenting Teens With Love and Logic* by Cline and Fay; *How to Talk So Kids Will Listen and Listen So Kids Will Talk* by Faber and Mazlish; *The Everything Parent's Guide to Positive Discipline* by Pickhardt); process what they have learned from reading the material assigned.

25. Assist the parents in identifying ways to make the client feel more valued (e.g., work out age-appropriate privileges with the client, give the client specific responsibilities in the family, ask for client's input on family decisions) as an individual and as part of the family; elicit a commitment from the parents

for implementation of client-affirming behaviors.

15. Identify own needs in the family that are unsatisfied. (26)

26. Ask the client to make a list of his/her needs in the family that are not met; process the list in an individual session and at an appropriate later time in a family therapy session.

16. Identify ways that unmet needs might be satisfied by means outside the family. (27)

27. Assist the client in identifying how he/she might meet his/her own unmet needs (e.g., obtain a Big Brother or Big Sister, find a job, develop a close friendship). Encourage the client to begin to meet those unmet needs that would be age-appropriate to pursue.

17. Verbalize hurt and angry feelings connected to the family and how it functions. (28, 29, 30)

28. Assign the client to write a description of how he/she perceives the family dynamics and then to keep a daily journal of incidents that support or refute this perception (or assign the exercise "Home by Another Name" or "Undercover Assignment" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

29. Assist the client in identifying specific issues of conflict he/she has with the family (or assign the "Airing Your Grievances" exercise from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

30. Support and encourage the client when he/she begins to appropriately verbalize anger or other negative feelings.

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| 18. Identify and implement constructive ways to interact with the parents. (31) | 31. Help the client identify and implement specific constructive ways (e.g., avoiding involvement or siding on issues between parents, stating his/her own feelings directly to the parents on issues involving him/her) to interact with the parents. Confront the client when he/she is not taking responsibility for himself/herself in family conflicts. |
| 19. Verbalize fears associated with becoming more independent. (32) | 32. Explore the client's fears surrounding becoming more independent and responsible for himself/herself. |
| 20. Parents identify and implement ways to promote the client's maturity and independence. (33) | 33. Help the parents find ways to assist in the advancement of the client's maturity and independence such as giving the client age-appropriate privileges, encouraging activities outside of home, or requiring the client to be responsible for specific jobs or tasks in the home (or assign the parents "Transitioning from Parenting a Child to Parenting a Teen" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 21. Verbalize an understanding of various emotions, and express them appropriately. (34) | 34. Educate the client (e.g., using a printed list of feeling adjectives) in how to identify and label feelings and in the value of expressing them in appropriate ways. |
| 22. Identify specifically how acting out behavior (such as running away) rescues the parents from facing their own problems. (35, 36) | 35. Assist the client in becoming more aware of her/his role in the family and how it impacts the parents; focus on runaway behavior as a distraction from underlying family conflicts. |

36. Facilitate family therapy sessions with the objective of revealing underlying conflicts in order to release the client from being a symptom bearer.

23. Family members verbally agree to and then implement the structural or strategic recommendations of the therapist for the family. (37, 38)

37. Conduct family therapy sessions in which a structural intervention (e.g., parents will not allow the children to get involved in their discussions or disagreements, while assuring the children that the parents can work things out themselves) is developed, assigned, and then implemented by the family. Monitor the implementation and adjust intervention as required.

38. Develop a strategic intervention (parents will be responsible for holding a weekly family meeting and the client will be responsible for raising one personal issue in that forum for them to work out together) and have the family implement it. Monitor the implementation and adjust intervention as needed.

24. Move to a neutral living environment that meets both own and parents' approval. (39)

39. Help the parents and the client draw up a contract for the client to live in a neutral setting for an agreed-upon length of time. The contract will include basic guidelines for daily structure and for frequency of contact with the parents and the acceptable avenues by which the contact can take place (or utilize "Another Place to Live" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 314.01 | Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type |
| | 312.82 | Conduct Disorder, Adolescent-Onset Type |
| | 313.81 | Oppositional Defiant Disorder |
| | 300.01 | Panic Disorder Without Agoraphobia |
| | 300.4 | Dysthymic Disorder |
| | 309.24 | Adjustment Disorder With Anxiety |
| | 309.4 | Adjustment Disorder With Mixed Disturbance of Emotions and Conduct |
| | 312.30 | Impulse-Control Disorder NOS |
| | V61.20 | Parent-Child Relational Problem |
| | 995.54 | Physical Abuse of Child (Victim) |
| | 995.53 | Sexual Abuse of Child (Victim) |
| | 995.52 | Neglect of Child (Victim) |
| | _____ | _____ |
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| **Axis II:** | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
| | _____ | _____ |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 314.01 | F90.1 | Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive/Impulsive Type |
| 312.81 | F91.1 | Conduct Disorder, Childhood-Onset Type |
| 312.82 | F91.2 | Conduct Disorder, Adolescent-Onset Type |
| 313.81 | F91.3 | Oppositional Defiant Disorder |
| 300.01 | F41.0 | Panic Disorder |
| 300.4 | F34.1 | Persistent Depressive Disorder |

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| 309.24 | F43.22 | Adjustment Disorder With Anxiety |
| 309.4 | F43.25 | Adjustment Disorder With Mixed Disturbance of Emotions and Conduct |
| 312.9 | F91.9 | Unspecified Disruptive, Impulse Control, and Conduct Disorder |
| 312.30 | F91.8 | Other Specified Disruptive, Impulse Control, and Conduct Disorder |
| V61.20 | Z62.820 | Parent-Child Relational Problem |
| 995.54 | T74.12XA | Child Physical Abuse, Confirmed, Initial Encounter |
| 995.54 | T74.12XD | Child Physical Abuse, Confirmed, Subsequent Encounter |
| 995.53 | T74.22XA | Child Sexual Abuse, Confirmed, Initial Encounter |
| 995.53 | T74.22XD | Child Sexual Abuse, Confirmed, Subsequent Encounter |
| 995.52 | T74.02XA | Child Neglect, Confirmed, Initial Encounter |
| 995.52 | T74.02XD | Child Neglect, Confirmed, Subsequent Encounter |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# SCHOOL VIOLENCE PERPETRATOR

## BEHAVIORAL DEFINITIONS

1. Threats of violence have been made against students, teachers, and/or administrators.
2. Violent or aggressive behavior has been directed toward peers and/or school authority figures.
3. Feels alienated from most peers within the school.
4. Subjected to bullying or intimidation from peers.
5. Subjected to ridicule, teasing, or rejection from peers.
6. Engages in drug or alcohol abuse.
7. Has access to or a fascination with weapons.
8. Has a history of hurting animals.
9. Has a history of conflict with authority figures.
10. Exhibits poor academic performance.
11. Feels disrespected by peers and adults.
12. Lacks close attachment to family members.

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## LONG-TERM GOALS

1. Express hurt and anger in nonviolent ways.
2. Develop trusting relationships with peers.
3. Terminate substance abuse as a means of coping with pain and alienation.

4. Improve degree of connection and involvement with parents, siblings, and extended family.
5. Increase involvement in academic and social activities within the school environment.

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## SHORT-TERM OBJECTIVES

1. Identify attitudes and feelings regarding school experience as well as general emotional status. (1, 2, 3)

## THERAPEUTIC INTERVENTIONS

1. Explore the client's attitude and feelings regarding his/her school experience (e.g., academic performance, peer relationships, staff relationships).
2. Administer or arrange for psychological testing to assess the client's emotional adjustment, especially depth of depression (e.g., *Minnesota Multiphasic Personality Inventory-Adolescent, Millon Adolescent Clinical Inventory,* or *Beck Youth Inventories*); evaluate results and give feedback to the client and his/her parents.
3. Assess the current risk of the client becoming violent (e.g., depth of anger, degree of alienation from peers and family, substance abuse, fascination with and/or access to weapons, articulation of a violence plan, threats made directly or indirectly); notify the proper authorities, if necessary, and take steps to remove the client's access to weapons.

2. Complete a substance abuse evaluation, and comply with the recommendations that are offered by the evaluation findings. (4)

3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8, 9)

4. Arrange for a substance abuse evaluation to assess whether substance abuse problems are contributing to the client's violent behavior; refer him/her for treatment if indicated (see the Substance Use chapter in this *Planner*).

5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder), including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.

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|---|---|
| | 8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment). |
| | 9. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting). |
| 4. Describe social network and degree of support or rejection felt from others. (10, 11) | 10. Develop a sociogram with the client that places friends and other peers in concentric circles, with the client at the center and closest friends on the closest circle; ask him/her to disclose his/her impression of each person. |
| | 11. Explore the client's painful experiences of social rejection by peers; use active listening and unconditional positive regard to encourage sharing of feelings. |
| 5. Identify issues that precipitate peer conflict. (12) | 12. Assist the client in identifying issues that precipitate his/her conflict with peers (or assign "Why I Fight With My Peers" in the *Adolescent Psychotherapy* |

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| | *Homework Planner* by Jongsma, Peterson, and McInnis). |
| 6. Implement problem-solving skills to resolve peer conflict. (13, 14, 15) | 13. Teach the client problem-solving skills (e.g., identify the problem, brainstorm solution options, list pros and cons of each solution, select and implement an option, evaluate the outcome) that can be applied to peer conflict issues (or assign the "Problem-Solving Exercise" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 14. Use role-playing, modeling, and behavioral rehearsal to assist the client in learning the application of social problem-solving skills. |
| | 15. Teach the client means of coping with and improving conflicted peer relationships (e.g., social skills training; outside intervention with bullies; conflict resolution training; reaching out to build new friendships; identifying empathetic resource peers or adults in school to whom the client can turn when hurt, lonely, or angry); discuss the application of these skills to current conflicts (consider supplementing with "Negotiating a Peace Treaty" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 7. Increase participation in structured social activities within the school environment. (16, 17) | 16. Brainstorm with the client possible extracurricular activities he/she might enjoy being involved in; obtain a commitment to pursue one or two of these choices in order to build a positive attitude toward school and peers. |

17. Process the client's experience with increased social involvement; reinforce success and redirect failures.

8. Identify feelings toward family members. (18, 19)

18. Explore the client's relationships with and feelings toward his/her family members; be especially alert to feelings of alienation, isolation, emotional detachment, resentment, distrust, and anger.

19. In a family therapy session, facilitate an exchange of thoughts and feelings that can lead to increased mutual understanding and a reduction in negative feelings.

9. Caregivers and client identify common anger-provoking situations that contribute to loss of control and emergence of violent behavior. (20, 21, 22, 23)

20. Assist the client in recognizing early signs (e.g., tiredness, muscular tension, hot face, hostile remarks) that he/she is starting to become frustrated or agitated so that he/she can take steps to remain calm and cope with frustration.

21. Assist the caregivers and school officials in identifying specific situations or events that routinely lead to the client's explosive outbursts or aggressive behaviors (or assign to the client the "Reasons for Rage" exercise in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). Teach the caregivers and school officials effective coping strategies to help defuse the client's anger and to deter his/her aggressive behavior.

22. Assign the client to read material regarding learning to manage anger more effectively (e.g., *Everything You Need to Know*

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| | *About Anger* by Licata; *The Anger Workbook for Teens: Activities to Help You Deal With Anger and Frustration* by Lohmann and Taylor; or *Don't Let Your Emotions Run Your Life for Teens* by Van Dijk); process the reading with him/her. |
| | 23. Review an incident of threat or actual violent behavior at school and explore triggers, emotions, behaviors, and alternatives that were available (or suggest completion of "School Violence Incident Report" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 10. Identify family issues that contribute to violent behavior. (24) | 24. Conduct family therapy sessions to explore the dynamics (e.g., parental modeling of aggressive behavior; sexual, verbal, or physical abuse of family members; substance abuse in the home; neglect) that may contribute to the emergence of the client's violent behavior. |
| 11. Uninvolved or detached parent(s) increase time spent with the client in recreational, school, or work activities. (25, 26) | 25. Instruct the caregivers to set aside between 5 and 10 minutes each day to listen to the client's concerns and to provide him/her with the opportunity to express his/her anger in an adaptive manner. |
| | 26. Give a directive to uninvolved or disengaged parent(s) to spend more time with the client in leisure, school, or work activities. |
| 12. Increase active involvement in family activities. (27) | 27. Assist the family in identifying several activities they could engage in together, assigning the family to engage in at least one |

structured activity together every week; process the experience.

13. Caregivers increase the frequency of praise and positive reinforcement of the client for demonstrating good control of anger. (28)

28. Design a reward system to help the parents reinforce the client's expression of his/her anger in a controlled manner (or employ the "Anger Control" exercise in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

14. Implement anger management techniques to reduce violent outbursts. (29, 30)

29. Teach the client anger management techniques (e.g., take a time-out, journal feelings, talk to a trusted adult, engage in physical exercise); process his/her implementation of these techniques, reinforcing success and redirecting failure (see the Anger Control Problems chapter in this *Planner*).

30. Refer the client to an anger management group. Direct him/her to self-disclose at least one time in each group therapy session about his/her responses to anger-provoking situations.

15. Write a letter of forgiveness to a perpetrator of hurt. (31)

31. Instruct the client to write a letter of forgiveness to a target of anger in the latter stages of treatment as a step toward letting go of anger; process the letter in a follow-up session, and discuss what to do with the letter.

16. Identify and replace the irrational beliefs or maladaptive thoughts that contribute to the emergence of destructive or assaultive/aggressive behavior. (32)

32. Assist the client in identifying his/her irrational thoughts that contribute to the emergence of violent behavior (e.g., believing that aggression is an acceptable way to deal with teasing or name-calling, justifying acts of violence or aggression as a means to meet his/her needs or

to avoid restrictions). Replace these irrational thoughts with more adaptive ways of thinking to help control anger.

17. Identify and list strengths, interests, or positive attributes. (33, 34)

33. Give the client a homework assignment of identifying between 5 and 10 unique strengths, interests, or positive attributes. Review this list with the client in the following therapy session, and encourage him/her to utilize his/her strengths, interests, or positive attributes to build a positive self-image.

34. Assist the client in taking an inventory of his/her strengths, interests, or accomplishments, then ask him/her to bring objects or symbols to the next therapy session that represent those strengths or interests; encourage him/her to use strengths or interests to build self-esteem (or assign the exercise "Recognizing Your Abilities, Traits, and Accomplishments" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

18. Identify and implement effective strategies to improve self-esteem. (35, 36)

35. Assign the client to view the video entitled *10 Ways to Boost Low Self-Esteem* (available from The Guidance Channel) to learn effective strategies to elevate self-esteem and increase confidence in himself/herself.

36. Instruct the client to complete the exercise entitled "Self-Esteem—What Is It? How Do I Get It?" from *Ten Days to Self-Esteem* (Burns) to help increase his/her self-esteem.

19. Increase the frequency of positive self-descriptive statements. (37, 38)

20. Caregivers increase the frequency of praise and positive reinforcement for the client's prosocial or responsible behaviors. (39, 40)

37. Encourage the client to use positive self-talk (e.g., "I am capable," "I can do this," "I am kind," "I can dance well") as a means of increasing his/her confidence and developing a positive self-image.

38. Instruct the client to make three positive statements about himself/herself daily and record them in a journal (or assign "Positive Self-Talk" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review and reinforce these journal entries in follow-up therapy sessions.

39. Encourage the parents/caregivers and teachers to provide frequent praise and positive reinforcement for the client's prosocial and responsible behavior to help him/her develop a positive self-image (recommend *Positive Discipline for Teenagers: Empowering Your Teens and Yourself Through Kind and Firm Parenting* by Nelsen and Lott; or *The Kazdin Method for Parenting the Defiant Child* by Kazdin).

40. Instruct the parents/caregivers to observe and record between three and five positive responsible behaviors by the client before the next therapy session (or assign the parents "Catch Your Teen Being Responsible" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review these behaviors in the next session, and encourage the client

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| | to continue engaging in these behaviors to boost his/her self-esteem. |
| 21. Caregivers cease making overly hostile, critical remarks, and increase conveying positive messages to the client. (41, 42) | 41. Confront and challenge the parents/caregivers to cease making overly hostile or critical remarks about the client or his/her behavior that only reinforce his/her feelings of low self-esteem. Encourage the caregivers to verbalize the positive, specific behaviors or changes that they would like to see the client make. |
| | 42. Teach the client and his/her parents/caregivers effective communication skills (e.g., practicing active listening, using "I messages," avoiding blaming statements, identifying specific positive changes that other family members can make) to improve the lines of communication, facilitate closer family ties, and resolve conflict more constructively (recommend *How to Talk So Kids Will Listen and Listen So Kids Will Talk* by Faber and Mazlish; or *Parents and Adolescents Living Together* by Patterson and Forgatch). |
| 22. Increase the frequency of positive family activities. (43) | 43. Encourage the parents and client to plan a family activity together that everyone is willing to participate in for the sake of building family cohesiveness (or assign "Plan and Evaluate a Family Activity" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 23. Verbalize increased feelings of genuine empathy for others. (44, 45, 46) | 44. Attempt to sensitize the client to his/her lack of empathy for others by reviewing and listing |

the negative consequences of his/her aggression on others such as loss of trust, increased fear, distancing, or physical pain (or assign "How My Behavior Hurts Others" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

45. Use role reversal techniques to get the client to verbalize the impact of his/her aggression on others.
46. Assign the client to address an empty chair in giving an apology for pain that he/she has caused the victim.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 312.34 | Intermittent Explosive Disorder |
| | 312.30 | Impulse-Control Disorder NOS |
| | 312.8 | Conduct Disorder |
| | 312.9 | Disruptive Behavior Disorder NOS |
| | 314.01 | Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type |
| | 314.9 | Attention-Deficit/Hyperactivity Disorder NOS |
| | V71.02 | Adolescent Antisocial Behavior |
| | V61.20 | Parent-Child Relational Problem |
| | 300.4 | Dysthymic Disorder |
| | 296.xx | Major Depressive Disorder |

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| | 296.89 | Bipolar II Disorder |
| | 296.xx | Bipolar I Disorder |
| | _____ | _____ |
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| **Axis II:** | V799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
| | _____ | _____ |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 312.34 | F63.81 | Intermittent Explosive Disorder |
| 312.9 | F91.9 | Unspecified Disruptive, Impulse Control, and Conduct Disorder |
| 312.89 | F91.8 | Other Specified Disruptive, Impulse Control, and Conduct Disorder |
| 312.81 | F91.1 | Conduct Disorder, Childhood-Onset Type |
| 312.82 | F91.2 | Conduct Disorder, Adolescent-Onset Type |
| 314.01 | F90.1 | Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive/Impulsive Type |
| 314.01 | F90.9 | Unspecified Attention-Deficit/Hyperactivity Disorder |
| 314.01 | F90.8 | Other Specified Attention-Deficit/Hyperactivity Disorder |
| V71.02 | Z72.810 | Child or Adolescent Antisocial Behavior |
| V61.20 | Z62.820 | Parent-Child Relational Problem |
| 300.4 | F34.1 | Persistent Depressive Disorder |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 296.xx | F33.x | Major Depressive Disorder, Recurrent Episode |
| 296.xx | F31.xx | Bipolar I Disorder |
| 296.89 | F31.81 | Bipolar II Disorder |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# SEXUAL ABUSE PERPETRATOR

## BEHAVIORAL DEFINITIONS

1. Arrest and conviction for a sexually related crime, such as exhibitionism, exposure, voyeurism, or criminal sexual conduct (first, second, or third degree).
2. Sexual abuse of a younger, vulnerable victim.
3. Frequent use of language that has an easily noted sexual content.
4. Evident sexualization of most, if not all, relationships.
5. Focus on and preoccupation with anything of a sexual nature.
6. Positive familial history of incest.
7. History of being sexually abused as a child.
8. Interest in pornographic content in books, magazines, videos, and/or on the Internet that is more than mere curiosity.

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## LONG-TERM GOALS

1. Eliminate all inappropriate sexual behaviors.
2. Establish and honor boundaries that reflect a sense of mutual respect in all interpersonal relationships.
3. Form relationships that are not sexualized.
4. Reach the point of genuine self-forgiveness, and make apologies to the violated individual(s), along with an offer of restitution.

5. Acknowledge and take responsibility for all inappropriate sexual behavior.
6. Resolve issues of his/her own sexual abuse.

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## SHORT-TERM OBJECTIVES

1. Develop a working relationship with the therapist that allows for sharing thoughts and feelings openly regarding sexually abusive activity. (1, 2, 3)

## THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with the client in individual sessions through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help increase his/her ability to identify and express feelings.
2. Use a celebrity interview format in which the client is asked nonthreatening questions (e.g., his/her likes and dislikes, best times, favorite holidays) to initiate self-disclosure (or use "Celebrity-Style Interview" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
3. Gather a history of sexual abuse incidents perpetrated by the client, including age and gender of victims; victim grooming practices used; degree of coercion, threat, or violence used; feelings generated during and after the abuse; current thoughts and feelings about the abuse; how abuse came to light; previous treatment; and legal

status or charges pending (supplement with "Getting Started" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

2. Complete psychological testing and comply with the recommendations. (4)

4. Arrange or conduct psychological testing (e.g., *Beck Youth Inventories*) for the client to rule out the presence of psychopathology or other severe emotional issue; interpret the test results for the client and family, emphasizing the importance of following through on each recommendation.

3. Disclose any history of substance use that may contribute to and complicate the treatment of depression. (5)

5. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it.

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9, 10)

6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder), including

vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
10. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

5. Provide a complete sexual history. (11)

11. Gather a thorough sexual history of the client's life from the client and his/her parents.

6. Sign a no-sexual-contact agreement. (12, 13)

12. Assist the client and his/her family in developing and

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| | implementing a behaviorally specific no-sexual-contact agreement; ask the client to sign the agreement. |
| | 13. Monitor the client's no-sexual-contact agreement along with the parents, making any necessary adjustments and giving constructive praise and redirection as warranted; if the client is unable to keep the contract, facilitate a referral to a more restrictive setting. |
| 7. Take full responsibility for perpetrating the sexual abuse. (14, 15) | 14. Process all the incidents of sexual misconduct and/or abuse, focusing on having the client accept responsibility for his/her behavior and the painful impact of the abuse on victims and families (or assign the "Negative Effects of the Abuse" exercise in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 15. Assign an exercise on sexual boundaries from the Safer Society Press Series (see *Pathways: A Guided Workbook for Youth Beginning Treatment* by Kahn) to begin the client's process of education and treatment of his/her offense cycle (or assign the "Getting Started" exercise from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 8. Recognize and honor the personal boundaries of others as shown by the termination of inappropriate sexual contact. (16) | 16. Assist the client in becoming aware of personal space and boundaries and how to honor and respect them; role-play situations with him/her to reinforce and model appropriate actions that show respect for |

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| | personal space (recommend *Where to Draw the Line: How to Set Healthy Boundaries Every Day* by Katherine). |
| 9. Decrease the frequency of sexual references in daily speech and sexual actions in daily behavior. (17, 18) | 17. Point out to the client sexual references and content in his/her speech and behavior; process the feelings and thoughts that underlie these references. |
| | 18. Ask the client to gather feedback from teachers, parents, and so on regarding sexual references in his/her speech and behavior; process the feedback with the client and identify nonsexualized alternatives. |
| 10. Verbally acknowledge ever being a victim of sexual, physical, or emotional abuse. (19) | 19. Gently explore whether the client was sexually, physically, or emotionally abused by asking specific questions regarding others' respect for the client's physical boundaries when he/she was a child (or assign "My Story" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 11. State a connection between being a sexual abuse victim and a sexual abuse perpetrator. (20) | 20. Assist the client in identifying the connections between his/her own sexual abuse victimization and the development of his/her attitudes and patterns of sexual abuse perpetration. |
| 12. Demonstrate the ability to identify and express feelings. (21, 22) | 21. Assist the client in becoming capable of identifying, labeling, and expressing his/her feelings, using various therapeutic tools to increase and reinforce his/her new skills (e.g., The Talking, Feeling, and Doing Game by Gardner, available from Creative Therapeutics; or The |

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| | Ungame by Zakich, available from the Ungame Company; or assign "Your Feelings and Beyond" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 22. Give feedback to the client when he/she does not show awareness of his/her own feelings or those of others, and positive verbal reinforcement when he/she shows awareness without direction. |
| 13. Tell the story of being a victim of sexual, physical, or emotional abuse with appropriate affect. (23, 24) | 23. Encourage and support the client in telling the story of being a sexual, physical, or emotional abuse victim (see the Sexual Abuse Victim or Physical/ Emotional Abuse Victim chapters in this *Planner*). |
| | 24. Prepare, assist, and support the client in telling his/her parents of his/her own abuse experiences. |
| 14. Attend a sexual abuse perpetrators' group treatment. (25) | 25. Refer the client to group treatment for adolescent sexual abuse perpetrators. |
| 15. Identify thinking errors, feelings, and beliefs that give justification for sexual abuse and ways to handle each effectively. (26) | 26. Assist the client in identifying thoughts and beliefs that he/she used as justification for the abuse; assist him/her in identifying socially acceptable thoughts that are respectful, not exploitive, of others. |
| 16. Complete a psychiatric evaluation for medications. (27) | 27. Refer the client for a psychiatric evaluation as to the need for psychotropic medication. |
| 17. Take the prescribed medications to control impulses, decrease aggression, or stabilize mood. (28) | 28. Monitor the client's psychotropic medication prescription compliance, effectiveness, and side effects. |

18. Develop and utilize anger management techniques. (29, 30)

29. Encourage the client to read workbooks on anger management (e.g., *The Anger Control Workbook* by McKay and Rogers; *The Anger Workbook for Teens: Activities to Help You Deal with Anger and Frustration* by Lohmann and Taylor; or *The Anger Workout Book for Teens* by Stewart) to learn to recognize anger and ways to effectively handle these feelings (or assign the "Anger Control" exercise in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

30. Refer the client to a group focused on teaching anger management techniques.

19. Increase the formation of positive peer relationships. (31, 32, 33)

31. Assist the client in identifying specific ways he/she can become more involved with peers (e.g., join sports, music, art, hobby, or church youth groups; invite peers over to watch a DVD/video); role-play these situations to build the client's skill and confidence level in initiating these actions.

32. Ask the client to attempt one new social or recreational activity each week and/or to engage a peer in conversation (5 minutes) once daily (or assign "Developing Conversational Skills" or "Greeting Peers" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); process the experience and the results.

33. Assign the client to read material to help build his/her awareness of what is appropriate

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| | and inappropriate behavior when interacting with the opposite sex (e.g., *Dating for Dummies* by Browne; *The Complete Idiot's Guide to Dating* by Kuriansky). |
| 20. Verbalize reasonable guidelines to follow to avoid unhealthy, abusive relationships. (34) | 34. Teach the client the SAFE formula for relationships: Avoid a relationship if there is anything *S*ecret about it, if it is *A*busive to oneself or others, if it is used to avoid *F*eelings, or if it is *E*mpty of caring and commitment; monitor his/her use of the SAFE formula and give feedback and redirection as required. |
| 21. Parents verbalize awareness of the patterns, beliefs, and behaviors that support the client's sexual behavior. (35, 36) | 35. Conduct a family session in which a genogram is developed that depicts patterns of interaction and identifies family members who are sexual abuse survivors or perpetrators, or who have been involved in other sexual deviancy. |
| | 36. Hold family sessions in which sexual patterns, beliefs, and behaviors are explored; assist the family members in identifying what sexual patterns, beliefs, or behaviors need to be changed and how they can begin to change them. |
| 22. Parents verbalize changes they are trying to make to improve their parenting patterns. (37, 38, 39) | 37. Conduct family sessions in which structural interventions are developed and implemented by the family (e.g., family members begin closing doors for privacy within their home, remove children from roles as supervisors of siblings, terminate sexual references within family conversation). |

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| | 38. Recommend that the parents attend a didactic group on parenting teenagers. |
| | 39. Suggest that the parents read material to expand their understanding of adolescents and to build parenting skills (e.g., *Parenting Teens with Love and Logic* by Cline and Fay; *The Everything Parent's Guide to Positive Discipline* by Pickhardt; *Parents and Adolescents Living Together* by Patterson and Forgatch; *The Kazdin Method for Parenting the Defiant Child* by Kazdin; *Parents, Teens, and Boundaries* by Bluestein; *The 7 Habits of Highly Effective Families* by Covey). |
| 23. Parents develop and implement new family rituals. (40) | 40. Assist the parents and family members in developing rituals of transition, healing, membership, identity, and new beginnings that give structure, meaning, and connection to their family. |
| 24. Report instances of increased awareness of the feelings of others. (41) | 41. Teach the client the importance of expanding his/her awareness of the feelings of others (or assign the exercise "How I Have Hurt Others" from the *Adult Psychotherapy Homework Planner* by Jongsma). |
| 25. Report an increase in appropriate sexual fantasies. (42, 43) | 42. Ask the client to keep a fantasy journal, recording daily what sexual fantasies are experienced (or assign "Journal of Sexual Thoughts, Feelings, and Conflicts" from the *Adult Psychotherapy Homework Planner* by Jongsma); review the fantasies for patterns that are appropriate or inappropriate, and process this feedback with the client. |

43. Assist the client in creating appropriate sexual fantasies that involve consenting, age-appropriate individuals; reflect feelings for the other party, and reject fantasies that involve receiving or inflicting pain.

26. Verbalize a desire to make an apology to his/her victim(s). (44, 45, 46)

44. Explore the client's attitude regarding apologizing to his/her victim(s) and forgiving himself/herself (or assign the exercise "Perpetrator Apology to the Victim" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

45. Ask the client to write a letter of apology to one of his/her victims; assess the genuineness of the remorse and guilt present, and give the client feedback.

46. Role-play the client's apology to the victim of sexual abuse to determine if he/she is ready for this step or what additional work may need to be done for him/her to reach that point; use role reversal to sensitize the client to the victim's feelings and reactions.

27. Make an apology to the sexual abuse survivor and the family. (47)

47. Conduct a family session with the families of both the perpetrator and the survivor in which the perpetrator apologizes to the survivor and his/her family.

28. Identify relapse triggers for perpetrating sexual abuse and list strategies to cope with them. (48)

48. Help the client to identify his/her potential relapse triggers (e.g., environmental situations, fantasies, sexually explicit material); assist him/her in developing behavioral and cognitive coping strategies to

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| | implement for each trigger such as avoidance or removing himself/herself from high-risk situations, thought-stopping of inappropriate fantasies, or avoiding being alone with young children (or supplement with "Thought-Stopping" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 29. Develop and implement an aftercare plan that includes the support of the family. (49, 50) | 49. Ask the client and his/her family to develop a written aftercare plan (e.g., relapse prevention strategies, periodic checkups with therapist, support group participation, legal obligations); process the plan in a family session and make adjustments as necessary (supplement with "Evaluating My Treatment Progress" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 50. Hold checkup sessions in which the aftercare plan is reviewed for effectiveness and follow-through; give feedback and make adjustments as necessary. |
| 30. Comply with any investigations by child protective services or criminal justice officials. (51) | 51. Report to the appropriate authorities any criminal sexual abuse that comes to light. Ask the client to share the results of the resulting investigation, and then process the results in a session that focuses on the client taking full responsibility for his/her inappropriate sexual behavior(s). |

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 312.81 | Conduct Disorder, Childhood-Onset Type |
| | 312.82 | Conduct Disorder, Adolescent-Onset Type |
| | 302.2 | Pedophilia |
| | 302.4 | Exhibitionism |
| | 302.82 | Voyeurism |
| | V61.8 | Sibling Relational Problem |
| | 995.53 | Sexual Abuse of Child (Victim) |
| | V71.02 | Child or Adolescent Antisocial Behavior |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
| | _____ | _____ |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 312.81 | F91.1 | Conduct Disorder, Childhood-Onset Type |
| 312.82 | F91.2 | Conduct Disorder, Adolescent-Onset Type |
| 302.2 | F65.4 | Pedophilic Disorder |
| 302.4 | F65.2 | Exhibitionistic Disorder |
| 302.82 | F65.3 | Voyeuristic Disorder |
| V61.8 | Z62.891 | Sibling Relational Problem |
| 995.53 | T74.22XA | Child Sexual Abuse, Confirmed, Initial Encounter |
| 995.53 | T74.22XD | Child Sexual Abuse, Confirmed, Subsequent Encounter |

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| V62.83 | Z69.021 | Encounter for Mental Health Services for Perpetrator of Nonparental Child Sexual Abuse |
| V71.02 | Z72.810 | Child or Adolescent Antisocial Behavior |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# SEXUAL ABUSE VICTIM

## BEHAVIORAL DEFINITIONS

1. Self-report of being sexually abused.
2. Physical signs of sexual abuse (e.g., red or swollen genitalia, blood in the underwear, constant rashes, a tear in the vagina or rectum, venereal disease, hickeys on the body).
3. Vague memories of inappropriate childhood sexual contact that can be corroborated by significant others.
4. Strong interest in or curiosity about advanced knowledge of sexuality.
5. Pervasive pattern of promiscuity or the sexualization of relationships.
6. Recurrent and intrusive distressing recollections or nightmares of the abuse.
7. Acting or feeling as if the sexual abuse were reoccurring (including delusions, hallucinations, or dissociative flashback experiences).
8. Unexplainable feelings of anger, rage, or fear when coming into contact with the perpetrator or after exposure to sexual topics.
9. Pronounced disturbance of mood and affect (e.g., frequent and prolonged periods of depression, irritability, anxiety, and fearfulness).
10. Marked distrust of others as manifested by social withdrawal and problems with establishing and maintaining close relationships.
11. Feelings of guilt, shame, and low self-esteem.
12. Excessive use of alcohol or drugs as a maladaptive coping mechanism to avoid dealing with painful emotions connected to sexual abuse.
13. Sexualized or seductive behavior with younger or same-aged children, adolescents, or adults (e.g., sexualized kissing, provocative exhibition of genitalia, fondling, mutual masturbation, anal or vaginal penetration).

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## LONG-TERM GOALS

1. Obtain protection from all further sexual victimization.
2. Work successfully through the issue of sexual abuse with consequent understanding and control of feelings and behavior.
3. Resolve the issues surrounding the sexual abuse, resulting in an ability to establish and maintain close interpersonal relationships.
4. Establish appropriate boundaries and generational lines in the family to greatly minimize the risk of sexual abuse ever occurring in the future.
5. Achieve healing within the family system as evidenced by the verbal expression of forgiveness and a willingness to let go and move on.
6. Eliminate denial in self and the family, placing responsibility for the abuse on the perpetrator and allowing the survivor to feel supported.
7. Eliminate all inappropriate promiscuous or sexual behaviors.
8. Build self-esteem and a sense of empowerment as manifested by an increased number of positive self-descriptive statements and greater participation in extracurricular activities.

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## SHORT-TERM OBJECTIVES

1. Tell the entire story of the abuse. (1, 2)

## THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with the client through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help increase his/her ability to identify and express feelings connected to the abuse.
2. Explore, encourage, and support the client in verbally expressing the facts and clarifying his/her feelings associated with the abuse (or assign the exercise "My Story" in the *Adolescent*

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| | *Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 2. Complete a substance abuse evaluation and comply with the recommendations offered by the evaluation findings. (3) | 3. Arrange for a substance abuse evaluation and/or treatment for the client (see the Substance Use chapter in this *Planner*). |
| 3. Complete psychological testing. (4, 5) | 4. Arrange for psychological testing of the client to rule out the presence of severe psychological disorders (see Posttraumatic Stress Disorder chapter, if indicated, in this *Planner*). |
| | 5. Assess the client's self-esteem by having him/her draw self-portraits during the beginning, middle, and end stages of therapy. |
| 4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9, 10) | 6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change). |
| | 7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder), including vulnerability to suicide, if appropriate |

(e.g., increased suicide risk when comorbid depression is evident).

8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
10. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

5. Verbalize an understanding that criminal justice and protective services officials must be notified of the sexual abuse. (11, 12, 13)

11. Report the client's sexual abuse to the appropriate child protection agency, criminal justice officials, or medical professionals.
12. Consult with a physician, criminal justice officials, or child

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| | protection case managers to assess the veracity of the sexual abuse charges. |
| | 13. Consult with the physician, criminal justice officials, or child protection case managers to develop appropriate treatment interventions for the client. |
| 6. Decrease secrecy in the family by informing key members about the abuse. (14, 15) | 14. Facilitate conjoint sessions to reveal the client's sexual abuse to key family members or caregivers. |
| | 15. Actively confront and challenge denial of the client's sexual abuse within the family system (supplement with "Denial Within the Family" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 7. Implement steps to protect the client from further sexual abuse. (16, 17, 18, 19) | 16. Assess whether the perpetrator should be removed from the home. |
| | 17. Implement the necessary steps to protect the client and other children in the home from future sexual abuse. |
| | 18. Assess whether the client is safe to remain in the home or should be removed. |
| | 19. Empower the client by reinforcing steps necessary to protect himself/herself. |
| 8. Parents establish and adhere to appropriate intimacy boundaries within the family. (20) | 20. Counsel the client's family members about appropriate intimacy and privacy boundaries. |
| 9. Identify family dynamics or stressors that contributed to the emergence of sexual abuse. (21, 22, 23) | 21. Assess the family dynamics and identify the stress factors or precipitating events that contributed to the emergence of the client's abuse. |

22. Assign the client to draw a diagram of the house where the abuse occurred, indicating where everyone slept, and share the diagram with the therapist.
23. Construct a multigenerational family genogram that identifies sexual abuse within the extended family to help the client realize that he/she is not the only one abused and to help the perpetrator recognize the cycle of boundary violation.

10. Identify and express the consequences and feelings connected to the abuse. (24, 25, 26, 27)

24. Assist the client in describing the impact that the sexual abuse has had on his/her life.
25. Utilize the empty-chair technique to assist the client in expressing and working through his/her myriad feelings toward the perpetrator and other family members.
26. Direct the client to keep a journal in which he/she records experiences or situations that evoke strong emotions pertaining to sexual abuse, and share the journal in therapy sessions.
27. Use guided fantasy and imagery techniques to help the client express suppressed thoughts, feelings, and unmet needs associated with sexual abuse.

11. Cooperate in using art therapy techniques in expressing feelings about the sexual abuse. (28, 29)

28. Employ art therapy (e.g., drawing, painting, sculpting) to help the client identify and express his/her feelings toward the perpetrator.
29. Encourage the client to create a drawing or sculpture that reflects how sexual abuse impacted

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| | his/her life and feelings about himself/herself. |
| 12. Decrease expressed feelings of shame and guilt and affirm self as not being responsible for the abuse. (30) | 30. Explore and resolve the client's feelings of guilt and shame connected to the sexual abuse (or assign the "You Are Not Alone" exercise in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 13. Nonabusive parent and other key family members increase support and acceptance of client. (31, 32, 33) | 31. Elicit and reinforce support and nurturance for the client from other key family members.<br>32. Assign the parents and family members reading material to increase their knowledge of sexually addictive behavior and learn ways to help the client recover from sexual abuse (e.g., *Out of the Shadows* by Carnes).<br>33. Give directive to disengaged, nonabusive parent to spend more time with the client in leisure, school, or household activities. |
| 14. Perpetrator takes responsibility for the abuse. (34, 35) | 34. Hold a therapy session in which the client and/or the therapist confronts the perpetrator with the abuse.<br>35. Hold a session in which the perpetrator takes full responsibility for the sexual abuse and apologizes to the client and/or other family members (or assign first to the perpetrator "Perpetrator Apology to the Victim" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 15. Perpetrator agrees to seek treatment. (36) | 36. Require the perpetrator to participate in a sexual offenders' group. |

16. Verbalize a desire to begin the process of forgiveness of the perpetrator and others connected with the abuse. (37, 38)

17. Verbally identify self as a survivor of sexual abuse. (39, 40)

18. Attend and actively participate in group therapy with other sexual abuse survivors. (41)

19. Increase the level of trust of others as shown by increased socialization and a greater number of friendships. (42, 43, 44)

37. Assign the client to write a forgiveness letter and/or complete a forgiveness exercise in which he/she verbalizes forgiveness to the perpetrator and/or significant family members (or assign the "Letter of Forgiveness" exercise in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); process the letter before any decision is reached whether to ever read it to the perpetrator.

38. Assign the client a letting-go exercise in which a symbol of the abuse is disposed of or destroyed; process this experience.

39. Ask the client to identify the positive and negative consequences of being a victim versus being a survivor; compare and process the lists.

40. Introduce the idea in later stages of therapy that the client can survive sexual abuse by the therapist asking, "What will you be doing in the future that shows you are happy and have moved on with your life?" Process his/her responses and reinforce any positive steps that he/she can take to work through issues related to victimization.

41. Refer the client to a survivor group with other adolescents to assist him/her in realizing that he/she is not alone in having experienced sexual abuse.

42. Teach the client the share-check method of building trust, in which the degree of shared information is related to a proven level of trustworthiness.

43. Identify appropriate and inappropriate forms of touching and affection; encourage the client to accept and initiate appropriate forms of touching with trusted individuals.

44. Develop a list of resource people outside of the family to whom the client can turn for support, guidance, and affirmation.

20. Decrease the frequency of sexualized or seductive behaviors in interactions with others. (45, 46)

45. Assist the client in making a connection between underlying painful emotions (e.g., fear, hurt, sadness, anxiety) and sexualized or seductive behaviors; help the client identify more adaptive ways to meet his/her needs other than through seductive or sexually promiscuous behaviors.

46. Provide sex education and discuss the risks involved with sexually promiscuous or seductive behaviors.

21. Parents comply with recommendations regarding psychiatric or substance abuse treatment. (47)

47. Assess the parents for the possibility of having a psychiatric disorder and/or substance abuse problem; refer the parents for psychiatric or substance abuse evaluation and/or treatment if it is found that the parents have psychiatric disorders or substance abuse problems.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 309.81 | Posttraumatic Stress Disorder |
| | 308.3 | Acute Stress Disorder |
| | 296.xx | Major Depressive Disorder |
| | 309.21 | Separation Anxiety Disorder |
| | 995.53 | Sexual Abuse of Child (Victim) |
| | 307.47 | Nightmare Disorder |
| | 300.15 | Dissociative Disorder NOS |
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| **Axis II:** | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
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| 309.81 | F43.10 | Posttraumatic Stress Disorder |
| 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 |
| 309.21 | F93.0 | Separation Anxiety Disorder |
| 995.53 | T74.22XA | Child Sexual Abuse, Confirmed, Initial Encounter |
| 995.53 | T74.22XD | Child Sexual Abuse, Confirmed, Subsequent Encounter |
| 307.47 | F51.5 | Nightmare Disorder |
| 300.15 | F44.89 | Other Specified Dissociative Disorder |
| 300.15 | F44.9 | Unspecified Dissociative Disorder |

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# SEXUAL IDENTITY CONFUSION[1]

## BEHAVIORAL DEFINITIONS

1. Uncertainty about sexual orientation.
2. Sexual fantasies and desires about same-sex partners that cause distress.
3. Feelings of guilt, shame, and/or worthlessness.
4. Depressed mood; diminished interest in activities.
5. Concealment of sexual identity from parents.
6. Recent homosexual experimentation that has created questions about sexual orientation.
7. Parents verbalize distress over concern that the client may be homosexual.
8. Recent disclosure of homosexual identity to parents.
9. Parents express feelings of failure because the client is gay/lesbian.

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## LONG-TERM GOALS

1. Clarify own sexual identity and engage in a wide range of relationships that are supportive of same.
2. Reduce overall frequency and intensity of the anxiety associated with sexual identity so that daily functioning is not impaired.

[1] Most of the content of this chapter (with only slight revisions) originates from J. M. Evosevich and M. Avriette, *The Gay and Lesbian Treatment Planner* (Hoboken, NJ: Wiley, 1999). Copyright © 1999 by J. M. Evosevich and Michael Avriette. Reprinted with permission.

3. Disclose sexual orientation to parents.
4. Return to previous level of emotional, psychological, and social functioning.
5. Parents accept the client's homosexuality.
6. Resolve all symptoms of depression (e.g., depressed mood, guilt, shame, worthlessness).

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## SHORT-TERM OBJECTIVES

1. Describe fear, anxiety, and distress related to confusion over sexual identity. (1)
2. Openly discuss history of sexual desires, fantasies, and experiences. (2)
3. Verbalize reasons for questioning own sexual identity. (3, 4)
4. Cooperate with a psychological assessment. (5)

## THERAPEUTIC INTERVENTIONS

1. Actively build trust with the client and encourage the expression of fear, anxiety, and distress over his/her sexual identity confusion.
2. Assess the client's current sexual functioning by asking about his/her history of sexual experiences, fantasies, and desires.
3. Ask the client why he/she has questions about his/her sexuality, with specific questions about when he/she began to question his/her sexuality and why.
4. Educate the client about the commonality of same-sex experiences in youth and emphasize that these do not necessarily indicate a homosexual identity.
5. Administer psychological testing (e.g., *Minnesota Multiphasic Personality Inventory-Adolescent,*

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| | *Millon Adolescent Clinical Inventory,* or *Beck Youth Inventories*) to assess the client's emotional status and rule out serious mental health issues. |
| 5. Disclose any suicidal thoughts, actions, or plans. (6, 7) | 6. Conduct a suicide assessment and refer the client to the appropriate supervised level of care if a danger to self exists.<br>7. Encourage the client to verbalize and then sign a no-harm contract. |
| 6. Disclose any history of substance use that may contribute to and complicate the treatment of sexual identity confusion. (8) | 8. Arrange for a substance abuse evaluation and refer the client for chemical dependence treatment if the evaluation recommends it. |
| 7. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (9, 10, 11, 12, 13) | 9. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).<br>10. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder), including vulnerability to suicide, if appropriate (e.g., increased suicide risk |

when comorbid depression is evident).

11. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
12. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
13. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

8. Rate sexual attraction to males and females on a scale of 1 to 10. (14)

14. Have the client rate his/her sexual attraction to males and females on a scale of 1 to 10 with 10 being extremely attracted and 1 being not at all attracted (or supplement with "Unsure" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); process

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| | the results as to the implications for his/her sexual identity. |
| 9. Write a future biography detailing life as a heterosexual and as a homosexual to assist self in identifying primary orientation. (15) | 15. Assign the client the homework of writing a future biography describing his/her life 20 years in the future, both as a heterosexual and as a homosexual; read and process this biography (e.g., ask the client which life was more satisfying and which life had more regrets). |
| 10. Resolve sexual identity confusion by identifying self as homosexual or heterosexual. (16, 17) | 16. Allow the client to evaluate all the evidence from his/her experience in a nonjudgmental atmosphere so as to resolve his/her confusion and identify himself/herself as homosexual or heterosexual. |
| | 17. Ask the client to list all the factors that led to a decision regarding his/her sexual identity; process the list. |
| 11. Identify and verbalize feelings related to identifying self as gay or lesbian. (18, 19) | 18. Explore the client's feelings regarding seeing himself/herself as homosexual. |
| | 19. Explore the client's negative emotions (e.g., shame, guilt, anxiety, loneliness) related to hiding or denying his/her homosexuality. |
| 12. Verbalize an understanding of how religious beliefs have contributed to hiding or denying sexual orientation. (20, 21) | 20. Explore the client's religious convictions and how these may conflict with identifying himself/herself as homosexual and cause feelings of shame or guilt. |
| | 21. Refer the client to a member of the clergy who will listen compassionately to the client's religious struggle over his/her homosexual identity. |
| 13. Verbalize an understanding of safer-sex practices. (22) | 22. Teach the client the details of safer-sex guidelines. |

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| 14. List myths about homosexuals and replace them with more realistic, positive beliefs. (23) | 23. Assist the client in identifying myths about homosexuals (e.g., bad parenting causes homosexuality, homosexuals are never happy) and assist him/her in replacing them with more realistic, positive beliefs (e.g., there is no evidence that parenting causes homosexuality; gay men and lesbians can be as happy as heterosexuals). |
| 15. Describe social interaction with peers and identify any isolation and/or homophobia experienced because of having a homosexual identity. (24, 25) | 24. Explore the client's relationships with peers and assist him/her in describing any homophobic experiences and/or isolation as well as the feelings associated with these experiences.<br>25. Encourage the client to identify other lesbian and gay adolescents to interact with by reviewing people he/she has met in support groups, at school, or on a job, and encourage him/her to initiate social activities. |
| 16. Attend a support group for gay and lesbian adolescents. (26) | 26. Refer the client to a lesbian and gay adolescent support group (e.g., Gay and Lesbian Community Service Center, Youth Services). |
| 17. List the advantages and disadvantages of disclosing one's sexual orientation to significant people in one's life. (27) | 27. Assign the client to list advantages and disadvantages of disclosing his/her sexual orientation to family members and other significant people in his/her life; process the list. |
| 18. Write a plan detailing when, where, and to whom sexual orientation is to be disclosed. (28, 29) | 28. Assign the client homework to write a detailed plan to disclose his/her sexual orientation, including where, when, and to whom it will be disclosed, and possible questions and reactions the recipient might have (consider assigning "Disclosing |

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| | Homosexual Orientation" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 29. Have the client role-play within the session the disclosure of his/her sexual orientation to significant others; process the thoughts and feelings generated. |
| 19. Reveal sexual orientation to family members according to the written plan. (30, 31) | 30. Encourage the client to disclose his/her sexual orientation to family members according to the previously written plan. |
| | 31. Probe the client about the reactions of significant others to his/her disclosure of homosexuality; provide encouragement and positive feedback. |
| 20. Parents attend conjoint sessions that focus on resolving their feelings about the client's disclosure of his/her homosexual orientation. (32, 33) | 32. Arrange conjoint sessions that allow for a free exchange of thoughts and feelings within the family while the client discloses his/her gay orientation; encourage the client's parents to attend and participate. |
| | 33. Explore the emotional reactions of the parents to the client's disclosure of his/her homosexuality (or assign "Parents' Thoughts and Feelings About Son/Daughter's Sexual Orientation" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 21. Parents verbalize an increased understanding of homosexuality. (34, 35) | 34. Educate the parents about homosexuality and answer questions they may have in an honest, direct manner (e.g., assure the parents that homosexuality is not caused by |

faulty parenting, nor is it considered a mental illness).

35. Assign the parents books that offer positive, realistic information about homosexuality and homosexual adolescents (e.g., *Is It a Choice?* by Marcus; *Beyond Acceptance: Parents of Lesbians and Gays Talk about Their Experiences* by Griffin, Wirth, and Wirth; *Coming Out, Coming Home: Helping Families Adjust to a Gay or Lesbian Child* by LaSala; *Always My Child: A Parent's Guide to Understanding Your Gay, Lesbian, Bisexual, Transgendered or Questioning Son or Daughter* by Jennings).

22. Parents attend a support group for families of homosexuals. (36)

36. Refer the parents to a support group for families of homosexuals (e.g., Parents and Friends of Lesbians and Gays [PFLAG]) and encourage their attendance.

23. Parents identify any religious beliefs that contribute to rejecting the client's homosexuality. (37)

37. Probe the parents about the impact of their religious beliefs on accepting their child's homosexuality.

24. Parents verbalize an understanding that many religious leaders are accepting of homosexuals. (38, 39)

38. Refer the parents to gay/lesbian-positive clergy to discuss their concerns.

39. Assign the parents to read Chapter 4 in *Beyond Acceptance* by Griffin, Wirth, and Wirth and "The Bible and Homosexuality: The Last Prejudice" in *The Good Book* by Gomes; process their reactions to the material read.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 309.0 | Adjustment Disorder With Depressed Mood |
| | 309.28 | Adjustment Disorder With Mixed Anxiety and Depressed Mood |
| | 300.00 | Anxiety Disorder NOS |
| | 309.24 | Adjustment Disorder With Anxiety |
| | 300.4 | Dysthymic Disorder |
| | 302.85 | Gender Identity Disorder in Adolescents or Adults |
| | 300.02 | Generalized Anxiety Disorder |
| | 313.82 | Identity Problem |
| | 296.2x | Major Depressive Disorder, Single Episode |
| | 296.3x | Major Depressive Disorder, Recurrent |
| | V62.89 | Phase of Life Problem |
| | V61.20 | Parent-Child Relational Problem |
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| **Axis II:** | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
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| 309.0 | F43.21 | Adjustment Disorder With Depressed Mood |
| 309.28 | F43.23 | Adjustment Disorder With Mixed Anxiety and Depressed Mood |
| 300.00 | F41.9 | Unspecified Anxiety Disorder |
| 309.24 | F43.22 | Adjustment Disorder With Anxiety |
| 300.4 | F34.1 | Persistent Depressive Disorder |

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| 302.85 | F64.1 | Gender Dysphoria in Adolescents and Adults |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 296.2x | F32.x | Major Depressive Disorder, Single Episode |
| 296.3 | F33.x | Major Depressive Disorder, Recurrent Episode |
| V62.89 | Z60.0 | Phase of Life Problem |
| V61.20 | Z62.820 | Parent-Child Relational Problem |

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# SEXUAL PROMISCUITY

## BEHAVIORAL DEFINITIONS

1. Engagement in sexual intercourse with several different partners with little or no emotional attachment.
2. Engagement in sexual intercourse without birth control and without being at a stage of development to take responsibility for a baby.
3. Sexually active with one partner but with no sense of long-term commitment to each other.
4. No utilization of safer-sex practices.
5. Routine public engagement in sexually provocative dress, language, and behavior.
6. Talking freely of own sexual activity without regard for consequences to reputation or loss of respect from others.
7. Use of drugs and/or alcohol to alter mood and judgment prior to and during sexual activity.
8. Low self-esteem evidenced by self-disparaging remarks and predictions of future failure.
9. Depression evidenced by irritability, social isolation, low energy, and sad affect.
10. Hypomania evidenced by impulsivity, high energy, lack of follow-through, and pressured speech.
11. Angry, oppositional pattern of behavior that is in conflict with social mores, parental rules, and authority figures.
12. Conflict and instability within the family of origin.

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## LONG-TERM GOALS

1. Terminate sexual activity that does not reflect commitment, emotional intimacy, and a caring, mature relationship.
2. Implement birth control and safer-sex practices.
3. Develop insight into the maladaptive sexual activity as self-defeating and emanating from emotional needs and conflicts not related to sex.
4. Resolve underlying emotional conflicts that energize the maladaptive sexual activity.
5. Terminate substance abuse and understand its interaction with sexual promiscuity.
6. Resolve family-of-origin conflicts.

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## SHORT-TERM OBJECTIVES

1. Acknowledge history and current practice of sexual activity. (1, 2, 3)

## THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with the client in individual sessions through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help increase his/her ability to identify and express intimate facts and feelings.
2. Gather a detailed sexual history that includes number of partners, frequency of activity, birth control and/or safer-sex practices used, source of sexual information in childhood, first sexual experience, and degree of emotional attachment to partner.
3. Explore the client's thoughts and feelings that surround the facts

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| | of the sexual history and current practice. |
| 2. Disclose any history of substance use that may contribute to and complicate the treatment of depression. (4) | 4. Explore for the client's use of mood-altering drugs or alcohol before or during sexual activity; assess whether there are indications of ongoing substance abuse that would indicate a need for focused substance abuse treatment (see the "Substance Use" chapter in this *Planner*). |
| 3. Cooperate with psychological testing. (5, 6) | 5. Administer or arrange for psychological testing to assess for emotional or personality factors that may contribute to the client's sexual behavior. |
| | 6. Assess the client for signs or symptoms of depression or mania that could be influencing sexual behavior (see the Unipolar Depression chapter in this *Planner*). |
| 4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10, 11) | 7. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change). |
| | 8. Assess the client for evidence of research-based correlated disorders (e.g., oppositional |

defiant behavior with ADHD, depression secondary to an anxiety disorder), including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

9. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
10. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
11. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

5. Identify any and all known motivations for sexual activity. (12, 13)

12. Ask the client to list all possible reasons he/she has chosen to engage in sexual activity at this

early stage of life and why specific partners were selected (suggest the client complete the exercise "Looking Closer at My Sexual Behavior" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

13. Process the pros and cons of each reason given for the client's sexual activity (or assign "Pros and Cons of Having Sex" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

6. Disclose any history of sexual abuse that has occurred in childhood or adolescence and its effect on current sexual activity. (14, 15)

14. Explore for any history of the client having been sexually abused (see the Sexual Abuse Victim chapter in this *Planner*).

15. Assist the client in making a connection between being treated as a sexual object in childhood by a perpetrator and treating himself/herself and others as impersonal sexual objects currently (supplement with "Negative Effects of the Sexual Abuse" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

7. Verbalize insight into the sources and impact of low self-esteem. (16, 17, 18, 19, 20)

16. Explore the client's feelings of low self-esteem as to his/her awareness of it, depth of feeling, and means of expression (see the Low Self-Esteem chapter in this *Planner*).

17. Assist the client in identifying sources of his/her feelings of low self-esteem (e.g., perceived parental criticism or rejection; physical, sexual, or emotional

abuse; academic or social failures).

18. Help the client become aware of his/her fear of rejection and its connection with past rejection or abandonment experiences.
19. Assist the client in making a connection between his/her feelings of low self-esteem, fear of rejection, and current sexual activity (or suggest "Connecting Sexual Behavior with Needs" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
20. Interpret the client's sexual activity as a means of seeking relief from depression that only ends up deepening his/her depression.

8. Identify positive ways to build self-esteem. (21, 22)

21. Confront the self-defeating nature of trying to build self-esteem or gain acceptance through sexual activity, and assist the client in developing a constructive plan to build self-esteem (suggest the exercise "Maintaining Your Self-Esteem" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
22. Assign the client a homework exercise in which he/she is asked to draw pictures of the desired changes to himself/herself (or assign "Three Ways to Change Yourself" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

9. Describe family interaction patterns that may lead to feelings of rejection. (23, 24, 25)

23. Explore the dynamics of rejection versus affirmation present in the client's family of origin.

24. Hold family therapy sessions that focus on the family members' feelings toward each other and their style of interacting.

25. Interpret the client's sexual activity as a maladaptive means of seeking affirmation and attention that has been missed in the family; encourage the parents to maximize positive parenting methods (suggest *Parents and Adolescents Living Together* by Patterson and Forgatch, *The Everything Parent's Guide to Positive Discipline* by Pickhardt, *Self Esteem for a Lifetime* by Schweiger, or *Positive Discipline for Teenagers* by Nelsen and Lott).

10. Verbalize a value for sexual activity beyond physical pleasure and/or trying to "get someone to like you." (26, 27)

26. Teach the value of reserving sexual intimacy for a relationship that has commitment, longevity, and maturity.

27. Teach that sexual activity is most rewarding when it is a mutual expression of giving oneself as an act of love versus being sexual to try to get someone to love you or only to meet your own needs for pleasure or conquest.

11. Verbalize an understanding of the serious risks involved in not using birth control or safer-sex practices and affirm implementation of same. (28, 29)

28. Teach the client the value of using birth control and safer-sex practices.

29. Explore any underlying wishes (e.g., pregnancy, death) that have influenced the client's maladaptive behavior in not using birth control or safer-sex practices.

12. Admit that the use of drugs and/or alcohol before or during sexual activity is done to escape from feelings of shame, guilt, or fear. (30)

13. Terminate the use of mood-altering drugs and alcohol. (31)

14. Describe a pattern of impulsive behaviors that lead to negative consequences. (32)

15. Cooperate with an assessment for psychotropic medication. (33, 34)

16. Take medications as prescribed and report as to effectiveness and side effects. (35)

30. Assist the client in identifying the role of drugs or alcohol as a means of numbing his/her conscience and escaping feelings of shame, fear, and guilt associated with sexual acting out.

31. Ask the client for a commitment to terminate the use of drugs and alcohol (see the Substance Use chapter in this *Planner*).

32. Assess the client for a pattern of impulsivity that may characterize many aspects of his/her behavior and that may be related to ADHD or mania (see the Attention-Deficit/Hyper-activity Disorder and Bipolar Disorder chapters in this *Planner*).

33. Assess the client for the need for psychotropic medications to alleviate the factors underlying his/her maladaptive sexual activity (e.g., depression, mania, ADHD).

34. Refer the client to a physician to be evaluated for a prescription for psychotropic medication.

35. Monitor the client's compliance with medication and assess for effectiveness and side effects.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 296.xx | Major Depressive Disorder |
| | 300.4 | Dysthymic Disorder |
| | 296.89 | Bipolar II Disorder |
| | 296.4x | Bipolar I Disorder, Most Recent Episode Manic |
| | 303.90 | Alcohol Dependence |
| | 305.00 | Alcohol Abuse |
| | 304.30 | Cannabis Dependence |
| | 305.20 | Cannabis Abuse |
| | 314.01 | Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
| | _____ | _____ |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 296.xx | F33.x | Major Depressive Disorder, Recurrent Episode |
| 300.4 | F34.1 | Persistent Depressive Disorder |
| 296.89 | F31.81 | Bipolar II Disorder |
| 296.4x | F31.1x | Bipolar I Disorder, Most Recent Episode Manic |
| 303.90 | F10.20 | Alcohol Use Disorder, Moderate or Severe |
| 305.00 | F10.10 | Alcohol Use Disorder, Mild |
| 304.30 | F12.20 | Cannabis Use Disorder, Moderate or Severe |
| 305.20 | F12.10 | Cannabis Use Disorder, Mild |
| 314.01 | F90.1 | Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive/Impulsive Type |
| 312.89 | F91.8 | Other Specified Disruptive, Impulse Control, and Conduct Disorder |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# SOCIAL ANXIETY

## BEHAVIORAL DEFINITIONS

1. Limited or no eye contact, coupled with a refusal or reticence to respond verbally to social overtures from others.
2. Excessive shrinking from or avoidance of contact with unfamiliar people for an extended period of time (i.e., six months or longer).
3. Social isolation and/or excessive involvement in isolated activities (e.g., reading, listening to music in his/her room, playing video games).
4. Extremely limited or no close friendships outside of the immediate family members.
5. Hypersensitivity to criticism, disapproval, or perceived signs of rejection from others.
6. Excessive need for reassurance of being liked by others before demonstrating a willingness to get involved with them.
7. Marked reluctance to engage in new activities or take personal risks because of the potential for embarrassment or humiliation.
8. Negative self-image as evidenced by frequent self-disparaging remarks, unfavorable comparisons to others, and a perception of self as being socially unattractive.
9. Lack of assertiveness because of a fear of being met with criticism, disapproval, or rejection.
10. Heightened physiological distress in social settings manifested by increased heart rate, profuse sweating, dry mouth, muscular tension, and trembling.

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## LONG-TERM GOALS

1. Eliminate anxiety, shyness, and timidity in social settings.
2. Initiate or respond to social contact with unfamiliar people or when placed in new social settings.
3. Interact socially with peers on a consistent basis without excessive fear or anxiety.
4. Achieve a healthy balance between time spent in solitary activity and social interaction with others.
5. Develop the essential social skills that will enhance the quality of interpersonal relationships.
6. Elevate self-esteem and feelings of security in interpersonal, peer, and adult relationships.

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## SHORT-TERM OBJECTIVES

1. Describe the history and nature of social fears and avoidance. (1, 2, 3)

## THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a therapeutic alliance.
2. Assess the client's social anxiety and avoidance, including the focus of the fear, types of avoidance (e.g., distraction, escape, dependence on others), development of the fear, and the negative impact on daily functioning; consider using a structured interview (e.g., *The Anxiety Disorders Interview Schedule—Parent Version* or *Child Version*).
3. Assess the nature of any external stimulus, thoughts, or situations

that precipitate the client's social fear and/or avoidance.

2. Complete psychological tests designed to assess the nature and severity of social anxiety and avoidance. (4)

4. Administer an objective measure of social anxiety to the client to further assess the depth and breadth of social fears and avoidance (e.g., *Social Phobia and Anxiety Inventory for Children*).

3. Disclose any history of substance use that may contribute to and complicate the treatment of social anxiety. (5)

5. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it.

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9, 10)

6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder), including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and

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| | factors that could offer a better understanding of the client's behavior. |
| | 9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment). |
| | 10. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting). |
| 5. Cooperate with an evaluation by a physician for psychotropic medication. (11, 12) | 11. Arrange for the client to have an evaluation for a prescription of psychotropic medications. |
| | 12. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with the prescribing physician at regular intervals. |
| 6. Participate in small group therapy for social anxiety, with or without parents, or individual therapy if the group is unavailable. (13) | 13. Enroll the client, with parents if desired, in a small (closed enrollment) group for social anxiety or individual therapy if a group cannot be formed (see |

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| | *Cognitive-Behavioral Therapy for Social Phobia in Adolescents* by Albano and DiBartolo; *Social Effectiveness Therapy for Children and Adolescents* by Beidel, Turner, and Morris); recommend reading to support client's progress (e.g., *Stand Up, Speak Out Workbook* by Albano and DiBartolo). |
| 7. Parents teach and reinforce healthy social skills and attitudes. (14) | 14. Teach parents to model and reinforce positive and confident social skills to help the client become more comfortable socially (recommend *Helping Your Anxious Child* by Rapee et al.; *Nurturing the Shy Child: Practical Help for Raising Confident and Socially Skilled Kids and Teens* by Markway and Markway). |
| 8. Verbalize an accurate understanding of social anxiety and the rationale for its treatment. (15, 16) | 15. Convey a cognitive-behavioral model of social anxiety that supports the rationale for treatment (e.g., social anxiety derives from cognitive biases and leads to unnecessary avoidance that maintains the fear). |
| | 16. Discuss how cognitive restructuring and exposure serve as an arena to desensitize learned fear, build social skills and confidence, and reality-test biased anxious thoughts and beliefs. |
| 9. Read recommended material that supports therapeutic goals toward increasing understanding of social anxiety and its treatment. (17) | 17. Assign the client and/or parents to read psychoeducational material on social anxiety and its treatment (e.g., *The Shyness and Social Anxiety Workbook* by Antony and Swinson; *Say Goodbye to Being Shy* by Brozovich and Chase; *Managing Social Anxiety—Workbook: A* |

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| | *Cognitive-Behavioral Therapy Approach* by Hope, Heimberg, and Turk; *The Mindful Path Through Shyness* by Flowers). EBT |
| EBT 10. Learn and implement calming and coping strategies to manage anxiety symptoms and focus attention usefully during moments of social anxiety. (18) | 18. Teach the client relaxation (see *New Directions in Progressive Relaxation Training* by Bernstein, Borkovec, and Hazlett-Stevens) and attentional focusing skills (e.g., staying focused externally and on behavioral goals, muscle relaxation, evenly paced diaphragmatic breathing, ride the wave of anxiety) to manage social anxiety symptoms (recommend parents and child read *The Relaxation and Stress Reduction Workbook for Kids* by Shapiro and Sprague; *Applied Relaxation Training* [Audio Book CD] by Fanning and McKay). EBT |
| EBT 11. Identify, challenge, and replace fearful self-talk and beliefs with reality-based, positive self-talk and beliefs. (19, 20) | 19. Explore the client's schema and self-talk that mediate his/her social fear response; challenge the biases; assist him/her in generating appraisals that correct for the biases and build confidence (recommend *The Shyness and Social Anxiety Workbook* by Antony and Swinson). EBT |
| | 20. Assign the client a homework exercise in which he/she identifies fearful self-talk and creates reality-based alternatives; review and reinforce success, providing corrective feedback for failure (or assign "Restoring Socialization Comfort" from the *Adult Psychotherapy Homework Planner* by Jongsma). EBT |

12. Learn and implement social skills to reduce anxiety and build confidence in social interactions. (21)

13. Learn and implement social problem-solving skills for managing social stresses, solving daily problems, and resolving conflicts effectively. (22, 23, 24)

21. Use instruction, modeling, and role-playing to build the client's general social and/or communication skills (see *Social Effectiveness Therapy for Children and Adolescents* by Beidel, Turner, and Morris; consider assigning "Observe Positive Social behaviors" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

22. Teach the client tailored, age-appropriate social problem-solving skills, including calming skills (e.g., cognitive and somatic) and problem-solving skills (e.g., specifying problem, generating options, listing pros and cons of each option, selecting an option, implementing an option, and refining); encourage implementation in daily life and review for success (or assign "Progressive Muscle Relaxation" or "Problem-Solving Exercise" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

23. Teach the client conflict resolution skills (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise), to prevent or manage social problems and improve personal and interpersonal functioning (supplement with "Becoming Assertive" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

24. Use behavioral skill-building techniques (e.g., modeling, role-playing, behavior rehearsal, and corrective feedback) to develop skills and work through several current conflicts. EBT

14. Gradually practice and improve new skills in various feared social situations. (25, 26, 27) EBT

25. Direct and assist the client in construction of a hierarchy of anxiety-producing situations associated with social anxiety. EBT

26. Select initial *in vivo* or role-played exposures that have a high likelihood of being a successful experience for the client; do cognitive restructuring within and after the exposure, and use behavioral strategies (e.g., modeling, rehearsal, social reinforcement) to facilitate the exposure (see *Social Effectiveness Therapy for Children and Adolescents* by Beidel, Turner, and Morris). EBT

27. Assign the client a homework exercise in which he/she does an exposure exercise in a daily life situation and records responses; review and reinforce success, providing corrective feedback toward improvement (supplement with "Gradual Exposure to Fear" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). EBT

15. Increase participation in interpersonal or peer group activities. (28, 29) EBT

28. Foster generalization and strengthening of new personal and interpersonal skills by encouraging the client to participate in extracurricular or positive peer-group activities (or assign "Greeting Peers" in the *Adolescent Psychotherapy Homework Planner* by Jongsma,

Peterson, and McInnis; also, *The Shyness and Social Anxiety Workbook for Teens* by Shannon).

29. Build the client's one-to-one interactional skills by encouraging participation in a structured social activity such as inviting friends home or going to a school sporting event together (or assign "Developing Conversational Skills" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review toward building on successes and problem-solving obstacles.

16. Increase participation in school-related activities. (30)

30. Consult with school officials about ways to increase the client's socialization (e.g., tutoring a more popular peer, pairing the client with popular peer on classroom assignments).

17. Learn and implement strategies for building on gains made in therapy and preventing relapses. (31, 32, 33, 34)

31. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible return of symptoms, fear, or urges to avoid and relapse with the decision to return to fearful and avoidant patterns.

32. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.

33. Instruct the client to routinely use strategies learned in therapy (e.g., cognitive restructuring, social skills, exposure) while building social interactions and relationships.

34. Develop a "coping card" or other record (e.g., MP3

recording) on which coping strategies and other important information (e.g., "Pace your breathing," "Focus on the task at hand," "You can manage it," "It will go away") are available for the client's later use.

18. Family members learn skills that strengthen and support the client's positive behavior change. (35, 36, 37, 38)

35. Conduct sessions with parents or parents and client in which parents are taught how to prompt and reward courageous social behavior, empathetically ignore excessive complaining and other avoidant behaviors, manage their own anxieties, and model the behavior being taught in session.

36. Teach the family problem-solving and conflict resolution skills for managing problems among themselves and between them and the client.

37. Encourage the family to model constructive skills they have learned and to model and praise the therapeutic skills the client is learning (e.g., calming, cognitive restructuring, nonavoidance of unrealistic fears).

38. Conduct group Cognitive-Behavioral Therapy, including family members (see the *FRIENDS* series by Barrett et al.), in which the client learns anxiety management skills, and parents learn skills for managing the child's anxious behavior and for facilitating the client's progress (recommend *Friends for Life Workbook for Youth* by Barrett; *Helping Your Anxious Child* by Rapee et al.; *Nurturing the Shy Child: Practical Help for Raising Confident and Socially*

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| | *Skilled Kids and Teens* by Markway and Markway; *The Shy Child: Helping Children Triumph Over Shyness* by Swallow, to supplement treatment, if needed). |
| 19. Identify strengths and interests that can be used to initiate social contacts and develop peer friendships. (39, 40) | 39. Ask the client to list how he/she is like his/her peers; use this list to encourage contact with peers who share interests and abilities (supplement with "Greeting Peers" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 40. Assist the client in identifying 5 to 10 of his/her strengths or interests and then instruct the client to utilize three strengths or interests in the upcoming week to initiate social contacts or develop peer friendships (or assign the "Show Your Strengths" exercise in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 20. Learn to accept limitations in life and commit to tolerating, rather than avoiding, unpleasant emotions while accomplishing meaningful goals. (41) | 41. Use an Acceptance and Commitment Therapy approach (see *Acceptance and Mindfulness Treatments for Children and Adolescents* by Greco and Hayes) to help the client accept uncomfortable realities such as lack of complete control, imperfections, and uncertainty and tolerate unpleasant emotions and thoughts while accomplishing value-consistent goals (supplement with *The Mindful Path Through Shyness* by Flowers and *The Mindfulness and Acceptance Workbook for Anxiety* by Forsyth and Eifert, if needed). |

21. Verbalize how current social anxiety and insecurities are associated with past rejection experiences and criticism from significant others. (42, 43)

22. Verbally describe the defense mechanisms used to avoid close relationships. (44)

42. Explore for a history of rejection experiences, harsh criticism, abandonment, or trauma that fostered the client's low self-esteem and social anxiety.

43. Encourage and support the client in verbally expressing and clarifying feelings associated with past rejection experiences, harsh criticism, abandonment, or trauma.

44. Assist the client in identifying defense mechanisms (e.g., social withdrawal, being critical, exaggerating rejection, overreacting to mild criticism, etc.) that keep others at a distance and prevent him/her from developing trusting relationships; identify ways to minimize defensiveness.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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|---|---|---|
| **Axis I:** | 300.23 | Social Anxiety Disorder (Social Phobia) |
| | 300.02 | Generalized Anxiety Disorder |
| | 309.21 | Separation Anxiety Disorder |
| | 300.4 | Dysthymic Disorder |
| | 296.xx | Major Depressive Disorder |
| | 300.7 | Body Dysmorphic Disorder |
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| **Axis II:** | V71.09 | No Diagnosis |
| | _____ | _____ |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 300.23 | F40.10 | Social Anxiety Disorder (Social Phobia) |
| 300.02 | F41.1 | Generalized Anxiety Disorder |
| 309.21 | F93.0 | Separation Anxiety Disorder |
| 300.4 | F34.1 | Persistent Depressive Disorder |
| 296.xx | F32.x | Major Depressive Disorder, Single Episode |
| 296.xx | F33.x | Major Depressive Disorder, Recurrent Episode |
| 300.7 | F45.22 | Body Dysmorphic Disorder |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

# SPECIFIC PHOBIA

## BEHAVIORAL DEFINITIONS

1. Describes a persistent and unreasonable fear of a specific object or situation that promotes avoidance behaviors because an encounter with the phobic stimulus provokes an immediate anxiety response.
2. Avoids the phobic stimulus/feared environment or endures it with distress, resulting in interference with normal routines.
3. Acknowledges a persistence of fear despite recognition that the fear is unreasonable.
4. Sleep disturbed by dreams of the feared stimulus.
5. Dramatic fear reaction out of proportion to the phobic stimulus.
6. Parental reinforcement of the phobia by catering to the client's fear.

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## LONG-TERM GOALS

1. Reduce fear of the specific stimulus object or situation that previously provoked phobic anxiety.
2. Reduce phobic avoidance of the specific object or situation, leading to comfort and independence in moving around in public environment.
3. Eliminate interference in normal routines and remove distress from feared object or situation.
4. Live phobia-free while responding appropriately to life's fears.

5. Resolve the conflict underlying the phobia.
6. Learn to overcome fears of noise, darkness, people, wild animals, and crowds.

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## SHORT-TERM OBJECTIVES

1. Describe the history and nature of the phobia(s), complete with the impact on functioning and attempt to overcome it. (1, 2)
2. Complete psychological tests designed to assess features of the phobia. (3)
3. Disclose any history of substance use that may contribute to and complicate the treatment of the phobia. (4)

## THERAPEUTIC INTERVENTIONS

1. Actively build a level of trust with the client that will promote the open sharing of thoughts and feelings, especially fearful ones.
2. Assess the client's phobic fear and avoidance, including the focus of the fear, types of avoidance (e.g., distraction, escape, dependence on others), development of the fear, and the negative impact on daily functioning; consider using a structured interview (e.g., *The Anxiety Disorders Interview Schedule—Parent Version* or *Child Version*).
3. Administer a client and/or parent-reported measure (e.g., from *Measures for Specific Phobia* by Antony) to further assess the depth and breadth of phobic responses.
4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it.

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8, 9)
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder), including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess

this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

9. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

5. Cooperate with an evaluation by a physician for psychotropic medication. (10, 11)

10. Arrange for an evaluation for a prescription of psychotropic medications if the client requests it or if the client is likely to be noncompliant with gradual exposure.

11. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with the prescribing physician at regular intervals.

6. Verbalize an understanding of information about phobias and their treatment. (12, 13)

12. Discuss how phobias are very common, a natural but irrational expression of our fight-or-flight response, and are not a sign of weakness, but cause unnecessary distress and disability.

13. Discuss with the client and parents a cognitive-behavioral conceptualization of how phobic fear is maintained by a "phobic cycle" of unwarranted fear and avoidance that precludes positive, corrective experiences with the feared object or

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| | situation; discuss how treatment breaks the cycle by encouraging these corrective experiences (see *Helping Your Anxious Child* by Rapee et al.; *Mastering Your Fears and Phobias—Workbook* by Antony, Craske, and Barlow; *Anxiety and Phobia Workbook* by Bourne). EB |
| EB 7. Verbalize an understanding of how thoughts, physical feelings, and behavioral actions contribute to anxiety and its treatment. (14, 15) | 14. Discuss how phobias involve appraising threats unrealistically, bodily expressions of fear, and avoidance of what is threatening that interact in a cycle of fear and avoidance to maintain the problem. EB |
| | 15. Discuss how exposure to the feared stimulus serves as an arena to desensitize learned fear, build confidence, and feel safer by building a new history of success experiences (e.g., *Face Your Fears: A Proven Plan to Beat Anxiety, Panic, Phobias, and Obsessions* by Tolin; *Helping Your Anxious Child* by Rapee et al.; *Freeing Your Child from Anxiety* by Chansky). EB |
| EB 8. Learn and implement calming skills to reduce and manage anxiety symptoms. (16, 17, 18) | 16. Teach the client anxiety management skills (e.g., staying focused on behavioral goals, muscular relaxation, evenly paced diaphragmatic breathing, positive self-talk) to address anxiety symptoms that may emerge during encounters with phobic objects or situations (or assign "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). EB |
| | 17. Assign the client a homework exercise in which he/she practices |

daily calming skills; review and reinforce success, providing corrective feedback for failure (recommend parents and child read *The Relaxation and Stress Reduction Workbook for Kids* by Shapiro and Sprague).

18. Use biofeedback techniques to facilitate the client's success at learning calming skills.

9. Learn and implement applied tension skills to prevent phobic fainting in response to blood, injection, or injury. (19, 20)

19. Teach the client applied tension in which he/she tenses neck and upper torso muscles to curtail blood flow out of the brain to help prevent fainting during encounters with phobic objects or situations involving blood, injection, or injury (see *Applied Tension, Exposure in vivo, and Tension-Only in the Treatment of Blood Phobia* by Ost, Fellenius, and Sterner).

20. Assign the client a homework exercise in which he/she practices daily applied tension skills; review and reinforce success; problem-solve obstacles toward mastery.

10. Identify, challenge, and replace fearful self-talk with positive, realistic, and empowering self-talk. (21, 22, 23)

21. Explore the client's anxious self-talk and beliefs that mediate his/her fear response; teach him/her how to challenge the biases; assist him/her in replacing the biased messages with reality-based, positive alternatives.

22. Assign the client a homework exercise in which he/she identifies fearful self-talk and creates reality-based alternatives (or assign "Journal and Replace Self-Defeating Thoughts" from the *Adult Psychotherapy*

*Homework Planner* by Jongsma); review and reinforce success, providing corrective feedback for failure.

23. Use behavioral techniques (e.g., modeling, corrective feedback, imaginal rehearsal, social reinforcement) to teach the client cognitive self-control skills such as self-observation, positive self-talk, and self-reward to facilitate the client's approach behavior to feared objects and situations and help him/her to manage anxiety during exposures (supplement with "Positive Self-Talk" from the *Adult Psychotherapy Homework Planner* by Jongsma); integrate with calming skills or applied tension skills training, if applicable.

11. Participate in exposure therapy beginning with the identification of anxiety-producing situations and a list of rewards for therapeutic successes. (24)

24. Direct and assist the client and parents in construction of a hierarchy of anxiety-producing situations associated with the phobic response as well as a list of rewards for successes.

12. Client and parents develop and agree with a contract describing the client's exposure goals and the rewards he/she will receive for accomplishing them. (25)

25. Help the client and parents to approve of a contingency contract that details the client's exposure task (i.e., the step on the hierarchy) as well as the details of the rewards for successful completion.

13. Parents learn and implement strategies to facilitate the child's success with exposure. (26, 27)

26. Teach parents strategies to facilitate the client's exposure or approach behavior toward feared objects or situations, including positive reinforcement, shaping, extinction, following through, and consistency.

27. Assign the parents to read about situational exposure in books or

treatment manuals on specific phobias (e.g., *Helping Your Anxious Child* by Rapee et al.).

14. Participate in gradual repeated exposure to feared or avoided phobic objects or situations. (28, 29, 30)

28. Select initial exposures that have a high likelihood of being a successful experience for the client; develop a plan for managing the symptoms and rehearse the plan (or assign "Gradual Exposure to Fear" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

29. Conduct exposures in session with the client using graduated tasks, modeling, and reinforcement of the client's success until he/she can do the exposures unassisted.

30. Assign the client a homework exercise in which he/she does situational exposures and records responses (see *Mastery of Your Fears and Phobias—Therapist Guide* by Craske, Antony, and Barlow; *Mastery of Your Fears and Phobias—Client Workbook* by Antony, Craske, and Barlow); review and reinforce success or provide corrective feedback toward improvement.

15. Family members demonstrate support for the client as he/she engages in exposure therapy. (31, 32, 33, 34)

31. Conduct Family Anxiety Management sessions (see *FRIENDS Program for Children* series by Barrett et al.) in which the family is taught how to prompt and reward courageous behavior, empathetically ignore excessive complaining and other avoidant behaviors, manage their own anxieties, and model the behavior being taught in session.

32. Assist the family in overcoming the tendency to reinforce the client's phobia through avoidance; as the phobia decreases, teach them constructive ways to reward the client's progress.

33. Teach family members problem-solving and communication skills to assist the client's progress through therapy (supplement with "Problem-Solving Exercise" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

34. Assign the parents to read and discuss with the client psychoeducational material from books or treatment manuals (e.g., see *Helping Your Anxious Child* by Rapee et al.).

16. List coping strategies for reducing phobic fear avoidance. (35)

35. Ask the client to list strategies he/she has learned in therapy to reduce his/her phobic fear and minimize his/her avoidance (or assign "Finding a Strategy to Minimize My Fear" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

17. Implement relapse prevention strategies for managing possible future anxiety symptoms. (36, 37, 38, 39)

36. Discuss with the client the distinction between a lapse and relapse, associating a lapse with a temporary and reversible return of symptoms, fear, or urges to avoid and relapse with the decision to return to fearful and avoidant patterns.

37. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.

38. Instruct the client to routinely use strategies learned in therapy (e.g., cognitive restructuring, exposure), building them into his/her life as much as possible.

39. Develop a "coping card" on which coping strategies and other important information (e.g., "You're safe," "Pace your breathing," "Focus on the task at hand," "You can manage it," "Stay in the situation," "Let the anxiety pass") are written for the client's later use.

18. Collect pleasant pictures or stories regarding the phobic object or situation and share them in therapy sessions. (40, 41)

40. Use pleasant pictures, readings, or storytelling about the feared object or situation as a means of desensitizing the client to the fear-producing stimulus.

41. Use humor, jokes, riddles, and stories to enable the client to see his/her situation/fears as not as serious as believed and to help instill hope without disrespecting or minimizing his/her fears.

19. Identify the symbolic significance of the phobic stimulus as a basis for fear. (42)

42. Probe, discuss, and interpret the possible symbolic meaning of the client's phobic stimulus object or situation.

20. Verbalize the separate realities of the irrationally feared object or situation and an emotionally painful experience from the past. (43)

43. Clarify and differentiate between the client's current irrational fear and past emotionally painful experiences that are evoked by the phobic stimulus.

21. Verbalize the feelings associated with a past emotionally painful situation that is connected to the phobia. (44, 45)

44. Encourage the client to share feelings from the past through active listening, unconditional positive regard, and questioning.

45. Reinforce the client's insight into the past emotional pain and its connection to present anxiety.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 300.00 | Anxiety Disorder NOS |
| | 300.29 | Specific Phobia |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | V71.09 | No Diagnosis |
| | _____ | _____ |
| | _____ | _____ |

*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 300.09 | F41.8 | Other Specified Anxiety Disorder |
| 300.00 | F41.9 | Unspecified Anxiety Disorder |
| 300.29 | F40.xxx | Specific Phobia |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# SUBSTANCE USE

## BEHAVIORAL DEFINITIONS

1. Self-report of almost daily use of alcohol or illicit drugs or regularly using until intoxicated.
2. Caught or observed intoxicated and/or high on two or more occasions.
3. Changing peer groups to one that is noticeably oriented toward regular use of alcohol and/or illicit drugs.
4. Drug paraphernalia and/or alcohol found in the client's possession or in his/her personal area (e.g., bedroom, car, school locker, backpack).
5. Marked change in behavior (e.g., isolation or withdrawal from family and close friends, loss of interest in activities, low energy, sleeping more, a drop in school grades).
6. Physical withdrawal symptoms (shaking, seizures, nausea, headaches, sweating, anxiety, insomnia, and/or depression).
7. Continued substance use despite persistent physical, legal, financial, vocational, social, or relationship problems that are directly caused by the substance use.
8. Mood swings.
9. Absent, tardy, or skipping school on a regular basis.
10. Poor self-image as evidenced by describing self as a loser or a failure, and rarely making eye contact when talking to others.
11. Predominately negative or hostile outlook on life and other people.
12. Has been caught stealing alcohol from a store, the home of friends, or parents.
13. Has been arrested for minor in possession, driving under the influence, or drunk and disorderly charges.
14. Positive family history of chemical dependence.

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## LONG-TERM GOALS

1. Confirm or rule out the existence of chemical dependence.
2. Maintain total abstinence from all mood-altering substances while developing an active recovery program.
3. Reestablish sobriety while developing a plan for addressing relapse issues.
4. Confirm and address chemical dependence as a family issue.
5. Develop the skills that are essential to maintaining a drug-free life.
6. Reestablish connections with relationships and groups that will support and enhance ongoing recovery from chemical dependence.
7. Develop an understanding of the pattern of relapse and strategies for coping effectively to help sustain long-term recovery.

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## SHORT-TERM OBJECTIVES

1. Describe the type, amount, frequency, and history of substance abuse. (1, 2)

## THERAPEUTIC INTERVENTIONS

1. Using relevant verbal response modes (e.g., questioning, active listening, clarification reflection, empathy), build rapport toward creating a good working therapeutic alliance with the client.
2. Gather a complete drug/alcohol history from the client, including the amount and pattern of his/her use, signs and symptoms of use, and negative life consequences (e.g., social, legal, familial, vocational).

2. Complete psychological tests designed to assess the nature and severity of social anxiety and avoidance. (3)

3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (4, 5, 6, 7, 8)

3. Administer to the client an objective test of drug and/or alcohol abuse (e.g., *Adolescent Substance Abuse Subtle Screening Inventory, Teen Addiction Severity Index, Michigan Alcohol Screening Test*); process the results with the client; re-administer as need to assess therapeutic progress.

4. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

5. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder), including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

6. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better

understanding of the client's behavior.

7. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
8. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

4. Participate in a medical examination to evaluate the effects of substance use. (9)

9. Refer the client for a thorough physical examination to determine any physical/medical consequences of chemical dependence.

5. Cooperate with an evaluation by a physician for psychotropic medication. (10, 11)

10. Arrange for an evaluation for a prescription of psychotropic medications (e.g., serotonergic medications) or replacement pharmacotherapy (e.g., methadone, nicotine patches).
11. Monitor the client for prescription compliance, side effects, and overall effectiveness of the medication; consult with

the prescribing physician at regular intervals.

6. Explore motivation for treatment toward making a commitment to change. (12, 13, 14)

12. Using a motivational interviewing approach to assist the client in evaluating his/her motivation for change (see motivationalinterview.org or assign "Taking Your First Step" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis), process toward establishing motivation for change.

13. Facilitate exploration by the client of the negative and positive consequences of substance use and sobriety; ask the client to make a list of positives and negatives; process the list.

14. Assist the client in identifying positive changes that will be made in family relationships during recovery (or assign "Saying Goodbye to My Drug" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

7. Decrease the level of denial around using substances as evidenced by fewer statements about minimizing amount of use and its negative impact on life. (15, 16)

15. Assign the client to ask two or three people who are close to him/her to write a letter to the therapist in which they identify how they saw the client's chemical dependence negatively impacting his/her life.

16. Assign the client to complete a First-Step paper and then to process it with group, sponsor, or therapist to receive feedback.

8. Make verbal "I statements" that reflect a knowledge and acceptance of chemical dependence. (17)

17. Model and reinforce statements that reflect the client's acceptance of his/her chemical dependence and its destructive consequences for self and others.

9. Verbalize increased knowledge of substance use and the process of recovery. (18, 19)

18. Educate the client about chemical dependency and the recovery process; make supplemental psychoeducational assignments (e.g., didactic lectures, reading, films); ask the client to identify key points; reinforce increased knowledge.

19. Assign the client to meet with an Alcoholics Anonymous/Narcotics Anonymous (AA/NA) member who has been working the 12-step program for several years and find out speci-fically how the program has helped him/her to stay sober (or assign "Welcome to Recovery" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); after-ward, process the meeting.

10. Verbalize a commitment to abstain from the use of mood-altering drugs. (20)

20. Develop an abstinence contract with the client regarding the termination of the use of his/her drug of choice; process the client's feelings related to the commitment.

11. Verbalize a commitment to a harm reduction approach to using substances. (21)

21. Discuss the conditions of a harm reduction approach to substance use (e.g., abstinence may be desirable but reducing harm caused by substance use is the primary aim) and secure the client's commitment to it (see *Harm Reduction* by Marlatt, Larimer, and Witkiewitz).

12. Attend Alcoholics Anonymous/ Narcotics Anonymous (AA/NA) meetings as frequently as necessary to support sobriety. (22)

22. Recommend that the client attend AA or NA meetings and report on the impact of the meetings; process messages the client is receiving.

13. Agree to make amends to significant others who have been

23. Discuss the negative effects the client's substance abuse has had

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| hurt by the life dominated by substance abuse. (23, 24) | on family, friends, and work relationships, and encourage a plan to make amends for such hurt.<br>24. Elicit from the client a verbal commitment to make initial amends now to key individuals and further amends when working Steps Eight and Nine of AA program. |
| 14. Participate in Voucher-Based Reinforcement program by routinely providing chemical-free urine screens. (25) | 25. Enroll the client in a drug screening program that provides him/her with vouchers with increasing monetary value for each urine screen he/she passes (see *Contingency Management for Adolescent Substance Abuse* by Henggeler et al.). |
| 15. Verbalize an understanding of personal, social, and family factors that can contribute to development of chemical dependence and pose risks for relapse. (26, 27) | 26. Assess the client's intellectual, personality, and cognitive vulnerabilities, family history, and life stresses that contribute to his/her chemical dependence.<br>27. Facilitate the client's understanding of his/her genetic and environmental risk factors that led to the development of chemical dependency and serve as risk factors for relapse. |
| 16. Identify and make changes in social relationships that will support recovery. (28) | 28. Review the negative influence of the client continuing his/her chemical dependence–related friendships ("drinking buddies") and assist him/her in making a plan to develop new sober relationships, including "sobriety buddies"; revisit routinely and facilitate toward development of a new social support system. |
| 17. Identify projects and other social and recreational activities that sobriety will now afford and that will support sobriety. (29, 30) | 29. Assist the client in planning social and recreational activities that are free from association with substance abuse (or assign |

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| | "The Many Changes Necessary for Recovery" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); revisit routinely and facilitate toward development of a new social support system (see *A Community Reinforcement Approach to Addiction Treatment* by Meyers and Miller). |
| | 30. Plan household, school-related, work-related, and/or other projects that can be accomplished to build the client's self-esteem and self-concept as clean and sober. |
| 18. Verbalize how living situation contributes to chemical dependence and acts as a hindrance to recovery. (31) | 31. Evaluate the role of the client's living situation in fostering a pattern of chemical dependence; process coping skills with the client. |
| 19. Enroll and participate in Cognitive-Behavioral Therapy (CBT) to learn and implement knowledge and skills for overcoming substance use. (32) | 32. Conduct or refer to group (preferred) or individual CBT in which cognitive strategies (e.g., identifying maladaptive thinking patterns) are combined with behavioral strategies (e.g., coping with cravings, communication, problem-solving, substance refusal skills training, avoiding/managing high-risk drug use situations [see relevant treatment manuals such as Sampl and Kadden; Webb et al. at the SAMHSA website]). |
| 20. Identify, challenge, and replace destructive self-talk with positive, strength-building self-talk. (33, 34) | 33. Explore the client's schema and self-talk that weaken his/her resolve to remain abstinent; challenge the biases and assist him/her in generating realistic self-talk that corrects for the biases and builds resilience. |

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| | 34. Rehearse situations in which the client identifies his/her negative self-talk and generates empowering alternatives; review and reinforce success. |
| 21. Learn and implement coping strategies to manage urges to use substances. (35) | 35. Teach the client a "coping package" involving calming strategies (e.g., relaxation, breathing), thought-stopping, positive self-talk, and attentional focusing skills (e.g., using distraction to cope with urges, staying focused on behavioral goals of abstinence) to manage urges to use chemical substances. |
| 22. Participate in gradual repeated exposure to triggers of urges to use substances toward strengthening coping skills. (36, 37) | 36. Direct and assist the client in construction of a hierarchy of urge-producing cues to use substances. |
| | 37. Select initial *in vivo* or role-played cue exposures that have a high likelihood of being a successful experience for the client; facilitate coping and cognitive restructuring within and after the exposure; use behavioral strategies (e.g., modeling, rehearsal, social reinforcement) to facilitate gains (or assign "Gradual Exposure to Fear" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 23. Learn and implement personal skills to manage common day-to-day challenges without the use of substances. (38, 39) | 38. Assess current skill in managing common everyday stressors (e.g., work, social, family role demands); use behavioral techniques (e.g., instruction, modeling, role-playing) to build tailored social and/or communication skills to manage these challenges. |

39. Assign the client to read about general social skills in books or treatment manuals (e.g., *Cool, Calm, and Confident: A Workbook to Help Kids Learn Assertiveness Skills* by Schab; *The Shyness and Social Anxiety Workbook for Teens: CBT and ACT Skills to Help You Build Social Confidence* by Shannon); review the client's anxiety level in social situations and reinforce his/her attempts to reach out to others (or assign "Social Skills Exercise," "Greeting Peers," "Becoming Assertive," or "Show Your Strengths" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). EBP

EBP 24. Client and family participate in Multidimensional Family Therapy. (40)

40. Conduct or refer family to Multidimensional Family Therapy that targets characteristics of the adolescent (e.g., cognitive appraisals of substance use; using substances to regulate emotions); the parent(s) (e.g., parenting practices, parental stress); and other relevant family members (e.g., presence of drug-using adults); as well as the interactions of the family system (e.g., emotional disconnection) that influence the development and continuation of substance use and related problem behaviors (see *Multidimensional Family Therapy for Adolescent Drug Abuse: Clinician's Manual* by Liddle). EBP

EBP 25. Client and family participate in Functional Family Therapy. (41)

41. Conduct or refer family to an evidence-based Functional Family Therapy (see fftinc.com) in which problematic interactions within the family

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| | system are assessed and changed through the use of family systems and social learning interventions to support more adaptive communication and functioning. |
| 26. Client participates in Seeking Safety therapy. (42) | 42. Conduct or refer client with a substance use disorder and Posttraumatic Stress Disorder (PTSD) to Seeking Safety therapy, a present-focused, coping skills therapy in which cognitive, behavioral, interpersonal, and case management interventions are used to address trauma and substance use concurrently (see *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* by Najavits). |
| 27. Client and family participate in a Multisystemic Therapy program. (43) | 43. Conduct or refer client with substance and conduct problems to a Multisystemic Therapy program in which cognitive, behavioral, and family interventions target factors in the client's social network that are contributing to his/her antisocial behavior and/or substance abuse to improve caregiver discipline practices, enhance family affective relations, decrease youth association with deviant peers and increase youth association with prosocial peers, improve youth school or vocational performance, engage youth in prosocial recreational outlets, and develop an indigenous support network (see *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents* by Henggeler et al.). |

28. Implement relapse prevention strategies for managing possible future situations with high risk for relapse. (44, 45, 46, 47)

44. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible use of a substance and relapse with the decision to return to a repeated pattern of abuse.

45. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur (see *Relapse Prevention* by Marlatt and Donovan; or assign "Keeping Straight" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

46. Instruct the client to routinely use strategies learned in therapy (e.g., using cognitive restructuring, social skills, exposure) while building social interactions and relationships.

47. Recommend that the client read material on how to avoid relapse (e.g., *Adolescent Relapse Prevention Workbook: A Brief Strategic Approach* by Gorski).

29. Develop a written aftercare plan that will support the maintenance of long-term sobriety. (48)

48. Assign and review the client's written aftercare plan to ensure it is adequate to maintain long-term sobriety.

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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 303.90 | Alcohol Dependence |
| | 305.00 | Alcohol Abuse |
| | 304.30 | Cannabis Dependence |
| | 305.20 | Cannabis Abuse |
| | 304.20 | Cocaine Dependence |
| | 305.60 | Cocaine Abuse |
| | 304.80 | Polysubstance Dependence |
| | 291.2 | Alcohol-Induced Persisting Dementia |
| | 291.1 | Alcohol-Induced Persisting Amnestic Disorder |
| | 300.4 | Dysthymic Disorder |
| | 312.34 | Intermittent Explosive Disorder |
| | 309.81 | Posttraumatic Stress Disorder |
| | 304.10 | Sedative, Hypnotic, or Anxiolytic Dependence |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | V71.09 | No Diagnosis |
| | _____ | _____ |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 303.90 | F10.20 | Alcohol Use Disorder, Moderate or Severe |
| 305.00 | F10.10 | Alcohol Use Disorder, Mild |
| 304.30 | F12.20 | Cannabis Use Disorder, Moderate or Severe |
| 305.20 | F12.10 | Cannabis Use Disorder, Mild |
| 304.20 | F14.20 | Cocaine Use Disorder, Moderate or Severe |
| 305.60 | F14.10 | Cocaine Use Disorder, Mild |
| 300.4 | F34.1 | Persistent Depressive Disorder |
| 312.34 | F63.81 | Intermittent Explosive Disorder |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |
| 304.10 | F13.20 | Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate or Severe |
| 312.32 | F91.2 | Conduct Disorder, Adolescent-Onset Type |
| 312.81 | F91.1 | Conduct Disorder, Childhood-Onset Type |
| 312.9 | F91.9 | Unspecified Disruptive, Impulse Control, and Conduct Disorder |
| 312.89 | F91.8 | Other Specified Disruptive, Impulse Control, and Conduct Disorder |
| V61.20 | Z62.820 | Parent-Child Relational Problem |

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| 309.3 | F43.24 | Adjustment Disorder, With Disturbance of Conduct |
| 309.4 | F43.25 | Adjustment Disorder, With Mixed Disturbance of Emotions and Conduct |
| 314.01 | F90.1 | Attention-Deficit/Hyperactivity Disorder, Predominately Hyperactive /Impulsive Presentation |

Note: *The ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# SUICIDAL IDEATION

## BEHAVIORAL DEFINITIONS

1. Recurrent thoughts of or a preoccupation with death.
2. Recurrent or ongoing suicidal ideation without any plans.
3. Ongoing suicidal ideation with a specific plan.
4. Recent suicide attempt.
5. History of suicide attempts that required professional or family/friend intervention on some level (e.g., inpatient, safe house, outpatient, supervision).
6. Positive family history of depression and/or suicide.
7. Expression of a bleak, hopeless attitude regarding life.
8. Recent painful life events (e.g., parental divorce, death of a friend or family member, broken close relationship).
9. Social withdrawal, lethargy, and apathy.
10. Rebellious and self-destructive behavior patterns (e.g., dangerous drug or alcohol abuse, reckless driving, assaultive anger) that indicate a disregard for personal safety and a desperate attempt to escape from emotional distress.

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## LONG-TERM GOALS

1. Alleviate the suicidal impulses or ideation and return to the highest previous level of daily functioning.

2. Stabilize the suicidal crisis.
3. Place in an appropriate level of care to address the suicidal crisis.
4. Reestablish a sense of hope for future life.
5. Terminate the death wish and renew a zestful interest in social activities and relationships.
6. Cease the perilous lifestyle and resolve the emotional conflicts that underlie the suicidal pattern.

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## SHORT-TERM OBJECTIVES

1. State the strength of the suicidal feelings, the frequency of the thoughts, and the detail of the plans. (1, 2)

2. Cooperate with psychological testing to assess for the severity of depression and hopelessness. (3)

3. Disclose any history of substance use that may contribute to and complicate the treatment of depression. (4)

## THERAPEUTIC INTERVENTIONS

1. Assess the client's suicidal ideation, taking into account the extent of the ideation, the depth of the depressive feelings, the presence of primary and backup plans, past attempts, and family history of depression and suicide or attempts.

2. Assess and monitor the client's suicide potential on an ongoing basis.

3. Arrange for psychological assessment of the client (e.g., *Minnesota Multiphasic Personality Inventory—Adolescent, Beck Depression Inventory for Youth, Reynolds Adolescent Depression Scale*) and evaluate the results as to the depth of depression.

4. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it.

4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8, 9)
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder), including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
8. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess

this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

9. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

5. Parents, family members, and significant others agree to provide supervision and monitor suicide potential. (10)

10. Notify the client's family and significant others of any severe suicidal ideation; ask them to form a 24-hour suicide watch until the crisis subsides.

6. Cooperate with an evaluation by a physician for antidepressant medication. (11, 12)

11. Assess the client's need for antidepressant medication and arrange for a prescription, if necessary.

12. Monitor the client for medication compliance, effectiveness, and side effects.

7. Cooperate with hospitalization if the suicidal urge becomes uncontrollable. (13)

13. Arrange for hospitalization when the client is judged to be harmful to himself/herself.

8. Verbalize a promise (as part of a suicide prevention contract) to contact the therapist or some other emergency helpline if a serious urge toward self-harm arises. (14, 15, 16, 17)

14. Elicit a promise from the client that he/she will initiate contact with the therapist or a helpline if the suicidal urge becomes strong and before any self-injurious behavior.

15. Provide the client with an emergency helpline telephone number that is available 24 hours a day.

16. Make a written contract with the client, identifying what he/she will and will not do when experiencing suicidal thoughts or impulses (or complete the "No Self-Harm Contract" exercise from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).
17. Offer to be available to the client through telephone contact if a life-threatening urge develops.

9. Parents increase the safety of the home by removing firearms or other lethal weapons from the client's easy access. (18)

18. Encourage the parents to remove firearms or other lethal weapons from the client's easy access; monitor their follow-through in accomplishing this for the client's safety.

10. Increase communication with the parents, resulting in feeling attended to and understood. (19)

19. Meet with the parents to assess their understanding of the causes for the client's distress and to explain the client's perspective and need for empathy.

11. Identify feelings of sadness, anger, and hopelessness related to a conflicted relationship with the parents. (20, 21)

20. Probe the client's feelings of despair related to his/her family relationships.
21. Hold family therapy sessions to promote communication of the client's feelings of sadness, hurt, and anger.

12. Verbalize an understanding of the motives for self-destructive behavior patterns. (22, 23, 24)

22. Explore the sources of emotional pain underlying the client's suicidal ideation and the depth of his/her hopelessness.
23. Interpret the client's sadness, wish for death, or dangerous rebellion as an expression of hopelessness and helplessness (a cry for help).
24. Encourage the client to express his/her feelings related to the suicidal behavior in order to

clarify them and increase insight into the causes and motives for the behavior (or assign "Past and Present Hurt—Hope for the Future" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

13. Identify pain that would be caused to others by a suicide attempt. (25)

25. Assist the client in listing who and how others will be hurt by the client's act of suicide (or assign "Painful Effects of Suicide" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); process a sense of resolve not to subject others to this pain.

14. Verbally report and demonstrate an increased sense of hope for self. (26, 27, 28)

26. Teach the client the benefit of sharing emotional pain instead of internalizing it and brooding over it; assist the client in finding positive, hopeful things in his/her life at the present time.

27. Reinforce all of the client's statements that reflect hope and resolution of the suicidal urge (or assign "Overcoming Helplessness and Hopelessness" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

28. Ask the client to bring to session symbols of achievement and personal meaning and reinforce their importance (or assign the exercise "Symbols of Self-Worth" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

15. Implement more positive cognitive processing patterns that maintain a realistic and hopeful perspective. (29, 30, 31)

29. Assist the client in developing coping strategies for suicidal ideation (e.g., more physical exercise, less internal focus,

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| | increased social involvement, more expression of feelings). |
| | 30. Assist the client in developing an awareness of the cognitive messages that reinforce hopelessness and helplessness (or assign "Bad Thoughts Lead to Depressed Feelings" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 31. Identify and confront catastrophizing, fortune-telling, and mind-reading tendencies in the client's cognitive processing, teaching more realistic self-talk of hope in the face of pain. |
| 16. Identify how previous attempts to solve interpersonal problems have failed, resulting in helplessness. (32) | 32. Review with the client previous problem-solving attempts and discuss new alternatives that are available such as assertiveness, brainstorming with a friend, sharing with a mentor, and compromise (or consider assigning "Becoming Assertive" or "Problem-Solving Exercise" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| 17. Develop and implement a penitence ritual of expressing grief for victims and absolving self of responsibility for surviving an incident fatal to others. (33) | 33. Develop a penitence ritual for the client who is a survivor of an incident fatal to others and has feelings of "survivor guilt"; monitor and process the implementation. |
| 18. Strengthen the social support network with friends by initiating social contact and participating in social activities with peers. (34, 35, 36) | 34. Encourage the client to reach out to friends and participate in enriching social activities by assigning involvement in at least one social activity with his/her peers per week; monitor and process the experience. |

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| | 35. Use behavioral rehearsal, modeling, and role-playing to build the client's social skills with his/her peers (or assign "Greeting Peers," "Show Your Strengths," or "Developing Conversational Skills" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). |
| | 36. Encourage the client to broaden his/her social network by initiating one new social contact per week versus desperately clinging to one or two friends. |
| 19. Reestablish a consistent eating and sleeping pattern. (37) | 37. Encourage normal eating and sleeping patterns and monitor the client's compliance (or assign "Sleep Pattern Record" from the *Adult Psychotherapy Homework Planner* by Jongsma). |
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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 296.2x | Major Depressive Disorder, Single Episode |
| | 296.3x | Major Depressive Disorder, Recurrent Episode |
| | 300.4 | Dysthymic Disorder |
| | 296.xx | Bipolar I Disorder |
| | 296.89 | Bipolar II Disorder, Most Recent Episode Depressed |

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|---|---|---|
| | 311 | Depressive Disorder NOS |
| | 309.81 | Posttraumatic Stress Disorder |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
| | _____ | _____ |
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*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 296.2x | F32.x | Major Depressive Disorder, Single Episode |
| 296.3x | F33.x | Major Depressive Disorder, Recurrent Episode |
| 300.4 | F34.1 | Persistent Depressive Disorder |
| 296.53 | F31.4 | Bipolar I Disorder, Most Recent Episode Depressed, Severe |
| 296.89 | F31.81 | Bipolar II Disorder, Most Recent Episode Depressed |
| 311 | F32.9 | Unspecified Depressive Disorder |
| 309.81 | F43.10 | Posttraumatic Stress Disorder |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

# UNIPOLAR DEPRESSION

## BEHAVIORAL DEFINITIONS

1. Demonstrates sad or flat affect.
2. Reports a preoccupation with the subject of death.
3. Reports suicidal thoughts and/or actions.
4. Exhibits moody irritability.
5. Isolates self from family and/or peers.
6. Has deterioration in academic performance.
7. Lacks interest in previously enjoyed activities.
8. Refuses to communicate openly.
9. Demonstrates low energy.
10. Makes little or no eye contact.
11. Frequently expresses statements reflecting low self-esteem.
12. Exhibits a reduced appetite.
13. Demonstrates an increased need for sleep.
14. Exhibits poor concentration and indecision.
15. Expresses feelings of hopelessness, worthlessness, or inappropriate guilt.
16. Reports unresolved feelings of grief.
17. Uses alcohol and/or controlled substances to elevate mood.

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## LONG-TERM GOALS

1. Elevate mood and show evidence of usual energy, activities, and socialization level.

2. Renew typical interest in academic achievement, social involvement, and eating patterns as well as occasional expressions of joy and zest for life.
3. Reduce irritability and increase normal social interaction with family and friends.
4. Develop healthy cognitive patterns and beliefs about self and the world that lead to alleviation of and help prevent the relapse of depression symptoms.
5. Develop healthy interpersonal relationships that lead to alleviation of and help prevent the relapse of depression symptoms.
6. Appropriately grieve the loss in order to normalize mood and to return to previous adaptive level of functioning.

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| SHORT-TERM OBJECTIVES | THERAPEUTIC INTERVENTIONS |
|---|---|
| 1. Describe current and past experiences with depression, complete with its impact on functioning and attempts to resolve it. (1, 2) | 1. Using relevant verbal response modes (e.g., questioning, active listening, clarification reflection, empathy), build rapport toward creating trust and a good working therapeutic alliance with the client/parents/guardians.<br>2. Assess current and past mood episodes, including their features, frequency, intensity, and duration (e.g., supplement interview with *Inventory to Diagnose Depression* and/or *Diagnostic Inventory for Depression*). |
| 2. Verbally identify, if possible, the source of depressed mood. (3) | 3. Ask the client to describe and/or make a list of what he/she is depressed about; process the content toward identifying possible stressors; encourage the client to share his/her feelings of |

depression in order to clarify them and gain insight as to possible causes (consider assigning "Overcoming Helplessness and Hopelessness" or "Three Ways to Change the World" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

3. Complete psychological testing to assess the depth of depression, the need for antidepressant medication, and suicide prevention measures. (4)

4. Arrange for the administration of an objective assessment instrument for evaluating the client's depression and suicide risk (e.g., *Children's Depression Inventory*; *Beck Depression Inventory for Youth*); evaluate results and give feedback to the client.

4. Disclose any history of substance use that may contribute to and complicate the treatment of depression. (5)

5. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it.

5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9, 10)

6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary

to an anxiety disorder), including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.
9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
10. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional needs or physical needs, repeated changes in primary caregivers, limited opportunities for stable attachments, persistent harsh punishment, or other grossly inept parenting).

6. Verbalize any history of suicide attempts and any current suicidal urges. (11)

11. Explore the client's history and current state of suicidal urges and behavior (see the Suicidal Ideation chapter in this *Planner* if suicide risk is present).

7. State no longer having thoughts of self-harm. (12, 13)

12. Assess and monitor the client's suicide potential.

13. Arrange for hospitalization, as necessary, when the client is judged to be harmful to self.

8. Take prescribed psychotropic medications responsibly at times ordered by physician. (14)

14. Refer the client to a physician for a medication evaluation to assess the possible need for psychotropic medication; monitor and evaluate the client's psychotropic medication compliance, effectiveness, and side effects; communicate with prescribing physician as needed.

9. Learn about depression, factors that influence its development and continuance, and methods for overcoming it and preventing its relapse. (15)

15. Educate the client and/or parents, and explain the rationale for cognitive- behavioral treatment of depression to client that discusses how cognitive, behavioral, and interpersonal factors can contribute to depression and how changes in these factors can help overcome and prevent it; prescribe reading to support therapy (see *Thoughts and Feelings: Taking Control of Your Moods and Your Life* by McKay, Davis, and Fanning; *Freeing Your Child From Negative Thinking: Powerful, Practical Strategies to Build a Lifetime of Resilience, Flexibility, and Happiness* by Chansky; or *My Feeling Better Workbook: Help for Kids Who Are Sad and Depressed* by Hamil).

10. Participate in Cognitive-Behavioral Therapy for depression. (16, 17)

16. Conduct or refer the child to a cognitive-behavioral group therapy for depression (or treat individually if necessary) involving psychoeducation, cognitive restructuring, behavioral activation, as well as

personal and interpersonal skills building (see *Treating Depressed Youth: Therapist Manual for ACTION* by Stark et al.; *Depression: Cognitive Behaviour Therapy with Children and Young People* by Verduyn, Rogers, and Wood; *Adolescent Coping With Depression Course* [Online]; *Treating Depressed and Suicidal Adolescents* by Brent, Poling, and Goldstein).

17. Arrange for meetings with the client's parents/family members (ongoing/periodic, with/without client) to encourage and teach them how to assist their child in applying newly learned skills outside of group or individual sessions and to increase the frequency of positive family interactions (see *Treating Depressed Youth: Therapist Manual for ACTION* by Stark et al.); prescribe selected reading to support therapy (see *Thoughts and Feelings: Taking Control of Your Moods and Your Life* by McKay, Davis, and Fanning, or *Freeing Your Child from Negative Thinking: Powerful, Practical Strategies to Build a Lifetime of Resilience, Flexibility, and Happiness* by Chansky).

11. Identify and replace depressive thinking that leads to depressive feelings and actions. (18, 19, 20, 21)

18. Educate the client and/or parents about cognitive restructuring, including self-monitoring of automatic thoughts reflecting depressogenic beliefs, challenging depressive thinking patterns by examining evidence for and against them and replacing them with reality-based alternatives, and testing through behavioral experiments.

19. Assign the client to keep a daily journal of automatic thoughts associated with depressive feelings (e.g., "Bad Thoughts Lead to Depressed Feelings" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis; "Daily Record of Dysfunctional Thoughts" in *Cognitive Therapy of Depression* by Beck et al.); process the journal material to identify and challenge depressive thinking patterns and replace them with reality-based alternatives.

20. Design age-appropriate "behavioral experiments" in which depressive automatic thoughts are treated as hypotheses/predictions, reality-based alternative hypotheses/predictions are generated, and both are tested against the client's past, present, and/or future experiences.

21. Conduct attribution retraining in which the client is taught to identify pessimistic explanations for events and generate more optimistic and realistic alternatives; reinforce the client's positive, reality-based cognitive messages that enhance self-confidence and increase adaptive action (supplement with "Recognizing Your Abilities, Traits, and Accomplishments" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis or "Positive Self-Talk" in the *Adult Psychotherapy Homework Planner* by Jongsma).

12. Learn and implement calming skills to reduce overall tension and effectively manage periodic increases in anxiety, tension, or arousal. (22, 23)

22. Teach the client cognitive and somatic calming skills (e.g., calming breathing, cognitive distancing, decatastrophizing, distraction, progressive muscle relaxation, guided imagery); rehearse with the client how to apply these skills to his/her daily life (or assign "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); review and reinforce success while providing corrective feedback toward consistent implementation.

23. Assign the client and/or parents to read and discuss progressive muscle relaxation and other calming strategies in relevant books or treatment manuals (e.g., *The Relaxation and Stress Reduction Workbook* by Davis, Robbins-Eshelman, and McKay).

13. Learn and implement personal skills for managing stress, solving daily problems, and resolving conflicts effectively. (24)

24. Teach the client tailored, age-appropriate personal skills, including problem-solving skills (e.g., specifying problem, generating options, listing pros and cons of each option, plan development, implementation, and refining) and conflict resolution skills (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise), to manage daily stressors, improve personal and interpersonal functioning, and help alleviate depression; use behavioral skill-building techniques (e.g., modeling, role-playing, behavior rehearsal, and

corrective feedback) to develop skills, working through several current conflicts.

14. Learn new ways to overcome depression through activity. (25, 26)

25. Teach and engage the client in "behavioral activation" by scheduling activities that have a high likelihood for pleasure and mastery, are worthwhile to the client, and/or make him/her feel good about self; use behavioral techniques (e.g., modeling, role-playing, role reversal, rehearsal, and corrective feedback) as needed to assist adoption in the client's daily life (or assign to the client along with parents "Home, School, and Community Activities I Enjoyed" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis); reinforce advances.

26. Develop and reinforce a routine of physical exercise for the client; supplement intervention with prescribed reading (e.g., *Exercising Your Way to Better Mental Health* by Leith).

15. Learn and implement social skills to reduce anxiety and build confidence in social interactions. (27)

27. Use behavioral skill-building techniques such as instruction, modeling, and role-playing to build the client's general social and/or communication/assertiveness skills (see *Social Effectiveness Therapy for Children and Adolescents* by Beidel, Turner, and Morris; consider assigning "Becoming Assertive" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

16. Initiate and respond actively to social communication and interaction with family and peers. (28, 29)

28. Encourage the client to participate in social/recreational activities that increase social communication and interactions, enrich his/her life, and expand social network toward reducing anxiety and/or depression through increased positively reinforcing social interactions (or assign "Greeting Peers," "Developing Conversational Skills," or "Show Your Strengths" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

29. Employ self-reliance training in which the client assumes increased responsibility for routine activities (e.g., cleaning, cooking, shopping); reinforce success.

17. Identify important people in your life, past and present, and describe the qualities, good and bad, of those relationships. (30, 31, 32, 33)

30. Conduct Interpersonal Therapy beginning with the assessment of the client's "interpersonal inventory" of important past and present relationships; assess for depression related to grief, interpersonal disputes, role transitions, and interpersonal deficits (e.g., separation from parents, problematic relations with parents, interpersonal relationships with peers, initial experience with death of a relative or friend; see *Interpersonal Psychotherapy for Depressed Adolescents* by Mufson et al.).

31. Educate the client about the link between mood and problems that are occurring in his/her relationships; discuss how new skills in communication and problem-solving can improve

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| | these relationships, which can then lead to recovery from depression; agree with client on the interpersonal issues that will be the focus of therapy. EBP |
| | 32. Ask and guide the client in taking the lead in facilitating change by keeping him/her focused on talking about the problem areas and clarifying issues and conflicts; identify and implement specific strategies to help the client negotiate his/her interpersonal difficulties more successfully; rehearse and role-play interactions as needed, encouraging action and change where indicated (supplement with "Problem-Solving Exercise" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis). EBP |
| | 33. In conjoint sessions, help the client resolve interpersonal conflicts. EBP |
| EBP 18. Verbalize any unresolved grief issues that may be contributing to depression. (34) | 34. Explore the role of unresolved grief issues as they contribute to the client's current depression (see the Grief/Loss Unresolved chapter in this *Planner*). EBP |
| EBP 19. Learn and implement relapse prevention skills. (35) | 35. Build the client's relapse prevention skills by helping him/her identify early warning signs of relapse, reviewing skills learned during therapy, and developing a plan for managing challenges. EBP |
| 20. Read books on overcoming depression. (36) | 36. Recommend that the client read self-help books on coping with depression (e.g., *Beyond the Blues: A Workbook to Help Teens Overcome Depression* by Schab); process material read. |

21. State the connection between rebellion, self-destruction, or withdrawal and the underlying depression. (37, 38, 39)

22. Express feelings of hurt, disappointment, shame, and anger that are associated with early life experiences. (40, 41)

23. Specify what in the past contributes to current sadness. (42)

24. Express emotional needs to significant others. (43, 44)

37. Assess the client's level of self-understanding about self-defeating behaviors linked to the depression.

38. Interpret and confront the client's acting-out behaviors as avoidance of the real conflict involving his/her unmet emotional needs and reflection of the depression.

39. Teach the client the connection between angry, irritable behaviors and feelings of hurt and sadness (or assign "Surface Behavior/Inner Feelings" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

40. Explore experiences from the client's childhood that contribute to current depressed state.

41. Encourage the client to share feelings of anger regarding pain inflicted on him/her in childhood that contribute to current depressed state.

42. Assist the client in identifying his/her unmet emotional needs and specifying ways to meet those needs (or assign "Unmet Emotional Needs—Identification and Satisfaction" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, and McInnis).

43. Hold family therapy sessions to facilitate the client's expression of conflict with family members.

44. Support the client's respectful expression of emotional needs while teaching family members and significant others to encourage, support, and tolerate

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| | the client's respectful expression of his/her thoughts and feelings. |
| 25. Improve academic performance as evidenced by better grades and positive teacher reports. (45) | 45. Challenge and encourage the client's academic effort; arrange for a tutor, if needed, to increase the client's sense of academic mastery. |
| 26. Adjust sleep hours to those typical of the developmental stage. (46) | 46. Monitor the client's sleep patterns and the restfulness of sleep; teach sleep induction methods to increase sleep (or assign "Sleep Pattern Record" in the *Adult Psychotherapy Homework Planner* by Jongsma). |
| 27. Verbalize the amount and frequency of alcohol and/or drug use. (47, 48) | 47. Assess the client for substance abuse as a means of coping with depressive feelings. |
| | 48. Refer the client for treatment or treat his/her substance abuse problems (see the Substance Use chapter in this *Planner*). |
| 28. Describe the degree of sexual activity engaged in. (49) | 49. Assess the client for sexual promiscuity as a means of trying to overcome depression; confront and treat sexual acting out (see the Sexual Promiscuity chapter in this *Planner*). |
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## DIAGNOSTIC SUGGESTIONS

*Using DSM-IV/ICD-9-CM:*

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| **Axis I:** | 309.0 | Adjustment Disorder With Depressed Mood |
| | 296.xx | Bipolar I Disorder |

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| | 296.89 | Bipolar II Disorder |
| | 300.4 | Dysthymic Disorder |
| | 301.13 | Cyclothymic Disorder |
| | 296.2x | Major Depressive Disorder, Single Episode |
| | 296.3x | Major Depressive Disorder, Recurrent Episode |
| | 295.70 | Schizoaffective Disorder |
| | 310.1 | Personality Change Due to Axis III Disorder |
| | V62.82 | Bereavement |
| | _____ | _____ |
| | _____ | _____ |
| **Axis II:** | 799.9 | Diagnosis Deferred |
| | V71.09 | No Diagnosis |
| | _____ | _____ |
| | _____ | _____ |

*Using DSM-5/ICD-9-CM/ICD-10-CM:*

| *ICD-9-CM* | *ICD-10-CM* | *DSM-5* Disorder, Condition, or Problem |
|---|---|---|
| 309.0 | F43.21 | Adjustment Disorder With Depressed Mood |
| 296.xx | F31.xx | Bipolar I Disorder |
| 296.89 | F31.81 | Bipolar II Disorder |
| 300.4 | F34.1 | Persistent Depressive Disorder |
| 301.13 | F34.0 | Cyclothymic Disorder |
| 296.2x | F32.x | Major Depressive Disorder, Single Episode |
| 296.3x | F33.x | Major Depressive Disorder, Recurrent Episode |
| 295.70 | F25.0 | Schizoaffective Disorder, Bipolar Type |
| 295.70 | F25.1 | Schizoaffective Disorder, Depressive Type |
| 310.1 | F07.0 | Personality Change Due to Another Medical Condition |
| V62.82 | Z63.4 | Uncomplicated Bereavement |

Note: The *ICD-9-CM* codes are to be used for coding purposes in the United States through September 30, 2014. *ICD-10-CM* codes are to be used starting October 1, 2014. Some *ICD-9-CM* codes are associated with more than one *ICD-10-CM* and *DSM-5* disorder, condition, or problem. In addition, some *ICD-9-CM* disorders have been discontinued, resulting in multiple *ICD-9-CM* codes being replaced by one *ICD-10-CM* code. Some discontinued *ICD-9-CM* codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.

# Appendix A

# BIBLIOTHERAPY SUGGESTIONS

## General

Many references are made throughout the chapters to a therapeutic homework resource that was developed by the authors as a corollary to the *Adolescent Psychotherapy Treatment Planner* (Jongsma, Peterson, McInnis, and Bruce). This frequently cited homework resource book is:

Jongsma, A., Peterson, L. M., & McInnis, W. (2014). *Adolescent psychotherapy homework planner* (5th ed.). Hoboken, NJ: Wiley.

There are also frequent references made to the following homework planner, which is also part of the Practice*Planner* series:

Jongsma, A. E. (2014). *Adult psychotherapy homework planner* (5th ed.). Hoboken, NJ: Wiley.

## Academic Underachievement

Bloom, J. (1991). *Help me to help my child: A sourcebook for parents of learning disabled children*. Boston, MA: Little, Brown.

Lavoie, R. (2008). *The motivation breakthrough: 6 secrets to turning on the tuned-out child*. New York, NY: Touchstone.

Martin, M., & Greenwood-Waltman, C. (Eds.). (1995). *Solve your child's school-related problems.* New York, NY: HarperCollins.

Peters, R. (2000). *Overcoming underachieving: A simple plan to boost your kids' grades and end the homework hassles*. New York, NY: Broadway.

Romain, T. (2005). *How to do homework without throwing up.* Minneapolis, MN: Free Spirit.

Schumm, J. (2005). *How to help your child with homework.* Minneapolis, MN: Free Spirit.
Silverman, S. (2001). *13 steps to better grades.* Plainview, NY: Childswork/ Childsplay.
Smith, S. (1995). *No easy answers: The learning disabled child at home and at school*. New York, NY: Bantam Books.
Willingham, D. (2010). *Why don't students like school: A cognitive scientist answers questions about how the mind works and what it means for the classroom*. San Francisco, CA: Jossey-Bass.

## Adoption

Burlingham-Brown, B. (1998). *Why didn't she keep me?: Answers to the question every adopted child asks*. Lanham, MD: Taylor.
Covey, S. (1999). *The 7 habits of highly effective families: Building a beautiful family culture in a turbulent world*. New York, NY: Simon & Schuster.
Eldridge, S. (1999). *Twenty things adopted kids wish their adoptive parents knew*. Brooklyn, NY: Delta.
Jewett, C. (1979). *Adopting the older child*. Boston, MA: Harvard Common Press.
Jewett-Jarrett, C. (1994). *Helping children cope with separation and loss*. Boston, MA: Harvard Common Press.
Kazdin, A. (2009). *The Kazdin method for parenting the defiant child*. New York, NY: Mariner.
Keck, G. (2009). *Parenting adopted adolescents: Understanding and appreciating their journeys*. Colorado Springs, CO: NavPress.
Korb-Khalsa, K., Azok, S., & Leutenberg, E. (1992). *SEALS & Plus.* Beachwood, OH: Wellness Reproductions.
Krementz, J. (1996). *How it feels to be adopted*. New York, NY: Knopf.
Lifton, B. (2009). *Lost and found: The adoption experience.* Ann Arbor: University of Michigan Press.
McCreight, B. (2002). *Parenting your adopted older child: How to overcome the unique challenges and raise a happy and healthy child.* Oakland, CA: New Harbinger.
Melina, L. (1984). *Making sense of adoption*. New York, NY: Harper & Row.
Parr, T. (2007). *We belong together: A book about adoption and families*. New York, NY: Little, Brown.
Russell, M. (2010). *Adoption wisdom: A guide to the issues and feelings of adoption*. Lavalette, WV: Broken Branch Productions.
Schooler, J., & Atwood, T. (2008). *The whole life adoption book: Realistic advice for building a healthy adoptive family*. Colorado Springs, CO: NavPress.
Slade, S. (2007). *Adopted: The ultimate teen guide*. Lanham, MD: Scarecrow Press.
Strauss, J. (1994). *Birthright: The guide to search and reunion for adoptees, birthparents, and adoptive parents.* New York, NY: Penguin.
Tyson, J. (2005). C*ommon threads of teenage grief.* Lake Dallas, TX: Kathy Helm.

## Anger Control Problems

Canter, L., & Canter, P. (1993). *Assertive discipline for parents.* New York, NY: Morrow.

Clark, L. (1998). *S.O.S.—Help for emotions.* Bowling Green, KY: Parents' Press.

Deffenbacher, J. L., & McKay, M. (2000). *Overcoming situational and general anger: Client manual.* Oakland, CA: New Harbinger.

Edgette, J. (2002). *Stop negotiating with your teen: Strategies for parenting your angry, manipulative, moody, or depressed adolescent*. New York, NY: Perigee Trade.

Greene, R. (2010). *The explosive child: A new approach for understanding and parenting easily frustrated, chronically inflexible children*. New York, NY: Harper.

Harvey, P., & Penzo, J. K. (2009). *Parenting a child who has intense emotions: Dialectical behavior therapy skills to help your child regulate emotional outbursts and aggressive behaviors*. Oakland, CA: New Harbinger.

Huebner, P (2007). *What to do when your temper flares: A kid's guide to overcoming problems with anger*. New York, NY: Magination Press.

Kapalka, G. (2007). *Parenting your out-of-control child: An effective, easy-to-use program for teaching self-control*. Oakland, CA: New Harbinger.

Kazdin, A. (2009). *The Kazdin method for parenting the defiant child*. New York, NY: Mariner.

Larson, J., & Lochman, J. (2010). *Helping schoolchildren cope with anger: A cognitive-behavioral intervention*. New York, NY: Guilford Press.

Licata, R. (1999). *Everything you need to know about anger*. New York, NY: Rosen.

Lohmann, R., & Taylor, J. (2009). *The anger workbook for teens: Activities to help you deal with anger and frustration*. Oakland, CA: New Harbinger.

Maag, J. W. (1996). *Parenting without punishment: Making problem behavior work for you*. Philadelphia, PA: Charles Press.

McKay, M., & Rogers, P. (2000). *The anger control workbook*. Oakland, CA: New Harbinger.

Murphy, T. (2001). *The angry child.* New York, NY: Three Rivers Press.

Patterson, G., & Forgatch, M. (2005). *Parents and adolescents living together: Part 1, The basics.* Champaign, IL: Research Press.

Patterson, G., & Forgatch, M. (2005). *Parents and adolescents living together: Part 2, Family problem solving*. Champaign, IL: Research Press.

Potter-Efron, R. (2005). *Angry all the time: An emergency guide to anger control.* Oakland, CA: New Harbinger.

Stewart, J. (2002). *The anger workout book for teens.* Franklin, CA: Jalmer Press.

Van Dijk, S. (2011). *Don't let your emotions run your life for teens: Dialectical behavior therapy skills for helping you manage mood swings, control angry outbursts, and get along with others*. Oakland, CA: New Harbinger.

Wolf, A. (2002). *Get out of my life, but first could you drive me and Cheryl to the mall?: A parent's guide to the new teenager.* New York, NY: Farrar, Straus & Giroux.

## Anxiety

Benson, H. (2000). *The relaxation response*. New York, NY: Morrow.

Biegel, G. (2010). *The stress reduction workbook for teens: Mindfulness skills to help you deal with stress*. Oakland, CA: New Harbinger.

Bourne, E. (2011). *The anxiety and phobia workbook*. Oakland, CA: New Harbinger.

Burns, D. (1999). *Ten days to self-esteem*. New York, NY: Morrow.

Clark, D. A., & Beck, A. T. (2012). *The anxiety and worry workbook: A cognitive and behavioral solution*. New York, NY: Guilford Press.

Craske, M. G., & Barlow, D. H. (2006). *Mastery of your anxiety and worry—Workbook.* New York, NY: Oxford University Press.

Davis, M., Robbins-Eshelman, E., & McKay, M. (2008). *The relaxation and stress reduction workbook*. Oakland, CA: New Harbinger.

Faber, A., & Mazlish, E. (2012). *How to talk so kids will listen and listen so kids will talk.* New York, NY: Scribner.

Fanning, P., & McKay, M. (2008). *Applied relaxation training* (Audio Book CD). Oakland, CA: New Harbinger.

Forsyth, J., & Eifert, G. (2008). *The mindfulness and acceptance workbook for anxiety: A guide to breaking free from anxiety, phobias, and worry using acceptance and commitment therapy*. Oakland, CA: New Harbinger.

Freeston, M., & Meares, K. (2008). *Overcoming worry: A self-help guide using cognitive behavioral techniques.* New York, NY: Basic Books.

Jeffers, S. (2006). *Feel the fear and do it anyway*. New York, NY: Ballantine Books.

Kendall, P., Choudhury, M., Hudson, J., & Webb, A. (2002). *The C.A.T. project workbook for the cognitive behavioral treatment of anxious adolescents*. Ardmore, PA: Workbook.

Knaus, W. (2008). *The cognitive behavioral workbook for anxiety: A step-by-step program.* Oakland, CA: New Harbinger.

Leahy, R. (2006). *The worry cure: Seven steps to stop worry from stopping you.* New York, NY: Three Rivers.

Manassis, K. (2008). *Keys to parenting your anxious child*. Hauppauge, NY: Barron's.

Marks, I. (2005). *Living with fear: Understanding and coping with anxiety.* New York, NY: McGraw-Hill.

McKay, M., Davis, M., & Fanning, P. (2011). *Thoughts and feelings: Taking control of your moods and your life.* Oakland, CA: New Harbinger.

McKay, M., & White, J. (1999). *Overcoming generalized anxiety disorder—Client manual: A relaxation, cognitive restructuring, and exposure-based protocol for the treatment of GAD*. Oakland, CA: New Harbinger.

Orsillo, S. M., & Roemer, L. (2011). *The mindful way through anxiety: Break free from chronic worry and reclaim your life.* New York, NY: Guilford Press.

Rapee, R., Wignall, A., Spense, S., Cobham, V., & Lyneham, H. (2008). *Helping your anxious child: A step-by-step guide for parents*. Oakland, CA: New Harbinger.

Schab, L. (2008). *The anxiety workbook for teens: Activities to help you deal with anxiety and worry*. Oakland, CA: New Harbinger.

Shapiro, L., & Sprague, R. (2009). *The relaxation and stress reduction workbook for kids: Help for children to cope with stress, anxiety, and transitions*. Oakland, CA: New Harbinger.

Tolin, D. (2012). *Face your fears: A proven plan to beat anxiety, panic, phobias, and obsessions.* Hoboken, NJ: Wiley.

Tompkins, M., & Martinez, K. (2009). *My anxious mind: A teen's guide to managing anxiety and panic.* Washington, DC: Magination Press.

Van Dijk, S. (2011). *Don't let your emotions run your life for teens: Dialectical behavior therapy skills for helping you manage mood swings, control angry outbursts, and get along with others*. Oakland, CA: New Harbinger.

Wagner, A. P. (2005). *Worried no more: Help and hope for anxious children*. Rochester, NY: Lighthouse Press.

White, J. (2008). *Overcoming generalized anxiety disorder: A relaxation, cognitive restructuring, and exposure-based protocol for the treatment of GAD—Client manual.* Oakland, CA: New Harbinger.

## Attention-Deficit/Hyperactivity Disorder (ADHD)

Alexander-Roberts, C. (1995). *ADHD and teens: A guide to making it through the tough years*. Dallas, TX: Taylor.

Barkley, R. (2000). *Taking charge of ADHD: The complete authoritative guide for parents.* New York, NY: Guilford Press.

Barkley, R. A., & Murphy, K. R. (2005). *Attention-Deficit Hyperactivity Disorder: A clinical workbook.* New York, NY: Guilford Press.

Bertin, M. (2011). *The family ADHD solution: A scientific approach to maximizing your child's attention and minimizing parental stress*. New York, NY: Palgrave Macmillan.

Crist, J. (1997). *ADHD—A teenager's guide.* Plainview, NY: Childswork/Childsplay.

Dendy-Zeigler, C. (1995). *Teenagers with ADD: A parent's guide.* Bethesda, MD: Woodbine House.

DuPaul, G., & Stoner, G. (2004). *ADHD in the schools: Assessment and intervention strategies*. New York, NY: Guilford Press.

Frank, K. (2001). ADHD: *102 practical strategies for "reducing the deficit."* Chapin, SC: Youthlight.

Hallowell, E., & Ratey, J. (2011). *Driven to distraction: Recognizing and coping with attention deficit disorder*. New York, NY: Anchor.

Honos-Webb, L. (2011). *The ADHD workbook for teens: Activities to help you gain motivation and confidence*. Oakland, CA: New Harbinger.

Kazdin, A. (2009). *The Kazdin method for parenting the defiant child*. New York, NY: Mariner.

Monastra, V. (2005). *Parenting children with ADHD: 10 lessons that medicine cannot teach*. Washington, DC: American Psychological Association.

Parker, H. (1998). *Put yourself in their shoes: Understanding teenagers with Attention Deficit Hyperactivity Disorder*. Plantation, FL: Specialty Press.

Patterson, G., & Forgatch, M. (2005). *Parents and adolescents living together: Part 1, The basics.* Champaign, IL: Research Press.
Patterson, G., & Forgatch, M. (2005). *Parents and adolescents living together: Part 2, Family problem solving*. Champaign, IL: Research Press.
Power, T. G., Karustis, J. L., & Habboushe, D. F. (2001). *Homework success for children with ADHD: A family-school intervention program.* New York, NY: Guilford Press.
Quinn, P. (1995). *Adolescents and ADD: Gaining the advantage.* Washington, DC: Magination Press.
Robin, A., & Foster, S. (2002). *Negotiating parent/adolescent conflict.* New York, NY: Guilford Press.
Silverman, S. (2001). *13 steps to better grades.* Plainview, NY: Childswork/Childsplay.
Snyder, J. (2001). *ADHD and driving: A guide for parents of teens with ADHD.* Whitefish, MT: Whitefish Consultants.
Spodak, R., & Stephano, K. (2011). *Take control of ADHD: The ultimate guide for teens with ADHD.* Austin, TX: Prufrock Press.
Zeigler-Dendy, C. A. (2006). *Teenagers with ADD and ADHD: A parent's guide.* Bethesda, MD: Woodbine House.

## Autism Spectrum Disorder

Baker, J. (2003). *Social skills training for children and adolescents with Asperger syndrome and social-communications problems*. Overland Park, KS: Asperger Autism.
Baker, J. (2006). *Preparing for life: The complete guide for transitioning to adulthood for those with autism and Asperger's syndrome.* Marquette, MI: Future Horizons.
Baker, J. (2006). *Social skills picture book for high school and beyond.* Marquette, MI: Future Horizons.
Brill, M. (2001). *Keys to parenting the child with autism.* Hauppauge, NY: Barron's.
Etlinger, R., & Tomassi, M. (2005). *To be me.* Los Angeles, CA: Creative Therapy Store.
Faherty, C. (2010). *Asperger's: What does it mean to me?* Arlington, TX: Future Horizons.
Koegel, R. L., & Koegel, L. K. (2006). *Pivotal response treatments for autism communication, social, and academic development*. Baltimore, MD: Brookes.
Koegel, R. L., & Koegel, L. K. (2012). *The PRT pocket guide: Pivotal response treatment for autism spectrum disorders*. Baltimore, MD: Brookes.
Moyes, R. (2003). *I need help with school: A guide for parents of children with autism and Asperger's syndrome*. Marquette, MI: Future Horizons.
Sastry, A., & Aguirre, B. (2012). *Parenting your child with autism: Practical solutions, strategies, and advice for helping your family*. Oakland, CA: New Harbinger.
Simons, J., & Olsihi, S. (1987). *The hidden child.* Bethesda, MD: Woodbine House.

Simons, J., & Olsihi, S. (1987). *The hidden child.* Bethesda, MD: Woodbine House.
Stillman, W. (2010). *The everything parent's guide to children with Asperger's syndrome: The sound advice and reliable answers you need to help your child succeed*. Cincinnati, OH: Adams Media.
Tillon-Jameson, A. (2010). *The everything parents' guide to children with autism.* Cincinnati, OH: Adams Media.
Waltz, M. (2002). *Autistic spectrum disorders: Understanding the diagnosis and getting help*. Harrington Park, NJ: O'Reilly.

## Bipolar Disorder

Edgette, J. (2002). *Stop negotiating with your teen: Strategies for parenting your angry, manipulative, moody, or depressed adolescent*. New York, NY: Perigee Trade.
Miklowitz, D. (2010). *The bipolar disorder survival guide: What you and your family need to know*. New York, NY: Guilford Press.
Miklowitz, D., & George, E. (2007). *The bipolar teen: What you can do to help your child and your family*. New York, NY: Guilford Press.
Papolos, D., & Papolos, J. (2007). *The bipolar child: The definitive and reassuring guide to childhood's most misunderstood disorder.* New York, NY: Broadway Books.
Patterson, G., & Forgatch, M. (2005). *Parents and adolescents living together: Part 1, The basics.* Champaign, IL: Research Press.
Patterson, G., & Forgatch, M. (2005). *Parents and adolescents living together: Part 2, Family problem solving*. Champaign, IL: Research Press.
Pavuluri, M. (2008). *What works for bipolar kids: Help and hope for parents*. New York, NY: Guilford Press.
Schab, L. (2008). *Beyond the blues: A workbook to help teens overcome depression*. Oakland, CA: New Harbinger.
Van Dijk, S., & Guidon, K. (2010). *The bipolar workbook for teens: DBT skills to help you control mood swings*. Oakland, CA: New Harbinger.
Waltz, M. (2000). *Bipolar disorders: A guide to helping children and adolescents.* Sebastopol, CA: Patient-Centered Guides.
Wilens, T. (2004). *Straight talk about psychiatric medications for kids.* New York, NY: Guilford Press.

## Blended Family

Burns, D. (1999). *Ten days to self-esteem*. New York, NY: Morrow.
Burt, M. (1989). *Stepfamilies stepping ahead: An 8-step program for successful family living.* Lincoln, NE: Stepfamily Association.
Covey, S. (1997). *The 7 habits of highly effective families.* New York, NY: Golden Books.
Deal, R. (2006). *The smart stepfamily: Seven steps to a healthy family*. Grand Rapids, MI: Bethany House.

Dudley, S. (2009). *Blended family advice: A step-by-step guide to help blended families become stronger and successful.* Bloomington, IN: Xlibris.

Einstein, E., & Albert, L. (2005). *Strengthening your stepfamily.* Manassas Park, VA: Impact.

Fassler, D., Lash, M., & Ives, S. (1988). *Changing families.* Burlington, VT: Waterfront Books.

Lintermans, G. (2011). *The secrets to stepfamily success.* Fort Lauderdale, FL: Llumina Press.

Lowe, L. (1997). Scribble art. In H. Kaduson & C. Schaefer (Eds.), *101 Favorite play therapy techniques*. New York, NY: Jason Aronson.

Markman, H., Stanley, S., & Blumberg, S. (2010). *Fighting for your marriage: Enhancing marriage and preventing divorce.* San Francisco, CA: Jossey-Bass.

Marsolini, M. (2000). *Blended families: Creating harmony as you build a new home life.* Chicago, IL: Moody Press.

Newman, M. (1994). *Stepfamily realities: How to overcome difficulties and have a happy family*. Oakland, CA: New Harbinger.

O'Hanlon, B., & Beadle, S. (1999). *A guide to possibility land: Fifty-one methods for doing brief, respectful therapy*. New York, NY: Norton.

Philips, S. (2004). *Stepchildren speak: 10 grown-up stepchildren teach us how to build healthy stepfamilies*. Portland, OR: AWYN.

Visher, E., & Visher, J. (1991). *How to win as a stepfamily.* New York, NY: Routledge.

Wisdom, S., & Green, J. (2002). *Stepcoupling: Creating and sustaining a strong marriage in today's blended family.* New York, NY: Three Rivers Press.

## Conduct Disorder/Delinquency

Bernstein, N. (2001). *How to keep your teenager out of trouble and what to do if you can't*. New York, NY: Workman.

Bloomquist, M. (2005). *Skills training for children with behavior problems: A parent and practitioner guidebook.* New York, NY: Guilford Press.

Canter, L., & Canter, P. (1993). *Assertive discipline for parents: A proven, step-by-step approach to solving everyday behavior problems.* New York, NY: Morrow.

Deffenbacher, J. L., & McKay, M. (2000). *Overcoming situational and general anger: Client manual.* Oakland, CA: New Harbinger.

Edgette, J. (2002). *Stop negotiating with your teen: Strategies for parenting your angry, manipulative, moody, or depressed adolescent*. New York, NY: Perigee Trade.

Kazdin, A. (2009). *The Kazdin method for parenting the defiant child.* New York, NY: Mariner.

Maag, J. W. (1996). *Parenting without punishment: Making problem behavior work for you.* Philadelphia, PA: Charles Press.

Metcalf, L. (1997). *Parenting towards solutions*: *How parents can use skills they already have to raise responsible, loving kids.* Englewood Cliffs, NJ: Prentice-Hall.

Patterson, G., & Forgatch, M. (2005). *Parents and adolescents living together: Part 1, The basics.* Champaign, IL: Research Press.
Patterson, G., & Forgatch, M. (2005). *Parents and adolescents living together: Part 2, Family problem solving*. Champaign, IL: Research Press.
Robin, A., & Foster, S. (2002). *Negotiating parent/adolescent conflict.* New York, NY: Guilford Press.
Scab, L. (2009). *Cool, calm, and confident: A workbook to help kids learn assertiveness skills.* Oakland, CA: New Harbinger.
Shapiro, L. E. (1996). *The teens' solutions workbook*. Plainview, NY: Childswork/Childsplay.
York, P., York, D., & Wachtel, T. (1997). *Toughlove.* New York, NY: Bantam Books.

## Divorce Reaction

Cassella-Kapusinski, L. (2006). *Now what do I do?: A guide to help teenagers with their parents' separation or divorce*. Chicago, IL: ACTA.
Clark, L. (1998). *S.O.S.—Help for emotions.* Bowling Green, KY: Parents' Press.
Jones-Soderman, J., & Quattrocchi, A. (2006). *How to talk to your children about divorce.* Scottsdale, AZ: Family Mediation Center.
Krementz, J. (1988). *How it feels when parents divorce.* New York, NY: Knopf.
Lowry, D. (2002). *What can I do?: A book for children of divorce.* Washington, DC: Magination Press.
MacGregor, C. (2004). *The divorce helpbook for teens.* Manassas, VA: Impact.
Schab, L. (2008). *The divorce workbook for teens: Activities to help you move beyond the breakup*. Oakland, CA: New Harbinger.
Strain-Trueit, T. (2007). *Surviving divorce: Teens talk about what hurts and what helps*. Danbury, CT: Children's Press.
Swan-Jackson, A., Shapiro, J., & Rosenfield, L. (1998). *When your parents split: How to keep yourself together.* Los Angeles, CA: Price Stern Sloan.
Thayer, E., & Zimmerman, J. (2001). *The co-parenting survival guide: Letting go of conflict after a difficult divorce.* Oakland, CA: New Harbinger.
Turner, K. (2010). *New beginnings for divorcing parents: Co-parenting divorce workbook*. Parker, CO: Books to Believe In.

## Eating Disorder

Apple, R., & Agras, W. (2007). *Overcoming your eating disorders: A cognitive-behavioral therapy approach for bulimia nervosa and binge-eating disorder—Workbook*. New York, NY: Oxford University Press.
Astrachan-Fletcher, E., & Maslar, M. (2009). *The dialectical behavior therapy skills workbook for bulimia: Using DBT to break the cycle and regain control of your life*. Oakland, CA: New Harbinger.
Berg, F. (2000). *Children and teens afraid to eat.* Hettinger, ND: Healthy Weight.

Cash, T. (2008). *The body image workbook: An eight-step program for learning to like your looks*. Oakland, CA: New Harbinger.

Costin, C. (2006). *The eating disorders sourcebook: A comprehensive guide to the causes, treatments, and prevention of eating disorders*. New York, NY: McGraw-Hill.

Costin, C., & Schubert-Grabb, G. (2011). *8 keys to recovery from an eating disorder: Effective strategies from therapeutic practice and personal experience*. New York, NY: Norton.

Fairburn, C. G. (2013). *Overcoming binge eating: The proven program to learn why you binge and how you can stop.* New York, NY: Guilford Press.

Heffner, M., & Eitert, G. (2004). *The anorexia workbook.* Oakland, CA: New Harbinger.

Herrin, M., & Matsumoto, N. (2007). *The parent's guide to eating disorders: Supporting self-esteem, healthy eating, and positive body image at home*. Carlsbad, CA: Gurze Books.

Herzog. D., Franko, D., & Cable, P. (2007). *Unlocking the mysteries of eating disorders: A life-saving guide to your child's treatment and recovery.* New York, NY: McGraw-Hill.

Lock, J., & le Grange, D. (2005). *Help your teenager beat an eating disorder*. New York, NY: Guilford Press.

McCabe, R., McFarlane, T., & Olmsted, M. (2004). *The overcoming bulimia workbook: Your comprehensive step-by-step guide to recovery.* Oakland, CA: New Harbinger.

Metropolitan Height and Weight Tables. (1983). New York, NY: Metropolitan Life Insurance Company, Health and Safety Division.

Rodin, J. (1993). *Body traps: Breaking the binds that keep you from feeling good about your body.* New York, NY: Quill.

Schmidt, U., & Treasure, J. (1993). *Getting better bit(e) by bit(e): A treatment manual for sufferers of bulimia nervosa*. East Sussex, England: Psychology Press.

Siegel, M., Brisman, J., & Weinshel, M. (2009). *Surviving an eating disorder: Strategies for families and friends.* New York, NY: Harper Perennial.

Wilhelm, S. (2006). *Feeling good about the way you look: A program for overcoming body image problems*. New York, NY: Guilford Press.

## Grief/Loss Unresolved

Fitzgerald, H. (2000). *The grieving teen: A guide for teenagers and their friends*. New York, NY: Fireside.

Grollman, E. (1993). *Straight talk about death for teenagers: How to cope with losing someone you love*. New York, NY: Beacon Press.

Hambrook, D., & Eisenberg, E. (1997) *A mother loss workbook: Healing exercises for daughters.* New York, NY: HarperCollins.

Horsley, H., & Horsley, G. (2008). *Teen grief relief: Parenting with understanding, support, and guidance*. Highland City, FL: Rainbow Books.

Jewett-Jarrett, C. (1994). *Helping children cope with separation and loss*. Boston, MA: Harvard Common Press.

Schab, L. (2008). *Beyond the blues: A workbook to help teens overcome depression*. Oakland, CA: New Harbinger.

Smedes, L. (2000). *How can it be all right when everything is all wrong?* Colorado Springs, CO: Shaw Books.

Traisman, E. (1992). *Fire in my heart, ice in my veins: A journal for teenagers experiencing a loss*. Omaha, NE: Centering Corporation.

Tyson, J. (2005). *Common threads of teenage grief.* Lake Dallas, TX: Kathy Helm.

Wakenshaw, M. (2005). *Caring for your grieving child: A parent's guide.* Oakland, CA: New Harbinger.

Westberg, G. (2010). *Good grief.* Philadelphia, PA: Fortress Press.

Wolfelt, A. (2001). *Healing your grieving heart for teens: 100 practical ideas*. Bozeman, MT: Companion Press.

Wolfelt, A. (2002). *The healing your grieving heart journal for teens*. Bozeman, MT: Companion Press.

## Intellectual Development Disorder

Baker, B., & Brightman, A. (2004). *Steps to independence: Teaching everyday skills to children with special needs.* Baltimore, MD: Brookes.

Harris, J. (2010). *Intellectual disability: A guide for families and professionals.* New York, NY: Oxford University Press.

Mannix, D. (2009). *Life skills activities for special children*. San Francisco, CA: Jossey-Bass.

Shapiro, L., & Sprague, R. (2009). *The relaxation and stress reduction workbook for kids: Help for children to cope with stress, anxiety, and transitions.* Oakland, CA: New Harbinger.

Trainer, M. (2003). *Differences in common: Straight talk on mental retardation, Down syndrome, and life.* Rockville, MD: Woodbine House.

## Low Self-Esteem

Block, D. (2003). *The power of positive talk: Words to help every child succeed.* Minneapolis, MN: Free Spirit.

Burns, D. (1999). *Ten days to self-esteem.* New York, NY: Morrow.

Covey, S. (1998). *The 7 habits of highly effective teens.* New York, NY: Fireside.

Covey, S. (2004). *The 7 habits of highly effective teens: Personal workbook.* New York, NY: Fireside.

Fox, M., & Sokol, L. (2011). *Think confident, be confident for teens: A cognitive therapy guide to overcoming self-doubt and creating unshakable self-esteem*. Oakland, CA: New Harbinger.

Glenn, H., & Nelsen, J. (2000). *Raising self-reliant children in a self-indulgent world: Seven building blocks for developing capable young people*. New York, NY: Three Rivers Press.

Hipp, E. (1996). *Feed your head: Some excellent stuff on being yourself*. Center Court, MN: Hazelden.

Loomans, D., & Loomans, J. (1994). *Full esteem ahead: 100 ways to build self-esteem in children and adults*. Tiburon, CA: H. J. Kramer.

McKay, M., & Fanning, P. (2000). *Self-esteem: A proven program of cognitive techniques for assessing, improving, and maintaining your self-esteem*. Oakland, CA: New Harbinger.

Nelsen, J., & Lott, L. (2012). *Positive discipline for teenagers: Empowering your teens and yourself through kind and firm parenting*. New York, NY: Three Rivers Press.

Nelsen, J., Lott, L., & Glenn, H. (2007). *Positive discipline A–Z: 1001 solutions to everyday parenting problems*. New York, NY: Three Rivers Press.

Pickhardt, C. (2003). *The everything parent's guide to positive discipline.* Holbrook, MA: Adams Media.

Powell, J. (1995). *Why am I afraid to tell you who I am?* Chicago, IL: Thomas More Press.

Schab, L. (2009). *Cool, calm, and confident: A workbook to help kids learn assertiveness skills*. Oakland, CA: New Harbinger.

Schab, L. (2013). *The self-esteem workbook for teens: Activities to help you build confidence and achieve your goals.* Oakland, CA: New Harbinger.

Schiraldi, G. (2001). *The self-esteem workbook.* Oakland, CA: New Harbinger.

Schiraldi, G. (2007). *10 simple solutions for building self-esteem: How to end self-doubt, gain confidence, & create a positive self-image*. Oakland, CA: New Harbinger.

Schweiger, I. (2008). *Self-esteem for a lifetime: Raising a successful child from the inside out*. Bloomington, IN: AuthorHouse.

Scott, S. (1997). *How to say no and keep your friends.* Highland Ranch, CO: HRC Press.

Shapiro, L. (2001). *Teen solutions workbook.* Plainview, NY: Childswork/Childsplay.

## Medical Condition

Babcock, E. (1997). *When life becomes precious: A guide for loved ones and friends of cancer patients*. New York, NY: Bantam Books.

Bluebond-Langner, M. (2000). *In the shadow of illness.* Princeton, NJ: Princeton University Press.

Cline, F., & Greene, L. (2007). *Parenting children with health issues: Essential tools, tips, and tactics for raising kids with chronic illness, medical conditions, and special healthcare needs*. Golden, CO: Love and Logic Press.

Dorfman, E. (1998). *The C-word: Teenagers and their families living with cancer.* New York, NY: New Sage Press.

Fromer, M. (1998). *Surviving childhood cancer: A guide for families.* Oakland, CA: New Harbinger.

Gosselin, K. (1998a). *Taking asthma to school.* Princeton, NJ: Jayjo Books.

Gosselin, K. (1998b). *Taking diabetes to school.* Princeton, NJ: Jayjo Books.

Gosselin, K. (1998c). *Taking seizure disorder to school.* Princeton, NJ: Jayjo Books.
Greene, R. (2010). *The explosive child: A new approach for understanding and parenting easily frustrated, chronically inflexible children*. New York, NY: Harper.
Keene, N. (2010). *Childhood leukemia: A guide for families, friends, & caregivers.* Bellingham, WA: Childhood Cancer Guides.
Keene, N., Hobbie, W., & Ruccione, K. (2012). *Childhood cancer survivors: A practical guide to your future.* Bellingham, WA: Childhood Cancer Guides.
Kushner, H. (2004). *When bad things happen to good people.* New York, NY: Anchor.
Smedes, L. (2000). *How can it be all right when everything is all wrong?* Colorado Springs, CO: Shaw Books.
Strohm, K. (2007). *Being the other one: Growing up with a brother or sister who has special needs*. Boston, MA: Shambhala.
Westberg, G. (2010). *Good grief.* Philadelphia, PA: Fortress Press.
Woznick, L. (2002). *Living with childhood cancer: A practical guide to help parents cope.* Washington, DC: American Psychological Association.

## Negative Peer Influences

Bernstein, N. (2001). *How to keep your teenager out of trouble and what to do if you can't*. New York, NY: Workman.
Cherniss, H., & Sluke, S. (2001). *The complete idiot's guide to surviving peer pressure for teens*. New York, NY: Alpha Books.
Edgette, J. (2002). *Stop negotiating with your teen: Strategies for parenting your angry, manipulative, moody, or depressed adolescent*. New York, NY: Perigee Trade.
Goldstein, A., & McGinnis, E. (1997). *Skillstreaming the adolescent: Student manual.* Champaign, IL: Research Press.
Moles, K. (2001). *Teen relationship workbook.* Woodbury, NY: Wellness Reproductions.
Prinstein, M., & Dodge, K. (Eds.) (2010). *Understanding peer influence in children and adolescents*. New York, NY: Guilford Press.
Rosemond, J. (2000). *Teen-proofing: Fostering responsible decision making in your teenager*. Kansas City, MO: Andrews McMeel.
Scott, S. (1997). *How to say no and keep your friends.* Highland Ranch, CO: HRC Press.
Shapiro, L. (2001). *Teen solutions workbook.* Plainview, NY: Childswork/Childsplay.

## Obsessive-Compulsive Disorder (OCD)

Biegel, G. (2010). *The stress reduction workbook for teens: Mindfulness skills to help you deal with stress*. Oakland, CA: New Harbinger.
Chansky, T. E. (2001). *Freeing your child from obsessive-compulsive disorder: Powerful, practical solutions to overcome your child's fears, worries, and phobias.* New York, NY: Random House.

Fitzgibbons, L., & Pedrick, C. (2003). *Helping your child with OCD.* Oakland, CA: New Harbinger.

Foa, E., & Wilson, R. (2001). *Stop obsessing!: How to overcome your obsessions and compulsions*. New York, NY: Bantam Books.

Huebner, D. (2007). *What to do when your brain gets stuck: A kid's guide to overcoming OCD.* New York, NY: Magination Press.

March, J. (2006). *Talking back to OCD: The program that helps kids and teens say "no way"—and parents say "way to go."* New York, NY: Guilford Press.

Orsillo, S. M., & Roemer, L. (2011). *The mindful way through anxiety: Break free from chronic worry and reclaim your life*. New York, NY: Guilford Press.

Piacentini, J., Langley, A., & Roblek, T. (2007). *It's only a false alarm: A cognitive behavioral treatment program—Client workbook.* New York, NY: Oxford University Press.

Rompella, N. (2009). *Obsessive-compulsive disorder: The ultimate teen guide*. Lanham, MD: Scarecrow Press.

Schab, L. (2008). *The anxiety workbook for teens: Activities to help you deal with anxiety and worry*. Oakland, CA: New Harbinger.

Schwartz, J. (1997). *Brain lock: Free yourself from obsessive-compulsive behavior.* New York, NY: Harper Perennial.

Sisemore, T. (2010). *Free from OCD: A workbook for teens with obsessive-compulsive disorder*. Oakland, CA: New Harbinger.

Stallard, P. (2002). *Think good—feel good: A cognitive behaviour therapy workbook for children*. Hoboken, NJ: Wiley.

Wagner, A. P. (2002). *What to do when your child has obsessive-compulsive disorder: Strategies and solutions*. Rochester, NY: Lighthouse Press.

Waltz, M. (2000). *Obsessive-compulsive disorder: Help for children and adolescents.* Sebastopol, CA: Patient-Centered Guides.

Yadin, E., Foa, E., & Lichner, T. (2012). *Treating your OCD with exposure and response (ritual) prevention: Workbook*. New York, NY: Oxford University Press.

## Oppositional Defiant Disorder

Aborn, A. (1994). *Everything I do you blame on me: A book to help children control their anger.* Plainview, NY: Childswork/Childsplay.

Barkley, R., & Benton, C. (1998). *Your defiant child: Eight steps to better behavior.* New York, NY: Guilford Press.

Bernstein, J. (2006). *10 days to a less defiant child: The breakthrough program for overcoming your child's difficult behavior.* New York, NY: Marlowe & Company.

Bayard, R. T., & Bayard, J. (1998). *How to deal with your acting-up teenager: Practical self-help for desperate parents.* Markham, Ontario, Canada: Fitzhenry and Whiteside.

Deffenbacher, J. L., & McKay, M. (2000). *Overcoming situational and general anger: Client manual.* Oakland, CA: New Harbinger.

Edgette, J. (2002). *Stop negotiating with your teen: Strategies for parenting your angry, manipulative, moody, or depressed adolescent*. New York, NY: Perigee Trade.

Kaye, K. (2005). *Family rules: Raising responsible children.* Bloomington, IN: iUniverse.

Kazdin, A. (2009). *The Kazdin method for parenting the defiant child.* New York, NY: Mariner.

Maag, J. W. (1996). *Parenting without punishment: Making problem behavior work for you.* Philadelphia, PA: Charles Press.

MacKenzie, R. (2001). *Setting limits with your strong-willed child: Eliminating conflict by establishing clear, firm, and respectful boundaries*. New York, NY: Three Rivers Press.

Metcalf, L. (1997). *Parenting towards solutions*: *How parents can use skills they already have to raise responsible, loving kids.* Englewood Cliffs, NJ: Prentice-Hall.

Patterson, G., & Forgatch, M. (2005). *Parents and adolescents living together: Part 1, The basics.* Champaign, IL: Research Press.

Patterson, G., & Forgatch, M. (2005). *Parents and adolescents living together: Part 2, Family problem solving*. Champaign, IL: Research Press.

Riley, D. (1997). *The defiant child: A parent's guide to oppositional defiant disorder.* New York, NY: Taylor.

Schab, L. (2009). *Cool, calm, and confident: A workbook to help kids learn assertiveness skills*. Oakland, CA: New Harbinger.

Wenning, K. (1999). *Winning cooperation from your child: A comprehensive method to stop defiant and aggressive behavior in children.* Northvale, NJ: Aronson.

York, P., York, D., & Wachtel, T. (1997). *Toughlove.* New York, NY: Bantam Books.

Zodkevitch, R. (2006). *The Toughlove prescription: How to create and enforce boundaries for your teen*. New York, NY: McGraw-Hill.

## Overweight/Obesity

Block, D. (2003). *The power of positive talk: Words to help every child succeed.* Minneapolis, MN: Free Spirit.

Brown, C. (2012). *Thick bones: Cause of and cures for teen obesity*. Boston, MA: Lorac.

Brownell, K. (2004). *The LEARN program for weight management.* Dallas, TX: American Health.

Chansky, T. (2008). *Freeing your child from negative thinking: Powerful, practical strategies to build a lifetime of resilience, flexibility, and happiness.* Cambridge, MA: Da Capo Press.

Dolgoff, J. (2009). *Red light, green light, eat right: The food solution that lets kids be kids.* Emmaus, PA: Rodale Books.

Rockwell, L. (2009*). Good enough to eat: A kid's guide to food and nutrition*. New York, NY: HarperCollins.

Satter, E. (2005). *Your child's weight: Helping without harming—Birth through adolescence*. Madison, WI: Kelcy Press.

Schab, L. (2009). *Cool, calm, and confident: A workbook to help kids learn assertiveness skills.* Oakland, CA: New Harbinger.

Shapiro, L., & Sprague, R. (2009). *The relaxation and stress reduction workbook for kids: Help for children to cope with stress, anxiety, and transitions.* Oakland, CA: New Harbinger.

Sothern, M., von Almen, T., & Schumacher, H. (2003). *Trim kids: The proven 12-week plan that has helped thousands of children achieve a healthier weight.* New York, NY: Morrow.

Stallard, P. (2002). *Think good—feel good: A cognitive behaviour therapy workbook for children*. Hoboken, NJ: Wiley.

Vos, M. (2009). *The no-diet obesity solution for kids*. Bethesda, MD: AGA Institute Press.

Weight Watchers. (2010). *Weight watchers eat! move! play!: A parent's guide for raising healthy, happy kids*. Hoboken, NJ: Wiley.

Wollenberg, B. (2010). *Overweight kids in a toothpick world: How to solve the childhood obesity puzzle and get your kids in balance*. New York, NY: Choices Lifestyle.

## Panic/Agoraphobia

Antony, M. M., & McCabe, R. E. (2004). *10 simple solutions to panic: How to overcome panic attacks, calm physical symptoms, and reclaim your life*. Oakland, CA: New Harbinger.

Barlow, D., & Craske, M. (2006). *Mastery of your anxiety and panic: Workbook*. New York, NY: Oxford University Press.

Benson, H. (2000). *The relaxation response*. New York, NY: Morrow.

Biegel, G. (2010). *The stress reduction workbook for teens: Mindfulness skills to help you deal with stress*. Oakland, CA: New Harbinger.

Bourne, E. (2011). *The anxiety and phobia workbook*. Oakland, CA: New Harbinger.

Burns, D. (2006). *When panic attacks: The new, drug-free anxiety therapy that can change your life*. New York, NY: HarperAudio.

Carbonell, D. (2004). *Panic attacks workbook: A guided program for beating the panic trick*. Berkeley, CA: Ulysses Press.

Davis, M., Robbins-Eshelman, E., & McKay, M. (2008). *The relaxation and stress reduction workbook*. Oakland, CA: New Harbinger.

Jeffers, S. (2006). *Feel the fear and do it anyway*. New York, NY: Ballantine Books.

Knaus, W. (2008). *The cognitive behavioral workbook for anxiety: A step-by-step program.* Oakland, CA: New Harbinger.

Marks, I. M. (2001). *Living with fear.* London, England: McGraw-Hill.

Pincus, D., Ehrenreich, J., & Spiegel, D. (2008). *Riding the wave workbook*. New York, NY: Oxford University Press.

Rapee, R., Wignall, A., Spense, S., Cobham, V., & Lyneham, H. (2008). *Helping your anxious child: A step-by-step guide for parents*. Oakland, CA: New Harbinger.

Schab, L. (2008). *The anxiety workbook for teens: Activities to help you deal with anxiety and worry*. Oakland, CA: New Harbinger.

Shapiro, L., & Sprague, R. (2009). *The relaxation and stress reduction workbook for kids: Help for children to cope with stress, anxiety, and transitions.* Oakland, CA: New Harbinger.

Tolin, D. (2012). *Face your fears: A proven plan to beat anxiety, panic, phobias, and obsessions*. Hoboken, NJ: Wiley.

Tompkins, M., & Martinez, K. (2009). *My anxious mind: A teen's guide to managing anxiety and panic.* Washington, DC: Magination Press.

Van Dijk, S. (2011). *Don't let your emotions run your life for teens: Dialectical behavior therapy skills for helping you manage mood swings, control angry outbursts, and get along with others*. Oakland, CA: New Harbinger.

Wilson, R. R. (1996). *Don't panic: Taking control of anxiety attacks.* New York, NY: Harper.

## Parenting

Bluestein, J. (1993). *Parents, teens, and boundaries: How to draw the line.* Deerfield Beach, FL: Health Communications.

Cline, F., & Fay, J. (2005). *Parenting teens with love and logic.* Golden, CO: Love and Logic Press.

Cline, F., & Greene, L. (2007). *Parenting children with health issues: Essential tools, tips, and tactics for raising kids with chronic illness, medical conditions, and special health care needs*. Golden, CO: Love and Logic Press.

Faber, A., & Mazlish, E. (2012). *How to talk so kids will listen and listen so kids will talk.* New York, NY: Scribner.

Kazdin, A. (2009). *The Kazdin method for parenting the defiant child.* New York, NY: Mariner.

Kellner, M. (2003). *Staying in control: Anger management skills for parents of young adolescents*. Ottawa, Ontario: Research Press.

Nelsen, J., & Lott, L. (2012). *Positive discipline for teenagers: Empowering your teens and yourself through kind and firm parenting*. New York, NY: Three Rivers Press.

Patterson, G., & Forgatch, M. (2005). *Parents and adolescents living together: Part 1, The basics.* Champaign, IL: Research Press.

Patterson, G., & Forgatch, M. (2005). *Parents and adolescents living together: Part 2, Family problem solving*. Champaign, IL: Research Press.

Patterson, G. R. (1982). *Coercive family process.* Eugene, OR: Castalia.

Phelan, T. (1998). *Surviving your adolescents: How to manage and let go of your 13–18 year olds.* Glen Ellyn, IL: Parentmagic.

Pickhardt, C. (2003). *The everything parent's guide to positive discipline.* Holbrook, MA: Adams Media.

Renshaw-Joslin, K. (1994). *Positive parenting from A to Z*. New York, NY: Fawcett Books.

Schaefer, C., & DiGeronimo, T. (2000). *Ages and stages: A parent's guide to normal childhood development.* New York, NY: Wiley.

Taffel, R. (2001). *The second family: How adolescent power is challenging the American family*. New York, NY: St. Martin's Press.
Tracy, F. (1994). *Grounded for life: Stop blowing your fuse and start communicating.* Seattle, WA: Parenting Press.
Windell, J. (1997). *Children who say no when you want them to say yes: Failsafe discipline strategies for stubborn and oppositional children and teens.* New York, NY: Wiley.
Wolf, A. (2002). *Get out of my life but first could you drive me and Cheryl to the mall?: A parent's guide to the new teenager*. New York, NY: Farrar, Straus & Giroux.

## Peer/Sibling Conflict

Bieniek, D. (1996). *How to end the sibling wars.* Plainview, NY: Childswork/Childsplay.
Cohen, R. (2005). *Students resolving conflict: Peer mediation in schools*. Culver City, CA: Goodyear Books.
Crist, J., & Verdick, E. (2010). *Siblings: You're stuck with each other, so stick together*. Minneapolis, MN: Free Spirit.
Dellasega, C., & Nixon, C. (2003). *Girl wars: 12 strategies that will end female bullying.* New York, NY: Fireside.
Drew, N. (2004). *The kids' guide to working out conflicts: How to keep cool, stay safe, and get along*. Minneapolis, MN: Free Spirit.
Faber, A., & Mazlish, E. (2012). *How to talk so kids will listen and listen so kids will talk.* New York, NY: Scribner.
Faber, A., & Mazlish, E. (2012). *Siblings without rivalry: How to help your children live together so you can live too*. New York, NY: Norton.
Ginott, H. (1977). *Between parent and teenager.* New York, NY: Macmillan.
Goldenthal, P. (2000). *Beyond sibling rivalry: How to help your children become cooperative, caring, and compassionate*. New York, NY: Holt.
Kaplan, L. (1997). *Coping with peer pressure.* Center City, MN: Hazelden.
Moles, K. (2001). *Teen relationship workbook.* Plainview, NY: Childswork/Childsplay.
Sachs, S. (1997). *Street gang awareness: A resource guide for parents and professionals.* Minneapolis, MN: Fairview Press.
Scott, S. (1997). *How to say no and keep your friends: Peer pressure reversal for teens and preteens.* Amherst, MA: Human Resource Development Press.
Selekman, M. (2002). *Solution-focused therapy with children: Harnessing family strengths for systemic change*. New York, NY: Guilford Press.
Shapiro, L. (2001). *Teen solutions workbook.* Plainview, NY: Childswork/Childsplay.

## Physical/Emotional Abuse Victim

Copeland, M. E., & Harris, M. (2000). *Healing the trauma of abuse: A woman's workbook.* Oakland, CA: New Harbinger.

Holmes, M. (2000). *A terrible thing happened: A story for children who have witnessed violence or trauma.* Washington, DC: Magination Press.
Jantz, G. (2009). *Healing the scars of emotional abuse.* New York, NY: Revell.
Levine, P., & Kline, M. (2006). *Trauma through a child's eyes: Awakening the ordinary miracle of healing*. Berkeley, CA: North Atlantic Books.
Miller, A. (1984). *For your own good.* New York, NY: Farrar Straus Group.
Monahon, C. (1995). *Children and trauma: A parent's guide to helping children heal.* New York, NY: Lexington Press.

## Posttraumatic Stress Disorder (PTSD)

Allen, J. (2004). *Coping with trauma: Hope through understanding.* Arlington, VA: American Psychiatric Press.
Biegel, G. (2010). *The stress reduction workbook for teens: Mindfulness skills to help you deal with stress*. Oakland, CA: New Harbinger.
Brooks, B., & Siegel, P. M. (1996). *The scared child: Helping kids overcome traumatic events.* New York, NY: Wiley.
Carter, W. L. (2002). *It happened to me.* Oakland, CA: New Harbinger.
Chrestman, K., Gilboa-Schechtman, E., & Foa, E. (2008). *Prolonged exposure therapy for PTSD—Teen workbook*. New York, NY: Oxford University Press.
Davis, M., Robbins-Eshelman, E., & McKay, M. (2008). *The relaxation and stress reduction workbook*. Oakland, CA: New Harbinger.
Eifert, G. H., Forsyth, J. P., & McKay, M. (2006). *ACT on life not on anger.* Oakland, CA: New Harbinger.
Flannery, R., Jr. (1995). *Posttraumatic stress disorder: The victim's guide to healing and recovery.* New York, NY: Crossroad.
Kennerly, H. (2000). *Overcoming childhood trauma: A self-help guide using cognitive behavioral techniques.* New York, NY: New York University Press.
Knaus, W. (2008). *The cognitive behavioral workbook for anxiety: A step-by-step program.* Oakland, CA: New Harbinger.
Leith, L. (1998). *Exercising your way to better mental health.* Morgantown, WV: Fitness Information Technology.
Matsakis, A. (1996). *I can't get over it: A handbook for trauma survivors*. Oakland, CA: New Harbinger.
Monahon, C. (1995). *Children and trauma: A parent's guide to helping children heal.* New York, NY: Lexington Books.
Patterson, G., & Forgatch, M. (2005). *Parents and adolescents living together: Part 1, The basics.* Champaign, IL: Research Press.
Patterson, G., & Forgatch, M. (2005). *Parents and adolescents living together: Part 2, Family problem solving*. Champaign, IL: Research Press.
Rothbaum, B., Foa, E., & Hembree, E. (2007). *Reclaiming your life from a traumatic experience: A prolonged exposure treatment program workbook*. New York, NY: Oxford University Press.

Schiraldi, G. (2009). *The post-traumatic stress disorder sourcebook: A guide to healing, recovery, and growth*. New York, NY: McGraw-Hill.

Tolin, D. (2012). *Face your fears: A proven plan to beat anxiety, panic, phobias, and obsessions*. Hoboken, NJ: Wiley.

Tompkins, M., & Martinez, K. (2009). *My anxious mind: A teen's guide to managing anxiety and panic.* Washington, DC: Magination Press.

Williams, M. B., & Poijula, S. (2002). *The PTSD workbook: Simple, effective techniques for overcoming traumatic stress symptoms.* Oakland, CA: New Harbinger.

## Psychoticism

Adamec, C. (1996). *How to live with a mentally ill person: A handbook of day-to-day strategies*. New York, NY: Wiley.

Amador, X. (2011). *I am not sick, I don't need help!: How to help someone with mental illness accept treatment*. Peconic, NY: Vida Press.

Mueser, K., & Gingerich, S. (2006). *The complete family guide to schizophrenia: Helping your loved one get the most out of life*. New York, NY: Guilford Press.

Torrey, E. (2006). *Surviving schizophrenia: A family manual.* New York, NY: Harper & Row.

Wilens, T. (2004). *Straight talk about psychiatric medications for kids.* New York, NY: Guilford Press.

Woolis, R. (1996). *When someone you love has a mental illness: A handbook for friends, family, and caregivers*. New York, NY: Penguin.

## Runaway

Bowley, M. (2012). *The white umbrella: Walking with survivors of sex trafficking*. Chicago, IL: Moody Press.

Carter, W. L. (2002). *It happened to me.* Oakland, CA: New Harbinger.

Elkind, D. (1998). *All grown up and no place to go: Teenagers in crisis.* New York, NY: Da Capo Press.

Fox, M., & Sokol, L. (2011). *Think confident, be confident for teens: A cognitive therapy guide to overcoming self-doubt and creating unshakable self-esteem*. Oakland, CA: New Harbinger.

Hanson, L. (1996). *Feed your head: Some excellent stuff on being yourself.* Center Court, MN: Hazelden.

McKay, M., & Fanning, P. (2000). *Self-esteem: A proven program of cognitive techniques for assessing, improving, and maintaining your self-esteem*. Oakland, CA: New Harbinger.

Phelps, C. (2012). *Runaway girl: Escaping life on the streets, one helping hand at a time.* New York, NY: Viking.

Powell, J. (1995). *Why am I afraid to tell you who I am?* Chicago, IL: Thomas More Press.

Ryan, K., & Kelley, T. (2012). *Almost home: Helping kids move from homelessness to hope*. Hoboken, NJ: Wiley.

Schab, L. (2009). *Cool, calm, and confident: A workbook to help kids learn assertiveness skills*. Oakland, CA: New Harbinger.

Schab, L. (2013). *The self-esteem workbook for teens: Activities to help you build confidence and achieve your goals.* Oakland, CA: New Harbinger.

Schiraldi, G. (2001). *The self-esteem workbook.* Oakland, CA: New Harbinger.

Schiraldi, G. (2007). *10 simple solutions for building self-esteem: How to end self-doubt, gain confidence, & create a positive self-image*. Oakland, CA: New Harbinger.

Schweiger, I. (2008). *Self-esteem for a lifetime: Raising a successful child from the inside out*. Bloomington, IN: AuthorHouse.

Scott, S. (1997). *How to say no and keep your friends.* Highland Ranch, CO: HRC Press.

Shapiro, L. (2001). *Teen solutions workbook.* Plainview, NY: Childswork/Childsplay.

## School Violence Perpetrator

Begun, R., & Huml, F. (Eds.). (1998). *Ready-to-use violence prevention skills, lessons and activities for secondary students.* San Francisco, CA: Jossey-Bass.

Chrestman, K., Gilboa-Schechtman, E., & Foa, E. (2008). *Prolonged exposure therapy for PTSD—Teen workbook*. New York, NY: Oxford University Press.

Coloroso, B. (2009). *The bully, the bullied, and the bystander: From preschool to high school—How parents and teachers can help break the cycle*. New York, NY: Morrow.

Deffenbacher, J. L., & McKay, M. (2000). *Overcoming situational and general anger: Client manual.* Oakland, CA: New Harbinger.

Fried, S., & Fried, P. (1998). *Bullies & victims: Helping your child survive the schoolyard battlefield.* New York, NY: M. Evans & Co.

Green, R. (2010). *The explosive child: A new approach for understanding and parenting easily frustrated, chronically inflexible children*. New York, NY: Harper.

Haber, J. (2007). *Bullyproof your child for life: Protect your child from teasing, taunting, and bullying for good*. New York, NY: Perigee.

Harvey, P., & Penzo, J. K. (2009). *Parenting a child who has intense emotions: Dialectical behavior therapy skills to help your child regulate emotional outbursts and aggressive behaviors*. Oakland, CA: New Harbinger.

Huebner, P. (2007). *What to do when your temper flares: A kid's guide to overcoming problems with anger*. New York, NY: Magination Press.

Kapalka, G. (2007). *Parenting your out-of-control child: An effective, easy-to-use program for teaching self-control*. Oakland, CA: New Harbinger.

Kazdin, A. (2009). *The Kazdin method for parenting the defiant child.* New York, NY: Mariner.

Kennerly, H. (2000). *Overcoming childhood trauma: A self-help guide using cognitive behavioral techniques*. New York, NY: New York University Press.
Licata, R. (1999). *Everything you need to know about anger.* New York, NY: Rosen.
Lohmann, R., & Taylor, J. (2009). *The anger workbook for teens: Activities to help you deal with anger and frustration*. Oakland, CA: New Harbinger.
Matsakis, A. (1996). *I can't get over it: A handbook for trauma survivors.* Oakland, CA: New Harbinger.
Monahon, C. (1995). *Children and trauma: A parent's guide to helping children heal.* New York, NY: Lexington Books.
Murphy, T. (2001). *The angry child.* New York, NY: Three Rivers Press.
Nelsen, J., & Lott, L. (2012). *Positive discipline for teenagers: Empowering your teens and yourself through kind and firm parenting*. New York, NY: Three Rivers Press.
Potter-Efron, R. (2005). *Angry all the time: An emergency guide to anger control*. Oakland, CA: New Harbinger.
Rothbaum, B., Foa, E., & Hembree, E. (2007). *Reclaiming your life from a traumatic experience: A prolonged exposure treatment program workbook.* New York, NY: Oxford University Press.
Shearin-Karres, E. (2000). *Violence-proof your kids now.* Berkeley, CA: Conari Press.
Stewart, J. (2002). *The anger workout book for teens.* Franklin, CA: Jalmer Press.
Van Dijk, S. (2011). *Don't let your emotions run your life for teens: Dialectical behavior therapy skills for helping you manage mood swings, control angry outbursts, and get along with others*. Oakland, CA: New Harbinger.
Williams, M. B., & Poijula, S. (2002). *The PTSD workbook: Simple, effective techniques for overcoming traumatic stress symptoms.* Oakland, CA: New Harbinger.

## Sexual Abuse Perpetrator

Browne, J. (2011). *Dating for dummies.* Hoboken, NJ: Wiley.
Carnes, D. (2001). *Out of the shadows: Understanding sexual addiction.* Minneapolis, MN: Hazelden.
Cline, F., & Fay, J. (2005). *Parenting teens with love and logic.* Golden, CO: Love and Logic Press.
Covey, S. (1997). *The 7 habits of highly effective teens: The ultimate teenage success guide.* New York, NY: Fireside.
Covey, S. (1997). *The 7 habits of highly effective teens—Workbook:* New York, NY: Fireside.
Covey, S. (1999). *The 7 habits of highly effective families: Building a beautiful family culture in a turbulent world*. New York, NY: Simon & Schuster.
Hunter, J. (2010). *Help for adolescent males with sexual behavior problems: A cognitive-behavioral treatment program—Workbook*. New York, NY: Oxford University Press.
Kahn, T. (2002). *Pathways: Guide for parents*. Brandon, VT: Safer Society Press.

Kahn, T. (2011). *Pathways: A guided workbook for youth beginning treatment*. Brandon, VT: Safer Society Press.
Katherine, A. (1994). *Boundaries: Where you end and I begin.* Minneapolis, MN: Hazelden.
Katherine, A. (2000). *Where to draw the line: How to set healthy boundaries every day*. New York, NY: Fireside.
Kazdin, A. (2009). *The Kazdin method for parenting the defiant child.* New York, NY: Mariner.
Kuriansky, J. (2004). *The complete idiot's guide to dating.* New York, NY: Alpha Books.
Lohmann, R., and Taylor, J. (2009). *The anger workbook for teens: Activities to help you deal with anger and frustration*. Oakland, CA: New Harbinger.
McKay, M., & Rogers, P. (2000). *The anger control workbook*. Oakland, CA: New Harbinger.
Patterson, G., & Forgatch, M. (2005). *Parents and adolescents living together: Part 1, The basics.* Champaign, IL: Research Press.
Pickhardt, C. (2003). *The everything parent's guide to positive discipline.* Holbrook, MA: Adams Media.
Potter-Efron, R. (2005). *Angry all the time: An emergency guide to anger control*. Oakland, CA: New Harbinger.
Steen, C. (1999). *The relapse prevention workbook for youth in treatment for juvenile sex offenders*. Brandon, VT: Safer Society Press.
Stewart, J. (2002). *The anger workout book for teens.* Franklin, CA: Jalmer Press.
Van Dijk, S. (2011). *Don't let your emotions run your life for teens: Dialectical behavior therapy skills for helping you manage mood swings, control angry outbursts, and get along with others*. Oakland, CA: New Harbinger.

## Sexual Abuse Victim

Adams, C., & Fay, J. (1992). *Helping your child recover from sexual abuse.* Seattle: University of Washington Press.
Brohl, K., & Potter, J. (2004). *When your child has been molested: A parent's guide to healing and recovery.* San Francisco, CA: Jossey-Bass.
Carnes, D. (2001). *Out of the shadows: Understanding sexual addiction*. Minneapolis, MN: Hazelden.
Carter, W. L. (2002). *It happened to me: A teen's guide to overcoming sexual abuse workbook.* Oakland, CA: New Harbinger.
Copeland, M. E., & Harris, M. (2000). *Healing the trauma of abuse: A woman's workbook.* Oakland, CA: New Harbinger.
Feuereisen, P. (2009). *Invisible girls: The truth about sexual abuse*. New York, NY: Seal Press.
Katherine, A. (1994). *Boundaries: Where you end and I begin.* Minneapolis, MN: Hazelden.

Katherine, A. (2000). *Where to draw the line: How to set healthy boundaries every day*. New York, NY: Fireside.

Mather, C. (2004). *How long does it hurt: A guide to recovering from incest and sexual abuse for teenagers, their friends, and their families*. San Francisco, CA: Jossey-Bass.

McGee, S., & Holmes, C. (2008). *Finding sunshine after the storm: A workbook for children healing from sexual abuse*. Oakland, CA: New Harbinger.

Riskin, K., & Munson, L. (1995). *In their own words: A sexual abuse workbook for teenage girls.* Atlanta, GA: CWLA Press.

Rothbaum, B., Foa, E., & Hembree, E. (2007). *Reclaiming your life from a traumatic experience: A prolonged exposure treatment program workbook*. New York, NY: Oxford University Press.

## Sexual Identity Confusion

Bernstein, R. (2003). *Straight parents, gay children: Keeping families together*. Cambridge, MA: Da Capo Press.

Brill, S., & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. Berkeley, CA: Cleis Press.

Ehrensaft, D. (2011). *Gender born, gender made: Raising healthy gender-nonconforming children*. New York, NY: The Experiment.

Gomes, P. (2002). *The good book: Reading the Bible with mind and heart.* New York, NY: HarperOne.

Griffin, C., Wirth, A., & Wirth, M. (1997). *Beyond acceptance: Parents of lesbians and gays talk about their experiences.* New York, NY: St. Martin's Press.

Jennings, K. (Ed.). (1994). *Becoming visible: A reader in gay and lesbian history for high school and college students.* Los Angeles, CA: Alyson.

Jennings, K. (2002). *Always my child: A parent's guide to understanding your gay, lesbian, bisexual, transgendered or questioning son or daughter*. New York, NY: Touchstone.

LaSala, M. (2010). *Coming out, coming home: Helping families adjust to a gay or lesbian child*. New York, NY: Columbia University Press.

Marcus, E. (2005). *Is it a choice? Answers to the most frequently asked questions about gays and lesbians.* San Francisco, CA: HarperOne.

McDougall, B. (Ed.). (2007). *My child is gay: How parents react when they hear the news*. Sydney, Australia: Allen & Unwin.

Zucker, K., & Bradley, S. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York, NY: Guilford Press.

## Sexual Promiscuity

Cohen, K. (2011). *Dirty little secrets: Breaking the silence on teenage girls and promiscuity*. Naperville, IL: Sourcebooks.

Cohen-Hoffman, K. (2007). *Easy*. New York, NY: Simon & Schuster.
Meeker, M. (2007). *Your kids at risk: How teen sex threatens our sons and daughters.* Washington, DC: Regnery.
Pipher, M. (2005). *Reviving Ophelia: Saving the selves of adolescent girls.* New York, NY: Riverhead Books.
Scott, S. (1997). *How to say no and keep your friends.* Amherst, MA: HRD Press.

## Social Anxiety

Antony, M. M., & Swinson, R. P. (2008). *The shyness and social anxiety workbook: Proven, step-by-step techniques for overcoming your fear.* Oakland, CA: New Harbinger.
Barrett, P. M. (2006). *Friends for life workbook for youth*. Brisbane, Australia: Australian Academic Press.
Butler, G. (2008). *Overcoming social anxiety and shyness: A self-help guide using cognitive behavioral techniques*. New York, NY: Basic Books.
Brozovich, R., & Chase, L. (2008). *Say goodbye to being shy: A workbook to help kids overcome shyness*. Oakland, CA: New Harbinger.
Cain, B. (2000). *I don't know why—I guess I'm shy.* Washington, DC: Magination Press.
Carducci, B. (2003). *The shyness breakthrough.: A no-stress plan to help your shy child warm up, open up, and join the fun*. Emmaus, PA: Rodale Books.
Cohen, C. (2000). *Raising your child's social IQ.* Alfamonte Springs, FL: Advantage Books.
Craske, M. G., & Barlow, D. H. (2006). *Mastery of your anxiety and worry—Workbook.* New York, NY: Oxford University Press.
Davis, M., Robbins-Eshelman, E., & McKay, M. (2008). *The relaxation and stress reduction workbook*. Oakland, CA: New Harbinger.
Desberg, P. (1996). *No more butterflies: Overcoming shyness, stage fright, interview anxiety, and fear of public speaking.* Oakland, CA: New Harbinger.
Fanning, P., & McKay, M. (2008). *Applied relaxation training* (Audio Book CD). Oakland, CA: New Harbinger.
Flowers, S. (2009). *The mindful path through shyness: How mindfulness and compassion can help free you from social anxiety, fear, and avoidance*. Oakland, CA: New Harbinger.
Forsyth, J., & Eifert, G. (2008). *The mindfulness and acceptance workbook for anxiety: A guide to breaking free from anxiety, phobias, and worry using acceptance and commitment therapy*. Oakland, CA: New Harbinger.
Garner, A. (1997). *Conversationally speaking: Tested new ways to increase your personal and social effectiveness*. Los Angeles, CA: Lowell House.
Hope, D., Heimberg, R., & Turk, C. (2010). *Managing social anxiety—Workbook: A cognitive-behavioral therapy approach*. New York, NY: Oxford University Press.
Lamb-Shapiro, J. (2002). *Sometimes I don't like to talk (but sometimes I can't keep quiet).* Plainview, NY: Childswork/Childsplay.

Markway, B., & Markway, G. (2006). *Nurturing the shy child: Practical help for raising confident and socially skilled kids and teens.* New York, NY: St. Martin's Griffin.

Rapee, R. M. (1998). *Overcoming shyness and social phobia: A step-by-step guide*. Northvale, NJ: Aronson.

Rapee, R., Wignall, A., Spence, S., Cobham, V., & Lyneham, H. (2008). *Helping your anxious child: A step-by-step guide for parents.* Oakland, CA: New Harbinger.

Shannon, J. (2012). *The shyness and social anxiety workbook for teens: CBT and ACT skills to help you build social confidence*. Oakland, CA: New Harbinger.

Shapiro, L., & Sprague, R. (2009). *The relaxation and stress reduction workbook for kids: Help for children to cope with stress, anxiety, and transitions.* Oakland, CA: New Harbinger.

Soifer, S., Zgourides, G. D., Himle, J., & Pickering, N. L. (2001). *Shy bladder syndrome: Your step-by-step guide to overcoming paruresis.* Oakland, CA: New Harbinger.

Spencer, E., DuPont, R., & DuPont, C. (2003). *The anxiety cure for kids: A guide for parents.* Hoboken, NJ: Wiley.

Swallow, W. (2000). *The shy child: Helping children triumph over shyness*. New York, NY: Grand Central.

Tolin, D. (2012). *Face your fears: A proven plan to beat anxiety, panic, phobias, and obsessions*. Hoboken, NJ: Wiley.

Webster-Doyle, T. (1999). *Why is everybody always picking on me? A guide to understanding bullies for young people.* Boston, MA: Weatherhill.

## Specific Phobia

Antony, M. M., Craske, M. C., & Barlow, D. H. (2006). *Mastery of your fears and phobias—Workbook.* New York, NY: Oxford University Press.

Bourne, E. (2011). *Anxiety and phobia workbook.* Oakland, CA: New Harbinger.

Chansky, T. (2004). *Freeing your child from anxiety: Powerful, practical solutions to overcome your child's fears, worries, and phobias.* New York, NY: Three Rivers Press.

Chansky, T. (2008). *Freeing your child from negative thinking: Powerful, practical strategies to build a lifetime of resilience, flexibility, and happiness*. New York, NY: Da Capo Press.

Forsyth, J., & Eifert, G. (2008). *The mindfulness and acceptance workbook for anxiety: A guide to breaking free from anxiety, phobias, and worry using acceptance and commitment therapy*. Oakland, CA: New Harbinger.

Manassis, K. (2008). *Keys to parenting your anxious child.* Hauppauge, NY: Barron's.

Marks, I. M. (2005). *Living with fear: Understanding and coping with anxiety.* London, England: McGraw-Hill.

Rapee, R., Wignall, A., Spence, S., Cobham, V., & Lyneham, H. (2008). *Helping your anxious child: A step-by-step guide for parents.* Oakland, CA: New Harbinger.

Tolin, D. (2012). *Face your fears: A proven plan to beat anxiety, panic, phobias, and obsessions*. Hoboken, NJ: Wiley.
Wilson, R. (1996). *Don't panic: Taking charge of anxiety attacks.* New York, NY: Harper.

## Substance Use

Al-Anon Family Group Headquarters. (1983). *Alateen: A day at a time.* New York, NY: Al-Anon Family Group Headquarters.
Alcoholics Anonymous. (1976). *Alcoholics anonymous: The big book.* New York, NY: Alcoholics Anonymous World Services.
Bell, T. (1990). *Preventing adolescent relapse.* Independence, MO: Herald House.
Black, C. (2002). *It will never happen to me.* Center City, MN: Hazelden.
Bradshaw, J. (1988). *Bradshaw on the family.* Pompano Beach, FL: Health Communications.
Brown, S., & Lewis, V. (2000). *The family recovery guide: A map for healthy growth*. Oakland, CA: New Harbinger.
Ellis, D. (1986). *Growing up stoned.* Pompano Beach, FL: Health Communications.
Fanning, P., & O'Neil, J. (1996). *The addiction workbook.* Oakland, CA: New Harbinger.
Gorski, T. (1996). *Adolescent relapse prevention workbook: A brief strategic approach*. Haverton, PA: Independence Press.
Hornik-Beer, E. (2001). *For teenagers living with a parent who abuses alcohol/drugs*. Bloomington, IN: iUniverse.
Ketcham, K., & Pace, N. (2003). *Teens under the influence: The truth about kids, alcohol, and other drugs—How to recognize the problem and what to do about it*. New York, NY: Ballantine Books.
Narcotics Anonymous. (1982). *Narcotics anonymous.* Van Nuys, CA: NA World Services Office.
Wegscheider, S. (1989). *Another chance: Hope and health for the alcoholic family.* Palo Alto, CA: Science and Behavioral Books.
Williams, R., & Kraft, J. (2012). *The mindfulness workbook for addiction: A guide to coping with the grief, stress and anger that trigger addictive behaviors*. Oakland, CA: New Harbinger.
Woititz, J. G. (1983). *Adult children of alcoholics.* Pompano Beach, FL: Health Communications.

## Suicidal Ideation

Butler, P. (2008). *Talking to yourself: How cognitive behavior therapy can change your life*. Charleston, SC: BookSurge.
Ellis, T. (1996). *Choosing to live: How to defeat suicide through cognitive therapy*. Oakland, CA: New Harbinger.

Gilson, M., Freeman, A., Yates, M., & Freeman, S. (2009). *Overcoming depression: A cognitive therapy approach—Workbook*. New York, NY: Oxford University Press.
Helmstetter, S. (1990). *What to say when you talk to yourself.* New York, NY: Pocket Books.
Huddle, L., & Schleifer, J. (2011). *Teen suicide*. New York, NY: Rosen Classroom.
Knaus, B. (2012). *A cognitive behavioral workbook for depression: A step-by-step program*. Oakland, CA: New Harbinger.
Leith, L. (1998). *Exercising your way to better mental health.* Morgantown, WV: Fitness Information Technology.
Marra, T. (2004). *Depressed and anxious: The dialectical behavioral therapy workbook.* Oakland, CA: New Harbinger.
McCoy, K. (1994). *Understanding your teenager's depression.* New York, NY: Perigee.
McKay, M., Davis, M., & Fanning, P. (2011). *Thoughts and feelings: Taking control of your moods and your life.* Oakland, CA: New Harbinger.
Miklowitz, D. (2010) *Bipolar disorder survival guide: What you and your family need to know*. New York, NY: Guilford Press.
Pettit, J., & Joiner, T. (2005). *The interpersonal solution to depression: A workbook for changing how you feel by changing how you relate*. Oakland, CA: New Harbinger.
Schab, L. (2008). *Beyond the blues: A workbook to help teens overcome depression*. Oakland, CA: New Harbinger.
Seligman, M. (2006). *Learned optimism: How to change your mind and your life.* New York, NY: Vintage.
Seligman, M. (2011). *Flourish: A visionary new understanding of happiness and well-being*. New York, NY: Free Press.
Shapiro, L. (2001). *The teens' solutions workbook.* Plainview, NY: Childswork/Childsplay.

## Unipolar Depression

Barnard, M. (2003). *Helping your depressed child: A step-by-step guide for parents.* Oakland, CA: New Harbinger.
Burns, D. D. (1999). *Feeling good: The new mood therapy.* New York, NY: Harper.
Chansky, T. (2008). *Freeing your child from negative thinking: Powerful, practical strategies to build a lifetime of resilience, flexibility, and happiness.* Cambridge, MA: Da Capo Press.
Davis, M., Robbins-Eshelman, E., & McKay, M. (2008). *The relaxation and stress reduction workbook.* Oakland, CA: New Harbinger.
Fassler, D. G., & Dumas, L. S. (1998). *"Help me, I'm sad": Recognizing, preventing, and treating childhood and adolescent depression.* New York, NY: Penguin.
Gilson, M., Freeman, A., Yates, M., & Freeman, S. (2009). *Overcoming depression: A cognitive therapy approach workbook*. New York, NY: Oxford University Press.

Graham, P., & Hughes, C. (2005). *So young, so sad, so listen.* London, England: RCPsych.

Hamil, S. (2008). *My feeling better workbook: Help for kids who are sad and depressed.* Oakland, CA: New Harbinger.

Ingersoll, B., & Goldstein, S. (2001). *Lonely, sad, and angry: How to help your unhappy child.* North Branch, MN: Specialty Press.

Leith, L. (1998). *Exercising your way to better mental health.* Morgantown, WV: Fitness Information Technology.

Manassis, K., & Levac, A. M. (2004). *Helping your teenager beat depression: A problem-solving approach for families*. Bethesda, MD: Woodbine House.

Marra, T. (2004). *Depressed and anxious: The dialectical behavioral therapy workbook.* Oakland, CA: New Harbinger.

McKay, M., Davis, M., & Fanning, P. (2011). *Thoughts and feelings: Taking control of your moods and your life.* Oakland, CA: New Harbinger.

Mondimore, F. (2002). *Adolescent depression: A guide for parents*. Baltimore, MD: Johns Hopkins University Press.

Schab, L. (2008). *Beyond the blues: A workbook to help teens overcome depression*. Oakland, CA: New Harbinger.

Shapiro, L. (2001). *The teens' solutions workbook.* Plainview, NY: Childswork/ Childsplay.

Shapiro, L., & Sprague, R. (2009). *The relaxation and stress reduction workbook for kids: Help for children to cope with stress, anxiety, and transitions.* Oakland, CA: New Harbinger.

Stark, K., Yancy, M., Simpson, J., Schnoebelen, S., Hargrave, J., & Molnar, J. (2007). *"ACTION" workbook for parents of depressed girls*. Ardmore, PA: Workbook.

Stark, K., Yancy, M., Simpson, J., Schnoebelen, S., Hargrave, J., Molnar, J., & Glen, R. (2007). *"ACTION" workbook: Cognitive-behavioral therapy for treating depressed girls*. Ardmore, PA: Workbook.

# Appendix B

# PROFESSIONAL REFERENCES FOR EVIDENCE-BASED CHAPTERS

## SOURCES INFORMING EVIDENCE-BASED TREATMENT PLANNING AND PRACTICE


Agency for Healthcare Research and Quality. http://www.ahrq.gov/clinic/epcix.htm

American Academy of Child & Adolescent Psychiatry. http://www.aacap.org

American Psychiatric Association. *American Psychiatric Association practice guidelines.* Arlington, VA: American Psychiatric Association. Retrieved from http://psychiatryonline.org/guidelines.aspx

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: Author.

APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61,* 271–285.

Chambless, D. L., & T. H. Ollendick (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology, 52*, 685–716.

Cochrane Collaboration Reviews. http://www.cochrane.org/

Fisher, J. E., & O'Donohue, W. T. (Eds.) *Practitioners' guide to evidence-based psychotherapy.* New York, NY: Springer.

Jongsma, A. E., & Bruce, T. J. (2010–2012). *Evidence-based psychotherapy treatment planning* [DVD-based series]. Hoboken, NJ: Wiley. Available from www.wiley.com/go/ebtdvds

Nathan, P. E., & Gorman, J. M. (Eds.). (2007). *A guide to treatments that work* (3rd ed.). New York, NY: Oxford University Press.

National Institute for Health and Clinical Excellence. http://www.nice.org.uk/

Norcross, J. C. (Ed.). (2011). *Psychotherapy relationships that work* (2nd ed.). New York, NY: Oxford University Press.

Society of Clinical Child and Adolescent Psychology. *Effective child therapy: Evidence-based mental health treatment for children and adolescents.* Retrieved from http://effectivechildtherapy.com

Substance Abuse and Mental Health Services Administration (SAMHSA). *National Registry of Evidence-based Programs and Practices.* Retrieved from http://nrepp.samhsa.gov/index.asp

Therapy Advisor. www.therapyadvisor.com

Weisz, J. R., & Kazdin, A. E. (2010). *Evidence-based psychotherapies for children and adolescents* (2nd ed.). New York, NY: Guilford Press.

## Anger Control Problems

### *Empirical Support*

Barry, T. D., & Pardini, D. A. (2003). Anger control training for aggressive youth. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 263–281). New York, NY: Guilford Press.

Brestan, E. V., & Eyberg, S. M. (1998). Effective psychosocial treatments of conduct-disordered children and adolescents: 29 years, 82 studies, and 5,272 kids. *Journal of Clinical Child Psychology, 27*(2), 180–189.

Deffenbacher, J. L., Oetting, E. R., & DiGiuseppe, R. A. (2002). Principles of empirically supported interventions applied to anger management. *The Counseling Psychologist, 30*, 262–280.

Feindler, E. L. (1995). An ideal treatment package for children and adolescents with anger disorders. In H. Kassinove (Ed.), *Anger disorders: Definition, diagnosis, and treatment* (pp. 173–194). New York, NY: Taylor & Francis.

Feindler, E. L., & Baker, K. (2004). Current issues in anger management interventions with youth. In A. P. Goldstein, R. Nensen, B. Daleflod, & M. Kalt (Eds.), *New perspectives on aggression replacement training: Practice, research, and application* (pp. 31–50). Hoboken, NJ: Wiley.

Kazdin, A. E. (2005). *Parent management training: Treatment for oppositional, aggressive, and antisocial behavior in children and adolescents.* New York, NY: Oxford University Press.

Lochman, J. E., Boxmeyer, C. L., Powell, N. P., Barry, T. D., & Pardini, D. A. (2010). Anger control training for aggressive youths. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 227–242). New York, NY: Guilford Press.

Lochman, J. E., Powell, N. R., Whidby, J. M., & FitzGerald, D. P. (2006). Aggressive children: Cognitive-behavioral assessment and treatment. In P. C. Kendall (Ed.), *Child and adolescent therapy: Cognitive-behavioral procedures* (3rd ed., pp. 33–81). New York, NY: Guilford Press.

Meichenbaum, D. (1993). Stress inoculation training: A twenty-year update. In R. L. Woolfolk and P. M. Lehrer (Eds.), *Principles and practices of stress management*. New York, NY: Guilford Press.

Sukhodolsky, D. G., & Scahill, L. S. (2012). *Cognitive-behavioral therapy for anger and aggression in children*. New York, NY: Guilford Press.

Vecchio, T. D., & O'Leary, K. D. (2004). Effectiveness of anger treatments for specific anger problems: A meta-analytic review. *Clinical Psychology Review, 24*, 15–34.

Zisser, A., & Eyberg, S. M. (2010). Treating oppositional behavior in children using parent-child interaction therapy. In J. R. Weisz & A. E. Kazdin (Eds.) *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 179–193). New York, NY: Guilford Press.

### *Clinical Resources*

Feinder, E. L. (Ed.). (2006). *Anger related disorders: A practitioner's guide to comparative treatments*. New York, NY: Springer.

Functional Family Therapy. www.fftinc.com

Incredible Years. www.incredibleyears.com.

Kazdin, A. E. (2005). *Parent management training: Treatment for oppositional, aggressive, and antisocial behavior in children and adolescents.* New York, NY: Oxford University Press.

Larson, J., & Lochman, J. E. (2010). *Helping schoolchildren cope with anger: A cognitive-behavioral intervention* (2nd ed.). New York, NY: Guilford Press.

Lochman, J. E., Boxmeyer, C. L., Powell, N. P., Barry, T. D., & Pardini, D. A. (2010). Anger control training for aggressive youths. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 227–242). New York, NY: Guilford Press.

McMahon, R., and Forehand, R. (2005). *Helping the noncompliant child: Family-based treatment for oppositional behavior*. New York, NY: Guilford Press.

Patterson, G. R. (1976). *Living with children: New methods for parents and teachers*. Champaign, IL: Research Press.

Sexton, T. (2010). *Functional family therapy in clinical practice: An evidence-based treatment model for working with troubled adolescents*. New York, NY: Routledge.

Triple, P. www.triplep.net

Williams, E., and Barlow, R. (1998). *Anger control training manual*. New York, NY: Winslow Press.

Zisser, A., & Eyberg, S. M. (2010). Treating oppositional behavior in children using parent-child interaction therapy. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 179–193). New York, NY: Guilford Press.

## Anxiety

### *Empirical Support*

American Academy of Child & Adolescent Psychiatry. (2007). Practice parameters for the assessment and treatment of children and adolescents with anxiety

disorders. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*(2), 267–283.

Grills-Taquechel, A. E., & Ollendick, T. H. (2013). *Phobic and anxiety disorders in children and adolescents*. Cambridge, MA: Hogrefe.

James, A. A. C. J., Soler, A., & Weatherall, R. R. W. (2009). Cognitive behavioural therapy for anxiety disorders in children and adolescents. *Cochrane Database of Systematic Reviews, 2009*(4), CD004690. doi:10.1002/14651858.CD004690.pub2

Kendall, P. C., Furr, J. M., & Podell, J. L. (2010). Child-focused treatment of anxiety. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 45–60). New York, NY: Guilford Press.

Pahl, K. M., & Barrett, P. M. (2010). Interventions for anxiety disorders in children using group cognitive behavioral therapy with family involvement. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 61–79). New York, NY: Guilford Press.

Seligman, L. D., & Ollendick, T. H. (2011). Cognitive-behavioral therapy for anxiety disorders in youth. *Child and Adolescent Psychiatry Clinics of North America, 20*(2), 217–238.

Silverman, W. K., Pina, A. A., & Viswesvaran, C. (2008). Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents: A review and meta-analyses. *Journal of Clinical Child & Adolescent Psychology, 37*, 105–130.

### *Clinical Resources*

Barrett, P. M. (2005). *Friends for Life: Group leader's manual for youth* (4th ed.). Brisbane: Australian Academic Press.

Barrett, P. M. (2007). *Fun Friends: The teaching and training manual for group leaders.* Brisbane, Australia: Fun Friends.

Bernstein, D. A., Borkovec, T. D., & Hazlett-Stevens, H. (2000). *New directions in progressive relaxation training: A guidebook for helping professionals*. Westport, CT: Praeger.

Flannery-Schroeder, E., & Kendall, P. C. (1996). *Cognitive behavioral therapy for anxious children: Therapist manual for group treatment.* Retrieved from www.workbookpublishing.com

Howard, B., Chu, B. C., Krain, A. L., Marrs-Garcia, A. L., & Kendall, P. C. (2000). *Cognitive-behavioral family therapy for anxious children* (2nd ed.). Retrieved from www.workbookpublishing.com

Kendall, P. C., Choudhury, M., Hudson, J., & Webb, A. (2002). *"The C.A.T. Project" manual for the cognitive behavioral treatment of anxious adolescents.* Retrieved from www.workbookpublishing.com

March, J. S., Parker, J. D., Sullivan, K., Stallings, P., & Conners, C. K. (1997). The multidimensional anxiety scale for children (MASC): Factor structure, reliability, and validity. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*, 544–565.

Ollendick, T. H. (1987). The fear survey schedule for children—revised. In M. Hersen & A. S. Bellack (Eds.), *Dictionary of behavioral assessment techniques* (pp. 218–220). Elmsford, NY: Pergamon Press.

Ollendick, T. H., & March, J. C. (2004). *Phobic and anxiety disorders in children and adolescents: A clinician's guide to effective psychosocial and pharmacological interventions.* New York, NY: Oxford University Press.

Rapee, R. M., Wignall, A., Hudson, J. L., & Schniering, C. A. (2010). *Treating anxious children and adolescents*. Oakland, CA: New Harbinger.

Reynold, C. R., & Richmond, B. O. (2008). *Revised children's manifest anxiety scale* (2nd ed.). Torrance, CA: Western Psychological Services.

Semple, R. J., & Lee, J. (2011). *Mindfulness-based cognitive therapy for anxious children*. Oakland, CA: New Harbinger.

Silverman, W. K., & Albano, A. M. (1996). *The anxiety disorders interview schedule for DSM-IV—Child and parent versions*. London, England: Oxford University Press.

## Attention-Deficit/Hyperactivity Disorder (ADHD)

### *Empirical Support*

American Academy of Child & Adolescent Psychiatry. (2007). Practice parameters for the assessment and treatment of children and adolescents with attention deficit/hyperactivity disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*(7), 894–921.

Brown, R. T., Amler, R. W., Freeman, W. S., Perrin, J. M., Stein, M. T., Feldman, H. M., . . . American Academy of Pediatrics Subcommittee on Attention-Deficit/Hyperactivity Disorder. (2005). Treatment of attention-deficit/hyperactivity disorder: Overview of the evidence. *Pediatrics, 115*, 749–757.

Chronis, A. M., Chacko, A., Fabiano, G. A., Wymbs, B. T., & Pelham, W. E. (2004). Enhancements to the standard behavioral parent training paradigm for families of children with ADHD: Review and future directions. *Clinical Child and Family Psychology Review, 7,* 1–27.

Hinshaw, S. P., Klein, R. G., & Abikoff, H. (2007). Childhood attention deficit hyperactivity disorder: Nonpharmacological treatments and their combination with medication. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (pp. 3–27). New York, NY: Oxford University Press.

Kutcher, S., Aman, M., Brooks, S. J., Buitelaar, J., van Daalen, E., Fegert, J., . . . Tyano, S. (2004). International consensus statement on attention-deficit/hyperactivity disorder (ADHD) and disruptive behaviour disorders (DBDs): Clinical implications and treatment practice suggestions. *European Neuropsychopharmacology, 14*(1), 11–28.

Molina, B. S. G., Hinshaw, S. P., Swanson, J. M., Arnold, L. E., Vitiello, B., Jensen, P. S., . . . the MTA Cooperative Group. (2009). MTA at 8 years: Prospective follow-up of children treated for combined-type ADHD in a multisite study. *Journal of the American Academy of Child & Adolescent Psychiatry, 48,* 484–500.

MTA Cooperative Group. (1999). A 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. *Archives of General Psychiatry, 56,* 1073–1086.

MTA Cooperative Group. (2004). National Institute of Mental Health Multimodal Treatment Study of ADHD Follow-up: 24-month outcomes of treatment strategies for attention-deficit/hyperactivity disorder. *Pediatrics, 113*, 754–761.

National Institute for Health and Clinical Excellence. (2008). *Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people, and adults.* Clinical guideline 72. Retrieved from http://guidance.nice.org.uk/CG72

Pelham, W. E., & Fabiano, G. A. (2008). Evidence-based psychosocial treatments for attention-deficit/hyperactivity disorder. *Journal of Clinical Child and Adolescent Psychology, 37*(1), 184–214.

Pelham, W. E., Fabiano, G. A., Gnagy, E. M., Greiner, A. R., & Hoza, B. (2005). Comprehensive psychosocial treatment for ADHD. In E. Hibbs and P. Jensen (Eds.), *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice* (pp. 377–409). Washington, DC: American Psychological Association.

Pelham, W. E., Fabiano, G. A., Gnagy, E. M., Greiner, A. R., & Hoza, B. (2005). The role of summer treatment programs in the context of comprehensive treatment for ADHD. In E. Hibbs & P. Jensen (Eds.), *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice* (pp. 377–410). Washington, DC: APA Press.

Pelham, W. E., Gnagy, E. M., Greiner, A. R., Waschbusch, D. A., Fabiano, G. A., & Burrows-MacLean, L. (2010). Summer treatment programs for attention deficit disorder. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 159–168). New York, NY: Guilford Press.

Rickel, A. U., & Brown, R. T. (2007). *Attention deficit/hyperactivity disorder in children and adults*. Cambridge, MA: Hogrefe.

Yamashita, Y., & Pelham, W. E. (2005). Evidence-based comprehensive treatment for children and families with ADHD. *Journal of the Japanese Child Psychiatry and Neurology Society, 45*(1), 11–30.

### *Clinical Resources*

Barkley, R. A. (2005). ADHD: *A handbook for diagnosis and treatment* (3rd ed.). New York, NY: Guilford Press.

Barkley, R. A. (2013). *Defiant children: A clinician's manual for assessment and parent training* (3rd ed.). New York, NY: Guilford Press.

DuPaul, G. J. (1991). Parent and teacher ratings of ADHD symptoms: Psychometric properties in a community-based sample. *Journal of Clinical Child Psychology, 20*, 245–253.

DuPaul, G. J., & Stoner, G. (2003). *ADHD in the schools: Assessment and intervention strategies*. New York, NY: Guilford Press.

Kazdin, A. E. (2005). *Parent management training: Treatment for oppositional, aggressive, and antisocial behavior in children and adolescents.* New York, NY: Oxford University Press.

Pelham, W. E., Gnagy, E. M., Greenslade, K. E., & Milich, R. (1992). Teacher ratings of DSN-III-R symptoms for the disruptive behavior disorders. *Journal of the American Academy of Child & Adolescent Psychiatry*, *31,* 210–218.

Pelham, W. E., Greiner, A. R., & Gnagy, E. M. (1997). *Children's summer treatment program manual.* Buffalo, NY: Comprehensive Treatment for Attention Deficit Disorders.

## Bipolar Disorder

### *Empirical Support*

Goldstein, T. R., Axelson, D. A., Birmaher, B., & Brent, D. A. (2007). Dialectical behavior therapy for adolescents with bipolar disorder: A one-year open trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(7), 820–830.

Miklowitz, D. J., Axelson, D. A., Birmaher, B., George, E. L., Taylor, D. O., Schneck, C. D., . . . Brent, D. A. (2008). Family-focused treatment for adolescents with bipolar disorder: Results of a 2-year randomized trial. *Archives of General Psychiatry, 65*(9), 1053–1061.

Miklowitz, D. J., Biuckians, A., & Richards, J. A. (2006). Early-onset bipolar disorder: A family treatment perspective. *Developmental Psychopathology, 18*(4), 1247–1265.

West, A. E., & Pavuluri, M. N. (2009). Psychosocial treatments for childhood and adolescent bipolar disorder. *Child and Adolescent Psychiatric Clinics of North America, 18*(2), 471–482.

Young, M. E., & Fristad, M. A. (2007). Evidence-based treatments for bipolar disorder in children and adolescents. *Journal of Contemporary Psychotherapy, 37*, 157–164.

### *Clinical Resources*

Frank, E. (2005). *Treating bipolar disorder: A clinician's guide to interpersonal and social rhythm therapy*. New York, NY: Guilford Press.

Goldstein, T. R., Axelson, D. A., Birmaher, B., & Brent, D. A. (2007). Dialectical behavior therapy for adolescents with bipolar disorder: A one-year open trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*(7), 820–830.

Hlastala, S., & Frank, F. (2006). Adapting interpersonal and social rhythm therapy to the developmental needs of adolescents with bipolar disorder. *Developmental Psychopathology, 18*, 1267–1288.

Miklowitz, D. J. (2008). *Bipolar disorder: A family-focused treatment approach* (2nd ed.). New York, NY: Guilford Press.

Miklowitz, D. J. (2012). Family treatment for bipolar disorder and substance abuse in late adolescence. *Journal of Clinical Psychology, 68*(5), 502–513.

Miller, A. L., Rathus, J. H., & Linehan, M. M. (2006). *Dialectical behavior therapy with suicidal adolescents.* New York, NY: Guilford Press.

## Conduct Disorder/Delinquency

### *Empirical Support*

Alexander, J. F., Holtzworth-Munroe, A., & Jameson, P. B. (1994). The process and outcome of marital and family therapy research: Review and evaluation. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 595–630). New York, NY: Wiley.

Barry, T. D., & Pardini, D. A. (2003). Anger control training for aggressive youth. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 263–281). New York, NY: Guilford Press.

Brestan, E. V., & Eyberg, S. M. (1998). Effective psychosocial treatments of conduct-disordered children and adolescents: 29 years, 82 studies, and 5,272 kids. *Journal of Clinical Child Psychology, 27*(2), 180–189.

Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). Evidence-based psychosocial treatments for child and adolescent with disruptive behavior. *Journal of Clinical Child & Adolescent Psychology*, 37, 215–237.

Forgatch, M. S., & Patterson, G. R. (2010). Parent management training—Oregon model: An intervention for antisocial behavior in children and adolescents. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 159–168). New York, NY: Guilford Press.

Furlong, M., McGilloway, S., Bywater, T., Hutchings, J., Smith, S. M., & Donnelly, M. (2012). Behavioural and cognitive-behavioural group-based parenting programmes for early-onset conduct problems in children aged 3 to 12 years. Cochrane Database of Systematic Reviews, *2012*(2), CD008225. doi: 10.1002/14651858.CD008225.pub2

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic treatment of antisocial behavior in children and adolescents*. New York, NY: Guilford Press.

Kazdin, A. E. (2005). *Parent management training: Treatment for oppositional, aggressive, and antisocial behavior in children and adolescents*. New York, NY: Oxford University Press.

Kazdin, A. E. (2007). Psychosocial treatments for conduct disorder in children and adolescents. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (3rd ed., pp. 71–104). New York, NY: Oxford University Press.

Kazdin, A. E. (2010). Problem-solving skills training and parent management training for conduct disorder. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 211–226). New York, NY: Guilford Press.

Kutcher, S., Aman, M., Brooks, S. J., Buitelaar, J., van Daalen, E., Fegert, J., . . . Tyano, S. (2004). International consensus statement on attention-deficit/

hyperactivity disorder (ADHD) and disruptive behaviour disorders (DBDs): Clinical implications and treatment practice suggestions. *European Neuropsychopharmacology, 14*(1), 11–28.

Lochman, J. E., Boxmeyer, C. L., Powell, N. P., Barry, T. D., & Pardini, D. A. (2010). Anger control training for aggressive youths. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 227–242). New York, NY: Guilford Press.

Robbins, M. S., Horigian, V., Szapocznik, J., & Ucha, J. (2010). Treating Hispanic youths using brief strategic family therapy. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 375–390). New York, NY: Guilford Press.

Robbins, M. S., Schwartz, S., & Szapocznik, J. (2004). Structural ecosystems therapy with Hispanic adolescents exhibiting disruptive behavior disorders. In J. R. Ancis (Ed.), *Culturally responsive interventions: Innovative approaches to working with diverse populations* (pp. 71–99). New York, NY: Brunner-Routledge.

Woolfenden, S., Williams, K. J., & Peat, J. (2001). Family and parenting interventions in children and adolescents with conduct disorder and delinquency aged 10–17. *Cochrane Database of Systematic Reviews, 2001*(2), CD003015. doi: 10.1002/14651858.CD003015

### *Clinical Resources*

Achenbach, T. M., & Edelbrock, C. (1991). *Manual for the child behavior checklist*. Burlington, VT: Department of Psychiatry, University of Vermont.

Barkley, R. A. (2013). *Defiant children: A clinician's manual for assessment and parent training* (3rd ed.). New York, NY: Guilford Press.

Eyberg, S., & Pincus, D. (1999*). Eyberg child behavior inventory & Sutter-Eyberg student behavior inventory—revised: Professional manual.* Odessa, FL: Psychological Assessment Resources.

Forgatch, M. S., & Patterson, G. R. (2010). Parent management training—Oregon model: An intervention for antisocial behavior in children and adolescents. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 159–168). New York, NY: Guilford Press.

Functional Family Therapy. www.fftinc.com

Gerard, A. B. (1994). *Parent-child relationship inventory (PCRI) manual.* Los Angeles, CA: WPS.

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic treatment of antisocial behavior in children and adolescents.* New York, NY: Guilford Press.

Kazdin, A. E. (2005). *Parent management training: Treatment for oppositional, aggressive, and antisocial behavior in children and adolescents.* New York, NY: Oxford University Press.

Kazdin, A. E. (2010). Problem-solving skills training and parent management training for conduct disorder. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based*

*psychotherapies for children and adolescents* (2nd ed., pp. 211–226). New York, NY: Guilford Press.

Lochman, J. E., Boxmeyer, C. L., Powell, N. P., Barry, T. D., & Pardini, D. A. (2010). Anger control training for aggressive youths. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 227–242). New York, NY: Guilford Press.

Robbins, M. S., Szapocznik, J., Santisteban, D. A., Hervis, O., Mitrani, V. B., & Schwartz, S. (2003). Brief strategic family therapy for Hispanic youth. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 407–424). New York, NY: Guilford Press.

## Eating Disorder

### *Anorexia Nervosa*

**Empirical Support for Family-Based Therapy**

Eisler, I., Simic, M., Russell, G. F. M., & Dare, C. (2007). A randomized controlled treatment trial of two forms of family therapy in adolescent anorexia nervosa: A five year follow-up. *Journal of Child Psychology and Psychiatry, 48*(6), 552–560.

Keel, P. K., & Haedt, A. (2008). Evidence-based psychosocial treatments for eating problems and eating disorders. *Journal of Clinical Child & Adolescent Psychology, 37,* 39–61.

Lock, J., Agras, W. S., Bryson, S., & Kraemer, H. C. (2005). A comparison of short- and long-term family therapy for adolescent anorexia nervosa. *Academy of Child & Adolescent Psychiatry, 44,* 632–639.

Lock, J., le Grange, D., Agras, W. S., Moye, A., Bryson, S. W., & Jo, B. (2010). Randomized clinical trial comparing family-based treatment with adolescent-focused individual therapy for adolescents with anorexia nervosa. *Archives of General Psychiatry*, *67*(10), 1025–1032.

Loeb, K. L. (Accessed April 2012). Eating disorders and obesity. *American Psychological Association Division 12 website on research-supported psychological treatments. Retrieved from* http://www.div12.org/PsychologicalTreatments/disorders/eating_main.php

Robin, A. L., & le Grange, D. (2010). Family therapy for adolescents with anorexia nervosa. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 1345–358). New York, NY: Guilford Press.

**Clinical Resource**

Lock, J., & le Grange, D. (2012). *Treatment manual for anorexia nervosa: A family-based approach* (2nd ed.). New York, NY: Guilford Press.

## *Bulimia Nervosa*

**Empirical Support for Cognitive-Behavioral Therapies***

Agras, W. S., Walsh, T., Fairburn, C. G., Wilson, G. T., & Kraemer, H. C. (2000). A multicenter comparison of cognitive-behavioral therapy and interpersonal psychotherapy for bulimia nervosa. *Archives of General Psychiatry, 57*(5), 459–466.

Berkman, N. D., Bulik, C. M., Brownley, K. A., Lohr, K. N., Sedway, J. A., Rooks, A., & Gartlehner, G. (2006, April). *Management of eating disorders.* Evidence Report/Technology Assessment No. 135. (Prepared by the RTI International–University of North Carolina Evidence-Based Practice Center Under Contract No. 290-02-0016.) AHRQ Publication No. 06-E010. Rockville, MD: Agency for Healthcare Research and Quality.

Cooper, P. J., & Steere, J. (1995). A comparison of two psychological treatments for bulimia nervosa: Implications for models of maintenance. *Behaviour Research and Therapy, 33*, 875–885.

Fairburn, C. G., Jones, R., Peveler, R. C., Carr, S. J., Solomon, R. A., O'Connor, M. E., & Hope, R. A. (1991). Three psychological treatments for bulimia nervosa: A comparative trial. *Archives of General Psychiatry, 48,* 463–469.

Fairburn, C. G., Kirk, J., O'Connor, M., & Cooper, P. J. (1986). A comparison of two psychological treatments for bulimia nervosa. *Behaviour Research and Therapy, 24*, 629–643.

Garner, D. M., Rockert, W., Davis, R., Garner, M. V., Olmstead, M. P., & Eagle, M. (1993). Comparison of cognitive-behavioral and supportive-expressive therapy for bulimia nervosa. *American Journal of Psychiatry, 150*, 37–46.

Keel, P. K., & Haedt, A. (2008). Evidence-based psychosocial treatments for eating problems and eating disorders. *Journal of Clinical Child & Adolescent Psychology, 37,* 39–61.

Schmidt, U., Lee, S., Beecham, J., Perkins, S., Treasure, J., Yi, I., & Eisler, I. (2007). A randomized controlled trial of family therapy and cognitive behavior therapy guided self-care for adolescents with bulimia nervosa and related disorders. *American Journal of Psychiatry, 164,* 591–598.

Wilson, G. T., & Fairburn, C. G. (2007). Treatments for eating disorders. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (3rd ed., pp. 579–610). New York, NY: Oxford University Press.

Wilson, G. T., Grilo, C. M., & Vitousek, K. M. (2007). Psychological treatment of eating disorders. *American Psychologist, 62*(3), 199–216.

*The evidence base supporting CBT for BN is based largely on adult studies that included a high proportion of older adolescents and younger adults, and thus supports only this application.

**Clinical Resources**

Agras, W. S., & Apple, R. F. (2007). *Overcoming eating disorders: A cognitive-behavioral therapy approach for bulimia nervosa and binge-eating disorder—Therapist guide* (2nd ed.). New York, NY: Oxford University Press.

Fairburn, C. G. (1995). *Overcoming binge eating*. New York, NY: Guilford Press.

Fairburn, C. G. (2008). *Cognitive behavior therapy and eating disorders*. New York, NY: Guilford Press.

Grilo, C. M., & Mitchell, J. E. (2011). *The treatment of eating disorders: A clinical handbook*. New York, NY: Guilford Press.

Treasure, J., & Schmidt, U. (1997). *The clinician's guide to getting better bit(e) by bit(e)*. East Sussex, UK: Psychology Press.

Zweig, R. D., & Leahy, R. L. (2012). *Treatment plans and interventions for bulimia and binge-eating disorder*. New York, NY: Guilford Press.

**Empirical Support for Family-Based Treatment**

le Grange, D., Crosby, R. D., Rathouz, P. J., & Leventhal, B. L. (2007). A randomized controlled comparison of family-based treatment and supportive psychotherapy for adolescent bulimia nervosa. *Archives of General Psychiatry, 64,* 1049–1056.

Loeb, K. L. (Accessed April, 2012). Eating disorders and obesity. *American Psychological Association division 12 website on research-supported psychological treatments* [Online]. Available from http://www.div12.org/PsychologicalTreatments/disorders/eating_main.php

Schmidt, U., Lee, S., Beecham, J., Perkins, S., Treasure, J., Yi, I., & Eisler, I. (2007). A randomized controlled trial of family therapy and cognitive behavior therapy guided self-care for adolescents with bulimia nervosa and related disorders. *American Journal of Psychiatry, 164,* 591–598.

**Clinical Resources**

le Grange, D., & Lock, J. (2007). *Treating bulimia in adolescents: A family-based approach*. New York, NY: Guilford Press.

le Grange, D., & Lock, J. (2011). *Eating disorders in children and adolescents: A clinical handbook*. New York, NY: Guilford Press.

**Clinical Resources for Assessment and Interpersonal Therapy**

Cooper, P. J., Taylor, M. J., Cooper, Z., & Fairburn, C. G. *The Body Shape Questionnaire*. Retrieved from http://www.psyctc.org/tools/bsq/

Fairburn, C. G. (1997). Interpersonal psychotherapy for bulimia nervosa. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of treatment for eating disorders* (2nd ed., pp. 278–294). New York, NY: Guilford Press.

Garner, D. M. Eating Disorders Inventory–3. Retrieved from http://www4.parinc.com/Products/Product.aspx?ProductID=EDI-3

Stice, E. Eating Disorders Diagnostic Scale. Retrieved from http://homepage.psy.utexas.edu/homepage/group/sticelab/scales

## Medical Condition

### *Empirical Support*

Drotar, D. (2006). *Psychological interventions in childhood chronic illness*. Washington, DC: American Psychological Association.

Eccleston, C., Palermo, T. M., Fisher, E., & Law, E. (2012). Psychological interventions for parents of children and adolescents with chronic illness. *Cochrane Database of Systematic Reviews, 2012*(8), CD009660. doi:10.1002/14651858.CD009660.pub2

Eccleston, C., Palermo, T. M., Williams, A. C. D. C., Lewandowski, A., & Morley, S. (2009). Psychological therapies for the management of chronic and recurrent pain in children and adolescents. *Cochrane Database of Systematic Reviews, 2009*(2), CD003968. doi:10.1002/14651858.CD003968.pub2

Rodgers, M., Fayter, D., Richardson, G., Ritchie, G., Lewin, R., & Sowden, A. J. (2005). *The effects of psychosocial interventions in cancer and heart disease: A review of systematic reviews*. York, England: Centre for Reviews and Dissemination, University of York.

Thompson, R. J., & Gustafson, K. E. (1996). *Adaptation to chronic childhood illness.* Washington, DC: American Psychological Association.

### *Clinical Resources*

Brown, R. T., Daly, B. P., & Rickel, A. U. (2007). *Chronic illness in children and adolescents*. Cambridge, MA: Hogrefe.

Drotar, D. (2000). *Promoting adherence to medical treatment in chronic childhood illness: Concepts, methods, and interventions*. Mahwah, NJ: Erlbaum.

Drotar, D. (2006). *Psychological interventions in childhood chronic illness*. Washington, DC: American Psychological Association.

Hayman, L., Mahon, M., & Turner R. (2002). *Chronic illness in children: An evidence-based approach.* New York, NY: Springer.

Roberts, M. C., & Steele, R. G. (Eds.) (2010). *Handbook of pediatric psychology* (4th ed.). New York, NY: Guilford Press.

Szigethy, E., Thompson, R. Turner, S., Delaney, P., Beardslee, W., & Weisz, J. (2012). Chronic physical illness: Inflammatory bowel disease as a prototype. In E. Szigethy, J. Weisz, & R. Findling (Eds.), *Cognitive-behavior therapy for children and adolescents* (pp. 331–378). Washington, DC: American Psychiatric Publishing.

## Obsessive-Compulsive Disorder (OCD)

### *Empirical Support*

American Academy of Child & Adolescent Psychiatry. (2012). Practice parameters for the assessment and treatment of children and adolescents with obsessive-compulsive disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 51*(1), 98–113.

Barrett, P. M., Farrell, L. J., Dadds, M., & Boulter, N. (2005). Cognitive-behavioral family treatment of childhood obsessive-compulsive disorder: Long-term follow-up and predictors of outcome. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*, 1005–1014.

Barrett, P. M., Farrell, L., Pina, A. A., Piacentini, J., & Peris, T. S. (2008). Evidence-based psychosocial treatments for child and adolescent obsessive-compulsive disorder. *Journal of Clinical Child & Adolescent Psychology, 37*, 131–155.

Barrett, P. M., Healy-Farrell, L. J., & March, J. S. (2004). Cognitive-behavioral family treatment of childhood obsessive–compulsive disorder: A controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*, 46–62.

Franklin, M. E., Freeman, J., & March, J. S. (2010). Treating pediatric obsessive-compulsive disorder using exposure-based cognitive-behavioral therapy. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 80–92). New York, NY: Guilford Press.

Hiss, H., Foa, E. B., & Kozak, M. J. (1994). A relapse prevention program for treatment of obsessive compulsive disorder. *Journal of Consulting and Clinical Psychology*, *62*, 801–808.

Kircanski, K., Peris, T. S., & Piacentini, J. C. (2011). Cognitive-behavioral therapy for obsessive-compulsive disorder in children and adolescents. *Child and Adolescent Psychiatric Clinics of North America, 20*(2), 239–254.

O'Kearney, R. T., Anstey, K., von Sanden, C., & Hunt, A. (2010). Behavioural and cognitive behavioural therapy for obsessive compulsive disorder in children and adolescents. *Cochrane Database of Systematic Reviews, 2010*(4), CD004856. doi: 10.1002/14651858.CD004856.pub2

Pediatric OCD Treatment Study (POTS) Team. (2004). Cognitive-behavior therapy, sertraline and their combination for children and adolescents with obsessive-compulsive disorder: The Pediatric OCD Treatment Study (POTS) randomized controlled trial. *Journal of the American Medical Association, 292*, 1969–1976.

Pediatric OCD Treatment Study (POTS) Team. (2011). Cognitive behavior therapy augmentation of pharmacotherapy in pediatric obsessive-compulsive disorder: The Pediatric OCD Treatment Study II (POTS II) randomized controlled trial. *Journal of the American Medical Association, 306,* 1224–1232.

### *Clinical Resources*

Barrett, P. M. (2007). *FOCUS: Freedom from obsessions and compulsions using skills (Therapist manual and workbooks)*. Brisbane, Australia: Pathways Health and Research Centre.

Greco, L., & Hayes, S. C. (Eds.). (2008). *Acceptance and mindfulness treatments for children and adolescents: A practitioner's guide*. Oakland, CA: New Harbinger.

Haley, J. (1984). *Ordeal therapy*. San Francisco, CA: Jossey-Bass.

Haley, J. (1993). *Uncommon therapy: The psychiatric techniques of Milton H. Erickson, M.D.* New York, NY: Norton.

March, J., & Mulle, K. (1998). *OCD in children and adolescents: A cognitive-behavioral treatment manual*. New York, NY: Guilford Press.

Piacentini, J., Langley, A., & Roblek, J. (2007). *Cognitive behavioral treatment of childhood OCD: It's only a false alarm, therapist guide*. New York, NY: Oxford University Press.

Scahill, L., Riddle, M. A., McSwiggin-Hardin, M., Ort, S. I., King, R. A., Goodman, W. K., . . . Leckman, J. F. (1997). Children's Yale-Brown Obsessive-Compulsive Scale: Reliability and validity. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*, 844–852.

Wagner, A. P. (2003). *Treatment of OCD in children and adolescents: A cognitive-behavioral therapy manual.* Rochester, NY: Lighthouse Press.

## Oppositional Defiant Disorder

### *Empirical Support*

American Academy of Child & Adolescent Psychiatry. (2007). Practice parameters for the assessment and treatment of children and adolescents with oppositional defiant disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*(1), 126–141.

Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). Evidence-based psychosocial treatments for child and adolescent with disruptive behavior. *Journal of Clinical Child & Adolescent Psychology, 37*, 215–237.

Kazdin, A. E. (2005). *Parent management training: Treatment for oppositional, aggressive, and antisocial behavior in children and adolescents.* New York, NY: Oxford University Press.

Kazdin, A. E. (2010). Problem-solving skills training and parent management training for conduct disorder. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 211–226). New York, NY: Guilford Press.

Kutcher, S., Aman, M., Brooks, S. J., Buitelaar, J., van Daalen, E., Fegert, J., . . . Tyano, S. (2004). International consensus statement on attention-deficit/hyperactivity disorder (ADHD) and disruptive behaviour disorders (DBDs): Clinical implications and treatment practice suggestions. *European Neuropsychopharmacology, 14*(1), 11–28.

Lochman, J. E., Boxmeyer, C. L., Powell, N. P., Barry, T. D., & Pardini, D. A. (2010). Anger control training for aggressive youths. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 227–242). New York, NY: Guilford Press.

### *Clinical Resources*

Achenbach, T. M., & Edelbrock, C. (1991). *Manual for the child behavior checklist*. Burlington, VT: Department of Psychiatry, University of Vermont.

Barkley, R. A. (2013). *Defiant children: A clinician's manual for assessment and parent training* (3rd ed.). New York, NY: Guilford Press.

Eyberg, S., & Pincus, D. (1999). *Eyberg child behavior inventory & Sutter-Eyberg student behavior inventory–revised: Professional manual*. Odessa, FL: Psychological Assessment Resources.

Forgatch, M. S., & Patterson, G. R. (2010). Parent management training–Oregon model: An intervention for antisocial behavior in children and adolescents. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 159–168). New York, NY: Guilford Press.

Gerard, A. B. (1994). *Parent-child relationship inventory (PCRI) manual.* Los Angeles, CA: WPS.

Kazdin, A. E. (2005). *Parent management training: Treatment for oppositional, aggressive, and antisocial behavior in children and adolescents.* New York, NY: Oxford University Press.

Kazdin, A. E. (2010). Problem-solving skills training and parent management training for conduct disorder. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 211–226). New York, NY: Guilford Press.

Lochman, J. E., Boxmeyer, C. L., Powell, N. P., Barry, T. D., & Pardini, D. A. (2010). Anger control training for aggressive youths. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 227–242). New York, NY: Guilford Press.

## Overweight/Obesity

### *Empirical Support*

Barlow, S. E., & Expert Committee. (2007). Expert committee recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: Summary report. *Pediatrics, 120*(4), S164–S192.

Epstein, L. H., & Wing, R. R. (1987). Behavioral treatment of childhood obesity. *Psychological Bulletin, 101*, 331–342.

Golan, M. (2006). Parents as agents of change in childhood obesity: From research to practice. *International Journal of Pediatric Obesity, 1*(2), 66–76.

Golan, M., Kaufman, V., & Shahar, D. R. (2006). Childhood obesity treatment: Targeting parents exclusively v. parents and children. *British Journal of Nutrition, 95*, 1008–1015.

Loeb, K. L. *Obesity and pediatric overweight*. Retrieved from http://www.div12.org/PsychologicalTreatments/disorders/obesity_main.php

National Institute for Health and Clinical Excellence. (2005). *Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children.* Clinical guideline 43. Retrieved from http://guidance.nice.org.uk/CG43

Wadden, T. A., Foster, G. D., & Letizia, K. A. (1994). One-year behavioral treatment of obesity: Comparison of moderate and severe caloric restriction and

the effects of weight maintenance therapy. *Journal of Consulting and Clinical Psychology, 62*, 165–171.

Wadden, T. A., & The Look AHEAD Research Group. (2006). The Look AHEAD study: A description of the lifestyle intervention and the evidence supporting it. *Obesity, 14*, 737–752.

### *Clinical Resource*

Brownell, K. D. (2004). *The LEARN program for weight management* (10th ed.). Dallas, TX: American Health Publishing Company.

## Panic/Agoraphobia

### *Empirical Support**

American Psychiatric Association. (2009). *Practice guideline for the treatment of patients with panic disorder* (2nd ed.). Washington, DC: Author.

Grills-Taquechel, A. E., & Ollendick, T. H. (2013). *Phobic and anxiety disorders in children and adolescents*. Cambridge, MA: Hogrefe.

Hoffman, E. C., & Mattis, S. G. (2000). A developmental adaptation of panic control treatment for panic disorder in adolescence. *Cognitive and Behavioral Practice, 7*, 253–261.

James, A. A. C. J., Soler, A., & Weatherall, R. R. W. (2005). Cognitive behavioural therapy for anxiety disorders in children and adolescents. *Cochrane Database of Systematic Reviews, 2005*(4), CD004690. doi:10.1002/14651858CD004690 .pub2

Mattis, S. G., & Ollendick, T. H. (2002). *Panic disorder and anxiety in adolescence*. Oxford, England: BPS Blackwell.

National Institute for Health and Clinical Excellence. (2011, January). *Generalized anxiety disorder and panic disorder (with or without agoraphobia) in adults: Clinical guideline CG113*. Retrieved from http://guidance.nice.org.uk/CG113

Ollendick, T. H., & Pincus, D. (2008). Panic disorder in adolesents. In R. G. Steele, D. Elkin, & M. C. Roberts (Eds.), *Handbook of evidence-based therapies for children and adolescents: Bridging science and practice* (pp. 83–102). New York, NY: Springer.

Pincus, D. B., May, J. E., Whitton, S. W., Mattis, S. G., & Barlow, D. H. (2010). Cognitive-behavioral treatment of panic disorder in adolescence. *Journal of Clinical Child & Adolescent Psychology, 39*(5), 638–649.

*The evidence base supporting CBT for panic disorder in adolescents comes from adult studies that included older adolescents as well as case series and a recent randomized clinical trial of Panic Control Therapy for Adolescents.

### *Clinical Resources*

Chambless, D. L., Caputo, G. C., Jasin, S. E., Gracel, E. J., & Williams, C. (1985). The mobility inventory for agoraphobia. *Behaviour Research and Therapy, 23,* 35–44.

Grills-Taquechel, A. E., & Ollendick, T. H. (2013). *Phobic and anxiety disorders in children and adolescents*. Cambridge, MA: Hogrefe.

Pincus, D. B., Ehrenreich, J. T., & Mattis, S. G. (2008). *Mastery of anxiety and panic for adolescents: Riding the wave—Therapist guide.* New York, NY: Oxford University Press.

Reiss, S., Peterson, R. A., Gursky, D. M., & McNally, R. J. (1986). Anxiety sensitivity, anxiety frequency, and the prediction of fearfulness. *Behaviour Research and Therapy, 24,* 1–8.

Silverman, W. K., & Albano, A. M. (1996). *The anxiety disorders interview schedule for DSM-IV—Child and parent versions*. London, England: Oxford University Press.

## Parenting

### *Empirical Support*

Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). Evidence-based psychosocial treatments for child and adolescent with disruptive behavior. *Journal of Clinical Child & Adolescent Psychology, 37*, 215–237.

Forgatch, M. S., & Patterson, G. R. (2010). Parent management training—Oregon model: An intervention for antisocial behavior in children and adolescents. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 159–168). New York, NY: Guilford Press.

Hamilton, S. B., & MacQuiddy, S. L. (1984). Self-administered behavioral parent training: Enhancement of treatment efficacy using a time-out signal seat. *Journal of Clinical Child & Adolescent Psychology, 13*(1), 61–69.

Kazdin, A. E. (2005). *Parent management training: Treatment for oppositional, aggressive, and antisocial behavior in children and adolescents.* New York, NY: Oxford University Press.

Kazdin, A. E. (2007). Psychosocial treatments for conduct disorder in children and adolescents. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (3rd ed., pp. 71–104). New York, NY: Oxford University Press.

Kazdin, A. E. (2010). Problem-solving skills training and parent management training for conduct disorder. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 211–226). New York, NY: Guilford Press.

Kutcher, S., Aman, M., Brooks, S. J., Buitelaar, J., van Daalen, E., Fegert, J., . . . Tyano, S. (2004). International consensus statement on attention-deficit/hyperactivity disorder (ADHD) and disruptive behaviour disorders (DBDs): Clinical implications and treatment practice suggestions. *European Neuropsychopharmacology, 14*(1), 11–28.

Sanders, M. R. (2008). The Triple P—Positive Parenting Program as a public health approach to strengthening parenting. *Journal of Family Psychology, 22*, 506–517.

Woolfenden, S., Williams, K. J., & Peat, J. (2001). Family and parenting interventions in children and adolescents with conduct disorder and delinquency aged 10–17. *Cochrane Database of Systematic Reviews, 2001*(2), CD003015. doi: 10.1002/14651858.CD003015

### *Clinical Resources*

Achenbach, T. M., & Edelbrock, C. (1991). *Manual for the child behavior checklist*. Burlington, VT: Department of Psychiatry, University of Vermont.

Barkley, R. A. (2013). *Defiant children: A clinician's manual for assessment and parent training* (3rd ed.). New York, NY: Guilford Press.

Eyberg, S., & Pincus, D. (1999*). Eyberg child behavior inventory & Sutter-Eyberg student behavior inventory—revised: Professional manual.* Odessa, FL: Psychological Assessment Resources.

Forgatch, M. S., & Patterson, G. R. (2010). Parent management training—Oregon model: An intervention for antisocial behavior in children and adolescents. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 159–168). New York, NY: Guilford Press.

Gerard, A. B. (1994). *Parent-child relationship inventory (PCRI) manual.* Los Angeles, CA: WPS.

Kazdin, A. E. (2005). *Parent management training: Treatment for oppositional, aggressive, and antisocial behavior in children and adolescents.* New York, NY: Oxford University Press.

Kazdin, A. E. (2010). Problem-solving skills training and parent management training for conduct disorder. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 211–226). New York, NY: Guilford Press.

Lochman, J. E., Boxmeyer, C. L., Powell, N. P., Barry, T. D., & Pardini, D. A. (2010). Anger control training for aggressive youths. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 227–242). New York, NY: Guilford Press.

Parenting Stress Index. Available from www4.parinc.com

Sanders, M. R., & Murphy-Brennan, M. (2010). The international dissemination of the Triple P—Positive Parenting Program. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 519–537). New York, NY: Guilford Press.

Triple P. www.triplep.net

Zisser, A., & Eyberg, S. M. (2010). Treating oppositional behavior in children using parent-child interaction therapy. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 179–193). New York, NY: Guilford Press.

## Posttraumatic Stress Disorder (PTSD)

### *Empirical Support*

American Academy of Child & Adolescent Psychiatry. (2010). Practice parameters for the assessment and treatment of children and adolescents with posttraumatic stress disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, *49*(4), 414–430.

Amaya-Jackson, L., Reynolds, V., Murray, M., McCarthy, G., Nelson, A., Cherney, M., . . . March, J. (2003). Cognitive behavioral treatment for pediatric posttraumatic stress disorder: Protocol and application in school and community settings. *Cognitive and Behavioral Practice, 10*, 204–213.

Cohen, J. A., Berliner, L., & Mannarino, A. P. (2010). Trauma focused CBT for children with co-occurring trauma and behavior problems. *Child Abuse and Neglect, 34*, 215–224.

Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. (2004). A multi-site, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*, 393–402.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2010). Trauma-focused cognitive-behavioral therapy for traumatized children. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 295–311). New York, NY: Guilford Press.

Foa, E. B., Keane, T. M., & Friedman, M. J. (2004). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. New York, NY: Guilford Press.

Gillies, D., Taylor, F., Gray, C., O'Brien, L., & D'Abrew, N. (2012). Psychological therapies for the treatment of posttraumatic stress disorder in children and adolescents. *Cochrane Database of Systematic Review, 2012*(12), CD006726. doi: 10.1002/14651858.CD006726.pub2

Silverman, W. K., Ortiz, C. D., Viswesvaran, C., Burns, B. J., Kolko, D. J., Putnam, F. W., & Amaya-Jackson, L. (2008). Evidence-based psychosocial treatments for child and adolescent exposed to traumatic events: A review and meta-analysis. *Journal of Clinical Child & Adolescent Psychology, 37,* 156–183.

### *Clinical Resources*

Barkley, R. A. (2013). *Defiant children: A clinician's manual for assessment and parent training* (3rd ed.). New York, NY: Guilford Press.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York, NY: Guilford Press.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2012). *Trauma-focused CBT for children and adolescents: Treatment applications*. New York, NY: Guilford Press.

Deblinger, E., & Heflin, A. H. (1996). *Treating sexually abused children and their nonoffending parents: A cognitive-behavioral approach.* Thousand Oaks, CA: Sage.

Foa, E. B., Johnson, K. M., Feeny, N. C., & Treadwell, K. R. H. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology, 30,* 376–384.

Frederick, C. J., Pynoos, R., & Nader, K. (1992). *Childhood Post-Traumatic Stress Reaction Index* [A copyrighted instrument]. (Available from UCLA Department of Psychiatry and Biobehavioral Sciences, 760 Westwood Plaza, Los Angeles, CA 90024).

Greenwald, R. (1999). *Eye movement desensitization and reprocessing (EMDR) in child and adolescent psychotherapy*. Northvale, NJ: Jason Aronson.

Nader, K., Kriegler, J. A., Blake, D. D., Pynoos, R. S., Newman, E., & Weathers, F. W. (1996). *Clinician administered PTSD scale, child and adolescent version.* White River Junction, VT: National Center for PTSD.

Najavits, L. M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse.* New York, NY: Guilford Press.

Silverman, W. K., & Albano, A. M. (1996). *The anxiety disorders interview schedule for DSM-IV—Child and parent versions*. London, England: Oxford University Press.

Tinker, R. H., & Wilson, S. A. (1999). *Through the eyes of a child: EMDR with children*. New York, NY: W. W. Norton.

## Social Anxiety

### *Empirical Support*

Albano, A. M. (2003). Treatment of social anxiety in adolescents. In M. Reinecke, F. Datillo, & A. Freeman (Eds.), *Casebook of cognitive behavioral therapy with children and adolescents* (2nd ed., pp. 128–161). New York, NY: Guilford Press.

American Academy of Child & Adolescent Psychiatry (2007). Practice parameters for the assessment and treatment of children and adolescents with anxiety disorders. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*(2), 267–283.

Barrett, P. M., & Shortt, A. (2003). Parental involvement in the treatment of anxious children. In A. E. Kazdin & J. R. Weisz (Eds.). *Evidence-based psychotherapies for children and adolescents* (pp. 101–119). New York, NY: Guilford Press.

Beidel, D. C., Turner, S. M., & Morris, T. L. (2000). Behavioral treatment of childhood social phobia. *Journal of Consulting Clinical Psychology, 68,* 1072–1080.

Beidel, D. C., Turner, S. M., & Morris, T. L. (2004). *Social effectiveness therapy for children and adolescents: Manual.* North Tonawanda, NY: Multi-Health Systems.

Grills-Taquechel, A. E., & Ollendick, T. H. (2013). *Phobic and anxiety disorders in children and adolescents*. Cambridge, MA: Hogrefe.

James, A. A. C. J., Soler, A., & Weatherall, R. R. W. (2009). Cognitive behavioural therapy for anxiety disorders in children and adolescents. *Cochrane Database of Systematic Reviews, 2009*(4), CD004690. doi:10.1002/14651858.CD004690.pub2

Kendall, P. C., Furr, J. M., & Podell, J. L. (2010). Child-focused treatment of anxiety. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 45–60). New York, NY: Guilford Press.

Pahl, K. M., & Barrett, P. M. (2010). Interventions for anxiety disorders in children using group cognitive behavioral therapy with family involvement. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 61–79). New York, NY: Guilford Press.

Silverman, W. K., Pina, A. A., & Viswesvaran, C. (2008). Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents: A review and meta-analyses. *Journal of Clinical Child & Adolescent Psychology, 37*, 105–130.

Spence, S. H., Donovan, C., & Brechman-Toussaint, M. (2000). The treatment of childhood social phobia: The effectiveness of a social skills training-based, cognitive-behavioural intervention, with and without parental involvement. *Journal of Child Psychology and Psychiatry, 41*, 713–726.

### *Clinical Resources*

Albano, A. M., & DiBartolo, P. M. (2007). *Cognitive-behavioral therapy for social phobia in adolescents: Stand up, speak out–therapist guide*. New York, NY: Oxford University Press.

Barrett, P. M. (2005). *Friends for Life: Group leader's manual for youth* (4th ed.). Brisbane: Australian Academic Press.

Barrett, P. M. (2007). *Fun Friends: The teaching and training manual for group leaders.* Brisbane, Australia: Fun Friends.

Beidel, D. C., Turner, S. M., & Morris, T. L. (1998). *Social phobia and anxiety inventory for children*. North Tonawanda, NY: Multi-Health Systems.

Beidel, D. C., Turner, S. M., & Morris, T. L. (2004). *Social effectiveness therapy for children and adolescents: Manual.* North Tonawanda, NY: Multi-Health Systems.

Bernstein, D. A., Borkovec, T. D., & Hazlett-Stevens, H. (2000). *New directions in progressive muscle relaxation: A guidebook for helping professionals*. Westbury, CT: Praeger.

Flannery-Schroeder, E., & Kendall, P. C. (1996). *Cognitive behavioral therapy for anxious children: Therapist manual for group treatment.* Retrieved from www.workbookpublishing.com

Friends for Life Information. Retrieved from http://www.friendsinfo.net/downloads/FRIENDSintrobooklet.pdf

Greco, L. A., & Hayes, S. C. (2008). *Acceptance and mindfulness treatments for children and adolescents.* Oakland, CA: New Harbinger.

Howard, B., Chu, B. C., Krain, A. L., Marrs-Garcia, A. L., & Kendall, P. C. (2000). *Cognitive-behavioral family therapy for anxious children* (2nd ed.). Retrieved from www.workbookpublishing.com

Kendall, P. C., & Hedtke, K. A. (2006). *Cognitive-behavioral therapy for anxious children* (3rd ed.). Retrieved from www.workbookpublishing.com

Silverman, W. K., & Albano, A. M. (1996). *The anxiety disorders interview schedule for DSM-IV—Child and parent versions*. London, England: Oxford University Press.

## Specific Phobia

### *Empirical Support*

American Academy of Child & Adolescent Psychiatry. (2007). Practice parameters for the assessment and treatment of children and adolescents with anxiety disorders. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*(2), 267–283.

Barrett, P. M., & Shortt, A. (2003). Parental involvement in the treatment of anxious children. In A. E. Kazdin & J. R. Weisz (Eds.). *Evidence-based psychotherapies for children and adolescents* (pp. 101–119). New York, NY: Guilford Press.

Friends for Life Information. Retrieved from http://www.friendsinfo.net/downloads/FRIENDSintrobooklet.pdf

Grills-Taquechel, A. E., & Ollendick, T. H. (2013). *Phobic and anxiety disorders in children and adolescents*. Cambridge, MA: Hogrefe.

James, A. A. C. J., Soler, A., & Weatherall, R. R. W. (2009). Cognitive behavioural therapy for anxiety disorders in children and adolescents. *Cochrane Database of Systematic Reviews, 2009*(4), CD004690. doi:10.1002/14651858.CD004690.pub2

Kendall, P. C., Furr, J. M., & Podell, J. L. (2010). Child-focused treatment of anxiety. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 45–60). New York, NY: Guilford Press.

Ost, L. G., Fellenius, J., & Sterner, U. (1991). Applied tension, exposure in vivo, and tension-only in the treatment of blood phobia. *Behaviour Research and Therapy, 29*(6), 561–574.

Pahl, K. M., & Barrett, P. M. (2010). Interventions for anxiety disorders in children using group cognitive behavioral therapy with family involvement. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 61–79). New York, NY: Guilford Press.

Silverman, W. K., Kurtines, W. M., Ginsburg, G. S., Weems, C. F., Rabian, B., & Serafini, L. T. (1999). Contingency management, self-control, and education support in the treatment of childhood phobic disorders: A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 67*, 675–687.

Silverman, W. K., Pina, A. A., & Viswesvaran, C. (2008). Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents: A review and meta-analyses. *Journal of Clinical Child & Adolescent Psychology, 37*, 105–130.

### *Clinical Resources*

Antony, M. M. (2001). Measures for specific phobia. In M. M. Antony, S. M. Orsillo, & I. Roemer (Eds.), *Practitioner's guide to empirically-based measures of anxiety*. New York, NY: Kluwer Academic/Plenum.

Barrett, P. M. (2005). *Friends for Life: Group leader's manual for youth* (4th ed.). Brisbane, Australia: Australian Academic Press.

Barrett, P. M. (2007). *Fun Friends: The teaching and training manual for group leaders.* Brisbane, Australia: Fun Friends.

Bernstein, D. A., Borkovec, T. D., & Hazlett-Stevens, H. (2000). *New directions in progressive relaxation training: A guidebook for helping professionals*. Westport, CT: Praeger.

Craske, M. G., Antony, M., & Barlow, D. H. (2006). *Mastery of your fears and phobias—Therapist guide* (2nd ed.). New York, NY: Oxford University Press.

Flannery-Schroeder, E., & Kendall, P. C. (1996). *Cognitive behavioral therapy for anxious children: Therapist manual for group treatment.* Available from www.workbookpublishing.com

Howard, B., Chu, B. C., Krain, A. L., Marrs-Garcia, A. L., & Kendall, P. C. (2000). *Cognitive-behavioral family therapy for anxious children* (2nd ed.). Retrieved from www.workbookpublishing.com

Kendall, P. C., & Hedtke, K. A. (2006). *Cognitive-behavioral therapy for anxious children* (3rd ed.). Retrieved from www.workbookpublishing.com

March, J. S., Parker, J. D., Sullivan, K., Stallings, P., & Conners, C. K. (1997). The multidimensional anxiety scale for children (MASC): Factor structure, reliability, and validity. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*, 544–565.

Ollendick, T. H. (1987). The fear survey schedule for children–revised. In M. Hersen & A. S. Bellack (Eds.), *Dictionary of behavioral assessment techniques* (pp. 218–220). Elmsford, NY: Pergamon Press.

Ollendick, T. H., & March, J. C. (2004). *Phobic and anxiety disorders in children and adolescents: A clinician's guide to effective psychosocial and pharmacological interventions.* New York, NY: Oxford University Press.

Reynold, C. R., & Richmond, B. O. (2008). *Revised children's manifest anxiety scale* (2nd ed.). Torrance, CA: Western Psychological Services.

Silverman, W. K., & Albano, A. M. (1996). *The anxiety disorders interview schedule for DSM-IV—Child and parent versions*. London, England: Oxford University Press.

## Substance Use

### *Empirical Support*

Denis, C., Lavie, E., Fatseas, M., & Auriacombe, M. (2006). Psychotherapeutic interventions for cannabis abuse and/or dependence in outpatient settings. *Cochrane Database of Systematic Reviews, 2006*(3). doi:10.1002/14651858

Dennis, M., Godley, S. H., Diamond, G., Tims, F. M., Babor, T., Donaldson, J., . . . Funk, R. (2004). The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized trials. *Journal of Substance Abuse Treatment, 27*, 197–213.

Galanter, M., Glickman, L., & Singer, D. (2007). An overview of outpatient treatment of adolescent substance abuse. *Substance Abuse, 28*(2), 51–58.

Kaminer, Y., Burkstein, O. G., & Tarter, R. E. (1991). The Teen Addiction Severity Index: Rationale and reliability. *International Journal of the Addictions, 26*, 219–226.

Kaminer, Y., Wagner, E., Plummer, B., & Seifer, R. (1993). Validation of the Teen Addiction Severity Index. *American Journal of the Addictions, 2*(3), 250–254.

Lazowski, L. E., & Miller, F. G. (2001). Estimates of the reliability and criterion validity of the adolescent SASSI-A2. Springville, IN: The SASSI Institute.

Lussier, J. P., Heil, S. H., Mongeon, J. A., Badger, G. J., & Higgins, S. T. (2006). A meta-analysis of voucher-based reinforcement therapy for substance use disorders. *Addiction, 101*, 192–203.

National Institute for Health and Clinical Excellence. (2011). *Alcohol dependence and harmful alcohol use.* Clinical guideline 115. Retrieved from http://guidance.nice.org.uk/CG28

National Institute on Drug Abuse. (2009, April). *Principles of drug addiction treatment: A research based guide* (2nd ed.). Bethesda, MD: National Institute of Health.

Selzer, M. L. (1971). The Michigan Alcoholism Screening Test (MAST): The quest for a new diagnostic instrument. *American Journal of Psychiatry, 127*, 1653–1658.

Selzer, M. L., Vinokur, A., & VanRooijen, L. (1975). A self-administered short version of the Michigan Alcoholism Screening Test (SMAST). *Journal of Studies on Alcohol, 36*, 117–126.

Teitelbaum, L., & Mullen, B. (2000). Validity of the MAST in psychiatric settings: A meta-analytic integration. *Journal of Studies on Alcohol, 61*(2), 254–261.

Toumbourou, J. W., Stockwell, T., Neighbors, C., Marlatt, G. A., Sturge, J., & Rehm, J. (2007). Interventions to reduce harm associated with adolescent substance use. *The Lancet, 369*(9570), 1391–1401.

Waldron, H. B., & Turner, C. W. (2008). Evidence-based psychosocial treatments for adolescent substance abuse. *Journal of Clinical Child & Adolescent Psychology, 37*, 238–261.

### *Clinical Resources*

Daley, D. C., & Marlatt, G. A. (2006). *Overcoming your alcohol or drug problem: Effective recovery strategies–therapist guide* (2nd ed.). New York, NY: Oxford University Press.

Henggeler, S. W., Cunningham, P. B., Rowland, M. D., & Schoenwald, S. K. (2011). *Contingency management for adolescent substance abuse.* New York, NY: Guilford Press.

Kaminer, Y., & Winters, K. C. (2011). *Clinical manual of adolescent substance abuse treatment*. Arlington, VA: American Psychiatric Publishing.

Liddle, H. A. (2009). *Multidimensional family therapy for adolescent drug abuse: Clinician's manual*. Center City, MN: Hazelden.

Marlatt, G. A., & Donovan, D. M. (Eds.). (2005). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors* (2nd ed.). New York, NY: Guilford Press.

Marlatt, G. A., Larimer, M. E., & Witkiewitz, K. (Eds.). (2011). *Harm reduction: Pragmatic strategies for managing high-risk behaviors.* New York, NY: Guilford Press.

Meyers, R. J., & Miller, W. R. (2006). *A community reinforcement approach to addiction treatment*. Cambridge, UK: Cambridge University Press.

Motivational Interviewing. Available from http://www.motivationalinterview.org

Sampl, S., & Kadden, R. (2001). *Motivational enhancement therapy and cognitive behavioral therapy (MET-CBT-5) for adolescent cannabis users*. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

SASSI Institute. *Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2)*. Retrieved from http://www.sassi.com/products/SASSIA2/shopSA2-pp.shtml

Webb, C., Scudder, M., Kaminer, Y., Kadden, R., & Tawfik, Z. (2002). *The MET/CBT 5 supplement: 7 sessions of cognitive behavioral therapy (CBT 7) for adolescent cannabis users*. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

For clinical resources related to several of the evidence-based treatment approaches represented in this chapter, see the website of the Substance Abuse and Mental Health Services Administration (SAMHSA). Publications ordering. Available from http://store.samhsa.gov/facet/Substances

## Unipolar Depression

### *Empirical Support*

American Academy of Child & Adolescent Psychiatry. (2007). Practice parameters for the assessment and treatment of children and adolescents with depressive disorders. *Journal of the American Academy of Child & Adolescent Psychiatry*, *46*(11), 1503–1526.

Brent, D., Emslie, G., Clarke, G., Wagner, K. D., Asarnow, J. R., Keller, M., . . . Keller, M. K. (2008). Switching to another SSRI or to venlafaxine with or without cognitive behavioral therapy for adolescents with SSRI-resistant depression: The TORDIA randomized controlled trial. *Journal of the American Medical Association, 299*, 901–913.

Clarke, G. N., & DeBar, L. L. (2010). Group cognitive-behavioral treatment for adolescent depression. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 110–125). New York, NY: Guilford Press.

David-Ferdon, C., & Kaslow, N. J. (2008). Evidence-based psychosocial treatments for child and adolescent depression. *Journal of Clinical Child & Adolescent Psychology, 37*, 62–104.

Garber, J., Clarke, G. N., Weersing, V. R., Beardslee, W. R., Brent, D. A., Gladstone, T. R., . . . Iyengar, S. (2009). Prevention of depression in at-risk adolescents: A randomized controlled trial. *Journal of the American Medical Association*, *301*(21), 2215–2224.

Jacobson, C. M., & Mufson, L. (2010). Treating adolescent depression using interpersonal psychotherapy. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 140–158). New York, NY: Guilford Press.

Mufson, L., Dorta, K. P., Wickramaratne, P., Nomura, Y., Olfson, M., & Weissman, M. M. (2004). A randomized effectiveness trial of interpersonal psychotherapy for depressed adolescents. *Archives of General Psychiatry, 61*, 577–584.

Muratori, F., Picchi, L., Bruni, G., Patarnello, M., & Romagnoli, G. (2003). A two-year follow-up of psychodynamic psychotherapy for internalizing disorders in children. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*, 331–339.

National Institute for Health and Clinical Excellence. (2005). *Depression in children and young people: Identification and management in primary, community, and secondary care.* Clinical guideline 28. Retrieved from http://guidance.nice.org.uk/CG28

Stark, K. D., Hargrave, J., Hersh, B., Greenberg, M., Herren, J., & Fisher, M. (2008). Treatment of childhood depression: The ACTION program. In J. R. Z. Abela & B. L. Hankin (Eds.), *Handbook of depression in children and adolescents* (pp. 224–227). New York, NY: Guilford Press.

Stark, K. D., Streusand, W., Krumholz, L., & Patel, P. (2010). Cognitive-behavioral therapy for depression: The ACTION treatment program for girls. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 93–109). New York, NY: Guilford Press.

The Treatment for Adolescents With Depression Study (TADS) Team. (2007). The Treatment for Adolescents With Depression Study (TADS): Long-term effectiveness and safety outcomes. *Archives of General Psychiatry, 64,* 1132–1144.

Weersing, V. R., & Brent, D. A. (2010). Treating depression in adolescents using individual cognitive behavioral therapy. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 126–139). New York, NY: Guilford Press.

### *Clinical Resources*

Adolescent Coping With Depression Course. Available from http://www.kpchr.org/research/public/acwd/acwd.html

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York, NY: Guilford Press.

Beck, J. S., Beck, A. T., & Jolly, J. B. (2005). *Beck depression inventory for youth.* Retrieved from www.pearsonassessments.com

Beidel, D. C., Turner, S. M., & Morris, T. L. (2004). *Social effectiveness therapy for children and adolescents (SET-C)*. Toronto, Ontario: Multi-Health Systems.

Brent, D., Poling, K. D., & Goldstein, T. R. (2011). *Treating depressed and suicidal adolescents: A clinician's guide*. New York, NY: Guilford Press.

Clarke, G. N., & DeBar, L. L. (2010). Group cognitive-behavioral treatment for adolescent depression. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 110–125). New York, NY: Guilford Press.

Jacobson, C. M., & Mufson, L. (2010). Treating adolescent depression using interpersonal psychotherapy. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 140–158). New York, NY: Guilford Press.

Kovacs, M. (1980). Rating scales to assess depression in school-aged children. *Acta Paediatrica, 46*, 305–315.

Mufson, L., Dorta, K. P., Moreau, D., & Weissman, M. M. (2011). *Interpersonal psychotherapy for depressed adolescents* (2nd ed.). New York, NY: Guilford Press.

Stark, K. D., Simpson, J., Schnoebelen, S., Hargrave, J., Glenn, R., & Molnar, J. (2006). *Therapist's manual for ACTION*. Broadmore, PA: Workbook.

Stark, K. D., Yancy, M., Simpson, J., & Molnar, J. (2006). *Treating depressed children: Therapist's manual for parent component of ACTION*. Ardmore, PA: Workbook.

Verduyn, C., Rogers, J., & Wood, A. (2009). *Depression: Cognitive behaviour therapy with children and young people*. New York, NY: Routledge.

Weersing, V. R., & Brent, D. A. (2010). Treating depression in adolescents using individual cognitive behavioral therapy. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 126–139). New York, NY: Guilford Press.

Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2007). *Clinician's quick guide to interpersonal psychotherapy*. New York, NY: Oxford University Press.

Zimmerman, M., Coryell, W., Corenthal, C., & Wilson, S. (1986). A self-report scale to diagnose major depressive disorder. *Archives of General Psychiatry, 43*, 1076–1081.

# Appendix C

# RECOVERY MODEL OBJECTIVES AND INTERVENTIONS

The Objectives and Interventions that follow are created around the 10 core principles developed by a multidisciplinary panel at the 2004 National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation, convened by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2004):

1. **Self-direction:** Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path toward those goals.

2. **Individualized and person-centered:** There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

3. **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.

4. **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

5. **Nonlinear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

6. **Strengths-based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

7. **Peer support:** Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

8. **Respect:** Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

9. **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps toward their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

10. **Hope:** Recovery provides the essential and motivating message of a better future—that people can overcome the barriers and obstacles that confront them. Hope is internalized, but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.[1]

The numbers used for Objectives in the treatment plan that follows correspond to the numbers for the 10 core principles. Each of the 10 Objectives was written to capture the essential theme of the like-numbered core principle. The numbers in parentheses after the Objectives denote the Interventions designed to assist the client in attaining each respective Objective. The clinician may select any or all of the Objectives and Intervention statements to include in the client's treatment plan.

One generic Long-Term Goal statement is offered should the clinician desire to emphasize a recovery model orientation in the client's treatment plan.

## LONG-TERM GOAL

1. To live a meaningful life in a self-selected community while striving to achieve full potential during the journey of healing and transformation.

## SHORT-TERM OBJECTIVES

1. Make it clear to therapist, family, and friends what path to recovery is preferred. (1, 2, 3, 4)

## THERAPEUTIC INTERVENTIONS

1. Explore the client's thoughts, needs, and preferences regarding his/her desired pathway to recovery (from depression, bipolar disorder, posttraumatic stress disorder [PTSD], etc.).
2. Discuss with the client the alternative treatment

[1] From: Substance Abuse and Mental Health Services Administration's (SAMHSA) National Mental Health Information Center: Center for Mental Health Services (2004). *National consensus statement on mental health recovery.* Washington, DC: Author. Available from http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/

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| | interventions and community support resources that might facilitate his/her recovery. |
| | 3. Solicit from the client his/her preferences regarding the direction treatment will take; allow for these preferences to be communicated to family and significant others. |
| | 4. Discuss and process with the client the possible outcomes that may result from his/her decisions. |
| 2. Specify any unique needs and cultural preferences that must be taken under consideration during the treatment process. (5, 6) | 5. Explore with the client any cultural considerations, experiences, or other needs that must be considered in formulating a mutually agreed-upon treatment plan. |
| | 6. Modify treatment planning to accommodate the client's cultural and experiential background and preferences. |
| 3. Verbalize an understanding that decision making throughout the treatment process is self-controlled. (7, 8) | 7. Clarify with the client that he/she has the right to choose and select among options and participate in all decisions that affect him/her during treatment. |
| | 8. Continuously offer and explain options to the client as treatment progresses in support of his/her sense of empowerment, encouraging and reinforcing the client's participation in treatment decision making. |
| 4. Express mental, physical, spiritual, and community needs and desires that should be integrated into the treatment process. (9, 10) | 9. Assess the client's personal, interpersonal, medical, spiritual, and community strengths and weaknesses. |
| | 10. Maintain a holistic approach to treatment planning by integrating the client's unique |

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| | mental, physical, spiritual, and community needs and assets into the plan; arrive at an agreement with the client as to how these integrations will be made. |
| 5. Verbalize an understanding that during the treatment process there will be successes and failures, progress and setbacks. (11, 12) | 11. Facilitate realistic expectations and hope in the client that positive change is possible, but does not occur in a linear process of straight-line successes; emphasize a recovery process involving growth, learning from advances as well as setbacks, and staying this course toward recovery. |
| | 12. Convey to the client that you will stay the course with him/her through the difficult times of lapses and setbacks. |
| 6. Cooperate with an assessment of personal strengths and assets brought to the treatment process. (13, 14, 15) | 13. Administer to the client the *Behavioral and Emotional Rating Scale (BERS): A Strength-Based Approach to Assessment* (Epstein). |
| | 14. Identify the client's strengths through a thorough assessment involving social, cognitive, relational, and spiritual aspects of the client's life; assist the client in identifying what coping skills have worked well in the past to overcome problems and what talents and abilities characterize his/her daily life. |
| | 15. Provide feedback to the client of his/her identified strengths and how these strengths can be integrated into short-term and long-term recovery planning. |
| 7. Verbalize an understanding of the benefits of peer support during the recovery process. (16, 17, 18) | 16. Discuss with the client the benefits of peer support (e.g., sharing common problems, receiving advice regarding successful coping skills, getting |

encouragement, learning of helpful community resources, etc.) toward the client's agreement to engage in peer activity.

17. Refer the client to peer support groups of his/her choice in the community and process his/her experience with follow-through.

18. Build and reinforce the client's sense of belonging, supportive relationship building, social value, and community integration by processing the gains and problem-solving the obstacles encountered through the client's social activities.

8. Agree to reveal when any occasion arises that respect is not felt from the treatment staff, family, self, or the community. (19, 20, 21)

19. Discuss with the client the crucial role that respect plays in recovery, reviewing subtle and obvious ways in which disrespect may be shown to or experienced by the client.

20. Review ways in which the client has felt disrespected in the past, identifying sources of that disrespect.

21. Encourage and reinforce the client's self-concept as a person deserving of respect; advocate for the client to increase incidents of respectful treatment within the community and/or family system.

9. Verbalize acceptance of responsibility for self-care and participation in decisions during the treatment process. (22)

22. Develop, encourage, support, and reinforce the client's role as the person in control of his/her treatment and responsible for its application to his/her daily life; adopt a supportive role as a resource person to assist in the recovery process.

10. Express hope that better functioning in the future can be attained. (23, 24)

23. Discuss with the client potential role models who have achieved a more satisfying life by using their personal strengths, skills, and social support to live, work, learn, and fully participate in society toward building hope and incentive motivation.

24. Discuss and enhance internalization of the client's self-concept as a person capable of overcoming obstacles and achieving satisfaction in living; continuously build and reinforce this self-concept using past and present examples supporting it.

# Appendix D

# ALPHABETICAL INDEX OF SOURCES FOR ASSESSMENT INSTRUMENTS AND CLINICAL INTERVIEW FORMS CITED IN INTERVENTIONS

Sources are presented in the following format:
Title
    Author(s)
        Publisher, Source, or Citation

*ADHD Rating Scale–IV (ADHD-RS)*
    DuPaul, Power, Anastopoulos, and Reid
        Guilford Press

*Adolescent Psychopathology Scale–Short Form (APS-SF)*
    Reynolds
        PAR

*Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2)*
    The SASSI Institute
        The SASSI Institute

*Anxiety Disorders Interview Schedule (ADIS)—Parent Version or Child Version*
    Silverman and Albano
        Oxford University Press

*Anxiety Sensitivity Index (ASI)*
    Reiss, Peterson, Gursky, and McNally
        IDS Publishing

*Beck Depression Inventory for Youth (BDI-Y)*
Beck, Beck, and Jolly
Pearson

*Beck Depression Inventory–II (BDI-II)*
Beck, Steer, and Brown
Pearson

*Beck Hopelessness Scale (BHS)*
Beck
Pearson

*Beck Youth Inventories–Second Edition (BYI-II)*
Beck, Beck, and Jolly
Pearson

*Body Shape Questionnaire (BSQ)*
Cooper, Taylor, Cooper, and Fairburn
Cooper, P. J., Taylor, M. J., Cooper, Z., & Fairburn, C. G. (1986). The development and validation of the Body Shape Questionnaire. *International Journal of Eating Disorders, 6,* 485–494. Available from http://www.psyctc.org/tools/bsq/

*Child Behavior Checklist (CBCL)*
Achenbach
ASEBA

*Child Posttraumatic Stress Reaction Index (CPTS-RI)*
Frederick, Pynoos, and Nader
Available from http://www.ptsd.va.gov/professional/pages/assessments/cpts-ri.asp

*Child PTSD Symptom Scale (CPSS)*
Foa, Johnson, Feeny, and Treadwell
Available from http://www.istss.org/ChildPTSDSymptomScale.htm

*Children's Depression Inventory (CDI)*
Kovacs
MHS

*Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS)*
Scahill et al.
Scahill, L., Riddle, M. A., McSwiggin-Hardin, M., Ort, S. I., King, R. A., Goodman, W. K., . . . Leckman, J. F. (1997). Children's Yale-Brown Obsessive-Compulsive Scale: Reliability and validity. *Journal of the American Academy of Child & Adolescent Psychiatry, 36,* 844–852.

*Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-C)*
Nader
Available from http://www.ptsd.va.gov/professional/pages/assessments/caps-ca.asp

*Disruptive Behavior Rating Scale (DBRS)*
Erford
Slosson Educational Publishers

*Eating Disorder Diagnostic Scale (EDDS)*
Stice, Telch, and Rizvi
Stice, E., Telch, C. F., & Rizvi, S. L. (2000). Development and validation of the Eating Disorder Diagnostic Scale: A brief self-report measure of anorexia, bulimia, and binge-eating disorder. *Psychological Assessment, 12*(2), 123–131.
Available from http://homepage.psy.utexas.edu/homepage/group/sticelab/scales/

*Eating Disorders Inventory-3 (EDI-3)*
Garner
PAR

*Eyberg Child Behavior Inventory (ECBI)*
Eyberg
PAR

*Fear Survey Schedule for Children–Revised (FSSC-R)*
Ollendick
Ollendick, T. H., King, N. J., & Frary, R. B. (1989). Fears in children and adolescents: Reliability and generalizability across gender, age, and nationality. *Behaviour Research and Therapy, 27*, 19–26. Available from http://onlinelibrary.wiley.com/doi/10.1002/9780470713334.app3/pdf

*Inventory to Diagnose Depression (IDD)/Diagnostic Inventory for Depression (DID)*
Zimmerman and Coryell; Zimmerman, Sheeran, and Young
Zimmerman, M., & Coryell, W. (1987). The inventory to diagnose depression: A self-report scale to diagnose major depressive disorder. *Journal of Consulting and Clinical Psychology, 55*(1), 55–59.
Zimmerman, M., Sheeran, T., & Young, D. (2004). The Diagnostic Inventory for Depression: A self-report scale to diagnose *DSM-IV* major depressive disorder. *Journal of Clinical Psychology, 60*(1), 87–110. Available from http://onlinelibrary.wiley.com/doi/10.1002/jclp.10207/pdf

*Michigan Alcohol Screening Test (MAST)*
Selzer

Selzer, M. L. (1971). The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. *American Journal of Psychiatry, 127*(12), 1653–1658.
Available from http://www.projectcork.org/clinical_tools/html/MAST.html

*Millon Adolescent Clinical Inventory (MACI)*
Millon, Millon, David, and Grossman
Pearson

*Minnesota Multiphasic Personality Inventory–Adolescent (MMPI-A)*
Butcher, Graham, Ben-Porath, Tellegen, and Dahlstrom
Pearson

*Mobility Inventory for Agoraphobia (MIA)*
Chambless, Caputo, Jasin, Gracely, and Williams
Chambless, D. L., Caputo, G. C., Jasin, S. E., Gracely, E., & Williams, C. (1985). The Mobility Inventory for Agoraphobia. *Behaviour Research and Therapy, 23*, 35–44.
Available from http://www.psych.upenn.edu/~dchamb/questionnaires/index.html

*Montgomery-Asberg Depression Rating Scale (MADRS)*
Montgomery and Asberg
Montgomery, S. A., & Asberg, M. (1979). A new depression scale designed to be sensitive to change. *British Journal of Psychiatry, 134*, 382–389.
Available from http://www.psy-world.com/madrs.htm

*Multidimensional Anxiety Scale for Children (MASC)*
March
MHS

*Parent-Child Relationship Inventory (PCRI)*
Gerard
Western Psychological Services

*Parenting Stress Index (PSI)*
Abidin
PAR

*Perceived Criticism Measure (PCM)*
Hooley and Teasdale
Hooley, J. M., & Teasdale, J. D. (1989). Predictors of relapse in unipolar depressives: Expressed emotion, marital distress, and perceived criticism. *Journal of Abnormal Psychology, 98*, 229–235.

*Revised Children's Manifest Anxiety Scales, 2nd Edition (RCMAS-2)*
Reynolds and Richmond
Western Psychological Services

*Reynolds Adolescent Depression Scale, 2nd Edition (RADS-2)*
Reynolds
PAR

*Rosenberg Self-Esteem Scale (RSES)*
Rosenberg
Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press. Available from at: http://www.wwnorton.com/college/psych/psychsci/media/rosenberg.htm

*Screen for Anxiety Related Emotional Disorders: Child and/or Parent Version (SCARED)*
Birmaher, Khetarpal, Cully, Brent, and McKenzie
Available from http://psychiatry.pitt.edu/research/tools-research/assessment-instruments

*Social Phobia and Anxiety Inventory for Children (SPAI-C)*
Beidel, Turner, and Morris
MHS

*Sutter-Eyberg Student Behavior Inventory–Revised (SESBI-R)*
Eyberg
PAR

*Teen Addiction Severity Index (T-ASI)*
Kaminier, Bukstein, and Tarter
Kaminer, Y., Bukstein, O. G. & Tarter, R. E. (1991). The Teen Addiction Severity Index: Rationale and reliability. *International Journal of the Addictions, 26*, 219–226.
Available from http://www.emcdda.europa.eu/html.cfm/index4004EN.html

*Wechsler Intelligence Scale for Children–Fourth Edition (WISC–IV)*
Wechsler
Pearson

*Wechsler Adult Intelligence Scale–Fourth Edition (WAIS-IV)*
Wechsler
Pearson

## Additional Sources of Commonly Used Scales and Measures

American Psychiatric Association. Online assessment measures. Available from www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Baer, L., & Blais, M. A. (2010). *Handbook of clinical rating scales and assessment in psychiatry and mental health*. New York, NY: Humana Press.

Outcome Tracker. Available from Outcometracker.org

Rush, A. J., First, M. B., & Blacker, D. (2008). *Handbook of psychiatric measures* (2nd ed.). Washington, DC: American Psychiatric Publishing.