BEHAVORIAL HEALTH DEPARTMENT – PRIMARY CARE CENTER AND FIREWEED
TREATMENT GUIDELINES FOR

ADJUSTMENT DISORDERS

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CBG Approval Date: 11/21/2005
PIC Approval Date: 02/02/2006

Executive Summary

Introduction and statement of Intent

This treatment guideline is intended to assist clinicians in the Behavioral Health department in treatment planning and service delivery for patients with an Adjustment Disorder. It may also assist clinicians treating patients who have some of the symptoms of adjustment disorder, but who do not meet the full spectrum of the disorder. The treatment guideline is not intended to cover every aspect of clinical practice, but to focus specifically on the treatment models and modalities that clinicians in our outpatient facility can provide. These guidelines were developed through a process of literature review and discussions amongst clinicians in the Behavioral Health department and represent a consensus recommendation for service provision for this disorder. The guideline is intended to inform both clinical and administrative practices with the explicit goals of outlining treatment that is: effective, efficient, culturally relevant and acceptable to clinicians, program managers, and patients.

Definition of disorder

Adjustment Disorder is defined as the development of emotional or behavioral symptoms in response to an identifiable stressor(s). These symptoms or behaviors are clinically significant as evidenced by a marked distress that is in excess of what would be expected from exposure to the stressor, and/or significant impairment in social or occupational (academic) functioning. The stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

General Goals of treatment

As with treatment of all psychiatric illnesses, the goals of treatment are to reduce or eliminate symptoms and to restore to previous functioning. With Adjustment Disorders, the ultimate treatment goal is to assist client with a level of adaptation that is comparable to the affected person's level of functioning before the stressful event.

Summary of 1st, 2nd and 3rd line treatment

Based on our clinical experience and review of the literature, BHS clinicians feel that the first line of treatment for Adjustment Disorder involves psychotherapy. Psychotherapy is most commonly used with these disorders, helps the individual understand how the stressor has affected his life, and how to build upon coping skills. Psychotherapy can be done in individual and/or group format. Group is sometimes ideal for adolescents diagnosed with adjustment disorder, as it may help them reduce their sense of isolation. A contraindication for group attendance with adjustment disorders is if the client is dangerous to self or others (i.e., homicidal or suicidal).

Family therapy may be indicated for clients with adjustment disorders, whom family relationships are being impacted by the disorder or if family dynamics are exacerbating the symptoms.
Psychoeducation is also important in the first line of therapy, especially for the caregivers of children 0-5 and for adolescents.
A combination of all the above may be implemented, if appropriate and some clients may need psychiatric assessment and medication management.

Approaches for patients who do not respond to initial treatment

If individual or group treatment is not effective, therapist will discuss with treatment team why this is unsuccessful and provide further recommendations to engage the client in participation. The client should be monitored, for psychiatric evaluation and medication monitoring, as needed or requested. If no progress is noted, the therapist should assess ineffectiveness and what is the new approach, or appropriate referral.

Clinical and demographic issues that influence treatment planning

Co- morbidity, (presence of more than one diagnosable condition), needs to be taken into consideration. As do learning disorders, communication disorders, mental retardation, FAE and FASD (Fetal Alcohol Effects and Fetal Alcohol Spectrum Disorders), pervasive developmental disorders, and other infancy, childhood, or adolescent disorders may also be present.

Issue's of past aggression, homicidal or suicidal ideation/gestures towards self or others, will impact treatment planning. This should be evaluated in the initial assessment phase of treatment planning and will be monitored throughout. Please refer to contraindications and relative contraindications for services under "Modalities and Treatment Models" section.

Low Socioeconomic Status may increase the incidents of stressful events that may precipitate an Adjustment Disorder, (for example: unemployment, poverty, housing unaffordability).

Acculturation may also be a factor in the increase in incidents of stressful events that may trigger an Adjustment Disorder. During acculturation many aspects of an individual are modified and this can bring on dramatic changes upon living conditions, occupation, status, family structure, social networks, traditional values and socialization,

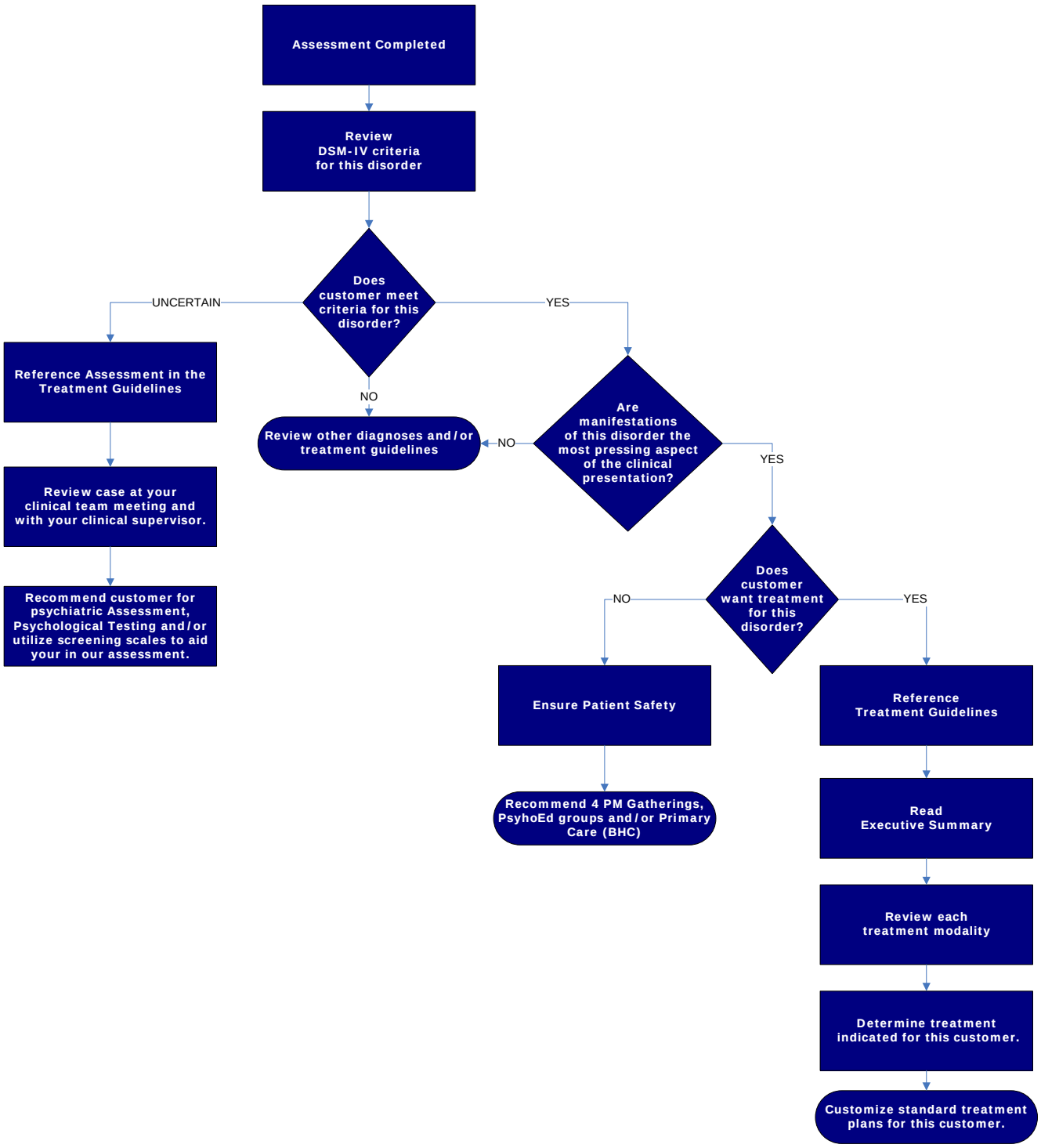
Cultural relevance must always be taken into consideration throughout treatment. Without a clear cultural benchmarking of reactions, clinicians may be susceptible to over diagnosing or over pathologizing a client.

Triggering Events

Below is a list of some of the life events that can trigger an adjustment disorder:

- Moving / Relocation from village
- Divorce, / Custody Battle
- Shared Custody and/or removal from home
- Abuse/ trauma/ neglect
- Death--Violent/ trauma deaths
- Additional family members
- Illness in family
- Health problems
- Accidents
- Parental/ Caregiver financial concerns
- Sibling Conflict
- Domestic violence
- Substance abuse in family
- Legal difficulties in family
- Abandonment
- School difficulties
- Additional family members
- Illness in family
- Academic Failure
- Substance use by patient and family
- Puberty issues/ Developmental changes
- Criminal activity by patient
- Depression/ Anxiety/ Conduct Problems
- School difficulties--strict rules
- Independent Living / Living on the street
- High School / College Stresses
- Teen parents
- Career
- Sexual Concerns/ GID
- Body image/ Self- esteem / Identity issues
- Academic Failure
- Illness in family and/or health problems
- High School / College Stresses
- Teen parents
- Career
- Identity issues

Flow Diagram



Assessment

The Diagnostic Testing team will be reviewing and commenting on the Psychological Testing column for every disorder.

	Psychiatric Assessment	Psychological Testing	Screening/Scales
Indications	▪ Diagnostic dilemma or clarification of co-morbidity ▪ Unmanageable behavior or other symptoms that have not improved with standard interventions ▪ Patients is already on psychotropic medication and is requesting continuation ▪ Patient or guardian requests a second opinion or wishes to consider pharmacologic intervention ▪ Rule out organic cause and/or contributions to symptoms	▪ Diagnostic clarification following assessment by PCP or ANP. ▪ Question only answerable by psychological testing ▪ Appropriate physical assessment completed	• Establish baseline and/or monitor treatment effectiveness • Clarify symptoms
Contraindications	▪ Diagnosed severe cognitive disorder or developmental delay and collateral source not available ▪ Consent not available (if patient has guardian) ▪ Patient or guardian has forensic rather than therapeutic goal (i.e. compliance with court or parole requirements, disability determination, etc.)	▪ Extremely dangerous to self and/or others ▪ Untreated psychosis ▪ Initial evaluation / assessment is not done ▪ Referral question not answerable and/or not clear ▪ Any physical causes of the disorder have not been ruled out ▪ Attention span inadequate ▪ School or other source has already conducted psychological testing within the last year ▪ Severely depressed	▪ Limited English proficiency. ▪ Attention span inadequate ▪ Lack of cooperation
Structure	In patients with cognitive impairment who cannot give adequate history, parent or guardian with knowledge of the patient's history must be available for assessment.	▪ Depends on the referral question	▪ Self-administered for adults and adolescents ▪ Completed by Parent and/or care giver for children or incompetent adults.

Modalities & Treatment Models

Group Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Customer is 3 years old or older ▪ Mild to moderate severity ▪ Able to tolerate affect without behavior destructive to group ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible.	▪ Dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Sexually acting out behaviors ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Severe untreated hyperactivity ▪ Untreated Psychosis or mania ▪ History of chronic or extreme disruptive behavior in groups ▪ Untreated substance dependence ▪ Acute intoxication or withdrawal from alcohol or other substances	• Diagnosis social phobia (May need individual therapy for group preparation) • Relatives or significant others in the same group (unless it is a family group and/or couples group) • Meets CMI or SED criteria without receiving rehab services

STRUCTURE

- Groups will be facilitated by a Master's Level Therapist and Case Manager
- For 17 years old and below, some age grouping recommended
- For 18 years old and above consider adult services

Duration	60 to 90 minutes for 10 to 15 weeks
Frequency	Once a week
Size	▪ 3 to 9 years old 4 customers per provider ▪ 10 years old and over 8 to 10 customers per provider
Open vs. Closed	Open or Closed with windows

TREATMENT MODEL

In the absence of clinical and scientific literature on the treatment of Adjustment Disorders we recommend no particular treatment model.

Individual Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
• Group therapy contraindicated • Sufficient verbal and/or cognitive ability to benefit from treatment • Moderate to Severe severity • Unable to tolerate affect without behavior destructive to group ▪ Customer is 3 years old or older • Recent sexual, physical, abuse and/or neglect • For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible.	▪ Imminent dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Untreated Psychosis or mania ▪ Acute intoxication or withdrawal from alcohol or other substances	

STRUCTURE

Duration	60 minutes
Frequency	▪ Weekly or Twice a Month ▪ Up to 8 sessions for treatment

TREATMENT MODEL

In the absence of clinical and scientific literature on the treatment of Adjustment Disorders we recommend no particular treatment model.

Family Therapy / Couples Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ First line of treatment for 0 to 5 year old ▪ Disorder is impacting the family and/or relationship ▪ Family dynamic exacerbating or triggering symptoms ▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ No buy-in to group and/or individual therapy ▪ For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible. ▪ Concurrent with group and/or individual treatment for children or adults with severe mental illness	▪ Imminent dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Current Domestic violence or abuse of child ▪ Custody dispute ▪ Untreated Psychosis ▪ Acute intoxication or withdrawal from alcohol or other substances	

STRUCTURE

Duration	60 minutes
Frequency	▪ Weekly or Twice a Month ▪ Up to 8 sessions for treatment

TREATMENT MODEL

In the absence of clinical and scientific literature on the treatment of Adjustment Disorders we recommend no particular treatment model.

For Couple's Therapy, treatment of clinicians choice would include a parenting component if client with adjustment disorder is a young child.

For Family Therapy, there should be a psychoeducational component, with treatment brief solution or strategic focused based.

Medication Management

This modality is not applicable for Adjustment Disorders

Psychoeducational Groups

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ Able to tolerate affect without behavior destructive to group ▪ Could benefit from skills development	▪ Dangerousness to self or others ▪ Sexually acting out behaviors ▪ Untreated Psychosis or mania ▪ History of chronic or extreme disruptive behavior in groups ▪ Untreated substance dependence ▪ Severe untreated hyperactivity	

STRUCTURE

Groups will be facilitated by 1 to 2 Case Managers.

Duration	60 to 90 minutes for up to 8 weeks
Frequency	Once a week
Open vs. Closed	Open

TREATMENT MODEL

In the absence of clinical and scientific literature on the treatment of Adjustment Disorders we recommend no particular treatment model.

Case Management

All Ages	
Assessment	▪ Collect psychosocial history ▪ Collect collateral history and/or past treatment records ▪ Obtain patient and/or guardian consent ▪ Liaison with outside agencies and/or link to community resources ▪ Administer standardized scales ▪ Lead orientation to services ▪ Review and/or conduct client initial screening and triage
Treatment	▪ Psychosocial education ▪ Maintain supportive contact ▪ Triage current clients in crisis ▪ Crisis management (e.g. triage, risk assessment, skills coaching, referrals when needed) ▪ Community liaison work and coordination of care ▪ Manage charts ▪ Provide aspects of treatment ▪ Assist with group preparation ▪ Draft treatment plans ▪ Follow-up when customer fails to keep appointments. ▪ Encourage medication and treatment compliance
Follow-up	▪ Liaison with outside agencies ▪ Link to community resources ▪ Gather and disseminate information from external referral sources

Referral

INDICATIONS

- Services needed are not available within the Behavioral Health department.
- Meets CMI criteria and not receiving rehab services
- Legal custody or other issues predominate
- Needed treatment is available elsewhere.

CONTRAINDICATIONS

Meets criteria for treatment within the Behavioral Health department system

Primary Care

INDICATIONS

- Refuses specialty mental health care
- Specialty Mental Health care not available
- Uncomplicated Medication Management
- Maintenance Medication Management

CONTRAINDICATIONS

Higher intensity services needed to ensure safety to patient or others

Appendix A: Glossary

Term or Acronym	Term Definition
Acute Intoxication	A reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. Clinically significant maladaptive behavior or psychological changes that are due to the effect of the substance on the central nervous system and develop during or shortly after use of the substance. (Adapted from DSM-IV)
Acute Withdrawal	A substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy and prolonged. (Adapted from DSM-IV)
CBT	Cognitive Behavioral Therapy
Closed Group	Customers may enter only at initial formation of group.
Closed Group with Windows	Customer enrollment available intermittently
Eclipse	Overshadow, for example, when the symptoms and dysfunction related to one disorder overshadow another making treatment of one more pressing.
Exposure Therapy	Exposure therapy (Haug et al, 2003) with or without response inhibition is most cited as effective for specific phobia, obsessive compulsive disorder and PTSD. Generally, these run 10 -12 sessions with each session targeting a specific skill, exposure level and cognitive reframing. Manuals are available to guide clinical work.
Intervention	Any thoughtful action taken by a clinician or customer with the purpose of addressing a perceived problem or therapeutic goal
IPT	Interpersonal Therapy
NOS	Not Otherwise Specified
Open Group	Participants can enter at any time.
PDD	Pervasive Developmental Disorder
Play Therapy	Play therapy is a form of psychotherapy for children who have been traumatized. It encourages children to explore their emotions and conflicts through play, rather than verbal expression.
Psychiatric Assessment	Formal assessment by a psychiatrist or ANP
Psychoeducation	teaching and training about the disease or problem for which the customer or family member is seeking treatment. Psychoeducation is frequently presumed to be part of all forms of assessment and treatment, yet additional interventions that emphasize education about an illness are often shown to improve outcomes over treatment as usual. Psychoeducation can be incorporated into many treatments, but can be viewed as an intervention in its own right and can be delivered by non-professional staff such as case managers or health educators.
Psychological Testing	Formal psychological assessment which includes clinical interview and appropriate tests conducted by a psychologist and/or psychometrician. This testing is standardized and normed.
Screening/Scales	Brief, easily administered screening and scales which do not require advance training to interpret.
Social Rhythm Therapy	A structured psychotherapy combining elements of behavioral therapy and psychoeducation and shown to reduce rates of relapse and rehospitalization in bipolar disorder

Term or Acronym	Term Definition
Structural Family Therapy (SFT)	Structural Family Therapy is model of treatment in which a family is viewed as a system with interdependent parts. In this treatment model, the family system is understood in terms of the repetitive patterns of interaction between the parts. From such a perspective, the goal of structural family therapy is to identify maladaptive or ineffective patterns of interactions, then alter them to improve functioning of the subparts and the whole.
TBI	Traumatic Brain Injury
Treatment Modality	For purposes of this guideline, we have defined "modality" as the structure in which the customer receives treatment, for example, individual psychotherapy, group psychotherapy, or psychoeducation.
Treatment Model	For purposes of this guideline, we have defined the "model" of care as the underlying theoretical approach to clinical intervention, for example, Cognitive Behavioral Therapy, Insight Oriented Therapy, Interpersonal Therapy.
Untreated Psychosis	For the purposes of this treatment guideline, we define untreated psychosis as psychotic symptoms that are prominent, disruptive in some way, and for which the customer is not accepting or engaging in care that would mitigate such symptoms. The diagnosis of a psychotic disorder, or the presence of psychotic symptoms at some point in the course of illness or treatment should not be a barrier to participation in treatment that might be helpful. However, nor should a customer with a significant psychotic disorder be treated with some forms of psychotherapy from which they are not likely to benefit. Clinical judgment will be needed in selecting appropriate treatment for each customer.
Untreated Substance Dependence	Because "dual diagnosis" is the norm, rather than the exception in behavioral health settings, customers with substance abuse problems should not be excluded, a priori, from participation in treatment for other mental health conditions. However, the impact of their substance use on their capacity to participate in treatment must be assessed on an ongoing basis. Customers with current substance dependence may not be appropriate candidates for some forms of treatment.

Appendix B: Literature Summary

Evidence Based Clinical Guidelines
Southcentral Foundation Research Project
Summary Sheet
ADJUSTMENT DISORDERS

Diagnosis: Adjustment Disorders 309._ _ The development of emotional or behavioral symptoms in response or relationship to a specific stressor. The reaction must be clinically significant by either 1) marked distress (outside the expected range) or 2) significant impairment in social or productivity functioning.

Subtypes: With depressed mood; With anxiety; With mixed anxiety and depressed mood; With disturbance of conduct; With mixed disturbance of emotions and conduct; Unspecified

General Information: The clinical and scientific literature on adjustment disorder is thin and mixed in with research and reviews of other major psychiatric/physical/medical topics. There is **No** empirically-supported research on adjustment disorders per se. A literature search on national and professional data bases produced few hits. Nevertheless, the topic has sufficient coverage via alternative sources and by extrapolation as to provide a platform on which to base treatment and intervention model development. Since, by definition, adjustment disorders are far from monolithic in either dimension or effect, clinical adaptation of other known treatments and models appears necessary and sufficient. Assessment concerns, from a clinical view, seem to be primary skills that practitioners will need to employ in distinguishing between the advent of adjustment disorders and prodromal or NOS categories of other Axis I disorders and syndromes. It is not the intent of this summary to explore those skills but rather offered this as an observation arising from the literature search. Adjustment disorders are a common first line diagnosis for specific reactions to life stress, environmental changes and relational conflicts. This summary will extrapolate and offer reasoned arguments salient to the requested areas of group interventions, age distinctions and model structure.

Group Therapy and AJD Disorders: Since the literature is clear about the effectiveness of group therapy with depression (McDermut, 2004), anxiety (Scapillatro and Manassis, 2002), sexual dysfunction after cancer (Caldwell et al, 2003), and sexual abuse (Trowell et al, 2002) and other externalizing disorders like substance abuse as well as the power of multifamily therapy with conduct disorder youth (a form of family group therapy) (Meezan and O'Keefe, 1998), the correlated psychiatric manifestations of adjustment disorders readily fall within these larger categories.

Structure of Groups: The basics of effective and efficient group therapy apply to adjustment disorders. Since manualization is non-existent, the research on a particular model lacking and specifics about groups conducted under the uniform diagnostic category were not uncovered in this search, the literature on cancer and work-place stress that parallel adjustment disorders are reasonable anchors. Calwell et al (2003) demonstrated a positive outcome following a 12- week group intervention focusing on sexual function and mood improvement post cancer treatment. Solution focused, problem targeted psychoeducation as well as supportive-expressive activities seem to be the general structure. This parallels the models in depression and anxiety disorders. Schaefer (1999) outlines empirically supported group work for children on specific problems including depression and depressive like problems. This fits with Shechtman (2002) review on child group psychotherapy in the school. Adjustment to divorce, moving and new environments are specific stressors that can be addressed in well fitted groups. CBT is often cited as a theory on which the structure and intention of

the group should be based. The comparison literature continues to cite less differentiation between models and more effectiveness based on problem focused, solution targeted, educational programming within the length of group. Group size is generally held to be most effective when under 10 and acuity and issues are relative and related.

Professional Status and Effectiveness in Groups: There is no significantly different outcome in client rated depressive symptoms based on professional or paraprofessional status in either cognitive-behavioral therapy or mutual support group therapies (Bright, 1999, previously cited). There is a moderate difference in clinician-based symptom relief based on two factors 1) professionally lead CBT groups and 2) adherence to a manual based format of group. This review also concluded that group is as effective as individual therapy regardless of clinician orientation. Professional aptitude and technique with children is particular essential when running groups for high functioning children or at risk youth with adjustment disorders or any other diagnosis (Shechtman, 2002, Psychology Today July 2002)

Brief Therapy Models and ADJ Disorders: The literature forming the basis of this summary all use interventions that fall within the brief definition. The cancer project cited above was 12 weeks, the at-risk citation above promotes eight to 12 sessions, 12 sessions for children with anxiety and seven to 12 sessions for work-related stress problems. The nature of the diagnosis lends itself to the application of a brief intervention model.

Professional Status in Brief Therapy: Although no specific research was found, brief therapy mechanics can be taught. There is no evidence that I found, that paraprofessionals could not be taught to execute the foci of treatment. There are obviously some advantages to experience and education in that the theoretical underpinnings are understood, ability to draw on numerous models, and diagnostic abilities are more honed. Some of the common factors supporting all good therapy though are not the exclusive domain of professionally trained practitioners.

Structure of most Brief Therapy: No manual or specific models were uncovered. The application of brief therapy models to the client population based on the nature of their stressor-reaction in adjustment disorders seems logical and ethically sound.

Counter Indications to Group or Brief Therapy: There were none found.

Multi-Cultural Considerations: Since reactivity and expectancy are world-view anchored and contextualized within specific cultural structures and environments, any application of treatment must be sensitive to the interpretation of the symptoms, appraisal of the stressor and the expected outcome. Effectiveness will be based on conservative clinical assessment of the meaning of the stressor and reaction, clear need to provide education and support consistent with the client's world and a mutually understood measure of symptom relief. Without a clear cultural benchmarking of reactions, adjustment disorders might be susceptible to an over-reaching pathologizing.

Pharmacological Interventions: There were no medications algorithms on the Texas or Harvard sites. All medication management related to adjustment disorders is contexted within the specific reaction matrix (depression, anxiety, conduct etc). Physician preference, severity of symptoms that justify medication and the duration and acuity of the disturbances, distress or dysfunction are the considerations. SSRIs are the most common anti-depressants, and anti-anxiety medications.

Manuals: None specifically found for adjustment disorders

Literature Summary References:

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Trowell, J., Kolvin I., Weeramanthri, T., et al,: Psychotherapy of sexually abuse girls, Psychopathological outcome findings and pattern of change. *British Journal of Psychiatry* 2002; 180: 234-47

Short-Term Psychotherapy Groups for Children: Adapting Group Processes for Specific Problems (1999) Ed. Charles E. Schaefer. Jason Aronson Inc, Northvale New Jersey

The Art and Science of Brief Psychotherapies: A Practitioner guide (2004). Dewan, Steenbarger and Greenberg. American Psychiatric Publishing, Washington, DC

Appendix C: Sample Treatment Plans

Treatment Plan for Grief / Loss Unresolved

Problem #1:
Grief and Loss Unresolved

As evidenced by:
- Loss of contact with a parent figure due to divorce.
- Loss of contact with a parent figure due to the person's chronic illness or death.
- Loss of contact with a parent figure due to termination of parental rights.
- Loss of contact with a parent figure due to the parent's incarceration.
- Loss of contact with a positive support network due to the client's geographic move.
- Loss of meaningful contact with a parent figure due to the parent's emotional abandonment.
- Strong emotional response exhibited when the loss is mentioned.
- Symptoms of lack of appetite, nightmares, restlessness, or inability to concentrate as well as other indicators of depression that began subsequent to a loss.
- Marked drop in school grades, increase in angry outbursts, hyperactivity, or clinginess when separating from parents, all of which are out of character for the client.
- Feelings of guilt associated with the unreasonable belief in having done something to cause the loss or not having prevented it.
- Avoidance of talking at length or in any depth about the loss.

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 with joy.
4. Create a supportive emotional environment in which to successfully grieve the loss.
5. Resolve the loss and begin reinvesting in relationships with others and in age-appropriate activities.
6. Patient returns to previous level of functioning as evidenced by _____.

Objectives:
1. Tell the story of the loss.
2. Identify feelings connected to the loss.
3. Increase the ability to verbalize and experience feelings connected with the loss.
4. Identify how the use of mood-altering substances has aided the avoidance of feelings connected to the loss.
5. Develop questions about the loss and work to obtain answers for each.
6. Verbalize an increase in understanding of the process of grieving and letting go.
7. Identify positive things about the deceased loved one and/or the relationship and how these things may be remembered.
8. Decrease the expression of feelings of guilt and blame for the loss.
9. Verbalize and resolve feelings of anger or guilt focused on him/herself or on the deceased loved one that block the grief process.
10. Verbalize or write a list of how the client's life will demonstrate that he/she is letting go of the loss.
11. The parents verbalize an increase in their understanding of the grief process. (27, 28, 29, 3
12. The parents increase their verbal openness about the loss.
13. The parents identify ways to encourage and support the client in the grieving process.
14. The parents who are losing custody verbally say good-bye to the client.
15. Attend and participate in a formal session to say good-bye to the parents whose parental rights are being terminated.

Treatment Plan for Adjustment Disorders

Summary List of Problems
1. Depression
2. Anxiety
3. Anger Control / Frequent Temper Tantrums

Problem #1:
Depression

As evidenced by:
- Depressed mood
- Sleep disturbance
- Appetite disturbance
- Anhedonia
- Decreased libido
- Negative self-image
- Decreased energy
- Irritable mood
- Withdrawal
- Suicidal Ideation
- Problems concentrating / Remembering Things
- Problems making decisions
- Feeling hopeless / helpless
- Thinking that life is terrible
- Problems remembering things
- Social withdrawal
- Sleep disturbance
- Problems making decisions
- Feeling hopeless
- Decreased energy
- Negativity
- Irritable mood
- Negative self-image
- Appetite disturbance
- Suicidal ideation

Goals:
1. Improve mood by X% or appropriate measure
2. Improve sleep by X% or appropriate measure
3. Improve energy by X% or appropriate measure
4. Improve self-image by X% or appropriate measure
5. Increase hopefulness by X% or appropriate measure
6. Decrease suicidal thoughts by X% or appropriate measure

Objectives:
1. Develop safety plan
2. Increase ability to develop reassuring thinking
3. Take medication as prescribed
4. Identify cause of depression
5. Commit to reporting to LSSC or ER when suicidal ideations occurs
6. Improve knowledge of depression
7. Increase expressions of feelings about causes
8. Increase ability to develop reassuring thinking
9. Practice reassuring thinking
10. Improve sleep patterns
11. Practice sleep hygiene
12. Seek psychiatrist and follow-up as directed
13. Take medication as prescribed
14. Learn to express feelings appropriately
15. Improve support network / Learn when to ask for help
16. Behave assertively
17. Exercise at least three times per week
18. Learn anger management skills
19. Practice anger management skills

PROBLEM #2:
Anxiety

As evidenced by:
- Excessive anxiety, worry, or fear that markedly exceeds the level for the client's stage of development.
- High level of motor tension such as restlessness, tiredness, shakiness, or muscle tension.
- Autonomic hyperactivity such as rapid heartbeat, shortness of breath, dizziness, dry mouth, nausea, or diarrhea.
- Hyper vigilance such as feeling constantly on edge, difficulty concentrating, trouble falling or staying asleep, and a general state of irritability.
- 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.
- Excessive anxiety or worry due to a parent's threat of abandonment, over use of guilt, denial of autonomy and status, friction between parents, or interference with physical activity.

Goals:
1. Reduce the overall frequency and intensity of the anxiety response so that daily functioning is not impaired.
2. Stabilize the anxiety level while increasing the ability to function on a daily basis
3. Resolve the key issue that is the source of the anxiety or fear.
4. Reach the point where the client can interact with the world without excessive fear, worry, or anxiety.

Objectives:
1. Develop a working relationship with the therapist in whom the client openly shares thoughts and feelings.
2. Verbally identify fears, worries, and anxieties.
3. Implement positive self-talk to reduce or eliminate the anxiety.
4. Increase the coping behaviors of peer socialization, physical activity, and self-reassurance.
5. Increase participation in daily social and academic activities.
6. Develop and implement appropriate relaxation and diversion activities to decrease the level of anxiety.
7. Identify areas of conflict in the client's life.
8. The parent's verbalize an understanding of the client's anxieties and fears.
9. The parents develop specific ways to empathically help the client with the anxiety and fear.

PROBLEM #3:
Anger Control / Frequent Temper Tantrums

As evidenced by:
- Lack of Anger Control
- Frequent Temper Tantrums
- Frequent temper tantrums
- Frequent anger outburst
- Throwing things in a fit of anger
- Biting
- Hitting
- Scratching
- Getting into arguments
- Starting verbal fights when angry
- Pouting
- Sulking

Goals:
1. Reduce anger outburst by X% or other appropriate measure
2. Reduce temper tantrums by X% or other appropriate measure
3. Reduce arguments by X% or other appropriate measure
4. Reduce fighting by X% or other appropriate measure
5. Reduce yelling by X% or other appropriate measure
6. Reduce cursing and swearing at people by X% or other appropriate measure
7. Reduce throwing things in a fit of anger by X% or other appropriate measure

Objectives:

For Children:
1. Parents to ignore temper tantrums
2. Practice relaxation skills
3. Practice deep breathing exercises
4. Practice "time-out"
5. Redirect anger to an appropriate expression
6. Praise child for appropriate expression
7. Assess child for depression
8. Assess child for anxiety
9. Assess child for ADHD
10. Refer child to psychiatrist for medication evaluation
11. Learn anger management skills
12. Give attentions to child when acting appropriately
13. Share feelings appropriately
14. Verbally express frustrations
15. Verbally express disappointments
16. Set appropriate limits on inappropriate behavior

For Adolescents and Adults:
1. Practice "time-out"
2. Know warning signs
3. Monitor anger level
4. Determine anger level
5. Take cooling off period
6. Manage anger
7. Recover from anger
8. Plan approach from angering situation
9. Ventilate anger
10. Learn assertiveness skills
11. Practice assertiveness skills
12. Learn tactful problem solving
13. Keep from yelling
14. Keep from arguing
15. Keep from interrupting when angry
16. Learn anger management skills
17. Learn my own pattern of anger expression