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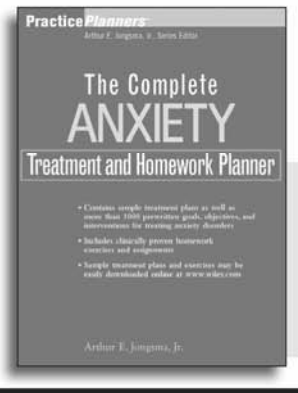

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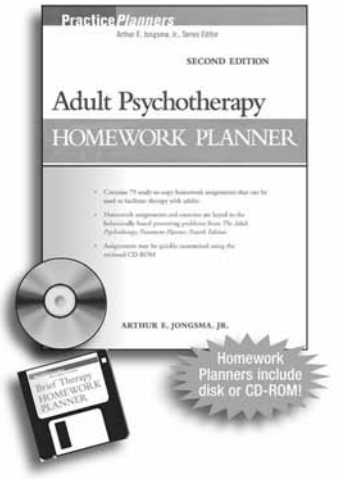

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The Family Therapy Treatment Planner, Second Edition

Frank M. Dattilio

Arthur E. Jongsma, Jr.

Sean D. Davis, Contributing Editor



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To my wife Maryann, three children, and seven grandchildren, who taught me most of what I need to know about happy families.

—Frank M. Dattilio

To Jennifer Byrne, who, as my thoroughly organized, faithful assistant and perseverant transcriptionist, helped me launch this series of Treatment Planners many years ago. Blessings to you, Jen.

—Arthur E. Jongsma, Jr.

To my wife Elizabeth and children Andrew, Hannah, Rachel, and William—you've taught me more about happiness than anything I've learned in my profession.

—Sean D. Davis

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PRACTICE*PLANNERS*® SERIES PREFACE

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

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

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- Neuropsychology
- Older adults
- Parenting skills
- Pastoral counseling
- Personality disorders
- Probation and parole
- Psychopharmacology
- Rehabilitation psychology
- School counseling

- Severe and persistent mental illness
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- Veterans and Active Duty Military

In addition, there are three branches of companion books which 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:

- **Thera*Scribe*®**, the #1 selling treatment planning and clinical record-keeping software system for mental health professionals. Thera*Scribe*® 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.

Adjunctive books, such as *The Psychotherapy Documentation Primer* and *The Clinical Documentation Sourcebook*, contain forms and resources to aid the clinician in mental health practice management.

The goal of our series is to provide practitioners with the resources they need in order to provide high quality care in the era of accountability. To put it simply: We seek to help you spend more time on patients, and less time on paperwork.

ARTHUR E. JONGSMA, JR.
Grand Rapids, Michigan

ACKNOWLEDGMENTS

Many thanks go to my fine assistant and expert typist, Carol A. Jaskolka, who spent countless hours in the revision of this second edition. I would also like to extend my gratitude to the outstanding staff at John Wiley & Sons for their guidance and support with this project.

Frank M. Dattilio, Ph.D.

There are times when you just know that the working chemistry is right. Such has been the case working with Sean Davis. Sean took the lead in revising these chapters as part of a team with Frank Datillio, the internationally respected expert in family therapy who wrote the original edition with me 10 years ago. I appreciated Sean's knowledge of the family therapy field and his focus on bringing evidence-based treatment interventions into the content of these chapters. Along with being a knowledgeable marriage and family therapist, he is a kind and thoughtful man. I am proud to be a collaborator with you, Sean.

Although Frank Datillio was not the lead on this revision, he was definitely involved in reviewing suggested revisions and offering insights for the EBT interventions to be included. And, of course, we were building on his very fine original work. Thank you, Frank, for bringing your expertise to bear on this work and for your oversight of this new edition.

Finally, I want to recognize the ongoing expertise brought to the table by my manuscript manager, Sue Rhoda. She is a gift to me and I thank her again for being there for me and my coauthors and for submitting another clean manuscript. Only the Wiley production staff and I know just how good you are at your job!

Arthur E. Jongsma, Jr., Ph.D.

First and foremost, I wish to thank Frank Dattilio for inviting me to collaborate with him on this second edition of the popular *Family Therapy Treatment Planner*. Frank, it has been an honor to work alongside you on this project. I am grateful for your kindness, friendship, and generosity.

I also wish to thank Art Jongsma, Sue Rhoda, and the staff at John Wiley & Sons for their support during this project. I thank Alliant International University graduate students Nicole Crandall and Jayson Gawthorpe for their invaluable help with editing the manuscript; this project might still be going on without your involvement.

Lastly, I thank my wife Elizabeth and children Andrew, Hannah, Rachel, and William for their patience with me as I have worked on this project. I am humbled by your patience and am excited to be back as a fully present husband and father!

Sean D. Davis, Ph.D.

INTRODUCTION

ABOUT PRACTICE*PLANNERS*® TREATMENT PLANNERS

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

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 THE FAMILY THERAPY TREATMENT PLANNER

This second edition of the popular *Family Therapy Treatment Planner* comes as a result of the positive response that we received over the past decade with the success of the first planner. The first edition, which ran for almost 10 years, was a bestseller. As a revision, we have included two additional chapters, totaling 40 in all, along with the refortification of evidenced-based treatment interventions throughout the existing text. The existing chapters now reflect the updated research that has become available over the past decade.

As stated in the previous preface, the field of family therapy has continued to grow exponentially since its introduction in the 1950s. Virtually all graduate programs in the field of mental health offer some curriculum in family therapy (Piercy, Sprenkle, and Wetchler, 1996), and all 50 states now have licensing laws for marital and family therapists.

With this explosive growth has come the increasing acceptance of family therapy interventions in the mental health service delivery system. In fact, recent research supports family therapy as one of the most effective forms of psychotherapeutic treatment for a wide variety of problems (Shadish and Baldwin, 2002). In addition, recent research has begun to demonstrate that marriage and family therapy treatments have a positive effect on physical health and health care usage (Caldwell, Woolley, and Caldwell, 2007). Hence, it is no surprise that insurance companies and managed care programs have increased their awareness and acceptance of family therapy as a mode of treatment for a number of mental health problems and have included it as a reimbursable intervention. Since millions of patients receive their mental health care through a managed care arrangement, it is essential that clinicians have access to structured treatment plan materials that efficiently meet their needs.

This book also goes hand-in-hand with the *Couples Psychotherapy Treatment Planner* since very often family conflicts emanate from problems in the spouses' relationship. In such cases, the therapist should refer to the *Couples Psychotherapy Treatment Planner* (O'Leary, Heyman, and Jongsma, 1998) for more specific suggestions regarding treating the couple's relationship. With this concept in mind, the reader should also expect that there will, at times, be some overlap between the *Family Therapy* and *Couples Psychotherapy Treatment Planners*. We acknowledge our indebtedness to Dan O'Leary and Rick Heyman for their thorough work on the *Couples Psychotherapy Treatment Planner*.

INCORPORATING EVIDENCE-BASED TREATMENT INTO THE TREATMENT PLANNER

Evidence-based or empirically supported treatment (that is, treatment that has shown efficacy in research trials) is rapidly becoming of critical importance to the mental health community as the demand for quality and accountability increase. Indeed, identified empirically supported treatments (e.g., those of the APA Division 12 [Society of Clinical Psychology], the Substance Abuse and Mental Health Services Administration's [SAMHSA] National Registry of Evidence-based Programs and Practices [NREPP]) are being referenced by a number of local, state, and federal funding agencies, some of which are beginning to restrict reimbursement to these treatments, as are some managed care and insurance companies.

In this second edition of *The Family Therapy Treatment Planner*, we have made an effort to empirically inform some chapters by highlighting Short-term

Objectives (STOs) and Therapeutic Interventions (TIs) that are consistent with psychological treatments or therapeutic programs that have demonstrated some level of efficacy through empirical study. Watch for this icon EBT as an indication that an Objective/Intervention is consistent with those found in evidence-based treatments (EBT).

References to the empirical work supporting these interventions have been included in the reference section as Appendix B. For information related to the identification of evidence-based practices (EBPs), including the benefits and limitations of the effort, we suggest the APA Presidential Task Force on Evidence-Based Practice (2006); Bruce and Sanderson (2005); Chambless et al. (1996, 1998); Chambless and Ollendick (2001); Castonguay and Beutler (2006); Drake, Merrens, and Lynde (2005); Hofmann and Tompson (2002); Nathan and Gorman (2007); and Stout and Hayes (2005). Sprenkle, Davis, and Lebow (2009) provide a review of this literature as it pertains to Marriage and Family Therapy.

In this *Planner*, we have included STOs and TIs consistent with identified EBTs for family problems and mental disorders commonly seen by practitioners in public agency and private practice settings. It is important to note that the empirical support for the EBT material found in each chapter has not necessarily been established for treating that problem within a family context, but rather is particular to the problem identified in the chapter title. For example, the STOs and TIs consistent with cognitive therapy for anxiety that can be found in the chapter entitled "Anxiety" are based on this treatment approach, which has been well established as an empirically supported individual treatment for anxiety, yet can be easily modified for treatment in a family setting. Furthermore, it is important to remember that an EBT such as Cognitive-Behavioral Family Therapy (Dattilio, 2010) can be applied to a wide variety of problems. Therefore, although many chapters present common problems faced by families (e.g., geographic relocation) for which no studies have specifically focused on, an EBT, such as behaviorally based parenting techniques or problem-solving skills, can be utilized to help the family through that particular challenge.

Beyond references to the empirical studies supporting these interventions, we have provided references to therapist- and client-oriented books and treatment manuals that describe the use of identified EBTs or treatments consistent with their objectives and interventions. Of course, recognizing that there are STOs and TIs that practicing clinicians have found useful but that have not yet received empirical scrutiny, we have included those that reflect common best practice among experienced clinicians. The goal is to provide a range of treatment plan options, some studied empirically, others reflecting common clinical practice, so the user can construct what they believe to be the best plan for a particular client. Most of the STOs and TIs associated with the EBTs are described at a level of detail that permits flexibility and adaptability in their specific application. As with all *Planners* in this series, each chapter includes the option to add STOs and TIs at the therapist's discretion.

Criteria for Inclusion of Evidence-Based Therapies

The EBTs from which STOs and TIs were taken have different levels of empirical evidence supporting them. For example, some have been well established as efficacious for the problems that they target (e.g., exposure-based therapies for anxiety disorders). Others have less support, but nonetheless have demonstrated efficacy. We have included EBPs the empirical support for which has either been well established or demonstrated at more than a preliminary level as defined by those authors who have undertaken the task of identifying them, such as the APA Division 12 (Society of Clinical Psychology), Drake and colleagues (2003, 2005), Chambless and colleagues (1996, 1998), and Nathan and Gorman (2007).

At minimum, efficacy needed to be demonstrated through a clinical trial or large clinical replication series with features reflecting good experimental design (e.g., random assignment, blind assignments, reliable and valid measurement, clear inclusion and exclusion criteria, state-of-the-art diagnostic methods, and adequate sample size or replications). Well-established EBTs typically have more than one of these types of studies demonstrating their efficacy, as well as other desirable features such as demonstration of efficacy by independent research groups and specification of client characteristics for which the treatment was effective.

Lastly, all interventions, empirically supported or not, must be adapted to the particular client in light of his/her personal circumstances, cultural identity, strengths, and vulnerabilities. The STOs and TIs included in this *Planner* are written in a manner to suggest and allow this adaptability.

Summary of Required and Preferred EBT Inclusion Criteria

Required

- Demonstration of efficacy through at least one randomized controlled trial with good experimental design, or
- Demonstration of efficacy through a large, well-designed clinical replication series.

Preferred

- Efficacy has been shown by more than one study.
- Efficacy has been demonstrated by independent research groups.
- Client characteristics for which the treatment was effective were specified.
- A clear description of the treatment was available.

HOW TO USE THIS TREATMENT PLANNER

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

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

Some suggested interventions listed in the *Planner* refer to specific books that can be assigned to the client for adjunctive bibliotherapy. Appendix A contains a full bibliographic reference list of these materials. For further information about self-help books, mental health professionals may wish to consult *The Authoritative Guide to Self-Help Resources in Mental Health, Revised Edition* (2003) by Norcross et al. (available from Guilford Press, New York).

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-IV-TR*. 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-IV-TR* 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 anger management is provided at the end of this introduction.

A FINAL NOTE ON TAILORING THE TREATMENT PLAN TO THE CLIENT

One important aspect of effective treatment planning is that each plan should be tailored to the individual client's problems and needs. Treatment plans should not be mass-produced, even if clients have similar problems. The individual's strengths and weaknesses, unique stressors, social network, family circumstances, and symptom patterns must be considered in developing a treatment strategy. Drawing upon our own years of clinical experience, 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, objects, 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, clinicians, and mental health community.

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SAMPLE TREATMENT PLAN

PRIMARY PROBLEM: ANGER MANAGEMENT

Definitions: Expressions of anger that include threats, breaking objects, violating others' individual space, and refusal to speak to certain family members.

Expressions of anger that are perceived by others as demeaning, threatening, or disrespectful.

Disagreement among family members about the threat created by the angry member.

Goals: Terminate expressions of anger that are demeaning, threatening, disrespectful, or violent.

Get in touch with feelings of emotional pain and express them verbally in appropriate ways rather than through angry outbursts.

OBJECTIVES	INTERVENTIONS
1. Each family member identifies the destructive effects that his/her uncontrolled anger has had on all family members, including self.	1. Have each family member describe how his/her respective uncontrolled expression of anger is counterproductive to himself/herself and to other family members; assist them in identifying the negative effects of uncontrolled anger (e.g., fear, withdrawal, guilt, revenge, etc.) on others.
2. Identify any secondary gain that has been derived through expressing anger in an intimidating style.	1. Assist family members in identifying what secondary gain (acquiescence to demands, fear-based service, etc.) is derived from uncontrolled anger.
3. Family members sign a contract stipulating that they will attempt to manage their anger with the support and guidance of family therapy.	1. Urge family members to sign a contract agreeing to accept responsibility for containing their own anger and managing it effectively.

4. Implement assertiveness as a replacement for angry aggression to declare independence.	1. Clearly define examples of nonassertive, assertive, and aggressive expressions of anger and then have each family member give personal examples of each to demonstrate their understanding of the concept (see *Your Perfect Right* by Alberti and Emmons). 2. Use role-playing and modeling to teach assertiveness as an alternative to angry aggressiveness used to declare independence.
5. Identify the various cues for anger as it escalates.	1. Teach family members how to identify the cognitive, affective, behavioral, and physiological cues of anger and how to differentiate low, moderate, and high ranges; recommend the book *Angry All the Time* by Potter-Efron.
6. Verbalize an understanding of the steps in using time-out as an anger control technique.	1. Teach family members the five steps in using time-out to control anger: (1) *self-monitoring* for escalating feelings of anger and hurt; (2) *signaling* to another family member that verbal exchange is not a good idea; (3) *acknowledgment* of the need for the other family members to back off; (4) *separation* to cool down and use cognitive self-talk to regain composure; and (5) *returning* to calm verbal exchange.
7. Report on the use of time-out at home to control anger.	1. Assign family members to implement the time-out technique at home; review results, reinforcing success and redirecting for failures.
8. Implement the use of the "turtle" technique of retreat to control anger escalation.	1. Suggest the use of the "turtle" technique, in which family members imagine themselves individually retreating into their shells until they cool down.

DIAGNOSIS

Axis I:	312.34	Intermittent Explosive Disorder

ACTIVITY/FAMILY IMBALANCE

BEHAVIORAL DEFINITIONS

1. Tension develops in the family as a result of one of the family members' excessive time given to outside activities (parent's job or sport, a child's activity, etc.).
2. Family members question the issue of priorities because of the unusual amount of time that is dedicated to the outside activities.
3. Conflict and tension arise over the fact that certain duties and responsibilities are being shifted onto other family members unfairly due to the time absorbed by the external activity.
4. Jealousy and envy brew between family members unfairly due to the time absorbed by the external activity.
5. Family members compete over time with the often-absent family member, leading to disagreements (e.g., children arguing over time with parent).
6. A family member's excessive involvement with external activities is due to a mental illness (e.g., bipolar disorder).

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LONG-TERM GOALS

1. Eliminate family tension by encouraging family members to acknowledge the excessive outside activity and willfully give more time to family matters.
2. Find an acceptable balance between the competing demands of external activities and family responsibilities.
3. Implement a fair and equal system for assignment of chores and responsibilities among family members.
4. Family members strive to spend an equal amount of time with each other.
5. Obtain treatment for mental illness in order to restore balance and proper priorities to the allocation of time.
6. Successfully resolve family tension by dealing with issues directly rather than avoiding them through outside pursuits.

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SHORT-TERM OBJECTIVES

1. Define the external activity that is contributing to family disharmony. (1, 2, 3, 4)

THERAPEUTIC INTERVENTIONS

1. Allow each family member to have his/her say about who is frequently absent from the family and for what activity (e.g., dad and work, sibling and sports); discuss any differences in perception.
2. Facilitate the ventilation of feelings as experienced by each family member over a particular family member's absence(s).
3. Have each family member take ownership of his/her feelings and behaviors.
4. Help the family identify the problem and define the specifics (e.g., mom works too much and does not have enough time for us).

2. Trace the history of the activity/family imbalance problem and what contributed to its origin. (5, 6, 7)

5. Trace how the activity/family imbalance problem evolved (e.g., due to financial need, learned behaviors from family of origin)

6. Utilize assessment techniques to help define the problem and its historical roots (e.g., genograms, Family-of-Origin Scale [Hovestadt, Anderson, Piercy, Cochran, and Fine], or Family of Origin Inventory [Stuart]).

7. Solicit each family member's opinion on why the excessive energy is directed outside of the family.

3. Each family member lists his/her time allocation priorities in a rank-ordered fashion. (8, 9)

8. Have each family member express his/her priorities for how time is spent (family time, work, recreation, friends, Internet, etc.); request that they rank order them according to what each perceives as being most important.

9. Have family members compare their lists of priorities and discuss how and why they are different; explore how the priorities have come to be so different.

4. Agree on a list of activity priorities that all members can endorse. (10, 11, 12)

10. Develop a joint family list of priorities by attempting to facilitate agreement between members on what the ranking of priorities in the family should be.

11. Explore issues that may be interfering with the cohesive, rank-ordered list of priorities (e.g., need for attention, avoidance of conflict, or fear of not having enough income).

12. Assist family members in finding a healthy way (e.g., using assertive rather than aggressive or passive-aggressive communication and using active listening techniques) to

	address issues that interfere with the rank-ordered list of priorities.
5. Each member identifies the expectations he/she believes the family holds for him/her. (13)	13. Explore the perceived expectations the family members hold for one another (e.g., dad's belief of what his wife and children expect of him, an oldest child's perception of his family's expectation of him); compare these to actual expectations.
6. Using "I" statements, express disagreement with each other over the activity/family imbalance issue in a respectful, constructive manner. (14)	14. Suggest some appropriate, more constructive means of expressing disagreement over the activity issue (e.g., using "I" statements rather than "you" statements, staying calm and respectful in tone); use role-playing and modeling to demonstrate this skill to the family.
7. Cooperate with completing an inventory to assess family relationships. (15, 16)	15. Use an assessment inventory to define the nature of relationships within the family (e.g., the Index of Family Relations [IFR] in the *Walmyr Assessment Scales Scoring Manual* by Hudson).
	16. Discuss with the family the results of the assessment inventory and the implications for family relationships.
8. List the home-based duties, chores, and responsibilities that are assigned to each family member. (17, 18)	17. Open up a forum for the discussion of what home-based duties and responsibilities have been assigned to individual family members; poll each family member on what he/she believes would be a fair distribution of duties and responsibilities and why.
	18. Bring to the surface any underlying beliefs about how the delegation of chores should be based on income earners versus non-income earners, adults versus children, males versus females, and so on.

9. Agree on an assignment of chores that all find equitable. (19)	19. Assist the family in developing a fair method for assigning chores to various family members (e.g., suggest using a lottery drawing to randomize assignment of chores).
10. Each family member acknowledges a responsibility to work on behalf of the family unit, not just self-interest. (20)	20. Help family members confront those who appear to be attempting to shirk their responsibilities; discuss the need to take responsibility for their own behavior and to work for the good of the family unit, not just themselves.
11. Acknowledge and resolve feelings of jealousy over time and attention given to various family members. (21, 22)	21. Explore the issue of jealousy and envy and how this plays into the conflicts between family members over the activity/family imbalance issue.
	22. Focus on specific arguments over time allocation within the family and how these have developed.
12. Verbalize feelings and beliefs over the lack of quality time family members spend together. (23, 24)	23. Facilitate family members in ventilating their feelings about the lack of time they have with each other or the unequally great amount of time spent with a specific family member.
	24. Probe whether certain family members may be avoiding each other or avoiding intimacy by remaining overly involved in the external activities.
13. Each family member lists the pros and cons about being close with one another. (25)	25. Ask each family member to list the pros and cons of being a part of a close family unit; assess whether the family has a problem with being closely knit.
14. Participate in activities that build family unity and bonding. (26)	26. Suggest ways to build family intimacy, such as social or recreational activities, using such strategies as playing the UnGame [Zakich] or an equivalent activity together.

15. Identify symptoms of a mental illness in the too-often-absent family member or in his/her family of origin. (27, 28, 29)

16. Accept referral for psychological treatment of the mentally ill family member. (30, 31, 32)

17. Verbalize acceptance of the presence of a mental illness and the need to obtain treatment. (33, 34)

27. Investigate whether or not there is a history of mental health problems in the family of origin of the frequently absent member.

28. Determine whether the family member who is spending excessive time outside the home may be struggling with a mental health issue (e.g., obsession, addiction, or a more serious psychiatric problem, such as bipolar disorder).

29. Suggest a more in-depth evaluation via referral of the frequently absent member to another mental health professional (e.g., clinical psychologist, psychiatrist, etc.).

30. Discuss the various treatment options for the mentally ill family member (e.g., outpatient, inpatient, etc.).

31. Assist the family in identifying methods for supporting the mentally ill family member (e.g., intervention, support groups, etc.).

32. Discuss using a buddy system for family members both within and outside of the family (e.g., local chapter of Families of the Mentally Ill or the American Red Cross) to gain support in coping with mental illness in the family.

33. Confront the issue of denial of mental illness on the part of any family member, including the one with the diagnosed illness.

34. Attempt to uncover any enabling process within the family system that may be reinforcing the denial of mental illness.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
	300.02	Generalized Anxiety Disorder
	296.2x	Major Depressive Disorder, Single Episode
	V61.20	Parent-Child Relational Problem
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
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	_____	_____
Axis II:	301.81	Narcissistic Personality Disorder
	301.50	Histrionic Personality Disorder
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ADOLESCENT/PARENT CONFLICTS

BEHAVIORAL DEFINITIONS

1. Parents experience conflicts with adolescent child that begin to interfere with the family's overall functioning.
2. Parents argue with each other over how to respond to the adolescent's disruptive, nonconforming behaviors.
3. Family members resent the adolescent-centered conflict, increasing tension in the home.
4. Parents feel a loss of control and the adolescent feels empowered by parent's dilemma, making his/her own rules and resisting parental intervention.
5. Adolescent acts out in areas of substance abuse, sexuality, school performance, and/or delinquency.

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LONG-TERM GOALS

1. Parents arrive at some level of agreement regarding how to respond to the adolescent.
2. Parents reduce the effects of the adolescent's misbehavior on other family members.
3. Parents learn new methods for working together to achieve harmony and balance in the family.

4. Parents devise and enforce a set of rules and standards that promote peace and harmony in the family.
5. Parents feel empowered to take control of the family and react firmly to adolescent acting out.

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SHORT-TERM OBJECTIVES

1. Define the specifics about what needs to change in the adolescent's behavior. (1, 2)

2. Parents clarify philosophy on parenting expectations for the adolescent. (3)

3. Parents and adolescent cooperate with psychological testing to identify specific areas of parent/child conflict. (4, 5)

THERAPEUTIC INTERVENTIONS

1. Open up the forum for family members to share their perception of the adolescent's behavior and discuss feelings about the adolescent's behavior.
2. Assess whether the adolescent's acting-out behavior is transient or is a more persistent pattern.
3. Ask the parents to share their philosophy on parenting and what expectations they have for their son or daughter.
4. Use questionnaires and inventories to assess specific areas of conflict and how the family may be contributing to the problems (e.g., Adolescent Coping Orientation for Problem Experiences [A-COPE] in *Family Assessment Inventories for Research and Practice* by McCubbin and Thompson).
5. Assess the family members' belief system about appropriate versus inappropriate behavior by utilization of interviews and questionnaires (e.g., Family Beliefs Inventory [Roehling and

	Robin] or Parent-Adolescent Relationship Questionnaire [Robin, Koepke, and Moye]).
4. Identify family, school, or marital factors that may be contributing to the adolescent's undesirable behavior. (6, 7)	6. Explore familial interaction patterns or dynamics that may be exacerbating the conflict between the adolescent and parents (underlying conflicts, family-of-origin issues, unrealistic expectations, marital problems, etc.) (see Dattilio, 2010).
	7. Explore environmental stressors that may be exacerbating the adolescent's acting out (e.g., family transitions, inconsistent rules, school or social difficulties, peer relationships, or peer pressure).
5. Parents identify their strengths and weaknesses in parenting style. (8)	8. Role-play a parent/adolescent conflict to assess how parents solve the problem; give parents feedback regarding the strengths and weaknesses of their approach.
6. Parents read books and watch videotapes on parenting adolescents. (9)	9. Recommend that the parents read books on parenting techniques (e.g., *The Five Love Languages of Teenagers* by Chapman; *Parents, Teens, and Boundaries: How to Draw the Line* by Bluestein; *Parents and Adolescents: Living Together,* vol. 1, *The Basics*, and vol. 2, *Family Problem Solving* by Patterson and Forgatch; *Raising an Emotionally Intelligent Child* by Gottman and Declaire; or *Parenting Teens with Love and Logic* by Cline and Fay).
7. Parents develop and implement a monitoring system for the adolescent's whereabouts, and indicate any deficiencies in the monitoring system. (10, 11)	10. Assist the parents in developing a monitoring system for their adolescent, knowing *where* he/she is, *who* he/she is with, *what* he/she is doing, and *when* he/she will be home.

11. Assign parents to record their joint monitoring efforts with the adolescent as a homework assignment and identify events or situations in which monitoring requires improvement.

8. Parents identify and record the occurrence of a specific desirable behavior of the adolescent that they would like to see increase in frequency. (12)

12. Ask parents to select a behavior of the adolescent's that they would like to see increase in frequency; ask them to record its occurrence every day for a week, and notice the behaviors or situations that precede it (antecedents) and follow it (consequences).

9. Implement a behavioral contract to increase the frequency of the adolescent's target behavior. (13, 14)

13. Have parents decide on an appropriate reward system (e.g., verbal praise, use of the car, allowance) to reinforce the positive target behavior of the adolescent; seek agreement between the parents and the adolescent for implementation of this behavioral contract.

14. Review the implementation of the behavioral contract; reinforce the family for successes and adjust the contract for failures.

10. Increase the frequency of positive social- or activity-oriented interactions between parents and the adolescent. (15)

15. Solicit topics and activities that could be initiated between the adolescent and the parents; recommend that each parent increase the number of parent-initiated, casual, positive conversations with the adolescent.

11. Establish and implement consequences for negative adolescent behavior. (16)

16. Develop with the parents a response/cost procedure to use in conjunction with the adolescent's targeted negative behavior; assign implementation and review success.

12. Parents identify and make an effort to terminate any undesirable behaviors that they may be modeling for the adolescent. (17, 18)

17. If parents are modeling for the adolescent the behavior they would like to extinguish (e.g., yelling or becoming sarcastic), help parents become aware of this; contract with them to change their own behavior before trying to change the same behavior in the adolescent.

18. Introduce the parents to techniques of anger control to better mediate conflict (e.g., recommend the *Anger & Aggression Workbook* by Liptak, Leutenberg, and Sippola or *The Anger Trap* by Carter).

13. Parents confer with each other frequently to increase mutual support in parenting. (19, 20)

19. Ask parents to role-play support for each other regarding their reaction to the adolescent's misbehavior; have the supportive parent ask (in a nonthreatening manner) how the other parent deals with the misbehavior and whether the supportive parent can do anything in the future to help.

20. Have parents contract to support the other's parenting by not interfering during the other's parent/adolescent interactions or with the other's decisions (i.e., avoid splitting their parental unity).

14. Parents use structured dialogue techniques to ensure good parental communication for problem-solving. (21)

21. Teach parents communication and problem-solving skills (see *Relationship Enhancement* by Guerney and *Fighting for Your Marriage* by Markman, Stanley, and Blumberg) to use with the adolescent as well as each other (e.g., problem definition, brainstorming solutions, evaluation of alternatives, solution enactment, and enactment evaluation).

15. Parents minimize criticism of the other's parenting efforts. (22)

22. Help each parent identify when he/she is engaging in criticizing

the other parent in a nonconstructive manner.

16. Parents discuss disagreements only at times when discussion is likely to be constructive, and not in the presence of the children. (23)

23. Help parents establish a practice of meeting in private so they can discuss parenting decisions and come to a mutual agreement before presenting it to the adolescent.

17. Parents identify and replace distorted cognitive beliefs that relate to parenting their teenager. (24, 25)

24. Ask parents to track their thoughts and emotional reactions during problematic situations with their adolescent; review these cognitive messages for distortions.

25. Challenge parents' unreasonable beliefs by asking them to provide evidence for the truth of their beliefs and persuasively illuminating the illogical premise involved (e.g., "If my daughter stays out late, she will become pregnant or a drug addict" can be replaced by "I can make my opinions and the house rules known, but ultimately her behavior is up to her").

18. Family members hold family meetings regularly and conform to the rules of interaction. (26)

26. Assign parents to initiate regular family meetings for constructive problem-solving and evaluation of earlier contracts. Family meetings should be time-limited (starting with 15 minutes) and should observe set ground rules (see page 117 of *Parents and Adolescents: Living Together,* vol. 2: *Family Problem Solving* by Patterson and Forgatch).

19. Family members demonstrate empathy and respect for other individuals' points of view. (27)

27. Role-play respectful communication rules for use in family meetings, such as taking turns talking, paraphrasing, or reflecting speaker's position before responding, treating each other with respect, and no lecturing (see page 118 of *Parents and Adolescents: Living Together,*

vol. 2: *Family Problem Solving* by Patterson and Forgatch).

20. Parents list alternatives to their current parenting methods. (28)

28. Have parents brainstorm alternative styles of parenting that they have learned as a result of their assigned readings (see Intervention #9), speaking with other parents (through parenting groups, etc.), or previous family therapy sessions; review with them the potential pros and cons of these new parenting styles.

21. Parents enact alternative parenting styles and evaluate their effectiveness. (29)

29. Ask parents to try an alternative parenting style to evaluate its effectiveness; facilitate parents in providing each other with critical feedback afterward as to how well they perceived the alternative to work.

22. Identify and challenge unreasonable beliefs and expectations regarding adolescent behaviors. (30)

30. Assign parents and adolescents to list what they each believe is reasonable and unreasonable expectations in adolescent behavior; review these expectations for reality basis.

23. Parents establish consistent house rules and regulations. (31, 32)

31. Have parents establish consistent house rules; make sure consequences for rule violations and compliance are specified; rules can be modified and negotiated in family meetings if necessary.

32. Reinforce the need for parents to follow through on praise for following rules, as well as consequences for not following rules.

24. Family establishes rituals such as a regular dinner hour and sets rules regarding participation in rituals. (33)

33. Discuss with parents and adolescent(s) the feasibility of the family eating meals together and other family rituals; set rules about frequency and attendance; recommend *The Intentional Family* by Doherty.

25. Parents go out alone at least one night per week for socialization and/or recreation. (34)

34. Encourage the parents to have one or two nights per week out alone together, or with adult friends, when children are not the focus of the conversation or of the relationship.

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DIAGNOSTIC SUGGESTIONS

Axis I:

V61.21	Neglect of Child
995.52	Neglect of Child (Victim)
V61.20	Parent-Child Relational Problem
V61.10	Partner Relational Problem
995.54	Physical Abuse of Child (Victim)
V61.21	Sexual Abuse of Child
995.53	Sexual Abuse of Child (Victim)
313.81	Oppositional Defiant Disorder
312.9	Disruptive Behavior Disorder NOS
312.82	Conduct Disorder, Adolescent-Onset Type
_____	_____
_____	_____

Axis II:	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
	_____	_____
	_____	_____

ADOPTION ISSUES

BEHAVIORAL DEFINITIONS

1. Parents struggle with the issue of infertility and are considering contacting a child adoption agency or making a private adoption arrangement.
2. Parents struggle with a sense of failure and disconnectedness with the adopted child due to the lack of a biological link.
3. Parents struggle with when and if to inform the child that he/she is adopted, and become overprotective and overindulgent or detached and permissive.
4. Adopted child feels different, isolated, and removed from the parents and siblings, and struggles with abandonment issues regarding his/her biological parents.
5. Parents feel a lack of connection with the adopted child as opposed to biological children.
6. Tension exists between biological and adopted children, with the adopted child sustaining badgering and ridicule from siblings, extended family-of-origin members, and so on.
7. Adopted child questions the whereabouts of his/her biological parents and make overtures to search for them.
8. Adopted child fantasizes about and idealizes the biological parents.
9. Adoptive parents feel a sense of threat, rejection, abandonment, and even betrayal by adopted child's overtures to search for his/her biological parents and/or biological siblings.
10. Adopted child successfully locates biological parents and/or biological siblings and begins to form a bond, creating friction among the adoptive family members.
11. Adopted child encounters a cold and/or rejecting reception from biological parents and experiences negative emotions as a result.
12. Adoptive parents meet the adopted child's biological parents, and tension results for all parties involved.

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LONG-TERM GOALS

1. Parents work through their struggles over their inability to conceive and accept this as a dysfunction of their genetic/biological disposition as opposed to a sense of failure.
2. Parents accept and bond with adopted and biological children equally.
3. Adopted child develops positive feelings regarding adoptive family.
4. Parents educate themselves on the issue of when and if they should inform a child that he/she is adopted.
5. Adopted and biological children resolve tension between themselves.
6. Parents decide when and if to provide the adopted child with information regarding biological parents, and deal appropriately with any threat that develops as a result of the child's inquiry.
7. Adopted child accepts the outcome of meeting his/her biological parents regardless of whether their reaction is positive or negative.

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SHORT-TERM OBJECTIVES

1. Identify the negative impact that infertility and its treatment have had on each partner and on the relationship. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Allow the couple to vent about the hardship of enduring the infertility process.
2. Explore the stress and strain that infertility has had on the couple's relationship and how it may be

	precluding their ability to conceive; recommend *Infertility and Identity* (Deveraux and Hammerman).
2. Attend an infertility support group. (3)	3. Help the couple locate an infertility support group in their area, either through their obstetrician/gynecologist or the American Red Cross directory.
3. Parents verbalize an understanding that the inability to conceive is a matter of genetic/ biological factors and not due to personal failure. (4, 5)	4. Educate the couple on the biological factors of failure to conceive via referral to fertility experts and readings (e.g., *The Long-Awaited Stork*, 2nd ed. by Glazer).
	5. Discuss with the parents the notion that giving birth to a child is only a small part of the picture, that parenting is independent of birthing, and that a strong bond can form irrespective of the biological connection.
4. The adopted child expresses feelings associated with being adopted. (6, 7)	6. Allow the adopted child to vent his/her feelings regarding adoption in family therapy; focus on productively processing these feelings.
	7. Teach the family members that the adoptive child's emotions (e.g., anger, isolation, acting-out behaviors, and depression) over being adopted are common.
5. The adopted child verbalizes positive feelings toward adoptive family. (8)	8. Encourage family activities that will promote the rebonding of the adopted child to parents and siblings (e.g., parental nurturing behaviors, games, family outings, one-to-one activities for the child and a parent, etc.).

6. Parents verbalize acceptance of the child's need to search for his/her biological parents. (9, 10)

7. Parents and the adopted child verbalize and resolve their fears about the adopted child investigating into his/her biological parents. (11)

8. Parents and the adopted child prepare for the possibility of the adopted child's biological parents having a negative reaction to an inquiry. (12)

9. Parents identify the pros and cons of telling the child of his/her adoption. (13)

10. Parents agree as to when and what to tell the adopted child regarding his/her adoptive origins. (14)

9. Help the parents accept the fact that it is very natural and common for adopted children to be curious about their biological parents.

10. Reinforce with the parents that the adopted child's inquiries are not an overture of rejection, but a quest for his/her existence and reframing of the self.

11. Reassure all family members that their feelings are not unusual and that fear of rejection and guilt are very common.

12. Use stress inoculation techniques and specific coping skills (e.g., brainstorming with all family members their potential reactions to meeting the biological parents and how they feel about it, role-playing the initial meeting with biological parents, etc.) as advance preparation for any potential negative reaction by the biological parents.

13. Review with the parents the pros (e.g., not having the child accidentally learn from someone else that he/she is adopted) and cons (e.g., risking the child's withdrawal from the adoptive family to search for his/her biological parents) and timing regarding telling the child of his/her adoption; refer them to readings (e.g., *The Adoption Resource Book*, 4th ed. by Gilman).

14. Help the parents make an initial decision regarding what and when a child should be told about his/her adoption; explain to them that this decision is not carved in stone and can be re-evaluated and changed later.

11. Read assigned material on the emotions associated with being adopted. (15)

12. Parents accept the responsibility for the child learning of his/her adoption from a source outside of their immediate adoptive family. (16, 17)

13. The adopted child meets with older adopted children who have come to accept their adoption without emotional pain. (18)

14. Parents identify the factors that cause them to experience a lack of connection with the adopted child, as opposed to their biological children. (19, 20, 21)

15. All family members identify the true source of tension between biological children and the adopted child. (22)

15. Recommend that the child and parents read books on how it feels to be adopted (e.g., *How It Feels to Be Adopted* by Krementz).

16. Help the parents process their guilt over not having informed the child of his/her adoption, which has resulted in the child experiencing anger and rage.

17. Through family therapy sessions, process how the parents arrived at the decision not to inform the child of the adoption so that the child can better understand their logic.

18. Facilitate contact between the child and older adopted children outside of the immediate family who have accepted being adopted.

19. Assist the parents in identifying possible factors (lack of physical resemblance, absence of time in utero, etc.) that could contribute to differences in bonding with adopted versus biological children.

20. Help the parents to resolve any differences in their feelings for their adopted and biological children and to understand how this is likely to affect the entire family. (If it is identified as a more individual issue, consider referring for individual psychotherapy.)

21. Suggest to the parents that a separate couples meeting take place between them and the therapist so that the issue of a lack of bonding with the adopted child may be addressed without any of the children present.

22. Address the entire family on the tension between the biological and adopted children. Search for any conflict between the parents to

explain why this might exist. Also, help the children mediate their tensions or feuds regarding their differences.

16. Verbalize ways to be supportive of one another if the biological parents reject inquiry attempts. (23)

23. Discuss how the parents and children of the family can support one another in the event that the biological parents reject any inquiry by either the adoptive parents or the adopted child.

17. Parents verbalize acceptance of the adopted child, who is of age, choosing to reside with or close to his/her biological parents or siblings. (24)

24. Help the parents and family members to accept the adopted child's decision and his/her need to rebond with his/her biological family of origin.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
	300.4	Dysthymic Disorder
	296.x	Major Depressive Disorder
	V61.10	Partner Relational Problem
	V61.12	Physical Abuse of Adult
	V61.20	Parent-Child Relational Problem
	995.81	Physical Abuse of Adult (Victim)
	_____	_____
	_____	_____
Axis II:	301.6	Dependent Personality Disorder
	301.83	Borderline Personality Disorder
	301.81	Narcissistic Personality Disorder
	_____	_____
	_____	_____

ALCOHOL ABUSE

BEHAVIORAL DEFINITIONS

1. The regular excessive use of alcohol by one or more members of a family unit leads to interference with functioning at work or school; to ignoring the dangers to health; to vocational, social, or legal problems; and to family and/or marital conflict.
2. Verbal or physical abuse associated with alcohol abuse leads to serious conflicts between family members.
3. Alcohol abusers make continued failed promises to discontinue use, despite family members' pleas.
4. Violence or threats of violence have occurred, during periods of intoxication as well as during sobriety, which has placed family members at risk.
5. Communication between family members has deteriorated to such a level that familial interaction is greatly reduced, and members simply coexist without any cohesiveness.
6. Non-substance-abusing family members function in a manner that serves to enable the abusers by generating excuses for their drinking.
7. All members engage in denial of the seriousness of the alcohol abuse and the effects that this has had on the family dynamics.
8. Serious financial problems have developed as a result of excessive or frivolous spending, frequent work absences, loss of employment, and so on.
9. Social alienation between family members develops as the substance abuser gravitates toward socializing with other alcohol abusers.
10. Children engage in acting-out behaviors or become excessively inhibited as a result of the lack of structure and boundaries in the family.
11. Alcohol-abusing parents overlook children's alcohol use and inadvertently reinforce early substance-abusing patterns in children.
12. Isolation from extended family and friends as alcoholic member has become unavailable or unwelcome by others.

13. Bills are not paid, checks bounce, and there is no follow-through on daily responsibilities.
14. Family experiences shame and humiliation and makes excuses for the alcohol abuser's behavior to save face.

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LONG-TERM GOALS

1. Alcohol-abusing family members accept the need for abstinence and become proactive in a recovery program.
2. Alcohol-abusing family members successfully achieve a sustained and consistent reduction in the frequency and amount of alcohol consumption, avoiding further negative effects on the family unit.
3. Family achieves improved communication and problem-solving, and positive family reactions.
4. The non-alcohol-abusing family members unite and become a strong entity to support the alcohol-abusing family members in recovery.
5. Alcohol abusers develop coping strategies for dealing with the issues related to establishing long-term sobriety (e.g., depression and anxiety, as well as physical problems such as nutritional deficiencies and high blood pressure).

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Identify the untoward effects of the substance abuse on the self-esteem, family life, employment,	1. Gather family members' perspectives on the negative effects that the alcohol abuse has

health, social relations, and personal finances of all family members. (1, 2)	had on family members and the general family dynamics; also focus on the destructive effects on the substance abuser and the impact that denial has played in this process. 2. Use inventories or rating scales such as the Alcohol Beliefs Scale (Connors and Maisto) to evaluate attitudes toward alcohol and the effects of alcohol abuse on the quality of the alcohol abuser's and the family's life.
2. Alcohol abuser signs a contract with respect to the controlled and moderate use of all alcohol. (3)	3. Ask the alcohol abuser to sign a contract stipulating the parameters for controlled or social drinking, such as the Sobell method (see *Behavioral Treatment of Alcohol Problems* by Sobell and Sobell); solicit an agreement that should the contract be broken after a designated number of times (e.g., 2), then a complete alcohol abstinence contract will be signed.
3. Alcohol abuser proves his/her ability to control alcohol consumption at moderate levels by keeping a record of frequency and quantity of use. (4)	4. Develop a daily record form to track the frequency and quantity of alcohol use, using this record to determine the alcohol abuser's ability to consistently control his/her alcohol intake; recommend *How to Cut Down on Your Drinking* (National Institute on Alcohol Abuse and Alcoholism).
4. Read literature on controlled drinking, the effects of alcohol abuse, and family dynamics of alcohol abuse. (5, 6)	5. Research and assign to the alcohol abuser and to family members the most appropriate reading materials regarding alcohol addiction and its effects, controlled drinking, and the family dynamics of alcoholism (see *Overcoming Alcohol Use Problems* by Epstein and McCrady, *Controlling Your*

	Drinking by Miller and Muñoz, and *Alcoholism: Getting the Facts* [National Institute on Alcohol Abuse and Alcoholism]).
	6. Facilitate a discussion on the materials recommended and have family members compare their reactions to what they have read; highlight the differences in perceptions of family members and explore how they perceive this to contribute to the overall problem.
5. All family members agree to mandatory attendance at all treatment sessions except in the case of serious physical illness. (7)	7. Develop a family contract that all members sign, agreeing to attend all sessions unless ill; emphasize the importance of continuity and follow-through on homework assignments.
6. All family members sign a contract to be completely free of mood-altering substances during sessions. (8)	8. Develop a family contract that all members sign, agreeing to be completely free of mood-altering substances when in attendance at treatment sessions (not including legitimate prescription medication).
7. Alcohol abuser signs a contract for complete abstinence at all times from mood-altering substances and for attendance at AA, group, or individual alcohol treatment. (9, 10)	9. If the controlled-drinking contract is broken, ask the alcohol abuser to sign an agreement of abstinence from all alcohol use, accompanied by an agreement to attend a support group (AA) or group psychotherapy for substance abusers.
	10. Refer the alcohol abuser to a psychiatrist specializing in alcohol abuse for an evaluation for pharmacotherapy (e.g., Antabuse).
8. All family members sign a behavioral contract that stipulates that no violence or threats will be	11. Ask each family member to sign a written family contract specifying that no member of the family will engage in aggressive or assaultive

engaged in toward any other family member. (11, 12)

threats on any other family member.

12. Develop a refuge plan for the safety of family members if violence does erupt.

9. Family members implement cognitive/behavioral techniques to manage their angry feelings. (13, 14, 15)

13. Suggest the use of cognitive behavioral strategies (deep breathing, cognitive restructuring, etc.) for anger control and the implementation of stress inoculation techniques (see *Cognitive-Behavioral Stress Management: Workbook* by Antoni and Irons).

14. Teach family members the five steps in using time-out to control anger: (1) *self-monitoring* for escalating feelings of anger and hurt; (2) *signaling* to another family member that verbal exchange is not a good idea; (3) *acknowledgment* of the need for the other family members to back off; (4) *separation* to cool down and use cognitive self-talk to regain composure; and (5) *returning* to calm verbal exchange (see *The Anger & Aggression Workbook* by Liptak, Leutenberg, and Sippola).

15. Suggest assertiveness training and assign family members to read the book *Your Perfect Right* by Alberti and Emmons.

10. Violent family member accepts referral for specialized behavioral treatment of explosive disorder. (16)

16. Assess the case for the appropriateness of either individual, couple, or family therapy and for referring the acting-out family member to another provider for individual or group treatment of explosive disorder.

11. Alcohol abuser identifies attractions to or perceived benefits

17. Explore those perceived benefits that the alcohol abusers are obtaining by engaging in alcohol

of the excessive use of alcohol. (17, 18)	use (e.g., acceptance by friends and peers; reduction of anxiety, social or otherwise; sleep induction; escape from family tensions). 18. Trace the alcohol abuser's history and help identify how alcohol abuse behavior has been reinforced at home and in the community.
12. Alcohol abuser implements alternative stress management actions to achieve the same desirable effects that alcohol has produced in the past. (19, 20)	19. Strategize with the alcohol abuser as to what specific behavioral exercises (e.g., meditation, relaxation, social skill or assertiveness training, etc.) can be used to replace alcohol use and/or intoxication but obtain the benefits sought. 20. Instruct the alcohol abuser on the use and implementation of stress management (e.g., deep breathing, progressive muscle relaxation, guided imagery, meditation, etc.).
13. Alcohol abuser implements assertiveness and other social skills as a replacement for alcohol use to cope with social anxiety. (21, 22)	21. Use modeling and role-playing to teach assertiveness and social skill techniques, helping the alcohol abuser to weigh the pros and cons of using such techniques. 22. Administer measurement scales to assess any progress made as a result of the assertiveness and social skills training (e.g., Assertiveness Self-Report Inventory [Herzberger, Chan, and Katz] and the Social Problem Solving Inventory [D'Zurilla and Nezu]).
14. All family members agree to engage in several weeks of "caring days," during which each member does something pleasing for the other family members without prompting. (23)	23. Instruct family members on the technique of "caring days" (see *Comprehensive Cognitive-Behavior Therapy for Couples and Families* by Dattilio) in which each member does something

pleasant for other members (e.g., do a special chore without being asked, pay a nice compliment).

15. Implement social activities with other families that do not involve alcohol consumption. (24)

24. Encourage and assist the family in formulating a plan for social activities with other couples or families that do not include alcohol consumption; suggest church, hobby, and recreational groups or work associates as possible social network opportunities for outreach.

16. Implement alternative recreational actions that all family members could engage in and that would be rewarding to all. (25, 26)

25. Brainstorm a list of recreational or educational activities the family might enjoy; schedule a specific family recreational activity in which each family member is assigned a specific role in making the activity happen.

26. Assign the family to implement one social or recreational activity and assess how they fare on the outcome; have them keep notes on what they enjoy about the activity and what they do not.

17. All family members identify what specific characteristics derail or impede healthy communication between themselves. (27, 28, 29)

27. Have each family member reflect on the manner in which they obstruct the smooth, productive course of communication (e.g., cut the others off during conversation, refuse to respond).

28. Attempt to track and resolve the origins of any miscommunication patterns that have developed (family-of-origin patterns of dysfunctional communicating, foreign language, etc.).

29. While discussing communication skills, review rules for the speaker and for the listener such as taking turns talking, paraphrasing, or reflecting the speaker's position before responding, treating each

other with respect, and no lecturing (see *Fighting for Your Marriage* by Markham, Stanley, and Blumberg).

18. All family members discuss an incident or conflict using a new mode of communication that is free from any blaming or condescending language. (30, 31)

30. Use role-playing, empty chair, or psychodrama techniques to have family members work out a conflict, with the emphasis on using nondegrading, assertive methods of communication.

31. Reinforce positive changes toward well-mannered, respectful, empathetic communication between family members.

19. Verbalize an understanding of and implement techniques for problem-solving. (32, 33, 34)

32. Teach the following five steps of problem-solving: (1) define the problem (with the help of the therapist, if necessary); (2) generate many solutions, even if some are not practical, allowing for creativity; (3) evaluate the pros and cons of the proposed solutions; (4) obtain agreement on the proposed solution; and (5) implement the solutions (see "Family Applications of Problem-Solving Methods" in *Language System and Therapy: An Evolving Idea* by Goolishian and Anderson or the *Family Therapy Sourcebook* by Piercy, Sprenkle, and Wetchler).

33. Suggest family meetings (see *Comprehensive Cognitive Behavioral Therapy for Couples and Families* by Dattilio) in order to promote family discussion of a conflictual issue in the session to view how members deal with an area of conflict, and then model implementation of problem-solving steps; encourage implementation of these skills at home.

34. Review family members' experience with problem-solving at home, reinforcing success and redirecting for failure.

20. Alcohol abusers formally apologize to other family members for the pain and suffering they have caused due to their substance abuse. (35, 36)

35. Recommend that the alcohol abuser formally apologizes for the pain caused to other family members due to his/her substance abuse.

36. Help family members obtain closure on the ritual of apology so that it minimizes any barriers to the alcohol abuser's future progress.

21. Alcohol abusers identify triggers to episodes of drinking and agree to alternative, nondrinking responses to cope with trigger situations. (37, 38)

37. Help the family identify triggers of relapse of alcohol use and instruct them on what can be done to help avoid future relapses (see *Treating Alcohol Problems* by O'Farrel).

38. Suggest to the family members that they develop index cards with alternative strategies for coping with alcohol abuse in the face of stimuli that trigger relapse (e.g., connecting with sponsors at AA or support groups, using stress inoculation techniques).

22. Family members who are not alcohol abusers acknowledge how they have been primary and secondary enablers of the alcohol abusers. (39, 40)

39. Help the non-alcohol-abusing family members identify the behaviors that they engage in (e.g., lying to cover up for the alcohol abuser's irresponsibility; minimizing the seriousness of the alcohol abuser's drinking problem; taking on most of the family responsibilities; tolerating the verbal, emotional, and/or physical abuse) that support the continuation of the alcohol abuser's abusive drinking.

40. Use role-playing of family scenarios to guide the non-alcohol-abusing family members in not

accepting responsibility for the alcohol abuser.

23. Family members confront each other about behaviors that continue the enabling process and reinforce each other for avoiding enabling behaviors. (41, 42)

41. Review instances of family interaction at home in which family members have avoided and engaged in enabling behaviors; reinforce success and redirect for failure.

42. Brainstorm ideas among the family members as to how to more constructively respond to situations that previously precipitated enabling behaviors (e.g., not making excuses for broken promises or unfulfilled responsibilities, telling the truth regarding intoxication even if it brings painful consequences, reporting physical abuse to police).

24. Family members identify stressors that are affecting them all, especially those that encourage the alcohol use, and formulate a plan of coping. (43, 44)

43. Explore and identify stressors facing each member of the family.

44. Assist the family members in devising a strategy for dealing with each of the identified stressors (e.g., financial restructuring, job search, apologies to friends, neighbors, or extended family members, tutoring assistance, etc.).

25. Identify the genetic, emotional, and environmental factors that have fostered a pattern of alcohol abuse. (45)

45. Investigate the emotional, social, and genetic factors that facilitate the alcohol abuse and that reinforce the need for abstinence.

26. Children identify the unhealthy role each has assumed in the family due to the effects of the alcoholism, and adopt healthier roles. (46, 47, 48)

46. Teach family members the roles usually adopted by children of alcoholic parents (e.g., the family hero, the scapegoat, the lost child, and the mascot; see *Families Under the Influence* by Elkin and *Bradshaw on the Family* by Bradshaw); help the children

identify the role (or roles) each has adopted. 

47. Encourage the children to give up their unhealthy role assumptions and express their needs, feelings, and desires directly and assertively. 
48. Help the children brainstorm healthy alternatives to dysfunctional behaviors. 

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DIAGNOSTIC SUGGESTIONS

Axis I:	303.90	Alcohol Dependence
	305.00	Alcohol Abuse
	300.4	Dysthymic Disorder
	V61.10	Partner Relational Problem
	V61.20	Parent-Child Relational Problem
	_____	_____
	_____	_____
Axis II:	301.6	Dependent Personality Disorder
	301.82	Avoidant Personality Disorder
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	_____	_____

ANGER MANAGEMENT

BEHAVIORAL DEFINITIONS

1. Expressions of anger that include threats, breaking objects, violating others' individual space, and refusal to speak to certain family members.
2. Intimidation and coercion of some family members into relinquishing their rights in response to another member's expression of anger.
3. Hostile, aggressive behavior that alienates neighbors, extended family members, and school personnel, as well as nuclear family members.
4. Expressions of anger that are perceived by others as demeaning, threatening, or disrespectful.
5. Disagreement among family members about the threat created by the angry member.

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LONG-TERM GOALS

1. Terminate expressions of anger that are demeaning, threatening, disrespectful, or violent.
2. Learn the precursors of inappropriate anger escalation as a step in temper control.
3. Get in touch with feelings of emotional pain and express them verbally in appropriate ways rather than through angry outbursts.

4. Family members support each other during periods when one or more of them is expressing hurt or vulnerability.
5. Recognize the various levels of anger expression and identify when and how to intervene to avoid explosive tirades and destructive outbursts.
6. Understand the impetus for the anger and how certain needs get set aside when acquiescing to threats of violation of the rights of others.

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SHORT-TERM OBJECTIVES

THERAPEUTIC INTERVENTIONS

1. Verbalize an understanding of anger as an emotion necessary to human survival, but which must be controlled. (1, 2, 3)

1. Verify the notion that anger is a necessary and useful emotion that needs to be harnessed and recognized as a sign that something is amiss or troubling.
2. Review some of the positive uses of anger—namely, as a reaction to a perceived threat and a means of communicating that some personal violation has occurred.
3. Educate family on the need for anger management and control as a method of better expressing one's feelings in order to obtain a positive outcome; recommend reading material on the topic of anger management (e.g., *The Anger & Aggression Workbook* by Liptak, Leutenberg, and Sippola; *The Anger Trap* by Carter; or *Don't Sweat the Small Stuff with Your Family* by Carlson).

2. Each family member identifies the destructive effects that his/her uncontrolled anger has had on all

4. Have each family member describe how his/her respective uncontrolled expression of anger is

family members, including self. (4)

counterproductive to himself/herself and to other family members; assist them in identifying the negative effects of uncontrolled anger (fear, withdrawal, guilt, revenge, etc.).

3. Recall an incident in which one family member's strategy for managing anger may have been misinterpreted by the others. (5)

5. Ask family members to take turns volunteering and explaining examples of how their anger has been misinterpreted; ask them to clarify what message they wanted to convey.

4. Identify any secondary gain that has been derived through expressing anger in an intimidating style. (6)

6. Assist family members in identifying what secondary gain (acquiescence to demands, fear-based service, etc.) is derived from uncontrolled anger.

5. Each family member cites at least one example each in which his/her anger was expressed constructively and destructively. (7)

7. Review various means of anger expression that have worked well in the past, as contrasted with ways in which anger has been expressed destructively.

6. Family members sign a contract stipulating that they will attempt to manage their anger with the support and guidance of family therapy. (8, 9, 10)

8. Urge family members to sign a contract agreeing to accept responsibility for containing their own anger and managing it effectively.

9. Discuss methods for instituting family support systems to help each other control anger levels (signaling time-out, breathing cues, etc.).

10. Discuss the dilemma of how each family member needs to express anger, while finding the difficult balance of doing it appropriately.

7. Each family member identifies an anger control technique that seems to work for him/her. (11, 12)

11. Describe specific techniques for anger control (thought-stopping, controlled breathing, counting to 10, self-talk, etc.) and determine which one suits each family member.

12. Use paradoxical intention techniques by instructing family members to try cues that cause them to become angry one at a time; highlight how difficult it is to become angry when we deliberately attempt to provoke it in ourselves (see Dattilio, 2010).

8. Each family member identifies his/her three main reasons for becoming angry. (13)

13. Explore with each family member his/her three primary reasons for becoming angry.

9. Each family member identifies an example from his/her own behavior of anger that was used to manipulate. (14)

14. Assist family members in identifying instances when their expression of anger was used as a means of manipulation.

10. Demonstrate the use of healthy, direct, respectful communication of a desire for change in the behavior of another family member. (15)

15. Use modeling and role-playing to teach alternative methods (using "I" messages, making calm and respectful requests for change, etc.) to achieve the goal of change in another member's behavior without manipulating one another with anger.

11. Each family member identifies an example from his/her own behavior of anger that was used to assert independence. (16)

16. Assist family members in identifying instances when their expression of anger was an attempt at asserting independence.

12. Implement assertiveness as a replacement for angry aggression to declare independence. (17, 18)

17. Clearly define examples of nonassertive, assertive, and aggressive expressions of anger and then have each family member give personal examples of each to demonstrate their understanding of the concept (see *Your Perfect Right* by Alberti and Emmons).

18. Use role-playing and modeling to teach assertiveness as an alternative to angry aggressiveness used to declare independence.

13. Identify expressions of anger that are in reaction to a perceived threat or means of defense against fear. (19)

19. Help family members identify situations that are perceived as threatening, both at home as well

	as in public; process how anger is often a reaction to threat.
14. Acknowledge the difference between uncontrolled anger outbursts while at home as opposed to controlled expression while in public. (20)	20. Illustrate that anger is often controlled while in public but uncontrolled at home, indicating that the ability to control is present.
15. Each family member gives examples of his/her own use of passive-aggressive behavior and states how assertiveness could have been used instead. (21)	21. After clearly defining passive-aggressive behavior, have each family member recall specific examples in which his/her past behaviors have fit into this category; redirect this behavior into appropriate assertiveness.
16. Report on the use of the Subjective Units of Distress (SUD) scale to measure anger escalation. (22)	22. Instruct family members in the use of the Subjective Units of Distress (SUD) scale from 0 to 100 as a barometer for measuring their anger.
17. Identify the various cues for anger as it escalates. (23)	23. Teach family members how to identify the cognitive, affective, behavioral, and physiological cues of anger and how to differentiate low, moderate, and high ranges; recommend the book *Angry All the Time* by Potter-Efron.
18. Verbalize an understanding of the steps in using time-out as an anger control technique. (24)	24. Teach family members the five steps in using time-out to control anger: (1) *self-monitoring* for escalating feelings of anger and hurt; (2) *signaling* to another family member that verbal exchange is not a good idea; (3) *acknowledgment* of the need for the other family members to back off; (4) *separation* to cool down and use cognitive self-talk to regain composure; and (5) *returning* to calm verbal exchange (see *The Anger & Aggression Workbook* by Liptak, Leutenberg, and Sippola).
19. Report on the use of time-out at home to control anger. (25)	25. Assign family members to implement the time-out technique at home; review results,

reinforcing success and redirecting for failure.

20. State a verbal agreement to talk about angry feelings earlier rather than letting them grow in intensity. (26)

26. Develop a family agreement to begin talking about angry feelings and thoughts earlier as opposed to allowing them to reach the level of intense behavioral expression, passive-aggressive maneuvers, or manipulative behaviors.

21. Implement the use of the "turtle" technique of retreat to control anger escalation. (27)

27. Suggest the use of the "turtle" technique, in which family members imagine themselves individually retreating into their shells until they cool down.

22. Report on the successful development of sensitivity to the feelings of anger developing within, and to the precursors of anger. (28)

28. Assign homework to each family member that utilizes anger-tracking exercises, identifying the precursors to anger along with the accompanying emotions and behaviors that fuel it.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
	312.34	Intermittent Explosive Disorder
	296.x	Major Depressive Disorder
	V61.10	Partner Relational Problem
	V61.12	Physical Abuse of Adult
	995.81	Physical Abuse of Adult (Victim)
	V61.21	Physical Abuse of Child
	V61.20	Parent-Child Relational Problem
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	301.81	Narcissistic Personality Disorder
	_____	_____
	_____	_____

ANXIETY

BEHAVIORAL DEFINITIONS

1. One or more family members experience excessive worry or a sense of impending doom that precludes their daily normal functioning in their roles in the family.
2. One or more family members experience jitteriness, restlessness, insomnia, high-level autonomic activity, palpitations, sweaty palms, or similar symptoms of anxiety.
3. One family member's symptoms of anxiety have caused undue distress within the family to the point that concessions are made to him/her.
4. Ruminations or controlling behaviors by the anxiety-ridden family member agitate other family members and alienate him/her from the others.
5. Anxiety symptoms in a parent or older family member lead to a child's dysfunctional behavior.
6. One or more family members experience the inability to fly, travel by boat, or drive on the freeway due to irrational phobic fears.

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LONG-TERM GOALS

1. Utilize cognitive and behavioral techniques to reduce anxiety.
2. Confront anxiety-producing stimuli gradually to overcome debilitating fears.

3. Resolve the underlying biochemical, interpersonal, or emotional issues that result in symptoms of anxiety.
4. Family members learn about the symptoms, origins, and treatment of anxiety.
5. Family members provide support to one another in learning to reduce anxiety.
6. Family members learn their appropriate role in supporting the anxious family member in employing specific techniques for reducing anxiety levels and avoidance behaviors.

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SHORT-TERM OBJECTIVES

1. Identify the nature and precipitators of anxiety symptoms. (1, 2, 3)

THERAPEUTIC INTERVENTIONS

1. Have the anxious family member list the specific symptoms and avoidance behaviors by utilizing one of the many anxiety inventories (Beck Anxiety Inventory [Beck and Steer], Body Sensations Questionnaire [Chambless, Caputo, and Bright], State-Trait Anxiety Inventory [Spielberger], etc.).
2. Gather reports from extended family members and the anxious family member's imagery or recollections of how anxiety developed to assist all family members in understanding the symptomatic effects of anxiety.
3. Gather the nonanxious family members' perspectives on the anxiety and avoidance patterns and attempt to uncover information not

	mentioned by the anxious family member.
2. Each family member lists the specific impact that the anxiety symptoms or disorders have had on him/her. (4)	4. Ask each family member to select a mode of expression that best characterizes the impact that the anxiety disorder has had on him/her; this may be through dramatization or written or artistic expression.
3. Each family member assesses how he/she has dealt with the anxiety, as well as how the family as a whole has coped with the anxiety to this point. (5)	5. Ascertain the current coping skills of each family member regarding the anxiety problem within the family, and attempt to determine which coping mechanisms have been effective.
4. Nonanxious family members identify how they try to be supportive of the anxious family member. (6)	6. Have the nonanxious family members describe how they have each tried to be supportive of the anxious family member; brainstorm along with the anxious family member additional ways to be supportive to the anxious family member.
5. Nonanxious family members identify any resentments they may have for the anxious family member. (7)	7. Ask each nonanxious family member to identify specific incidents in which he/she has felt resentment as a result of the side effects of another family member's anxiety (e.g., family members having to forfeit activities due to the anxiety); strategize ways in which to reduce this conflict.
6. Family members discuss how the anxiety problems have changed family roles, if applicable. (8, 9)	8. Discuss with each family member how the specific anxiety disorder has affected them and what role they have adopted in the situation (supporter, antagonist, etc.).
	9. Explore how each family member came to assume their role in the family (supporter, comforter, etc.) —by choice or via assignment by another family member.

7. Family members verbalize an understanding that anxiety is a survival mechanism and its maladaptive patterns can be corrected with specific therapeutic interventions. (10, 11, 12)

10. Focus on the psychoeducational aspect of treatment by informing family members of the specific role that anxiety plays in every human being's system—that it is a survival mechanism that can, at times, be misinterpreted to the point of causing distress and debilitating symptoms (attempt to simplify this information for young children). Suggest the use of such books as *The Worry Cure* by Leahy.

11. Teach family members that anxiety is a survival mechanism to be managed and that it is not a dichotomous entity, but one that fluctuates in intensity (see *The Worry Cure* by Leahy).

12. Reinforce the notion that the anxious family member must constantly confront or expose himself/herself to his/her anxiety or fear in order to reduce it to a manageable level.

8. Nonanxious family members verbalize a constructive role for themselves in support of the anxious family member without becoming enmeshed in an unhealthy way. (13, 14, 15)

13. Discuss particular methods of how family members can encourage the anxious family member to follow his/her treatment plan (words of affection, encouragement, nonenabling behaviors, etc.).

14. Encourage the nonanxious family members to serve as coaches to the anxious family member; if more than one family member is anxious, employ "buddy systems."

15. Brainstorm potential problems or pitfalls (parentification of the child, secondary gain, etc.) of the use of other family members as coaches and supporting agents; identify ways to circumvent these problems (e.g., detriangulation, promotion of personal

	responsibility in the anxious family member).
9. Family members verbalize an understanding of anxiety (16)	16. Encourage the use of various educational materials on anxiety so family members gain an understanding of the interplay between physiology, cognitions, emotions, and behaviors affecting the anxious family member (e.g., *The Anxiety and Phobia Workbook* by Bourne; or *Mastery of Your Anxiety and Worry* by Craske and Barlow).
10. Anxious family member identifies automatic thoughts that produce anxious feelings. (17, 18)	17. Assist the anxious family member in identifying internal anxiety-producing stimuli (e.g., catastrophic thoughts, overgeneralizations).
	18. Sensitively illustrate the anxious family member's propensity to overestimate anxious situations and to catastrophize anticipated situations or events.
11. All family members verbalize an understanding of cognitive restructuring concepts and techniques. (19, 20)	19. Teach the anxious family member to replace distorted, negative thoughts with positive, realistic thoughts that counteract anxiety; recommend using the *Mastery of your Anxiety and Worry: Workbook* by Craske and Barlow.
	20. Use role-modeling techniques with the anxious family member to teach cognitive restructuring of catastrophic thoughts and other distortions and how to restructure and reframe events.
12. Nonanxious family members coach the anxious family member in the use of cognitive restructuring. (21)	21. Transfer the role-modeling of cognitive restructuring over to the other family members so that they can aid in coaching the situation with the anxious family member.

13. Develop a common language for family members to discuss varying levels of anxiety discomfort among the anxious family members. (22, 23)

22. Introduce the Subjective Units of Distress (SUD) scale as a means for the anxious family member to rate his/her level of anxiety (i.e., rating on a scale of 1-10) or other scales in books such as *Anxiety Free: Unravel Your Fears Before They Unravel You* by Leahy.

23. Encourage a line of open communication between family members regarding the SUD anxiety level in order to increase their awareness of when the anxious family member is experiencing difficulty.

14. Practice the use of deep breathing and relaxation skills to reduce anxiety. (24, 25)

24. Teach all family members various methods of behavioral physiology techniques for reducing anxiety (e.g., deep breathing and progressive relaxation); have them read *The Relaxation and Stress Reduction Workbook* (Davis et al.); teach these techniques to nonanxious family members to aid them in better understanding the techniques and helping the anxious family member not to feel like the identified patient.

25. Provide family members access to audio- or videotapes to assist them in practicing breathing retraining and relaxation methods; have them practice several times per day for at least 10 to 15 minutes to support them in coaching the anxious family member, but also for their own personal health and stress reduction.

15. Anxious family member records daily anxiety symptoms, Subjective Units of Distress Scale (SUD) rating, and anxiety triggers. (26)

26. Assign the anxious family member to keep an anxiety diary on a daily basis, recording his/her anxiety symptoms and SUD rating, tracking cues that trigger his/her anxiety symptoms, and noting how

his/her symptoms diminish over time (see *Progressive Muscle Relaxation* by Dattilio).

16. Anxious member creates a hierarchy of external stimulus events that produce increasing levels of anxiety. (27)

27. Assist the anxious family member in identifying anxiety-producing external situations or events and organizing them in a hierarchy with accompanying SUD ratings.

17. Anxious family members expose themselves to gradually increasing levels of anxiety-producing situations. (28, 29, 30)

28. Initiate imagery exposure to a stimulus situation associated with a low-anxiety situation or event while the anxious family member utilizes relaxation techniques.

29. Assign graduated *in vivo* exposure at home to the stimulus situations in the hierarchy, and ask the anxious family member to practice relaxation and record the results in his/her daily anxiety log.

30. Continue to reinforce anxiety inoculation techniques, and use reverse role-playing and role-modeling in the therapy sessions to teach how potential anxiety situations may be addressed.

18. Anxious family member implements thought-stopping techniques to reduce anxiety-producing or intrusive cognitions. (31)

31. Teach the use of thought-stopping techniques (e.g., say "Stop!" in your mind while imagining a stop sign, snap a rubber band on the wrist to interrupt negative thoughts and control anxiety symptoms).

19. Anxious family member takes anti-anxiety medication as prescribed. (32, 33)

32. Assess the need for anti-anxiety medication and refer the anxious family member to a physician for evaluation and the use of psychotropic medication, if indicated.

33. Monitor the anxious family member's medication compliance, effectiveness, and side effects.

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DIAGNOSTIC SUGGESTIONS

Axis I:

300.00	Anxiety Disorder NOS
300.02	Generalized Anxiety Disorder
300.21	Panic Disorder with Agoraphobia
300.01	Panic Disorder without Agoraphobia
300.29	Specific Phobia
300.23	Social Phobia
309.24	Adjustment Disorder with Anxiety
309.28	Adjustment Disorder with Mixed Anxiety and Depressed Mood
_____	_____
_____	_____

Axis II:

301.6	Dependent Personality Disorder
301.82	Avoidant Personality Disorder
301.4	Obsessive-Compulsive Personality Disorder
_____	_____
_____	_____

BLAME

BEHAVIORAL DEFINITIONS

1. Family members continually blame one another for conflicts in the family relationships or for things not operating to their respective expectations.
2. One or more family members overtly express their disenchantment with relationships within the family system as a whole.
3. Those family members most vociferous in their discontent and blame are resistant to accepting responsibility for their own contribution to family conflict or disenchantment.
4. Blaming family members externalize the responsibility for their own behavior and emotions.
5. The majority of interactions between family members lean toward the shifting of blame as opposed to responsible and honest self-admission of fault.
6. The chronic blaming behaviors have significantly affected communication and cohesiveness within the family.
7. Family members who engage in the greatest degree of externalization of blame verbalize low self-esteem and demonstrate poor interpersonal skills.

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LONG-TERM GOALS

1. Minimize blame patterns among family members, replacing them with more effective methods of problem solving.
2. Reduce the anger and agitation that accompanies blaming behavior.
3. Reduce the frequency and intensity of derogatory comments that are associated with blaming behaviors.
4. Restructure the view of the causes of family conflicts so as to seek solutions rather than placing blame.
5. Family members agree on replacement behaviors for those that attribute blame in family conflicts.
6. Family members foster high self-esteem through direct, open, and assertive communication with one another.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Identify and isolate conflicts in the family in a civil and productive fashion. (1, 2)	1. Take turns asking each family member to define the problems in his/her own words and to discuss the blaming habits of one another in an appropriate and respectful manner. 2. Explore what factors may be underlying the actions of blame with each family member (e.g., old injustices, physical abuse, alcohol abuse, etc.).
2. Each family member accepts responsibility for his/her own contribution to the conflicts and to the pattern of blaming. (3, 4, 5)	3. Encourage the family members to take responsibility for their respective contributions to the conflict in the family as opposed to the projection of all blame onto others; recommend reading material on blame (e.g., *Beyond*

	Blame by Lukeman and Lukeman or *The Language of Letting Go* by Beattie).
	4. Seek to help the family members equally divide the responsibility for satisfaction as well as for dissatisfaction in the family.
	5. Using a typical example of a conflict in the family, have family members divide their responsibilities for contribution to the conflict.
3. Reduce the frequency of blaming exchanges in communication among family members. (6)	6. Use role-playing, positive reinforcement, and modeling to facilitate members in adopting new noninflammatory communication that is incompatible with blaming.
4. Increase the frequency of the use of "I" statements to communicate feelings. (7)	7. Encourage the use of "I" statements for all family members, with the majority of the focus on the present tense; point out how "I" statements reduce blaming.
5. Express forgiveness to other family members for past hurts. (8)	8. Encourage the use of rituals (physical embrace, written letter of forgiveness, etc.) during the process of forgiveness, after anger issues are worked through; recommend reading material on forgiveness (e.g., *Forgiveness: The Healing Gift We Give Ourselves* by Carson or *Forgive and Forget* by Smedes).
6. Family members express ownership and responsibility for their respective thoughts, feelings, and behaviors. (9)	9. Use modeling and positive reinforcement to teach members to accept responsibility for their own thoughts, feelings, and behaviors; identify specific examples of how acceptance of responsibility precludes blaming of others.
7. Family members identify pleasurable behaviors desired from	10. Assist the family members in each identifying two or more pleasing behaviors that each of the other

others, as opposed to maintaining the same pattern of blame. (10)

8. Compliment, praise, and express appreciation for other family members' engaging in behaviors that are pleasing. (11, 12, 13)

9. Implement constructive alternatives to blaming when trigger behaviors occur. (14, 15)

10. Family members engage in problem-solving skills individually as well as a unit in order to cope with the external stressors that arise in their lives and reduce their propensity to blame others. (16)

members could engage in; solicit agreement from the other members for engaging in these pleasing behaviors.

11. Assign specific homework exercises that will regularly allow family members to benefit from the pleasing behaviors *quid pro quo* (e.g., adapt Stuart's "caring days" exercise from *Helping Couples Change* to the family unit).

12. Assign family members the task of reinforcing other members for pleasing behaviors in order to encourage their recurrence so that a fluid pattern of a more satisfying interchange can emerge.

13. Ask the blaming family member to review occasions when he/she has complimented the behavior of another family member; encourage and reinforce the blaming family member's behavior in shifting to a position of praise rather than criticism.

14. Assist the family members in identifying the specific words or behaviors that trigger blaming.

15. Develop constructive alternatives to blaming (e.g., "I" messages, assertiveness, reinforcement of incompatible behavior, etc.) as a response to common triggers to externalization.

16. Teach the family the six steps to problem solving: (1) define the problem in specific terms; (2) brainstorm alternatives; (3) list the pros and cons of each alternative; (4) choose a mutually acceptable alternative; (5) develop a plan to put the chosen alternative into practice, including a fall-back

plan; and (6) evaluate the success of the chosen alternative.

11. Family members engage in *quid pro quo* behaviors in attempts to be more pleasing to the others. (17)

17. Encourage family members to formally agree to *quid pro quo* contracts to promote cooperation; identify several of these contracts where members agree to do things for each other in exchange for another member doing something for them.

12. Reduce the frequency and intensity of expressions of anger within the family. (18)

18. If anger or resentment is interfering with a blaming family member's ability to change, then shift the focus to anger reduction (e.g., anger management techniques, working through causes for anger, letter-writing to explain hurt, cognitive restructuring to reduce distorted thinking, etc.).

13. Increase the use of assertiveness to express needs or desires rather than using blame. (19)

19. Re-emphasize the use of assertiveness in order to circumvent aggressive or passive-aggressive behaviors; assist each member in listing needs or desires that he/she has that family members can meet.

14. Verbalize an understanding that a means of meeting one's own needs is through performing pleasing actions for others. (20)

20. Teach the family members that they have specific choices as to the quality of their family life and the comfort of their own lives, underscoring the choice of performing pleasing actions for each other as a means of fulfilling their own needs.

15. Agree on the tasks (chores) each member will undertake to promote the smooth, efficient functioning of the household. (21, 22, 23)

21. Assist the family members in accepting "rules of the family"—that is, taking responsibility for basic chores or tasks for the sake of family functioning (e.g., the father should help put the children to bed; the mother should assist in the yard work; the children will make their beds or pick up their toys).

22. Clarify how the "rules of the family" are being broken and how those rule violations evoke negative feelings.

23. Assist the family members in renegotiating rules and roles that are agreeable to each as a means of reducing blaming behavior; allow each member to have input into the rule-making and a vote on how they should be reinforced.

16. Identify the pain that blaming has brought and how to better express disappointment. (24)

24. Have each family member list how they have specifically been hurt by another family member's blaming and what future mode of expression (e.g., "I" message) should be followed to avoid blaming.

17. Each family member lists specific external pressures that may contribute to blaming behaviors, and contribute to listing behaviors that will help reduce the impact of these stressors. (25)

25. Assign each family member to list the external stressors that are placing pressure on him/her and that lead to irritability toward others; discuss ways that each member can help to reduce the impact of these external stressors.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
	305.00	Alcohol Abuse
	303.90	Alcohol Dependence
	296.x	Major Depressive Disorder *[include specifier]*
	312.34	Intermittent Explosive Disorder
	V61.10	Partner Relational Problem
	V61.20	Parent-Child Relational Problem
	_____	_____
	_____	_____
Axis II:	301.0	Paranoid Personality Disorder
	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	301.81	Narcissistic Personality Disorder
	_____	_____
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BLENDED FAMILY PROBLEMS

BEHAVIORAL DEFINITIONS

1. Biological parent's and stepparent's experience conflict with parenting practices.
2. Child's expressed loyalty is to the absent biological parent.
3. Child's behavioral and/or emotional problems arise due to the adjustment to a new third parent (e.g., child rejects the stepparent's enforcement of rules and regulations).
4. Biological parent who lives outside of the home encourages the child to protest against the stepparent.
5. Biological parent and stepparent conflict over issues of power, control, and favoritism.
6. Family experiences monetary pressures arising from a reduction in or loss of child support.
7. Rivalry develops between children of the blended family due to differences in parenting style and resentment of attention to others.
8. Jealousy and/or insecurity arise as a result of a parent displaying affection for the stepchild, causing tension in the marriage and guilt in the child.
9. Conflict arises between the noncustodial parent and the custodial parent over the visitation schedule (spending more visitation time than agreed upon, ex-spouse deliberately undermining wishes of the child's custodial parent, etc.).
10. An ex-spouse interferes with family issues that pertain to the blended family's lifestyle (e.g., curfew, rules, and regulations).

The term *blended family* includes two or more families living together as a result of a divorce, a foster family situation, and/or an adoptive situation. Blended family problems are probably among the most frequent and challenging problems that family therapists will face. Due to the high divorce rate, the likelihood that marriages will include children from previous marriages is escalating. This problem only intensifies when the blended family consists of adolescents or children with emotional or behavioral problems. Most parents struggle with their biological adolescent offspring, let alone having to interact with their spouse's adolescents.

11. Parent and/or stepparent personalizes the child's behavioral problems, causing fragmentation within the family.
12. Children of the blended family feel they are treated unfairly or ignored by the stepparent.
13. Grown children living outside of the family of origin ask for financial support, causing conflict within the blended family.

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LONG-TERM GOALS

1. Family members accept the responsibility of the adjustment that comes with joining a new family and agree to make compromises in order to live together more harmoniously.
2. Children of the blended family accept the new spouse as a co-parent and display respect to him/her as an adult and an equal caretaker.
3. Parents learn to be flexible in parenting their spouse's children in order to develop a positive relationship.
4. Parents reduce or eliminate the ex-spouse's interference in the blended family's issues.
5. Stepparent remains conscientious about not ignoring or treating the spouse's children unfairly.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Each family member defines, from his/her own perspective, the specific conflicts and issues between family members. (1, 2)	1. Establish a neutral zone for family members to express themselves without fear of retaliation by other family members. 2. Utilize such techniques as metaphors (see *Problem-Solving Therapy* by Haley) or family sculpting (see *The New People Making* by Satir) to facilitate family members in talking openly about their feelings and emotions over present conflicts with one another.
2. Identify issues of the stepparent's rule enforcement or discipline. (3, 4, 5)	3. Facilitate open dialogue between the disgruntled children and the stepparent or adoptive parent; explore the child's feelings of disloyalty to his/her biological parents. 4. Facilitate release of the child's feelings (fear of control, fear of abandonment, displaced anger toward absent parent, etc.) that may be inhibiting acceptance of the stepparent's directives. 5. Assess the strictness or rigidity of the stepparent's style and whether it may be interfering with acceptance by the children; use role-playing and modeling to help the parent consider more flexible alternative methods.
3. Spouses terminate blaming an ex-spouse for the conflicts within the current marriage and blended family. (6)	6. Assess the parent and stepparent's potential for unfairly and too easily blaming an ex-spouse for internal conflicts within their marriage and blended family; ask each spouse to acknowledge and own their own family and relationship issues.

4. Parents and ex-spouse agree to set aside their differences and cooperate in the parenting task. (7)

5. Spouses implement communication skills to strengthen the bond between them. (8)

6. Biological parent living outside of the home attends a session with parents and stepparent to discuss parenting. (9)

7. Parents identify and resolve conflicts between themselves as to parenting patterns. (10, 11, 12)

7. Meet with the biological parents alone to resolve any residual feelings about their prior union.

8. Teach assertiveness and communication skills (use of "I" messages, empathetic listening and reflective responding, undivided attention and good eye contact, respectful and controlled expression of emotions, etc.) to the parents to strengthen their relationship and reduce the impact of an ex-spouse; recommend reading material on communication within marriage (e.g., *Core Communications, Skills and Processes* by Miller and Miller).

9. Invite the biological parent or ex-spouse into a conjoint session with the other biological parent and/or the stepparent in order to discuss differences in parenting philosophies, strategies, and misperceptions; suggest the use of a unified parenting program such as STEP or PET (see *Parents and Adolescents,* vol. 2, *Family Problem Solving* by Forgatch and Patterson).

10. Conduct a conjoint meeting with parents of the blended family and address personal insecurities, feelings of loss of power, and need to demonstrate favoritism; suggest alternative methods for dealing with these issues and how spouses can be supportive of each other (see *The Couples Psychotherapy Treatment Planner* by O'Leary, Heyman, and Jongsma).

11. Recommend that the parents read material on ways to resolve conflicts within blended families

(e.g., *Step-Families* by Bray and Kelly); process within session what was learned from the reading.

12. Use role exchange and role alternatives to reduce parental conflicts; have them consider the advantages and disadvantages of behavioral change and deal with the emotional fear that accompanies this change (see *Comprehensive Cognitive Behavioral Therapy with Couples and Families* by Dattilio, 2010).

8. Parents agree to cooperate and communicate so as to eliminate their being manipulated by the children. (13)

13. Address the potential manipulation by the child in playing one parent against the other for power and territorial advantages.

9. List actions that can reduce the tension over reduced child support. (14, 15, 16)

14. Discuss the anger and resentment that has risen between family members regarding the financial effect of a reduction in child support.

15. Encourage the children to express their feelings regarding finances to both biological parents.

16. Brainstorm financial (e.g., adding part-time jobs for family members) or emotional (e.g., more time spent in family activities that are free or low cost) solutions to the cut in income due to the reduction in child support.

10. Parents identify any insecurity or jealousy regarding affection displayed between a parent and a stepchild. (17, 18)

17. Assess whether a display of affection by a parent to a stepchild may arouse anxiety, anger, suspicion, or jealousy in the biological parent; explore how this may relate to the biological parent's own neglect or abuse in his/her family of origin.

18. Suggest ways in which the biological parent can deal with

	his/her insecurities and reframe their expression in the family system; teach alternative ways of viewing the situation (e.g., "It's an honor to have my spouse show such fondness toward my son or daughter").
11. Biological parents reach agreement on a visitation schedule with the children. (19, 20)	19. Reassure the children that they are not responsible for their parents' disagreements regarding visitation scheduling and that these conflicts do not reflect a lack of parental love.
	20. Suggest a meeting between the custodial and the noncustodial parent in order to address the issue of visitation; if this proves fruitless, then suggest professional mediation.
12. Children express and identify the basis for their feelings that they are treated unfairly by the stepparent. (21, 22)	21. Facilitate the children in expressing directly or through a letter the basis for their feelings of being treated unfairly by a stepparent.
	22. Explore whether the parent is consciously or unconsciously ignoring the stepchildren; review methods for increasing the awareness of this (e.g., have parents listen to the children's feedback and evaluate whether they are listening to them; suggest the use of reflective listening, in which parent and child give each other feedback on what is being said) and obtain a commitment from them toward involvement.
13. All family members agree on changes necessary to facilitate a feeling of equality in treatment of the children by both parents. (23, 24)	23. Negotiate between the children and the stepparent actions that would be perceived as more fair by the children.
	24. Suggest a list of special activities that the parent and the stepchildren

can do to reduce their feelings of alienation from each other.

14. Verbalize agreement about if and when any financial assistance will be given to adult children of either spouse who reside outside of the home. (25, 26, 27)

25. Review the pros and cons of lending money or giving gifts to adult offspring; brainstorm the potential resentments that may occur on the part of either the spouse or other family members.

26. Take a family vote on whether and how adult members will be assisted; address how to deal with the tension that arises from feelings of guilt and anger.

27. Encourage assertiveness for parents who are afraid of negative responses from children to whom they refuse financial assistance.

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DIAGNOSTIC SUGGESTIONS

Axis I:	V61.20	Parent-Child Relational Problem
	V61.10	Partner Relational Problem
	V61.8	Sibling Relational Problem
	_____	_____
	_____	_____
Axis II:	301.9	Personality Disorder NOS
	_____	_____
	_____	_____

CHILD/PARENT CONFLICTS

BEHAVIORAL DEFINITIONS

1. Children under the age of 13 have behavioral problems that cause conflict for the parents and the rest of the family members (e.g., acting out, destructive behaviors, refusal to go to school).
2. The children's behavior sparks ongoing arguments and dissension between the parents, weakening their effectiveness with the children.
3. Boundaries weaken and issues of power and control surface, contributing to the decreasing effectiveness of the parents.
4. The children's behavioral problems lead to strained relationships in the community (e.g., neighborhood or school), causing added stress to the family.
5. All family members experience tension and conflict due to the dysfunction in the home.
6. The children pick up on the parents' schism and play one against the other.
7. The parents become angry with each other and engage in undercutting behavior that escalates the children's misbehavior to more serious levels.

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LONG-TERM GOALS

1. Reduce or eliminate the children's behavioral problems that cause conflict for the parents and other family members.
2. Parents work together as a team in making clear and firm decisions regarding discipline.
3. Reduce or eliminate tension and conflict in the family by improvement of coping skills and communication.
4. Reduce the children's manipulative behavior and increase the parent's alignment and control.

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SHORT-TERM OBJECTIVES

1. Operationally define the behavioral problems that are occurring with the children and how they impact the family. (1, 2, 3)

2. Identify the family interactional patterns that are contributing to the problematic behavior. (4, 5)

THERAPEUTIC INTERVENTIONS

1. Help the family specifically outline the problematic behavior and conceptualize the problem.
2. Have each family member express how he/she is being affected by the children's misbehaviors.
3. Utilize some specific inventories that will define the behavioral problem and help determine whether they are individual or part of the system or both (e.g., Child Behavior Checklist—Ages 4–18 [Achenbach]).
4. Search for specific familial interaction patterns that may be subtly or overtly supporting problematic behaviors (dissension between parents, favoritism, etc.).

	5. Assess the specific characteristics the children may have that contribute to their behavior problems (e.g., hyperactivity, temperament).
3. Identify external factors that may be contributing to the behavioral problems. (6, 7)	6. Explore for any emotional and/or environmental stressors that may be precipitating the problem (e.g., family transitions, inconsistent rules, school or social difficulties).
	7. Develop a plan for how to reduce the amount of stress from external factors; refer to books such as *Coping Cat Workbook* by Kendall.
4. Parents identify ways to support each other in disciplining the children. (8, 9)	8. Assist parents in identifying methods for supporting each other and not undercutting each other's attempts at setting limits on the children.
	9. Role-play scenarios with parents and children in which discipline is required, and model appropriate support for the parent who takes the lead in setting limits.
5. Parents verbalize an understanding of the principles of effective parenting and behavior modification. (10)	10. Assign the use of readings and videotapes that may increase parenting skills (e.g., *Parenting Young Children* by Dinkmeyer, McKay, and Dinkmeyer, *1-2-3 Magic* by Phelan, or *Raising an Emotionally Intelligent Child* by Gottman and DeClaire).
6. Parents confront and resolve disagreements between themselves discreetly and not in the presence of the children. (11, 12)	11. Discuss the necessity for parents not to give the children too much information about their disagreements in order to strengthen parental unity.
	12. Recommend to parents strategies for controlling their urges to bicker in the presence of the children (e.g., utilize self-talk or nonverbal

signals to each other as a cue for curtailing their statements).

7. All family members list specific behaviors that they may be engaging in that are negative modeling for the child. (13)

13. Solicit examples from family members of behaviors that are negative models for younger children (e.g., temper tantrums, aggressive verbalizations, disrespectful name-calling, or ignoring another family member); brainstorm healthy alternatives to the negative behavior models.

8. Implement healthy alternative behaviors and agree to attempt to serve as a positive role model for younger children. (14, 15)

14. Role-play the implementation of healthy alternatives to negative behavior models.

15. Contract with all family members to seek to implement positive alternative behavior and to be positive role models for younger family members.

9. Family members identify and challenge their own unreasonable cognitions or unrealistic expectations of the children. (16, 17)

16. Have family members track their thoughts and emotional reactions during problematic behaviors with their children, identifying distorted cognitions.

17. Help family members to challenge unreasonable expectations by persuasively illuminating the illogical premise involved (e.g., "This behavior will never change and therefore my child is doomed to be a social misfit").

10. Implement new methods of effective communication and problem-solving between family members. (18, 19, 20)

18 Provide the family members with some basic communication and problem-solving skills training (e.g., see *Relationship Enhancement* by Guerney, *Parenting Young Children* by Dinkmeyer, McKay, and Dinkmeyer).

19. Role-play newly learned communication and problem-solving skills (e.g., problem definition, brainstorming solutions,

	evaluation of alternatives, solution enactment, and enactment evaluation).
	20. Have parents rate the effectiveness of the newly learned skills and discuss their positive and negative experiences with them.
11. Implement family meetings to increase mutual understanding and improve overall family communication. (21, 22)	21. Discuss the concept of family meetings held at home on a regular basis in which all members express their thoughts and feelings; establish a set of basic rules to follow at meetings (length, frequency, attendance requirements, leadership, participation, etc.) (see Dattilio, 2010).
	22. Assign family meetings on a regular basis that include all family members; have family members agree on days and times for family meetings.
12. Parents increase their communication focused on reducing the frequency of manipulating behaviors by the children and their acceptance of limits set by the parents. (23, 24, 25)	23. Help parents to recognize inconsistencies in their parenting and encourage them to communicate with each other so that the children do not successfully manipulate them.
	24. Ask parents to schedule parenting meetings with each other in order to review the children's behavior of past weeks and confront the children about their manipulations.
	25. Help parents become aware of how they are undercutting each other due to frustration and how this may be inadvertently facilitating the children's manipulations.
13. Parents express their own emotions and frustrations in a controlled, respectful manner. (26, 27)	26. Facilitate the parents' verbalization of their own emotions and frustrations associated with the trials of parenting.

27. Devise strategies for increasing the parents' anger control and frustration tolerance (e.g., deep breathing, cognitive self-talk, diversion techniques); recommend reading material on anger management (e.g., *The Anger & Aggressive Workbook* by Liptak, Leutenberg, and Sippola, or *The Anger Trap* by Carter). 

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DIAGNOSTIC SUGGESTIONS

Axis I:

V61.21	Neglect of Child
995.52	Neglect of Child (Victim)
V61.20	Parent-Child Relational Problem
V61.10	Partner Relational Problem
V61.21	Physical Abuse of Child
995.54	Physical Abuse of Child (Victim)
V61.21	Sexual Abuse of Child
995.53	Sexual Abuse of Child (Victim)
313.81	Oppositional Defiant Disorder
312.9	Disruptive Behavior Disorder NOS
314.01	Attention-Deficit/Hyperactivity Disorder, Combined Type
_____	_____
_____	_____

Axis II:

799.9	Diagnosis Deferred
V71.09	No Diagnosis
_____	_____
_____	_____

COMMUNICATION

BEHAVIORAL DEFINITIONS

1. Family members are experiencing frequent arguments and misinterpretations with one another.
2. Certain family members elect not to verbally express themselves much at all, due to either their inhibitions or passive-aggressive behaviors, causing a breakdown in communication.
3. Basic as well as complex verbal exchanges in the family are fraught with misconstrued information and miscommunication.
4. Positive affirmations and compliments are rarely or never expressed, contributing to alienation between family members.
5. In order to reach conclusions, family members rely on "mind reading" or "assumptions" based on observing nonverbal behaviors of other family members.
6. Family members often interrupt or talk over each other.

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LONG-TERM GOALS

1. Communication improves to the point that intrafamilial conflict and dysfunction are significantly reduced.
2. Gradually discuss particularly volatile topics with reduced tension and conflict.

3. Address the issues that underlie nonverbal expressions with one another (anger, need for control, resentment, etc.).
4. Improved speaker/listener techniques allow for reduced misconstrual of verbal miscommunications.
5. Improve and increase the rate of positive verbal comments and pleasurable exchanges between family members.
6. Learn to avoid relying on assumptions and inferences (mind reading) through the improved use of communication skills and assertive behaviors.
7. Individuals stop interrupting one another and cease other rude behavior.
8. Work toward more family cohesiveness, more of a sense of engagement, and less isolation.

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SHORT-TERM OBJECTIVES

1. All family members admit to and assume responsibility for poor communication and related tensions. (1, 2, 3)

2. Identify problem areas of communication. (4)

THERAPEUTIC INTERVENTIONS

1. Ask defining and identifying questions to clarify the communication problems.
2. Develop a genogram or use another family-of-origin exploration technique to determine communication problems that have trickled down from the parents' families of origin (see Family of Origin Inventory by Stuart and Genograms: Assessment and Intervention by McGoldrick, Gerson, and Petry).
3. Reinforce family members who readily admit to communication problems and confront those who deny them.
4. Have the family select a topical issue to discuss, and observe or

videotape the discussion and identify times when they each engage in faulty communication.

3. All family members cease and desist blaming each other for poor communication and take personal responsibility for their own faults. (5, 6)

5. Contract with the family members to shift away from blaming each other and practice using "I" statements; role-play members taking responsibility for their own faulty communication skills; start with the parents first, particularly if the children are resistant or oppositional.

6. Discuss a system for tracking when family members are successful in not blaming each other and in taking personal responsibility; reinforce success.

4. Suggest an alternative to relying on nonverbal communication or speaking through other family members. (7, 8)

7. Introduce the use of the speaker-listener technique (see *Fighting for Your Marriage* by Markman, Stanley, and Blumberg or *Core Communications, Skills, and Processes* by Miller and Miller) to structure family conversations; model reflective listening and teach rephrasing of confusing statements and requesting clarification when something is not understood.

8. Confront patterns of speaking through other family members or using only nonverbal communication; instruct members to speak directly, respectfully, clearly, and for themselves.

5. Identify any underlying dynamics that may be hindering or confounding communication. (9)

9. Explore for any underlying dynamic that may be affecting the communication process (e.g., hidden resentment, fear of emotional intimacy, avoidant behavior).

6. Reduce expressions of anger that are triggered by poor

10. Teach cognitive-behavioral techniques (e.g., deep breathing,

communication in the family. (10, 11)

cognitive restructuring) to help family members mediate anger or frustration that results from problems in communication (see *The Anger & Aggression Workbook* by Liptak, Leutenberg, and Sippola or *The Anger Trap* by Carter).

11. Have family members practice alternative behaviors for venting their frustration (e.g., journaling, sports activities) and report on their experiences; recommend books on journaling (e.g., *Journalution* by Grason).

7. Increase the frequency of assertive communication as a replacement for passive withdrawal or aggressive attacking. (12)

12. Use assertiveness training techniques to counter passivity or aggression in family members (recommend *Your Perfect Right* by Alberti and Emmons).

8. Implement constructive problem-solving techniques to resolve differences. (13, 14)

13. Teach problem-solving techniques (e.g., problem definition, brainstorming solutions, evaluation of alternatives, solution enactment, and enactment evaluation) as outlined in *Fighting for Your Marriage* by Markman, Stanley, and Blumberg.

14. Have family members attempt to reverse roles and review a problem from the other family members' perspective; process the experience.

9. Share feelings that underlie the isolation behavior. (15, 16)

15. Discuss with family members how they have gravitated away from each other and probe for a desire to become closer together.

16. Explore the feelings of fear, anger, hurt, or depression that may contribute to isolation between family members.

10. List the benefits and risks of becoming a more cohesive, open, close family. (17, 18)

11. Identify potential pitfalls that may contribute to any backsliding into poor communication and disengagement/alienation. (19, 20)

12. Agree to use family meetings for communication and problem-solving in the future. (21, 22, 23)

13. Provide positive feedback to other family members as communication progress is observed. (24)

17. Empathize with the family about how becoming more cohesive may take time and feel different or unusual.

18. Facilitate the process of family members sharing their feelings about getting closer; discuss the pros and cons of a more cohesive family from each member's perspective.

19. Brainstorm about what may cause the family member to slide back into old habits of isolation (laziness, strength of old patterns, crisis, etc.).

20. Brainstorm a plan for avoiding backslides into old habits (e.g., monitoring, family meetings, etc.).

21. Help the family members to set up a structure for weekly or monthly family meetings to constructively discuss issues in the family.

22. Use role-play and modeling techniques to practice initiating and implementing the family meetings, including how communication techniques/skills (e.g., "I" statements, active listening, soft startups) should be utilized during those meetings.

23. Reinforce all family members when they contribute to open, respectful communication and reduce the isolation between family members.

24. Use modeling or role-playing techniques to teach and practice the process of family members giving positive feedback to one another.

14. Implement actions that are designed to please the other family members as a means of serving each other. (25, 26)

15. Parents monitor the family progress and keep everyone motivated. (27)

25. Discuss and assign the implementation of "pleasing behaviors" (e.g., doing chores for one another, etc.) in order to support and promote positive/ productive family interaction.

26. Suggest the planning of some family outings or activities in order to strengthen family interaction and then have the family discuss their reactions to the exercise.

27. Consider follow-up visits with the parents to reinforce their role in supporting the family change.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
	305.00	Alcohol Abuse
	303.90	Alcohol Dependence
	300.4	Dysthymic Disorder
	296.x	Major Depressive Disorder *[include specifier]*
	V61.20	Parent-Child Relational Problem
	_____	_____
	_____	_____
Axis II:	301.83	Borderline Personality Disorder
	301.50	Histrionic Personality Disorder
	301.81	Narcissistic Personality Disorder
	_____	_____
	_____	_____

COMPULSIVE BEHAVIORS

BEHAVIORAL DEFINITIONS

1. A family member engages excessively in an activity (e.g., gambling, shopping, Internet use, exercise) to the point where it interferes with daily functioning.
2. Family members' response to the individual's excessive behavior leads to a change in the pattern of relationships and contributes to tension and conflict within the family.
3. Verbal and/or physical abuse occurs when the family member is confronted about the excessive behavior.
4. Enabling by family members contributes to the ongoing pattern of addictive behavior.
5. Dysfunctional communication, loss of work and/or financial support, or medication problems result from the excessive behavior pattern.
6. Children act out as a result of the long-term effects of a lack of structure or boundaries in the environment that are a consequence of the excessive behavior.
7. The family member becomes isolated from extended family and friends due to the preoccupation with the excessive activity.
8. There is a lack of follow-through on daily responsibilities (e.g., bills are not paid, checks bounce) because of the time spent on the excessive activity.
9. The family experiences shame and humiliation and makes excuses for the family member's excessive behavior in order to save face.

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LONG-TERM GOALS

1. Achieve a significant reduction or elimination of the compulsive behavior.
2. Eliminate the verbal, physical, and/or psychological abuse in the home.
3. Redirect enabling behaviors and develop new, healthier patterns of familial interaction.
4. An extended family member or some other responsible adult takes over the parental role with the children, preventing the parentizing of the children.

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SHORT-TERM OBJECTIVES

1. Identify the excessive behavior and give evidence that it is engaged in compulsively. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Use interviewing and/or inventories to determine the degree of compulsivity or excessive engagement in activities (e.g., the Daily Activity chart in *Cognitive Therapy: Basics and Beyond* by Beck or *Measuring Non-Pathological Anxiety and Compulsiveness* by Kagan and Squires).
2. Poll all family members about why they believe the activity is excessive or compulsive.

2. Identify the untoward effects of the excessive behavior on all family members. (3)	3. Gather family members' perspectives on the negative effects (e.g., self-esteem, family life, employment, health, social relations, and personal finances) that the compulsive behavior has had on all family members and the family dynamics; focus on the impact that denial has played in this process.
3. Read literature on controlling compulsive behaviors and on the effects of excessive behavior on family dynamics. (4, 5)	4. Assign reading materials regarding the compulsive behavior and its effects, controlled behavior, and the family dynamics of addiction (e.g., *Sex, Drugs, Gambling, and Chocolate: A Workbook for Overcoming Addictions* by Horvath and Hester; *Compulsive Gamblers and Their Families* by McEnvoy; *Caught in the Net* by Young; and *Consuming Passions: Help for Compulsive Shoppers* by Catalano and Sonenberg).
	5. Hold a discussion session with family members to process the material that they have read and focus on new insights.
4. Sign a contract agreeing to attend family therapy meetings with openness and honesty. (6, 7)	6. Develop a joint family contract that all members sign, agreeing to attend all counseling sessions and to be completely open about any compulsive behaviors that they may engage in themselves.
	7. If the counseling session attendance contract is broken, ask the compulsive family member to sign an agreement of abstinence from all excessive behaviors accompanied by an agreement to attend a support group (e.g., Gambler's Anonymous [GA] or group psychotherapy).
5. Compulsive family member cooperates with referral to a	8. Refer the compulsive family member to a psychiatrist

physician for a medication evaluation. (8)

specializing in obsessive-compulsive behavior to evaluate for the use of pharmacotherapy (e.g., SSRI antidepressants).

6. Compulsive family member signs a behavioral contract that stipulates that no violence or threats will be engaged in or tolerated toward any other family member. (9, 10)

9. Develop a written contract stipulating that no member of the family will engage in aggressive or assaultive threats on any other family member.

10. Develop a refuge plan for the safety of family members if violence does erupt when compulsive behavior is challenged.

7. Violent family member accepts referral for specialized behavioral treatment of explosive disorder. (11)

11. Refer the acting-out, violent, or threatening family member to another provider for individual or group treatment of the explosive disorder.

8. Sign a contract with respect to controlled and moderate involvement in the excessive activity/behavior. (12, 13)

12. Assign the compulsive family member to follow a structured format for controlling the excessive behavior (e.g., use of a stipulated, written activity schedule and/or attendance at a 12-step program); solicit an agreement that, should the contract be broken a designated number of times (e.g., twice), a complete abstinence contract will be instituted.

13. Ask the compulsive family member to sign a written contract that stipulates the moderate frequency of behavior to be engaged in on a daily and weekly basis.

9. Prove the ability to control the excessive behavior to moderate levels by keeping a record of the frequency of the activity/behavior. (14)

14. Develop a daily record form to track the frequency and intensity of compulsive behaviors, using this record to determine the family member's ability to consistently control the behaviors.

10. Implement the use of cognitive/behavioral techniques to manage angry feelings. (15)

15. Teach the use of cognitive-behavioral strategies, such as controlled breathing, cognitive

restructuring, thought-stopping, and Meichenbaum's stress inoculation techniques (see *Talking to Yourself: How Cognitive Behavior Therapy Can Change Your Life* by Butler), for anger and stress control.

11. Compulsive family member identifies attractions to or perceived benefits of the excessive behavior. (16)

16. Explore those perceived benefits that the compulsive family member is obtaining by engaging in the excessive behaviors (acceptance by friends/peers, reduction of social or other anxiety, escape from family tensions, etc.).

12. List and implement alternative constructive behaviors that can replace the compulsive behavior and still produce the benefits sought. (17, 18, 19)

17. Strategize about the specific behavioral exercises (e.g., meditation, relaxation, social skill or assertiveness training) that can be used to replace compulsive behaviors, while still obtaining the benefits sought.

18. Teach stress management techniques (deep breathing, progressive muscle relaxation, guided imagery, meditation, etc.) as replacements for compulsive behaviors.

19. Use modeling and role-playing to teach assertiveness and social skill techniques, helping the compulsive family member to weigh the pros and cons of using such techniques as alternatives to the excessive behavior.

13. Engage in "caring days," when each member does something pleasing for the other family members without prompting. (20)

20. Instruct family members in the technique of "caring days" (see *Helping Couples Change: A Social Learning Approach to Marital Therapy* by Stuart), in which each family member does something pleasant for other members (e.g., performing a special chore without being asked, paying a compliment, etc.).

14. Identify opportunities that exist for social interaction with other families and together develop a plan for initiating contact for activities that do not involve compulsive behavior. (21)

15. Identify alternative recreational activities that all family members could engage in that would be rewarding for all. (22)

16. Identify triggers to episodes of compulsive behavior and agree to alternative responses to cope with situations. (23, 24)

17. Acknowledge how primary and secondary enabling of the excessive behavior pattern has occurred. (25, 26)

18. Cite assertive incidences whereby enabling or taking responsibility for the compulsive family member has been avoided. (27)

19. Confront each other's behaviors that continue the enabling process. (28)

21. Encourage and assist in formulating a plan for social activities (e.g., church, hobby, work associates, and recreational groups) with other couples or families that does not include the compulsive activity.

22. Schedule a specific family recreational activity in which each family member is assigned a specific role in making the activity happen.

23. Help the family identify triggers of relapse for the compulsive behavior and what may help to avoid future relapse.

24. Suggest to the family that they develop index cards listing alternative coping strategies for compulsive behaviors in the face of stimuli that trigger relapse (e.g., connecting with sponsors at the support groups, using stress inoculation techniques).

25. Address the issue of subtle enabling or cover-up behaviors by family members; use educative techniques to make the members more aware of enabling and use more direct confrontation when necessary.

26. Using role-play techniques of family scenarios, guide the noncompulsive family members in not accepting responsibility for the compulsive member's choices.

27. Review instances of family interaction at home in which family members have successfully avoided enabling behaviors.

28. Brainstorm ideas among family members about how to more constructively respond to

situations that previously precipitated enabling behaviors.

20. Children identify the unhealthy role in the family that each has assumed as a result of the dysfunction the compulsive behaviors have brought. (29, 30)

29. Teach family members the roles usually adopted by children of addictive parents (e.g., the family hero, the scapegoat, the lost child, and the mascot); help children identify the role(s) each has adopted (see *The Family Recovery Guide: A Map for Healthy Growth* by Brown, Lewis, and Liotta).

30. Encourage children to give up their unhealthy role assumptions and express their needs, feelings, and desires directly and assertively.

21. Compulsive family member apologizes to other family members for the pain and suffering he/she has caused by his/her excessive behaviors. (31)

31. Recommend that the compulsive family member formally apologize for the pain caused to other family members as a result of the excessive behavior and time taken away from the family.

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DIAGNOSTIC SUGGESTIONS

Axis I:	300.3	Obsessive-Compulsive Disorder
	296.xx	Bipolar I Disorder *[include specifier]*
	300.4	Dysthymic Disorder
	296.xx	Major Depressive Disorder, Single Episode *[include specifier]*
	V61.10	Partner Relational Problem
	V61.20	Parent-Child Relational Problem
	995.54	Physical Abuse of Child (Victim)
	_____	_____
	_____	_____
Axis II:	301.83	Borderline Personality Disorder
	301.4	Obsessive-Compulsive Personality Disorder
	301.50	Histrionic Personality Disorder
	_____	_____
	_____	_____

DEATH OF A CHILD

BEHAVIORAL DEFINITIONS

1. The accidental, sudden death of a child occurs, causing grief to the surviving family members.
2. The death of a child occurs *in utero* (stillborn) or at birth, causing expectant parents and family members to grieve over the loss.
3. The death of a child occurs following a long terminal illness (e.g., congenital heart disease, cystic fibrosis, or muscular dystrophy).
4. The death of a child occurs due to an acute illness (e.g., brain tumor or cancer).
5. The parents and/or family members witness and/or participate in the accidental death of a child (e.g., auto accident), causing extreme guilt and trauma.
6. The child's death has an impact on the family dynamics and the way siblings reorder their lives with one another in order to cope with the loss.
7. The parents have a fear of future loss and display overprotectiveness of the surviving children.
8. One or more family members gets stuck in the grieving process, causing other family members to suffer and overfunction for the stuck family member.

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LONG-TERM GOALS

1. Adjust to the shock and trauma of the death/loss and learn to cope effectively with the grief and the absence of the deceased family member.
2. Come to terms with the notion that death is part of life and can occur at any time, whether it be *in utero* or during the developmental life span.
3. Become aware of the various stages of grief and prepare for dealing with the emotions that accompany those stages.
4. Learn to mediate guilt, whether it be a result of being a survivor or due to some peripheral or direct involvement in the child's accidental death.
5. Parents and family members resolve the need to overprotect the surviving children.
6. Family members learn to support each other through the grieving process.

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SHORT-TERM OBJECTIVES

1. Each family member expresses his/her grief associated with the shocking death of the child. (1, 2, 3)

2. Family members verbalize an understanding of the various stages of grief associated with the loss of a loved one. (4)

THERAPEUTIC INTERVENTIONS

1. Allow the family members to vent their grief as a family and express the loss as a whole.
2. Promote a sense of unity and facilitate cohesiveness among the surviving family members.
3. Facilitate each family member in expressing how the grief has affected him/her on an individual basis and define how the experience differs from that of other family members.
4. Educate the family about the stages of grief for survivors; recommend that adults read *How to Survive the Loss of a Child* by Sanders, and that children read *The*

	Fall of Freddie the Leaf by Buscaglia.
3. Implement the use of rituals and imagery for coping with the loss of a loved one. (5, 6)	5. Discuss with the family methods for coping with the loss of a child and sibling; explore the use of various rituals (e.g., wearing certain clothing that belonged to the deceased or constructing a shrine).
	6. Teach cognitive behavioral coping strategies for grief (e.g., imagery that suggests how the deceased would want the survivors to go on, how the deceased would be dealing with the reverse situation if the circumstances had been different).
4. Family members reaffirm their faith-based beliefs regarding death. (7, 8)	7. Explore with family members their religious beliefs about life after death, including suggesting meeting with their priest, rabbi, minister, or bishop; reinforce the notion that the deceased is safe and free from pain. Recommend the book *The Grieving Garden: Living with the Death of a Child* by Redfern and Gilbert.
	8. Explore with the family the possibility of making arrangements for a memorial service to honor the deceased and reaffirm their faith.
5. Family members identify those aspects within themselves that were touched by the deceased while he/she was alive. (9, 10, 11)	9. Consider holding a family session at the graveside of the deceased child to allow family members to express thoughts and feelings to each other and the deceased.
	10. Have each family member share his/her favorite image or photo of the deceased child with the other family members in order to keep the deceased alive in spirit.

11. Speak about how the deceased lives within each family member spiritually and recognize the characteristics of the deceased when they appear.

6. Verbalize the resolution of guilt surrounding the death of the family member. (12, 13)

12. Discuss in detail the actual circumstances of the child's death; differentiate between survivor guilt and guilt for not being able to do more to save the child from death or ease pain and suffering.

13. Educate the family members about survivor guilt and how this is a natural stage of grief and loss; suggest that adults read *Survivor Guilt* by Matsakis.

7. Parents acknowledge their propensity to be overprotective of the surviving children. (14)

14. Help family members to recognize their excessive overprotective behaviors both as a natural reaction and as a means of assuaging guilt; help them look at alternative ways of self-reassurance and letting go of the deceased.

8. Parents identify the negative impact of being overprotective of surviving children. (15)

15. Review with family members potential negative side effects of being overprotective of the surviving children (e.g., anxious attachment, social anxiety, separation anxiety).

9. Parents and/or family members cooperate with the assessment and treatment of preexisting anxiety or depression that has been exacerbated by the death. (16, 17)

16. Conduct an assessment of any preexisting psychopathology that may have been brought to a head by the death of the child.

17. Refer individual family members to a therapist or psychiatrist for treatment of any determined preexisting psychological disorder.

10. Siblings express any irrational feelings of responsibility for the death of the child. (18)

18. Explore for the presence of irrational guilt in siblings (especially young siblings) for the death of the child; process this guilt and reassure the child of not

being responsible for this tragic event; suggest reading *Overcoming Loss: Activities and Stories to Help Transform Children's Grief and Loss* by Sorensen.

11. Family members terminate blaming of themselves or each other for the child's death. (19)

19. In a family session, expose any hidden blame for the child's death that may exist.

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DIAGNOSTIC SUGGESTIONS

Axis I:	296.2x	Major Depressive Disorder, Single Episode
	309.81	Posttraumatic Stress Disorder
	309.x	Adjustment Disorder with *[include specifier]*
	308.3	Acute Stress Disorder
	V61.20	Parent-Child Relational Problem
	V61.10	Partner Relational Problem
	V62.82	Bereavement
	V62.89	Religious/Spiritual Problem
	_____	_____
	_____	_____
Axis II:	301.6	Dependent Personality Disorder
	301.83	Borderline Personality Disorder
	301.50	Histrionic Personality Disorder
	_____	_____
	_____	_____

DEATH OF A PARENT

BEHAVIORAL DEFINITIONS

1. The accidental, sudden death of a parent leaves a single-parent or parentless home, causing grief to the survivors.
2. The death of a parent occurs following a long terminal illness (heart disease, cancer, leukemia, etc.).
3. The death of a parent occurs due to an acute illness (heart attack, auto accident, etc.).
4. The spouse and/or family members of the deceased witness and/or participate in the accidental death of a parent (e.g., auto accident, drowning), causing extreme guilt and trauma.
5. The parent's death has a negative impact on the family dynamics and the way surviving family members reorder their lives with one another in order to cope with the loss.
6. Family member(s) become fixated on the loss of the deceased, refusing to flexibly adjust to the new increased demands of home life.
7. Survivors have a fear of future loss of other family members and display overprotectiveness of one another.
8. Financial hardships fall on the surviving family, which causes undue stress in addition to the stress of losing the parent.

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LONG-TERM GOALS

1. Adjust to the shock and trauma of the death/loss and learn to cope effectively with the grief and the absence of the deceased parent.
2. Come to terms with the notion that death is an unavoidable part of life and can occur at any time during the developmental life span.
3. Become aware of the various stages of grief and prepare for dealing with the emotions that accompany those stages.
4. Learn to flexibly adjust to the new change by adopting new roles and responsibilities without letting go of the memory of the deceased parent.
5. Learn to mediate guilt, whether it be a result of being a survivor or due to some peripheral or direct involvement in the parent's accidental death.
6. Surviving parent and family members work through their resistance to and rejection of parental replacements (e.g., relatives, foster parents, etc.).

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Each family member expresses his/her grief associated with the death of the parent. (1, 2)	1. Allow the family to vent their grief and express the loss. 2. Promote a sense of unity and facilitate cohesiveness among the surviving family members; also, focus on how the caretaking role will be fulfilled in the family.
2. Family members verbalize an understanding of the various stages of grief, as well as the fact that each family member will likely progress through the stages differently. (3, 4)	3. Each family member will express how the grief has affected him/her on an individual basis and define how the experience differs from those of the others (for adults, use journaling, poetry, etc.; for children under the age of 12, utilize picture drawings, music, etc.).

4. Educate the family regarding the stages of grief for survivors; recommend that adults read *On Grief and Grieving* by Kubler-Ross and Kessler and that children read *The Fall of Freddie the Leaf* by Buscaglia.

3. Implement rituals and imaging techniques for coping with the loss of a loved one. (5, 6)

5. Discuss with the family methods for coping with the loss of a spouse/parent; explore the use of various rituals (e.g., wearing certain clothing that belonged to the deceased, constructing a shrine). If meeting with the family prior to the viewing or burial service, consider having family members place certain symbolic items in the deceased's coffin, provided the item is congruent with the survivors' religious beliefs.

6. Teach cognitive behavioral coping strategies for grief (e.g., imagery that suggests how the deceased would want the survivors to go on, how the deceased would be dealing with the reverse situation if the circumstances had been different). Recommend reading *Grief: Climb Toward Understanding,* 5th ed. by Davies.

4. Family members reaffirm their faith-based beliefs regarding death. (7, 8)

7. Explore with family members their religious/spiritual beliefs about life after death, including meeting with their priest, rabbi, minister, or bishop; reinforce the notion that the deceased is safe and free from pain.

8. Explore with the family the possibility of making arrangements for a memorial service to honor the deceased and reaffirm their faith.

5. Verbalize the resolution of guilt surrounding the death of the parent. (9, 10)

6. Family members identify those aspects within themselves that were touched by the deceased while he/she was alive. (11, 12, 13)

7. Acknowledge the propensity to be overprotective with the surviving family members, both as a natural reaction and as a means of assuaging guilt. (14)

9. Discuss in detail the actual circumstances of the parent's death; differentiate between survivor guilt and guilt for not being able to do more to save the parent from death or ease pain and suffering.

10. Educate the family members about survivor guilt and how this is a natural stage of grief and loss; suggest that adults read *Survivor Guilt* by Matsakis, and that children read *Overcoming Loss: Activities and Stories to Help Transform Children's Grief and Loss* by Sorensen.

11. Consider holding a family session at the graveside of the deceased parent to allow family members to express thoughts and feelings to each other and to the deceased.

12. Have each family member share his/her favorite image or photo of the deceased parent with the other family members in order to keep the deceased alive in spirit (e.g., children or adults could wear a picture in a locket).

13. Speak about how the deceased lives within each family member spiritually and recognize the deceased's characteristics when they appear.

14. Help family members recognize their excessive overprotective behaviors and to look at alternative ways of self-reassurance and letting go of the deceased; for children, begin to identify other potential role models (e.g., older siblings, aunt/uncle).

8. Identify the negative impact of being overprotective of surviving family members. (15)

15. Review with family members potential negative side effects of being overprotective of each other (e.g., separation anxiety, instilling an unrealistic fear of the world as a dangerous place) and assess whether or not this is a healthy aspect of survival.

9. Parents and/or family members cooperate with the assessment and treatment of preexisting anxiety or depression that has been exacerbated by the death. (16, 17)

16. Conduct an assessment (use psychological testing, inventories, history taking, etc.) of any preexisting psychopathology that may have been brought to a head by the parent's death.

17. Refer individual family members to a therapist or psychiatrist for treatment of any determined preexisting psychological disorder.

10. Children express any irrational feelings of responsibility for the death of the parent. (18)

18. Explore for the presence of irrational guilt in children (especially young children) for the death of the parent; process this guilt and reassure that such feelings are not reality-based; suggest reading *Overcoming Loss: Activities and Stories to Help Transform Children's Grief and Loss* by Sorensen.

11. Family members terminate blaming of themselves or each other for the parent's death. (19)

19. In a family session, expose any hidden blame that may exist for the parent's death; resolve unreasonable accusations.

12. Children express resistance to bonding with a parental substitute or replacement. (20, 21)

20. Facilitate the process of extended family members bonding with the children as a replacement for the deceased parent (e.g., relative, stepparent); focus on how this individual can never replace the deceased, but can only follow in his/her footsteps, allowing for the children's expressions of resistance and fear of bonding.

21. Recommend that the children talk about the missing parent as much as needed and be allowed to keep a log or diary to write to the deceased on a regular basis.

13. Family members express frustration with financial hardships that result from the death of the parent. (22)

22. Search for alternative means of financial support and begin to face the reality of having limited resources; process the anger and resentment among family members over the loss of income.

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DIAGNOSTIC SUGGESTIONS

Axis I:	296.2x	Major Depressive Disorder, Single Episode *[include specifier]*
	300.4	Dysthymic Disorder
	311	Depressive Disorder NOS
	309.x	Adjustment Disorder with *[include specifier]*
	308.3	Acute Stress Disorder
	309.21	Separation Anxiety Disorder
	300.02	Generalized Anxiety Disorder
	V62.82	Bereavement
	_____	_____
	_____	_____
Axis II:	301.6	Dependent Personality Disorder
	301.83	Borderline Personality Disorder
	301.50	Histrionic Personality Disorder
	_____	_____
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DEPENDENCY ISSUES

BEHAVIORAL DEFINITIONS

1. One family member has an extreme need to be taken care of by other family members, which leads to clinging and submissive behaviors.
2. The family member overtly expresses fear of abandonment.
3. Dependency issues place tension and a burden of responsibility onto others, causing resentment and friction in the home.
4. The family member seeks reassurance from others and does everything possible to avoid disagreement and conflict.
5. The family member readily experiences guilt, leading to low self-esteem.
6. The family member is unable to render independent decisions without confirmation and support from other family members.
7. Nondependent family members enable the dependent family member by giving in to frequent demands for contact, reassurance, and manipulative behaviors.
8. The dependent family member experiences anxiety and depression during periods of absence from other family members.
9. The dependent family member experiences loss of purpose and meaning in life when he/she perceives insufficient support from other family members.

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LONG-TERM GOALS

1. Eliminate the pressure for caretaking by others and display less clingy and submissive behaviors.
2. Increase assertiveness and demonstrate self-reliance.
3. Eliminate feelings of guilt and increase self-esteem.
4. Eliminate unrealistic fear of abandonment.
5. Nondependent family members recognize their enabling behavior and give in less frequently to the dependent family member's demands and manipulations.
6. Increase tolerance for separation from family members.
7. Dependent family member makes decisions without reassurance from others.

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SHORT-TERM OBJECTIVES

1. Identify those specific behaviors that constitute the dependency. (1, 2)

2. Each family member describes the impact the dependency has had on family members. (3)

3. Identify the history of the development of dependency. (4, 5)

THERAPEUTIC INTERVENTIONS

1. Ask each family member to describe the evidence for excessive dependency in one family member.
2. Assist the family in developing operational definitions or, possibly, metaphors to identify specific dependent behaviors and dynamics that need to change.
3. Have each family member express how the dependency issues have affected him/her personally and the family unit.
4. Promote acceptance by everyone in the family that the dependency issue truly exists and explore the dynamics of how it may have developed.
5. Explore the parents' families of origin and/or use genograms to

	make connections with other possible dependency issues in the family.
4. Verbalize an increased awareness of the nature and dynamics of dependency. (6, 7)	6. Educate the family about the dynamics of unhealthy dependency (e.g., enabling, exploitation of power).
	7. Suggest specific readings on dependency (e.g., *Codependent No More* and *Beyond Codependency* by Beattie) and discuss with the family members the concepts involved.
5. Dependent family member identifies the unrealistic fear of abandonment. (8, 9)	8. Explore the dependent family member's fears of abandonment and what it means to him/her to be alone; utilize techniques for helping reframe his/her fear (e.g., see *Cognitive Therapy of Personality Disorders,* 2nd ed. by Beck, Freeman, and Davis and/or *Schema Therapy* by Young, Klosko, and Weishaar).
	9. Ask other family members to share their beliefs about being alone and contrast these with those of the dependent member.
6. List constructive behavioral and cognitive coping activities to overcome the fear of abandonment. (10)	10. Facilitate brainstorming on how family members can overcome irrational thoughts regarding abandonment (e.g., utilize rational self-talk, fill free time with constructive activities, implement thought-stopping).
7. Facilitate the direct expression of thoughts and feelings. (11)	11. Utilize family sculpting or reverse role-playing to facilitate the expression of difficult emotions or issues (see *Family Sculpture and Relationship Wrapping Techniques* by Constantine or *Satir Step-by-Step* by Satir and Baldwin).

8. Identify how conflicts are avoided due to the irrational fear of rejection. (12, 13, 14, 15)

12. Have individual family members take responsibility for their contributions to the overall tension in the family.
13. Discuss the issue of avoidance of conflict and how each family member feels about dealing with this issue.
14. Identify irrational thoughts about conflict, such as thoughts that one will be totally rejected by other family members if disagreement arises.
15. Review methods of conflict resolution and styles of disagreement; reinforce the notion that all families experience conflict and that it is necessary for family growth and development.

9. Dependent family member acknowledges irrational guilt and implements cognitive restructuring to overcome it. (16, 17, 18, 19)

16. Have family members engage in role-playing to demonstrate the thoughts they have in response to guilt.
17. Compare family members' thoughts associated with guilt to those of the dependent family member and help him/her revise or restructure the way of dealing with guilt.
18. Educate the family about the dynamics of guilt and how most guilt is self-inflicted.
19. Recommend homework from *Ten Days to Self-Esteem* by Burns to teach cognitive restructuring techniques that will reduce guilt and build self-esteem.

10. Identify fears associated with making independent decisions. (20, 21)

20. Facilitate family discussion about decision-making and fears of making bad decisions or failing.
21. Help the family adopt a less perfectionistic style and a more accepting attitude about making bad decisions or failing.

11. Increase the frequency of independent decision-making and report a reduction in the fear associated with it. (22, 23, 24)

22. Teach structured techniques to assist in decision-making (e.g., using a decision tree, listing the pros and cons of choices); attempt to address this as a family behavior with less emphasis on the dependent family member.

23. Encourage family members to use positive reinforcement when the dependent family member makes independent decisions and displays less of a need to rely on other family members (see *Cognitive Behavioral Therapy with Couples and Families: A Comprehensive Guide for Clinicians* by Dattilio).

24. Discuss incidents when the dependent family member has successfully made decisions; reinforce success.

12. Acknowledge enabling behaviors on the part of the nondependent family members. (25, 26, 27)

25. Encourage family members to admit that they have enabled the dependent member and discuss how that enabling may have developed.

26. Explore for the origins of guilt in other family members that may be underlying their enabling behaviors.

27. Assess the need of family members to keep the dependent family member dependent (for their own self-esteem, because of power issues, fears, etc.).

13. List behaviors of the family that will encourage independence in the dependent member. (28)

28. Assist the family in identifying alternative behaviors on the part of the nondependent family members that will contribute to the support of overall family change (refusal to respond to the dependent member's calls for reassurance of being loved or being capable, reinforcing independent behaviors, etc.).

14. All family members increase the frequency of the assertive expression of beliefs and emotions. (29, 30)

15. Implement changes in roles within the family unit that foster growth in independence. (31)

29. Define the differences between assertive and aggressive expressions of emotions; use role-playing and modeling to teach assertive expressions of thoughts and feelings.

30. Refer the dependent family member to assertiveness training classes.

31. Utilize role reversal exercises to foster support for role changes among family members (the dominant decision maker becoming more passive, the quiet member becoming more expressive, the passive member becoming more assertive, etc.).

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DIAGNOSTIC SUGGESTIONS

Axis I:	311	Depressive Disorder NOS
	300.4	Dysthymic Disorder
	296.x	Major Depressive Disorder *[include specifier]*
	309.21	Separation Anxiety Disorder
	_____	_____
	_____	_____
Axis II:	301.6	Dependent Personality Disorder
	301.82	Avoidant Personality Disorder
	_____	_____
	_____	_____

DEPRESSION IN FAMILY MEMBERS

BEHAVIORAL DEFINITIONS

1. Ongoing sadness, hopelessness, or pessimism.
2. Disengagement with or disinterest in previously enjoyable activities in life (e.g., visiting relatives or dining out).
3. A decrease in the ability to remain focused or to concentrate (frequent daydreaming, losing place while reading or doing schoolwork, etc.).
4. Insomnia (onset or interrupted sleep) with excessive fatigue or a general malaise.
5. Decreased sense of self-worth.
6. Social withdrawal.
7. Psychomotor agitation or retardation (slowed movement, low motivation, etc.).
8. Feelings of guilt and lack of desire to live.
9. Suicidal ideation and/or gestures to incur harm to oneself.
10. Outright rejection of antidepressant medication or poor response to any type of therapeutic intervention.
11. A decrease in energy level and appetite, and/or a chronic anhedonia.
12. Increased irritability and low frustration tolerance.
13. Children begin to act out or get depressed themselves in reaction to the emotionally unavailable parent.

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LONG-TERM GOALS

1. Resolve the depression and return to a normal level of participation in, and contribution to, family activities.
2. Reduce feelings of helplessness and lack of control over one's life.
3. Eliminate suicidal beliefs and/or gestures with an increased desire to live and a lessened sense of general hopelessness.
4. Improve feelings of self-esteem.
5. Increase involvement with and enjoyment of normal social activities.
6. Reduce feelings of hopelessness and dissatisfaction with life.
7. Reduce acting out or depression in children by getting the depressed parent to re-engage his/her caretaking responsibilities.

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SHORT-TERM OBJECTIVES

1. Identify the signs of depression and the factors that may have triggered the depression. (1, 2)

2. Depressed family member cooperates with psychological testing to assess the depth of the depression. (3, 4)

THERAPEUTIC INTERVENTIONS

1. Have each family member give his/her perception of the evidence for depression in one family member.
2. Assist family members in identifying any specific event that may have triggered the depressive symptomatology.
3. Administer diagnostic inventories of depression to the depressed family member (e.g., the Beck Hopelessness Scale [Beck] or the Children's Depression Inventory [Kovacs]).
4. Review the results of the assessment measures for depression, hopelessness, and

	suicidality with the family and explain what they mean.
3. Family members identify how they have been affected by the symptoms of the depressed family member. (5, 6)	5. Ask family members to share their perceptions of how the depression of the other member affects them individually.
	6. Allow for the expression of negative emotions such as resentment from the nondepressed family members in reaction to the pall that is cast over the family by the depressed family member.
4. Any family member acknowledges a belief that the depression is a manipulation. (7)	7. Inquire about any family member who might believe that the depression is not real or may be a means of manipulation.
5. Depressed family member increases social engagement with other family members and friends. (8, 9, 10)	8. Assess how the depression has contributed to the family member's social disengagement or disinterest in regular activities.
	9. Develop a behavioral contract and/or a weekly schedule of a specified number of social activities for the depressed family member with friends and family (see *Feeling Good: The New Mood Therapy* by Burns).
	10. Teach techniques to reduce behavioral deficits that contribute to the depression (e.g., teach assertiveness or social skills).
6. Depressed family member identifies negative, distorted cognitive messages and replaces with positive, realistic self-talk that reduces depression and builds self-esteem. (11, 12, 13)	11. Assist the depressed member and other family members to recognize and identify distorted, negative cognitive messages that support depressed feelings and low self-esteem (recommend *The Feeling Good Handbook* by Burns or *Mind over Mood* by Greenberger and Padesky).
	12. Teach positive, reality-based self-talk that can replace distorted

	cognitive messages; encourage nondepressed family members to remind the depressed member to think positively and realistically.
	13. Use genogram or family-of-origin techniques for discussing the history of self-perception and the overall level of mental health in the family.
7. Depressed family member reports increased concentration and reduced brooding. (14)	14. Suggest techniques for maintaining the level of concentration and avoidance of daydreaming (e.g., staying active, engaging in brief reading activities, and practicing recall exercises).
8. Family encourages less daytime sleeping by depressed family member and an overall increase in activity. (15)	15. Support nondepressed family members in encouraging the depressed member to establish healthy sleeping and eating habits and involve himself/herself in family activities.
9. Depressed family member evidences improved self-esteem through his/her verbal expressions as well as the ability to take on more risk. (16)	16. Recommend that the family implement self-esteem-building exercises such as practicing assertiveness, positive affirmations, or praising others, etc. (see *Ten Days to Self Esteem* by Burns).
10. Depressed family member decreases the frequency of avoidant behaviors. (17)	17. Explore for a pattern of avoidant behaviors in the depressed family member; use techniques such as graded exposure and coping skills training to reduce avoidant behavior (see *Mind over Mood* by Greenberger and Padesky).
11. Depressed family member expresses anger directly, respectfully, and under control. (18, 19, 20)	18. Explore how family members deal with anger issues; teach how suppressed anger can lead to avoidance behavior and depression.
	19. Teach the use of assertiveness versus passivity, passive-

aggressiveness, and aggressiveness as related to anger expression.

20. Incorporate techniques (e.g., journaling and artwork) as alternative forms of expression of anger and depression; facilitate positive processing and avoid any unnecessary attacking between family members.

12. Agree to the implementation of a solid prevention plan to reduce the risk of suicide. (21, 22, 23)

21. Carefully assess the level of risk for suicide; implement a plan for the support and safety of the depressed family member.

22. List methods for family members to stay in contact with each other or to use a crisis hotline during periods of high suicide risk.

23. Develop a no-self-harm contract that is signed by all members of the family; include an agreement that immediate hospitalization will be used if any hopelessness symptoms are exacerbated into gestures of or attempts at suicide.

13. Obtain an assessment of the role of chemical imbalance, genetic predisposition, or other medical factors of depression. (24)

24. Assess for an extended family history of depression and make a referral to a psychiatrist or family physician to evaluate the need for psychotropic medication; encourage close communication with the health professional.

14. Depressed family member agrees to take antidepressant medication if necessary and/or accept more intensive treatment (e.g., individual psychotherapy, partial hospitalization, occupational therapy). (25, 26)

25. Monitor depressed family member for medication prescription compliance, effectiveness, and side effects.

26. Brainstorm and develop a list of alternative treatments (hospitalization, day treatment programs, intensive individual and/or group psychotherapy, etc.) if the depression becomes unmanageable.

15. Depressed family member displays improved energy level and appetite and more zest for life, and other family members reinforce the improvement. (27)

16. Nondepressed family members make unsolicited contact with the depressed member throughout the day. (28)

17. Increase the frequency and intensity of physical exercise. (29)

18. Identify markers for potential relapse into depression. (30)

19. Disclose any childhood history of abuse. (31)

20. All family members terminate attempts to inflict guilt subtly or directly. (32)

21. Nondepressed family members terminate enabling behavior directed at maintaining depression. (33)

27. Assist family members in identifying and implementing the specific reinforcers that are effective for the depressed family member (e.g., verbal praise).

28. Facilitate an agreement from other family members to make unsolicited contact with the depressed family member throughout the day (e-mail, phone calls, etc.).

29. Devise a plan that involves all family members interacting in physical activities (e.g., swimming, going to the fitness center, playing badminton or winter sports, ice skating).

30. Help the family recognize the markers (an increase in the level of depression, engaging in denial, etc.) for potential relapse in the future.

31. Explore the possibility of early trauma (e.g., sexual, physical, or psychological abuse) and how this might be contributing to the depression.

32. If other family members are subtly inducing guilt on the depressed person, discuss and consider alternatives to guilt-inflicting behaviors (other means of communication, etc.).

33. Address the issue of potential enabling behaviors on the part of other family members; discuss matters such as the need for others to overpower or enhance control.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.0	Adjustment Disorder with Depressed Mood
	300.4	Dysthymic Disorder
	301.13	Cyclothymic Disorder
	296.xx	Major Depressive Disorder *[include specifier]*
	V62.82	Bereavement
	_____	_____
	_____	_____
Axis II:	301.83	Borderline Personality Disorder
	301.82	Avoidant Personality Disorder
	301.6	Dependent Personality Disorder
	_____	_____
	_____	_____

DISENGAGEMENT/LOSS OF FAMILY COHESION

BEHAVIORAL DEFINITIONS

1. Disengagement from one another and disillusionment with the state of the family's development.
2. A lack of laughing or having fun together.
3. Feelings of alienation and estrangement from the family unit.
4. Over-involvement with individual activities and other relationships outside of the family unit.
5. Quick escalation of tension and conflict, especially when situations force family members to interact (e.g., crisis, death).
6. Negative reaction of external parties to family members because of the lack of communication, cohesion, and disharmony in the family (e.g., children or parents begin to notice coldness in the family).
7. Appearance of negative psychological or behavioral side effects of the family's disengagement (e.g., mental or physical illness, substance abuse, criminal activity).
8. Lack of shared activities and joint celebrations.
9. Lost sense of self due to the effects of the family disengagement.
10. Loss of family rituals leads to a poor or nonexistent sense of family identity.

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LONG-TERM GOALS

1. Family members admit to having a problem with intimacy and cohesiveness with each other.
2. Eliminate feelings of alienation through engagement in behaviors that facilitate cohesiveness and intimacy.
3. Achieve the desire and ability to laugh and have fun together.
4. Redirect the focus of the family to devoting more time to immediate family members than to external relationships.
5. Devise methods for coping with tension and crisis situations in the family.
6. Initiate and maintain family rituals.

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SHORT-TERM OBJECTIVES

1. Identify the evidence for and history of family disengagement. (1, 2, 3, 4)

THERAPEUTIC INTERVENTIONS

1. Facilitate a discussion about each family member's perception of the family and how it functions.
2. Explore the emotional responses and the behavioral displays that have been generated as a result of the family's disengagement.
3. Assist family members in defining in behavioral terms what is contributing to the disengagement; consider using the Family-of-Origin Inventory (Stuart) or a genogram to aid in determining how this may have been learned in childhood experiences.
4. Assign each family member to list what he/she feels is desirable but missing within the family, and discuss each family member's list

	in the session; recommend *The Seven Habits of Highly Effective Families* by Covey.
2. Cooperate with psychological testing to assess family disengagement. (5)	5. Use test instruments to assess the family's cohesion (e.g., Family Adaptability and Cohesion Scales [Olson] or Family Sense of Coherence and Family Adaptation Scales [Antonovsky and Sourani]).
3. Each family member expresses how he/she experiences a sense of alienation and estrangement from the others. (6, 7)	6. Consider having family members select, watch, and discuss a video that best exemplifies their sense of disengagement (e.g., a film such as *Ordinary People*).
	7. Open a forum for each family member to express how he/she individually experiences the alienation and loss of closeness in the family; use creative techniques (songs, poems, artwork, etc.) to achieve this disclosure, if indicated.
4. Articulate the external relationships and activities that have been replacements for the lack of family closeness. (8, 9)	8. Discuss with family members their gravitation to outside activities and relationships and how this is a natural reaction to the family disengagement situation.
	9. Have each family member acknowledge how he/she has personally sought out relationships with others outside of the family and how this has helped to fill the void in their own family.
5. Accept individual responsibility for contribution to the disengagement. (10, 11)	10. Have each family member take responsibility for his/her own contribution to the family's gravitating toward disengagement.
	11. Aim toward the reduction of blaming behaviors by having family members use "I" messages instead of "you" messages.

6. Agree to make an effort to overcome resistance and rebuild family cohesion and communication through emotional investment. (12, 13, 14)

12. Discuss the fear of, and difficulties inherent in, gravitating back to the family unit and how this will be an adjustment for everyone; ask each family member to describe how it will affect him/her personally.

13. Brainstorm methods for coping with the reinvestment in the family and how to respond to fears and resistance (e.g., taking one step at a time, discussing the risk involved with trusting each other, considering how to start spending time with each other and what to expect).

14. Encourage family members' faith and trust in taking a risk by reinvesting in their own family.

7. Describe the conflicts that develop as a result of reengaging with one another. (15, 16)

15. Have each family member describe the conflicts that arise when they must interact with one another in a crisis (see the Conflict Tactics Scale in *Physical Violence in American Families* by Straus and Gelles).

16. Prepare the family for tension and conflict to be a natural part of the rehabilitation process and discuss ways to inoculate against this (e.g., using progressive muscle relaxation, identifying likely areas of conflict and how to anticipate and resolve them, weighing alternative responses to conflict, etc.).

8. Implement conflict resolution techniques rather than withdrawal to cope with friction due to reengagement. (17, 18)

17. Suggest conflict resolution strategies or tension-reducing techniques (e.g., time-out procedures, venting sessions, compromise, third-party mediators) to deal with tension and conflict.

18. Brainstorm ways to better prepare for interaction during family crises

	(e.g., a death in the family); use role-playing to practice these new ways to interact.
9. Implement healthy communication and problem-solving skills to overcome conflict. (19, 20)	19. Suggest to the family principles of healthy communication (e.g., speaker/listener technique, "I" messages, etc.) and problem-solving strategies (e.g., problem definition, brainstorming solutions, evaluation of alternatives, solution enactment, and enactment evaluation; see *Fighting for Your Marriage* by Markman, Stanley, and Blumberg).
	20. Use role-playing techniques to enact an actual situation of conflictual communication and coach the family through the process of using communication and problem-solving skills.
10. Acknowledge and address any negative behavioral or psychological side effects that the disengagement has had. (21, 22, 23)	21. Assess for signs of physical or mental illness, substance abuse problems, or criminal behavior in any of the family members.
	22. Discuss whether the psychological or behavioral problems are directly or indirectly related to the disengagement within the family.
	23. Facilitate the expression of feelings related to the psychological or behavioral problem of a family member.
11. Troubled family member accepts referral for more individualized treatment. (24)	24. Refer the troubled family member to a family physician or psychiatrist for medication or individual counseling for help coping with individual psychological issues.
12. Troubled family member terminates blaming or projecting responsibility for his/her own behavior. (25)	25. Confront the troubled family member for unnecessarily blaming or manipulating through his/her acting out.

13. Family members commit to rebuilding an active social life together and to engaging in more family celebrations. (26, 27, 28)

26. Have family members generate a list of different family activities that they would like to see occur.

27. Ask each family member to fantasize about how the proposed family activities would unfold; discuss the fear of failure and disappointment that may be present.

28. Brainstorm with family members on ways to avoid failure to engage each other and to facilitate more successful and enjoyable family activities.

14. Report a reinforced sense of personal identity and identify how the family can fortify this in the future. (29, 30, 31)

29. Have each family member list how he/she has experienced a weakened or lost part of himself/herself and compare this with the experiences of other family members.

30. Generate a list of family activities or rituals that may help to restore a sense of self and connection between family members (e.g., volunteering time together to aid the less fortunate, other activities that involve survival and working together such as a rafting trip); assign reading *The Intentional Family* by Doherty.

31. Suggest including family-of-origin members in a session to address the lack of personal identity and allow for a process of ventilation of the emotion attached to it (see *Family-of-Origin Therapy: An Intergenerational Approach* by Framo).

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.0	Adjustment Disorder with Depressed Mood
	305.00	Alcohol Abuse
	303.90	Alcohol Dependence
	300.4	Dysthymic Disorder
	296.x	Major Depressive Disorder *[include specifier]*
	V61.10	Partner Relational Problem
	V61.20	Parent-Child Relational Problem
	_____	_____
	_____	_____
Axis II:	301.20	Schizoid Personality Disorder
	301.82	Avoidant Personality Disorder
	_____	_____
	_____	_____

EATING DISORDER

BEHAVIORAL DEFINITIONS

1. Preoccupation with body weight and size related to a grossly unrealistic perception of oneself as being fat or heavy.
2. Denial of the effect that the weight loss has had on the body.
3. Severe weight loss with the deliberate refusal to maintain a minimal healthy weight.
4. Self-limiting intake of food and a high frequency of self-induced vomiting, excessive use of laxatives, and/or excessive strenuous exercise.
5. Females experience amenorrhea.
6. Periodic consumption of high-calorie foods and then the use of self-induced vomiting and/or an inappropriate use of laxatives to avoid gaining weight.
7. Desperate fear of losing control over weight gain and/or appearing fat or heavy.
8. Reduction in potassium and chloride levels in the body due to excessive vomiting and/or elimination.
9. Electrolyte and fluid imbalance due to the restriction of food intake and vomiting.
10. Reduced interest in sexual activities.
11. A change in the level of intimacy with others or a flattening of mood and affect.
12. Extreme defensiveness about eating patterns, particularly aspects of food selection and dieting.
13. Family tension surrounding eating habits.
14. Excessive exercise.

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LONG-TERM GOALS

1. Restore normal eating patterns, body weight, balanced fluid and electrolytes, and a realistic perception of body size.
2. Terminate the pattern of binge eating and purging behavior with a return to normal eating of enough nutritious foods to maintain a healthy weight.
3. Stabilize medical condition, resume patterns of food intake that will sustain life, and gain weight to a normal level.
4. Identify family patterns that are contributing to the cause or exacerbation of the eating disorder.
5. Eliminate conflict and dysfunctional family patterns involving control and the intake of food.
6. Stabilize physical and psychological condition.
7. Resolve family conflict around eating disorder

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SHORT-TERM OBJECTIVES

1. Identify the evidence for an eating disorder in a family member. (1, 2, 3)

THERAPEUTIC INTERVENTIONS

1. Review the *DSM* criteria for an eating disorder with all family members and highlight areas that are relevant.
2. Discuss the eating patterns among all family members and assess what is healthy behavior and what is not.

	3. Use assessment instruments to further refine a diagnosis (e.g., Eating Disorders Inventory-2 [Garner] and the Family-of-Origin Scale [Hovestadt, Anderson, Piercy, Cochran, and Fine]).
2. Identify the history of and possible contributing factors to the eating disorder. (4)	4. Family members express their beliefs about how the eating patterns developed; focus on perceived contributions of specific family members.
3. Identify conflicts within the family that might contribute to an eating disorder. (5, 6, 7)	5. Explore for patterns that may contribute to the eating disturbance in the family (e.g., criticism during mealtime, over-emphasis on weight and body image).
	6. Have the family member with the eating disorder share with the family details about his/her binging and purging and the specific cues that initiate the behaviors (e.g., anger, criticism, stress).
	7. Once the cues that contribute to binging and purging are established, discuss with family members their role in the specific interaction with the family member suffering from the eating disorder.
4. Family members verbalize an increased understanding of the eating disorder's symptoms, causes, and treatments. (8, 9)	8. Family members discuss the knowledge they have acquired about eating disorders through the media, from reading, or from other people; highlight accurate aspects of what they learned and how it applies to their family while correcting misconceptions.
	9. Have family members read materials on eating disorders to broaden their knowledge base (e.g., *Reviving Ophelia* by Pipher, *Eating Disorders* [National

Institute of Mental Health], and *The Secret Language of Eating Disorders* by Claude-Pierre).

5. Identify, challenge, and replace self-talk and beliefs that promote the eating disorder. (10, 11, 12)

10. Assign the family member with the eating disorder to self-monitor and record food intake, thoughts, and feelings (or assign "A Reality Journal: Food, Weight, Thoughts, and Feelings" in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma or "Daily Record of Dysfunctional Thoughts" in *Cognitive Therapy of Depression* by Beck, Rush, Shaw, and Emery); process the journal material with the family to allow them to challenge maladaptive patterns of thinking and behaving, and replace them with adaptive alternatives.

11. Assist the family in developing an awareness of automatic thoughts, underlying assumptions, associated feelings, and actions that lead to maladaptive eating and weight control practices (e.g., poor self-image, distorted body image, perfectionism, fear of failure and/or rejection, fear of sexuality).

12. Assist the family in the identification of negative cognitive messages (e.g., catastrophizing, exaggerating) that mediate dysfunctional eating behaviors, then train them to establish realistic cognitive messages regarding food intake and body size (or assign "Fears Beneath the Eating Disorder" from the *Adolescent Psychotherapy Homework Planner*, 2nd ed. by Jongsma, Peterson, and McInnis).

6. Family member with the diagnosed eating disorder obtains the level of care recommended by a team of professionals. (13)	13. Assess the need for a referral of the family member with the eating disorder to a treatment team of professionals aside from the family therapist (e.g., a clinical psychologist/psychiatrist).
7. Family members support the use of hospitalization and/or medication for the member with the eating disorder. (14, 15)	14. Solicit support from family members for the treatment team's decision to hospitalize the family member with an eating disorder if the condition becomes severe enough (this may involve an involuntary commitment if the family member with the eating disorder refuses inpatient care).
	15. Ask all family members to talk openly about the necessity for medical treatment (e.g., hospitalization or psychotropic medication) and to give support to the family member with the eating disorder.
8. Highlight positive attributes of the family member with the eating disorder and express his/her worth as a valued member of the family. (16)	16. Ask each family member to list the positive traits and talents, as well as the value of the member with the eating disorder.
9. Express anger and frustration over the effect that the eating disorder has had on the family dynamics. (17, 18, 19)	17. Facilitate an expression of family members' anger and resentment and review constructive ways to appropriately express these feelings.
	18. Assist family members in identifying the behavioral, cognitive, and affective cues that their anger is escalating to a level of unhealthiness (e.g., use scale from 0–10).
	19. Introduce family members to the components of time-out for anger control (e.g., *self-monitoring* for escalating feelings of anger and hurt, *signaling* to the family

	member that verbal engagement should end, *acknowledging* the need to disengage, *separating, cooling down,* and regaining control and composure, eventually returning to controlled verbal engagement).
10. Each family member, including the family member with the eating disorder, acknowledges his/her role with respect to the eating disorder. (20)	20. Discuss with each family member the need to take ownership for specific behaviors that contribute to the family dynamics; urge the use of "I" statements instead of "you" statements; educate family members about the tendency to externalize blame as a means of defense and denial over the eating disorder.
11. Individual with the eating disorder agrees to comply with the dietary recommendations outlined by the treatment team. (21, 22)	21. Refer the family to meet with a dietitian to review meal planning. 22. Encourage and reinforce the family support of gradual movement toward a balanced diet and increased food intake by the family member with the eating disorder.
12. Identify the role that obsessiveness and perfectionism play in maintaining the eating disorder. (23, 24, 25)	23. Educate the family about how compulsivity may be a means of expressing anger or compensating for feelings of low self-esteem or poor self-worth. 24. Suggest methods for dealing with perfectionism and control in one's life (e.g., deliberate exposure to situations in which the person experiences failure and has to live with it or being in situations where he/she is out of control). 25. Focus on the way criticism is expressed in the family and the impact this has had on the need to be compulsive and perfect.
13. Agree to practice new communication skills and conflict resolution techniques. (26, 27)	26. Discuss how change in the family will affect the dynamics of the family interaction; highlight the

need for improved communication and conflict resolution skills (e.g., use of assertive rather than aggressive or passive/aggressive communication, use of "I" statements).

27. Teach the family the use of communication skills as well as techniques for conflict resolution (see *From Conflict to Resolution: Skills and Strategies for Individual, Couple and Family Therapy* by Heitler and *Relationship Enhancement* by Guerny).

14. Identify the role of a desire for control as the basis for the eating disorder. (28, 29)

28. Address boundary issues with family members and encourage the use of enactments and imbalancing techniques for purposes of restructuring; discuss alternatives (journaling, developing a hobby, etc.) for dealing with feelings of loss of control and redirection of power.

29. Explore with family members whether control has been an issue in the family in the past and the role this may have played in the development of the eating disorder.

15. Identify the role of perfectionism in the relationship to the need for control and low self-esteem. (30, 31)

30. Discuss how perfectionism may interfere with various aspects of the development of self-concept, control, relationships, communication, sexual functioning/acting out, and so on.

31. Educate the family about the link between perfectionism and eating disorders and how the disorder functions as a means of overcompensating for perceived inadequacy and unacceptability.

16. Report less fear of failure, reduced need for perfectionism, and increased feelings of self-esteem. (32, 33)

32. Brainstorm methods for replacing perfectionistic schemas and behaviors with more healthy behaviors (e.g., accentuating positive qualities, providing each other with room for failure, and changing family schemas about making mistakes).

33. Ask the family member with the eating disorder to describe in some detail the specific positive feedback that is most desired and that will build self-esteem while he/she attempts to overcome the eating disorder; consider the use of strategies (e.g., focus on other activities that involve skills that do not rely on body image such as crafts) for improving self-esteem and body image affected by perfectionism.

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DIAGNOSTIC SUGGESTIONS

Axis I:	307.1	Anorexia Nervosa
	307.51	Bulimia Nervosa
	307.50	Eating Disorder NOS
	296.x	Major Depressive Disorder *[include specifier]*
	V61.10	Partner Relational Problem
	300.3	Obsessive-Compulsive Disorder
	_____	_____
	_____	_____

Axis II:	301.83	Borderline Personality Disorder
	301.6	Dependent Personality Disorder
	301.4	Obsessive-Compulsive Personality Disorder
	301.50	Histrionic Personality Disorder
	_____	_____
	_____	_____

EXTRAFAMILIAL SEXUAL ABUSE

BEHAVIORAL DEFINITIONS

1. A verbal demand to accede to sexual interaction is made to a family member by someone outside of the immediate and extended family (neighbor, coworker, stranger).
2. A physical threat or psychological coercion to fulfill sexual demands causes the victim to submit to ongoing abuse.
3. The abused family member is reluctant to share the trauma of the abuse with anyone, including other family members, for fear of rejection, retaliation, and so on.
4. The abused family member struggles with issues of guilt, shame, anger, resentment, and/or depression as a result of the abuse.
5. Family members are confused by the change in emotions and behaviors (agitation, avoidance, depression, withdrawal, etc.) of the abused family member and suspect that abuse may have occurred.
6. Family members experience a range of emotions, including rage, guilt, depression, and sorrow, in reaction to learning of the abuse.
7. The abused family member begins to act out sexually.
8. Family members refuse to accept that the abuse occurred, compounding the shame that the victim experiences.
9. Family members pressure the victim of abuse to report the abuse to the authorities, causing the victim to press charges and enter the due process of the court system, adding additional stress to the situation.
10. The abuse victim becomes pregnant as a result of the rape.
11. Family members pressure the victim to recount the details of the story before he/she is ready, thus adding to the trauma.

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LONG-TERM GOALS

1. Family members become educated about the trauma of sexual abuse and learn the effects of various types of sexual abuse (forcible rape, being exposed to pornography, continued victimization, etc.).
2. Family members learn how to comfort the victim and be supportive in helping the victim express feelings and to slowly deal with the effects of the abuse.[1]
3. Family members resolve their own reactions to the victim's abuse and support the victim.
4. Family members help the victim with the decision of whether to report the abuse to the authorities.[2]
5. Family members cope with the victim's acting-out behaviors that result from the abuse.
6. Family members develop improved ways to protect each other from future abuse.
7. Family members aid the abuse victim in making the best decision regarding whether to abort the pregnancy, relinquish the child for adoption, etc.
8. Family members learn how to help the victim through her/his fluctuating emotions.

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[1] Sexual abuse often occurs in combination with psychological abuse, and can be accompanied by physical abuse as well. Psychological abuse and physical abuse are more common when the sexual abuse is extrafamilial (neighbor, stranger in community, etc.). Sexual interaction or demands may be defined by any type of inappropriate intimate touch, including petting, frotteurism (rubbing against), or other forms of manual or oral contact. This definition can also include, but does not limit itself to, the perpetrator masturbating in the presence of a victim, exposing the victim to pornography, or performing other explicit sexual acts in the presence of the victim.

[2] We are not suggesting in any way that a therapist should engage in supporting the failure to report sexual abuse/violation, however, therapists should remain sensitive to helping the family come to the best decision, especially in those situations that may involve borderline violations (e.g., exposing an 18-year-old family member to pornography, etc.).

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Victim talks openly about the sustained abuse. (1, 2)	1. Facilitate being nonjudgmental, warm, accepting, and have good eye contact when the victim expresses facts and feelings associated with the abuse; help him/her to realize that he/she is not responsible for the abuser's actions.
	2. Use indirect methods to facilitate expression of the effects of the abuse (i.e., play therapy, artwork, psychodrama, questionnaires/ inventories such as the Modified Posttraumatic Symptom Scale [Resick, Falsetti, Resnick, and Kilpatrick] or the Sexual Assault Symptom Scale [Ruch, Gartell, Amedeo, and Coyne]).
2. Victim accepts a referral to a victim's abuse support group. (3)	3. Refer the abused family member to a victim's abuse group; solicit family support for this attendance.
3. Victim identifies a mode of expression of feelings that promotes relief and avoids victimization and self-recrimination. (4)	4. Facilitate different modes of emotional expression for the victim (e.g., journaling or artwork) and assess what comforts him/her and what promotes anxiety.
4. List the common psychological effects of a sexual trauma. (5, 6)	5. Introduce the family to some readings on sexual abuse and how it affects the victim (e.g., *Hush* by Bromley).

	6. Educate the family and the victim about the posttraumatic effects of sexual abuse (withdrawal, acting-out behaviors, etc.) and how the effects may vary from subtle to blatant.
5. List ways to support the victim's feelings toward the perpetrator. (7)	7. Discuss/brainstorm ways in which the family can support the victim's feelings toward the perpetrator (e.g., avoiding anything to do with the perpetrator or his/her family, desiring revenge, etc.).
6. Victim reports a reduction in fear of the perpetrator. (8, 9)	8. Address the issue of distortions that often occur on the part of the victim that lead to a fear of reporting the perpetrator to the authorities because it may hurt him/her and recanting his/her testimony.
	9. Help the family to deal with the victim's fear of retaliation by the perpetrator by reassuring the victim of safety and support.
7. Verbalize an understanding of the effects of the abuse, both on the victim as well as on the family. (10)	10. Educate the family members about both victims and perpetrators of sexual abuse: why it happens, how it starts, the role of nonoffending members, and so on; specifically focus on the effects on the victim (refer to *Repair for Kids* by McKinnon).
8. List supportive techniques for helping the victim overcome trauma symptoms. (11, 12)	11. Brainstorm about both individual (e.g., rewriting a new rendition of the abusive event) and family group techniques (e.g., providing physical comfort such as hugs) for dealing with symptoms in the victim as they appear.
	12. Caution the nonabused family members not to overanticipate symptoms in the victim to the point of seeing what is not there and/or inducing it.

9. Family members learn how to share their own emotional and behavioral reactions to the abuse. (13, 14, 15)	13. Redirect the focus onto the behaviors and emotions of other family members that have developed in reaction to the abuse experience. 14. Brainstorm and suggest various coping skills (e.g., cognitive restructuring of negative self-talk) for family members to deal with emotions such as anger, guilt, and despair (see *Cognitive Behavioral Therapy with Couples* and *Families: A Comprehensive Guide for Clinicians* by Dattilio). 15. Encourage the victim to become part of the healing process for the other family members as well (e.g., by expressing anger over his/her vulnerability).
10. Identify conflicts between family members that have developed since discovery of the abuse. (16)	16. Explore conflict that emerges among family members over the abuse (e.g., blaming of one another for not protecting the victim better; resentment by siblings that the victim is getting too much attention).
11. Report a reduction in family conflict. (17)	17. Use strategies (e.g., conflict resolution, behavioral contracts, or cognitive restructuring) to assist the family in reducing conflict among themselves (see *Families in Crisis* by Dattilio).
12. Victim of abuse reports a reduction in feelings of vulnerability, guilt, and shame with the support of family members. (18)	18. Help family members develop the best method of supporting the victim in dealing with his/her vulnerability (supportive listening, empathetic understanding, determination of comfort zones, etc.).
13. Family and victim verbalize acceptance of periods of anxiety, depression, despair, and anger that result from the abuse. (19)	19. Help the family to develop strategies for dealing with the victim's anxiety and depression, using relaxation methods and other cognitive-behavioral techniques.

14. Family members refrain from informally confronting the perpetrator of the abuse. (20)

15. Family members discuss and agree on the best way to proceed regarding reporting the perpetrator to legal authorities. (21, 22)

16. Make contact with the legal authorities to report the perpetrator. (23)

17. Family members agree to proceed in a manner that is sensitive to the feelings of the victim regarding the legal reporting of the abuse. (24, 25)

18. Each family member describes a specific role for himself/herself in dealing with the emotions and behaviors of the victim. (26)

20. Help the family to understand how dealing with the perpetrator in an appropriate, legal manner is often the best course of action rather than confronting the perpetrator themselves.

21. Process with the family their thoughts and feelings about reporting the perpetrator to legal authorities; arrive at a consensus decision about how to proceed, with the victim's feelings and comfort level being of paramount importance.

22. Refer the family to the victim's rights advocate and a support group that is usually associated with the local district attorney's office or police department.

23. Refer the family to the local authorities (police abuse unit, child protective agencies, district attorney's office, etc.) to report the sexual abuse perpetrator.

24. Help nonabused family members see their own emotions as secondary and become sensitive to the pace of the victim (doing too much too quickly can have a negative effect on the victim, testifying can be intimidating, etc.).

25. Allow for the ventilation of the nonabused family members' emotions and frustrations, particularly over not having the prosecution move faster.

26. Discuss how each of the nonabused family members can best aid the victim in dealing with the victim's behavioral and emotional outbursts from the abuse (e.g., the differences between a

	parent comforting the victim and a sibling comforting the victim, using humor as opposed to physical embracing). EB
EB 19. Family members verbalize adherence to a goal of healing from the pain of the abuse and describe how to move on in light of what has occurred. (27, 28)	27. Brainstorm methods for going forward and healing from the effects of the abuse; utilize such techniques as rituals and taking advantage of various community support programs. EB
	28. Reinforce the agreement between family members not to revisit the trauma too often once the healing has occurred, and also not to use the event to blame or as an excuse for other, nonrelated, behaviors in the future. EB
19. Identify family conflict or individual victim's factors that may be contributing to the victim's sexual acting out. (29, 30)	29. Attempt to help family members sift through the aspects of the victim's sexual acting out that may be due to preexisting individual or family issues (i.e., lack of attention, low self-esteem, need for additional comfort, anger toward men/women).
	30. Assess the specific aspects of the victim's sexual acting out that can be dealt with intrafamilially, as well as what needs to be addressed in individual or group therapy.
20. Family makes a decision about the option of relocation. (31)	31. If the situation is too intimidating to the victim, explore with the family the final option of relocating geographically; weigh the pros and cons of this option.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.81	Posttraumatic Stress Disorder
	309.x	Adjustment Disorder with *[include specifier]*
	300.4	Dysthymic Disorder
	312.9	Disruptive Behavior Disorder NOS
	313.81	Oppositional Defiant Disorder
	V61.21	Sexual Abuse of Child
	995.53	Sexual Abuse of Child (Victim)
	V61.20	Parent-Child Relational Problem
	307.42	Primary Insomnia
	307.44	Primary Hypersomnia
	300.6	Depersonalization Disorder
	300.15	Dissociative Disorder NOS
	296.2x	Major Depressive Disorder, Single Episode
	296.3x	Major Depressive Disorder, Recurrent
	_____	_____
	_____	_____
Axis II:	301.20	Schizoid Personality Disorder
	301.83	Borderline Personality Disorder
	301.9	Personality Disorder NOS
	_____	_____
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FAMILY ACTIVITY DISPUTES

BEHAVIORAL DEFINITIONS

1. Strong disagreements arise over family activities, causing a sense of disengagement between family members.
2. Younger children complain about not being permitted to do the same activities as their older siblings.
3. The family splinters into doing separate activities, causing feelings of disengagement and loss of cohesion among family members.
4. Family members become more invested in other families' activities in order to compensate for what is missing from their own family.
5. Disagreements occur over how money should be spent for family needs, wants, and pleasurable pursuits.

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LONG-TERM GOALS

1. Reduce conflict over leisure-time family activities.
2. Younger members of the family learn to accept their need to wait until a more appropriate age in order to enjoy certain activities.
3. Accept the need for sharing and patience in planning and implementing family activities.

4. Reduce family members' involvement in activities that are meant to compensate for what is missing within their own family and instead focus energy on fostering activities in their own family.
5. Eliminate tension and conflict between family members over the perceived violation of their own needs for recreation, stimulation, or learning.

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SHORT-TERM OBJECTIVES

1. Define disagreement with each other over family activities by using specific operational terms. (1, 2)

2. Demonstrate tolerance for listening to the likes and dislikes of other family members for various activities in a civil and respectful manner. (3, 4)

THERAPEUTIC INTERVENTIONS

1. Facilitate a session in which members describe their discontent about family activities.
2. Help family members clearly articulate how they feel (selfish, cheated, left out, lonely, resentful, etc.) about the family's activities.
3. Ascertain through interview and/or inventory what activities are pleasing and satisfying to each family member and identify where any overlap exists; utilize inventories to assess for activities that are enjoyed by each family member (e.g., the Family Inventory of Life Events and Changes in *Family Assessment Inventories for Research and Practice* by McCubbin and Thompson).
4. Assess whether certain family members lack tolerance for the preferences of other family members and where this stems from; suggest exercises that would help to build better tolerance

(e.g., the use of positive talk and weighing the value of having to put their own needs on hold).

3. Verbalize the basis for dislike of family activities. (5)

5. Try to determine whether the discontent with family activities is an all-or-nothing matter or there are only aspects of the activities that family members do not care for.

4. List the pros and cons as well as the impact of the activity. (6, 7)

6. Assign family members to share their opinions on the pros and cons of other family members' activities.

7. Allow family members to talk personally about the effect a particular activity had on them; help them to evaluate whether this effect is due to their own personality traits or to the dynamics of the activity or to both.

5. Engage in activities that are enjoyable to some individual family members, but not to all. (8, 9, 10)

8. Facilitate a discussion about maintaining an open mind and remaining flexible about activities suggested by other family members.

9. Ask family members to agree to try one of the other members' activity suggestions one time, recording their thoughts and feelings, and evaluate the outcome in the subsequent family visit.

10. Schedule an activity for all family members to attempt, using a list of each member's favorite activities; start with activities that involve a minimal amount of time.

6. Rate the degree of enjoyment for family social/recreational activities. (11)

11. Have each family member rate the degree of enjoyment of an activity on a scale from 0 to 10 (or use the Family Time and Routines Index by McCubbin and Thompson); allow for the expression of discontent with certain activities, but stipulate that family members must list positives along with negatives.

7. List activities that are enjoyed by all family members. (12)

8. Agree to participate in other family members' enjoyed activities because it is a means of sacrificing self-interest for the good of another. (13, 14, 15)

9. Schedule activities in combinations such that various things will appeal to different family members. (16, 17)

10. Identify any underlying negative feelings or personality traits that may be contributing to the lack of cooperation with each other's activities. (18, 19, 20, 21)

12. Use brainstorming and consult assessment results to develop a list of mutually enjoyable activities.

13. Encourage all family members to invest effort and cooperation into an activity that may not appeal to them initially.

14. Teach the concept of family members' sacrificing personal interest for the pleasure of another family member; this is a means of showing love, respect, and unity.

15. Ask family members to consider committing to sacrificing by displaying interest in an activity that they might not be pleased with and then weigh some of the potential rewards of such a sacrifice (giving a gift of self, making other family members happy, learning a new activity, etc.).

16. Solicit agreement that after engaging in one family member's enjoyable activity, the family will engage in another family member's enjoyable activity in order to balance the scales.

17. Discuss additional ways to increase the attractiveness of certain activities that family members may not care for (e.g., pair together two activities that are enjoyed by different members).

18. Brainstorm with family members about what factors might be underlying disputes about family activities (jealousy, insecurity, favoritism, etc.).

19. Determine whether there are other issues that are influencing the conflict over family activities (e.g., the need to avoid social contact or the need for power and control).

20. Develop ways in which to address underlying conflicts or to compensate for personality traits in alternative ways other than by disagreeing over activities.
21. Assess the need to refer family members for individual counseling due to more ingrained issues (e.g., self-centeredness, depression, narcissism, etc.).
22. Propose the idea of using a lottery or some type of random drawing to rotate activities.
23. Discuss the need for mutual courtesy and that activities should involve some tolerance for give-and-take.
24. Prepare the family for the idea that not everyone will always be pleased, that they need to inoculate themselves against disagreement, etc.

11. Agree to seek fairness and balance in scheduling activities that are more enjoyable to some members than to others. (22, 23, 24)

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
	305.00	Alcohol Abuse
	303.90	Alcohol Dependence
	300.4	Dysthymic Disorder
	300.02	Generalized Anxiety Disorder
	296.x	Major Depressive Disorder *[include specifier]*
	V61.10	Partner Relational Problem
	V61.20	Parent-Child Relational Problem
	_____	_____
	_____	_____
Axis II:	301.82	Avoidant Personality Disorder
	301.6	Dependent Personality Disorder
	301.81	Narcissistic Personality Disorder
	_____	_____
	_____	_____

FAMILY BUSINESS CONFLICTS

BEHAVIORAL DEFINITIONS

1 The children and/or spouse are angry and jealous because of the time and energy consumed by the family business.
2. The children and/or spouse are angry and resentful about having to dedicate their own time to the family business.
3. Conflict arises between two or more family members vying for control of the family business.
4. The parents continue to interfere with the operation of the family business after handing over the reins to the children.
5. Conflict arises between the spouses of siblings who are involved with the family business.
6. Conflict arises over a parent's new spouse's role in the family business.
7. Resentment surfaces over variations within the family in power, compensation, or privileges associated with the business.
8. Family members employed in the family business feel anger and resentment toward family members who derive financial remuneration from the business but are not employed in it.
9. Some family members fail to consult with other family members about important business decisions.
10. Hidden anger and resentments are harbored by certain family members over business issues, which serves to erode the family relationships.
11. Family members engage in blaming each other for the lack of financial success of the family business.
12. Schisms in the family over business issues lead to the exclusion of certain members from holiday celebrations and special events.

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LONG-TERM GOALS

1. Reduce or eliminate the amount of anger and jealousy regarding the amount of time that the family business consumes from the working family members.
2. Reduce, eliminate, or restructure the amount of time and energy that is consumed by the family business.
3. Achieve agreement regarding who will run the family business or how the level of leadership might permit the sharing of power and responsibilities.
4. Achieve some guidelines for the boundaries, responsibilities, compensation, decision-making, and roles of all family members in the business.
5. Settle all issues over the roles and ownership that non-family-of-origin members will have in the family business.
6. Reduce feelings of anger and resentment associated with the business to eliminate the erosion of family relations.

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SHORT-TERM OBJECTIVES

1. Verbalize any anger, jealousy, or resentment about the family business. (1)
2. Identify how the expression of anger or resentment has affected the dynamics of the family. (2)

THERAPEUTIC INTERVENTIONS

1. Explore family members' thoughts and feelings generated by the issue of the family business.
2. Poll each family member about how he/she has expressed feelings and explore the conflicts that have

	resulted from expression and nonexpression of feelings.
3. Rank the goals and objectives for the company and compare this list with the original charter that was designed. (3)	3. Facilitate the construction of a hierarchy of goals and objectives for the family business and stipulate how they will be used to achieve the projections set forth for the business each year.
4. Vote on who can best direct the business to achieve the goals identified. (4)	4. Assist family members in ranking the skills of each family member and his/her suitability for directing the company; have family members vote on who should be in control.
5. Process emotions related to transitions within the family business. (5)	5. Explore how some parents or older siblings may have difficulty letting go of the reins emotionally, even though they have done so formally; use role-playing, empty-chair technique, and cognitive restructuring techniques to facilitate the expression of struggling with a sense of the loss of power or control, lessened self-esteem, and/or a lack of planning for a post-leadership position.
6. Retired or retiring members verbalize the emotional struggle with relinquishing control of the business. (6)	6. Secure some understanding from family members of the role of former leaders of the family business and develop specific rules of disengagement for them to follow.
7. Verbalize agreement on the role of the spouses of family members during their tenure as employees of the family business. (7, 8)	7. Brainstorm about the way spouses of family members should be treated regarding power in the family business; facilitate an agreement about the role of non-family-of-origin members.
	8. Assist family members in designing a formal mechanism for working through the conflict that exists over the role of spouses of family members within the business.

8. Identify relationship and role boundaries in the family business versus boundaries for non-business-related activities. (9, 10)

9. Explore with family members resentments regarding boundary issues in the family of origin; facilitate the expression of emotions over restrictions imposed by boundaries.

10. Assist family members in developing a set of rules that govern interaction within the business versus non-business-related family interaction and the avoidance of co-mingling the two.

9. Family members agree on how much and when non-working family-of-origin members will receive financial benefit from the family business. (11, 12)

11. Solicit agreement with the concept that family-of-origin members are all equally eligible for some financial benefit from the family business, allowing for a differentiation between contributing and noncontributing members.

12. Recommend utilizing a skilled family business consultant to help family members with issues of fairness, succession, buy-sell agreements, and so on; recommend *Family Wars* by Gordon and Nicholson.

10. Verbalize a feeling of resolution and understanding regarding all resentment and anger associated with family business issues. (13)

13. After agreements have been reached and a little time has passed, hold a family session to poll each family member as to whether a resolution of feelings has been achieved; process any remaining issues.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
	V61.10	Partner Relational Problem
	V61.20	Parent-Child Relational Problem
	_____	_____
	_____	_____
Axis II:	301.0	Paranoid Personality Disorder
	301.81	Narcissistic Personality Disorder
	301.9	Personality Disorder NOS
	_____	_____
	_____	_____

FAMILY MEMBER SEPARATION

BEHAVIORAL DEFINITIONS

1. Family members are forced to temporarily separate from one another due to employment obligations, military duty, incarceration, illness, or other involuntary situations.
2. Feelings arise of disengagement, insecurity, and difficulty in coping with the separation.
3. Conflict and turmoil ensue due to the redistribution of the balance of power in the family system.
4. Children regress emotionally and behaviorally due to the separation.
5. The family experiences difficulty in readjusting to the return of the absent family member(s), especially after a significant period of adjustment to the absence.
6. Conflict arises between those family members who react with relief or indifference versus those who react with grief over the separation.

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LONG-TERM GOALS

1. Family members accept the fact that loss may occur at any time in many different ways and prepare themselves for how to deal with the situation should it arise.
2. Develop skills for working together to cope with the interim time of absence.
3. Reorder the balance of power between remaining family members in order to compensate for the absence of the other family member(s).
4. Children learn improved ways to cope with the absence of a family member and locate viable nurturing substitutes until the absent family member returns.
5. Welcome the absent family member(s) back into the home and make a positive transition to the change.

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SHORT-TERM OBJECTIVES

1. Departing family member describes feelings about the absence and how it may affect the family. (1)
2. Departing family member verbalizes mechanisms that he/she will use to cope with the separation. (2)
3. Agree on ways to communicate with each other during the absence. (3)
4. Identify how the absence will affect or has affected each family member. (4)

THERAPEUTIC INTERVENTIONS

1. Bring family member who will be leaving into a predeparture family session and gather his/her perceptions of how separation will affect the family as a whole.
2. The family member who is departing will talk about ways in which he/she plans to cope with the separation until his/her return.
3. Brainstorm ways in which family members can stay in touch with each other (e.g., video, e-mail, etc.).
4. Explore how the loss of contact with a family member will impact or has impacted each family member.

5. Children and parents verbalize coping skills for dealing with the absence of a parent. (5, 6, 7)	5. Determine whether the absence is likely to be short-term, long-term, or permanent and, depending on the length of the loss, introduce various coping skills (e.g., finding a surrogate parent through a relative or friend, setting up frequent telephone calls or web-cam chats, etc.) for the separation period.
	6. Open a line of discussion about how each family member is attempting to deal with the loss.
	7. Discuss how and why the various internal coping skills differ among family members.
6. Identify conflicts that arise in light of the absent family member's departure. (8)	8. Assist family members in identifying conflicts over the absence by tracing when they surfaced and relate their development to the absent family member.
7. Report a resolution of conflicts that have resulted from the family member's absence. (9)	9. Help family members work through their issues of conflict resulting from the family member's absence and learn to respect each other's perceptions and viewpoints; aim for some form of compromise regarding the conflicts that are being produced.
8. Identify changes in roles, power, and alliances that have resulted from the family member's absence. (10)	10. Assist the family in identifying changes in specific roles, balance of power, alliances, and caretakers that have emerged during the absence.
9. Agree to a change in roles and responsibilities within the family structure. (11, 12, 13)	11. Teach that the redistribution of roles is a necessary mechanism for adjustment to the new situation (see *101 Interventions in Family Therapy* by Nelson and Trepper).
	12. Introduce techniques (e.g., cognitive restructuring, weighing the

alternatives, and challenging the evidence) that reinforce alteration in roles and expectations and restructuring of perception (see *Cognitive-Behavioral Therapy with Couples and Families: A Comprehensive Guide for Clinicians* by Dattilio). 

13. Teach family members how to support each other in the use of coping skills and in the redistribution of the roles in the household. 

10. Acknowledge a child's regressive behaviors and how they pertain to the way the child is coping with the situation. (14, 15)

14. Educate the family about how regressive behaviors in children are common during periods of stress, crisis, or loss (see *Helping Children Cope with Change and Loss* by Wells).

15. Instruct family members on how to avoid berating children for regressive behaviors by using methods of comfort, nurturance, and role-modeling of desirable, more productive behaviors.

11. Grieving child utilizes memory-preserving techniques to cope with the loss of the absent family member. (16)

16. Encourage children to use imaging techniques or to periodically view videos or photos of the absent family member; have the children keep in their possession different mementos or personal items belonging to the absent member.

12. Grieving child increases activity level with the family generally and with the remaining parent to strengthen the dependency bond. (17, 18)

17. Support the grieving children by developing activities (e.g., reading books together, playing together, going for a walk or to a movie together, watching children's video together) that strengthen the bond with the remaining parent or family members as a means of coping with the absence.

18. Review activities (e.g., self-constructed board games, sculptural

metaphors) that promote family cohesiveness and engagement (see *101 More Interventions in Family Therapy* by Nelson and Trepper).

13. Acknowledge the conflict that develops as a result of some family members experiencing relief that the absent family member has departed. (19)

14. Verbalize ways to deal with the return of the absent family member and adjust to the person's reintroduction into the family. (20, 21)

19. Investigate with the entire family why certain members have experienced relief as a result of the other family member's absence, exploring possible issues of jealousy, physical/sexual abuse, and so on.

20. Explore the issue of anger/resentment toward the absent family member for returning to the family unit and review constructive methods for venting this anger/resentment (e.g., assign readings such as *The Dance of Anger* by Lerner; *When Anger Hurts* by McKay, Rogers, and McKay; or *The Anger and Aggression Workbook* by Liptak, Leutenberg, and Sippola).

21. Discuss the effect that the reintroduction of the absent member will have on the changed family.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
	309.21	Separation Anxiety Disorder
	300.4	Dysthymic Disorder
	300.02	Generalized Anxiety Disorder
	312.9	Disruptive Behavior Disorder NOS
	313.81	Oppositional Defiant Disorder
	787.6	Encopresis
	307.6	Enuresis
	313.23	Selective Mutism
	_____	_____
	_____	_____
Axis II:	301.6	Dependent Personality Disorder
	301.82	Avoidant Personality Disorder
	_____	_____
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FAMILY-OF-ORIGIN INTERFERENCE

BEHAVIORAL DEFINITIONS

1. The spouse's parents express unsolicited opinions and judgments about behavior or decisions of the couple in an apparent attempt to control the spouse.
2. The grandparents attempt to impose their beliefs about how the parents should raise the grandchildren.
3. The parents' siblings interfere with issues regarding raising the children.
4. The couple argues over the perception that one spouse's family of origin is overstepping their boundaries.
5. The children begin to act out emotionally/behaviorally as a result of extended family interference.
6. Dissension occurs within the family of origin due to a confrontation over extended family interference (e.g., how much time is spent at a family function, accusations of spending more time with one side of the family than another, etc.).

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LONG-TERM GOALS

1. The parents' family-of-origin members accept boundaries and terminate the practice of directly imposing their beliefs and values onto their children's immediate family.
2. The parents make clear to all members of their families of origin that they have a specific set of rules and regulations by which they govern their children and wish no outside interference.
3. Marital conflict regarding a spouse's family-of-origin interference with family issues is reduced.
4. Children learn alternative ways of expressing the tension that builds in the family due to the parents' family-of-origin interference.
5. Family-of-origin members understand that their interference can be a very destructive force when not invited or welcomed and, therefore, they refrain from offering opinions, judgments, or directives.

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SHORT-TERM OBJECTIVES

1. Each family member outlines the family-of-origin interference problem. (1)
2. Each family member expresses feelings that have been generated by the interference issue. (2, 3)

THERAPEUTIC INTERVENTIONS

1. Explore issues related to extended family interference, getting the perspective of each family member.
2. Facilitate family members' expression of feelings to each other to promote understanding and empathy.
3. Utilize techniques such as thought-stopping, cognitive restructuring, and anger management to reduce the level of tension between family members over the issue of extended family interference in their lives.

3. Parents cooperate with training in assertiveness and problem-solving. (4, 5)	4. Educate parents about how to deal effectively with interfering family-of-origin members through training in assertiveness, communication, and problem-solving strategies; assign reading material on extended family relations (e.g., *Toxic Parents* by Forward).
	5. Use role-playing, modeling, and behavior rehearsal to teach parents how to approach difficult family-of-origin members and set boundaries on their interference.
4. Parents express support for each other in dealing with the interference issue. (6)	6. Reinforce the parents' need to unite and be supportive of each other in maintaining a stance with their respective family-of-origin members.
5. Parents confront interfering members of the family of origin. (7, 8)	7. Assign the parents as a unit to set boundaries on interfering family members.
	8. If the family-of-origin members will agree to come into a specially-held family session with the therapist, then address the interference directly (see *Family-of-Origin Therapy: An Intergenerational Approach* by Framo).
6. Parents tell family-of-origin members how they can make suggestions to them in an appropriate fashion. (9)	9. Assist parents in developing acceptable ways that extended family members can offer suggestions to them when invited.
7. Each parent curtails his/her anger at the spouse and rechannels any resentment maintained for the spouse's family-of-origin members. (3, 10)	3. Utilize techniques such as thought-stopping, cognitive restructuring, and anger management to reduce the level of tension between family members over the issue of extended family interference in their lives.
	10. Share with spouses techniques (e.g., detriangulation, "I" statements, metaphorical objects)

for not holding each other responsible for the other's family-of-origin interference.

8. Children verbalize an understanding that parents, not extended family members, are in control. (11)

11. Explore any confusion that has occurred in the children, reaffirming the parents' sense of power and control in the situation.

9. Parents identify personal issues that promote family-of-origin interference. (12)

12. Address with each parent any residual individual issues that may be perpetuating family interference (e.g., unresolved guilt; a history of having always been controlled by, or dependent on, his/her family of origin).

10. Parents tacitly suggest to interfering members of the family of origin that they need to address their own issues that cause them to interfere. (13, 14)

13. Support the parents in being assertive enough to confront their respective family-of-origin members about getting counseling for themselves; use role-playing, letter-writing techniques, and so on to help them communicate with the family-of-origin members.

14. Offer to the interfering members of the family of origin the option of family-of-origin sessions or individual/family therapy elsewhere.

11. Children assert themselves with those who interfere by directing them to their parents. (15)

15. Utilize assertiveness training, role-playing, and modeling to teach children how to direct interfering people to their parents.

12. Increase the frequency of enjoyable family unit activities. (16)

16. Encourage family communication and group activities to increase cohesiveness, tighten the family bond, and close gaps that may be facilitating external interference.

13. Children reduce the acting-out behaviors that result from external interference by extended family. (17)

17. Confront children's acting-out behavior, assisting parents in setting limits and interpreting the children's behavior as a reflection of the confusion generated by outside interference in family dynamics.

14. Parents verbalize a sense of balance and achieve a resolution of their marital conflict. (18, 19)

18. Explore why and how the interference has had such a significant effect on the marital relationship and suggest methods for rebalancing the relationship; address issues of loyalty to parents and utilize problem-solving techniques.

19. Refer parents to couples therapy, particularly if the marital problems are more extensive.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.4	Adjustment Disorder with *[include specifier]*
	V61.10	Partner Relational Problem
	_____	_____
	_____	_____
Axis II:	301.83	Borderline Personality Disorder
	301.50	Histrionic Personality Disorder
	301.6	Dependent Personality Disorder
	301.9	Personality Disorder NOS
	_____	_____
	_____	_____

FINANCIAL CHANGES

BEHAVIORAL DEFINITIONS

1. A drastic decrease in family income occurs through either one or both parents' loss of employment or some other type of financial crisis (e.g., major illness, bills).
2. Family members feel the pinch of less money and argue over the amount of money spent on miscellaneous items and extras.
3. Children and/or spouse are critical of the breadwinning parent for the financial change or crisis (e.g., as being the result of alcohol or substance abuse).
4. Family arguments occur over the amount of money to be saved and how much is spent.
5. Other members exert pressure on certain family members to always shop for the lowest possible prices.
6. Family arguments arise over the children's desire to earn income for themselves without having to account to their parents for the expenditure of their own money.
7. The family is unable to pay bills for fixed expenses and must relocate, cancel commitments, face bill collectors, cancel phone service, and so on.
8. Anger and tension build over financial stress, leading to verbal or physical abuse.

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LONG-TERM GOALS

1. Develop a structured, detailed financial plan for budgeting the income that does exist.
2. Reduce the arguments over the decrease in financial resources and improve coping skills for a reduced standard of living.
3. Develop open and fair communication of all feelings regarding the perceived reasons for the financial change.
4. Focus energy on solving the financial problem rather than blaming each other.
5. Develop a plan for income supplementation and reassignment of family/home duties.
6. Terminate parental maladaptive behaviors (e.g., substance abuse, gambling, compulsive shopping) that contribute to financial crisis.
7. Learn anger management skills and decatastrophization skills in order to cope with stress without resorting to verbal or physical abuse.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Verbalize anger, frustration, and resentment pertaining to financial stress. (1, 2)	1. Facilitate an atmosphere in which family members can freely express emotions about the financial situation. 2. Focus specifically on eliciting feelings and beliefs about the restrictions caused by the financial situation.
2. Identify how and why arguments develop over finances. (3)	3. Explore the nature of anger expression over financial strictures, emphasizing how conflicts and arguments only exacerbate the situation.

3. List alternatives to the verbal expression of frustration within the family. (4)

4. Brainstorm alternatives that can be used to ventilate frustration (e.g., express aggression via sports, develop an exercise routine, keep a feelings journal).

4. Family members agree to work on improving communication skills and implementing alternative ways to express themselves more productively. (5)

5. Train family members in communication skills via structured techniques (e.g., see Soft Startup in *The Seven Principles for Making Marriage Work* by Gottman and Silver); review their attempts to implement these skills in daily life; reinforce success and redirect for failure.

5. Focus energy on proactively solving the problem rather than placing blame or fighting. (6)

6. Encourage clients to separate their feelings of frustration with the financial situation from the people in the situation; focus energy on solving the problem rather than fighting.

6. Acknowledge and seek treatment for any compulsive or addictive behaviors that interfere with family income. (7)

7. Help the family to confront individual family members' issues that may be contributing or causing the financial problems (e.g., substance abuse, gambling, compulsive shopping); refer them for treatment.

7. Identify the differences in spending priorities that exist between family members. (8)

8. Assist family members in identifying their priorities regarding financial expenditures and discuss how they arrived at their values.

8. List the future income, saving, and spending expectations. (9)

9. Ask the family members to share their individual (or joint) expectations regarding future income, expenses, and savings; discuss how realistic their expectations are.

9. Set financial goals that are plausible and make realistic budgetary decisions jointly without undue reactions to family pressure. (10)

10. Brainstorm various avenues for financial planning that will involve family cooperation and a reduction in conflict (e.g., consultations with financial advisors, use of computer

software for budgeting income and recording expenditures, consulting with a reputable debt reduction agency); ask the parents to develop a budget for actual income and expenses (or assign "Plan a Budget" in the *Adult Psychotherapy Homework Planner,* 2nd ed. by Jongsma).

10. Practice showing patience with each other when expressing various financial plans and expense-saving strategies. (11, 12)

11. Encourage the use of communication skills and anger/frustration management skills (e.g., "I" messages, reflective listening, time-out) to cope with other family members' ideas that violate expectations.

12. Refer to individual and/or group anger management counseling.

11. Agree on the steps that will be taken to cope with the financial problem. (13, 14)

13. Explore the need for consolidating loans, declaring bankruptcy, applying for welfare, and so on; if financial planning is deemed necessary, refer the family to a professional financial planner (see *Consumer Reports,* January 1998, for a review of financial planning services, or *Family Economics Review,* published by the U.S. Department of Agriculture).

14. Assist family members in identifying the specific coping skills needed because of the change in their financial situation (e.g., living with less, spending more wisely, borrowing items, or bartering).

12. Implement a mutual agreement on how decisions are made regarding allocation of money in the family. (15)

15. Reinforce changes in money management that reflect compromise, responsibility, planning, perseverance, and respectful cooperation.

13. Acknowledge that a mental illness or personality disorder is

16. Assess whether a mental illness or personality disorder (e.g., bipolar

interfering with financial disposition within the family. (16)

14. Verbalize agreement for a plan for spending income earned by the children. (17)
15. Identify alternative ways that income can be increased. (18)

disorder or narcissistic personality) is interfering with responsible financial planning; refer for individual treatment as necessary.

17. Develop a plan for income earned by the children and how it will be spent.
18. Assist the family in identifying how other sources of income can be developed.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
	303.90	Alcohol Dependence
	305.00	Alcohol Abuse
	296.0x	Bipolar I Disorder *[include specifier]*
	V62.2	Occupational Problem
	296.2x	Major Depressive Disorder, Single Episode
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.4	Obsessive-Compulsive Personality Disorder
	301.81	Narcissistic Personality Disorder
	_____	_____
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GEOGRAPHIC RELOCATION

BEHAVIORAL DEFINITIONS

1. One or both parents are forced to relocate due to transfer to another geographic area to maintain employment.
2. One or both parents want to relocate due to climate, family connections, job opportunity, or a perceived better way of life.
3. Spouse and/or family members do not want to relocate because they are comfortable in the present home and environment.
4. Dissension and opposition arise over the notion of the family relocating.
5. Spouse and/or children protest with demands that the breadwinner find another job locally instead of agreeing to relocate.
6. Children threaten noncompliance and acting-out behaviors (e.g., runaway behaviors, assault threats, false allegations of abuse, demands to live with a friend, threats of not doing well academically) in reaction to relocation.
7. Several months after relocation, various family members feel that they cannot adjust to the new location.
8. Feelings of grief, anger, and depression arise related to the issue of relocation.

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LONG-TERM GOALS

1. Resolve negative feelings associated with relocation and accept without hostility the necessity for the change.
2. All family members treat each other with respect and fairness during the course of the conflict and its resolution.
3. Increase and improve the communication between family members and the level of empathy for each other's position.
4. Family members stop hurtful verbal attacks on, and behaviors toward, each other, as well as behavioral attempts to sway the decision (e.g., running away).
5. Accept that the probability of relocation is a family problem that must be worked out as a unit rather than an individual problem.
6. Develop coping skills for better adjustment to the relocation.

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SHORT-TERM OBJECTIVES

1. Family members describe the specific conflict regarding relocation. (1, 2)

2. Discover any hidden motivations behind the desire to relocate. (3)

THERAPEUTIC INTERVENTIONS

1. Explore each family member's thoughts and feelings regarding the possible relocation.

2. Promote discussion by the spouse or family members who are reluctant to relocate. If this is a marital issue, refer to couples therapy where they can consider financial realities as well as power and control issues.

3. Explore the possibility that the move is to escape a problem that would be best dealt with without moving (e.g., feeling bored or restless rather than a true financial necessity or job relocation).

3. Family members agree that they must deal with this conflict openly and as a unit. (4)

4. Address the interfamilial dynamics regarding conflict in general and focus on how the family normally deals with disagreements; attempt to prevent the family from dividing, forming schisms and subgroup alliances. Deal with the conflict as a unit, utilizing a systemic approach.

4. Make an extensive list of the pros and cons of moving. (5)

5. Assign the family members to brainstorm about possible advantages and disadvantages of moving without focusing on the emotional impact of each.

5. Identify alternatives to solving the relocation conflict. (6)

6. Ask the family to identify three alternative resolutions to the relocation conflict and to strongly consider the possibility of implementing aspects of all three alternatives.

6. Identify and replace the spouse's or children's threatening or noncompliant behaviors. (7)

7. Address the noncompliant, rebellious behaviors of each family member as they emerge in response to being mandated to relocate; discuss the impact of these specific behaviors on other family members and effective ways in which they can be modified (see the chapters on Adolescent-Parent Conflicts or Child-Parent Conflicts in this *Planner*).

7. Parents express understanding for the feelings behind the children's acting out, but implement firm limits on such behavior. (8, 9, 10, 11)

8. Assist parents in responding to children's acting out (e.g., threats or actual running away from home, criminal behavior, etc.) by setting limits (e.g., response cost, grounding, etc.) and teach parents how to validate their children's feelings as a means of helping the child feel heard and thus reducing the child's acting out.

9. In a separate conjoint session with the parents, suggest appropriate

	behavioral responses to each child's acting-out behavior (e.g., loss of privileges, selected chores, or community service).
	10. Discuss disciplinary measures with the parents and alternative recourse (e.g., removal of privileges or temporary removal from the home) for not tolerating acting out behavior by children (e.g., runaway behavior or threats, criminal behavior).
	11. Facilitate the family in separating the children's anger and involvement in criminal behavior; utilize techniques such as family sculpting and reverse role-play to address feelings and behavior separately and how they affect the overall family.
8. Children express feelings of powerlessness regarding the decision to move. (12)	12. Facilitate the children's expressions of feelings of powerlessness and/or frustration with parents or other family members over the issue of relocation; teach parents reflective listening skills.
9. Parents engage in activities that strengthen the bond with their children in order to reduce acting out. (13)	13. Help the parents strengthen the relationship with their children (e.g., encourage parent/child dates, family game nights, etc.) as a means of increasing connection and reducing acting out behaviors.
10. Children express anger verbally and respectfully, without threat of or actual violence toward parents. (14, 15)	14. Address the children's anger and teach controlled expression of this anger to prevent violence or threats toward any family member.
	15. Offer the children alternatives (sports, music, use of a punching bag, etc.) for expressing their anger and resentment/ frustration.

11. Children verbalize an accusation of physical/sexual abuse against one or both parents. (16, 17, 18)	16. Explore the issue of children's accusations of physical or sexual abuse in both family therapy and with parents alone; address issues of power and control/resentment. 17. Refer the family to protective services or another social service agency, working in concert with them to resolve the accusations of physical or sexual abuse and to determine the veracity of the children's allegations versus a means to get themselves removed from the home. 18. Consider the temporary removal of the children if the possibility exists that physical or sexual abuse has occurred.
12. Identify losses related to relocation and express grief feelings. (19, 20)	19. Assist family members in identifying losses associated with relocation. 20. Facilitate the expression of all family members' grief feelings to promote mutual understanding and empathy.
13. Identify ways of developing replacements for the losses once the move is complete. (21)	21. Validate real losses and challenge family members to focus on utilizing new horizons to expand their ideas, friendships, and experiences.
14. Children propose a viable plan for residing with a friend or an extended family member as an alternative to relocating with the family of origin. (22)	22. Address the issue of children residing with a friend or an extended family member; discuss the pros and cons of such an alternative and address how such a decision would affect the general dynamics of the family.
15. Parents affirm their role as authority figures who must make decisions in the best interest of the family as a unit. (23)	23. Reinforce the structure of the family with parents having the role of executives who have ultimate authority to make the final decision about what the family will do.

16. The family uses rituals or ceremonies to commemorate their relocation. (24)

24. Have the family devise a ritual or ceremony (e.g., compiling a scrapbook of memories of the old home, taking certain mementos from the old home to the new home, etc.) to commemorate the loss of their old home and the future in their new home.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
	313.81	Oppositional Defiant Disorder
	312.9	Disruptive Behavior Disorder NOS
	V61.10	Partner Relational Problem
	V61.20	Parent-Child Relational Problem
	_____	_____
	_____	_____
Axis II:	301.9	Personality Disorder NOS
	_____	_____
	_____	_____

INCEST SURVIVOR

BEHAVIORAL DEFINITIONS

1. Verbal demands for sexual interactions are made to a family member by another immediate or extended family member (i.e., parent, sibling, relative).
2. Refusal of verbal demands for sexual interaction is met by psychological or physical threat to fulfill sexual demands, causing the victim to submit to ongoing abuse and secrecy.
3. The sexually abused family member is reluctant to share the trauma of the abuse with anyone for fear of blame, rejection, retaliation, and so on.
4. The sexually abused family member struggles with guilt, shame, anger, resentment, depression, and isolation as a result of the abuse.
5. Family members are confused by the change in emotions and behavior (agitation, avoidance, depression, withdrawal, etc.) of the sexually abused family member and suspect that abuse may be occurring or has occurred in the past.
6. Family members learn of the sexual abuse sustained by the victim and experience a range of emotions, including rage, guilt, depression, denial, and sorrow.
7. The sexually abused family member begins to act out sexually (e.g., abusing family members or individuals outside of the immediate family), causing problems in the family.
8. Family members pressure the victim of sexual abuse not to report the abuse to the authorities.
9. Family members take responsibility for reporting the sexual abuse to authorities, thus causing the abused victim to feel guilty.
10. Family members deny that the abuse is occurring once the victim discloses the abuse, thus leading the victim to feel shameful.

11. The sexual abuse victim is temporarily removed from the home by court-appointed authorities, causing stress and strain to the family and potentially communicating to the victim that the abuse was his or her fault.
12. The sexual abuse victim threatens to expose the abuse to relatives, neighbors, friends, or others.

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LONG-TERM GOALS

1. Family members become educated about the trauma of sexual abuse and learn the effects of various types of sexual abuse (e.g., forcible rape versus being exposed to pornography).
2. Family members learn how to comfort the sexual abuse victim and help the victim to express himself/herself and to slowly deal with the effects of the abuse.
3. Family members work through their guilt and shame, as well as shock and anger, toward the perpetrator.
4. The family helps the sexual abuse victim with the decision about how to report the sexual assault to the authorities and/or press charges and helps the victim deal with the negative side effects of this decision.
5. The family acknowledges the abuse and takes steps to ensure the safety of the victim and the legal prosecution of the offender.
6. The family learns to cope with the sexually abused victim's own expression of acting-out behaviors as a result of the abuse.
7. The family develops ways to protect each other from future sexual abuse.
8. The family bands together to insist that the perpetrator stop the abusive behavior immediately, get therapeutic help, and/or move out.[1]

[1] In some instances, state laws may require perpetrators of abuse to be physically separated from the victims despite ongoing intervention or treatment.

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SHORT-TERM OBJECTIVES

1. Sexual abuse victim talks openly about the sustained abuse. (1, 2, 3, 4)

2. Sexual abuse victim attends a support group. (5)

THERAPEUTIC INTERVENTIONS

1. Actively build the level of trust with the sexual abuse victim in individual sessions through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help increase his/her ability to identify and express feelings.
2. Explore, encourage, and support the sexually abused victim in verbally expressing and clarifying his/her feelings associated with the abuse.
3. Encourage family members to offer verbal and, possibly, physical support to the sexually abused family member.
4. Use indirect methods of describing the abuse and its effects (e.g., play therapy, artwork, psychodrama, or questionnaires/inventories such as the Modified Posttraumatic Symptom Scale [Resick, Falsetti, Resnick, and Kilpatrick] or the Sexual Assault Symptom Scale [Ruch, Gartell, Amedeo, and Coyne]).
5. Refer the sexual abuse victim to a community-based support group focused on sexual abuse.

3. Family members verbalize an increased understanding of the dynamics of sexual abuse and its effects. (6, 7)

4. Family members protect the victim from the perpetrator and from any ongoing abuse. (8)

5. Sexual abuse victim affirms being comfortable with reporting the abuse. (9, 10)

6. Family members list ways to respond supportively to the victim as symptoms of abuse evolve. (11, 12, 13)

6. Educate family members about incest – why incest happens, how it starts, how it affects the victim, how to heal from it, and so forth; recommend that the family read books on sexual abuse (e.g., *Repair for Kids* by McKinnon or *Hush* by Bromley).

7. Educate the family and the victim about the posttraumatic effects of incest (e.g., flashbacks, external cues, hypervigilance) and how these effects may vary in their display (see *Counseling Survivors of Childhood Sexual Abuse* by Draucker and Martsolf).

8. Discuss or brainstorm ways in which the family can protect the victim from being alone with or having contact with the perpetrator.

9. Assist the victim in resolving his/her fear of reporting the abuse due to fear of the perpetrator being criminally prosecuted or nobody believing the victim's accusations; address the tendency for victims to retract their statements due to familial, social, or financial pressures.

10. Help the family deal with the victim's fear of retaliation by the perpetrator for reporting the abuse and the victim's inclination toward retraction of charges.

11. Brainstorm about both individual and family group methods for responding to symptoms in the victim (e.g., isolation, depression, agitation, shame, anger, sexually provocative behavior, etc.) as they appear.

12. Caution the nonabused family members not to overanticipate symptoms in the victim to the point of seeing what is not there and/or inducing it.
13. Assist family members in identifying the best method of supporting the victim in dealing with his/her vulnerability (e.g., supportive listening, empathetic understanding, or determining comfort zones).

7. Family members verbalize their own emotional and behavioral reactions to the abuse. (14, 15, 16)

14. Explore how the incidence of abuse has emotionally affected the nonabused family members and how they have been expressing these feelings about it.
15. Implement various coping skills (e.g., venting, psychodrama, reverse role-play) for dealing with emotions such as anger, guilt, and despair.
16. Encourage the victim to become part of the healing process for the other family members by showing support for their pain and anger.

8. Verbalize the conflict that has developed between family members in reaction to the abuse. (17, 18)

17. Teach assertive communication and active listening techniques to address conflict that emerges within the family over the abuse (e.g., blaming one another for not protecting the victim, resentment by siblings that the victim is getting too much attention).
18. Utilize strategies such as conflict resolution, behavioral contracts, and cognitive restructuring to help family members resolve the issues that separate them.

9. Utilize relaxation and positive self-talk to decrease anxiety. (19, 20, 21)

19. Teach the victim and the family deep muscle relaxation techniques; discuss situations where relaxation could be applied.

20. Assist all family members in identifying dysfunctional, negative automatic thoughts that generate anxiety; teach them how thoughts trigger emotions.

21. Teach all family members to replace negative self-talk (e.g., "I'm dirty and bad") with positive, realistic messages that promote confidence and calm (e.g., "I'm a good person who had something bad happen to me").

10. Nonabused family members learn how to support the victim's healing process. (22)

22. Help nonabused family members see past their own emotions and develop a feel for the pace of the victim's healing process (e.g., don't push too much too quickly, fear of testifying, etc.).

11. Nonabused family members express their anger and frustration at a slower pace of processing the abuse. (23)

23. Allow for the ventilation of the nonabused family members' emotions and frustrations, particularly over the seemingly slow pace of the prosecution; facilitate expression of sensitivity to the victim's feelings.

12. The victim seeks individual or group counseling as necessary to process the emotions surrounding the trauma. (24)

24. Assess the victim as to the need for individual or group therapy to process the trauma; make a referral to a group or individual therapist with an understanding of sexual abuse.

13. The family as a whole sets a goal of healing from the sustained abuse and moving on. (25, 26)

25. Brainstorm methods for going forward and healing from the effects of the abuse; suggest methods such as rituals, taking advantage of various community support programs, or accepting an apology from the perpetrator.

26. Reinforce the agreement between family members not to revisit the trauma too often once healing has begun.

14. Agree to the best ways to legally and appropriately handle the perpetrator in the best interest of all family members, being especially sensitive to the feelings of the victim. (27, 28)

27. Help the family understand that dealing with the perpetrator in an appropriate legal and/or therapeutic manner is better than confronting the perpetrator informally.

28. Refer the family to the victims' rights and support group that is usually associated with the local district attorney's office or police department.

15. Follow through with contact with the legal authorities and/or medical team. (29, 30)

29. Refer the victim and his/her family to the local authorities (e.g., police abuse victim's unit, district attorney's office), while being sensitive to the feelings of the victim.

30. Refer the victim for a medical evaluation to screen for sexually transmitted diseases, pregnancy, and so forth.

16. Family members verbalize an understanding of the potential acting-out behaviors that may manifest in the victim of incest. (31, 32, 33, 34)

31. Assess for sexual acting out as a response by the victim to the abuse.

32. Teach the family the connection between the sexual acting out by the victim and the sexual abuse, urging calm limit-setting and no overreaction.

33. Help family members sift through the aspects of the victim's sexual acting out that may be due to preexisting individual or family issues (e.g., lack of attention, low self-esteem, need for additional comfort, or anger toward men/women).

34. Separate specific aspects of the sexual acting-out issue that can be dealt with familially as well as what needs to be addressed in individual or group therapy for the victim.

17. Family members decide as a group on the most appropriate time and place to listen to the perpetrator's request for forgiveness. (35, 36)

18. Perpetrator accepts responsibility for his/her sexual abuse victim. (37)

19. Perpetrator offers apology and seeks forgiveness. (38)

35. Explore the victim's and family members' readiness for accepting an apology from the perpetrator.

36. Outline with the family the changes they would like to see in the incest perpetrator and whether they are willing to support him/her through rehabilitation.

37. Provide a family forum for the perpetrator to be confronted with his/her responsibility for the abuse, allowing the victim the priority in expressing feelings.

38. Provide a family forum for the perpetrator to ask for forgiveness of the victim and the family, allowing the victim to respond as fully as possible or even to delay responding until a later time.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.81	Posttraumatic Stress Disorder
	308.3	Acute Stress Disorder
	309.x	Adjustment Disorder with *[include specifier]*
	313.81	Oppositional Defiant Disorder
	V61.21	Physical Abuse of Child
	V61.21	Sexual Abuse of Child
	995.54	Physical Abuse of Child (Victim)
	995.53	Sexual Abuse of Child (Victim)
	_____	_____
	_____	_____

Axis II:	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
	_____	_____
	_____	_____

INFIDELITY

BEHAVIORAL DEFINITIONS

1. One or both parents engage in sexual behavior (e.g., coitus, oral sex, etc.) or some "exchange of intimacy" with an extramarital partner that violates the marital relationship.
2. One or both parents share intimate feelings or thoughts with an extramarital partner and maintain secrecy that violates the explicit or implicit expectations of the marital relationship (e.g., sending messages, e-mails, or gifts that carry a tone of romance; overtly or covertly expressing romantic attraction).
3. The children discover the extramarital involvement by one parent prior to the other parent's becoming aware of this himself/herself.
4. The non-offending parent becomes aware of his/her spouse's involvement with an extramarital partner and confides in the children either prior or subsequent to confronting the spouse.
5. The offending parent secretly shares with the children his/her feelings for a nonspousal partner.

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LONG-TERM GOALS

1. Parents confront each other and agree to submit to couples therapy to address the infidelity issue, as well as the problems with the relationship.
2. Parents arrive at an agreement about how to inform the children only if they suspect or know that the children are aware of the infidelity.
3. Children feel understood regarding the emotional impact of the infidelity on them.
4. Resolve how a marital separation will be introduced to the children and understand the impact that it will have on them.
5. Children resolve their feelings of guilt about knowing of the secret infidelity of one parent and struggling with how to divulge it to the other parent.
6. Children resolve their feelings about the parent inappropriately confiding in them about the affair.
7. Parents understand the harm done by putting their children in a position of holding secrets, and commit to addressing all future relationship problems between themselves.

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SHORT-TERM OBJECTIVES

1. Parents commit to relationship therapy to address their private issues. (1)

2. Parents agree to separation therapy. (2)

THERAPEUTIC INTERVENTIONS

1. Refer the parents to couples therapy without involvement of the children to address the deterioration in the marriage, as well as the impact of the extramarital affair.

2. If the parents separate, discuss with the children their feelings about the option of the parents separating and address the impact and coping skills required (e.g., not feeling responsible for the separation, communicating openly with both parents); discuss living

	arrangements for all parties involved with some potential time line.
3. Children identify the emotional impact that infidelity has had on them. (3, 4)	3. Conduct an open-ended discussion about the children's feelings of anger, frustration, and betrayal of trust toward the unfaithful parent; utilize assertiveness training, confrontational skills, and letter-writing as means of expressing emotions.
	4. Use exercises for anger mediation and rituals (e.g., *After the Affair* by Abrams-Spring) to deal with lack of trust and feelings of abandonment experienced by the children and the faithful spouse.
4. Unfaithful partner expresses understanding regarding the impact of his/her actions on the family and apologizes for the hurt caused. (5)	5. Attempt to solicit an apology from the offending parent to the non-offending parent and/or children; indicate that forgiveness may take time, but is necessary to move beyond the affair; suggest the book, *How Can I Forgive You?* by Abrams-Spring.
5. Children disclose and resolve their feelings of guilt, anger, frustration, disappointment, fear, and loyalty conflict that result from knowing secret infidelity information. (6)	6. Address the issues of the children's guilt, anger, frustration, and disappointment, and the awkwardness around the bind of loyalty concerning whether to tell the other parent of the infidelity.
6. Parents acknowledge the need for boundaries between themselves and the children and for using good judgment about the information to share with the children. (7, 8)	7. Discuss the appropriateness of boundaries, as well as the negative results of enmeshment with and parentification of the child; assign the parents reading material on healthy family boundaries (e.g., *Boundaries* by Katherine) to facilitate understanding.
	8. Have parents commit to not using the children as pawns in their marital conflict; list behaviors that all agree would be unfair, retaliatory, and destructive to the children

(e.g., denial of visitation, telling children complaints about the spouse, urging the children to not visit the spouse, asking the children to "spy" on the spouse, etc.).

7. Children verbalize that they are not responsible for their parents' behavioral choices. (9, 10)

9. Ask the parents to give a clear message that the children are not to blame for the parents' relationship failure.

10. Support the children in understanding that they carry no responsibility for either parent's behavior and should not be held accountable, nor should they feel the need to fix the situation.

8. Parents and children agree on how to respond to others who hear about and react to the news of the infidelity. (11)

11. Address with the family how to cope with word of the infidelity reaching extended family members and the community (e.g., other children in the neighborhood and in school); provide supportive listening and coping skills; recommend books such as *Private Lies* by Pittman.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
	296.xx	Bipolar I Disorder *[include specifier]*
	296.x	Major Depressive Disorder *[include specifier]*
	V61.10	Partner Relational Problem
	V61.20	Parent-Child Relational Problem
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.6	Dependent Personality Disorder
	301.81	Narcissistic Personality Disorder
	_____	_____
	_____	_____

INHERITANCE DISPUTES BETWEEN SIBLINGS

BEHAVIORAL DEFINITIONS

1. A significant sum of money and/or assets are willed to the children by grandparent(s), parent(s), or other relative(s).
2. Allocations of inheritance funds are perceived by one or several siblings to be unfair or imbalanced, precipitating conflict between surviving family members.
3. Disputes arise between surviving family members over how to equally divide money or assets among surviving siblings.
4. Former feelings of favoritism spark resentment and negative feelings between siblings and toward the deceased.
5. Siblings are suspicious of one another with regard to having influenced the deceased while they were alive to bias the will in their favor, causing the distribution to be unfair.
6. Distribution of the inheritance was based on the quality of the relationship between offspring and the parent(s) prior to death.
7. Siblings refuse to speak with each other, leading to either difficult times during or complete avoidance of family gatherings, holidays, and special events.

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LONG-TERM GOALS

1. Family members reach a level of understanding and/or acceptance of the probated will and its asset distribution.
2. Resolve misperceptions of siblings regarding the fairness of distribution of an inheritance.
3. Resolve family members' conflicts that stem from the perceived unfair distribution of an inheritance.
4. Agree to a possible redistribution of inheritance assets that is acceptable to all once the assets have been fully disbursed.
5. Resolve any disputes regarding notions of favoritism toward certain siblings by the deceased.
6. Quell suspiciousness on the part of the siblings for each other.
7. Accept the fact that the distribution of an inheritance may be related to the quality of the recipient's relationship to the deceased prior to death.
8. Siblings agree to use assertive rather than aggressive or passive-aggressive communication.

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SHORT-TERM OBJECTIVES

1. Outline the facts of the probated will's disbursement of assets. (1)

2. Each sibling identifies the effect the unequal distribution of the inheritance has had. (2, 3)

THERAPEUTIC INTERVENTIONS

1. Collect the facts regarding asset distribution from legal documents and/or from input from various family members.

2. Brainstorm ideas of how the deceased may have arrived at his/her decision to distribute assets in the manner that he/she did; address the emotional impact that the deceased's decision has had on each family member.

3. Discuss specific resentments that have surfaced between siblings by holding face-to-face confrontations;

utilize exercises such as sitting opposite each other, holding hands, looking directly into each other's eyes, and softly, respectfully saying what they think and feel.

3. Identify ways in which the inheritance might have been distributed more fairly. (4, 5)

4. Assign the siblings to rewrite the will of the deceased as they would have liked it to read; have them discuss the effects of this exercise with each other, highlighting obvious inequities in each person's version of the will.

5. Discuss what it means for siblings to accept the conditions of the will the way it was written and how this will affect their relationship; explore whether they are open to legally redistributing the inheritance among themselves.

4. Identify how the inheritance meets financial and emotional needs. (6, 7)

6. Explore what the inheritance means to each family member and how it fulfills their individual needs financially and emotionally.

7. Ask each sibling to assess his/her need to gain the parents' love, attention, and acceptance; examine the impact of the will, as written, on these needs.

5. Define the relationship with the deceased parent. (8)

8. Facilitate the confiding of siblings in one another regarding their relationship with the deceased and how this affected their self-esteem.

6. Agree to relinquish certain assets in a more equitable distribution of the inheritance. (9, 10)

9. Recommend mediational strategies that include redivision of allocations, healing of previous wounds, and providing a sense of comfort to one another.

10. Assist the siblings in negotiating a more equitable formula for distribution of the inheritance.

7. Resolve feelings of suspicion regarding one or more siblings having influenced the deceased to favor them in the will. (11)

8. Identify and implement alternative methods of dealing with anger, frustration, and disappointment. (12, 13)

9. Identify and resolve any individual psychopathology that may be underlying failed attempts to resolve the dispute. (14)

11. Assist the siblings that are suspicious in reevaluating their perceived evidence that supports their belief, and challenge them with any new, contrary information that is uncovered during the family meeting.

12. Facilitate a brainstorming session in which siblings consider alternative methods (e.g., assertiveness, "I" messages to express feelings, active listening to promote communication) rather than silence to deal with their feelings.

13. Facilitate role-playing of the communication strategies that emanate from the brainstorming; encourage implementation *in vivo*.

14. Assess whether the suspicious family member may be suffering from any additional psychopathology (e.g., paranoia, depression, delusion, etc.); refer this family member for psychological testing or a clinical evaluation if this is the case.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
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Axis II:	301.6	Dependent Personality Disorder
	301.50	Histrionic Personality Disorder
	301.81	Narcissistic Personality Disorder
	301.0	Paranoid Personality Disorder
	301.7	Antisocial Personality Disorder
	_____	_____
	_____	_____

INTERFAMILIAL DISPUTES OVER WILLS AND INHERITANCE

BEHAVIORAL DEFINITIONS

1. Parent or relative dies, leaving beneficiaries with an uneven inheritance distribution (i.e., some beneficiaries receive more than others, while others receive nothing).
2. Beneficiaries of inheritance blame certain family members with manipulating the decedent to change or modify their will prior to their death, thus contributing to the uneven distribution for beneficiaries.
3. Intense hostility and resentments build toward the family member(s) who received the larger amount of the inheritance.
4. Family member(s) make demands of the beneficiaries of the larger amounts of the inheritance to share their portion with the others in order to even out the distribution.
5. Conflict and fighting develops between family members who are beneficiaries over the inequitable distribution and the symbolic nature of the favoritism expressed on the part of the decedent.
6. As a result of the conflict and fighting, family members enter into a major battle and even become estranged from their families-of-origin.
7. Family members resent how keepsake items of sentimental value formerly belonging to the deceased have been distributed among family members.

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LONG-TERM GOALS

1. Define the specific areas of conflicts and establish effective resolutions.
2. Facilitate a working alliance with family members who are in conflict.
3. Define specific areas of dispute and what the potential remedies might be.
4. Facilitate some understanding of what may have contributed to unequal distribution and dispel any myths about potential manipulation with the writing or rewriting of the will.
5. Address issues of preexisting conflicts between family members prior to the development and/or reading of the will.
6. To achieve some sense of harmony between family members in conflict by looking past the inequities and addressing bonds and issues with the interfamilial dynamics.

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SHORT-TERM OBJECTIVES

1. Review the specifics outlined in the will regarding the distribution to beneficiaries. (1, 2)

2. Identify and list the angry or charged emotions pertaining to the distribution and how this is connected to behavioral interaction between family members. (3, 4, 5)

THERAPEUTIC INTERVENTIONS

1. Identify the specific thoughts and emotions attached to the details of the will.
2. Probe for the inferences that family members make about the distribution of the estate and how it affects them personally.
3. Have each family member ventilate about their personal hurt related to the estate distribution.
4. Discuss what the expectations were of family members regarding the distribution of the estate; probe on what basis the expectations were developed.
5. Discuss any violation of these expectations and specific

resentments toward other family members, including the deceased.

3. Identify any blaming that occurs between family members regarding the details of the will and distribution of benefits. (6, 7)

6. Discuss thoughts and beliefs regarding family members' suspicion about pre-death manipulation of the decedent and changing or modification of the will.

7. Address the rationality of such interpretation and whether or not this might constitute a defense mechanism (denial) for dealing with the genuine wishes of the deceased.

4. Identify family members who experienced conflict with the decedent and help them process their thoughts and emotions about it. (8, 9)

8. Utilize techniques for emotional regulation and cognitive restructuring about their own sense of self-worth and rejection by the decedent (see *Cognitive Behavioral Therapy with Couples and Families: A Comprehensive Guide for Clinicians* by Dattilio).

9. Explore family members' best recollections about spitefulness on the part of the decedent or any ulterior motive that might explore his/her actions with the will.

5. Discuss with family members the possibility of sharing some of the inheritance as a means of quelling the unrest among existing family members. (10, 11, 12, 13)

10. Poll family members about the notion of sharing or redistributing items or funds from the estate and determine their openness to the idea.

11. Identify what would be a reasonable distribution and how this would be done.

12. Discuss some of the pros and cons of redistribution and discuss possible resentments.

13. Identify how this redistribution might impact the overall sense of family dynamics.

6. If sharing of the benefits is not an option, then explore other avenues for how to balance out the feelings of inequities and strengthen family units. (14, 15)

14. Poll family members on other means for balancing out the inequity (sharing family memories, heal wounds between siblings, etc.).
15. De-emphasize the importance and symbolism of material goods and emphasize the nature of close relationships and family bonds; suggest reading *The Settlement Game* by Morris.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
	300.02	Generalized Anxiety Disorder
	300.4	Dysthymic Disorder
	296.x	Major Depressive Disorder, *[include specifier]*
	_____	_____
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Axis II:	301.83	Borderline Personality Disorder
	301.81	Narcissistic Personality Disorder
	301.50	Histrionic Personality Disorder
	_____	_____
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INTERRACIAL FAMILY PROBLEMS

BEHAVIORAL DEFINITIONS

1. Children of interracial marriage experience conflict in their environment due to rejection by peers, society, and so on.
2. Parents experience backlash from children who resent their mixed race and feel the need to punish their parents for having exposed them to a difficult life.
3. Parents display some of their own hidden racial prejudices, creating marital conflict, which inadvertently affects the children.
4. Children who are discontent with their mixed heritage attempt to cope by downplaying or even denying their "undesirable" race (ignoring cultural aspects, superficial changes in physical image such as dying hair, etc.).
5. Children are rejected by extended family members who are opposed to the parents' interracial partnership.
6. An offspring decides to choose a mate who is of a different race than themselves, which causes family tensions

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LONG-TERM GOALS

1. Children of interracial marriage learn to effectively cope with the stress of being mixed-race.
2. Parents recognize and address the children's resentment and find a way to supportively help the children work through their anger, resentment, and frustration for the mixed-race situation.
3. Parents acknowledge any personally harbored racial prejudices and take responsibility for not allowing them to affect the psychological welfare of the children.
4. Children who are discontent with their heritage learn to accept themselves as mixed-race without a loss of self-esteem.
5. Parents and family members confront rejecting grandparents and/or extended family members about their insensitivity toward innocent children, leading to more acceptance and kindness toward the children.
6. Acceptance or better coping by family members who have problems accepting the family member's choice of an interracial mate.

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SHORT-TERM OBJECTIVES

1. Parents and children describe situations in which they have felt rejection and racial prejudice and the feelings that resulted from those experiences. (1, 2, 3)

THERAPEUTIC INTERVENTIONS

1. Explore the nature of the rejection children have experienced due to their biracial heritage; probe the feelings generated by these hurtful experiences.
2. Explore the parents' feelings that were generated by them and their children having experienced racial prejudice.
3. Empathize with and show respect for children and adults who have to endure social prejudice.

2. Children express feelings toward parents for choosing to produce mixed-race children. (4)	4. Facilitate a session whereby children are able to ventilate their feelings of anger and resentment toward parents for being the cause of the mixed-race heritage without recrimination or fear of retaliation from parents.
3. Parents verbalize acceptance of their children's resentment and acknowledge their anger as real and justified. (5)	5. Use role-playing and role reversal to help parents connect with their children's sense of anger and resentment toward them as the cause of their mixed heritage.
4. Parents explain the history of their relationship and their desire to have children in spite of social prejudices. (6, 7)	6. Have parents explain their reasons and decisions for marrying and having children in an environment hostile to interracial relationships and children of mixed heritage.
	7. Have parents share with the children their specific struggles with being victims of prejudice as a young couple during their courtship and how they coped with it.
5. Children read about the struggles of other individuals of mixed heritage. (8)	8. Introduce mixed-race children to literature about great individuals (e.g., Frederick Douglass) who have struggled through interracial challenges.
6. Children and/or parents attend a support group for mixed-race families. (9)	9. Refer children and/or parents to mixed-race support groups in the community.
7. Parents admit to their own hidden prejudices and acknowledge a need to change their belief system. (10)	10. Have parents explore the sources of their prejudices against a particular race and how they were developed and sustained.
8. Children verbalize acceptance of who they are and abandon methods of trying to change or deny their race or culture. (11, 12, 13)	11. Help children search behind the superficial rejection of their race and identify the real reason for their desire to be different (e.g., low self-esteem, desire for power and control, fear of prejudicial rejection, etc.).

	12. Explore methods for children to positively identify with their particular race and assist them in creating a list of individuals of their race whom they can look up to (e.g., scientists, astronauts, religious leaders, politicians, sports figures, movie stars, etc.).
	13. Have children freely express their fantasies of the race they would prefer to be if they could change and why; ask them to make a list of the pros and cons of such a change.
9. Children develop a set of friends and peers within their own race. (9, 14)	9. Refer children and/or parents to mixed-race support groups in the community.
	14. Assist the family in developing a list of avenues of social exchange and interaction with members of various races through either community or church activities.
10. Verbalize the feelings surrounding extended family members' prejudice-based rejection of children. (15, 16)	15. Explore the feelings that result from grandparents' or other extended family members' prejudice-based rejection of children.
	16. Propose a course of individual treatment for family members who are struggling with the rejection expressed by the grandparents and/or extended family members.
11. Children verbalize possible causes for grandparents' rejection that have nothing to do with the child. (17)	17. Lead the family in an exploration of what may lurk behind the grandparents' rejection of their own grandchildren (e.g., jealousy, need to overcontrol, etc.) and help the children to understand this.
12. Parents confront and attempt to resolve extended family members' rejection. (18)	18. Encourage the parent from the rejecting family-of-origin to establish a family-of-origin meeting to discuss the issue of inappropriate rejection

(see *Family-of-Origin Therapy: An Intergenerational Approach* by Framo).

13. Extended family members verbalize acceptance of biracial children. (19)

19. Propose family-of-origin or multigenerational meetings with rejecting grandparents and/or extended family members and biracial children in an attempt to heal the wounds of the rejection.

14. Parents and siblings accept the family member's choice of an interracial mate. (20, 21, 22)

20. Teach coping strategies for tolerance as opposed to acceptance as an initial step to reduce tension within the family over another family member's choice of an interracial partner.

21. Facilitate familiarity with the family member's interracial mate in order to ease tension within the family.

22. Emphasize the strengths and positive qualities of the family member's choice of a mate.

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DIAGNOSTIC SUGGESTIONS

Axis I:	V61.10	Partner Relational Problems
	V61.20	Parent-Child Relational Problems
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Axis II:	301.81	Narcissistic Personality Disorder
	301.0	Paranoid Personality Disorder
	_____	_____
	_____	_____

INTOLERANCE/DEFENSIVENESS

BEHAVIORAL DEFINITIONS

1. Development of tension and conflict over some family members' attitudes of self-righteousness and convictions that their opinions are superior to those of other family members.
2. Refusal to keep an open mind about considering other family members' opinions.
3. Irritability on the part of certain family members toward others' habits, actions, and/or the expression of their feelings and opinions.
4. Expression of denial on the part of some family members when confronted about their intolerance.
5. Ultimatum for change issued by one or more family members against another, placing the other members of the family in an awkward position of having to choose sides.

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LONG-TERM GOALS

1. Eliminate tension and conflict in the family, along with attitudes of self-righteousness and superiority over others.
2. Become more open-minded and tolerant of one another.

3. Use less critical methods for expressing displeasure over other family members' habits, actions, and so on.
4. Develop improved skills in conflict resolution and mediation techniques.
5. Work toward harmony and affirmation among all family members in a way that is realistic and achievable.

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SHORT-TERM OBJECTIVES

1. Define the nature and intensity of family conflict. (1, 2, 3)

2. Each family member defines the nature of his/her positive and negative family qualities. (4, 5, 6)

THERAPEUTIC INTERVENTIONS

1. Conduct an assessment of the level of conflict and relationship satisfaction via interview and/or use of an inventory (e.g., Conflict Tactics Scale [Strauss and Gelles] or Family Awareness Scale [Kolevzon and Green; cited in Green, Kolevzon, and Vosler]).
2. Give feedback on the assessment results and categorize the conflict areas (e.g., reasoning, verbal aggression and violence/family structure, autonomy, and family expression).
3. Have family members replace conflict terms that they don't understand with their own terms that they can relate to (e.g., change the term "defensive" to the phrase "copping an attitude").
4. Assess the current strengths and needs in family relationships via interview and/or the use of an inventory (e.g., Index of Family Relationships in the *Walmyr Assessment Scales Scoring Manual*

	[Hudson] or Kansas Family Life Satisfaction Scale [Schumm, Jurich, and Bollman]).
	5. Help each family member get in touch with his/her strong points as a family member and compare and contrast them with the weaknesses.
	6. Probe how each family member's weaknesses developed or what they may be based on.
3. Each family member defines the likes and dislikes that he/she has for one another and for the functioning of the family as a unit. (7, 8, 9)	7. Assess the development of family dynamics via interview and/or use of an inventory (e.g., Family-of-Origin Scale [Hovestadt, Anderson, Piercy, Cochran, and Fine] or Family of Origin Questionnaire [Stuart]).
	8. Have family members make an overall assessment of what they do/do not like about how the family functions, qualities of members that are desirable/ undesirable, historical high points/low points, and what they would change if they could.
	9. Request that each family member be honest about his/her feelings toward the others, admitting to possible jealousy and envy.
4. Compare family-of-origin intolerance to current attitudes. (10)	10. Trace intolerance, criticism, and judgmental attitudes within the parents' families of origin and compare these to what is witnessed within the current family dynamics.
5. Cite examples of intolerance within the family and the feelings associated with being the object of that rejection. (11, 12)	11. Ask each family member to cite examples of when his/her ideas were rejected, criticized, or ignored by other members with closed minds; explore the feelings related to this rejection.

12. Poll each family member in order to determine what it would take for each of them to keep an open mind toward the others and how it would feel to live in an atmosphere of acceptance.

6. Implement empathy development techniques to increase open-mindedness and sensitivity to others' feelings. (13, 14)

13. Use role-playing to teach family members how to keep open minds, asking one member to talk to other members to get them to see a different side of a rather neutral issue; use role reversal to highlight the feelings of hurt and frustration associated with being rejected.

14. Assign a homework exercise for the family to apply a role-playing technique to get other family members to respect their points of view with a real situation at home and then discuss the results in a follow-up session.

7. Cite examples of irritability among family members, what triggers the irritability, and its impact on others. (15, 16)

15. Explore irritability in the family and discuss how each family member expresses his/her irritability and what triggers it.

16. Explore the impact of the expression of irritability on each family member and assess whether or not irritability may be used to manipulate or control others.

8. List alternate behaviors to irritability that promote family harmony. (17, 18, 19)

17. If it is determined that irritability is used to control or manipulate other family members, teach how this is destructive and suggest some alternative behaviors (e.g., assertiveness, positive statements, etc.).

18. Brainstorm some alternative methods for expressing anger and frustration (e.g., "I" messages, letter writing, time-out before sharing feelings, etc.); encourage family members to be as creative and as accepting as possible.

9. Implement adaptive conflict resolution techniques. (20, 21, 22, 23, 24)

19. Suggest the use of techniques (e.g., meditation, deep breathing, journaling, or cognitive restructuring) to reduce tension and the frequency of irritable responses.
20. Ask the family to work through an issue of actual conflict while in session; observe the process and point out ineffective strategies used (e.g., talking when others are talking, misinterpreting statements, cutting each other off, labeling people, etc.).
21. Propose alternative strategies to those maladaptive ones used in the family's conflict resolution interaction (e.g., reflective listening, clarification, gaining closure, etc.); suggest reading material on conflict resolution (e.g., *The Anatomy of Peace* by The Arbinger Institute or *The Joy of Conflict Resolution* by Harper).
22. Use modeling and role-playing to teach successful and effective conflict resolution strategies (e.g., stage an argument and coach each family member on how to respond; role-play examples of the effective and noneffective ways to interact).
23. Teach the family problem-solving skills that they can apply in a group exercise (i.e., define the problem narrowly, brainstorm options for solutions, generate the pros and cons of each option, select one option for implementation, implement the selected option, evaluate the results, adjust the solution as needed).

24. Review the family's implementation of conflict resolution and problem-solving skills to everyday issues; reinforce successes and redirect for failures. EBP

10. Each family member acknowledges and reduces the use of denial of intolerance and agrees to take responsibility for his/her own behavior. (25, 26, 27, 28)

25. Be direct with family members who engage in denial of their intolerance; facilitate confrontation by other family members.

26. Point out that denial can be a primitive form of defense and suggest that it might be used because of an underlying helplessness or feeling of vulnerability.

27. If it comes to the surface that vulnerability does underlie denial in family members, then allow the expression of their vulnerability.

28. Assess for the presence of blaming behaviors that are based in denial of taking personal responsibility (see the chapter on Blame in this *Planner*).

11. Terminate the use of ultimatums as a means of expressing frustration with other family members. (29, 30, 31, 32, 33)

29. Educate the family about the notion that once family members have reached a point of issuing ultimatums as a means of controlling others, problem-solving has become stalled.

30. Probe the level of frustration in the family member issuing the ultimatum.

31. Develop a behavioral contract that stipulates that family members will not issue ultimatums to one another; define in concrete terms which ultimatum behaviors are to be avoided.

32. Suggest a family meeting when family members are feeling so

desperate that they want to issue an ultimatum to get things to change to their satisfaction.

33. Address whether the issuing of an ultimatum may be a means of exerting power or calling attention to oneself; open a discussion on who has power and control in the family and how it is governed.

12. List ways that power and control can be distributed within the family. (34, 35)

34. Brainstorm with family members ways in which power and control can be restructured and redistributed within the family; develop a list of tasks or decisions where each family member has respective strengths to bring to this area and should take the lead role.

35. Use strategies, such as give-and-take exercises, in which family members alternate times when they take the lead in planning an activity or directing a major task in the household that needs to be accomplished; process how it feels to be in command and also how it feels to be a follower.

13. Verbalize an understanding that some frustration with one another is expected, but that this should not result in anger, rejection, or ultimatums as a means of control. (36, 37, 38, 39)

36. Play the UnGame (Zakich) in session to illustrate power and control dynamics within the family.

37. Prepare the family for the fact that there will be times in the future when they become frustrated with each other and to accept this as common to all families rather than lashing out in intolerance.

38. Ask family members to consider the advantages of learning to love the other members and accept or tolerate irritating behaviors as a means of coping with it.

39. Discuss the use of coping strategies (e.g., engaging in self-talk and perceptual reconstruction of what it means to give in and accept each other's shortcomings) for building family members' respective tolerances; recommend the reading material on coping strategies within the family (e.g., *Simple Courtesies* by Gallant). 

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
	305.00	Alcohol Abuse
	303.90	Alcohol Dependence
	296.x	Major Depressive Disorder *[include specifier]*
	V61.10	Partner Relational Problem
	V61.20	Parent-Child Relational Problem
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	301.4	Obsessive-Compulsive Personality Disorder
	301.81	Narcissistic Personality Disorder
	_____	_____
	_____	_____

JEALOUSY/INSECURITY

BEHAVIORAL DEFINITIONS

1. Existence of tension and conflict due to jealousy and insecurity within the family context.
2. Arguments among family members over the amount of time spent with each other.
3. Accusations by family members regarding parental favoritism and the lack of a display of interest and concern for certain family members.
4. Certain family members overcontrol other family members, which causes resentment.
5. Certain family members exhibit dependent behaviors that are based on the need for attention.
6. Children act out in the form of delinquent or incorrigible behaviors.
7. Insatiable jealousy that results in physical destruction when expressing rage.
8. Certain family members exhibit a deep mistrust over other family member's actions, motives, and time spent away from the family.

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LONG-TERM GOALS

1. Eliminate tension and conflict over issues involving jealousy and/or insecurity.
2. Reduce frustration regarding lack of time spent with one another.
3. Eliminate blaming of each other regarding favoritism.
4. Acquire an alternate means of dealing with the need to be in control.
5. Reduce dependent behaviors and acquire more independent behaviors.
6. Children eliminate delinquent and acting-out behaviors.
7. Learn anger management techniques in order to avoid acting out when feelings of jealousy arise.
8. Establish trust between family members.

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SHORT-TERM OBJECTIVES

1. Identify the origins of the jealousy and insecurity in the family. (1, 2, 3)
2. Identify any evidence of jealousy and insecurity being modeled by adults and imitated by children. (4)

THERAPEUTIC INTERVENTIONS

1. Have family members discuss their feelings that relate to jealousy and insecurity by having them cite specific examples of times when jealousy arose.
2. Compare and contrast the perception of the jealous family member with those of the nonjealous family members when the same event is interpreted very differently.
3. Have family members cite specific conflicts by verbal description or by having them role-play the scene in session.
4. Assess whether jealousy and/or insecurity in children may be the result of modeling by older family members.

3. Detail how jealous/insecure behaviors have affected each family member emotionally. (5)

4. Identify and replace irrational, dysfunctional thoughts that trigger jealousy. (6, 7, 8)

5. List and specifically describe the jealous behaviors that need to change. (9)

6. Identify alternative reactions that can replace episodes of jealousy or insecurity. (10, 11, 12)

5. Facilitate the open expression of how each family member has been affected by the dynamics of jealousy and insecurity in the family.

6. Explore for irrational thoughts that may typically accompany jealousy and educate the family about how jealousy is related to insecurity and possessiveness; suggest to family members that they educate themselves by reading material on the topic (e.g., *The Psychology of Jealousy and Envy* by Salovey or *Overcoming Jealousy* by Dryden).

7. Brainstorm with the family members more rational self-talk, which can replace irrational thoughts that trigger jealousy.

8. Educate the family about the Rational Emotive Behavior Therapy model of restructuring thoughts and how the A-B-C-D theory (see *The Practice of Rational Emotive Therapy* by Ellis and Dryden) may be applied to jealousy and insecurity in the family.

9. Have all family members compose individual lists of jealous and insecure behaviors expressed in the family.

10. Facilitate the development of a list of alternative, healthy behaviors the family would like to see in place of jealousy.

11. Trace in specific detail how jealous and insecure thoughts lead to emotional deterioration and destructive behavior.

12. Recommend ways in which family members can intervene when

	jealous rage arises and rely on alternative reactions (e.g., time-out procedures, deep breathing for behavior control, etc.).
7. Acknowledge the presence of favoritism within family relationships. (13, 14)	13. Search the family dynamics for coalitions or favoritism displayed by one family member toward another/others.
	14. Confront the presence of favoritism that exists and determine reasons for its development.
8. Verbalize an understanding of the destructive, negative effects of favoritism on the family unit. (15, 16)	15. Help family members understand how favoritism is an unhealthy dynamic and point out its devastating effects.
	16. Use role reversal techniques to teach how it feels to be on the receiving end of exclusion and favoritism; note feelings of rejection, resentment, and guilt.
9. Family members identify and replace their use of subtle or overt overcontrolling behaviors. (17, 18, 19)	17. Define overcontrolling behaviors for the family (i.e., when one family member wants to dictate other family members' personal choices) and assist in identifying their existence in the family.
	18. Help the family see why overcontrolling behaviors developed and how they provide only a false sense of security.
	19. Address and resolve any fears that family members may have about relinquishing overcontrolling behaviors.
10. Terminate aggressive or immature acting out that may result from jealous feelings and identify replacement behaviors that are more constructive. (20, 21)	20. Solicit agreement that the family will not tolerate any aggressive, assaultive behaviors; use behavioral contracting with clear ramifications for what will occur if the agreement is broken.

21. Brainstorm alternative ways to express feelings of jealousy or insecurity without being aggressive (e.g., direct expression of insecurities so they can be disconfirmed by family members).

11. Accept referral to adjunctive treatment outside of family therapy for anger management. (22, 23)

22. Consider adjunctive treatment for individual family members who cannot control their anger or aggressive behaviors (e.g., group therapy, medication, anger management classes, etc.).

23. Help family members be supportive and encouraging to the family member who requires outside treatment.

12. Identify dependent behaviors and how they are enabled within the family system. (24, 25, 26)

24. Trace the origin of dependent, insecure behaviors and how they have emerged within the family.

25. Explore how family members may be enabling the dependent behaviors and identify specific enabling patterns (e.g., not telling the family member of annoying behavior for fear of offending him/her).

26. Teach how the dependent behaviors interfere with the family's functioning (e.g., one family member constantly needing to rely on other family members, restricting their mobility and independence, and thwarting their personal growth).

13. Dependent family member implements assertiveness and other independent behaviors. (27, 28)

27. Encourage the dependent family member to practice independent-type behaviors; teach strategies that promote independence (e.g., assertiveness, "I" messages, self-affirmation, etc.).

28. Reinforce family support for the acquisition of the new independent behaviors by the dependent member.

14. Identify delinquent or incorrigible behaviors on the part of the children. (29)

29. Explore for incidents of delinquent or incorrigible behavior with the family; discuss how they may be a means for children to act out a fairness imbalance in the family.

15. Parents institute behavior contracting to reduce delinquent and/or aggressive behaviors in the family. (30, 31)

30. Redirect parents toward pulling together to confront the child's incorrigible behavior and to reinforce more appropriate, desirable behaviors.

31. Help parents devise a behavior contract against delinquent or incorrigible behavior.

16. Acting-out children give their perspective on the family dynamics and their feelings in reaction to them. (32)

32. Facilitate the delinquent child in giving free expression to his/her perception of and reactions to difficulties in the family; ask how this perception may be tied to delinquent behavior.

17. Parents implement more intense treatment measures for children who are acting out. (33, 34)

33. Develop an alternative plan of individual treatment for the child if delinquent behaviors continue.

34. Explore alternative living arrangements (e.g., group home, residential treatment, foster home) for the child if acting out continues or escalates.

18. Jealous or insecure family member cooperates with an evaluation for the presence of an emotional, personality, or cognitive disorder. (35, 36, 37, 38)

35. Educate the family about the difference between jealous/insecure behaviors and symptoms of mental illness (e.g., paranoia, major depression, bipolar disorder, etc.).

36. Use assessment techniques (e.g., the Minnesota Multiphasic Personality Inventory-2 [Hathaway and McKinley]) to determine if emotional, personality, or cognitive disorders are present.

37. Refer the jealous, insecure family member for an individual assessment and therapy with a clinical psychologist or psychiatrist.
38. Devise a follow-up plan for working with the family while the ill family member is either hospitalized or in outpatient follow-up.
19. Give support and encouragement to a family member receiving treatment for an emotional disorder. (39)
39. If the use of medication and/or hospitalization is necessary, help the family find ways that they can provide encouragement and support to the mentally ill family member.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
	296.xx	Bipolar I Disorder
	296.x	Major Depressive Disorder *[include specifier]*
	V61.10	Partner Relational Problem
	V61.12	Physical Abuse of Adult
	995.81	Physical Abuse of Adult (Victim)
	_____	_____
	_____	_____

Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	301.81	Narcissistic Personality Disorder
	301.0	Paranoid Personality Disorder
	_____	_____
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LIFE-THREATENING/CHRONIC ILLNESS

BEHAVIORAL DEFINITIONS

1. Family member is diagnosed with a life-threatening or chronic illness (e.g., AIDS, severe coronary disease, brain tumor, schizophrenia, etc.).
2. Slow but progressive deterioration throughout the course of illness.
3. Tremendous time and attention is devoted to the ill family member, detracting from time for other family members.
4. Healthy family members experience guilt over their own state of good health.
5. Development of tension and strain over the uncertainty surrounding the course of the illness and impending death, as well as a feeling of helplessness to do anything about it.
6. Healthy family members are in denial over the severity of the other family member's illness.
7. Healthy family members experience worry, fatigue, anger, and resentment because of ill family member's condition.
8. Increased financial stress due to the expenses and/or the loss of income related to the illness.
9. Family members experience social isolation as a result of the illness.
10. Conflict over decisions about what is medically best for ill family member versus what is best for the family (e.g., home hemodialysis can mobilize ill family member, but places greater demands on family).

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LONG-TERM GOALS

1. Become educated regarding what is to be expected during the course of the illness.
2. Learn to avoid boundary problems such as enmeshment or over/underinvolvement with the illness.
3. Healthy family members overcome their guilt and tendency to self-blame due to their own state of good health.
4. Prepare for unexpected downturns in the illness and potential relapse or sudden death.
5. Find an outside support system that can help to offset the financial burden caused by the illness.
6. Make family decisions that are balanced and in the best interests of both the ill family member and the family as a whole.

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SHORT-TERM OBJECTIVES

1. Verbalize the symptoms, treatment, and course of the illness for the purpose of clarification. (1, 2, 3)

THERAPEUTIC INTERVENTIONS

1. Refer family members to written material, support groups, lectures, and the treating physician/specialist to learn about the symptoms, treatment, and course of the other family member's illness.
2. Suggest that family members share newly acquired medical information with each other during family meetings.
3. Encourage family members to become involved with other families through networking with those who have endured a similar illness (i.e., a support group).

2. Share how the illness has impacted family members and how they relate to the ill family member. (4, 5)

3. Ill family member verbalizes feelings of isolation resulting from the illness and the causes for these feelings. (6)

4. Identify ways to overcome the ill family member's isolation. (7)

5. Identify which phase of the grief cycle the family is in and the impact the illness has had at this stage. (8)

6. Identify how a parent's incapacitation has affected the mode of caretaking and leadership. (9, 10)

4. Facilitate family members' sharing of thoughts and feelings associated with the illness; include the ill family member for his/her feedback as well.

5. Allow for the ventilation of emotions (e.g., anger, guilt, blame, fear, or frustration) related to the illness of the family member and explore how these feelings affect the relationship with the ill family member.

6. Explore the ill family member's sense of isolation from the rest of the family and identify the factors that are contributing to these feelings.

7. Brainstorm ways to reduce the ill family member's sense of being excluded from the rest of the family (e.g., think of things that the ill family member can do for healthy family members).

8. Educate the family on how they will progress through various stages of grief (e.g., shock, denial, sadness, etc.); help them identify the stage they are presently in and allow for the expression of the impact of the illness at this stage of family development (recommend *Beliefs: The Heart of Healing in Families and Illness* by Wright, Watson, and Bell).

9. Explore how the illness of a parent has affected caretaking and leadership in the family.

10. Help the family to reassign a leader in the family, soliciting input from the ill family member; utilize a democratic family vote in order to take pressure off of the ill family member.

7. List the chores associated with the illness and agree about their assignment and the need for outside assistance. (11)

8. Identify ways to avoid polarization or enmeshment as responses to the family crisis. (12, 13)

9. Identify the strengths of the family. (14)

10. Reduce expressions of guilt and blame toward each other for the illness and its impact on the family. (15)

11. Utilize problem-solving strategies to cope with the medical crisis. (16, 17)

11. Discuss the assignment of chores related to the illness and weigh the benefits of hiring or enlisting outside help to lessen the amount of time absorbed by the illness.

12. Educate the family on the importance of boundaries and how families can become either polarized or enmeshed when faced with a crisis; focus on techniques for disengagement (see *Families and Family Therapy* by Minuchin) or depolarization.

13. Help family members to recognize their beliefs and find resources that may help them to prevent the illness from dominating their lives (recommend *Beliefs: The Heart of Healing in Families and Illness* by Wright, Watson, and Bell).

14. Assist the family in identifying and building on their strengths (e.g., playing table games together; developing a family hobby such as coin collecting) rather than bemoaning and being overwhelmed by their deficits (e.g., complaining of not having enough money or criticizing each other for not doing a fair share of work).

15. Encourage family members to take their focus off of guilt and blame and to acknowledge their own individual and joint responsibilities to deal with the crisis.

16. Teach the family negotiation skills and problem-solving strategies (e.g., family forum meetings, "I" message communication, role reversal empathy enhancement) to be applied to the family's response to coping with the illness.

17. Teach the family members problem-solving skills (e.g., identifying the problem, brainstorming possible solutions, weighing the pros and cons, selecting an option for action, reviewing the results of implementation) and role-play its implementation (or assign "Problem-Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner* 2nd ed. by Jongsma). 

12. List sources of social/emotional support outside of the family. (18)

18. Assist the family in identifying outside sources of social support (e.g., hospice, church, extended family, and friends).

13. Each family member identifies how he/she will change to increase family harmony. (19)

19. Ask each family member to assess how he/she has contributed to the family conflict surrounding the illness and then what he/she will do differently to contribute to harmony.

14. Identify how family conflicts could contribute to the worsening of the ill family member's condition. (20)

20. Ask the family to identify how tensions due to negative reactions or conflicts have exacerbated or inhibited the improvement of the condition of the ill family member.

 15. Utilize stress reduction and conflict resolution techniques to reduce tension within the family. (21)

21. Suggest measures and/or techniques for stress reduction (e.g., relaxation training, respite care, exercise, or programmed family recreation) and conflict resolution (e.g., family forum meetings, "I" message communication, role reversal empathy enhancement, problem-solving) between family members. 

 16. Acknowledge becoming overly protective of one another as a result of the impact of the chronic/life-threatening illness. (22, 23)

22. Help family members to become aware of the fact that overprotectiveness is not unusual when one family member is seriously ill; teach the need to

exercise some independence between members to aid in promoting less intensity and conflict. 

23. Provide family members with attentive behaviors (e.g., verbal expression of need for support) to use in place of overprotectiveness. 

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DIAGNOSTIC SUGGESTIONS

Axis I:	296.xx	Major Depressive Disorder, *[include specifier]*
	300.4	Dysthymic Disorder
	309.x	Adjustment Disorder with *[include specifier]*
	308.3	Acute Stress Disorder
	309.21	Separation Anxiety Disorder
	300.02	Generalized Anxiety Disorder
	_____	_____
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Axis II:	301.6	Dependent Personality Disorder
	301.83	Borderline Personality Disorder
	301.50	Histrionic Personality Disorder
	_____	_____
	_____	_____

MULTIPLE BIRTH DILEMMAS

BEHAVIORAL DEFINITIONS

1. Parents experience a pregnancy that yields multiple newborns (triplets, quadruplets, and higher-order multiples), causing them and other family members to become emotionally and physically overwhelmed.
2. The family is burdened with added work stress, increased food and supply expenses, as well as sleepless nights.
3. Parents are plagued by potential infant mortality, neurological defects, eye or lung disorders, and developmental abnormalities.
4. Parents experience clinical depression as a result of the added burden of multiple-birth children.
5. The need to obtain larger living quarters and/or transportation is paramount and an immediate burden on the family.

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LONG-TERM GOALS

1. Secure financial, emotional, and child care support from extended family and friends to accommodate the immediate situation until a longer-term arrangement can be developed.
2. Utilize stress management techniques to deal with the burden and obligations of the abrupt increase in family members.

3. Participate in a support group to provide comfort and encouragement for dealing with infant mortality.
4. Resolve feelings of depression.
5. Relocate to a new home or remodel the family's existing dwelling in order to accommodate the multiple births.
6. Add paid or volunteer domestic help to alleviate the overwhelming child care needs.

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SHORT-TERM OBJECTIVES

1. Verbalize feelings of anxiety and fatigue related to the addition of multiple-birth children. (1)
2. List options available for child care and emotional support. (2)
3. Parents express positive thoughts regarding the present and future situation. (3)
4. Parents and family express grief about infant mortality associated with multiple births. (4, 5)

THERAPEUTIC INTERVENTIONS

1. Provide a system for venting the family members' initial shock and fear of not being able to handle the extra burden of multiple-birth children.
2. Brainstorm and list options available to the family regarding child care and emotional support.
3. Assist parents in identifying negative self-talk associated with the responsibility of multiple-birth children; replace with positive, realistic automatic thoughts.
4. Help family members deal with the death of the infant(s) through bereavement counseling; assign parents such readings as *Necessary Losses* by Viorst and, for children, *The Fall of Freddy the Leaf* by Buscalglia.
5. Suggest rituals for the family to follow to grieve the death of the infant(s) (e.g., compiling a

	scrapbook of memories, visiting the grave, planting a tree in the name of the deceased) and to focus on the surviving infants as a blessing.
5. Utilize methods of learned optimism to deal with the stress of medical problems. (6)	6. Teach the family methods of learned optimism (see *Learned Optimism* by Seligman) for dealing with the stress of the medical problems.
6. Family members share responsibilities associated with medical care of infants. (7)	7. Assist the family in scheduling all members to share in attending to the medical necessities of the infants (feeding, changing diapers, assisting in-home nurses, attending to appointments, giving medications, etc.).
7. Preexisting children verbalize their concerns and fears associated with the dramatic change in family dynamics. (8)	8. Allow for preexisting children of the family to vent their feelings and concerns about the instant addition of new offspring and their fear of being ignored and neglected.
8. Parents and preexisting children spend structured time together. (9)	9. Solicit parents' reassurance to preexisting children that they will not be ignored; schedule some structured individual attention from a parent for each child.
9. Parents develop a financial plan to help with the burden of increased expenses. (10, 11)	10. Brainstorm with family members about how they can solicit extra financial support and/or reduce/ contain overhead costs to improve the family's financial situation; create a family budget together.
	11. Reinforce the notion of the family's bond and how everyone needs to work together in a cohesive fashion to contend with the financial situation and the overload of responsibility.
10. Identify emotional needs and the extended family and friends who can provide support. (12, 13)	12. Assist the family in identifying and defining what type of emotional support the family needs in order

	to survive the current situation, and encourage them to seek that support.
	13. Identify specific extended family members and friends on whom the family can rely for emotional support.
11. Parents and children implement behavioral and cognitive stress reduction techniques. (3, 9, 14, 15)	3. Assist parents in identifying negative self-talk associated with the responsibility of multiple-birth children; replace with positive, realistic automatic thoughts.
	9. Solicit parents' reassurance to preexisting children that they will not be ignored; schedule some structured individual attention from a parent for each child.
	14. Teach techniques for stress management and stress inoculation (e.g., cognitive restructuring, progressive muscle relaxation, lighthearted recreational family activities, exercise).
	15. Use cognitive behavior therapy, medication, or a combination of both to assist parents in reducing depression; recommend the books, *Feeling Good* and *Feeling Good Handbook* by Burns.
12. Parents report a reduction in their level of depression. (16, 17)	16. Refer the parent for depression treatment on an outpatient or inpatient basis, depending on the severity of the depression.
	17. Provide supportive family therapy to the nondepressed family members.
13. Parents decide to either relocate or have an addition built onto the home in order to accommodate the new infants. (18)	18. Teach the family to utilize a decision-making paradigm to review their living space options and select the best decision to suit their needs.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.0	Adjustment Disorder with Depressed Mood
	309.x	Adjustment Disorder with *[include specifier]*
	300.4	Dysthymic Disorder
	V61.20	Parent-Child Relational Problem
	V61.0	Postpartum Depression
	_____	_____
	_____	_____
Axis II:	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
	_____	_____
	_____	_____

PHYSICAL/VERBAL/PSYCHOLOGICAL ABUSE

BEHAVIORAL DEFINITIONS

1. Physical pain or injury is inflicted on family members intentionally by one or more family members.
2. Family members are called insulting names (e.g., fat, stupid, ugly).
3. Intentional threat of physical pain or injury (i.e., verbal threat, damaging of personal items).
4. Critical comments are made about family members' mental states (e.g., "you're crazy," "you need a shrink").
5. Fear, apprehension, and intimidation felt by some or all family members.
6. Ignoring of or refusal to talk to other family members for days ("silent treatment").
7. Failure by family members to warn other family members of situations, incidents, or events in which they have knowledge of potential physical harm that may befall the others (e.g., knowing of a planned physical assault against a sibling by another sibling or an individual outside the immediate family).
8. Domination or excessive control over one or more family members.

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LONG-TERM GOALS

1. Family members discontinue all use of physical aggression and verbal and psychological abuse, and identify viable alternatives (other forms of verbal exchange, etc.).
2. Replace hostile, threatening, and critical comments with respectful communication that builds self-esteem and positive relationships with one another.
3. Nonabusive family members protect identified victims (e.g., using avoidance techniques, alternative shelter or respite, etc.).
4. Identify the underlying dynamics in the family that may be promoting tension and abusive behavior.
5. Discontinue alcohol or drug abuse that serves as a precipitant of violence.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Identify and acknowledge the existence of physical, verbal, or psychological abuse. (1, 2, 3)	1. Initiate individual therapy, family therapy, or both in order to address the issues of the abuse; operationally identify abusive comments and behaviors. 2. Explore the dynamics of the family that facilitate the abusive behavior; also, address the victimization of nonabusive family members. 3. Recommend individual therapy with a separate therapist for the abusive family member, focusing on anger issues and impulse control.
2. Implement a plan that guarantees the protection of abused family members. (4, 5, 6)	4. Assist the family in developing an immediate plan for family safety (e.g., relocation of nonabusive

	family members) that ensures the safety of abused members (call police, escape to safe environment, etc.) if abuse is a continuing threat.
	5. Develop a list of resources in the community (shelters, friends, extended family members, etc.) for escape from abuse.
	6. Fulfill legally mandated requirement for reporting the abuse of a minor by contacting the appropriate protective agency.
3. The physically abusive family member signs a nonviolence, nonintimidation contract as well as a contract agreeing to attend treatment. (7, 8)	7. Assist family members in constructing a written contract assuring that no abusive behavior will be tolerated, that it will be readily pointed out by the abuse victim, and that the abuser will attend treatment (perhaps not in the company of the abused if clinically indicated).
	8. Assist family members in defining what constitutes violation of the nonabuse contract and what steps will be taken to ensure safety (e.g., abuser vacates the situation; victims seek alternative shelter, call police, etc.).
4. Identify the destructive results of physical abuse on the family. (9)	9. Educate all family members about the emotional destructiveness and illegality of even the slightest incidences of physical abuse and why such abuse should not be tolerated.
5. Family members reach an agreement on what constitutes psychological and verbal abuse. (10)	10. Aid the family in defining what constitutes psychological and verbal abuse in specific behavioral/emotional terms; focus on the subtle, more tacitly implied verbal and psychological abuse and the vulnerability of the victims.

6. Accept referrals to treatment and self-help groups. (11)

7. Identify the signs of escalating anger. (12, 13, 14, 15)

8. Family members agree not to use incidences discussed during the course of treatment as weapons outside of the sessions. (16)

9. Family members agree to use time-out procedures in the therapy session and at home if the circumstances become volatile. (17, 18)

11. Refer victims to a victims' support group and the abuser to an offenders' treatment program; solicit their agreement for this treatment.

12. Aid the family in identifying early cues of potential violence.

13. Teach family members how to identify the cognitive, affective, behavioral, and physiological cues of anger and how to differentiate low, moderate, and high ranges; recommend the book *Angry All the Time* by Potter-Efron.

14. Use role-plays to teach the difference between assertive, aggressive, and passive-aggressive communication; encourage assertive communication as a vehicle for expressing heated emotions.

15. Role-play exercises of heated situations and work on identifying the cues that indicate that the situation may spiral out of control (e.g., family members becoming quiet or seething, voices being raised).

16. Solicit agreement between family members to not use in-session material against each other when outside of the treatment session.

17. Teach family members the five steps in using time-out to control anger: (1) *self-monitoring* for escalating feelings of anger and hurt, (2) *signaling* to another family member that verbal exchange is not a good idea, (3) *acknowledgment* of the need for the other family members to back off, (4) *separation* to cool down and use of cognitive self-talk to regain composure, and

(5) *returning* to calm verbal exchange (see *The Anger & Aggression Workbook* by Liptak, Leutenberg, and Sippola).

18. Teach the importance of maintaining structure and boundaries, particularly during emotionally charged discussions and/or exchange; help family members make the connection that verbal and psychological abuse often lead to physical abuse.

10. Abusive family member states the emotional results of his/her abuse on the victim and the family. (9, 19, 20)

9. Educate all family members about the emotional destructiveness and illegality of even the slightest incidences of physical abuse and why such abuse should not be tolerated.

19. Use role reversal techniques, in which the abusive family member assumes the role of the victim, in order to learn the emotional impact of abuse.

20. Assist the abusive family member in listing 10 negative effects of his/her abuse on the victim and the family unit (e.g., modeling disrespect and violence for children, lowering self-esteem of victim, loss of own self-respect, conflict with other family members over abusive practices).

11. Identify the role that substance use plays in the physically or verbally abusive family patterns. (21)

21. Assess for the presence of substance abuse in each family member and examine how it may be contributing to the dysfunction in the family.

12. Terminate the use of mood-altering substances. (22)

22. Refer substance-abusing family members to Alcoholics Anonymous or to chemical dependence treatment and solicit a pledge to terminate the use of mood-altering substances.

13. Family members evaluate their own patterns of thoughts and actions and identify how they contribute to any maladaptive patterns of verbal/physical abuse. (23)

14. Parents identify the negative impact the abuse within their families of origin had on them. (24, 25)

15. Abusive family member accepts responsibility for abusive behavior and agrees to a non-blame contract for acts of abuse. (26, 27)

16. Abusive family member apologizes for abusive behavior, identifying the behavior and taking full responsibility for it. (28, 29)

23. Explore thought patterns and behavior that may be encouraging each family member in an abusive exchange (e.g., jealousy, prejudice, etc.); ask each family member to identify how he/she contributes to the violent atmosphere in the home.

24. Examine family-of-origin abuse issues with parents to identify the effects of any verbal/physical abuse sustained by them during their upbringing; include an examination of any learned enabling behaviors on the part of the nonabusive spouse; point out the repeating cycle of abuse.

25. Review with the aggressive family member(s) the family-of-origin experiences that reinforced physical and verbal abuse as acceptable ways of expressing anger/frustration.

26. Support and encourage family members in confronting the abuser without excusing his/her behavior or allowing the abuser to externalize blame.

27. Family therapist models the process of accepting the responsibility for individual behavior without excuses or externalizing blame; solicit acceptance for the responsibility of abuse from the abuser.

28. Ask the abusive family member to apologize for the abuse without externalizing blame.

29. Confront the abusive family member about not taking responsibility for the abuse and not expressing remorse and sensitivity.

17. Victims hold the abusive family member responsible for the abuse while accepting an apology for the abuse without excuse. (30)

18. Abusive family member constructs a plan that provides several alternatives to abusive behavior when anger is triggered. (31, 32, 33, 34)

19. Abusive family member reports instances where feelings of anger were expressed in a controlled, assertive, and respectful manner. (35)

20. Victims identify experiences in childhood that taught tolerance for and excuse of abusive behavior. (36)

30. Confront the victims' pattern of taking responsibility for abusive family member's behavioral decisions and reinforce the victims for holding the abusive family member responsible for the abusive behavior.

31. Establish the function of the family member's abuse and identify nonabusive means to accomplish such goals.

32. Process the abusive family member's angry feelings or angry outbursts that have recently occurred and review available alternative behaviors.

33. Suggest that the abusive family member write a list of several alternative behaviors other than abuse when anger is experienced (e.g., taking a time-out, contacting a support system, taking a walk, writing out feelings, reviewing a list of the negative consequences of violence).

34. Assign the abusive family member to read one or more of the following books: *The Anger Trap* by Carter, *The Angry Book* by Rubin, *The Anger & Aggression Workbook* by Liptak, Leutenberg, and Sippola, or *The Verbally Abusive Relationship* by Evans.

35. Reinforce assertiveness behaviors in session and family members' reports of successful assertiveness between sessions.

36. Review with victims previous experiences that modeled physical or verbal abuse as behavior that is to be expected, excused, and tolerated.

21. Victims identify a pattern of self-blame for the abusive behavior by other family members. (37)

37. Help victims identify a pattern of blaming themselves for another family member's abusive behavior and teach them that everyone is personally responsible for behavioral decisions.

22. Victims report instances when aggressive or abusive behavior occurred and they did not verbalize being at fault for it. (38)

38. Have victims cite instances in which abusive behavior occurred and they did not take responsibility for it; provide emotional support to victims for holding the abusive family member responsible for abusive behavior.

23. Abusive family member identifies instances in childhood when he/she was a victim of abuse and the feelings of pain, helplessness, and rage this generated. (25, 39)

25. Review with the aggressive family member(s) the family-of-origin experiences that reinforced physical and verbal abuse as acceptable ways of expressing anger/frustration.

39. Have the abusive family member list hurtful life experiences that have led to his/her abusive acting-out behavior; explore the feelings of hurt and rage associated with this abuse.

24. Abusive family member verbalizes and learns to let go of feelings of inadequacy, failure, and fear that fuel the anger. (40, 41)

40. Empathize with and clarify feelings of hurt and anger tied to past traumas; once the abuse is contained, help the family understand the damage that abuse brings to the abuser's self-esteem.

41. Make the connection between the abuser's past feelings of rage when abused and current uncontrolled anger leading to the abuse of others.

25. Abusive family member verbalizes an understanding of the need for a process of forgiveness of others and self to begin to reduce anger. (42, 43)

42. Discuss the need for forgiveness of abuse from the past and the process of letting go of anger and resentment associated with that past abuse.

43. Request that the abusive family member read the book *Forgiveness is a Choice* by Enright, or *How Can I Forgive You?* by Abrams-Spring.

26. Family members identify negative communication patterns that facilitate abuse. (44)

44. Make the family aware of dysfunctional communication patterns that co-occur with, and increase the likelihood of, physical abuse (e.g., vocalized attributions of family members' blame of fault for problems, fast reciprocation of family members' anger, lack of empathy, contempt for or lack of respect for family members, defensiveness, withdrawal, coercive control/entitlement); suggest that the family read *Controlling People* by Evans.

27. Family members implement positive communication skills. (45)

45. Use role-playing and behavioral rehearsal techniques to teach positive communication skills (e.g., problem identification, "I" statements, listening skills, problem-solving skills, behavioral contracting) and assign practice.

28. Family members identify and implement alternative means of venting their anger and aggression. (46)

46. Teach the use of displacement techniques to ventilate anger (punching bag, jogging, bowling, kickboxing, etc.); caution the clients against seeing these activities as practice for aggression, but rather as energy-draining activities to reduce tension.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
	305.00	Alcohol Abuse
	303.90	Alcohol Dependence
	300.4	Dysthymic Disorder
	296.x	Major Depressive Disorder *[include specifier]*
	V61.10	Partner Relational Problem
	V61.12	Physical Abuse of Adult
	V61.20	Parent-Child Relational Problem
	995.81	Physical Abuse of Adult (Victim)
	995.54	Physical Abuse of Child (Victim)
	V61.21	Physical Abuse of Child
	_____	_____
	_____	_____
Axis II:	301.7	Antisocial Personality Disorder
	301.83	Borderline Personality Disorder
	301.6	Dependent Personality Disorder
	301.81	Narcissistic Personality Disorder
	_____	_____
	_____	_____

RELIGIOUS/SPIRITUAL CONFLICTS

BEHAVIORAL DEFINITIONS

1. Conflict between parents and/or children erupts over differently espoused creeds (e.g., father is Jewish, mother is Catholic).
2. Religious conflicts between parents affect decisions about rearing children in a particular faith.
3. Adolescent child decides to reject parents' religious faith/beliefs and refuses to attend services.
4. Parents conflict over disciplining children due to their respective religious faiths or spiritual beliefs (e.g., the use of physical versus nonphysical chastisement).
5. Family becomes lax in their faith practices and feels the loss of spirituality in their lives.
6. Parents attempt to instill their religious/spiritual beliefs in their children in a way (e.g., physical abuse, shaming) that is pushing the children away from the parents' faith.

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LONG-TERM GOALS

1. Family members resolve interfaith conflicts.
2. Parents and family members reach an accord about how children will be raised according to a chosen faith.
3. Family members decide at what age children are permitted to choose how they wish to worship and whether they attend services.
4. Parents reach agreement regarding how children will be reared that is in harmony with religious beliefs and wishes.
5. Family members attend church or synagogue services and engage in other faith practices on a regular basis.
6. Parents instill their faith's values in their children in a kind and respectful manner.

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SHORT-TERM OBJECTIVES

1. Parents verbalize the role that religion played in their upbringing and the beliefs that they brought to the marriage from their family of origin. (1)

2. Parents state current spiritual beliefs. (2)

3. Parents review their thoughts and perceived agreements regarding an interdenominational marriage and their earlier discussions on raising children. (3, 4, 5)

THERAPEUTIC INTERVENTIONS

1. Explore parents' histories of religious training, beliefs, and practices from their families of origin; ask each spouse to explain how his/her childhood experiences influence present practices and beliefs.

2. Ask each parent to articulate his/her current spiritual beliefs and the faith practices that he/she finds meaningful.

3. Have parents discuss what their expectations were once they decided to enter into an interdenominational marriage; explore any agreements regarding religious practices that were

	understood either implicitly or explicitly.
	4. Have parents explore, in the presence of children, how preexisting agreements regarding religious practices and/or children's training fell by the wayside and led to the present conflict.
	5. Explore any previously unverbalized misgivings about the religious training of the children.
4. Parents identify the impact their different religious beliefs have had on the marriage and later on the children. (6, 7)	6. Assist parents in identifying the effect their different spiritual beliefs and practices have had on their relationship and on the children.
	7. Explore any conflicts between a spouse and his/her in-laws over the issue of religious beliefs and practices.
5. Pinpoint the specific problem that exists about the differing religious beliefs and/or practices. (8)	8. Assist parents in identifying the specific conflict that exists between them regarding religious beliefs and/or practices; explore each spouse's belief system in terms of its view of the other spouse's belief system (suggest books such as *Peacemakers in Action* by Little).
6. Identify how the two religions strengthen the family and how they contribute to conflict. (9)	9. Brainstorm among family members to construct a list in which each family member cites pros and cons of the impact of two religions on the family.
7. Each family member acknowledges respect for each parent's religious beliefs and practices. (10)	10. Help family members construct a list of reasons to respect each parent's religious beliefs and practices; develop a contract to display respect for the freedom to exercise choice of belief.

8. Family members vent their frustration, resentment, and confusion about the religious conflict. (11)

9. Parents identify the problems that differing religions cause with child-rearing. (12, 13)

10. Children express what they like and dislike about their parents' respective religious beliefs and practices. (14)

11. Parents agree on the religious education and practice for the children. (15)

12. Family members express the need for flexibility in accepting different beliefs. (16, 17)

11. Facilitate an open expression of feelings regarding the conflict over religious beliefs and practices; focus on the children's confusion, frustration, and loyalty conflicts.

12. Highlight areas of conflict such as pressure for children to conform to one or the other religion, or grandparents' disappointment about certain milestones not reached, (e.g., Confirmation for Catholics, Bar/Bat Mitzvahs for Jews, Ramadan for Muslims).

13. Explore any lifestyle strictures that each parent's religious beliefs would impose on the children (e.g., not engaging in some forms of entertainment, dress code, foods eaten); resolve parental conflicts over these issues.

14. Ask the children to state their thoughts about desirable and undesirable characteristics of the parents' religious beliefs and practices.

15. Assist parents in expressing their desires regarding religious education for the children and what aspects of both religions they would like to see adopted; solicit agreement about religious education and practice.

16. Explore how family members could participate in practices of both religions and how a degree of flexibility may aid in conflict resolution.

17. Highlight core beliefs of each parent and how these may be respected and shared by all family members.

13. Family members list ways they will support the religious changes being made. (18)
14. Adolescent children attend special seminars that deal with an adolescent's life in an interdenominational family. (19)
15. Children delay pressing for religious autonomy until reaching an age agreed to by parents. (20, 21)
16. Family members increase religious practice behaviors that strengthen their faith and increase their spirituality. (22, 23)
17. Family members examine their own religious practices and verbalize how they can correct incongruencies between their behavior and the principles of their religion. (24, 25)
18. Discuss ways in which family members can support the agreements reached over religious training issues.
19. Have family members search through the congregation's denomination of each parent to locate teen programs addressing the issue of interdenominational families.
20. Assist parents in reaching an agreement about when children can make independent decisions regarding participation in religious practices.
21. Solicit agreement from the children to accept the parents' decision regarding when the children may make an independent decision about participation in religious practices.
22. Brainstorm about the denomination-related activities that the family can become involved in to help them avoid drifting away from their religion.
23. Encourage the family to engage in some recommitment exercises (e.g., meet with their religious leader privately, read meditational literature together) that promote the adherence to and practice of their religious beliefs.
24. Encourage the parents to examine whether their methods of instilling their religious values in their children are congruent with the value they are trying to instill (e.g., do they yell when trying to teach peaceful conflict resolution?).
25. Ask each family member to list changes he/she can work on to align their behavior with their religious belief system.

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DIAGNOSTIC SUGGESTIONS

Axis I:	V61.10	Partner Relational Problem
	V61.20	Parent-Child Relational Problem
	V62.89	Religious or Spiritual Problem
	_____	_____
	_____	_____
Axis II:	799.9	Diagnosis Deferred
	V71.09	No Diagnosis
	_____	_____
	_____	_____

REUNITING ESTRANGED FAMILY MEMBERS

BEHAVIORAL DEFINITIONS

1. Parents and offspring or siblings are voluntarily estranged and not communicating with each other due to a specific dispute or altercation.
2. Several offspring or siblings form coalitions with their siblings or parents against the estranged family member(s).
3. Resentment grows as time increases between estranged parties, causing alienation and negative sentiments to increase.
4. Conflict rises over new information received from third parties about the estranged family member(s) (e.g., an illness, a death, etc.).
5. Certain family members blame each other for the ongoing family conflictual estrangement.
6. Certain family members struggle during holidays or special occasions over the fracturing of the family and ultimate loss of cohesiveness.
7. Family members wrestle with the anger and resentment pent up over the conflict and estrangement.
8. Certain family members feel pressure by serving as the go-between for the estranged parties.

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LONG-TERM GOALS

1. Facilitate a reunification between estranged family members.
2. Dissolve coalitions between family members in an attempt to begin to dismantle roadblocks to reunification.
3. Reestablish contact between family members in an attempt to reduce unsettled feelings.
4. The family member(s) serving as the go-between extricate themselves from the familial conflict.
5. Solidify and strengthen rejuvenated relationships between the estranged family member(s).

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Family members verbalize anger, jealousy, or resentment about family conflicts and estrangements. (1)	1. Explore family members' thoughts and feelings about the estrangement via empathic listening; compare and contrast the different family members' feelings.
2. Define the specifics of the estrangement and what is perceived to have led to the original conflicts and subsequent estrangement. (2)	2. Gather perceptions and recollections about the specific areas of conflict and how each family member may take responsibility for his/her own actions in the conflict.
3. Family members share the specific emotions they are experiencing. (3)	3. Have each family member list the specific emotions (e.g., anger, resentment, etc.) they experience and how they change from day to day.

4. Specify the conflict and how this has affected the dynamics of the family. (4, 5, 6, 7)	4. Clarify and define the specifics of the conflict, indicating a timeline as to how it has unfolded.
	5. Identify what factors may have contributed to the actual estrangement over the conflict.
	6. Discuss and identify specific instances in which family dynamics have changed since the conflicts began.
	7. Demonstrate for the family how the emotional factors might be serving as a roadblock more than the actual conflicts themselves.
5. Identify the pros and cons of a reunification of estranged family members. (8, 9)	8. Assign the family members to make a list of the positive outcomes (pros) of reunification of the family; process this list in session.
	9. Assign the family members to generate a list of the negative outcomes (cons) if reunification fails.
6. Identify potential roadblocks to reunification. (10)	10. Make a list of the potential roadblocks of the reunification process (i.e., emotional, geographic distance, financial, health, etc.).
7. Identify potential ways to facilitate reunification. (11)	11. Consider various mediums of initial contact (i.e., written correspondence via e-mail, telephone contact, video).
8. Outline initial steps to facilitating reunification. (12, 13)	12. Delineate a written plan of action for initiating reunification of the family – how it will unfold, who will execute it and where, etc.
	13. Based on a positive reaction to the initial overture to the estranged family members, list any subsequent steps to take as follow- up.

9. Family members give their consent to go forward with reunification initiatives. (14)

10. Agree to a backup plan for failure of the initial steps of reunification. (15)

11. List reasons for a second attempt at reunification. (16, 17)

12. Agree as to how a second contact with the detached family member(s) will be done. (18, 19)

13. Identify a spokesperson for the initial contact with the estranged member(s). (20)

14. Determine and establish an area for the initial meeting. (21)

15. All family members share feelings and thoughts respectfully. (22, 23)

14. Have family members state their commitment to the process of reunification; work through any hesitancy or resistance by some members.

15. If the initial steps fail, brainstorm potential remedies (e.g., waiting for a period of time before making a second attempt, a different person making the overture).

16. Ask the family members to list the reasons that would warrant a second attempt at reunification.

17. Poll each family member about how he/she feels about further attempts at reunification.

18. Discuss the interventions that will be used with this second attempt.

19. Anticipate objections and potential roadblocks; brainstorm constructive responses to these roadblocks.

20. Ask for volunteers or have the group determine what family member would be less threatening and most effective at making the overture to the estranged family member.

21. Brainstorm potential locations based on their potential level of success.

22. Meet with the estranged member(s) and the rest of the family members to open the dialogue; encourage “I” messages and listening skills (e.g., eye contact, facial expression, empathic or reflective listening, etc.); give opportunity for the expression of individual perceptions and feelings.

23. Ask each family member to commit to keeping lines of respectful communication open even if disagreements persist.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
	V61.20	Parent-Child Relational Problem
	300.4	Dysthymic Disorder
	296.x	Major Depressive Disorder *[include specifier]*
	_____	_____
	_____	_____
Axis II:	301.83	Borderline Personality Disorder
	301.81	Narcissistic Personality Disorder
	301.50	Histrionic Personality Disorder
	_____	_____
	_____	_____

SEPARATION/DIVORCE

BEHAVIORAL DEFINITIONS

1. Marital difficulties lead to disagreements and arguments, causing ongoing erosion of the marital and family relationship.
2. Partners are alienated from each other, which places tension on the family unit.
3. Talk of separation sparks fears and concern among various family members, causing them to compensate in various ways (e.g., parentification or overindulgence).
4. Parents decide to separate, giving rise to questions about which family members remain in the home.
5. Children experience conflicted loyalties over being separated from one parent and perhaps from their siblings.
6. Parents decide to separate and/or divorce but remain under the same roof, contributing to coldness and estrangement in the home.
7. Financial difficulties arise as the result of operating two separate households, thus restricting family members' resources.
8. Symptoms of anxiety, depression, or acting-out behaviors (e.g., substance use, poor school performance, etc.) develop in family members.
9. New family members, in the form of stepparents, stepchildren, and stepsiblings, must be accommodated.
10. Child management problems develop as a result of single parenting and lack of support from ex-spouse.
11. Children assume some responsibility and guilt for the marital failure.

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LONG-TERM GOALS

1. Work through fears and learn to cope with the separation/divorce harmoniously.
2. Parents continue to nurture the children and reassure them that they are loved and are not responsible for the marital discord.
3. Reach a fair and reasonable financial settlement that places the needs of the children as a high priority.
4. Cope with new additions to the family as the result of remarriage or cohabitation and cooperate in supporting each other.
5. Parents agree to cooperate in issues of parenting and reduce the amount of conflict between them.
6. Children accept the breakup of their parents' relationship as being independent of anything they have said or done.

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SHORT-TERM OBJECTIVES

1. Parents verbalize their assessment of the marriage relationship. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Explore the nature and intensity of the marital conflict.
2. Assess whether there is motivation on the part of both spouses to attempt to resolve their conflicts.

2. Parents indicate they are amenable to couples therapy. (3, 4)	3. Refer the parents to a couples therapist or some other type of relationship intervention such as marriage encounter (see *Cognitive Behavior Therapy with Couples and Families: A Comprehensive Guide for Clinicians* by Dattilio). 4. Recommend selected readings on conflict resolution in marriage for the couple to review (e.g., *Fighting for Your Marriage* by Markman, Stanley, and Blumberg, or *The Seven Principles for Making Marriage Work* by Gottman and Silver).
3. Children state their perception of the nature and intensity of the parents' conflict. (5, 6)	5. Poll the other family members and assess their perceptions of the marital difficulties, determining whether or not they have an accurate picture of what is happening with the marriage. With children ages 10 and over, use direct dialogue or the Thinking, Feeling, and Doing Game (Gardner); with younger children, use drawings and play activity. 6. Facilitate the children in expressing their feelings about the marriage conflict; suggest that they write a story about the family or draw pictures to depict the dynamics.
4. Parents reduce the frequency of arguments and simultaneously engage in activities that promote cohesiveness within the family unit. (7, 8)	7. Suggest that the parents contain the ugliness of their marital problems (e.g., arguments, disagreements, etc.) and disengage from their battle when necessary to stay engaged with their children. 8. Encourage the use of structured family meetings to focus on the children's needs with less focus on the parents' issues.

5. Each family member openly shares his/her fears regarding the separation and/or divorce. (9, 10, 11)

6. Each family member explores his/her role in the family and how it has been impacted by the separation/divorce. (12, 13, 14)

9. Open up discussion about family members' fears and concerns regarding the marital breakup, walking them through the most dreaded outcome as if it were indeed to occur. Suggest reading books such as *Mom's House, Dad's House* by Ricci and *Dinosaurs Divorce* by Brown and Brown.

10. Suggest specific coping mechanisms for dealing with the defined fears and concerns (e.g., living with one parent and visiting the other on weekends, having less money to live on, etc.) such as open communication between the parents regarding the children, everyone pledging to sacrifice together financially, or holding periodic family meetings to exchange views.

11. Help the family members to identify support systems in the community as part of a coping mechanism (e.g., extended family, church groups, school services).

12. Facilitate family members in describing their roles in the family in light of the marital difficulties; use analogies or family sculpting techniques to accentuate these roles and discuss how they impact each family member.

13. Assess for family members who attempt to cope by using overcompensatory strategies (e.g., a child taking the role of the caretaker; a parent overindulging a child with material items).

14. Explore issues of balance of power, alliances, and caretakers that have emerged in the wake of the separation/divorce.

7. Family members identify and assume new roles as a reasonable adaptation to the situation. (15, 16)	15. Suggest exercises for role change or substitution by assigning different roles and having family members elaborate on how the roles feel.
	16. Introduce techniques (e.g., cognitive restructuring, challenging the evidence) that reinforce alteration in roles, expectations, and restructuring of perception (see *Case Studies in Couples and Family Therapy: Systemic and Cognitive Perspectives* by Dattilio).
8. Parents verbalize a desire to be sensitive to the children's feelings and needs in reaction to the separation/divorce. (17)	17. Suggest that parents read and discuss *How It Feels When Parents Divorce* by Krementz, or *Why Are We Getting Divorced?* by Mayle and Robbins.
9. Parents list the benefits of keeping the children in the original home as opposed to relocating them. (18, 19)	18. Brainstorm ways to avoid moving the children (e.g., having both parents rent an apartment outside of the home that each can use when he/she is spending time with the children; parents rotate in and out of the house while children remain; one parent rents a home very near the children to allow easy access and frequent visits).
	19. Reinforce the need for parents to work together in order to avoid placing the children in the position of having to choose which parent they want to live with; suggest that parents read *The Good Divorce* by Ahrons.
10. Children express any experience of being placed in a double bind and struggling with their loyalty toward parents. (20, 21)	20. Facilitate a mode of expression for children to convey how they feel about issues of loyalty and having to choose; consider using structured games (e.g., the UnGame by Zakich).
	21. Suggest that the family engage in creative exercises for children and

	adolescents to better understand the feelings about their parents' separation/divorce (e.g., for adolescents, use *Teens Are Nondivorceable* by Bonkowski, and for children, use *Children Are Nondivorceable* by Bonkowski).
11. Parents and children agree to maintain appropriate roles and boundaries. (22, 23)	22. Emphasize the need to maintain boundaries within the family and between family members. Address specific examples with children who attempt to become caretakers and parents who share intimate details with children, leaning on them for emotional support.
	23. Recommend that parents read material on family boundaries (e.g., *Boundaries: Where You End and I Begin* by Katherine).
12. Define the financial difficulties that have arisen due to the divorce and its negative impact. (24, 25)	24. Focus specifically on feelings and beliefs about how the loss of certain amenities will impact each family member; allow for the release of anger and resentment.
	25. Highlight specific coping skills needed due to the change in the financial situation (e.g., living with less, spending more wisely, borrowing items, generating other sources of income, or bartering; see the chapter on Financial Changes in this *Planner*).
13. Define the acting out occurring with the child/adolescent and how it is impacting the family. (26, 27)	26. Facilitate discussion for family members to outline the problematic behavior of children who are acting out in reaction to this family crisis, and the effects of that behavior on each family member.
	27. If the children's specific behavioral problems appear to be more than what can be addressed in family therapy, then refer them for individual or group therapy.

14. Children express their feelings and beliefs regarding interacting with a parent's dating partner and his/her children. (28, 29)

15. Identify the conflicts that result from attempting to blend children from two families. (30, 31)

16. Biological parents meet and agree to an approach to parenting together. (32, 33)

28. Allow for the children's ventilation of anger and resentment over having to meet and share with a parent's new mate and their children.

29. Establish a neutral zone in the family sessions for children to express themselves without fear of retaliation.

30. Have family members specifically define the conflict that occurs as a result of the blending of two family systems; use such techniques as Metaphors from *Problem-Solving Therapy* by Haley or Family Sculpting from *The New People Making* by Satir to facilitate the expression of emotion.

31. Assist the family in planning group activities involving children from both partners in an attempt to strengthen this bond (see *101 Interventions in Family Therapy* and *101 More Interventions in Family Therapy* by Nelson and Trepper); process the outcome of these activities.

32. Invite the biological parent/ ex-spouse into a conjoint session with the other biological parent in order to discuss differences in parenting philosophies, strategies, and misperceptions. Suggest the use of a unified parenting program (e.g., *Parent Effectiveness Training* by Gordon, "Parents and Adolescents" from *Behavioral Family Therapy* by Forgatch and Patterson, or *1-2-3 Magic* by Phelan).

33. Hold a separate conjoint meeting with the biological parents to address any resentments or feelings that may be feeding the children's acting-out behaviors.

17. Blended family parents report a plan for reducing their disagreements regarding stepparenting issues. (34, 35)

34. Conduct a separate conjoint meeting with parents of the blended family and address personal insecurities, feelings of loss of power, and needs to demonstrate favoritism; suggest alternative methods for dealing with these issues and explore how the spouse can be supportive during the change (see "Blended Family Problems" in *The Couples Psychotherapy Treatment Planner* by O'Leary, Heyman, and Jongsma).

35. Address the potential manipulation of the children against a single parent or in playing one parent against the other for power and territorial advantages.

18. Parents commit to making changes necessary to reduce parenting conflicts. (36)

36. Use role exchange and role alternatives for reducing parenting conflicts; ask family members to consider the advantages and disadvantages of behavior changes and deal with the emotional fear that accompanies change.

19. Children express resolution of any guilt over their parents' separation/divorce. (37, 38)

37. Have parents actively accept responsibility for the demise of their marriage and do whatever is necessary to help the children not to blame themselves.

38. Help the children engage in exercises that may reduce guilt and blame (e.g., monitoring statements of self-blame and telling themselves that it's okay to not assume the responsibility for the divorce).

20. Parents terminate blaming the spouse for the dissolution of the marriage. (39)

39. Encourage the parents to stop blaming each other and accept responsibility for their own behavior.

21. Children report successful social encounters in which they had to respond to questions about their parents' relationship. (40)

22. Children attend a support group for children of parents who are separating/divorcing. (41, 42)

40. Role-play various social contexts with the children and help them process situations that they may encounter socially that relate to questions about their parents' separation/divorce.

41. Refer the children to support groups for children of divorce in school or through the local church or community.

42. Process the children's experience in the support group and reinforce their success in responding to questions about the parents' divorce.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
	309.21	Separation Anxiety Disorder
	300.4	Dysthymic Disorder
	300.02	Generalized Anxiety Disorder
	313.81	Oppositional Defiant Disorder
	787.6	Encopresis
	307.6	Enuresis
	_____	_____
	_____	_____
Axis II:	301.6	Dependent Personality Disorder
	301.0	Paranoid Personality Disorder
	301.82	Avoidant Personality Disorder
	_____	_____
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SEXUAL ORIENTATION CONFLICTS

BEHAVIORAL DEFINITIONS

1. A family member divulges that he/she is homosexual/bisexual/transgendered.
2. The announcement of the family member's sexuality results in mixed emotions, rejection, and conflict with other family members.
3. The homosexual/bisexual/transgendered family member is ostracized, alienated, or mistreated by the other family members.
4. Parents blame themselves for the "abnormality" or "deviancy" of the offspring's sexual identity.
5. Parents externalize blame onto each other about their child's sexual preferences, causing heated arguments and ongoing conflict.
6. Family members reveal irrational fears that they will be negatively affected by the other family member's sexual orientation.
7. Family members fear social reprisal or rejection and avoid discussing the homosexuality issue outside or inside the family.
8. Family members have different views regarding homosexuality, causing major family schisms.
9. Family members reject the homosexual family member's friends or paramour.

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LONG-TERM GOALS

1. Family members acknowledge and accept the family member's sexual orientation.
2. Family members consider alternative responses to rejection of the family member and work through conflict issues that they have with the family member's sexual orientation.
3. Parents stop blaming themselves and each other for their child's sexual orientation and work together on a plan of acceptance.
4. Family members overcome their own irrational fears, as well as anticipation of societal rejection.
5. Family members respectfully accept differing views of sexual orientation without alienating one another.

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SHORT-TERM OBJECTIVES

1. Discuss the sexual preference revelation history and its impact. (1, 2)

2. Verbalize beliefs regarding the origins of sexual orientation. (3, 4, 5)

THERAPEUTIC INTERVENTIONS

1. Open a forum for discussion regarding how the sexual preference of a family member became known.
2. Allow for the ventilation of feelings regarding how the family member's sexual orientation is affecting everyone in the immediate family.
3. Open a discussion of family members' views surrounding the issue of heredity versus choice in determining a person's sexual orientation.
4. Talk about how each individual is influenced by family members, peers, and the media during their

	upbringing, and how this affects sexuality.
	5. Discuss some of the research on heredity and sexuality and how sexual preference may be genetically influenced.
3. Each family member articulates his/her moral values regarding the specific sexual practice. (6, 7, 8, 9)	6. Have family members express their moral values regarding sexual orientation and how their individual values may differ from those held by others in the family.
	7. Help the family members understand how they arrived at their moral values regarding sexual orientation.
	8. Help the family develop clarity regarding their religious and moral beliefs and whether or not the sexual orientation/behavior violates their religious beliefs.
	9. Assess any conflict that exists between family members regarding their differing moral beliefs about sexual orientation.
4. Eliminate statements and actions that convey rejection and judgment of the sexual orientation of the family member. (10, 11)	10. If family members believe that the individual member's sexual orientation violates their religious beliefs, then brainstorm ways individuals can address this issue (e.g., speak with their clergy, read literature with a different religious view, speak to clergy who are more accepting of non-heterosexual behavior, learn to accept the homosexual family member without necessarily condoning their behavior).
	11. Allow for a discussion of individual freedom to choose sexual practices and each individual family member's accountability for his/her own life choices without being subject to

judgment from others even though others may believe the sexual practice is immoral.

5. Respectfully express feelings that result from the family member's disclosure of his/her sexual orientation. (12)

12. Use role-playing, modeling, or assertiveness training to encourage family members to express their feelings of anger, outrage, alienation, or rejection in a manner that promotes release but is respectful of the gay/lesbian family member.

6. Identify and replace irrational beliefs that trigger negative emotions associated with sexual orientation. (13, 14)

13. Explore the family members' emotions associated with sexual orientation and assess for irrational beliefs that are triggering negative feelings.

14. Provide clear information regarding origins of sexual orientation to correct irrational beliefs based on erroneous information; allow the member to develop alternative thoughts that are based in reality.

7. Accurately state the differing beliefs of others concerning sexual orientation without acrimony. (15)

15. Use role-reversal techniques to allow family members to articulate and support the others' opinions so that they can consider some of the opposing views about sexual orientation.

8. Family members engage in social activities to build cohesiveness. (16)

16. Stress the importance of starting or continuing family activities and traditions that might reinforce family cohesiveness (see the chapter on Family Activity Disputes in this *Planner*).

9. Specify social rejection experiences and develop coping behaviors. (17)

17. Help family members determine whether or not they are indeed experiencing social alienation from others (e.g., by asking friends) because a member is gay/lesbian and how to cope with this (e.g., join a support group, locate community support resources for

	families of homosexual individuals).
10. Family members confront fears of social reprisal or rejection and develop ways to deal with it other than lying or avoidance. (18, 19, 20)	18. Review with family members what their specific fears are regarding societal reaction to homosexual orientation; have them rank the fears they consider to be realistic and those they consider unrealistic.
	19. Ask family members to role-play social events that deal with responding to questions about family members' marital status, sexual orientation, and so on; assist them in developing alternative, nondefensive responses.
	20. Ask family members to provide each other with feedback on the role-play.
11. Express feelings through the use of journaling or artwork. (21)	21. Suggest modes of expression of feelings through journal writing, artwork, or other modes that deviate from blunt, hurtful expression.
12. Verbalize a deeper understanding through reading about the issue of sexuality and various sexual preferences. (22, 23)	22. Suggest that the family members read literature in the area of human sexuality, such as *The Family Guide to Sex and Relationships* by Walker and *A Place at the Table* by Bawer.
	23. Discuss with the family what they have read about sexuality and how this affects their thoughts, feelings, and beliefs.
13. Parents terminate blaming themselves or each other regarding their child's sexual orientation. (24, 25, 26)	24. Allow parents to elaborate on why they blame themselves for their child's sexual orientation; look for instances of guilt or, possibly, fears about their own sexuality or being out of control.
	25. If unresolvable, significant, personal issues of guilt, anxiety, anger, rejection, or depression

	surface during the family session, suggest the possibility of meeting privately or refer the family member for individual therapy.
	26. If parents are blaming each other, interpret externalizing the blame as a defense for their own irrational guilt, fear, disappointment, or worry.
14. Family members express fears of "contagion" regarding sexual preferences. (27)	27. Explore family members' fears about their own sexual orientation, referring to educational materials (e.g., *Loving Someone Gay* by Clark) or specific lectures on the topic in the community.
15. Family members verbalize fears about social rejection or rejection from God. (28)	28. Allow family members to ventilate feelings regarding societal rejection or rejection from God, how this affects them, and the importance they place on this acceptance.
16. Family members attend a support group for families and friends of those with nonheterosexual orientations. (29)	29. Recommend that family members attend a support group such as Parents, Families, and Friends of Lesbians and Gays (PFFLAG); allow them to discuss their feelings about such a group and then process their attendance experience.
17. Identify commonalities and differences in beliefs regarding homosexuality. (30)	30. Brainstorm with family members about commonalities in their beliefs regarding homosexuality and where points of difference exist.
18. Verbalize understanding and acceptance of differing views regarding various sexual orientations, while embracing each other as loved family members. (31, 32)	31. Encourage cohesiveness within the family and weigh the costs of remaining divided versus forming more of a bond based on tolerance and acceptance.
	32. Review ways that family members can be more supportive of each other (e.g., increasing respectful communication; reinforcing the

idea that despite differing sexual orientations, they are still family).

19. Demonstrate acceptance of the family member's choice of a same-sex partner. (33, 34, 35)

33. Explore what is acceptable and what is not regarding a family member bringing home a same-sex partner (e.g., for a visit, for an overnight stay, sleeping together, etc.).

34. Discuss ways to increase acceptance for a same-sex partner of a family member and look beyond what might be superficial issues (e.g., disregard the individual's clothes or grooming and concentrate on the person, appreciate positive character traits, etc.).

35. Assign family members to list the positive and negative aspects of the family member's same-sex partner and the assets he/she brings to the family; process the lists together.

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DIAGNOSTIC SUGGESTIONS

Axis I:	300.4	Dysthymic Disorder
	302.6	Gender Identity Disorder NOS
	302.85	Gender Identity Disorder in Adolescents
	309.x	Adjustment Disorder with *[include specifier]*
	_____	_____
	_____	_____

Axis II:	301.82	Avoidant Personality Disorder
	301.6	Dependent Personality Disorder
	301.20	Schizoid Personality Disorder
	_____	_____
	_____	_____

TRAUMATIC LIFE EVENTS

BEHAVIORAL DEFINITIONS

1. A major event has occurred (e.g., natural disaster, crime victimization, employment loss, etc.), causing disruption and instability in the family.
2. Family dynamics become imbalanced as specific roles of family members are changed (e.g., one of the children has become parentified).
3. A sense of disengagement occurs with family members, causing feelings of alienation.
4. Feelings of helplessness and hopelessness develop in one or more family members.
5. Familiar family routines and rituals are disrupted.

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LONG-TERM GOALS

1. Face the major event, accept the changes that it has brought, and develop new methods for coping.
2. Resolve serious family conflicts and symptoms produced by the trauma or event.
3. Pull together and develop ways to function more cohesively in the face of the major life event.
4. Reestablish healthy and appropriate family role assignments.
5. Restore healthy family routines and rituals.

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SHORT-TERM OBJECTIVES

1. Identify the specific traumatic event that has affected the family. (1)
2. Describe the manner of coping with the traumatic event. (2)
3. Describe emotional, cognitive, and behavioral symptoms that have developed since the trauma. (3, 4, 5)

THERAPEUTIC INTERVENTIONS

1. Allow each family member to explain the traumatic event in his/her own words.
2. Assess the family's coping with the incidents, using instruments such as the Adolescent-Family Inventories of Life Events and Changes and Family Inventories of Life Events and Changes, in *Family Assessment Inventories for Research and Practice* by McCubbin and Thompson. For smaller children, use picture stories, drawings, or play assessment techniques.
3. Prompt each family member to describe any emotional, cognitive, or behavioral changes that have resulted from the trauma.
4. If the event was a major catastrophe (e.g., earthquake, assault/murder, robbery, etc.), then address the situation within the framework of a posttraumatic stress reaction; assess for symptoms related to posttraumatic stress disorder or an acute stress reaction.
5. If stress reactions are severe, consider referral of family

members for individual treatment (psychologist, psychiatrist, etc.) and maintain collateral involvement with the treating professional.

4. Describe the impact the trauma has had on individuals and the family unit. (6)

6. Facilitate the expression of family members' feelings and begin to discuss the differences in perception of the event and how it has affected each of them differently (e.g., construct lists of changes, make drawings, or write journals or poems).

5. Verbalize alternate interpretations of the crisis. (7)

7. Suggest exercises that may help facilitate viewing the trauma differently and reacting to it more adaptively (e.g., have them rewrite the story, describing how they could have coped with the situation in a more adaptive fashion).

6. Identify and implement more adaptive strategies to cope with the trauma. (8)

8. Use role-playing or modeling to teach new ways to react to unexpected, traumatic incidents (e.g., seeing challenges versus defeats, working together to overcome obstacles, relying on spiritual resources).

7. Implement conflict resolution techniques to reduce family tension. (9)

9. Use modeling and role playing to teach the family members conflict resolution techniques (e.g., "I" statements, complaining without blaming) to reduce tension in the family (see *Changing Families* by Fassler, Lash, and Ivers; also, see the chapters on Adolescent/Parent Conflicts and Child/Parent Conflicts in this *Planner*).

8. Engage in group activities as a family unit to build cohesiveness. (10, 11)

10. Assign the family to engage in cohesion-building activities (e.g., group or family activities with a goal of working together on a particular task).

	11. Teach the family that by engaging in more rewarding family activities, family members will improve the quality of the overall interaction and sense of cohesiveness; reinforce successful implementation of these assigned family activities.
9. Identify fears that cause resistance to family unity and cohesiveness. (12, 13)	12. Address the issue of any underlying fears (e.g., "If I get too close to you, you will try to control me" or "I'll lose my autonomy") that might exist regarding intimacy or cohesiveness.
	13. Help family members dispel fears of cohesiveness by facing them and considering alternative behaviors (e.g., "I can still be part of the family unit and maintain my autonomy and personal uniqueness") to aid in restructuring their belief systems.
10. Identify positive and negative behaviors that influence conflict resolution and coping with the trauma. (14)	14. Brainstorm with family members to generate a list of behaviors that will facilitate (e.g., active problem solving, focusing on things under their control), as well as those that will hinder (e.g., blaming, emotional "paralysis,") conflict resolution, and crisis coping.
11. Implement behavioral and cognitive strategies for inoculating against future stress resulting from life-changing events. (15)	15. Teach specific stress inoculation techniques (e.g., deep breathing, progressive muscle relaxation, cognitive restructuring, etc.) as crisis coping strategies (see "Family Therapy" in *Practicing Cognitive Therapy: A Guide to Interventions* by Dattilio or *Cognitive Behavior Modification* by Meichenbaum).
12. Attend community support groups to aid in crisis management. (16)	16. Help family members identify external support systems in the community to help them to cohesively respond to the crisis.

13. Verbalize acceptance of the fact that sometimes a situation is out of their control and they must simply cope effectively with it. (17, 18)

14. List changes that must occur in the manner in which the family is coping with the traumatic event. (19, 20, 21)

15. Identify a style of coping that fits individual strengths. (22)

16. Admit and terminate denial, and identify alternative coping strategies. (23, 24, 25)

17. When dealing with problems outside of their control, instruct family members to avoid trying to solve the external problem, but instead to support each other and decide how they can best react to the unchangeable problem.

18. Have family members imagine themselves in the near future coping successfully and share their thoughts about how they will handle the transition regarding the life-changing event that is out of their control.

19. Enlighten the family on how various families cope differently in the face of crisis; explain how the preexisting condition of the family predisposes them to deal with such events in a particular way.

20. Facilitate a discussion around what may need to change in the manner of the family's coping with the traumatic event.

21. Brainstorm with family members about how they might begin to introduce change in coping behavior in the face of the current event.

22. Help each family member adjust to a style of coping that fits best for him/her by using individual strengths as an advantage for self and the family unit.

23. Facilitate family members in admitting to their own denial as a defensive coping strategy in the face of trauma; use confrontative techniques or metaphors to help draw this out.

24. Have each family member identify alternative behaviors to counteract denial.

25. Facilitate family members' support/reinforcement of each other in overcoming denial and facing reality adaptively.

17. Each family member identifies his/her own stage of development in reaction to the current situation. (26, 27, 28)

26. Assess the level of adaptive functioning that exists with the family members by using an interview or an inventory (e.g., *Stages of Change Questionnaire in Health Psychology* [Prochaska et al.]).

27. Share the results of the assessment and lead the family in a discussion of their responses to the results.

28. Explain how their family differs from others and how their stage of development dictates how they cope with and survive traumatic crisis.

18. Identify conflicts that have arisen due to varying perceptions of the trauma and various styles of coping with it. (29)

29. Have family members describe the conflicts that exist within the family as a result of the crisis and the perceptions that contributed to them; seek out commonalities in members' perception to reduce divergent views.

19. Identify and resolve any underlying dynamics that are contributing to the family conflict. (30, 31)

30. Explore for any underlying dynamics in the family (e.g., jealousy, favoritism, etc.) that may be contributing to the conflict that results from the crisis.

31. Bring to light the underlying dynamics that contribute to conflict and have the family work toward resolution.

20. Identify role and routine changes that have resulted from the crisis and describe how to restore balance to the dynamics and routines of the family. (32, 33, 34)

32. Assist in defining the roles of each family member and discuss how they have come to be (e.g., how a particular child became parentified).

33. Discuss the effects of the crisis on family member roles and how a redefining of roles may contribute to the lessening of family pressures and tension.

34. Encourage the family to re-establish as many familiar routines as possible as soon as they are able.

21. Acknowledge changes that must occur within the family to resolve the conflict surrounding the trauma. (35, 36)

35. Assign family members to use the Miracle Question in *Clues: Investigating Solutions in Brief Therapy* by DeShazer by posing the question, "If all of you were to awaken tomorrow and, by way of a miracle, the conflict between you disappeared, how would you know it was gone?"

36. Discuss the Miracle Question responses in order to define the changes that must occur in the family to resolve conflict.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
	296.x	Major Depressive Disorder *[include specifier]*
	V61.10	Partner Relational Problem
	V61.20	Parent-Child Relational Problem
	_____	_____
	_____	_____
Axis II:	301.50	Histrionic Personality Disorder
	301.82	Avoidant Personality Disorder
	301.6	Dependent Personality Disorder
	_____	_____
	_____	_____

UNWANTED/UNPLANNED PREGNANCY

BEHAVIORAL DEFINITIONS

1. A teenage, unmarried family member becomes pregnant and decides that she wishes to keep and raise the child, contrary to her parents' and other family members' wishes.
2. Tension mounts over the disadvantages of keeping a child out of wedlock or when the mother is deemed too young as opposed to considering abortion or releasing the child for adoption.
3. A moral dilemma arises over the issues of considering abortion or releasing the child for adoption.
4. A parent is unexpectedly pregnant and experiences ambivalence about whether to keep the child, abort, or adopt the child out, because of the parent's age, economic constraints, medical/health problems, and so on.
5. Significant marital and/or family strife develops as a result of keeping the child in the family or seeking an abortion or adoption.
6. Family members become estranged over the issue of the pregnancy and choose not to confront it.
7. Parents who were contemplating divorce now discover they are expecting another child, placing pressure on them to attempt a reconciliation.

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LONG-TERM GOALS

1. Arrive at a united decision about how to respond to the unexpected/unwanted pregnancy.
2. Terminate self-blame and/or blame of others for the pregnancy.
3. Strengthen marital and/or family relationships by working through the dilemma.
4. Reunite estranged family members who have become alienated as a result of the pregnancy (see also the chapter on Reuniting Estranged Family Members in this *Planner*).
5. Parents consider pros and cons of reconciliation and whether or not to seek marital therapy for themselves.

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SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Identify feelings about the pregnancy and attempt to express them constructively. (1, 2, 3)	1. Open a forum for the expression of the emotions of the family members (e.g., fear and guilt on the part of the pregnant child, embarrassment and anger on the part of siblings, shame and anger on the part of the parents). 2. Reassure family members that these emotions are normal and real and can be used in the decision-making process. 3. Help family members bring their emotions to a stable level through venting, defining, bonding and the reassurance of solutions.
2. List the alternative courses of action that are available. (4, 5)	4. Help the family identify the situation as a crisis and that their initial emotional reaction may be

	clouding their use of sound judgment.
	5. Help the family to define the alternative responses to the pregnancy and reassure them that they have time to consider options.
3. Pregnant child reviews the options and arrives at a tentative decision. (6, 7)	6. Review with the pregnant child the options of adoption, abortion, or raising the baby; recommend readings (e.g., *In Good Conscience* by Runkle and *Should I Have This Baby?* by Jones).
	7. Recommend individual sessions with the pregnant child to evaluate whether her decision is reactionary, influenced by others, or soundly thought through and consistent with her moral beliefs.
4. Parents verbalize acceptance of their daughter's right to decide how to react to and treat her pregnancy. (8, 9, 10)	8. Encourage the family to be supportive of the pregnant child, to recognize her struggle and fear, and to acknowledge her right to choose a response.
	9. Review the concept of each individual's right to make life decisions and also that these decisions do not need to reflect the other family members' moral beliefs or feelings, but should be consistent with the moral beliefs of the pregnant child.
	10. Explore the parents' feelings of disappointment, loss of control, and fear for the child's and the unborn baby's futures.
5. Verbalize expectations regarding the future based on the current response plan. (11, 12)	11. Promote family discussion on what their expectations for the future are regarding the option selected.
	12. Refer the family to other families who may have been in similar situations (e.g., through an unwed mothers' group, adoption agencies, acquaintances).

6. Implement supportive communication styles to be used with the pregnant child. (13, 14)

13. Discuss coping strategies for living with each other after the action decision has been made; role-play and model appropriate versus inappropriate expressions of anger, fear, frustration, resentment, and guilt.

14. Discuss with family members ways in which to be supportive of one another (e.g., allowing time for venting anger, fear, or sadness; using "I" messages; using time-out to control anger); teach reflective listening skills.

7. Express respect for the right of the pregnant child to make the decision for abortion, even if it is contrary to the beliefs of others in the family. (15, 16)

15. Meet conjointly with the parents to establish and define what their feelings are regarding abortion and/or adoption, and then evaluate how this may be addressed in the course of family therapy.

16. Highlight the need for other family members to respect the rights of the pregnant individual despite any contrary feelings; help them recognize that they do not have to own the final choice.

8. Estranged nuclear or extended family members open lines of communication with the pregnant girl and other family members. (17, 18, 19)

17. Invite estranged family members to a therapy session; explore the feelings and thoughts of the estranged family members in regard to the pregnancy and the action decision that has been made.

18. Allow the pregnant child to express her feelings of hurt and sadness over the rift in the family in reaction to her pregnancy and response decision; ask each family member what he/she can do to reunite the family (see the chapter on Reuniting Estranged Family Members in this *Planner*).

19. Discuss the need for respect for another's decisions even though

	one may disagree with that decision; seek affirmation of love for one another in spite of differences and a stressful situation.
9. Parents express ambivalence about how to respond to the wife's unexpected pregnancy. (20, 21, 22, 23, 24)	20. If the spouses feel open to discussing the wife's unexpected pregnancy with other family members, then review the pros and cons of the response alternatives, remaining sensitive to the anger of the other family members.
	21. Explore the parents' ambivalence regarding the unexpected pregnancy, assisting them in clarifying the multiple factors and feelings they see as relevant.
	22. If the age or health of the pregnant parent is an issue, support the family in gathering all relevant medical information.
	23. Recommend that parents read *Should I Keep My Baby?* by Zimmerman to help them explore the issue of an unexpected pregnancy.
	24. Hold a separate conjoint interview with parents to discuss their feelings about the wife's unexpected pregnancy and any unconscious motives that may contribute to the wife's pregnancy.
10. Each family member expresses his/her feelings about the addition of a baby to the family. (25, 26, 27)	25. Explore what the addition of a baby means to each family member and how it will impact their lives; look for underlying feelings of resentment or jealousy in each family member, confronting any distortions or myths that may be fostering these feelings.
	26. Consider the use of some nondirective techniques such as

metaphors (e.g., an addition to the family is like adding extra baggage to an already overloaded cart) to reduce the tension within the family and address the estrangement over the decision to keep the child.

27. Discuss alternative ways of family members expressing feelings of resentment or discontent with the decision about how to respond to the pregnancy; use role-play and modeling to teach respectful use of "I" messages.

11. Parent who was contemplating separation or divorce verbalizes how this unexpected pregnancy affects that decision. (28)

28. Discuss the impact that the pregnancy has on the decision regarding whether to continue the marriage relationship; have parents consider how their decision will impact the other children.

12. Parents agree to further conjoint counseling. (29, 30)

29. Help the couple consider interim steps (e.g., separating within the household; traveling to the same location in separate vehicles; engaging in activities that give space in the relationship) prior to the decision to announce a separation and/or divorce to the family.

30. Review some of the alternatives to separating (e.g., separating within the household) and/or refer the couple for conjoint counseling.

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DIAGNOSTIC SUGGESTIONS

Axis I:	309.x	Adjustment Disorder with *[include specifier]*
	296.x	Major Depressive Disorder *[include specifier]*
	V61.10	Partner Relational Problem
	V61.20	Parent-Child Relational Problem
	308.3	Acute Stress Disorder
	_____	_____
	_____	_____
Axis II:	301.6	Dependent Personality Disorder
	301.83	Borderline Personality Disorder
	301.4	Obsessive-Compulsive Personality Disorder
	301.81	Narcissistic Personality Disorder
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Appendix A

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Appendix B

PROFESSIONAL REFERENCES FOR EVIDENCE-BASED CHAPTERS

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Appendix C

INDEX OF DSM-IV-TR™ CODES ASSOCIATED WITH PRESENTING PROBLEMS

Acute Stress Disorder **308.3**
- Death of a Child
- Death of a Parent
- Incest Survivor
- Life-Threatening/Chronic Illness
- Unwanted/Unplanned Pregnancy

Adjustment Disorder with *[include specifier]* **309.x**
- Activity/Family Imbalance
- Adoption Issues
- Anger Management
- Blame
- Blended Family Problems
- Communication
- Death of a Child
- Death of a Parent
- Extrafamilial Sexual Abuse
- Family Activity Disputes
- Family Member Separation
- Financial Changes
- Geographic Relocation
- Incest Survivor
- Infidelity
- Inheritance Disputes between Siblings
- Interfamilial Disputes over Wills and Inheritance
- Intolerance/Defensiveness
- Jealousy/Insecurity
- Life-Threatening/Chronic Illness
- Physical/Verbal/Psychological Abuse
- Reuniting Estranged Family Members
- Separation/Divorce
- Sexual Orientation Conflicts
- Traumatic Life Events
- Unwanted/Unplanned Pregnancy

Adjustment Disorder with Anxiety **309.24**
- Anxiety

Adjustment Disorder with Depressed Mood **309.0**
- Depression in Family Members
- Disengagement/Loss of Family Cohesion
- Multiple Birth Dilemmas

Adjustment Disorder with Mixed Anxiety and Depressed Mood **309.28**
- Anxiety
- Multiple Birth Dilemmas

Adjustment Disorder with Mixed Disturbance of Emotions and Conduct **309.4**
- Family Business Conflicts
- Family-of-Origin Interference

Alcohol Abuse **305.00**
- Alcohol Abuse
- Blame
- Communication

Disengagement/Loss of Family Cohesion
Family Activity Disputes
Financial Changes
Intolerance/Defensiveness
Physical/Verbal/Psychological Abuse

Alcohol Dependence 303.90
Alcohol Abuse
Blame
Communication
Disengagement/Loss of Family Cohesion
Family Activity Disputes
Financial Changes
Intolerance/Defensiveness
Physical/Verbal/Psychological Abuse

Anorexia Nervosa 307.1
Eating Disorder

Antisocial Personality Disorder 301.7
Anger Management
Blame
Financial Changes
Infidelity
Inheritance Disputes between Siblings
Intolerance/Defensiveness
Jealousy/Insecurity
Physical/Verbal/Psychological Abuse

Anxiety Disorder NOS 300.00
Anxiety

Attention-Deficit/Hyperactivity Disorder, Combined Type 314.01
Child/Parent Conflicts

Avoidant Personality Disorder 301.82
Alcohol Abuse
Anxiety
Dependency Issues
Depression in Family Members
Disengagement/Loss of Family Cohesion
Family Activity Disputes
Family Member Separation
Separation/Divorce
Sexual Orientation Conflicts
Traumatic Life Events

Bereavement V62.82
Death of a Child
Death of a Parent
Depression in Family Members

Bipolar I Disorder 296.xx
Activity/Family Imbalance
Compulsive Behaviors
Infidelity
Jealousy/Insecurity

Bipolar I Disorder, Single Manic Episode 296.0x
Financial Changes

Bipolar II Disorder 296.89
Activity/Family Imbalance

Borderline Personality Disorder 301.83
Adoption Issues
Anger Management
Blame
Communication
Compulsive Behaviors
Death of a Child
Death of a Parent
Depression in Family Members
Eating Disorder
Extrafamilial Sexual Abuse
Family-of-Origin Interference
Interfamilial Disputes over Wills and Inheritance
Intolerance/Defensiveness
Jealousy/Insecurity
Life-Threatening/Chronic Illness
Physical/Verbal/Psychological Abuse
Reuniting Estranged Family Members
Unwanted/Unplanned Pregnancy

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Eating Disorder

Conduct Disorder, Adolescent-Onset Type 312.82
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Cyclothymic Disorder 301.13
Depression in Family Members

Dependent Personality Disorder 301.6
Adoption Issues
Alcohol Abuse
Anxiety
Death of a Child
Death of a Parent
Dependency Issues

Depression in Family Members
Eating Disorder
Family Activity Disputes
Family Member Separation
Family-of-Origin Interference
Infidelity
Inheritance Disputes between Siblings
Life-Threatening/Chronic Illness
Physical/Verbal/Psychological Abuse
Separation/Divorce
Sexual Orientation Conflicts
Traumatic Life Events
Unwanted/Unplanned Pregnancy

Depersonalization Disorder 300.6
Extrafamilial Sexual Abuse

Depressive Disorder NOS 311
Death of a Parent
Dependency Issues

Disruptive Behavior Disorder NOS 312.9
Adolescent/Parent Conflicts
Child/Parent Conflicts
Extrafamilial Sexual Abuse
Family Member Separation
Geographic Relocation

Dissociative Disorder NOS 300.15
Extrafamilial Sexual Abuse

Dysthymic Disorder 300.4
Adoption Issues
Alcohol Abuse
Communication
Compulsive Behaviors
Death of a Parent
Dependency Issues
Depression in Family Members
Disengagement/Loss of Family Cohesion
Extrafamilial Sexual Abuse
Family Activity Disputes
Family Member Separation
Interfamilial Disputes over Wills and Inheritance
Life-Threatening/Chronic Illness
Multiple Birth Dilemmas
Physical/Verbal/Psychological Abuse
Reuniting Estranged Family Members
Separation/Divorce
Sexual Orientation Conflicts

Eating Disorder NOS 307.50
Eating Disorder

Encopresis 787.6
Family Member Separation
Separation/Divorce

Enuresis 307.6
Family Member Separation
Separation/Divorce

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Sexual Orientation Conflicts

Gender Identity Disorder NOS 302.6
Sexual Orientation Conflicts

Generalized Anxiety Disorder 300.02
Activity/Family Imbalance
Anxiety
Death of a Parent
Family Activity Disputes
Family Member Separation
Interfamilial Disputes over Wills and Inheritance
Life-Threatening/Chronic Illness
Separation/Divorce

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Activity/Family Imbalance
Communication
Compulsive Behaviors
Death of a Child
Death of a Parent
Eating Disorder
Family-of-Origin Interference
Inheritance Disputes between Siblings
Interfamilial Disputes over Wills and Inheritance
Life-Threatening/Chronic Illness
Reuniting Estranged Family Members
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Anger Management
Blame

Major Depressive Disorder 296.x
Adoption Issues
Anger Management
Blame
Communication
Dependency Issues
Disengagement/Loss of Family Cohesion
Eating Disorder
Family Activity Disputes
Infidelity
Intolerance/Defensiveness

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Physical/Verbal/Psychological Abuse
Traumatic Life Events
Unwanted/Unplanned Pregnancy

Major Depressive Disorder, Single Episode 296.2x
Activity/Family Imbalance
Compulsive Behaviors
Death of a Child
Death of a Parent
Depression in Family Members
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Financial Changes
Interfamilial Disputes Over Wills and Inheritance
Life-Threatening/Chronic Illness
Reuniting Estranged Family Members

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Extrafamilial Sexual Abuse

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Anger Management
Blame
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Family Activity Disputes
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Financial Changes
Infidelity
Inheritance Disputes Between Siblings
Interfamilial Disputes Over Wills and Inheritance
Interracial Family Problems
Intolerance/Defensiveness
Jealousy/Insecurity
Physical/Verbal/Psychological Abuse
Reuniting Estranged Family Members
Unwanted/Unplanned Pregnancy

Neglect of Child V61.21
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Child/Parent Conflicts

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Adolescent/Parent Conflicts
Child/Parent Conflicts

No Diagnosis or Condition V71.09
Adolescent/Parent Conflicts
Child/Parent Conflicts
Incest Survivor
Multiple Birth Dilemmas
Religious/Spiritual Conflicts

Obsessive-Compulsive Disorder 300.3
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Eating Disorder

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Anxiety
Compulsive Behaviors
Eating Disorder
Financial Changes
Intolerance/Defensiveness
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Child/Parent Conflicts
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Geographic Relocation
Incest Survivor
Separation/Divorce

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Anxiety

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Separation/Divorce

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Adoption Issues
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Anger Management
Blame
Blended Family Problems
Child/Parent Conflicts
Communication

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Disengagement/Loss of Family Cohesion
Extrafamilial Sexual Abuse
Family Activity Disputes
Family Business Conflicts
Geographic Relocation
Infidelity
Interracial Family Problems
Intolerance/Defensiveness
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Physical/Verbal/Psychological Abuse
Religious/Spiritual Conflicts
Reuniting Estranged Family Members
Traumatic Life Events
Unwanted/Unplanned Pregnancy

Partner Relational Problem V61.10
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Adoption Issues
Alcohol Abuse
Blame
Blended Family Problems
Child/Parent Conflicts
Compulsive Behaviors
Death of a Child
Disengagement/Loss of Family Cohesion
Eating Disorder
Family Activity Disputes
Family Business Conflicts
Family-of-Origin Interference
Geographic Relocation
Infidelity
Interracial Family Problems
Intolerance/Defensiveness
Jealousy/Insecurity
Physical/Verbal/Psychological Abuse
Religious/Spiritual Conflicts
Traumatic Life Events
Unwanted/Unplanned Pregnancy

Personality Disorder NOS 301.9
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Extrafamilial Sexual Abuse
Family Business Conflicts
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Adoption Issues
Anger Management
Jealousy/Insecurity
Physical/Verbal/Psychological Abuse

Physical Abuse of Adult (if focus of clinical attention is on victim) 995.81
Adoption Issues
Jealousy/Insecurity
Physical/Verbal/Psychological Abuse

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Anger Management
Child/Parent Conflicts
Incest Survivor
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Anger Management
Child/Parent Conflicts
Compulsive Behaviors
Incest Survivor
Physical/Verbal/Psychological Abuse

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Multiple Birth Dilemmas

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Extrafamilial Sexual Abuse
Incest Survivor

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Extrafamilial Sexual Abuse

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Extrafamilial Sexual Abuse

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Schizoid Personality Disorder 301.20
Disengagement/Loss of Family Cohesion
Extrafamilial Sexual Abuse
Sexual Orientation Conflicts

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Family Member Separation

Separation Anxiety Disorder 309.21
Death of a Parent
Dependency Issues
Family Member Separation
Life-Threatening/Chronic Illness
Separation/Divorce

Sexual Abuse of Child	**V61.21**
Adolescent/Parent Conflicts	
Child/Parent Conflicts	
Extrafamilial Sexual Abuse	
Incest Survivor	
Sexual Abuse of Child (if focus of clinical attention is on victim)	**995.53**
Adolescent/Parent Conflicts	
Child/Parent Conflicts	
Extrafamilial Sexual Abuse	
Incest Survivor	
Sibling Relational Problem	**V61.8**
Blended Family Problems	
Social Phobia	**300.23**
Anxiety	
Specific Phobia	**300.29**
Anxiety	

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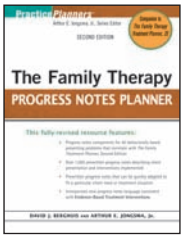

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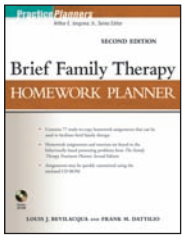

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