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Child Planning: A Treatment Planning Overview for Children Suffering Divorce

A Treatment Overview for Children Experiencing Parents Divorce or Separation

Duration: 3 hours

Learning Objectives:

Obtain a basic understanding of how to identifying, causes, symptoms of children with lying problems or history, and learn different options to complete a treatment plan that includes:

a. Behavioral Definitions
b. Long Term Goals
c. Short Term Goals
d. Strategies to Achieve Goals
e. DSM V diagnosis Recommendations

***For a full list of 24 short term goals with dozens strategies listed next to each goal check the Child Treatment App for Windows or Apple PC and Android Devices, under our main menu Windows-Apple Apps. Download the Free Demo to Evaluate***

Course Syllabus:
Introduction

Symptoms

Probable Causes

Diagnosis and Treatment

Steps to Develop a Treatment Plan that includes Behavioral Descriptors, Long Term Goals, Short Term Goals, Interventions/Strategies and DSM V CODE Paired with ICD_9 and 10-CM Codes for ODD

Sample Treatment Plan

Introduction:

One out of every two marriages today ends in divorce and many divorcing families include children. Parents who are getting a divorce are frequently worried about the effect the divorce will have on their children. During this difficult period, parents may be preoccupied with their own problems, but continue to be the most important people in their children's lives.

While parents may be devastated or relieved by the divorce, children are invariably frightened and confused by the threat to their security. Some parents feel so hurt or overwhelmed by the divorce that they may turn to the child for comfort or direction. This can add to the pressure and stress a child is experiencing. Divorce can be misinterpreted by children unless parents tell them what is happening, how they are involved and not involved, and what will happen to them. It is important to become familiar with the following divorce facts:

1. Women initiate divorce twice as often as men

2. 90% of divorced mothers have custody of their children (even if they did not receive it in court)

3. 60% of people under poverty guidelines are divorced women and children

4. Single mothers support up to four children on an average after-tax annual income of $12,200

5. 65% divorced mothers receive no child support (figure based on all children who could be eligible, including never-married parents, when fathers have custody, and parents without court orders); 75% receive court-ordered child support (and rising since inception of uniform child support guidelines, mandatory garnishment and license renewal suspension)

6. After divorce, women experience less stress and better adjustment in general than do men. The reasons for this are that (1) women are more likely to notice marital problems and to feel relief when such problems end, (2) women are more likely than men to rely on social support systems and help from others, and (3) women are more likely to experience an
increase in self-esteem when they divorce and add new roles to their lives.

7. Women who work and place their children in child care experience a greater stigma than men in the same position. Men in the same position often attract support and compassion.

8. Men are usually confronted with greater emotional adjustment problems than women. The reasons for this are related to the loss of intimacy, the loss of social connection, reduced finances, and the common interruption of the parental role.

9. Men remarry more quickly than women.

10. As compared to "deadbeat dads," men who have shared parenting (joint legal custody), ample time with their children, and an understanding of and direct responsibility for activities and expenses of children stay involved in their children's lives and are in greater compliance with child support obligations. There is also a greater satisfaction with child support amount when negotiated in mediation. Budgets are prepared, and responsibility divided in a way that parents understand.

11. Men are initially more negative about divorce than women and devote more energy in attempting to salvage the marriage.

Causes:

Most marriages failed for many reasons. However, most marriages follow a prescribed pattern before divorce happens:

I. DISILLUSIONMENT OF ONE PARTY (sometimes 1-2 years before verbalized)
   A. Vague feelings of discontentment, arguments, stored resentments, breaches of trust
   B. Problems are real but unacknowledged
   C. Greater distance; lack of mutuality
   D. Confidential, fantasy, consideration of pros and cons of divorce
   E. Development of strategy for separation
   F. Feelings: fear, denial, anxiety, guilt, love, anger, depression, grief

II. EXPRESSING DISSATISFACTION (8-12 months before invoking legal process)
   A. Expressing discontent or ambivalence to other party
   B. Marital counseling, or
C. Possible honeymoon phase (one last try)

D. Feelings: relief (that it's out in the open), tension, emotional roller coaster, guilt, anguish, doubt, grief

III. DECIDING TO DIVORCE (6-12 months before invoking legal process)

A. Creating emotional distance (i.e., disparaging the other person/situation in order to leave it)

B. Seldom reversible (because it's been considered for awhile)

C. Likely for an affair to occur

D. Other person just begins Stage I (considering divorce) and feels denial, depressed, rejected, low self-esteem, anger

E. Both parties feel victimized by the other

F. Feelings: anger, resentment, sadness, guilt, anxiety for the family, the future, impatience with other, needy

IV. ACTING ON DECISION (beginning the legal process)

A. Physical separation

B. Emotional separation (complicated by emotional flare ups)

C. Creating redefinition (self orientation)

D. Going public with the decision

E. Setting the tone for the divorce process (getting legal advice and setting legal precedent: children, support, home)

F. Choosing sides and divided loyalties of friends and families

G. Usually when the children find out (they may feel responsible, behave in ways to make parents interact)

H. Feelings: traumatized, panic, fear, shame, guilt, blame, histrionics

V. GROWING ACCEPTANCE (during the legal process or after)

A. Adjustments: physical, emotional

B. Accepting that the marriage wasn't happy or fulfilling
C. Regaining a sense of power and control, creating a plan for the future, creating a new identity, discovering new talents and resources

D. This is the best time to be in mediation: parties can look forward and plan for the future; moods can be more elevated (thrill of a second chance at life)

Symptoms in Children:

Children often believe they have caused the conflict between their parents. Many children assume the responsibility for bringing their parents back together, causing them additional stress.

Vulnerability to both physical and mental illnesses can originate in the traumatic loss of one or both parents through divorce. With care and attention, however, a family’s strengths can be mobilized during a divorce, and children can be helped to deal constructively with the resolution of parental conflict.

Divorce brings change, with many children adapting and welcoming new people into their lives. Divorce can also bring chaos, with parents in the survival mode and having less energy for their kids and constantly changing child custody. Physical and behavioral symptoms in children can be a cry for help and attention during this chaotic period.

1. Children may exhibit stomach and headaches. As a part-time school nurse, I see students who routinely have stomach aches and say they feel ill. The antacids given seem to be more of a placebo, since their real need is to talk or regroup in a quiet place away from peers. Some express what is not working out with visitation or other divorce concerns. When kids are stressed; little things can tip them over the edge; a test, a blow up with a buddy, etc.; and they come in with headaches. After a short break and voicing frustrations, these kids are ready to go back to class.

2. Some kids develop behavioral or neurological issues. One young lad was caught in the middle of a tug-of-war between his divorced parents and started having tics. His stress was compounded by a task oriented teacher who was not nurturing. His doctor appropriately ran neurological tests, but it seemed to me to be the result of an emotional issue. Delving into this matter brought to light that the boy was unable to handle 50/50 shared care. His parents and a third party worked together and decided to have the mother’s house as his primary residence allowing liberal contact with his father. The tics became a thing of the past with this amended custody arrangement. A second grader started pulling out his eyelashes due to stress. He saw a child psychologist for short-term therapy which ended this abnormal behavior and gave him strategies to deal with his volatile world.

3. Some children revert back to more infantile behavior after their parents’ divorce. They may regress to bedwetting or having accidents during the day. A few may want their bottle again or speak in baby talk. Yet others become clingier or cry more often. If a child was sleeping through the night, she may wake up and want to come into a parent’s room. Some kids experience nightmares. One four year old started having frightening dreams of giants chasing her after her parent’s divorce. It does not take a therapist to analyse that the giants represented her parents and the girl’s lack of control in her situation.
4. A little acting out in the aftermath of divorce is normal, being belligerent teetering on the brink of violence, is not. If kids are not following rules and are trying to dodge consequences, then help may be required. If possible, check with the co-parent on the kid’s behavior with them, and devise a consistent code of conduct and repercussions for infractions. Family counselling can be helpful for airing concerns and getting all back on track.

5. Mood swings may become dramatic post-divorce. The teens may answer in one word syllables or demand more time alone. They cry more easily or become restless. One young student became jittery after his parent’s divorce and requires a release of this pent-up energy. Sometimes he and I do a few laps around the track and then he can be more still in the classroom.

6. Children may become quiet and more withdrawn. Needing extra down time is fine, but retreating into a fantasy world is not. One high school boy became immersed in a fictional place of wizards and other creatures as a place of safety after his parents acrimonious divorce. He had short-term therapy which propelled him back to reality. Forgetting about one’s woes during a movie, TV show, or book is healthy, but dwelling there is not.

7. If a child shuns friends and activities, discuss this with them. Get feedback from teachers, coaches and other adults in the child’s life and let them know about the divorce. Get an evaluation if the child is continuing to be withdrawn, since this may be a red flag for an underlying condition. The child may be clinically depressed and need intervention. Several students developed eating disorders after their parents’ divorces and one ended up in a hospital for several months.

8. Check for signs of impairment from drugs or alcohol usage. Are they secretive or is money missing from around the house? They may be experimenting with drugs. Discuss these concerns with your child’s doctor. It is better to nip these destructive tendencies in the bud, rather than do a series of stints in rehab, like some celebrities. If new friends are a bad influence, see what can be changed, such as enrolling in a different school, or a summer away from home at the grandparents’ summer cottage.

Children’s psychological reactions to their parents’ divorce vary in degree dependent on three factors:

(1) the quality of their relationship with each of their parents before the separation,

(2) the intensity and duration of the parental conflict, and

(3) the parents’ ability to focus on the needs of children in their divorce.

Older studies showed boys had greater social and academic adjustment problems than girls. New evidence indicates that when children have a hard time, boys and girls suffer equally; they just differ in how they suffer. Boys are more externally symptomatic than girls, they act out their anger, frustration and hurt. They may get into trouble in school, fight more with peers and parents. Girls tend to internalize their distress. They may become depressed, develop headaches or stomach aches, and have changes in their eating and sleeping patterns.
What follows are some typical experiences of children to divorce and separation:

A. DENIAL

This especially occurs in young children and surfaces as story telling (Mommy and Daddy and me going to Disneyland; we're moving into a duplex and Daddy will live next door; they will also have reconciliation fantasies).

B. ABANDONMENT

When parents separate, children worry who will take care of them. They are afraid they too are divorceable and will be abandoned by one or both of their parents. This problem is worsened by one or both parents taking the children into their confidence, talking about the other parent in front of the children, using language like "Daddy is divorcing us," being late for pick-up, or abducting the children. Children who are feeling insecure will say things to a parent which is intended to evoke a mama bear/papa bear response (a demonstration of protective ness). If children do not have "permission" to have a good relationship with the other parent, or if they think they need to "take care of" one of their parents in the divorce, they are likely to end up having feelings of divided loyalties between their parents or, in the extreme, they may become triangulated with one parent against the other parent.

C. PREOCCUPATION WITH INFORMATION

Children will want details of what is happening and how it affects them. Communication from the parents needs to be unified and age appropriate.

D. ANGER AND HOSTILITY

Children may express anger and hostility with peers, siblings, or parents. School performance may be impaired. Hostility of children toward parents is often directed at the parent perceived to be at fault. Hostility turned inward looks like depression in children.

E. DEPRESSION

Lethargy, sleep and eating disturbances, acting out, social withdrawal, physical injury (more common in adolescents).

F. IMMATURITY/HYPERMATURITY
Children may regress to an earlier developmental stage when they felt assured of both parents' love. They may do some "baby-talk" or wet their beds. Children may become "parentified" by what they perceive to be the emotional and physical needs of their parents ("Someone needs to be in charge here.")

G. PREOCCUPATION WITH RECONCILIATION

The more conflict there is between the parents, the longer children hold onto the notion of their parents' reconciliation. It is clear that the parents are not "getting on" with their lives. Children will often act out in ways which force their parents to interact (negatively or positively). Children whose parents were very conflictual during the marriage often mistake the strong emotions of conflict with intimacy. They see the parents as engaged in an intimate relationship.

H. BLAME AND GUILT

Because so much marital conflict may be related to the stress of parenting, children often feel responsible for their parents' divorce--they feel that somehow their behavior contributed to it. This is especially true when parents fight during exchanges of the children or in negotiating schedules: children see that parents are fighting over them. They may try to bargain their parents back together by promises of good behavior; they may have difficulty with transitions or refuse to go with the other parent.

I. ACTING OUT

Children will often act out their own and their parents' anger. In an attempt to survive in a hostile environment, children will often take the side of the parent they are presently with. This may manifest in refusals to talk to the other parent on the phone or reluctance to share time with the other parent.

Adolescents will typically act out in ways similar to how the parents are acting out.

Signs of Stress in Children:

Sometimes parents need help identifying stress in children, especially little ones. What follows are some typical experiences and signs of stress in children of different ages.

I. INFANTS AND TODDLERS:

A. Regression in terms of sleeping, toilet training or eating; slowing down in the mastery of new skills
B. Sleep disturbances (difficulty going to sleep; frequent waking)
C. Difficulty leaving parent; clingingness
D. General crankiness, temper tantrums, crying.

II. THREE TO FIVE YEARS:
A. Regression: returning to security blankets and discarded toys, lapses in toilet training, thumb sucking

B. Immature grasp of what has happened; bewildered; making up fantasy stories

C. Blaming themselves and feeling guilty

D. Bedtime anxiety; fitful/fretful sleep; frequent waking

E. Fear of being abandoned by both parents; clinginess

F. Greater irritability, aggression, temper tantrums. III. SIX TO EIGHT YEARS:

A. Pervasive sadness; feeling abandoned and rejected

B. Crying and sobbing

C. Afraid of their worst fears coming true

D. Reconciliation fantasies

E. Loyalty conflicts; feeling physically torn apart

F. Problems with impulse control; disorganized behavior. IV. NINE TO TWELVE YEARS:

A. Able to see family disruption clearly; try to bring order to situation

B. Fear of loneliness

C. Intense anger at the parent they blame for causing the divorce

D. Physical complaints; headaches and stomach aches

E. May become overactive to avoid thinking about the divorce

F. Feel ashamed of what's happening in their family; feel they are different from other children.

Signs of Stress in Adolescenses:

A. Fear of being isolated and lonely

B. Experience parents as leaving them; feel parents are not available to them

C. Feel hurried to achieve independence

D. Feel in competition with parents

E. Worry about their own future lives and marriage; preoccupied with the survival of
relationships

F. Discomfort with a parent's dating and sexuality

G. Chronic fatigue; difficulty concentrating

Also check for:

Regressive behaviors-baby talk- rocking- etc

Emergence of bed-wetting

Onset of mature behaviors

Suppressing painful emotions about parents' divorce

Assuming of parental roles or responsibilities

Psychosomatic complaints due to stress and frustration

Loss of contact with a parental figure due to separation

Loss of contact due to geographic move

Intense emotional reactions (such as- crying- anger- begging)

Fears and worries about being abandoned or separated from a parent
Marked increase of acting out

Aggressive behaviors since separation- or divorce

Loss Identify adult role models

Major decline in school performance

Lack of interest or motivation in schoolwork

Strong feelings of grief and sadness

Feelings of low self-worth

Social withdrawal

Feelings of guilt for failing to prevent divorce

Diagnosis and Treatment:

Numerous kids can manage divorce or separation in a sensibly productive way on account of their innate strength; the parents' capacity and readiness to convey and work together in a sound way; and the help of more distant family individuals and others in the group. Then again, youngsters might be battered and harmed by factors that are specifically or in a roundabout way connected with the separation: lessened child rearing time with one or the two guardians; monetary shakiness; migration, which includes changing schools and losing parents; and the bother of going between the parents' homes. Mental Health Clinicians must realize that the absolute most essential factor that damages children experiencing separation
is ceaseless clash between the parents during the divorce process. Youngsters are harmed when their parents battle before them, over them, and through them.

Mental Health Clinicians may recognize various mental conditions in kids who encounter high-clash separation or divorce, which are portrayed in this article and doled out suitable phrasing in DSM-5.

Parental estrangement

Parental estrangement isn't a mental issue; it alludes to a youngster's dismissal of a parent for a justifiable reason. For instance, a youngster may decline to have an association with a parent who beforehand was damaging or careless or who deserted the family. On the off chance that one of the parents executed abusive behavior at home inside the family, it is reasonable that the youngster may abstain from child rearing time with that individual. It isn't a mental issue to dismiss a relationship and abstain from investing energy with an injurious individual; it is typical for a youngster to act in that way.

Even when parental estrangement isn’t a mental issue, there are terms in DSM-5 that can be used to identify children who experience this condition. In DSM-5 abuse and neglect are found in the section “Other Conditions That May Be a Focus of Clinical Attention,” which are referred to as “conditions and problems,” rather than “mental disorders.” This segment incorporates individual history of physical abuse and a history of neglect. At the point when a clinician confirms that a youngster displays parental estrangement, one of those terms might be utilized to set up the suitable diagnosis.

Transitory adjustment problem

Divorce or separation can have many manifestations, which may appear as excessive stressing, bitterness, outrage, oppositional conduct, hindered social connections, and low school performance. These side effects may happen when the child first learns about his parents separation or divorce folks intend to separate, when the parents fight or argue and major changes happen in the child's life, for example, moving to another area. The typical diagnosis is one of the adjustment disorders (eg, adjustment disorder with anxiety).

Loyalty conflict

Loyalty conflict happens when the kid tries to keep up a positive association with the two parents, despite the fact that their are fighting with each other. For instance, when the youngster is with parent A, he or she may miss parent B. when he or she is with parent B, he misses parent A. The higher the level of parental clash, the more exceptional struggle the child faces. When this conflict becomes too extreme, the child encounters psychological-cognitive dissonance, an uncomfortable mental state that occurs when a person holds at the same time 2 thoughts that are incompatible or contradictory. The higher cognitive dissonance becomes the more prominent the mental uneasiness increases.
A few kids endeavor to determine adapts in a way that appears to be versatile, given their troublesome conditions. For instance, a few youngsters can face their parents and request to left out of any conflict between them!" When parents argue, the child may opt to go to another room or play outside. During the initial assessment, the child may proclaim impartiality: he may state that he adores the two parents similarly proclaim that she or he needs both parents to share care. Some children try to resolve their loyalty conflict in a clearly maladaptive manner, by aligning with parent A and rejecting parent B. This mental process is called parental alienation.

DSM-5 introduced new terms "Relational Problems," which is part of "Other Conditions." One of the new mental conditions in DSM-5 where a child is affected by parental relationship distress. This category should be used when the focus of clinical attention is the negative effects of parental relationship conflict (eg, high levels of conflict, distress, or disparagement) on a child or family, including effects on the child's mental health or other medical disorders. If a child is experiencing a loyalty conflict that causes distress or dysfunction, the diagnosis may be affected by parental relationship distress.

Internalized chronic stress

If high conflict between the parents continues for an extended period, the child's symptoms may become internalized and develop into a more serious mental health condition. The symptoms may cluster to take the form of an anxiety disorder, a depressive disorder, or a somatic symptom disorder. Children of divorced parents had more sleeping problems, headaches, stomachaches, tenseness, and sadness than children in non divorced or conflict families.

Regarding possible DSM-5 diagnosis, major depressive disorder and suicidality may develop when a child grieves the loss of his previous family life or the loss of time with the other parent. If the child expresses the fear of losing the custodial parent, it may develop into a separation anxiety disorder. If a child repeatedly witnessed parental conflict during child transitions from one household to the other, it may cause physical symptoms before, during, and after the transition. In that case, the diagnosis may be somatic symptom disorder.

Children may follow several paths in a high-conflict separation or divorce. The children may avoid much of the conflict by declaring not taking any sides and being neutral. Nevertheless, the child may still experience some degree of loyalty conflict; they may internalize the stressors associated with the conflict and develop a serious mental disorder. A child may experience "parentectomy," meaning that he or she becomes enmeshed with one parent and soundly rejecting the other parent because of the false belief that the alienated parent is evil or dangerous. Fortunately, DSM-5 attempts to address by diagnosing:

child affected by parental relationship distress,

parent-child relational problem,
Steps to Develop a Treatment Plan:

The foundation of a good treatment plan is based on the gathering of the correct data. This involves following logical steps the built-in each other to help give a correct picture of the problem presented by the client or patient:

The mental health clinician must be able to listen, to understand what are the struggles the client faces. This may include:

- issues with family of origin,
- current stressors,
- present and past emotional status,
- present and past social networks,
- present and past coping skills,
- present and past physical health,
- self-esteem,
- interpersonal conflicts
- financial issues
- cultural issues

There are different sources of data that may be obtained from a:

- clinical interview,
- Gathering of social history,
physical exam,

psychological testing,

contact with client's or patient's significant others at home, school, or work

The integration of all this data is very critical for the clinician's effect in treatment. It is important to understand the client's or patient's present awareness and the basis of the client's struggle, to assure that the treatment plan reflects the present status and needs of the client or patient.

There are 5 basic steps to follow that help assure the development of an effective treatment plan based on the collection of assessment data.

Step 1, Problem Selection and Definition:

Even though the client may present different issues during the assessment process is up to the clinician to discern the most significant problems on which to focus during treatment. The primary concern or problem will surface and secondary problems will be evident as the treatment process continues. The clinician may need to plan accordingly and set some secondary problems aside, as not urgent enough to require treatment at this time. It is important to remember that an effective treatment plan can only deal with one or a few problems at a time. Focusing in too many problems can lead to the lost of direction and focus in the treatment.

It is important to be clear with the client or patient and include the client's or patient's own prioritization of the problems presented. The client's or patient's cooperation and motivation to participate in the treatment process is critical. Not aligning the client to participate my exclude some of the client's or patient's needs needing immediate attention.

Every individual is unique in how he or she presents behaviorally as to how the problem affects their daily functioning. Any problems selected for treatment will require a clear definition how the problem affects the client or patient.

It is important to identify the symptom patterns as presented by the DSM-5 or Diagnostic and Statistical Manual or the International Classification of Diseases (ICD).

DIVORCE BEHAVIORAL DESCRIPTORS:
1. Emergence of regressive behaviors such as thumb sucking, baby talk, rocking, bed-wetting.

2. Onset of mature behaviors and suppressing painful emotions about parents' divorce and assuming parental roles or responsibilities.

3. Psychosomatic complaints in response to stress and frustration.

4. Loss of contact or very little contact with a parental figure due to separation, or loss of contact due to geographic move.

5. Intense emotional reactions (such as, crying, anger, begging) associated with parents separation or divorce.

6. Real or imagined fears and worries about being abandoned or separated from a parent.

7. Marked increase of acting out, and aggressive behaviors since the parents' marital problems, separation, or divorce.

8. Identify adult role models to build a support network outside the family.

9. Major decline in school performance and lack of interest or motivation in schoolwork.

10. Strong feelings of grief and sadness combined with feelings of low self-worth, and social withdrawal.

11. Feelings of guilt for failing to prevent their divorce from occurring.

Step 2, Long Term Goal Development:

This step requires that the treatment plan includes at least one broad goal that targets the problem and the resolution the problem. These long term goals must be stated in non-measurable terms but instead indicate a desired positive outcome at the end of treatment.

LONG TERM GOALS FOR DIVORCE IN FAMILY:

1. Increase acceptance of separation or divorce.

2. Increase control of feelings and behavior experienced due to parents' separation.

3. Explore and relieve fear of abandonment and establish loving, secure relationship with both or at least one the parents.

4. Reduce guilt feelings that reflect self-blame for parents' divorce.

5. Stabilize and increase positive mood.
6. Assure consistent visitation arrangement that meets minor's emotional needs.

7. Develop with parents appropriate parent-child boundaries in discipline responsibilities.

8. Parents show mutual respect for one another, especially in front of the children.

9. Help minor develop a supportive social network outside immediate family to offset loss of support from within family.

Step 3, Objective or Short Term Goal Construction:

Objectives or short term goals must be stated in measurable terms or language. They must clearly specify when the client or patient can achieve the established objectives. The use of subjective or vague objectives or short term goals is not acceptable. Most or all insurance companies or mental health clinics require measurables objectives or short term goals.

It is important to include the patient's or client's input to which objectives are most appropriate for the target problems. Short term goals or objectives must be defined as a number of steps that when completed will help achieve the long-term goal previously stated in non-measurable terms. There should be at least two or three objectives or short-term goals for each target problem. This helps assure that the treatment plan remains dynamic and adaptable. It is important to include Target dates. A Target day must be listed for each objective or short-term goal.

If needed, new objectives or short-term goals may be added or modified as treatment progresses. Any changes or modifications must include the client's or patient's input. When all the necessary steps required to accomplish the short-term goals or objectives are achieved the client or patient should be able to resolve the target problem or problems.

If required all short term goals or objectives can be easily modify to show evidence based treatment objectives. The goal of evidence based treatment objectives (EBT) is to encourage the use of safe and effective treatments likely to achieve results and lessen the use of unproven, potentially unsafe treatments. To use EBT in treatment planning state restate short term goals in a way that steps to complete that goal and achieve results. For example, the short term goal “13. Increase positive self-descriptive statements.” Can be restated as; “By the end of the session the patient or client will list at least 5 positive self descriptions of himself or herself, and assess how they can help alleviate the presenting problem.” Remember, that it must be stated in a way one can measure effectiveness.

It is important to note that traditional therapies usually rely more heavily on the relationship between therapist and patient and less on scientific evidence of proven practices.

EXAMPLES OF SHORT TERM GOALS FOR DIVORCE IN FAMILIES:

1. Encourage minor to participate in positive peer group and extracurricular or school-related activities.
2. Encourage minor to attend a support group with other children of divorce.

3. Increase minor’s contacts with positive.

4. Help parents recognize how their guilt and failure to established and follow through with limits contributes to acting-out or aggressive behaviors.

5. Reduce the frequency and severity of anger.

**Step 4, Strategies or Interventions:**

Strategies or interventions are the steps required to help complete the short-term goals and long-term goals. Every short term goal should have at least one strategy. In case, short term goals are not met, new short term goals should be implemented with new strategies or interventions. Interventions should be planned taking into account the client’s needs and presenting problem.

**EXAMPLES OF INTERVENTIONS FOR DIVORCE IN FAMILIES:**

1. Reduce the frequency and severity of anger by helping minor build a pyramid out different plastic containers placing anger on top, and allow the minor to throw a small fabric ball at the tower while verbalizing feelings of anger connected to the divorce.

2. Encourage parents not to let their own guilt feelings about divorce interfere with the need to impose consequences for acting out or oppositional behaviors.

3. Encourage parents to establish clearly defined rules, boundaries, and consequences for acting-out, oppositional behaviors.

4. Help minor understand how an increase in acting-out behaviors is connected to emotional pain surrounding the parents' divorce.

5. Assign the parents to read information or a book that increases their skills to deal with acting-out, oppositional, and aggressive behaviors.

**Step 5, Diagnosis:**

The diagnosis is based on the evaluation of the clients present clinical presentation. When completing diagnosis the clinician must take into account and compare cognitive, behavioral, interpersonal, and emotional symptoms as described on the DSM-5 Diagnostic Manual. A diagnosis is required in order to get reimbursement from a third-party provider. Integrating the information presented by the DSM-5 diagnostic manual and the current client’s assessment data will contribute to a more reliable diagnosis. It is important to note that when completing a diagnosis the clinician must have a very clear picture all behavioral indicators as they relate to the DSM-5 diagnostic manual.
Adjustment Disorders Specify whether:

309.0 (F43.21) With depressed mood
309.24 (F43.22) With anxiety
309.28 (F43.23) With mixed anxiety and depressed mood
309.3 (F43.24) With disturbance of conduct
309.4 (F43.25) With mixed disturbance of emotions and conduct
309.9 (F43.20) Unspecified
309.89 (F43.8) Other Specified Trauma- and Stressor-Related Disorder
309.9 (F43.9) Unspecified Trauma- and Stressor-Related Disorder

Conduct Disorder Specify whether:

312.81 (F91.1) Childhood-onset type
312.32 (F91.2) Adolescent-onset type
312.89 (F91.9) Unspecified onset

Specify if: With limited prosocial emotions
Specify current severity: Mild, Moderate, Severe

Anxiety Disorders

309.21 (F93.0) Separation Anxiety Disorder

Major Depressive Disorder

Single episode

296.21 (F32.0) Mild
296.22 (F32.1) Moderate
296.23 (F32.2) Severe
296.24 (F32.3) With psychotic features
296.25 (F32.4) In partial remission
296.26 (F32.5) In full depression
296.20 (F32.9) Unspecified

V611.20 (Z62.820) Parent-Child Relational Problem
V61.8 (Z62.29) Upbringing Away From Parents
V611.29 (Z62.898) Child Affected by Parental Relationship Distress
V611.03 (Z63.5) Disruption of Family by Separation or Divorce
V61.8 (Z63.8) High Expressed Emotion Level Within Family

Sample Treatment Plan:

Present Behavioral Descriptors of Problem:

1. Loss of contact or very little contact with a parental figure due to separation, or loss of contact due to geographic move.
2. Marked increase of acting out, and aggressive behaviors since the parents' marital problems, separation, or divorce.
3. Major decline in school performance and lack of interest or motivation in schoolwork.

Long Term Goals:

1. Increase acceptance of separation or divorce.
2. Increase control of feelings and behavior experienced due to parents' separation.
3. Reduce guilt feelings that reflect self-blame for parents' divorce.
4. Stabilize and increase positive mood.

Short Term Goals Objectives:
Allow the expression of any feelings of anger about the separation or divorce using respectful verbalizations.

Encourage parents not to let their own guilt feelings about divorce interfere with the needs of the child.

Strategy or Intervention for Goal 1:

Explore, encourage, verbal expressions and clarify any feelings associated with the separation or divorce.

Increase minor connection with the family unit by helping minor create a photo album of family and major memories by gathering a diverse collection of photographs, and allow him to verbalize feelings about changes in the family system.

Strategy or Intervention for Goal 2:

Challenge parents to cease making hostile or critical remarks about the other parent in the presence of the client.

Counsel the parents not place minor in the middle by having her or him solicit information
about the other parent or sending messages to the other parent about adult matters.

Explore feelings of guilt and self-blame about the separation, and identify the roots of these feelings to assist family deal with those behaviors.

DSM V Diagnosis:

313.81 (F91.3) Oppositional Defiant Disorder

Attention-Deficit/Hyperactivity Disorder Specify whether:

314.01 (F90.2) Combined presentation