A case study using best and normative treatments related to adjustment disorder, alcohol abuse, and sexual abuse of child

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A CASE STUDY USING BEST AND NORMATIVE TREATMENTS RELATED TO ADJUSTMENT DISORDER, ALCOHOL ABUSE, AND SEXUAL ABUSE OF CHILD

By
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ABSTRACT

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A CASE STUDY USING BEST AND NORMATIVE TREATMENTS RELATED TO ADJUSTMENT DISORDER, ALCOHOL ABUSE, AND SEXUAL ABUSE OF CHILD
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The purpose of this study was to examine the effectiveness of normative and best therapy techniques with individuals diagnosed with Adjustment Disorder, Alcohol Abuse, and Sexual Abuse of Child using a case study format. The subject of this study was a 15 year old female who presented with a three-week onset of depressed mood. For the purpose of this study she was seen over a four month period. Treatment emphasis was on reducing depression and anxiety related to the sexual abuse. The Trauma Symptom Checklist for Children and the Children’s Depression Inventory were chosen for this study. Post-testing suggested significant decrease in both depression and anxiety.
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Chapter 1

Psychosocial Assessment

Identifying Information

Name of Client: Christine Smith (real name confidential)
Age of Client: 15 years old

Presenting Problem:

Christine Smith was a 15 year old, white female student who presented with a three-week onset of depressed mood. Other symptoms reported were loss of energy, loss of interest in school, difficulty concentrating, social isolation, weight loss and increased alcohol consumption. Christine had missed eight school days during the past three weeks. Three weeks ago, Christine reported being sexually assaulted by a 19 year old male after she was “hanging out, drinking at his house with his friends.” Christine met this male at the mall about two months ago. They have spoken over the phone on several occasions before he invited her over to his house. Christine stated that he invited her into his bedroom when he started to unbutton her shirt. She said, “no” several times before he became very forceful and ripped the top button of her pants while pulling them down. Christine stated, “he held my arms above my head while having sex with me.” After this incident, the male insisted on driving Christine home. She asked to be dropped off at an apartment complex where she saw a payphone. When Christine was getting out of the car, he stated, “I’ll give you a call tomorrow,” which made Christine feel like he did
nothing wrong. Christine continued to cry and called her mother from the payphone. Her mother picked her up and took her to the hospital for an exam. The hospital gave Christine’s mother the phone number to call this agency for an initial assessment.

Christine had lost 10 pounds over three weeks; she reported this is due to not having an appetite.

**History of Presenting Problem:**

Christine reported experiencing symptoms of depression for the past three weeks. She reported that it is harder and harder to get out of bed everyday and go to school. She also stated that it is hard to do the things she once loved doing such as talking on the phone to friends. Christine stated that she would never go to the mall again for fear of meeting another male. She had never had a boyfriend before and had never engaged in any sexual experience. Prior to this incident, Christine stated that she was an average kid as evidenced by hanging out with friends, talking on the phone, playing sports, and attending school. While hanging out with friends, Christine reported consuming alcohol every weekend. She stated this behavior was normal and all of her friends would drink on weekends. For the past three weeks, Christine reported drinking every day or night. She would drink whatever alcohol was in the house without her family knowing. She preferred liquor called “Christians’ Brothers” or “99 Bananas,” but her garage had a beer meister in it, which is owned by her brother. Christine reported sneaking beer from it. Christine stated that her family would never know if any beer was missing. Christine stated that while growing up, she had episodes of crying and feeling sad. She attributes these feelings to her father being an alcoholic and drinking too much. Christine remembers crying herself to sleep, and then feeling better in the morning. She reported
that these episodes of crying would only last a few hours about once a month. Christine vividly remembers her father telling her to go to bed, “and if you make a noise, I’ll beat you.” Her bed squeaks especially when she was trying to get comfortable. Christine stated that every night she would lay in bed very still not to move for fear her father would beat her.

Prior Efforts to Address the Problem:

Christine reported never being in therapy before. She stated that one year ago, she spent three weeks in a shelter/detention center after she and her sister tried to run away because they both did not like the way their mother was treated by their father. Christine stated that she was 14 years old at the time and did not remember much of the situation except that her mother wanted her to go to “straighten out.” Christine felt that maybe her mother wanted her and her sister out of the house for fear of their safety. After she received the phone number to this agency, her mother wanted her to place the call. Christine reported that she was scared and wanted her mother to make the call. Her mother made the call two and a half weeks later.

Family Relationships:

At the time of intake Christine’s immediate family consisted of her mother, Janet and father, Bob who were married, sister, Mary aged 16, and brother, Tyler aged 18. The members living in the house with Christine were: mother, brother, sister, and her sister’s 9-month-old daughter, Sarah. Christine’s mother worked for the post office, her father worked for Septa, her sister worked for a catering company while attending school at night, and her brother worked for a furniture company. Christine’s occupation was a student. Christine reported that even though her father lives in Philadelphia, she saw him
at least once a week. Christine’s father was currently not residing in the home. Christine has been told by her mother that the reason is that her father does not get along with her brother. However, she felt that it has more to do with the fact that her father is a recovering alcoholic and Christine’s brother has a problem with alcohol. She also stated that her brother had gotten two DWI’s and her mother has to take him to work everyday. Christine reported that there was a high level of conflict in the family. Christine stated her brother had a bad temper and that they do not communicate at all. Christine also stated that, while growing up, there was a lot of screaming and yelling in the house between the mother and son and the father and son. When asked Christine could not think of any family strength until a reminder of the support she received from her mother after the assault. Christine reported that her mother tries to hold the family together by planning family functions such as a bar-b-que that she planned last summer. Christine stated that it was a disaster because her father and brother would not stop fighting. The biggest conflict the family had was when they found out that Christine’s sister, Mary, was pregnant at the age of 14. Mary’s boyfriend of 6 months is the father of Sarah. Mary and her boyfriend are still together. However, they do not live together, but he was emotionally and financially supportive towards Sarah. Christine reported that her mother was an emotional roller coaster at this time. She stated that her mother would always cry and say, “Are we ever going to be a normal family?” Christine’s mother had also stated she felt partly to blame in her daughter’s teenage pregnancy because she had failed to provide a stable family/home. She has never given justification about this statement, but Christine feels that her mother was referring to her father and not handling his anger and drinking properly. Sarah was about 2 years old and Christine reported that her mother
was a good grandmother and really enjoyed babysitting the baby when Mary had to work. Janet was upset about the initial news that her daughter was pregnant; and Bob would not speak to Mary for several months. This was a typical behavior from her father. He goes through periods of not speaking to anyone in the house. Christine felt as though he just takes turns being a non-supportive father to each of the children. She also stated that it was her turn as evidenced by his inability to talk to Christine about the sexual assault.

Christine reported that a normal day in her family was very quiet when her father was not present. Christine’s mother would cook dinner for everyone, except her brother who would never show up. Christine’s father usually comes down for dinner once or twice a week. Christine reported that while growing up her mother and father would fight at least once a month over money. Their relationship worsened when her father came home drunk. Her parents had a difficult time and unstable relationship throughout her childhood, including frequent physical abuse when her father was intoxicated. This accelerated as the marriage went on, with more conflict taking place in front of the children. Christine reported that she was physically abused by her father, but does not remember if her siblings were. The last episode of physical abuse took place when Christine was 12 years old, and soon after this incident, her father was treated for an alcohol addiction. She recalls only being abused by her father a few times during her life. He would mainly slap her across the face if she did not do what he asked immediately. She recalls being 12 years old and her father asking her to retrieve a beer out of the refrigerator. Since she was watching TV and planned to get it during a commercial, he leaned over and slapped her across the face. She would cry to her mother who was very comforting and sent the kids outside while she tried to reason with her husband. On one
hand, Christine felt emotionally supported by her mother, but on the other hand, she harbors some anger towards her mother for staying with an abusive man. Christine felt she can communicate with her mother and in the past has asked her why she stayed with her father. Christine’s mother replied that she loved him and he was a good financial provider for the family. Christine’s mother was the primary disciplinarian and would ground the children from any privileges when they deserved it. However, Christine feels that the discipline in the house has been unstable as evidenced by her mother’s inability to control the behavior of her children. For example, Christine’s brother has had two DWI’s in the past, but his mother has not taken away the beer meister he has in the garage. This showed an inconsistency in discipline as well as his mother enabling him to drink alcohol. Christine recalled her sister being grounded at the age of 13 when she stole $20 from her mother’s purse. Her father would discipline the kids when he was intoxicated, increasing the inconsistency of household discipline.

Drugs, Alcohol, and Addictive Behavior:

Christine stated that she has been consuming alcohol since the age of 13. She began drinking with friends on weekends. She recalled drinking at least a six-pack of beer and/or shots of hard alcohol. She did not have a preference of either. Last year, Christine’s sister called 911 after Christine fell down a flight of steps and was vomiting. Christine was admitted to the hospital and had her stomach pumped which she does not recall. After this incident, her mother took away phone privileges and grounded her from going out for two months. Christine recalled not consuming any alcohol during those two months. For the past three weeks, she had been drinking alone every day or night. She also hid this from her family and friends. However, prior to the past three weeks,
Christine reported that many of her friends would tell her to slow down, which would annoy her. She also reported consuming alcohol everyday to hide her depressed feelings. She reported consuming eight to ten shots of liquor or six to ten beers at each drinking interval. Her intervals are at least once a day for the past three weeks. Christine feels that she may have a problem drinking, but reported that she does not have a desire to stop. She stated, “It makes me feel good.” Christine reported smoking marijuana on two occasions about six months ago. She also used to smoke Newport cigarettes but quit after her dentist told her it was bad for her teeth. She quit smoking cigarettes about 4 months ago. Christine has not used any other drugs or prescription medication and reported no other addictive behaviors.

Early Development/Neurological History:

Christine reported no neurological problems or head injury. She also reported having a normal childhood as far as developmental milestones are concerned.

Medical and Psychiatric History:

Christine reported no medical problems. She last had a physical exam before this school year started in order to play sports and goes to the dentist every six months. She also reported no known knowledge of psychiatric problems in her family, with the exception of her father, who is recovering from an alcohol addiction. Christine reported no health changes in the past six months. Since the incident, she has been tested for the HIV virus and other sexually transmitted diseases, all of which have come back negative. Christine will be checked again in six months.

Education and Job History:
Christine is in 9th grade and reports adjusting well from middle to high school. It has only been since the sexual assault that she did not want to go to school and had missed eight out of the past 15 school days. Christine was an average student and in the middle school received mostly A's and B's in her courses. She reported doing homework, but since missing so many days, her grades have fallen behind. In the past, Christine has been involved in many sports such as basketball, track, and cross-country. She was involved in cross-country this year, but has not been to any practice or meets for the past three weeks. Christine earns an allowance for chores around the house.

Social Supports and Patterns of Relationships:

Christine received emotional support from her mother. Christine stated that her mother is very warm and understanding towards her. She felt different toward her father mainly due to his past drinking patterns and not being a permanent member in the house. Christine did not belong to a church or any community groups besides sports, which she has dropped out of. Christine has never had a serious boyfriend, but was initially interested in her attacker before the incident. She reported a fear of getting to know anyone of the opposite sex for fear they may do the same thing to her. She has never had sexual intercourse prior to the sexual assault. She has several female friends but had not made any contact with them in the past three weeks. Christine reported that she is very close to her sister and her 9-month-old niece. Prior, to the sexual assault, Christine would hang out with and talk to her friends on a daily basis.

Situational Stressors:

Christine reported that there have not been any situational stressors in the past six months except for the rape incident.
Coping Mechanisms and Interpersonal Strengths:

Christine had been coping with stress by consuming alcohol on a daily basis. She stated that when she was angry, she lost control and threw things such as a shoe in her bedroom. Prior to the assault, Christine would cope with stress by exercising and especially running. She would drink on the weekends. Christine appeared motivated to treatment as evidenced by her openness and directness in sharing her personal feelings.

Other Agency Involvement

The only other agency that has been involved is the hospital that Christine went to after the sexual assault and the local police department after the report was made.

Perception of Self and Motivation towards Treatment

Christine stated that she viewed herself as “a normal girl with a messed up family.” However, she also felt very weak as evidenced by her loss of energy, loss of interest in school, and difficulty concentrating. Christine also saw herself as not being able to trust any males, which is why she had socially isolated herself. Her main treatment goal was to learn how to “handle the bad things that happen to me.”

Mental Status:

Christine appeared her stated age and was appropriately dressed and groomed. She was oriented to person, place, and time and was cooperative with the evaluation. Her intelligence, language skills, and ability to abstract were above average, consistent with her 9th grade education. Her mood was moderately depressed, while her affect was slightly constricted but appropriate to the situation. No obvious perceptual or cognitive deficits were noted. Her immediate, short term, and long term memory appeared intact.
She denied suicidal and homicidal ideation, intentions or plan currently. Her insight into her current situation was fair. Her judgment was poor regarding substance abuse.
Chapter 2

Differential Diagnosis

Diagnosis

Axis I: 309.0 Adjustment Disorder with Depressed Mood, Acute
305.00 Alcohol Abuse
V61.21 Sexual Abuse of Child (995.52)
R/O Posttraumatic Stress Disorder, Acute Stress Disorder, Conduct Disorder, Oppositional Defiant Disorder, Major Depressive Disorder

Axis II: V71.09 No diagnosis

Axis III: None

Axis IV: Social isolation, loss of interest in school, loss of energy, difficulty concentrating, increased alcohol consumption, lack of consistent support from mother and father

Axis V: GAF=35 (current)

Axis I

309.0 Adjustment Disorder with Depressed Mood, Acute

DSM – IV (2001, p. 679) defines an Adjustment Disorder as a “psychological response to an identifiable stressor or stressors that result in the development of clinically significant emotional of behavioral symptoms.” In order to meet the criteria for the diagnosis of an Adjustment Disorder, the symptoms have to develop within 3 months...
after the stressor has occurred and the symptoms must be accompanied by either “marked
distress that is in excess of what would be expected from exposure to the stressor” or by
“significant impairment in social or occupational (academic) functioning” (DSM-IV, p. 683).

Christine’s symptoms appear consistent with the diagnosis of an Adjustment Disorder. Specifically, she developed emotional and behavioral symptoms in response to an identifiable stressor: the traumatic event of the sexual assault that took place three weeks prior to her referral. In reference to the diagnostic criterion of “marked distress” Christine developed emotional symptoms that include that include feeling sad, social isolation, loss of interest in school, loss of energy, difficulty concentrating, and increased alcohol consumption.

The diagnostic criteria of significant impairment in social or occupational functioning were documented in both of these areas. For example, Christine isolated herself from interactions with friends and family members. In addition, she stopped attending school and her after-school activities.

The specifier, “Acute” was used because the duration of symptoms has been less than 6 months. According to the DSM-IV criteria, symptoms of Adjustment disorder usually do not persist longer than 6 months after the stressor has terminated.

The specifier “with depressed mood” was given because Adjustment Disorders are coded according to the subtype that best characterizes symptoms displayed by the client. Specifically, Christine exhibits predominant manifestations such as depressed mood, tearfulness, and feelings of hopelessness.

305.00 Alcohol Abuse
DSM-IV (2001, p. 198) defines Substance Abuse as a “maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.” In order to meet the criteria for a diagnosis of Alcohol Abuse, a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by recurrent substance use in situations, which it is physically hazardous. In the past year, Christine fell down a flight of stairs, and had her stomach pumped after due to alcohol consumption. She also has been drinking alcohol on a consistent basis as a way of coping with her depressed feelings.

**Rule Outs**

An Adjustment Disorder can only be diagnosed if the symptoms are a response to a specific stressor and they do not meet the criteria for another Axis I disorder. In order to ensure diagnostic clarity, a number of other diagnostic options were explored.

First, Christine exhibited some of the symptoms characteristic of a depressive episode. According to the DSM-IV (2001, p. 355) Major Depressive Disorder can be differentiated from Adjustment Disorder with Depressed Mood by the failure to meet the full criteria for a Major Depressive Episode. Specifically, Christine did not meet the criteria of insomnia or hypersomnia nearly everyday, psychomotor agitation or retardation nearly everyday, recurrent thoughts of death, recurrent suicidal ideation, significant weight loss, and feelings of inappropriate guilt. Symptoms experienced by Christine did not meet the full criteria for Major Depressive Episode; therefore Major Depressive Disorder cannot be diagnosed.

The symptoms experienced by the Christine have developed after a traumatic event that involved sexual assault. This might suggest a diagnosis of Posttraumatic Stress
Disorder or Acute Stress Disorder. The DSM-IV (2001, p. 463) defines “the essential feature of Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person’ or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.” Christine clearly experienced a traumatic event but did not have the symptoms characteristic for these disorders such as; recurrent distressing dreams of the event, flashbacks, and reexperiencing the traumatic event are not present in this case.

Conduct Disorder and Oppositional Defiant Disorder were also ruled out. Christine did not show aggression to people and animals, destruction of property, theft, or show a pattern of defiant behavior lasting at least 6 month. Therefore, both disorders mentioned could not be diagnosed.

In summary, the psychological symptoms experienced by Christine did not meet the full criteria for any of the disorders discussed above. Taking into consideration the predominant symptoms, their severity and duration, Adjustment Disorder with Depressed Mood and Alcohol Abuse was diagnosed.

Axis II

V71.09 No diagnosis

Axis III

None
Axis IV

Psychosocial and Environmental Problems

➢ Social isolation
➢ Loss of interest in school
➢ Loss of energy
➢ Difficulty concentrating
➢ Increased alcohol
➢ Lack of consistent support from mother and father

Axis V

Global Assessment of Functioning (GAF) Scale

GAF = 35 at time of initial assessment

At the time of initial assessment, Christine’s functioning was at the seriously impaired level. She experiences major impairment in several areas, such as mood, school, and family/friends relations.
General Information on Adjustment Disorder

Adjustment disorder covers a wide range of emotional or behavioral symptoms that arise after the onset of certain disruptive life changes or "stressors" in an individual's life. While many different situations can certainly elicit varying degrees of upset, adjustment disorder is characterized by distress that is excessive in relation to the stressor and ends up hindering key areas of an individual's life, including social, academic, or occupational functioning.

Adjustment disorder can affect anyone and is fairly common. The stressor may be a single event or, in many cases, the disorder is a reaction to multiple stressors. An individual usually experiences the symptoms of the disorder within three months of the stressor. Adjustment disorder is considered acute if it lasts less than six months and chronic when it persists for more than six months. Prevalence figures vary widely. Andreasen and Wasek (1980) report adjustment reaction in 5% of all new psychiatric adolescents and adult in and outpatients seen during a 4-year period in an Iowa teaching hospital and clinic. In contrast, Jacobson, Goldberg, and Burns (1980) found that between 3.4% and 10.1% of children seen in four separate general medical setting suffered from mental illness and that from one-quarter to more than one-half of those children received the diagnosis of transient situational disturbance. It was the most common psychiatric diagnosis in three of the four settings. This may be partially due to
the reluctance of some practitioners to diagnosis more serious disorders in children. Adjustment disorder satisfies insurance needs.

The occurrence of Adjustment Disorder among children experiencing significant stress is also, not well researched. Older studies (Pless & Rohmann, 1971) suggested that approximately 30% percent of children suffering a chronic medical illness develop psychological symptoms. This agrees with more recent work (Kovac, Feinberg, & Paulauskas, 1985), which found that 33 % of children newly diagnosed with insulin-dependent diabetes mellitus developed an Adjustment Disorder within the first 3 months. Studies of community disasters as well have found that approximately one-third of children suffer symptoms of a severity approximating the adjustment disorders. The New York Longitudinal Study of Temperament (Chess & Thomas, 1984) sheds further light on prevalence by noting that adjustment disorder was the primary diagnosis in 40 of the 45 children in their study who developed a mental illness prior to 13 years of age.

Although reactions, or symptoms, largely depend on the individual and on the event or situation that caused the initial distress, Adjustment Disorder usually first presents as a negative change in work or school performance along with significant changes in social relationships. Some people with Adjustment Disorder experience symptoms very similar to depression. High levels of worry and separation anxiety are also possible symptoms. Some people manifest their symptoms through their personal conduct, such as becoming withdrawn.

Treatment Options for Adjustment Disorder in Adolescents

The predominant symptoms of Adjustment Disorder with Depressed Mood are depressed mood, tearfulness, and hopelessness. Children and adolescents with this
disorder can be quite distraught and may even have suicidal thoughts and make suicidal attempts on occasion. When Adjustment Disorder with depressed mood was studied longitudinally in children, 50 percent recovered in six months, and all recovered within seventeen months (Singer, Singer & Anglin, 1993). Even though some cases remit without intervention, Adjustment Disorder is not a minor condition requiring no treatment. It is painful for the client and their family and is likely to worsen if the illness and its underlying causes are not addressed.

Treatment begins with a thorough evaluation, including a search for physical causes for any physical symptoms present. Because Adjustment Disorder can mimic so many different psychiatric disorders, such other conditions must be sought in the hope of finding a specific treatment for the child's difficulties.

The next step is to remove the stressor, if possible. Treatment is greatly facilitated if the stressor can be eliminated. However, often that cannot be done. Death and loss, and similar traumas require adjustment rather than removal. The core of treatment typically centers on both working with the child individually to address his or her concerns and working with the family about many of the same issues. Treatment should be brief and focused, with an emphasis on the child's adjustments to the difficulties he or she has experienced. The stressor must not be ignored, and the child should be allowed and encouraged to express fear, anxiety, resentment, and anger. A supportive, problem-solving approach often works well, but an insight-oriented focus may be required if dynamic issues are prominent. Family therapy may be an equally essential mode of intervention. This should also be supportive and should pay attention to the parent's
distress over the child's situation. There is limited research in this area and treatment relies heavily on clinical judgment (Tomb, 1991).

The pharmacological treatment of depressive disorders in children and adolescents is confined to the treatment of Major Depressive Disorder. Virtually no empirically supported information is available about the use of medication to treat Adjustment Disorder with depressed mood (Singer, Singer & Anglin, 1993).

There are relatively few studies of Adjustment Disorder (Andreasen & Wasek, 1980, Andreasen & Hoenk, 1982, Cantwell & Baker, 1989, Newcorn & Strain, 1992 and Kovacs, Gatsonis, Pollack, & Parraone, 1994) and none that convey confidence in establishing its construct validity. In the last 25 years, there have been fewer than 25 articles dealing with Adjustment Disorder. In contrast, the estimated incidence of the disorder is high, ranging from 5-21% in psychiatric consultation services.

There is very little evidence about the appropriate treatments for adjustment disorder. The diagnosis itself has not been well studied. However, a therapy of choice may be solution-focused therapy (SFT). Solution-focused therapy was originally developed by the Brief Family Therapy Center in Milwaukee; it uses methods largely adapted from the work of Milton Erickson. SFT is the product of 20 years' work treating individuals, observing results, scrutinizing therapy sessions, and critically examining treatment procedures (Berg & De Jong, 1996). Solution-focused therapy emphasizes self-determination through its core belief that people "... are the experts about their own lives" (De Jong & Berg, 2002). SFT affirms the reliability of individuals' internal frame of reference throughout the solution-building process and charges the therapist with helping them explore their frame of reference (De Jong & Berg, 2002). Helping in this
context means awakening individuals to the fact that the solutions to problems rest within themselves, which places primary emphasis on the self-determination (Triantafillou, 1997). Throughout this approach, the individual holds the power to determine what is meaningful and important, thereby choosing to change through personal interpretations of meaning and not that of the practitioner. Solution-focused therapy has a great many strengths. It is effective and efficient with a broad range of problems, is generally well received by clients, is encouraging and empowering, and offers new ways of thinking about helping people (Seligman, 2001).

Solution-focused therapy can create a problem if the therapist and client do not co-create the problem definition, the approach may cause the clinician to focus prematurely on a presenting problem and thereby miss an issue of greater importance. Another drawback is the misapprehension among some therapist and clients, as well as some managed care organizations, that brief treatment is all that is ever needed to treat clients successfully. Therapist should exercise caution when using solution-focused therapy to be sure that this approach is adequate to meet their clients’ needs (Seligman, 2001).

Adjustment Disorder is very treatable. If left untreated, the symptoms of the condition can become progressively worse and or develop into other debilitating disorders such as depression or Posttraumatic Stress Disorder. Individuals suffering from Adjustment Disorder can even be at greater risk of suicide (Seligman, 2001).

There are therapists who are especially trained in helping those who suffer with Adjustment Disorder and provide help in relieving the symptoms, addressing the original stressor(s), developing new coping skills, and responding to the many ways the condition has affected personal and professional aspects of an individual’s life.
In summary, prior discussions of adjustment have assumed that it should respond well
to psychological interventions. However, there are very few empirical studies supporting
this conclusion. There is a particular lack of studies that compare different treatment
modalities in addressing this disorder.

General Information on Substance Abuse

Substance use disorders among adolescents share many similarities as well as several
important differences when compared to other psychiatric syndromes that occur during
the teenage years. Drug and alcohol abuse and dependence are unlike most other mental
disorders in at least two ways. First, their existence and prevalence require an external
agent (the drug) and vary according to the availability and potency of these agents.
Second, drug abuse disorders involve a willing host (the abuser) who is an active
participant in generating these disorders. If individuals did not choose to ingest these
substances or the drugs were not available, there would be no disorder (Newcomb and
Bentler 1989).

The similarities and differences between drug abuse and other types of mental
disorders must carefully be understood and appreciated. Prevention and treatment
strategies designed for depression, adjustment disorders, or other types of psychological
dysfunction cannot be aimlessly used for intervention in problems of drug abuse.

Treatment Options for Substance Abuse

The primary goal of substance abuse treatment is to help the client to achieve and
maintain long-term remission of the substance. In 1998, most adolescents receiving
treatment for substance abuse did so in an outpatient setting. Out of 147,899 adolescents
in treatment, 69% were in outpatient programs, 11% in intensive outpatient programs, 6%
in short-term residential programs, 9% in long-term residential programs, and 6% in other treatment settings (detoxification hospital inpatient, detoxification free standing, detoxification ambulatory, and hospital-based inpatient) (Dennis, Dawud-Noursi, Muck & McDermeit, in press). During the past 25 years, randomized clinical trials have evaluated universal interventions designed to prevent the onset of substance use among adolescents (Botvin, Baker, Dusenbury, Tortu, & Botvin., 1990; Donaldson, Grahamn, & Hansen, 1994). The Life Skills Training Program (Botvin et al. 1990) is designed to address and a wide range of risk and protective factors by teaching general personal and social skills in combination with drug resistance skills and normative education. The program consists of 3-year prevention curriculum intended for middle school or junior high students. It contains 15 periods the first year, 10 booster sessions during the second, and 5 sessions during the third. Three major content areas are covered by the Life Skills Training program: drug resistance skills and information, self-management skills, and general social skills. The Life Skills Training program has been extensively studied over the past 16 years. Results indicate that this prevention approach can produce 59- to 75 percent lower levels (related to controls) of tobacco, alcohol, and marijuana use. Booster sessions can help maintain program effects. Long-term follow-up data from randomized field trials involving nearly 6,000 students from 56 schools found significant lower smoking, alcohol, and marijuana use 6 years after the initial baseline assessment. The prevalence of cigarette smoking, alcohol use, and marijuana use for the students who received the Life Skills Training program was 44 percent lower than for control students, and the weekly use of multiple drugs was 66 percent lower (Botvin et al. 1990). The Adolescent Alcohol Prevention Trial (Donaldson et al. 1994) is a universal classroom
program designed for fifth grade students, with booster sessions conducted in the seventh grade. In the research design, the students received either information about consequences of drug use only, resistance skills only, normative education only, or resistance skills training in combination with normative education. Results showed that the combination of resistance skills training and normative education prevented drug use; resistance skills training alone was not sufficient. There has also been empirical evidence from multiple trials that selected and indicated interventions can sometimes prevent more serious forms of drug involvement among youth (Dishion, Poulin, & Burraaston, 2001).

By comparison, studies of treatments designed to promote abstinence among youth meeting diagnostic criteria for psychoactive substance use disorders are lacking (Williams & Change, 2001), though initial studies of multisystemic, family-based, and cognitive-behavioral treatment approaches have yielded promising results (Kaminer, Burleson, Blitz, Sussman, & Rounsaville, 1998; Liddle, Dakof, Parker, Diamond, Barrett, & Tejeda, 2001).

Integrated Family and Cognitive Behavioral Therapy (IFCBT) for adolescent substance abusers is a promising approach for the treatment of adolescent substance abuse (Latimer, Winters, D'Zurilla, & Nichols 2003). This treatment includes three cognitive-behavioral modules delivered to youth in a group format (Rational Emotive Therapy, Problem Solving Therapy, and Learning Strategy Training) and one family therapy module (i.e. Problem Solving-Focused Therapy) delivered in an individual format. Each of the four therapeutic modules incorporated within IFCBT was selected because of its use of strategies to foster a range of cognitive skills to effectively manage drug abuse risks operating across multiple social systems. Studies suggest that irrational

Behavioral approach focus on the underlying cognitive processes, beliefs, and environmental cues associated with the adolescent's use of drugs and alcohol and teach the adolescent coping skills to help him or her remain drug free. Whether called behavior therapy, cognitive therapy, or cognitive-behavioral therapy (CBT), all behavioral approaches view substance abuse as a learned behavior that is susceptible to alteration through the application of behavior modification interventions (Miller & Hester, 1989). To date published studies examining the effectiveness of behavioral programs focus on the comparison of behavioral models to other treatment methods. For instance, Azrin and colleagues (Azrin, Donohue, Besalel, Kogan, & Acierno, 1994; Azrin, McMahon, Donohue, Besalel, Lapinski, Kogan, 1994) compared the effectiveness of a behavioral outpatient treatment program to that of a supportive counseling program. In the behavioral program, the number of adolescents using drugs by the end of treatment decreased by 73% compared with a decrease of only 9% of those receiving the supportive counseling as treatment. Drug use was measured in three ways at each session-adolescent self-report, parent report, and urinalysis-and all three methods of measuring drug use showed substantial decreases during the course of the behavioral treatment. These measures showed only slight decreases during the non-behavioral treatment, and the average number of days per month of drug use actually increased. For the behavioral
program, reported alcohol use decreased by about 50%, whereas the comparison
treatment showed an increase of 50%.

Family-based approaches acknowledge the critical influence of the adolescent's
family system in the development and maintenance of substance abuse problems. Studies
examining the effectiveness of family-based programs also focus on the comparison of
this model to other modes of treatment. Several studies have compared family-based
models to education models of treatment (Joanning, Quinn, Thomas, & Mullen, 1992;
Lewis, Piercy, Sprenkle, & Trepper, 1990; Liddle, Dakof, Parker, Diamond, Barrett, &
Tejeda, 1999; Liddle & Hogue, in press). Lewis, Piercy, Sprenkle, and Trepper (1990)
reported that adolescents in a family-based therapy model showed a significant decrease
in ratings of seriousness of drugs used from pre- to post-treatment, whereas adolescents
in a family drug education program did not show similar decreases. Studies examining
the amount of drug use (Joanning, Quinn, Thomas, & Mullen, 1992; Liddle et al., 1999)
report greater reduction in drug use at immediate post-treatment using the family-based
therapy model. Similar results are reported at 6-month (Liddle et al., 1999) and 12-month
(Liddle et al., 1999; Liddle & Hogue, in press) follow-up.

The 12-step approach also known as the Alcoholics Anonymous (AA)/Narcotics
Anonymous (NA) approach is the most widely used model in the treatment of adolescent
drug abusers. Based on the tenets of AA and basic psychotherapy, the 12 step model
view "chemical dependency" as a disease that must be managed throughout one's own
life with abstinence as a goal (Winters, Stinchfield, Opland, Weller, & Latimer, 2000).
The backbone of 12-step treatment is step work, a series of treatment and lifestyle goals
that are worked in groups and individually. Studies examining the effectiveness of 12-
step programs typically focus on comparisons between program completers and non-completers rather than comparisons to other treatment models. Studies show that at 6-month follow-up, program completers had a significantly higher abstinence rate than non-completers (Winters, Stinchfield, Opland, & Weller, 1999; Winters et al., 2000). Results at a one and two year follow-ups, however are mixed. Both studies by Winters, et al. (1999) and Winters et al. (2000) found completers’ outcome to be far superior to non-completers’ at the 12-month follow up. However, abstinent rates fell sharply for boys and slightly for girls at 1 year post-treatment. There was no significant difference between completers and non-completers by 2 years post-treatment. Results for behavioral functioning show a similar pattern. Alford, Koehler, & Leonard (1991) reported that 45 percent of treatment completers were abstinent / essentially abstinent and successfully functioning in school or a job and in family-social activities, whereas this was true for only 25 percent of non-completers. At 1-year post-treatment, this difference narrowed to 27 percent versus 23 percent at 2 years post-treatment.

It has only been the last 10-15 years that treatment effectiveness has focused exclusively on outcomes for adolescents. Few rigorous evaluations have been done, and of those studies that exist, many have methodological problems that make definitive conclusions difficult (Muck, Zempolich, Titus, & Fishman, 2001).

General Information on Adolescent Sexual Abuse

Adolescence is the period beginning at puberty and extending to a socially defined period of adulthood. The end of adolescence tends to be defined more by legal statues than any developmental or physical milestones. The stereotypical picture of adolescence is one of moodiness, identity confusion, and rebelliousness. Yet, two
reviews summarizing a decade of research conclude that approximately 80% of adolescents manage the transition from childhood to adulthood smoothly, maintaining a positive self-image and adaptive coping (Offer & Boxer, 1991; Petersen, 1988).

The actual pattern of abuse of adolescents is not simple to delineate. According to 1997 data from 43 states, 440,944 youth were neglected, 197,557 experienced physical abuse, 98,339 experienced sexual abuse, and 49,338 experienced psychological abuse (U.S. Department of Health and Human Services, 1999). Older children and adolescents are less likely to be counted as neglected. Youth between the ages of 12 and 15 are as likely as younger children to be reported for physical abuse, but the rate drops dramatically for children older than 16 from approximately 27% to 8.1% (U.S. Department of Health and Human Services, 1999). Rates of sexual abuse appear to be slightly higher in the 12 to 15 year old range but again drop dramatically in youth age 16 and older.

Child sexual abuse is a significant public health problem in the United States and across the world. In the United States, one out of three females and one out of five males have been victims of sexual abuse before the age of 18 years. A report released by the National Institute of Justice in 1997 revealed that of the 22.3 million children between the ages of 12 and 17 years in the United States, one million were victims of a serious sexual assault/abuse (Dominquez, Nelke, and Perry, 2002).

Treatment Options for Adolescent Sexual Abuse

Friedrich (1990) emphasized the importance of viewing sexually abused children and adolescents as a heterogeneous population with correspondingly diverse treatment needs. There is no one size fits all treatment model. With a thorough assessment done,
the clinician is in a good position to suggest an individualized treatment plan and to understand the adolescent’s problem areas, strengths, and current family and social status. The first questions to be addressed are the following: Is the adolescent in a safe and appropriate environment? What is the least restrictive appropriate setting for treatment? Are there acute difficulties that require immediate relief? The goals of therapy generally deal with helping adolescents communicate about the abuse experience, enhancing self-esteem, learning about and discussing normal sexuality, talking about appropriate family roles and boundaries, overcoming isolation, and developing healthy peer relationships.

Abuse-Focus Therapy

Abuse-focused Therapy (AFT) is a dominant approach to treating abused children, adolescents, and adults. Emerging largely within the past two decades, AFT has been differentiated from other approaches (Briere, 1989, 1992; Friedrich, 1990; Gil, 1990). AFT is not affiliated with any particular theoretical perspective, neither is it wedded to any particular set of techniques or approaches. AFT borrows from a wide variety of behavioral, cognitive, systemic, and reconstructive or dynamic therapy approaches.

The common threads of AFT are rooted in the perspective that abuse is a form of victimization by the powerful against the relatively powerless. Early in therapy, it is important to address any acute painful abuse such as panic attacks, sleep problems, and or severe anxiety. A number of behavioral or cognitive techniques are employed, including relaxation training, distraction and self-control techniques, and procedures such as systematic desensitization and stress inoculation training (Lipovsky, 1991). These procedures have been shown to have the most empirical support and should be among the
first tried (Cohen, Berliner, & March, 2002; Rothbaum, Meadows, Resnick, & Foy, 2000).

**Individual Therapy**

The combination of group therapy and individual therapy is often seen as the optimal approach to treating adolescents who have been sexually abused. Individual therapy varies in duration and format. Deblinger, McLeer, and Henry (1990) described a structured short-term cognitive treatment for sexually abused adolescents, using parallel modules for children and their non-abusing parent. Coping skills, modeling, gradual exposure, education, and prevention are used to target specific symptoms. Clients showed significant decreases from baseline in anxiety, depression, and behavior problems. Similar treatment approaches involving anxiety reduction techniques, stress inoculation therapy, exploration of attributions, cognitive restructuring, and problem solving techniques have been clinically described as useful (Berliner & Wheeler, 1987; Saunders, 1992).

**Group Therapy**

Few controlled studies have examined the efficacy of group therapy among adolescent victims of sexual abuse. Nevertheless, group therapy is widely used for this age group (Blick & Porter, 1982). Many sexually abused adolescents are initially so emotionally constricted that structured exercises can be useful to decrease anxiety and initiate communication about personal issues. An icebreaker at the first group meeting may be helpful in reducing the tension in the group. An example of this, may be to ask the members to produce drawings of what animal they would like to be and why. Therapeutic techniques that can be utilized during ongoing group sessions include
reflection of feelings, role-playing, art therapy, and films (Hazzard, King, & Webb, 1986). Role playing, a technique used extensively in groups and individual therapy, is especially useful for adolescents. Role-playing can be used to rehearse court testimony, to express feelings to family members, or enact different ways of handling sexually abusive situations. Art therapy is also helpful with this population because of the degree of their affective constriction. Blick and Porter (1982) report using a body tracing exercise to deal with body image issues. Films can be used to provide information concerning sexuality and to address sexual decision-making. Having the adolescents write down and hand in questions prior to sex-education sessions promoted a more open discussion around this anxiety provoked topic. Group therapy for sexually abused adolescents may be a particularly helpful treatment modality. In setting up a group treatment program, careful attention must be given to a number of pragmatic decisions such as place and time of meetings, selection criteria for therapist and group members, and duration of treatment. In addition, the need of other family members must be considered and addressed in some fashion in order to maintain family support for the adolescents' participation in group (Hazzard, King, & Webb, 1986).

**Family Therapy**

Children and adolescents who have experienced within family sexual abuse are likely to have experienced multiple family problems, which both precede sexual abuse, and exacerbate its negative effects (Bagley, 1995). While not all children manifest behavioral or emotional problems following sexual abuse, up to a half of those experiencing long-term within family abuse do (Bagley, 1995).
Among the best known “whole family” treatment programs for child sexual abuse is that pioneered by Giarretto (1982) based on his Child Sexual Abuse Treatment Program (CSATP). Giarretto’s humanistic program for healing families in which a child has been psychologically damaged by incestuous abuse is based on two principles for counselor training: A person cannot become an effective counselor without first attending to his or her own self-realization; and a person’s self-realization cannot be sought successfully if he or she does not continually strive for social conditions that foster the self-realization of other. The fundamental goal of all treatments using the Giarretto Model is to help the individual to feel positive about themselves in ways, which have permanent validation by all significant others.

After reviewing Abuse-Focus, Individual, Group, and Family Therapy in the treatment of sexually abused adolescents, encouraging the child to find out more about sexual abuse and its dynamics by reading and talking to professionals and other victims in group and individual therapy would be most beneficial for the child’s recovery.

In summary, a therapy of choice may be solution-focused therapy (SFT) in the treatment of Adjustment Disorder. However, there is very little evidence about the appropriate treatments for adjustment disorder. The best practice in treating an adolescent with a substance abuse problem is the Integrated Family and Cognitive Behavioral Therapy (IFCBT). There are four therapeutic modules incorporated into IFCBT to foster a range of cognitive skills to effectively manage drug abuse risks operating across multiple social systems. The combination of group and individual therapy is often seen as the optimal approach to treating adolescents who have been sexually abused.
Chapter 4

Normative Practice/Outcomes

General Information

This agency offers a variety of counseling services to teenage victims of sexual assault or abuse. It begins with a five-session assessment of the individual and family functioning and recommends appropriate treatment options. Treatment was conducted and consisted of 20 individual sessions. Each session lasted 1 hour, and sessions were conducted on a weekly basis. The office telephone number was available to the client in case of psychiatric emergency.

Referral Information

Most referrals come through a crisis unit. Referrals are accepted from other sources through private insurances or self-pay.

Outcome Measures

This therapy was focused on emotional problems related to an incident of sexual assault. The client had reported experiencing some symptoms of loss of energy, loss of interest in school, difficulty concentrating, social isolation, weight loss and increased alcohol consumption as a result of a 3-week onset of depressed mood. Therefore, the Trauma Symptom Checklist for Children (TSCC) and the Children’s Depression Inventory were chosen for this study.
The Trauma Symptom Checklist for Children is a self-report measure of posttraumatic distress and related psychological symptomatology. Because of the shorter attention span of children, especially those who have been psychologically traumatized, the TSCC consists of a relatively small number of particularly trauma-responsive items. The full version of the TSCC consists of 54 items that yield two validity scales (Underresponse and Hyperresponse); six clinical scales (Anxiety, depression, Anger, Posttraumatic Stress, Dissociation, (with two subscales), and Sexual Concerns (with two subscales); and eight critical items. The 54 items are rated on a 4-point Likert Scale ranging from 0 to 3 in terms of symptom severity. The client is presented with a list of thoughts, feelings, and behaviors and asked to mark how often each of these things to him or her. The full TSCC requires 15 to 20 minutes to complete for most children and can be scored and profiled in approximately 10 minutes (Briere, 1995).

Christine’s scores on the anxiety scale (T-score of 80) reflected a high level of anxiety as evidenced by specific fears of men and of being killed. The depression scale (T-score 74) reflected a high level of feeling lonely, sad or unhappy, crying, feeling stupid or bad, and feeling like she did something wrong. However, Christine did not report feelings of wanting to hurt herself or other people. Christine reported having feelings of anger (T-score 61) as evidenced by arguing too much, wanting to yell and break things, getting mad and can’t calm down, wanting to yell at people, feeling mad, feeling mean, and feeling like she hates people. The posttraumatic stress scale (t-score 72) consists of items reflecting classic posttraumatic symptoms. Christine did not have any nightmares, bad dreams or scary ideas or pictures popping in her head. However, she is continually remembering things that happened to her that she did not like. The
The dissociation scale measures the extent to which the child experiences mild to moderate dissociative symptomology. The dissociation items include derealization; one’s mind going blank, emotional numbing, pretending to be someone else or somewhere else, daydreaming, memory problems, and dissociative avoidance (Briere, 1995). Christine did not appear to have any issues with dissociation (T-score 50). The sexual concerns scale measures sexual distress and preoccupation. She was afraid to trust people because they may want sex from her.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Raw</th>
<th>T-score</th>
</tr>
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<tbody>
<tr>
<td>Anxiety</td>
<td>16</td>
<td>80</td>
</tr>
<tr>
<td>Depression</td>
<td>14</td>
<td>74</td>
</tr>
<tr>
<td>Anger</td>
<td>15</td>
<td>61</td>
</tr>
<tr>
<td>Posttraumatic Stress</td>
<td>18</td>
<td>72</td>
</tr>
<tr>
<td>Dissociation</td>
<td>6</td>
<td>50</td>
</tr>
</tbody>
</table>

The Children’s Depression Inventory (CDI) is a 27-item self-rated symptom oriented scale suitable for school-aged children and adolescents. Each CDI item consists of three choices, keyed 0, 1, or 2 with higher scores indicating increasing severity. For each item, the meaning of each choice can be summarized by the following (Kovacs, 1992):

<table>
<thead>
<tr>
<th>Item Score</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Absence of symptom</td>
</tr>
<tr>
<td>1</td>
<td>Mild symptom</td>
</tr>
<tr>
<td>2</td>
<td>Definite symptom</td>
</tr>
</tbody>
</table>
The child uses the options to rate the degree to which each statement describes him or her for the past two weeks. The CDI can be completed in 15 minutes or less.

Christine’s total score using the CDI was 25, which is elevated to a clinically significant T-score of 74. In addition, her T-scores on the Negative Mood and Ineffectiveness are also greater that 70, and is clinically significant. Her scores on Interpersonal Problems, Anhedonia, and Negative Self Esteem were higher than average. The T-scores have an average of 50 and a standard deviation of 10.

Christine scored mild or definite symptoms stating the following situations:

“I am sad most of the time,”
“I am not sure if things will work out for me,”
“I do many things wrong,”
“I have fun in some things,”
“I worry that bad things will happen to me,”
“I do not like myself,”
“I have to push myself all the time to do my schoolwork.”
“Most days I do not feel like eating,”
“l do very badly in subjects I used to do good in.”

The result in both the Trauma Symptom Checklist for Children and the Children’s Depression Inventory indicated that she has had levels of depression and anxiety that were at least moderate when she entered treatment. Therefore, it was necessary to develop an appropriate treatment plan addressing areas of compliant.
Treatment Goals

1. To develop and implement effective coping skills that allow for carrying out normal responsibilities and participating in relationships and social activities. This goal was detailed in several sub-goals.
   a. Increase social interaction, particularly with family and friends.
   b. Improve client’s coping skills when dealing with strong emotions, such as anger, frustration, and sadness.
   c. To visit activity and places where the traumatic event took place.

2. To show a renewed typical interest in academic achievement, social involvement, and eating patterns, as well as occasional expressions of joy and zest for life.

3. To reduce excessive use of alcohol or drugs as a maladaptive coping mechanism to avoid dealing with painful emotions connected to sexual abuse.

Techniques

1. Relaxation and Positive Imagery

The client was asked to practice and implement relaxation and positive imagery as a coping mechanism for tension, panic, stress, anger, and anxiety. This technique is a cognitive strategy in teaching Christine to improve her thinking and change her coping skills. Christine was taught deep muscle relaxation, deep breathing exercises, and positive imagery to induce relaxation. Christine was also trained to calm herself down by using relaxation tapes.

2. Identify the Symptoms Associated with the Traumatic Event
The client was asked to identify how the traumatic event has negatively impacted her life, comparing pre-trauma functioning to current functioning. By doing this, the client also explored the effect the symptoms have had on her personal relationships, functioning at school, and social/recreation life. Christine also scheduled daily activities after her school day to distract her from negative thoughts and depressive symptoms. This is a behavioral technique, which is intended to activate the client and distract her from preoccupation with negative thoughts, and to decrease her depressive symptoms. It is also meant to organize her thoughts and daily activities since Christine's concentration skills have been diminished as well as get her reconnected with friends and family.

3. Social Skills Training

Christine initiated and responded actively to social communication with family and friends. She was encouraged by this therapist to participate in social/recreational activities that enrich life after exploring pleasurable interests and activities that could be pursued, then assigned participation and processed the experience. First, Christine identified people that she would like to become more assertive with and the specific problems she experienced with them. Second, she was encouraged to express her feelings rather than opinions and use “I” statements while expressing feelings. The “I” statement was modeled by this therapist and practiced with the client. In dealing with Christine’s feelings toward her father and brother, she really struggled with “I feel...” statements when confronting them in a role-play. People in gestalt therapy are encouraged to own and focus on their own feelings and experiences rather than talk about other people or events. These techniques were modeled and practiced with
the client during sessions. Their aim was to improve her social skills. Christine’s family will be assisted in establishing a routine of positive structured activities with the client, such as playing a board game or going to the movies. Christine will formulate a plan that leads to taking action to meet her social and emotional needs.

4. Stop, Think, Listen, And Plan

Christine used modeling, role-playing, and behavioral rehearsal to implement the stop, think, listen, and plan before acting technique in day-to-day situations. We will review its use by the client in day-to-day life, identifying the positive results. This is to help Christine not consume alcohol.

5. Attend AA Meetings

Christine established regular attendance at a support group meeting (AA) at least once a week. She reported to the therapist the impact of the meetings.

6. Journaling

Christine kept a journal of her feelings and emotions as they related to every therapy session. She wrote in the journal at least three times a week. She also included in the journal how she reacted to certain situations as well as if her reaction helped her or harmed her.

Treatment Outcomes

Christine was re-evaluated after 4 months of treatment, and 20 individual sessions. Both outcome measures, Trauma Symptom Checklist for Children and the Children’s Depression Inventory were administered to the client. A difference between the results obtained on both measures before treatment and at four-month follow up suggested a clinically significant reduction in depression and anxiety.
Christine’s results for the Trauma Symptom Checklist for Children showed a significant reduction in posttraumatic distress and related psychological symptomatology. She reported that she no longer has a fear of men and of being killed. Although, she still has days of feeling sad and occasionally crying, she does not feel like she did something wrong.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Raw</th>
<th>T-score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>9</td>
<td>62</td>
</tr>
<tr>
<td>Depression</td>
<td>11</td>
<td>65</td>
</tr>
<tr>
<td>Anger</td>
<td>12</td>
<td>56</td>
</tr>
<tr>
<td>Posttraumatic Stress</td>
<td>13</td>
<td>62</td>
</tr>
<tr>
<td>Dissociation</td>
<td>6</td>
<td>50</td>
</tr>
</tbody>
</table>

At the four-month follow up, Christine’s total score using the Children’s Depression Inventory was 19 and the suicide item was not endorsed. Christine scored mild symptoms stating the following situations, which have decreased from the previous assessment:

“I eat pretty well,”

“Doing school work is not a big problem.”

“My schoolwork is not as good as before.”

During the past four months, Christine was taught to relax by shifting her breathing to a pattern of slow abdominal breaths while focusing on her breathing. She was taught to relax her body, progressing from her head to her toes, until her entire body felt relaxed. This helped Christine in feeling calm when bad thoughts
entered her mind. Christine reports using this technique on a weekly basis and reports that it has helped her feel more relaxed.

Over the course of treatment, Christine began to identify the negative symptoms associated with the traumatic event. During therapy, Christine realized and was able to describe her pre-trauma functioning to her current functioning. An example that Christine used was that before the rape, she could get out of bed and go to school as opposed to after the traumatic event she is having a hard time getting out of bed.

Christine appeared to have a difficult time using “I” statements to help her become more assertive with her feelings. When asked Christine identified her father and brother as people she would like to be more assertive with and discuss specific problems with them. She does not feel that she could actually confront her father or brother, but the techniques were practiced and role-played in therapy several times. One example of an “I” statement that she really struggled with was, “I feel like you have never been there for me, dad.” Christine stated that practicing “I” statements made her feel more secure in talking to her father, but on the other hand, she doesn’t know if she is ready to take that step.

Christine’s mother participated in therapy approximately five times in the past four months. The purpose was to get the family involved in establishing a routine of positive structured activities. Christine wanted her family to collectively do activities together at least one time a week. She felt this would enable them to become united and become a “real family.” However, Christine’s father, brother or sister never participated in treatment. They were invited to several sessions and this therapist even used incentives to try to get them to come, but they never showed. Family
therapy would have been ideal, but the family as a whole would not make that commitment. Of course, this indicates that the family dynamics were a key contributor to her problem.

Using the stop, think, listen, and plan technique, Christine was able to stop and think before deciding to take a drink of alcohol when she was feeling lonely or down. She would listen to her own thoughts about the negative consequences of taking a drink and then plan another activity at that time to take her mind off drinking alcohol. By doing this, Christine did not eliminate alcohol consumption, but had reduced her drinking to only weekends. This activity was practiced and modeled in sessions.

Christine had attended 15 AA meetings in her hometown. She reported that this helped her in not drinking during the week, but she would still consume alcohol at least once on the weekends. Christine stated that on the weekends, she would consume about 3-4 beers, and rarely any hard alcohol. She significantly reduced her alcohol consumption over the past four months.

Christine kept a journal every week, which she shared with this therapist. In her journal, she discussed how she felt about discussions that took place during therapy, events that happened at home, with her family. The journal has helped Christine express her feelings.

Additional information about Christine’s progress was obtained from clinical notes and observations. It was observed that she looked more relaxed and happier (by smiling and laughing with much greater frequency) at the four-month follow-up session. Christine reports crying less, which was noted in several sessions. It was
observed that Christine is still emotionally sensitive but her emotional response to upsetting events or discussions are less extreme.

There are some complaints that have remained unchanged with no or minimal improvement. First, Christine is worried that bad things will happen to her. However, she no long has a specific fear of men in general. Second, her alcohol consumption is still present, but she reports that she only drinks on the weekends. Christine self-reports that she has decreased her drinking tremendously. Third, she remains socially isolated to a certain degree. Christine stated that time will heal that.
Chapter 5

Comparison of Best and Normative Practice

The purpose of this study was to measure efficacy of different treatment options for individuals diagnosed with Adjustment Disorder, Substance Abuse, and Adolescent Sexual Abuse. There is very little evidence about the appropriate treatments for adjustment disorder and there are relatively few studies of adjustment disorder; therefore, treatment relies heavily on clinical judgment.

When dealing with an individual diagnosed with Adjustment Disorder, the best practice may be Solution Focused Therapy. Christine identified how the traumatic event negatively impacted her life using solution-focused therapy. However, during the first few sessions, Christine would answer the question with, “I don’t know.” She would be asked, “Is it important for you to know,” or “how would your life be better if you did know,” or “suppose you did know?” The technique of just waiting with Christine and using silence to get her to answer the question was helpful. Throughout solution-focused therapy, Christine held the power to determine what is meaningful and important, which allows her to change through personal interpretations. Using this approach, Christine was able to identify her symptoms and associate them to the traumatic event. However, a consistent model of Solution Focused Therapy (SFT) was not used. For example, the appropriate techniques such as asking miracle questions, expectations, and setting small behavioral goals were not used.
Christine was also diagnosed with Alcohol Abuse. After reviewing the research, best practice for treating an individual with alcohol abuse may be a family based approach. Several studies have compared family-based models to education models of treatment (Joanning, Quinn, Thomas, & Mullen, 1992; Lewis, Piercy, Sprenkle, & Trepper, 1990; Liddle, Dakof, Parker, Diamond, Barrett, and Tejeda., 1999; Liddle & Hogue, in press). Lewis, Piercy, Sprenkle, and Trepper (1990) reported that adolescents in a family-based therapy model showed a significant decrease in ratings of seriousness of drugs used from pre- to post-treatment, whereas adolescents in a family drug education program did not show similar decreases. Multiple attempts were made to get Christine’s family in for several family sessions, however, these were unsuccessful. Therefore, it was not possible in this context to implement a true family based program. Alcoholics Anonymous is the most widely used model in the treatment of adolescent drug abusers. However, it has only been the last 10-15 years that treatment effectiveness has focused exclusively on outcomes for adolescents. Christine attended AA meetings, and self-reported a decrease in alcohol consumption to zero during the week and less than a six-pack during the weekend.

Individual therapy was used to treat Christine with the sexual abuse. During individual therapy, Christine used modeling and role playing to implement the stop, think, listen, and plan before acting in day to day situations. She also used relaxation and positive imagery to help her cope with her feelings. Christine also engaged in social skills training to help her feel comfortable socially communicating with her family and friends. According to the literature, individual and group therapy is often seen as the optimal approach to treating adolescents who have been sexually abused.
As mentioned earlier, the best practice treating Adjustment Disorder, Alcohol Abuse, and Sexual Abuse is solution-focused therapy, family therapy, and a combination of individual and group therapy, consecutively. Psychological treatment should also cooperate with other professionals providing treatment for additional complaints. In general, the normative practice did not follow directly guidelines of the best practice. While the improved outcome indicated that the client benefited from the normative practice, it is likely that even stronger therapeutic results could have been achieved by implementing more elements of the best practice model.
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