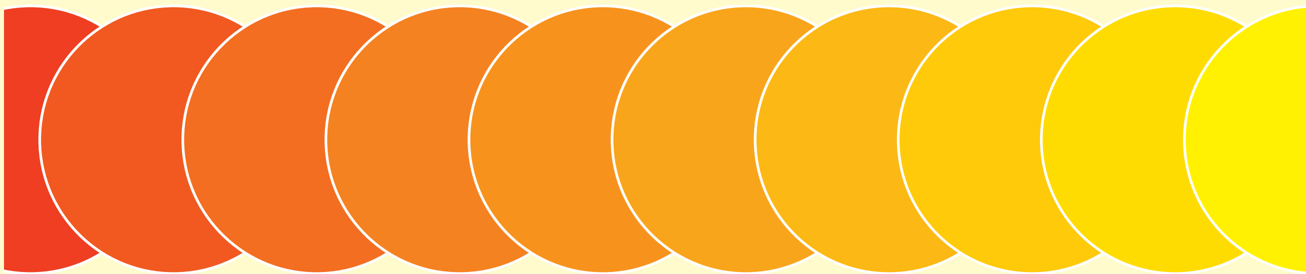
Psychotherapy with Adolescents and Their Families

Essential Treatment Strategies



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CONTENTS

PART I: INTRODUCTION

1 The Changing Face of Psychotherapy 3
Managed Care and Adolescent Psychotherapy 3
Medical Necessity 5
When the Appeal Process Fails 6
Treatment Planning 7
How to Use This Guide 8

2 The Paper Trail 10
The Outpatient Treatment Report (OTR) 11
Other Forms and Reports 11

PART II: THE TREATMENT PLANS

3 Critical Incident Stress Management 15

4 Anxiety Disorders 37
Acute Stress Disorder 37
Generalized Anxiety Disorder 50
Obsessive-Compulsive Disorder 61
Post-traumatic Stress Disorder 71
Separation Anxiety Disorder 83
Social Phobia 95
Specific Phobia 108

5 Behavior Disorders 121
Attention Deficit/Hyperactivity Disorder 121
Conduct Disorder 133
Oppositional Defiant Disorder 135
Disruptive Behavior Disorder NOS 136

6 Bipolar Disorders **146**
Bipolar I Disorder 146
Bipolar Disorder NOS 149
Bipolar II Disorder 151
Cyclothymic Disorder 153

7 Depressive Disorders **170**
Major Depressive Disorder 170
Dysthymic Disorder 172
Depressive Disorder NOS 173
Bereavement 187

8 Eating Disorders **201**
Anorexia Nervosa 201
Bulimia Nervosa 203

9 General Medical Conditions **216**
Personality Change Due to a General Medical Condition 216
Mental Disorder Not Otherwise Specified
Due to a General Medical Condition 217
Psychological Factors Affecting Medical Condition 218

10 Impulse Control Disorders **232**
Intermittent Explosive Disorder 232
Kleptomania 246
Pathological Gambling 258
Trichotillomania 272

11 Relational Problems **285**
Parent–Adolescent Relational Problem 285
Sibling Relational Problem 287
Divorce or Separation-Related Problems 294
Adolescent Abuse or Neglect 308

12 Sleep Disorders **326**
Dyssomnias 326
Parasomnias 326

13 Substance Disorders **342**
Substance Dependence 342
Substance Abuse 344

PART III: TREATMENT AIDS

14 Behavioral Techniques 359
Bad Dreams 359
Change 361
Family Sculpturing 362
Genograms 363
Hypnosis 364
Learning 365
Relaxation 365
Role-Playing 368

15 Therapeutic Games 374

16 Homework Assignments 377
Automatic Thought Log 377
The Steps to Constructing a Rational Response 379
Challenging Cognitions 380
Common Cognitive Distortions 381

17 Bibliotherapy 382
Self-Help Books For Adolescents 382
Self-Help Books For Parents and Families 393
Videotapes 403
Audiotapes 403

18 Self-Help Groups and 800 Numbers 406

19 Online Resources 408

PART IV: APPENDIX

20 Practice Management Reports 417
Psychosocial Intake Report 418
Outpatient Medical Management Report 419
Payment and Session Monitor 421
Progress Notes 424
CPT Codes 426
Discharge Summary 426

References 429
Index 435

1
THE CHANGING FACE OF PSYCHOTHERAPY

MANAGED CARE AND ADOLESCENT PSYCHOTHERAPY

The language of adolescent psychotherapy changed when therapists contracted with insurance companies and became "service providers." The process of treating adolescents was once regarded as a "talking cure" in which therapy was often non-directive and the emphasis was on the relationship between the client and the therapist. The therapist provided a safe holding environment to help the teenager, in a non-directive way, gain insights into his or her problems and their possible causes. Although this process worked over time, it was perceived by managed care as too lengthy and too expensive. They found it more expeditious to cover measurable, short-term behavioral changes rather than long-term structural change in the client's psyche.

The treatment goals and interventions in this book have been presented in cognitive, solution-focused language. The purpose "is to describe the treatment process in behavior-focused and measurable language, thereby allowing case managers to relate to what providers are trying to accomplish rather than being put off by psychoanalytic terms that may be foreign to their training or experience.

Managed care's overnight rise to dominance brought with it more than just behavioral management. A fundamental concern with cost-effectiveness led logically to the basic business techniques of project management: establishing long-term goals, choosing short-term tasks or objectives to get there, and tracking the process from start to finish. Suddenly, these terms were incorporated into the managed care lexicon and the more psychoanalytic-oriented, non-directive techniques were considered archaic. Gone were the concepts of "working through the resistance," "repetition compulsion," "maintaining a holding environment," and "exploring the underlying transference." Free association, a

standard treatment mode since the early days of Freud, was replaced with a mode that could be charted step by step along a predetermined path to the final achievement of a treatment goal.

Psychotherapists, who had spent years studying the giants of psychiatry and mastering the proven techniques of maintaining a sound holding environment, listening, and intervening, suddenly discovered they could not talk to managed care case managers in terms they understood. The language of psychotherapy had changed. Mental disorders gave way to "behavioral impairments," patients became "clients," and psychotherapists became "service providers." Now, all terms that suggest long-term treatment, such as "psychoanalysis," "improve client's low self-esteem," or "enhance quality of life," are in danger of being labeled vague and not "medically necessary." Chances are that treatment authorization will be denied.

Managed care is concerned with Axis I impairments. These are disorders normally coded on Axis I of the Multiaxial Assessment System of the *Diagnostic and Statistical Manual of Mental Disorders* Fourth Edition (*DSM-IV*) published by the American Psychiatric Association. Managed care providers do not want to pay for the treatment of irresolvable diagnoses, and Axis II diagnoses are usually considered irresolvable by insurance companies. However, if you have a client with a personality disorder, the diagnosis can be coded as Axis II, and the behavioral symptoms coded and treated as Axis I impairments. Most, if not all, personality disorders also have Axis I impairments. Managed care providers are also concerned that therapists treating an adolescent for one long-term disorder may be fostering a dependent personality disorder. So, if managed care case managers spot a provider with a cluster of long-term clients, they are more apt to refer future clients to other providers who provide short-term treatment. Goals that are not achievable within three months should be avoided or replaced with more focused, resolvable goals. Managed care providers want quick, cost-effective change using modalities that are consistent with the client's needs. Most insurance companies accept behavioral, solution-focused, brief dynamic, group, medication management, or psychopharmacology. Prior approvals are normally required for evaluation of medication by a psychiatrist or for psychological testing. Some companies will pay for psychological testing, biofeedback, and hypnosis, sometimes referred to as relaxation technique. Check with each company before using these in your outpatient treatment reports. Most insurance companies find the term "relaxation technique" more acceptable than "hypnosis."

Another potential problem appears to be the idea of a therapeutic alliance between patient and therapist. Although many insurance case managers balk at the term therapeutic alliance, "research demonstrates that in successful cognitive-behavioral therapy, patients view the therapy relationship as 'crucial in helping them change'" (McGinn and

Sanderson, 1999, p. 6). The development of a positive therapeutic relationship is critical in psychotherapy and is considered to be most predictive of positive treatment outcome. The therapeutic relationship is even more important in the treatment of adolescents. “The therapist must make contact with the client, engage the client, and engender his or her trust if treatment is to be effective” (Knell, 1993, p. 46). The current focus appears to be on a more active role for the client in therapy. O’Hanlon (1987) echoes the view of Milton Erickson, noted hypnotherapist, that it is the therapist’s responsibility “to create a climate, an atmosphere for change in which people change themselves” (p. 19). Rossi, Ryan, and Sharp (1983) use Erickson’s analogy of the starting pistol at a race: “The therapist merely initiates the race by firing the starting pistol; it is the patient who must actually run and win the race” (pp. 102–3).

In adolescent psychotherapy, treatment often extends to parents in family sessions with or without the client present. William O’Hanlon, author of many books on brief, solution-focused therapy and Ericksonian hypnosis, (personal communication, 2000) explains that it is sometimes important to involve parents of adolescents in treatment in order to disrupt the maladaptive patterns of behavior in the family.

Insurance companies want clients to take a more active role in treatment. They encourage the use of homework assignments and self-help books, as well as referrals to self-help groups. Suggested homework assignments are included in Chapter 16 of this book, self-help books in Chapter 17, self-help groups and 800 numbers in Chapter 18 and online resources in Chapter 19.

Treatment frequency is usually crisis-driven. Once a week is standard and may temporarily be increased to twice a week. Some companies also may reduce sessions to every other week or once a month as a prelude to termination. Most insurance companies will allow up to 10 sessions per treatment plan. If you divide a complex goal into several simpler goals, it is more likely that a case manager will see gradual improvement and authorize further sessions. In the next treatment plan, you can request further sessions for another problem or part of the original problem that remains unresolved.

MEDICAL NECESSITY

Medical necessity is the criterion used by managed care companies to authorize treatment sessions. There are various definitions of medical necessity in use today. The term and its meaning are usually published in the insurance companies’ provider manuals. Value Options, one of the nation’s larger behavioral management organizations, defines medical necessity treatment as “that which is intended to prevent, diagnose,

correct, cure, alleviate or preclude deterioration of a diagnosable condition (*ICD-9* or *DSM-IV*) that threatens life, causes pain or suffering, or results in illness or infirmity" (*Value Options Provider Handbook*, 1999, p. B-2). Medical necessity is usually limited to resolvable issues. The term resolvable is vague and subject to definition by the insurance company's case manager.

The *Value Options Provider Handbook* lists other qualifications as well. The treatment must also be:

1. Expected to improve the client's condition or level of functioning;
2. Consistent with the symptoms, diagnosis, and nationally accepted standards of care;
3. Representative of a safe level of service where no effective, less expensive treatment is available;
4. Not intended for the convenience of client or provider;
5. No more restrictive than necessary to balance safety, effectiveness, and efficiency (p. B-2).

Medical necessity is open to interpretation by a case manager who determines what is appropriate. In my private practice, one insurance company authorized 30 sessions for one patient and only 10 for another with the identical diagnosis.

Frager (2000) stresses that "Medical necessity determination is not a clinical decision, nor is it a clinical concept of relevance to practice. Despite the name … it is a kind of code governing the rationing of sessions [and is] open to a good deal of speculation, depending on the benefit plan of the client and the purchaser's contract with the insurance managed care company" (p. 102). She adds, "Most medical necessity guidelines specify clearly that treatment must focus on symptom-reduction and restoration of functioning or the resolution of a specific problem…. It is the resolvability clause that managed care companies tend to use when they think they have paid for too many sessions and are looking for a way to deny treatment" (p. 108).

If you feel the authorization decision has been unfairly made, you can usually appeal. Most insurance companies provide for at least two levels of appeal. However, the process is different for each company and is usually outlined in the provider handbooks or available from the company's provider service center.

WHEN THE APPEAL PROCESS FAILS

It may seem as if insurance companies have the last word, but that is not always true. The National Association of Insurance Commissioners (NAIC) is an organization of insurance regulators from each of the

ACUTE STRESS DISORDER TREATMENT PLAN

Patient: Date:

I. OBJECTIVES OF TREATMENT *(select one or more)*

1. Educate parents about the disorder
2. Investigate family history of the disorder
3. Help family develop better coping skills
4. Reduce anxiety related to the disorder
5. Reduce other symptoms: restlessness, sleep problems, irritability, poor concentration, or excessive vigilance
6. Encourage compliance with educational programs and referrals
7. Reduce irrational beliefs
8. Restore realization and personification
9. Promote socialization
10. Eliminate need for avoidance of people, places, or things reminiscent of the trauma
11. Reduce alienation
12. Restore to optimum level of functioning
13. Develop discharge plan for coping with everyday life

II. SHORT-TERM BEHAVIORAL GOALS AND INTERVENTIONS
(*select goals and interventions appropriate for your patient*)

NOTE: Separate goals and interventions are provided for Parents, Adolescent, and Family

PARENTS' GOALS	THERAPIST'S INTERVENTIONS
Collaborate with therapist in development of a treatment plan.	Establish therapeutic alliance with parents to enhance outcome of treatment.
Undergo treatment for individual problems, which, in turn, enhances the outcome of therapy.	Explore for parental psychopathology (e.g. anxiety disorder, marital discord etc.) and refer for treatment or treat (see appropriate treatment plan.)

PARENTS' GOALS	THERAPIST'S INTERVENTIONS
Undergo testing and evaluation for possible medication.	If appropriate, refer parents for psychological testing and psychiatric evaluation.
Become aware of maladaptive messages you are sending to your adolescent.	Identify how parents deal with stress or anxiety.
Develop awareness of how your personal theory influences cognition of the problem.	Explore parental theory of the problem.
Learn the laws of anxiety: anxiety is not dangerous or permanent; avoidance increases anxiety; confronting the problem can reduce anxiety; exposure can produce growth.	Teach parents the laws of anxiety.
Examine distortions in reaction to the traumatic event stressors.	Discuss reactions to identify exaggerations and distortions.
Replace exaggerated reactions with positive reactions using evidence-based reality.	Reframe negative reactions with positive, reality-based reactions.
Help your adolescent practice coping skills in real-life situations. Report reactions and reward successes.	Instruct parents on how to help the adolescent challenge persons, places, things, and activities related to the traumatic event and record reactions. Reward successes.
Learn to reach beyond automatic cognitive reactions in viewing the problem.	Expand parental perspective beyond limited cognitive reactions.
Agree to allow therapist to confer with your adolescent's school to help in development of a comprehensive psycho-treatment plan.	If appropriate, request and receive parental permission to confer with the adolescent's teachers and school officials.

PARENTS' GOALS	THERAPIST'S INTERVENTIONS
Attend self-help group to improve parenting skills.	Evaluate parenting skills and, if necessary, refer to parenting skills group (see Self-Help Groups and 800 Numbers, Chapter 18, and Online Resources, Chapter 19).
Read about and improve parenting skills.	Assign reading of *Positive Parenting From A to Z* or *Your Anxious Child* (see Bibliotherapy, Chapter 17).
Discuss a treatment termination plan and resolve termination issues.	Develop a treatment termination plan and discuss issues of separation and dependency.

9
GENERAL MEDICAL CONDITIONS

Mental disorders are often associated with comorbid medical conditions and vice versa. For the purposes of this book, General Medical Conditions include Personality Change Due to a General Medical Condition—(310.1), Mental Disorder Not Otherwise Specified Due to a General Medical Condition—(293.9), and Psychological Factor Affecting Medical Condition—(316). The medical condition is coded on Axis III of the *DSM-IV* Muliaxial Assessment System with an appropriate ICD-9 number. However, the name of the psychological condition should be included on Axis I.

PERSONALITY CHANGE DUE TO A GENERAL MEDICAL CONDITION—(310.1)

The essential feature of this diagnosis is a persistent personality disturbance that is due to a medical problem. There is a change in the adolescent's previous personality patterns. Common manifestations include instability, aggression out of proportion to the associated stressors, apathy, or paranoid ideations. The adolescent is usually regarded as "not himself or herself." The diagnosis is coded on Axis I and the general medical condition, in ICD-9 notation on Axis III.

Behavioral Symptoms
(severity index: 1–mild; 2–moderate; 3–intense)

Specify: Labile
Disinhibited
Aggressive
Apathetic
Paranoid
Other
Combined

		Severity
1.	Persistent change in personality not considered normal development and lasting for one year	________
2.	Personality disturbance is related to medical condition	________
3.	Causes problems or impairments in school and/or in other important areas of functioning	________

MENTAL DISORDER NOT OTHERWISE SPECIFIED DUE TO A GENERAL MEDICAL CONDITION—(293.9)

This category is used when the disturbance does not fully meet the criteria (i.e. dissociative symptoms due to complex partial seizures).

PSYCHOLOGICAL FACTORS AFFECTING MEDICAL CONDITION—(316)

Included here are behavioral or psychological factors that adversely affect a medical condition and constitute a significant risk to health. Such factors may be founded in *DSM-IV* Axis I and II disorders, personality traits that do not fully meet the criteria for these disorders, and social and environmental stressors. This disorder, too, is coded on *DSM-IV* Axis III. (Note: Pain is not diagnosed as a psychological factor causing medical symptoms, but as Pain Disorder with psychological factors or medical conditions.)

Behavioral Symptoms
(severity index: 1–mild; 2–moderate; 3–intense)

NOTE: A General Medical Condition (Axis III) exists

		Severity
1.	Substance use/dependence interferes with medical treatment	________
2.	Mental disorder affects general medical condition	________
3.	Psychological factor affects, exacerbates, or delays recovery from general medical condition	________
4.	Personality or coping style affects general medical condition	________
5.	Negative health behavior affects general medical condition	________
6.	Stress-related responses exacerbate medical symptoms	________
7.	Psychological factor increases health risk	________
8.	Major impairment in educational, social, or other areas of functioning	________

This outstanding work is a comprehensive manual designed to help therapists develop behavioral treatment plans for virtually every adolescent client. The book covers all of the major diagnostic categories of DSM-IV, effectively translating the traditional psychiatric approach to mental disorders into behavioral terms readily understood by managed care case managers.

Forms are provided for monitoring payments and progress. Also included are full descriptions and symptom summaries of common adolescent mental disorders, a complete outline of long-term treatment objectives, measurable short-term behavioral goals and suggested interventions. The entire package will help you deal more quickly and easily with the requirements of managed care and optimize treatment authorizations. It belongs on the desk of every practitioner who deals with adolescents.

Muriel P. Warren, DSW, ACSW is a psychotherapist, hypnotherapist, author, and educator engaged in private practice in Rockland County, where she is the former Executive Director of the Psychoanalytic Center for Communicative Education and Past President of the International Society for Psychoanalytic Psychotherapy. She holds degrees from Fordham, Columbia, and Adelphi Universities in Psychology and Social Work, as well as a Certificate in Psychoanalysis from Lenox Hill Hospital in New York. She is a Diplomat at the American Academy of Experts in Traumatic Stress and Executive Director and President of the Warren Trauma Center established in May 2004.

"Muriel Prince Warren has written the definitive guide to treatment planning and strategies for change with adolescents and families. With sensitivity given to the influence of managed care, Dr. Warren offers specific ways that practitioners can work collaboratively to strengthen the therapeutic alliance, clarify objectives of treatment, become goal-oriented, and intervene through multiple pathways, all within a diagnostic framework. This is an important accomplishment given that clinicians must continually satisfy the requirements of third-party payers while maintaining their allegiances to adolescents and their families. This is collaboration at its best. I highly recommend this wonderful book to any practitioner or student who wants to have a better understanding of how to increase therapeutic effectiveness in ways that are respectful of clients' contributions to change."

Bob Bertolino, PhD, Therapeutic Collaborations LLC

"I highly recommend *Psychotherapy with Adolescents and Their Families*, by Dr. Muriel P. Warren. It is clearly written, the examples are invaluable as they are true to life. Therapists at all levels of professional practice as well as mentors of all academic stages alike will benefit from the use of well established theories and their practical applications. Dr. Warren replaces tradition with new help for the 'tired' therapist."

Linda Douville Watson, MPS, RN

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