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K. DANIEL O'LEARY, RICHARD E. HEYMAN, AND ARTHUR E. JONGSMA, JR.

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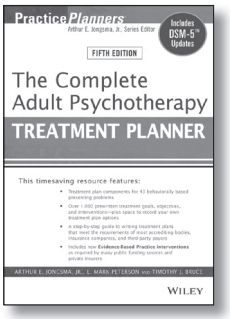

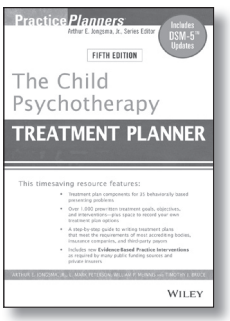

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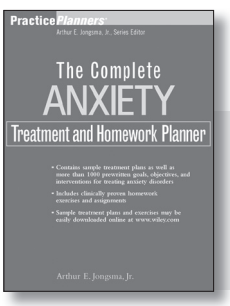

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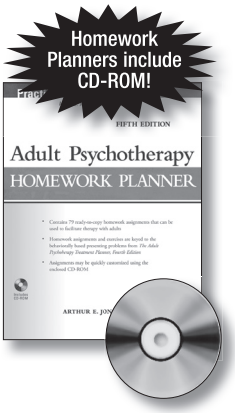

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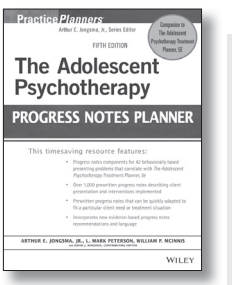

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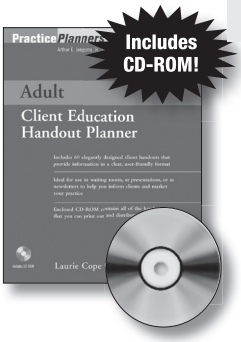

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The College Student Counseling Treatment Planner
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Arthur E. Jongsma, Jr., Series Editor

The Couples Psychotherapy Treatment Planner, with DSM-5 Updates, Second Edition

K. Daniel O'Leary

Richard E. Heyman

Arthur E. Jongsma, Jr.

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To my wife, Judy, who has made us much better as a couple for 47 years than I could ever be as a single person.

—AEJ

To Maria, with whom 24 years of marriage has been like one long date, and to Bob Weiss, for teaching me most everything I'll ever need to know about couples interventions.

—REH

To Susan, who has been a strong support, sounding board, and professional colleague since graduate school.

—KDO

CONTENTS

EBT Indicates that selected Objective/Interventions are consistent with those found in evidence-based treatments.

PRACTICE*PLANNERS*® SERIES PREFACE

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

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- Juvenile justice and residential care
- Mental retardation and developmental disability
- Neuropsychology
- Older adults
- Parenting skills
- Pastoral counseling
- Personality disorders
- Probation and parole
- Psychopharmacology
- Rehabilitation psychology
- School counseling and school social work
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- ***Client Education Handout Planners*** provide brochures and handouts to help educate and inform clients on presenting problems and mental health issues, as well as life skills techniques. The handouts are included on CD-ROMs for easy printing from your computer and are ideal for use in waiting rooms, at presentations, as newsletters, or as information for clients struggling with mental illness issues. The topics covered by these handouts correspond to the presenting problems in the *Treatment Planners*.

The series also includes adjunctive books, such as *The Psychotherapy Documentation Primer* and *The Clinical Documentation Sourcebook*, containing forms and resources to aid the clinician in mental health practice management.

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

ARTHUR E. JONGSMA, JR.
Grand Rapids, Michigan

ACKNOWLEDGMENTS

We want to acknowledge the hundreds of couples whom we have treated and who provided us with their insights and perspectives on relationships. There are many ways that individuals work with one another and they often do so in highly idiosyncratic ways. The ability of individuals to work with their partners under quite difficult circumstances due to external and internal pressures is remarkable and honorable. We thank individuals and couples who have shown us how to cope with problems and how to change their attitudes and behaviors so that they can function in a fashion that is more acceptable and satisfying to both.

Our first *Couples Therapy Treatment Planner* was written over a decade ago and some new problems that couples face have emerged across this period such as problems related to use of the Internet for sexual purposes, problems associated with our aging population, and couple issues related to an economic recession. To address some of these trends we have added chapters on problems related to retirement, the transition to parenthood, and the use of Internet sex. The chapters on couple problems related to intimate partner violence and to financial matters have been updated to bring the chapters into a more current perspective.

In all our chapters, we have relied on both the empirical literature and the observations, reactions, and insights of the couples who have faced and coped with the various problems covered in this book, and we thank them for their assistance and perspectives. In many cases, the changes were so positive that the individuals in the relationship felt more caring and love for one another. In some cases the changes were not enough for individuals to decide to stay together, but in such cases the decision not to stay together often allowed the individuals to feel significantly better about themselves.

Throughout many of the chapters we are indebted to the self-regulation work of Kim Halford (e.g., Halford, 2004) and to the "situational analysis" approach to cognitive behavioral therapy pioneered by Jim McCullough (2003). These two approaches are complementary and encourage self-regulation by clients. Perhaps most importantly, they are pragmatic—joining with clients to examine and change thoughts and behaviors to increase the probability of achieving important outcomes rather than on denigrating clients as thinking "irrationally." We also acknowledge the intellectual input

of researchers in the couples arena whose work has informed our assessment and treatment. They include Steven Beach, Ileana Arias, Mark Whisman, Donald Baucom, Doug Snyder, Alan Gurman, and Murray Straus. We are also indebted to our colleagues, Dina Vivian and Jose Luis Grana with whom we have repeatedly discussed the treatment of individual cases over the years.

K. DANIEL O'LEARY and RICHARD E. HEYMAN

It is with great respect that I acknowledge the depth of knowledge and expertise that Rick Heyman and Dan O'Leary brought to this project. They are both very busy psychologists but they managed to give quality time to the content in this book. It was my privilege to work with them over the last year to update this second edition of the *Couples Psychotherapy Treatment Planner.* They are familiar with the research literature on counseling with couples over a variety of presenting problems and they brought that expertise to bear as they informed the Objectives and Interventions in this book with this evidence-based data. I salute them and thank them for their collaborative manner and gracious spirit throughout the project.

I also want to thank the editorial and production staff at John Wiley & Sons. They are professionals of the highest order and I am indebted to them for many years of fine work on the Practice*Planner* series. Kudos to you all!

A final thanks is due to Sue Rhoda, our manuscript manager, who brings organization out of chaos and style out of a jumble of good content. Thank you again, Sue.

ARTHUR E. JONGSMA, JR.

The Couples Psychotherapy Treatment Planner, with DSM-5 Updates, Second Edition

INTRODUCTION

ABOUT PRACTICE*PLANNERS*® TREATMENT PLANNERS

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

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- Has an easy-to-use reference format that helps locate treatment plan components by behavioral problem or *DSM-5* diagnosis.

As with the rest of the books in the Practice*Planners*® series, our aim is to clarify, simplify, and accelerate the treatment planning process, so you spend less time on paperwork, and more time with your clients.

ABOUT *THE COUPLES THERAPY TREATMENT PLANNER*

This second edition of the popular *Couples Therapy Treatment Planner* comes as a result of the positive response that we received over the past decade with the success of the first planner. The first edition, which ran for almost 10 years, was a bestseller. As a revision, we have included three new chapters (Internet Sexual Use, Retirement, Transition to Parenthood Strains) and separated the intimate partner violence (IPV) chapter into two, one covering bidirectional IPV and one covering "intimate terrorism" IPV. All chapters, totaling 32 in all, were updated to include research and clinical

developments over the last decade and to indicate evidence-based treatment interventions throughout.

The cornerstone of early behavioral marital interventions was clearly on decreasing negative interchanges and increasing positive interchanges between partners (Jacobson & Margolin, 1979; O'Leary & Turkewitz, 1978) because discordant couples differ from happy couples in positive and negative interactions (Broderick & O'Leary, 1986; Johnson & O'Leary, 1996; Wills, Weiss, & Patterson, 1974). Studies based largely on these foci showed that significant increases in marital satisfaction could be obtained, but it also became evident that, while there were significant improvements, there were many couples who needed more specific assistance in dealing with various and often long-standing problems. In fact, this *Couples Therapy Treatment Planner* is organized around various problems that often coexist with relationship problems, and each chapter provides up-to-date references related to the numerous and varied problems that often occur simultaneously with relationship problems.

Many of the chapters in this *Treatment Planner* incorporate elements of a cognitive behavioral self-regulation model (e.g., Bandura, 1986, 1995; Karoly, 1993), which has emerged in recent years as a unifying component and active ingredient in a wide variety of empirically supported programs. Halford (2001; Halford, Moore, Wilson, Dyer, & Farrugia, 2004; Wilson & Halford, 2008) has made the most use of this model with couples and we are indebted to his approach. In a self-change or self-regulatory model, clients (a) self-select elements relevant to them that they determine will assist them in achieving their goals; (b) develop and enact plans to make changes; and (c) self-assess their progress and make corrections to improve future success. This model has demonstrated effectiveness for targets as diverse as alcohol problems (e.g., Lundahl et al., 2010), chronic depression (e.g., Keller et al., 2000), relationship enhancement (e.g., Halford et al., 2004), and child behavior problems in the context of both prevention and intensive intervention services (e.g., de Graaf et al., 2008a).

Many of the chapters also incorporate McCullough's (2003) distillation of cognitive-behavioral therapy (CBT) using "situational analysis." We have included a sample situational analysis form in Appendix D. Instead of focusing on purportedly "irrational thoughts," the situational analysis has clients focus on what actually happened (e.g., beginning, middle, and end of a discrete incident), what the actual outcome was, and what the desired outcome was. Clients then examine their thoughts and behavior through the pragmatic lens of whether they helped or hurt the client getting the desired outcome. We have found this focused form of CBT to be incredibly useful in couples treatment. Therapists wishing to use this approach would be well served by reading McCullough's (2003) book, *Treatment for Chronic Depression: Cognitive Behavioral Analysis System of Psychotherapy (CBASP)*. Though focused on chronic depression, further instruction on situational analysis can be found there.

This book also goes hand-in-hand with the the *Family Therapy Treatment Planner,* Second Edition (Dattilio, Jongsma, & Davis) since very often family conflicts emanate from problems in the couples' relationship. In such cases, the therapist should refer to the *Family Therapy Treatment Planner,* Second Edition for more specific suggestions regarding treating the couple's relationship.

INCORPORATING EVIDENCE-BASED TREATMENT INTO THE *TREATMENT PLANNER*

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

In this second edition of *The Couples Therapy Treatment Planner*, we have made an effort to include, in almost all of the chapters, evidence-based interventions by highlighting Short-term Objectives (STOs) and Therapeutic Interventions (TIs) that are consistent with psychological treatments or therapeutic programs that have demonstrated some level of efficacy through empirical study. Such STOs and TIs are noted with an icon as an indication that an Objective/Intervention is consistent with those found in evidence-based treatments (EBT).

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

In this *Planner*, we have included STOs and TIs consistent with identified EBTs for couple problems and mental disorders commonly seen by practitioners in public agency and private practice settings. It is important to note that the empirical support for the EBT material found in each chapter has *not* necessarily been established for treating that problem within a

couples context, but rather, is particular to the problem identified in the chapter title. For example, the STOs and TIs consistent with cognitive behavioral therapy for anxiety, which can be found in the chapter entitled "Anxiety," are based on this treatment approach, which has been well established as an empirically supported individual treatment for anxiety, yet can be easily modified for treatment in a couples setting. Furthermore, it is important to remember that an EBT such as Behavioral Couples Therapy (e.g., Epstein & Baucom, 2002), Integrative Behavioral Couple Therapy (Jacobson & Christensen, 1996), and Emotionally Focused Marital Therapy (e.g., Johnson, 2004) can be applied to a wide variety of problems. Therefore, although many chapters present common problems faced by couples (e.g., parenting conflicts) on which no studies have specifically focused, an EBT, such as behaviorally based parenting techniques or problem-solving skills, can be used to help the couple through that particular challenge.

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

Criteria for Inclusion of Evidence-Based Therapies

The EBTs from which STOs and TIs were taken have different levels of empirical evidence supporting them. For example, some have been well established as efficacious for the problems that they target (e.g., exposure-based therapies for anxiety disorders). Others have less support, but nonetheless have demonstrated efficacy. We have included EBPs, the empirical support for which has either been well established or demonstrated at more than a preliminary level as defined by those authors who have undertaken the task of identifying them, such as the APA Division 12 (Society of Clinical Psychology); Drake and colleagues (2003, 2005); Chambless and colleagues (1996, 1998); Gurman (2008); and Nathan and Gorman (2007).

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

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

Summary of Required and Preferred EBT Inclusion Criteria

Required

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

Preferred

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

HOW TO USE THIS *TREATMENT PLANNER*

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

1. **Problem Selection.** Although the client may discuss a variety of issues during the assessment, the clinician must determine the most significant problems on which to focus the treatment process. Usually a primary problem will surface, and secondary problems may also be evident. Some other problems may have to be set aside as not urgent enough to require treatment at this time. An effective treatment plan can only deal with a

few selected problems or treatment will lose its direction. Choose the problem within this *Planner* that most accurately represents your client's presenting issues.

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

   Some suggested interventions listed in the *Planner* refer to specific books that can be assigned to the client for adjunctive bibliotherapy. Appendix A contains a full bibliographic reference list of these materials. For further information about self-help books, mental health professionals may wish to consult *The Authoritative Guide to Self-Help Resources in Mental Health, Revised Edition* (2003) by Norcross et al. (available from Guilford Press, New York).
6. **Diagnosis Determination.** The determination of an appropriate diagnosis is based on an evaluation of the client's complete clinical presentation. The clinician must compare the behavioral, cognitive, emotional, and interpersonal symptoms that the client presents with the criteria for diagnosis of a mental illness condition as described in *DSM-5*. Despite

arguments made against diagnosing clients in this manner, diagnosis is a reality that exists in the world of mental health care, and it is a necessity for third-party reimbursement. It is the clinician's thorough knowledge of *DSM-5* criteria and a complete understanding of the client assessment data that contribute to the most reliable, valid diagnosis.

Congratulations! After completing these six steps, you should have a comprehensive and individualized treatment plan ready for immediate implementation and presentation to the client. A sample treatment plan for anger management is provided at the end of this introduction.

A FINAL NOTE ON TAILORING THE TREATMENT PLAN TO THE CLIENT

One important aspect of effective treatment planning is that each plan should be tailored to the individual's client's problems and needs. Treatment plans should not be mass-produced, even if clients have similar problems. The individual's strengths and weaknesses, unique stressors, social network, family circumstances, and symptom patterns must be considered in developing a treatment strategy. Drawing upon our own years of clinical experience, we have put together a variety of treatment choices. These statements can be combined in thousands of permutations to develop detailed treatment plans. Relying on their own good judgment, clinicians can easily select the statements that are appropriate for the individuals whom they are treating. In addition, we encourage readers to add their own definitions, goals, objectives, and interventions to the existing samples. As with all of the books in the *Treatment Planners* series, it is our hope that this book will help promote effective, creative treatment planning—a process that will ultimately benefit the client, clinicians, and the mental health community.

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SAMPLE TREATMENT PLAN

COMMUNICATION

BEHAVIORAL DEFINITIONS

1. Frequent arguments or arguing in ways that cause significant upset.
2. Difficulty resolving problems.
3. Frequent misunderstandings during discussions.

LONG-TERM GOALS

1. Partners discuss and resolve problems effectively without verbal fighting.
2. Each partner listens to and understands the other partner's perspective.

SHORT-TERM OBJECTIVES	THERAPEUTIC INTERVENTIONS
1. Identify specific communication deficits.	1. Have the couple attempt to solve a major problem while the therapist quietly watches and takes notes about communication skills and deficits. EBP 2. Praise the couple for things they do well (such as making eye contact or attempting to define the problem) and provide direct feedback regarding things that need improvement (such as maintaining a civil tone of voice or overcoming tendency to interrupt). EBP
2. Partners implement the two overarching communication skills of: "Be Clear" and "Be Considerate."	1. Teach the partners the communication skill that emphasizes that interchanges should be (a) clear (i.e., be specific; share thoughts and feelings; pay attention; ask

	clarifying questions; summarize content and feelings); and (b) considerate (i.e., include positives, show consideration when expressing negatives, let partner know that one is listening even if one disagrees; reserve judgment).
	2. Ask the partners to discuss a low-conflict area of desired change and ask them to rate how well they did being clear.
	3. Ask the partners to discuss a low-conflict area of desired change and ask them to rate how well they did being considerate.
3. Practice defining problems in specific, non-blaming terms.	1. Have the partners take turns pinpointing problems (that is, making requests for change that are specific, observable, and ask for increases rather than decreases in the other partner's behavior).
	2. Have the partners use the "speaker-listener" technique, with the listener trying to convey understanding after the speaker makes an "I" statements in the following form: "When _____ happens, I feel _____. I would like _____."
4. Demonstrate an understanding of communication that is focused on problem-solving and on venting.	1. Teach partners that communication tends to serve one of two purposes —venting (i.e., sharing feelings) or problem-solving; have partners identify how they feel when one person is pursuing venting and the other problem-solving.
	2. Role-play the couple discussing a current problem while having the

	listener ask the speaker which he/she wants out of the discussion—venting or problem-solving.
5. Identify cues for arguments and practice argument-control strategies.	1. Help the partners identify cues that an argument is impending (e.g., behaviors, thoughts, feelings, bodily sensations) and have them contract with each other actions they will take time to cool off (e.g., pause the conversation, calm themselves down separately, and think about ways in which they are contributing to the problem) before talking further. 2. Help the partners identify times that are conducive to discussing and/or solving problems (such as after the children are in bed) and times that are not conducive (such as when dinner is being prepared).
6. Use problem-solving skills to resolve a problem.	1. Choose a moderate area of conflict that has been pinpointed and have the partners practice brainstorming, whereby each partner generates at least two solutions to a problem before trying to solve that problem. 2. Teach partners to evaluate the pros and cons of the brainstormed solutions and have them practice this in session on areas of conflict. 3. Teach partners how to select specific, operationalized plan for attaining a solution based on the pros and cons of that solution; ask the partners to implement the selected action plan before the next session.