

Toy Story's Jessie

Introducing the Character

Jessie is one of the main characters in the Pixar/Disney animated blockbuster movie *Toy Story 2* (Plotkin, Jackson, & Lasseter, 1999). In the story, Jessie is a cowgirl doll modeled after the fictitious cowgirl character in a 1960s children's western TV show called *Woody's Roundup*. The story centers on a band of toys who are going to be sold to a Japanese toy museum and their efforts to undermine that sale and remain together. As the story unfolds, we learn that Jessie, once a favored toy to her owner, was abandoned when the girl grew out of her interest in childhood play things. Jessie was subsequently purchased by Al of Al's Toy Barn, who was in the process of collecting a full set of toys that were marketed in conjunction with the *Woody's Roundup* television show. As *Toy Story 2* unfolds, the pain of Jessie's abandonment becomes obvious to the other toys, and especially to Woody, who is also struggling to remain in the favor of his boy owner, Andy. As the toys work together to overcome the differences that divide them, they ultimately rally to liberate themselves, and in the process, stage a last-minute rescue of Jessie and provide her once again with connection, attachment, and a sense of being loved.

Jessie's is a poignant story of abandonment, loss, and reconnection. Using her experiences in *Toy Story 2* as our building blocks, in the following basic case summary and diagnostic impressions, we reinvent Jessie in order to illustrate Reactive Attachment Disorder.

Basic Case Summary

Identifying Information. Jessie, who refuses to use her last name because "it reminds me of them" (her foster parents), is an 11-year-old white preteen who has, for the last 3 months, been living at the Storyland Home for Girls. She has displayed increasingly disturbing asocial behavior at this facility, which has led to her spending increasing time alone, "shying away" from staff, and watching other peer residents with what was described as

a “cold aloofness.” In appearance, she can be described as a wiry, energetic, and wide-eyed red-haired waif. She has her own room at the facility because of her wary behavior and unwillingness to interact with the other residents.

Presenting Concerns. Jessie was referred for counseling by the disciplinary dean at the Storyland School due to escalating concerns about her highly ambivalent reactions to staff and peers.

Background, Family Information, and Relevant History. Jessie was born in Muskegon, Wisconsin, the youngest and unexpected third child to parents who were both under 20 years old. Jessie’s mother and father were both raised in the Wisconsin Foster Care System after being abandoned at birth; her father was in recovery for Alcohol Use Disorder. When Jessie was born, her parents were living in a one-bedroom apartment over a grocery store in downtown Muskegon, were receiving government support, and had recently placed Jessie’s older brother up for adoption.

Jessie was born 5 weeks premature and presented a significant challenge to her young parents, who were referred to, but did not take advantage of, pre- and postnatal social services resources. As a result, Jessie received poor postnatal care and was often left in the company of her parents’ friends, where she was also neglected. When Jessie was 1 year old, she was removed from her parents’ care and placed with a private foster family who hoped to adopt her; however, when those plans fell through, Jessie was moved into a foster-care facility where she remained until 4 years of age. By that time, Jessie was already showing signs of disrupted attachment, including resisting the attentions of her foster parents, avoiding her foster parents’ soothing touch or comforting remarks, hiding from foster siblings in the home, and carefully watching babysitters before responding. She also began a habit of sometimes leaving the home and telling strangers that she was lost. Invariably, she would be returned to the foster home. In spite of her troubled history, Jessie was once again adopted at age 6 by an ostensibly loving and older couple who convinced the state that they had ample financial and psychological resources to provide for the girl’s needs. However, Jessie was harassed by the biological child of this couple and when she began running away from their care at age 8 she had already displayed a pattern of seeming to indiscriminately approach strangers on the sidewalk as if she was closely familiar to them.

When one of these “strangers” turned out to be a state care worker, Jessie was immediately removed from this couple’s care and placed with a middle-aged couple who had successfully raised their own children and who had been foster parents for 15 years. In that home, Jessie appeared to thrive and slowly began to trust her new parents. Although she tested limits, attempted to run away from home, aggressed toward them, and challenged their patience and experience, the couple’s commitment to the 9-year-old seemed to be having a positive effect on her. By the time Jessie was enrolled in Storyland Middle School she, at least outwardly, appeared ready to enter into a new social world. She was placed in a small classroom with a teacher who had been extensively trained in providing for the educational and emotional needs of troubled children, and Jessie seemed to trust this woman, at least as much as she had ever trusted anyone before. She formed very tentative bonds with several classmates, mostly other troubled children, joined the school’s Martial Arts Program, and was referred to the school guidance department for possible inclusion in group and individual therapy.

Problem and Counseling History. Jessie was referred by the Storyland facility to Creative Counseling Consultants, where she was seen for three sessions separated by a week in time. She was a very charming and superficially endearing child who was playfully dressed in what appeared to be a cowgirl outfit and indicated that “this reminds me of that movie cartoon character who lost her parents and was looking for a family.” Ironically, much of Jessie’s creative play, whether it was art, story-telling, clay modeling, or dollhouse activities, centered on themes of disrupted families, abuse of children, and retaliatory behavior against parents. Jessie’s affect during this disturbing play was quite flat as she recounted incidents in several of the foster and adoptive placements that “make me feel so angry and sad.” The results were a very highly destructive element to her play in that she would angrily erase, destroy, or negate her various creations, followed by a tantrum and withdrawal to a corner of the room. She resisted supportive and compassionate gestures by the evaluator and made it quite clear that “I don’t like you and I’m only doing this because they made me.” At such moments, her body stiffened, her face reddened, and she quickly withdrew and stared off into space for minutes at a time.

Jessie spoke dispassionately about the various families with whom she had lived over the years and noted that “if they really loved me they would have kept me . . . I hate them all so much.” She angrily added

that “they all thought that if they just sent me to a shrink, that I could be fixed . . . like some sort of broken toy.” When asked about her current living situation, she quickly shot back with, “Oh yeah, they’re nice enough people, but I don’t think they’re going to keep me and maybe they’re just using me to get money from the state like everybody else.” Nevertheless, Jessie acknowledged that they seemed different from previous foster or adoptive parents but that “I’m going to keep a really close eye on them and if they make one wrong move, that’s it.” Jessie denied having difficulty with her anger, trusting people, or feeling safe, but reluctantly agreed to return to counseling.

Goals for Counseling and Course of Therapy to Date. Jessie has been seen for three sessions, and conjointly receives facilitative care at the Storyland home. It is recommended that she continue to participate in intensive therapeutic experiences as outlined in the attached treatment plan.

Diagnostic Impressions

313.89 (F94.1) Reactive Attachment Disorder Persistent.

Other factors: V61.8 (Z62.29) Upbringing Away from Parent—social problems in current residential facility

Discussion of Diagnostic Impressions

Jessie was referred for counseling by her school’s disciplinary dean because the faculty was concerned about her lack of appropriate sociability at the Storyland Home for Girls. She appeared highly ambivalent about receiving the affections and professional support of staff, shied away from other residents, and seemed warily watchful of others. Her behaviors were of enough concern for her to be assigned a single room at the foster care facility to assist with her transition there.

The Trauma- and Stressor-Related Disorders chapter is a specific section of the *DSM-5*, which is comprised of disorders that all share the feature of “exposure to a traumatic or stressful event” (APA, 2013, p. 265) that is either directly experienced or witnessed.

Using Jessie the Cowgirl’s story as our starting point, in this case example we presented an 11-year-old girl named Jessie whose background history included repeated changes in primary caregivers: She began life before age 1 in the Wisconsin Foster Care System, lived in several homes where adoption was attempted, moved among various foster families, and currently is residing in a foster-care home. As early as age 4, she engaged in disrupted interpersonal behaviors: She persistently declined to respond in developmentally appropriate ways to social and supportive advances by adoptive and foster parents and families and others. She avoided their responses, resisted comforting, and was watchful of babysitters and others. At the same time, she developed a pattern of overapproach to strangers and was indiscriminate in her social advances toward adults she did not know.

A logical presumption made by social service workers and counseling staff was that Jessie’s history of social relatedness problems was a consequence of her disturbed early social experiences characterized by removal from her parents around age 1, followed by repeated disruptions in care. Jessie’s situation in this case suggests a diagnosis of Reactive Attachment Disorder. Most of her behaviors center on “a pattern of markedly disturbed and developmentally inappropriate attachment behaviors” (APA, 2013, p. 266). As these behaviors have been present for over 12 months (in fact, they have been present for most of Jessie’s life), the diagnosis can be subtyped as Persistent.

One set of differential considerations might be Autism Spectrum Disorder, based partly upon impaired social interaction. However, this diagnosis generally requires not only disrupted formation of developmentally appropriate social attachment, but also patterns of restricted, repetitive, or stereotypical behaviors, which Jessie did not demonstrate. Generally speaking, Autism Spectrum Disorder is also characterized by developmental disruptions in social communication in the context of normally expected, supportive family or social environments—whereas an essential feature of Reactive Attachment Disorder is a history of pathogenic care (disregard for the child’s psychoemotional needs or physical needs, or repeated changes in primary caregiver) such as Jessie experienced.

To finish the diagnosis, Jessie’s critical psychosocial stressors associated with her primary supports are emphasized in the “Other factors” section. The information presented in this section is consistent with the primary mental health diagnosis describing Jessie’s situation.

Case Conceptualization

When Jessie was referred to counseling, the first step was to take part in an intake and evaluation session. The intake counselor collected as much information as possible about the problematic situations in school and outside of school that led to Jessie’s referral. The counselor first used this information to develop diagnostic impressions. Jessie’s concerns were described by Reactive Attachment Disorder. Next, the counselor developed a case conceptualization. Whereas the purpose of diagnostic impressions is to *describe* the client’s concerns, the goal of case conceptualization is to better *understand* and clinically *explain* the person’s experiences (Neukrug & Schwitzer, 2006). It helps the counselor understand the etiology leading to Jessie’s presenting concerns and the factors maintaining these needs. In turn, case conceptualization sets the stage for treatment planning. Treatment planning then provides a road map that plots out how the counselor and client expect to move from presenting concerns to positive outcomes (Seligman, 1993, p. 157)—helping increase Jessie’s successful, normally expected, developmentally appropriate attachments in relationships with adults and peers.

When forming a case conceptualization, the clinician applies a purist counseling theory, an integration of two or more theories, an eclectic mix of theories or a solution-focused combination of tactics, to his or her understanding of the client. In this case, Jessie’s counselor based her conceptualization on a purist theory applicable to the behavioral needs of child clients: Theraplay. She selected this approach based on her knowledge of current outcome research and the best-practice literature pertaining to child clients dealing with disorders that initially present in infancy and childhood (Kazdin & Weisz, 2003; Mowder, Rubinson, & Yasik, 2009). The Theraplay conceptual approach also is consistent with this counselor’s professional therapeutic viewpoint.

The counselor used the Inverted Pyramid Method of case conceptualization because this method is especially designed to help clinicians more easily form their conceptual pictures of their clients’ needs

(Neukrug & Schwitzer, 2006; Schwitzer, 1996, 1997). The method has four steps: Problem Identification, Thematic Groupings, Theoretical Inferences, and Narrowed Inferences. The counselor's clinical thinking can be seen in the figure that follows.

1. IDENTIFY AND LIST CLIENT CONCERNS

Biological parents were both abandoned at birth and raised in foster care themselves	Early child foster care hiding from others
Biological father in alcohol recovery	Early child foster care avoided touch of others
Economically impoverished parents	Early child foster care suspicious and wary of others
Hiding, avoidant, wary throughout placements, settings, and developmental time periods	Older brother given for adoption
Increasingly aggressive or hostile reactions to others	Born biologically premature
Destructive aspects of play	Poor access to prenatal and postnatal health care
Adopted but harassed by sibling at elementary age	Removed to foster family at age 1
Later fostered by current foster family	Relocated to foster group home at ages 1–4
	Feels "sad and angry"

2. ORGANIZE CONCERNS INTO LOGICAL THEMATIC GROUPINGS

Reactive Attachment Disorder of Infancy or Childhood: negative, avoiding, wary, suspicious with adults and peers—occurring since an early infant age and in reaction to a history of poor very early parenting relationships; early and subsequent foster family care, foster facility care; adopted care; and current foster care

3. THEORETICAL INFERENCES: ATTACH THEMATIC GROUPINGS TO INFERRED AREAS OF DIFFICULTY

Theraplay Inference

Jessie missed out on access to models of healthy interaction between parents and children from age 1 onward

4. NARROWED INFERENCES: SUICIDALITY AND DEEPER DIFFICULTIES

Deeper Theraplay Inference

Jessie required but did not receive exposure to healthy experiences of: relationship structure and limits; challenges; intrusion versus engagement; and nurture

Step 1: Problem Identification. The first step is Problem Identification. Aspects of the presenting problem (thoughts, feelings, behaviors, physiological features), additional areas of concern besides the presenting concern, family and developmental history, in-session observations, clinical inquiries (medical problems, medications, past counseling, substance use, suicidality), and psychological assessments (problem checklists, personality inventories, mental status exam, specific clinical measures) all may contribute information at Step 1. The counselor “casts a wide net” in order to build Step 1 as exhaustively as possible (Neukrug & Schwitzer, 2006, p. 202). As can be seen in the figure, the counselor thoroughly noted not just all of Jessie’s poor relationship behaviors and related difficulties at school and at home—but also as much important information as she could find regarding Jessie’s earlier developmental experiences, childhood life transitions, environmental factors, and medical notes. The counselor attempted to go beyond just listing the main behaviors causing the referral and to be as complete as she could.

Step 2: Thematic Groupings. The second step is Thematic Groupings. The clinician organizes all of the exhaustive client information found in Step 1 into just a few intuitive-logical clinical groups, categories, or themes, on the basis of sensible common denominators (Neukrug & Schwitzer, 2006). Four different ways of forming the Step 2 theme groups can be used: Descriptive-Diagnosis Approach, Clinical Targets Approach, Areas of Dysfunction Approach, and Intrapsychic Approach. As can be seen in the figure, Jessie’s counselor selected the Descriptive-Diagnosis Approach. This approach sorts together all of the various Step 1 information about the client’s adjustment, development, distress, or dysfunction “to show larger clinical problems as reflected through a diagnosis” (Neukrug & Schwitzer, 2006, p. 205).

In this case, the counselor formed just a single theme by grouping together all of Jessie’s behavioral, cognitive, and affective challenges comprising Reactive Attachment Disorder—occurring since an early age and throughout family changes, foster arrangements, adoptions, and further transitions—into one clear, logical grouping. The counselor’s conceptual work at Step 2 gave her a way to begin thinking about Jessie’s functioning and concerns more insightfully.

So far, at Steps 1 and 2, the counselor has used her clinical assessment skills and her clinical judgment to begin critically understanding Jessie's presentation. Now, at Steps 3 and 4, she applies the theoretical approach she has selected. She begins making theoretical inferences to explain the factors leading to Jessie's issues as they are seen in Steps 1 and 2.

Step 3: Theoretical Inferences. At Step 3, concepts from the counselor's selected theory, Theraplay, are applied to explain the experiences causing, and the mechanisms maintaining, Jessie's problematic behaviors. The counselor tentatively matches the theme groups in Step 2 with this theoretical approach. In other words, the symptom constellations in Step 2, which were distilled from the symptoms in Step 1, now are combined using theory to show what are believed to be the underlying causes or psychological etiology of Jessie's current needs (Neukrug & Schwitzer, 2006; Schwitzer, 2006, 2007).

Theraplay is based on the assumption that relationships "modeled on healthy interaction between parents and their children" can lead to enhanced "attachment, self-esteem, trust, and joyful engagement" (Koller & Booth, 1997, p. 204). According to the theory, when these types of relationships occur successfully in the family, they lead to healthy, normally expected child attachments and capacities for relationships. Alternatively, according to the model, the absence of these types of ideal experiences in the family can lead to relational and other types of developmental difficulties. Correspondingly, using the approach, therapeutic relationships involving counselors, parents, or primary caretakers and a child who is in need are constructed via the Theraplay treatment method. The relationships, modeled on healthy parent-child interactions, emphasize several relational dimensions: structure and limits, challenge, intrusion and engagement, and nurture (Jernberg & Booth, 1999; Jernberg & Jernberg, 1993). These therapeutic activities are expected to remediate and remedy problems in the attachment process that lead to children's intrapersonal and interpersonal difficulties (Jernberg & Jernberg, 1993).

As can be seen in the figure, when the counselor applied these concepts to her conceptualization of Jessie's presentation, she made the following theoretical inference at Step 3: Jessie missed out on access to models of healthy interaction between parents and children from pre-age-1 years onward.

Step 4: Narrowed Inferences. At Step 4, the clinician’s selected theory continues to be used to address still-deeper issues when they exist (Schwitzer, 2006, 2007). At this step, “still-deeper, more encompassing, or more central, causal themes” are formed (Neukrug & Schwitzer, 2006, p. 207). Continuing to apply Theraplay concepts at Step 4, Jessie’s counselor presented a single, most-fundamental construct that she inferred to be most explanatory and causal regarding Jessie’s reasons for referral: Jessie required but did receive exposure to healthy experiences of relationship structure and limits, challenges, intrusion and engagement, and nurture (see the figure). When all four steps are completed, the client information in Step 1 leads to logical-intuitive groupings on the basis of common denominators in Step 2, the groupings then are explained using theory at Step 3, and then, finally, at Step 4, further deeper explanations are made. From start to finish, the thoughts, feelings, behaviors, and physiological features in the topmost portions are connected on down the pyramid into deepest dynamics.

The completed pyramid now is used to plan treatment to assist Jessie in multiple psychosocial systems.

Treatment Planning

At this point, Jessie’s clinician at Creative Counseling Consultants has collected all available information about the problems that have been of concern to her and her school. Based upon this information, the counselor developed a *DSM-5* diagnosis and then, using the “inverted pyramid” (Neukrug & Schwitzer, 2006; Schwitzer, 1996, 1997), formulated a working clinical *explanation* of Jessie’s difficulties and their etiology that we called the *case conceptualization*. This, in turn, guides us to the next critical step in our clinical work, called the *treatment plan*, the primary purpose of which is to map out a logical and goal-oriented strategy for making positive changes in the client’s life. In essence, the treatment plan is a road map “for reducing or eliminating disruptive symptoms that are impeding the client’s ability to reach positive mental health outcomes” (Neukrug & Schwitzer, 2006, p. 225). As such, it is the cornerstone of our work with not only Jessie, but with all clients who present with disturbing and disruptive symptoms and/or personality patterns (Jongsma & Peterson, 2006; Jongsma et al., 2003a, 2003b; Seligman, 1993, 1998, 2004).

A comprehensive treatment plan must integrate all of the information from the biopsychosocial interview, diagnosis, and case conceptualization into a coherent plan of action. This *plan* comprises four main components, which include (1) a behavioral definition of the problem(s), (2) the selection of achievable goals, (3) the determination of treatment modes, and (4) the documentation of how change will be measured. The *behavioral definition of the problem(s)* consolidates the results of the case conceptualization into a concise hierarchical list of problems and concerns that will be the focus of treatment. The *selection of achievable goals* refers to assessing and prioritizing the client's concerns into a *hierarchy of urgency* that also takes into account the client's motivation for change, level of dysfunction, and real-world influences on his or her problems. The *determination of treatment modes* refers to selection of the specific interventions, which are matched to the uniqueness of the client and to his or her goals and clearly tied to a particular theoretical orientation (Neukrug & Schwitzer, 2006). Finally, the clinician must establish how change will be measured, based upon a number of factors, including client records and self-report of change, in-session observations by the clinician, clinician ratings, results of standardized evaluations such as the Beck Anxiety Inventory (Beck & Steer, 1990) or a family functioning questionnaire, pre-post treatment comparisons, and reports by other treating professionals.

The four-step method discussed above can be seen in the text and is outlined below for the case of Jessie, followed by her specific treatment plan.

Step 1: Behavioral Definition of Problems. The first step in treatment planning is to carefully review the case conceptualization, paying particular attention to the results of Step 2 (Thematic Groupings), Step 3 (Theoretical Inferences), and Step 4 (Narrowed Inferences). The identified clinical themes reflect the core areas of concern and distress for the client, while the theoretical and narrowed inferences offer clinical speculation as to their origins. In the case of Jessie, there is one overarching area of concern. "Reactive attachment disorder" refers to her increasingly aggressive and hostile reactions toward others, destructive play, feelings of sadness, and anger and hatred toward caretakers. These symptoms and stresses are consistent with the diagnosis of Reactive Attachment Disorder, Persistent (APA, 2013; Hersen & Ammerman, 2000; Lieberman & Pawl, 1990; Parritz & Troy, 2011; Zeanah & Boris, 2005; Zero to Three Association, 2005).

Step 2: Identify and Articulate Goals for Change. The second step is the selection of achievable goals, which is based upon a number of factors, including the most pressing or urgent behavioral, emotional, and interpersonal concerns and symptoms as identified by the client and clinician, the willingness and ability of the client to work on those particular goals, and the realistic (real-world) achievability of those goals (Neukrug & Schwitzer, 2006). At this stage of treatment planning, it is important to recognize that not all of the client's problems can be addressed at once, so we focus initially on those that cause the greatest distress and impairment. New goals can be created as old ones are achieved. In the case of Jessie, all of the goals are related to her primary problem, "reactive attachment disorder." This complex developmental challenge requires that we help Jessie resolve the impediments to forming healthy attachments, establish and maintain a bond with her primary caregivers, help her maintain appropriate boundaries with others, and tolerate absences from her primary caregivers without excessive anxiety and behavioral/emotional dyscontrol.

Step 3: Describe Therapeutic Interventions. This is perhaps the most critical step in the treatment planning process because the clinician must now integrate information from a number of sources, including the case conceptualization, the delineation of the client's problems and goals, and the treatment literature, paying particular attention to *empirically supported treatment* (EST) and *evidence-based practice* (EBP). In essence, the clinician must align his or her treatment approach with scientific evidence from the fields of counseling and psychotherapy. Wampold (2001) identifies two types of evidence-based counseling research: studies that demonstrate "absolute efficacy," that is, the fact that counseling and psychotherapy work, and those that demonstrate "relative efficacy," that is, the fact that certain theoretical/technical approaches work best for certain clients with particular problems (Psychoanalysis, Gestalt Therapy, Cognitive Behavior Therapy, Brief Solution-Focused Therapy, Cognitive Therapy, Dialectical Behavior Therapy, Person-Centered Therapy, Expressive/Creative Therapies, Interpersonal Therapy, and Feminist Therapy); and when delivered through specific treatment modalities (individual, group, and family counseling).

In the case of Jessie, we have decided to use a multimodal treatment strategy as "specific interventions proposed for clinical disturbances or disorders of attachment have included individual psychotherapy for the

child and/or caregiver, parent training with emphasis on developmental expectations and sensitive responsiveness, family therapy or caregiver/child dyadic therapy” (Zeanah & Boris, 2005, p. 365).

Developmental Play Therapy (Brody, 1999) is based on six basic premises: (1) a child who experiences herself as touched develops a sense of self; (2) in order for a child to experience herself touched, a capable adult must touch her; (3) in order to be a Toucher, the adult must first be willing to learn to be the one Touched; (4) in order to feel touched, a child has to allow herself to be touched; (5) a child feels seen first through touch; (6) to provide the relationship the child needs to feel touched, the adult controls the activities that take place within the Developmental Play Therapy session. Together, Jessie and the therapist will safely explore their relationship through the use of highly structured touch-based activities, including the “Slippery Hand Game,” the “Hills and Valley Game,” the “Knock at the Door Game,” “Cradling,” and the “Portrait Game.” Each of these intimate contact activities will help Jessie to develop trust in the therapist and physical touch.

The therapist will also incorporate elements of Theraplay (Jernberg, 1979) into Jessie’s treatment, which, unlike Developmental Play Therapy, incorporates the parents in the training. Theraplay is a “playful, engaging, short-term treatment method that is intimate, physical, focused and fun” (Jernberg & Booth, 1999, p. 3). In Theraplay, parents are included in treatment, first as observers and then as co-therapists, with the ultimate goal being to enhance the physical and emotional bond between caregiver and child through the use of structured assessment called the Marshak Interaction Method (Jernberg, Booth, Koller, & Allert, 1991) and a series of play-based activities that are structured, engaging, nurturing, and challenging.

Finally, the therapist will use elements of Parent-Child Interaction Therapy (Hembree-Kigin & McNeil, 1995), which, although developed for use with children younger than Jessie, has been found effective in reducing disruptive behavior (Eyberg, Nelson, & Boggs, 2008; Timmer, Ware, Urquiza, & Zebell, 2010). This intervention relies on teaching parents/caregivers effective and positive parenting skills both interactively in the clinic and at home through the use of assignments.

Step 4: Provide Outcome Measures of Change. This last step in treatment planning requires that we specify how change will be measured and indicate the extent to which progress has been made toward realizing these goals

(Neukrug & Schwitzer, 2006). The counselor has considerable flexibility in this phase and may choose from a number of objective domains (psychological tests and measures of self-esteem, depression, psychosis, interpersonal relationship, anxiety, etc.), quasi-objective measures (pre-post clinician, client, and psychiatric ratings), and subjective ratings (client self-report, clinician's in-session observations). In Jessie's case, we have implemented a number of these, including client self-report of friendly and pro-social relationships with peers at school, parent-reported improvement in quality of attachment (increased affection and parent attention-seeking), and pre-post improvement on the Attachment Q-Sort (Van IJzendoorn, Vereijken, Bakermans-Kranenburg, & Riksen-Walraven, 2004).

The completed treatment plan is now developed through which the counselor, Jessie, and her caretakers can develop mutually rewarding bonds of affection; it appears below and is summarized in the table that follows.

TREATMENT PLAN

Client: Jessie

Service Provider: Creative Counseling Consultants

BEHAVIORAL DEFINITION OF PROBLEMS:

1. Reactive attachment disorder—Increasingly aggressive and hostile reactions toward others, destructive play, feelings of sadness along with anger and hatred toward caretakers
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GOALS FOR CHANGE:

1. Reactive attachment disorder
 - Resolve the impediments to forming healthy attachments
 - Establish and maintain a bond with her primary caregivers
 - Help her maintain appropriate boundaries with others
 - Tolerate absences from her primary caregivers without excessive anxiety and emotional/behavioral dyscontrol
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THERAPEUTIC INTERVENTIONS:

A moderate- to long-term course of multimodal treatment (9–12 months),

including Developmental Play Therapy, Theraplay, and Parent-Child Interaction Therapy

1. Reactive attachment disorder

- Elements of Developmental Play Therapy
- Elements of Theraplay
- Elements of Parent-Child Interaction Therapy

OUTCOME MEASURES OF CHANGE:

Improved quality of caregiver/client attachment and reduction in aggressive behaviors both at home and in school as measured by:

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- Client self-report of friendly and pro-social relationships with peers and teachers at school
 - Parent-reported improvement in quality of attachment (increased affection and parent attention-seeking)
 - Clinician-observed improvement in parent-client relationship and client-attachment behaviors
 - Pre-post improvement on the Attachment Q-Sort

Jessie's Treatment Plan Summary: Theraplay

<i>Goals for Change</i>	<i>Therapeutic Interventions</i>	<i>Outcome Measures of Change</i>
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<p><u>Reactive attachment disorder</u></p> <p>Resolve the impediments to forming healthy attachments</p> <p>Establish and maintain a bond with her primary caregivers</p> <p>Help her maintain appropriate boundaries with others</p> <p>Tolerate absences from her primary caregivers without excessive anxiety and emotional/behavioral dyscontrol</p>	<p><u>Reactive attachment disorder</u></p> <p>Elements of Developmental Play Therapy</p> <p>Elements of Theraplay</p> <p>Elements of Parent-Child Interaction Therapy</p>	<p><u>Improved quality of caregiver/client attachment and reduction in aggressive behaviors both at home and in school as measured by:</u></p> <p>Client self-report of friendly and pro-social relationships with peers and teachers at school</p> <p>Parent-reported improvement in quality of attachment (increased affection and parent attention-seeking)</p> <p>Clinician-observed improvement in parent-client relationship and client-attachment behaviors</p> <p>Pre-post improvement on the Attachment Q-Sort</p>
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