Peanuts' Snoopy

Introducing the Character

Snoopy is a dog who first appeared in the *Peanuts* comic strip, featuring Charlie Brown and his gang, drawn by Charles Schulz in 1950. Since his newspaper comic-strip introduction, Snoopy has appeared in television cartoons, in full-length animated movies, in countless *Peanuts* and Charlie Brown books, and even as a life-size Ice Capades character. Additionally, the famous beagle has appeared on a wide range of popular culture merchandise, including lunchboxes, clothing, stationery, cereal boxes, Halloween masks, and telephones. Since his introduction as a shy and homeless dog adopted by a suburban family, Snoopy has evolved into a bold, self-confident, and imaginative character who chooses to live his life on top of—rather than inside—the proverbial dog house. Best friend and lifelong companion to the loveable yet struggling Charlie Brown, Snoopy has fashioned himself as a World War I dogfighter, a detective, a dancer, and an international lover. His good-natured and playful antics are often juxtaposed with sarcasm, arrogance, and narcissistic self-assurance that have entertained children of all ages for six decades.

In the basic case summary and diagnostic impressions that follow, we take a different look at Snoopy's behaviors, from a clinical perspective that examines features including impaired development in social interaction and restricted interests and activities. You will see that, for the purposes of this case, dogs are allowed in school!

Basic Case Summary

Identifying Information. Snoopy Brown is a 12-year-old Canine American youth who resides in a middle-class suburban home in Austin, Texas, with an intact family comprising two parents, a brother, Charlie, and a sister, Sally.

Presenting Concern. Snoopy Brown has been a student at Charles Schulz Elementary School for the past 2 years, having transferred from a parochial school in a nearby city. Since being at the school, his teachers have been increasingly concerned about behavior that is highly atypical for children with whom they have worked. These behaviors include difficulty with expressive language, spinning, tapping, pacing, and other self-stimulating habits; inappropriate touching of the other students; occasional wetting of himself; and an inordinate preoccupation with fantasy. Snoopy was referred for evaluation by the school administrator, who says she has become increasingly frustrated by Snoopy's "strange behavior" and the increasing drain this has placed on her teachers to simultaneously meet both his and his classmates' needs.

Background, Family Information, and Relevant History. Snoopy was born several weeks prematurely to parents who had undergone fertility treatments in order to expand their family; however, Snoopy appeared to readily advance and begin making normally expected developmental progress through his first 3 years. At the same time, in comparison with other same-age peers, he appeared to have less interest in his parents or making eye contact with others, smiled less, and did not always come when called or attend to his parents' voices. However, his parents did not immediately identify these as concerns. As he continued to age in years 3 and beyond, his parents did begin to notice that he did not seem to seek relationships with peers as normally expected; did not engage his parents or adults with eye contact, body postures, or emotional expressions, as did Charlie and Sally. It became clearer he was more interested in repetitive and sensorimotor rather than symbolic and representational play, was more interested in playing with his toys—balls, rubber toys shaped like bones and mailmen, tugging ropes, and so on—than in engaging in play with people. He increasingly preferred to be alone in the backyard, basement, or his "house" out back.

By the time he was 6 years old, Snoopy's language skills had sufficiently developed so that he could communicate in simple phrases with his parents and Charlie and Sally. However, he was uncomfortable verbalizing with members outside of the family, and his parents decided to enroll him in a special education program within the public school system. There, he largely kept to himself, refused to do his work, and instead, sat quietly on floor fantasizing about being a World War I flying ace. By that time, Snoopy was working with

both a speech therapist and an occupational therapist. Although these professionals noted a minimal increase in his social interactions, occupational therapy was unsuccessful in reducing his growing obsession with toy objects. These professionals recommended to his parents that they limit Snoopy's time playing with his balls, rubber toys, and tugging ropes, and limit the time he spent engaged in his stereotypical ritual of watching out the window for birds and watching out the front door for the mailman. However, his protests were so vociferous that his parents ultimately conceded. Snoopy spent hours in his room pretending he was Snoopy, the World War I flying ace, and seemed happiest when left alone with his fantasy life. By the time he was 9, his parents had enrolled him in the Charles Schulz Learning Academy, which specialized in services for students with developmental delays, a designation that his parents struggled with but finally accepted. At the beginning of the school year, he was referred to the assessment team for a comprehensive developmental evaluation.

Problem and Counseling History. Mr. and Ms. Brown's primary concern was with Snoopy's almost complete lack of verbal human language, for which he compensated by movements, head-shaking, and alternative sounds. Along the same lines, they and his teachers were worried about his inability to sustain an engaged conversation of more than a few moments. They also were concerned about his repetitive self-stimulating play to the exclusion of interest in socializing with others his age. Although he played and had an imagination, his internal fantasy life was unvaried and dealt almost exclusively with pretending to be a World War I air combat pilot. Although they believed Snoopy to be highly intelligent based on the extent of his play and fantasy life, they were worried that in the absence of an interest in other children, his adolescent years would be extremely stressful. Along with his rituals of looking out the window and out the front door, he engaged in repetitive behaviors, including digging purposelessly in the backyard. Past therapeutic efforts were dedicated largely to increasing the range of his reciprocal interactive capacities but were individual rather than group-based. For this reason, his parents were now interested in providing whatever services were necessary.

Goals for Counseling and Course of Therapy to Date. As of this writing, Mr. and Mrs. Brown were confident in their decision to proceed with the comprehensive evaluation and in the treatment team's ability to successfully assess and develop a treatment plan for Snoopy's pattern of concerns. They saw this as an opportunity to finally

understand their child and set in motion the necessary resources to provide for his developmental and psychological needs.

Diagnostic Impressions

299.00 (F84.0) Autism Spectrum Disorder, Requiring very substantial support for deficits in social communication, Requiring substantial support for restricted, repetitive behaviors, Without accompanying intellectual impairment, With accompanying language impairment.

Discussion of Diagnostic Impressions

Snoopy was referred by his school administrator because she and his teachers at Charles Schulz Elementary School had become worried about his behavior, which was highly atypical for children with whom they usually work. Snoopy's behaviors included: difficulty with expressive language, spinning, tapping, pacing, and other self-stimulating habits; inappropriate touching of the other students; occasional wetting of himself; and an inordinate preoccupation with fantasy.

The far-reaching section of the *DSM-5* titled "Neurodevelopmental Disorders" is organized into a large number of groupings of disorders that all share the feature of early developmental deficits. One diagnosis found in the grouping known as Autism Spectrum Disorder describes a merged combination of developmental disorders previously in the *DSM-IV-TR,* including Autistic Disorder, Asperger's Disorder, Childhood Disintegrative Disorder, and Pervasive Developmental Disorder Not Otherwise Specified (APA, 2013). Increasingly, being able to identity, evaluate, diagnose, and provide treatment and support for students with Autism Spectrum Disorder are important clinical skills for counseling professionals who work with children, adolescents, young adults, and adults in school, college and university, and community settings (Adreon & Durocher, 2007; Van Bergeijk, Klin, & Volkmar, 2008).

We looked at Snoopy's behavior from a unique clinical perspective that examined features including impaired development in social interaction and restricted interests and activities. The primary symptoms that

Snoopy is experiencing include qualitative impairment in social interaction, as seen as by his absence of interest in same-age peers, impairment in the use of normally expected nonverbal behavior like facial expressions, and lack of engaged conversations or social reciprocity; qualitative impairment in communication, as seen by his almost total lack of spoken language; and inflexible behavior patterns centering on his imaginary role as a World War I pilot and purposeless repetitive behavior such as digging in the backyard. Onset was by age 2 or 3 years, with clear abnormal functioning in social interaction, language, and imaginative play. In such cases of impairment in social interaction, impairment in communication, and restricted repetitive behavior, the diagnosis is Autism Spectrum Disorder.

Regarding differential diagnoses, the Language Disorders or Social (Pragmatic) Communication Disorder might be considered. Common among several of the Neurodevelopmental Disorders are characteristic problems with social communication and interactions. However, neither Language Disorders nor Social (Pragmatic) Communication Disorder includes the criteria of restricted or repetitive behaviors. While far reaching, Autism Spectrum Disorder includes all of Snoopy's behaviors and is most appropriate.

To round out the diagnosis, the absence of clinically significant personality features, medical problems, or psychosocial stressors (beyond those interpersonal stresses already covered by a diagnosis of Autistic Disorder) indicates no need for an "Other factors" section. Snoopy's serious symptoms and serious impairment in school and social functioning are consistent with the primary and solitary diagnosis.

Case Conceptualization

During Snoopy's first meeting in the counseling office, his counselor conducted an intake meeting in order to collect as much information as she could about the symptoms and situations leading to Snoopy's referral. Included in the intake materials were a developmental history, client report, counselor observations, child-oriented clinical interview, play observation, parent report inventories, and information shared by his school principal and teachers (Knell, 1994). Based on the intake, Snoopy's counselor and the school's treatment team developed diagnostic impressions, describing Snoopy's presenting concerns as Autism Spectrum Disorder. A case conceptualization next was developed.

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 example, Snoopy's counselor based her conceptualization on an eclectic combination of counseling approaches and techniques (Corey, 2009). Dattilo and Norcross (2006) and Norcross and Beutler (2008) referred to this strategy as technical eclecticism. Clinicians using technical eclecticism attempt to select the best possible combination of treatment techniques from different theoretical approaches without necessarily making connections between the conceptual foundations of the different approaches or necessarily subscribing to the theories' underlying theoretical positions (Corey, 2009; Dattilo &Norcross, 2006; Norcross & Beutler, 2008). Whereas solution-focused approaches operate from a specific solution-focused framework, and psychotherapeutic integration is based on integrating the underlying theories of more than one compatible model, the technical eclectic approach requires clinicians to put together a number of techniques that derive from their clinical experience and professional judgment (Corey, 2009; de Shazer, 1988, 1991). To be effective with this approach, clinicians must critically and systematically combine methods using a rational decision-making process based on their training and supervision, clinical experience, and professional development (Corey, 2009; Neukrug & Schwitzer, 2006). Being effective at technical eclecticism requires well-formed knowledge and skill (Lazarus, Beutler, & Norcross, 1992; Norcross & Beutler, 2008).

Although the purpose of diagnostic impressions is to *describe* the client's concerns, the goal of case conceptualization when using technical eclecticism is to better *understand* and clinically *arrange* the person's experiences in preparation for applying a selection of interventions. It helps the counselor understand the etiology leading to Snoopy's behaviors that are characteristic of Autism Spectrum Disorder and the factors maintaining these concerns. 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 Snoopy improve his levels of intrapersonal and interpersonal functioning.

Snoopy's 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). Generally speaking, when the Inverted Pyramid Method is used with a purist theory-based conceptual model or a theoretical integration of psychotherapies, there are four steps: Problem Identification, Thematic Groupings, Theoretical Inferences, and Narrowed Inferences. However, when the eclectic approach is used, only the first two steps are needed: Problem Identification and Thematic Grouping. From an eclectic perspective, it is these two steps that set the stage for rationally combining a set of techniques to target the client's needs.

Snoopy's counselor was aware that the most effective treatments for the problems associated with Autism Spectrum Disorder are very intensive and address multiple needs (Amos, 2004; Rogers, 1998). In turn, she selected an eclectic mix of the DIR/Floortime Model (Developmental, Individual-Difference, Relationship-Based Model) (Greenspan & Wieder, 2006), Cognitive Behavior Therapy (Knell, 1993, 1994), and Expressive Creative Arts Play Therapy (Gladding, 1995, 2005). Snoopy's counselor's eclectic clinical thinking can be seen in the figure that follows.

Snoopy's Inverted Pyramid Case Conceptualization Summary: Eclectic Combination of DIR/Floortime Model, Behavior Therapy, and Expressive Creative Arts Play Therapy

1. IDENTIFY AND LIST CLIENT CONCERNS

Psychosocial development appeared normal during first few years
Sufficient basic language development in early years
Noticeably less interest in parent relationships
Noticeably less eye contact
Noticeably less smiling
Did not seek peer relationships
Speech and Occupational Therapy
No change in preoccupation with toys

Repetitive self-stimulating behaviors
Prefers playing with balls, rubber toy "mailman," bones, to playing with others
Prefers solitary fantasy games of being WWI flying ace to playing with others
Stereotypical behavior: Watching window for birds or mailman
Stereotypical purposeless behavior: Digging holes in backyard
Minimal improvement in social interest
Inappropriate touching of peers

2. ORGANIZE CONCERNS INTO LOGICAL THEMATIC GROUPINGS

1. Lack of social interests, social interactions, and verbal communications due to Autistic Disorder
2. Solitary, repetitive, stereotypical, and purposeless behaviors and play due to Autistic Disorder

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

4. NARROWED INFERENCES: SUICIDALITY AND DEEPER DIFFICULTIES

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 identified Snoopy's current and recent problematic repetitive, purposeless, and stereotypical behaviors at school and home (odd play, fantasy games, etc.), solitary social preferences (lack of engaging parents, preferring playing alone, etc.), details of early and recent developmental history, and speech and occupational therapy history. The counselor attempted to go beyond just the presenting symptoms in order to be as descriptive 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, Snoopy's counselor selected the Areas of Dysfunction Approach. This approach sorts together all of the Step 1 information into "areas of dysfunction according to important life situations, life themes, or life roles and skills" (Neukrug & Schwitzer, p. 205). She believed this approach would best set the stage for selecting an eclectic mix of counseling techniques to target Snoopy's different needs.

Snoopy's counselor first grouped together all of his symptoms, presentations, and history related to social isolation and solitary preferences into the theme "Lack of social interests, social interactions, and verbal communications due to Autistm Spectrum Disorder." The counselor then grouped together all of Snoopy's symptoms, presentations, and history related to stereotypical behaviors, stereotypical play preferences, and

stereotypical fantasies into the theme "Solitary, repetitive, stereotypical, and purposeless behaviors and play due to Autism Spectrum Disorder."

With this two-step conceptualization completed, the client information in Step 1 leads to logical-intuitive groupings on the basis of common denominators in Step 2, and the counselor is ready to engage the client in planning and implementing technical eclecticism in order to address Snoopy's current counseling situation as we have written his imagined clinical case illustration.

Treatment Planning

At this point, Snoopy's clinician at the Charles Schulz Elementary School has collected all available information about the problems that have been of concern to him and the treatment team that performed his assessment. 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 Snoopy'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 Snoopy, but with all clients who present with disturbing and disruptive symptoms and needs (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 Conners 3 (Conners, 2008) 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 Snoopy, followed by his specific treatment plan.

Step 1: Behavioral Definition of Problems. The first step in eclectic treatment planning is to carefully review the case conceptualization, paying particular attention to the results of Step 2 (Thematic Groupings). The identified clinical themes reflect the core areas of concern and distress for the client. In the case of Snoopy, there are two primary areas of concern. The first, "lack of social interests, social interactions and verbal communication," refers to his current deficiency in verbal communication despite early basic language development, noticeably less interest in parent relationships with minimal eye contact or smiling, disinterest in seeking out peer relationships, and minimal improvement in social interest or verbal communication despite speech and occupational therapy. The second, "solitary, repetitive, stereotypical and purposeless behaviors and play," refers to his repetitive self-stimulating behaviors, preference for play with balls, rubber toys, and military aviator fantasies over peer-based interactive play, ceaseless digging in the backyard, watching out the window and door for birds or the mailman, and inappropriate touching of peers. These symptoms and stresses are consistent with the diagnosis of Autism Spectrum Disorder (APA, 2013; Hersen & Ammerman, 2000; Parritz & Troy, 2011; Sicile-Kira & Grandin, 2004).

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 Snoopy, the goals are divided into two prominent areas. The first, "lack of social interests, social interactions and verbal communication," requires that we help Snoopy strengthen his basic language skills and the ability to communicate simply with others, strengthen the basic emotional bond with his parents, engage in reciprocal and cooperative interactions with others on a regular basis, and help his parents, teachers, and peers develop a level of understanding and acceptance of Snoopy's capabilities and set realistic expectations for his behavior. The second, "solitary, repetitive, stereotypical and purposeless behaviors and play," requires that we help Snoopy reduce self-stimulatory and repetitive behaviors, shape symbolic play behaviors, assist him in tolerating changes in his routine or immediate environment, and attain the highest, most realistic level of overall functioning.

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 Snoopy, we have decided to use an Eclectic Intervention Approach based upon the DIR/Floortime Model and elements of behavioral and expressive/creative therapies, supplemented with family counseling, psychoeducation, and social skills training. Because of the complexity of Autism Spectrum Disorder and the pervasiveness of its impact, intervention must be multifaceted and target neurological, psychological, and social factors (Rosenberg & Kosslyn, 2010). Although current treatments do not directly target neurological factors in Autism Spectrum Disorder, psychotropic medication may be used to address associated behavioral and emotional features, including disruptive behaviors, aggression, agitation, inattention, and hyperactivity (des Portes, Hagerman, & Hendren, 2003; Meyers, Plauche-Johnson, & Council on Children With Disabilities, 2007). Therefore, we will refer Snoopy's parents to a pediatric psychiatrist who specializes in the treatment of neurodevelopmental disorders. It will also be important to refer Snoopy for a comprehensive speech/language evaluation as well as an occupational therapy assessment in order to determine the current level of his daily living skills competencies.

In order to address Snoopy's behavioral and social skill deficits, we will use a combination of Applied Behavior Analysis (ABA) and the DIR/Floortime Model. It is important to note that "specific interventions proposed for clinical disturbances . . . 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). Applied Behavior Analysis (Lovaas et al., 1987) uses procedures derived from the principles of operant conditioning (reinforcement, extinction, shaping) in order to decrease the frequency of inappropriate and maladaptive behaviors while increasing the likelihood and frequency of desired and adaptive behaviors (social, communicative, and play skills in Snoopy's case). ABA relies heavily upon parents working alongside the therapist both in the clinic/school and at home in order to maximize behavioral gains and generalize them in the client's daily life. ABA has been found to be effective in enhancing daily living, play, social, communicative, and self-care skills in children with Autism Spectrum Disorder (Cooper, Heron, & Heward, 1987; Eikeseth, Smith, Jahr, & Eldevik, 2002; Howlin, Magiati, & Charman, 2009; Meyers et al., 2007). In Snoopy's case, the Applied Behavior analyst will work with the parents

to employ frequent use of praise and positive reinforcement to increase Snoopy’s verbalizations and social communication, implement a response-shaping program to facilitate his language and social interaction skills, use a token economy at home and in the school to build interactive play and social communication skills, teach the parents effective contingency management to decrease Snoopy’s idiosyncratic and purposeless play, and help them to extinguish Snoopy’s repetitive and purposeless play by reinforcing engagement with a broader array of play materials and activities.

The DIR/Floortime Model (Greenspan & Weider, 2006) is a highly hands-on and interactive assessment and intervention program, the objective of which is to increase opportunities for back-and-forth communication and engagement with the child that provide learning opportunities to enhance social communication skills. Based upon the premise that clinicians must honor the unique ways that children with Autism Spectrum Disorder experience their world, interact, and develop, the DIR/Floortime Model relies on the use of highly trained therapists to interact with the child and parent through increasingly challenging sensory, communicative, and social activities. It has been used extensively in working with children on the autism spectrum (Greenspan & Weider, 2006). Because effective use of this model requires extensive and highly specialized training, we will refer Snoopy’s parents to the Schulz Development Resources Academy, which specializes in the DIR/Floortime Model.

More recently, creative techniques, that is, those that employ art, music, dance, drama, and play, have been used to enhance sensory integration, social skills, communication, and symbolic thinking. Social Stories (Gray & Garand, 1983) is one such methodology that relies upon the use of picture stories to teach social problem-solving skills, and it has been found to be useful in working with children with Autism Spectrum Disorder (Kokina & Kern, 2010). Another play-based intervention that has been found to be both useful and effective with these children is Lego therapy (LeGoff, 2004), which uses Legos to teach social skills. Lego toys are naturally attractive and sensorily appealing and as such can capture the attention of autistic children for long periods. The play therapist works with children individually or in groups to build Lego-based social scenarios

through which clients can interact. In Snoopy's case, we will use elements of both Social Stories and Lego therapy to enhance his social and communication skills.

Finally, and working directly with Snoopy's parents, we will provide family counseling aimed at strengthening their relationship so they may work intensively with Snoopy, refer them to an Autism Spectrum support group, and encourage them to join the Autism Society of America to expand their knowledge and support.

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 Snoopy's case, we have implemented a number of these, including pre-post measures of adaptive functioning on the Gilliam Autism Rating Scale (Gilliam, 2006); clinician, teacher, and parent-reported improvement in verbal communication, social interaction, and creative/expressive play; parent and teacher report of improved communication between home and school; and compliance with psychopharmacotherapy.

The completed treatment plan is now developed through which the counselor, Snoopy, his parents, and teachers will begin their shared work of improving communication channels between home and school, connecting with Autism Spectrum support organizations, and, most importantly, helping him to communicate and interact more effectively and play in a nonrepetitive and more creative fashion at home and at school. The treatment plan is described below and summarized in the table that follows.

TREATMENT PLAN

Client: Snoopy

Service Provider: Charles Schulz Elementary School Counseling Department

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BEHAVIORAL DEFINITION OF PROBLEMS:

1. Lack of social interests, social interactions, and verbal communication—Current deficiency in verbal communication despite early basic language development, noticeably less interest in parent relationships with minimal eye contact or smiling, disinterest in seeking out peer relationship, and minimal improvement in social interest or verbal communication despite speech and occupational therapy
2. Solitary, repetitive, stereotypical, and purposeless behaviors and play—Repetitive self-stimulating behaviors, preference for play with balls, rubber toys, and military aviator fantasies over peer-based interactive play, digging in the backyard, watching out the window for birds or the mailman, and inappropriate touching of peers

GOALS FOR CHANGE:

1. Lack of social interests, social interactions, and verbal communication
    - Strengthen basic language skills and the ability to communicate simply with others
    - Strengthen the basic emotional bond with parents
    - Engage in reciprocal and cooperative interactions with others on a regular basis
    - Help parents, teachers, and peers develop a level of understanding and acceptance of client's capabilities and set realistic expectations for behavior
2. Solitary, repetitive, stereotypical, and purposeless behaviors and play
    - Reduce self-stimulatory and repetitive behaviors
    - Shape symbolic play behaviors
    - Assist in tolerating changes in routine and immediate environment
    - Attain the highest, most realistic level of overall functioning

THERAPEUTIC INTERVENTIONS:

An ongoing course of eclectic intervention targeting neurological, psychological, and social/interpersonal factors drawn from DIR/Floortime, behavior, and artistic/expressive therapies, supplemented with psychoeducation

and group support for parents and teachers

Targeting Neurological Factors (agitation, inattention, hyperactivity, disruptiveness)

- Referral to pediatric psychiatrists for management of related behavioral and emotional symptoms
- Referral for speech/language and occupational therapy evaluation

Targeting Psychological Factors (solitary, repetitive and purposeless play)

- Use effective contingency management to decrease idiosyncratic and purposeless play
- Extinguish repetitive and purposeless play by reinforcing engagement with a broader array of play materials and activities
- Referral for DIR/Floortime training
- Lego and Social Stories

Targeting Social Interactions and Communication

- Employ frequent use of praise and positive reinforcement to increase Snoopy's verbalizations and social communication
- Use a token economy at home and in the school to build interactive play and social communication skills
- Implement a response-shaping program to facilitate his language and social interaction skills
- Referral for DIR/Floortime training
- Lego and Social Stories

Targeting Parenting

- Provide family counseling aimed at strengthening relationship
- Referral to an Autism Spectrum support group
- Encouragement to join the Autism Society of America to expand knowledge and support base
- Referral for DIR/Floortime training

OUTCOME MEASURES OF CHANGE:

Improved social, communicative, and adaptive behavior both at home and in

school as measured by:

- Improved scores on the Gilliam Autism Rating Scale-II
- Clinician-, teacher-, and parent-reported improvement in verbal communication, social interaction, and creative/expressive play
- Parent and teacher report of improved daily communication between home and school
- Compliance with psychopharmacotherapy

Snoopy's Treatment Plan Summary: Eclectic Combination of DIR/Floortime Model, Behavior Therapy, and Expressive Creative Arts Play Therapy

Goals for Change	*Therapeutic Interventions*	*Outcome Measures of Change*
Lack of social interests, social interactions, and verbal communication Strengthen basic language skills and the ability to communicate simply with others Strengthen the basic emotional bond with parents Engage in reciprocal and cooperative interactions with others on a regular basis Help parents, teachers, and peers develop a level of understanding and acceptance of client's capabilities and set realistic expectations for behavior **Solitary, repetitive, stereotypical, and purposeless behaviors and play** Reduce self-stimulatory and repetitive behaviors Shape symbolic play behaviors Assist in tolerating changes in routine and immediate	**Lack of social interests, social interactions, and verbal communication** **Solitary, repetitive, stereotypical, and purposeless behaviors and play** *Targeting Neurological Factors (agitation, inattention, hyperactivity, disruptiveness)* Referral to pediatric psychiatrists for management of related behavioral and emotional symptoms Referral for speech/language and occupational therapy evaluation *Targeting Psychological Factors (solitary, repetitive, and purposeless play)* Use effective contingency management to decrease idiosyncratic and purposeless play Extinguish repetitive and purposeless play by reinforcing engagement with a broader array of play materials and activities Referral for DIR/Floortime training Lego and Social Stories *Targeting Social Interactions and Communication* Employ frequent use of praise and positive reinforcement to increase verbalizations and social communication	**Improved on-task, attentive, and prosocial attitudes and behavior both at home and in school as measured by:** Clinician-, teacher-, and parent-reported improvement in verbal communication, social interaction, and creative/expressive play Parent and teacher report of improved daily communication between home and school Compliance with psychopharmacotherapy

environment Attain the highest, most realistic level of overall functioning	Use a token economy at home and in the school to build interactive play and social communication skills Implement a response-shaping program to facilitate his language and social interaction skills Referral for DIR/Floortime training Lego and Social Stories *Targeting Parenting* Provide family counseling aimed at strengthening relationship Referral to an Autism Spectrum support group Encouragement to join the Autism Society of America to expand knowledge and support base Referral for DIR/Floortime training	

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