

PracticePlanners®

Arthur E. Jongsma, Jr., Series Editor

The Adolescent
Psychotherapy Treatment
Planner, Fourth Edition

Arthur E. Jongsma, Jr.

L. Mark Peterson

William P. McInnis

Timothy J. Bruce, Contributing Editor



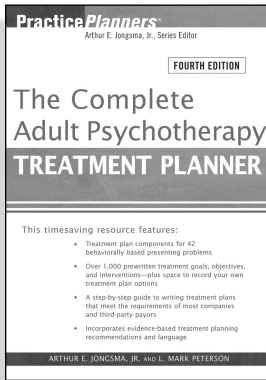
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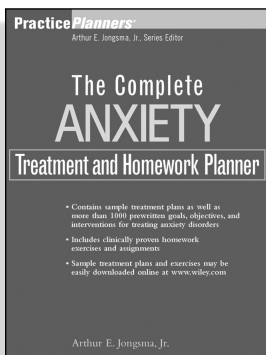
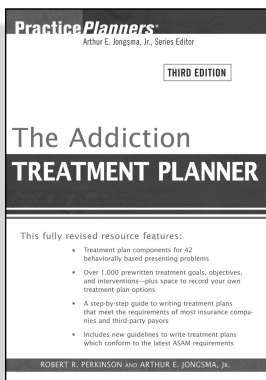
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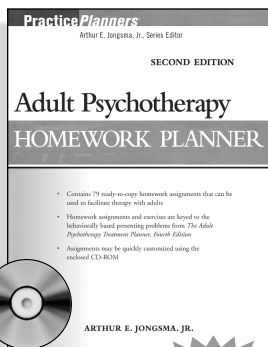


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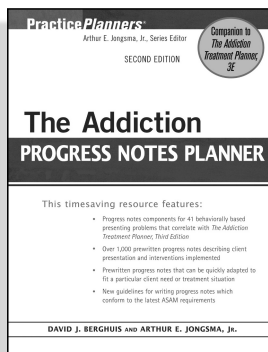




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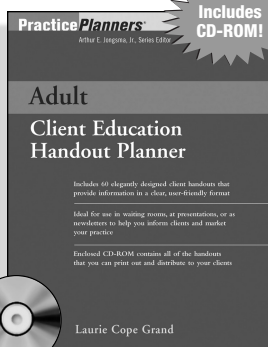
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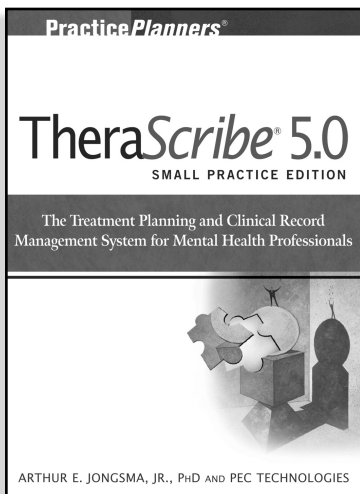
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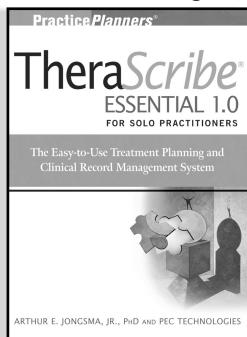
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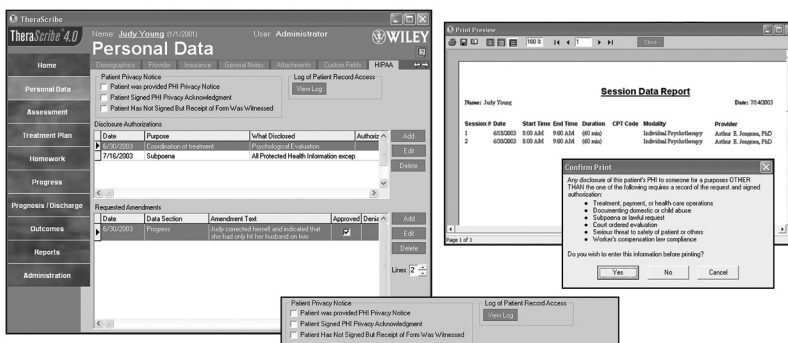
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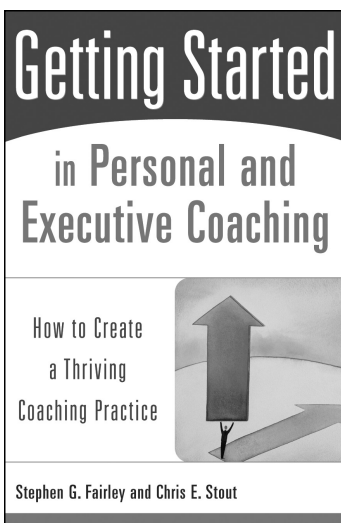
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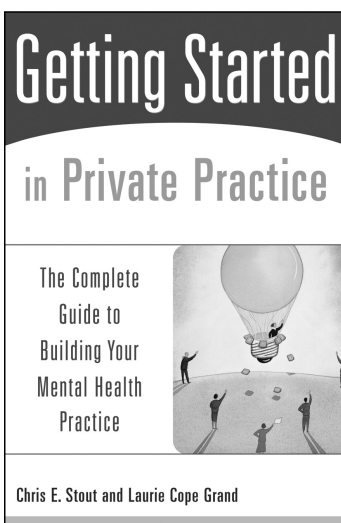
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ISBN-13: 978-0471-78539-2
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To our wives:
Judy, Cherry, Lynn, and Lori.
We reach our long-term goals only due to your
faithful interventions of love and encouragement.

CONTENTS

PracticePlanners® Series Preface	xiii
Acknowledgments	xv
Introduction	1
Sample Treatment Plan	7
Academic Underachievement	10
Adoption	19
Anger Management ^{EB} ▾	27
Anxiety ^{EB} ▾	37
Attention-Deficit/Hyperactivity Disorder (ADHD) ^{EB} ▾	46
Autism/Pervasive Developmental Disorder	55
Blended Family	63
Chemical Dependence ^{EB} ▾	72
Conduct Disorder/Delinquency ^{EB} ▾	81
Depression ^{EB} ▾	92
Divorce Reaction	100
Eating Disorder ^{EB} ▾	109
Grief/Loss Unresolved	118
Low Self-Esteem	127
Mania/Hypomania	135
Medical Condition ^{EB} ▾	142
Mental Retardation	150
Negative Peer Influences	158
Obsessive-Compulsive Disorder (OCD) ^{EB} ▾	168
Oppositional Defiant ^{EB} ▾	177
Panic/Agoraphobia ^{EB} ▾	187
Parenting ^{EB} ▾	195
Peer/Sibling Conflict	205

^{EB} ▾ indicates that selected Objective/Interventions are consistent with those found in evidence-based treatments.

xii CONTENTS

Physical/Emotional Abuse Victim	213
Posttraumatic Stress Disorder (PTSD) ^{EB} ▽	221
Psychoticism	230
Runaway	237
School Violence	245
Sexual Abuse Perpetrator	254
Sexual Abuse Victim	265
Sexual Acting Out	273
Sexual Identity Confusion	280
Social Phobia/Shyness ^{EB} ▽	286
Specific Phobia ^{EB} ▽	294
Suicidal Ideation	303
Appendix A: Bibliotherapy Suggestions	309
Appendix B: Professional References for Evidence-Based Chapters	325
Appendix C: Index of Therapeutic Games, Workbooks, Tool Kits, Video Tapes, and Audio Tapes	339
Appendix D: Index of DSM-IV Codes Associated with Presenting Problems	341

PRACTICEPLANNERS® 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 and software in the PracticePlanners® series are designed to help practitioners fulfill these documentation requirements efficiently and professionally.

The PracticePlanners® series includes a wide array of treatment planning books including not only the original *Complete Adult Psychotherapy Treatment Planner*, *Child Psychotherapy Treatment Planner*, and *Adolescent Psychotherapy Treatment Planner*, all now in their fourth editions, but also *Treatment Planners* targeted to a wide range of specialty areas of practice, including:

- Addictions
- Behavioral medicine
- College students
- Co-occurring disorders
- Couples therapy
- Crisis counseling
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- Employee assistance
- Family therapy
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- Sexual abuse victims and offenders
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In addition, there are three branches of companion books that can be used in conjunction with the *Treatment Planners*, or on their own:

- ***Progress Notes Planners*** provide a menu of progress statements that elaborate on the client's symptom presentation and the provider's therapeutic intervention. Each *Progress Notes Planner* statement is directly integrated with the behavioral definitions and therapeutic interventions from its companion *Treatment Planner*.
- ***Homework Planners*** include homework assignments designed around each presenting problem (such as anxiety, depression, chemical dependence, anger management, eating disorders, or panic disorder) that is the focus of a chapter in its corresponding *Treatment Planner*.
- ***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:

- ***TheraScribe***®, the #1 selling treatment planning and clinical record-keeping software system for mental health professionals. *TheraScribe*® allows the user to import the data from any of the *Treatment Planner*, *Progress Notes Planner*, or *Homework Planner* books into the software's expandable database to simply point and click to create a detailed, organized, individualized, and customized treatment plan along with optional integrated progress notes and homework assignments.

Adjunctive books, such as *The Psychotherapy Documentation Primer* and *The Clinical Documentation Sourcebook* contain 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

I have learned that it is better to acknowledge your weaknesses and to seek out those who complement you with their strengths. I was fortunate enough to have found the right person who brings his expertise in Evidence-Based Treatment to this project. He has contributed wisely and thoughtfully to greatly improve our *Adolescent Psychotherapy Treatment Planner* through his well-informed edits and additions to our content, to bring it in line with the latest psychotherapy research. He has been thoroughly professional in his approach while being a joy to work with, due to his wonderful sense of humor. I have said to many people since beginning this revision, “This guy really knows the literature!” For a person like me, who has spent his career in the psychotherapy trenches, it is a pleasure to get back in touch with my science-based roots by working with a Boulder Model clinician-scientist. I take my hat off to you, Dr. Tim Bruce. You have taken our product to a new level of contribution to the clinicians who are looking for Evidence-Based Treatment guidance. Your students are fortunate to have you for a mentor and we are fortunate to have you for a Contributing Editor. Thank you!

I also want to acknowledge the steady and perceptive work of my manuscript manager, Sue Rhoda. She stays on top of a thousand details while bringing the disjointed pieces of this work to a well organized finished product. Thank you, Sue.

A.E.J.

I want to acknowledge how honored I am to have had this chance to work with Art Jongsma, his colleague Sue Rhoda, and the staff at John Wiley and Sons on these, their well-known and highly regarded, treatment planners. These planners are widely recognized as works of enormous value to practicing clinicians as well as great educational tools for students of our profession. I didn't know Art when he asked me if I would join him on these editions, and the task he had in mind, to help empirically inform objectives and interven-

xvi ACKNOWLEDGMENTS

tions, was daunting. I knew it would be a challenge to retain the rich breadth of options that Art has offered in past editions while simultaneously trying to identify and describe the fundamental features of identified empirically supported treatments. Although I have trained in empirically supported treatment approaches, contributed to this literature, and used them throughout my professional career, I recognize that our product will be open to criticism. I can say that we have done our best to offer a resource to our colleagues and their clients that is practical, flexible, and appreciates the complexities of any of the treatment approaches it conveys. And in the process of working with Art and Sue toward these goals, I have found them not only to be consummate professionals, but also thoughtful, conscientious, and kind persons. It has been a great pleasure working with you, Art and Sue, and a privilege to call you my friends.

T.J.B.

The Adolescent
Psychotherapy Treatment
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INTRODUCTION

ABOUT PRACTICEPLANNERS® TREATMENT PLANNERS

Pressure from third-party payors, 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 payors and state and federal review agencies.

Each *Treatment Planner*:

- Saves you hours of time-consuming paperwork.
- Offers the freedom to develop customized treatment plans.
- Includes over 1,000 clear statements describing the behavioral manifestations of each relational problem, and includes long-term goals, short-term objectives, and clinically tested treatment options.
- Has an easy-to-use reference format that helps locate treatment plan components by behavioral problem or DSM-IV™ diagnosis.

As with the rest of the books in the *PracticePlanners*® 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.

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 treat-

2 THE ADOLESCENT PSYCHOTHERAPY TREATMENT PLANNER

ment 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* which 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-IV* 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 strengths 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 B contains a full bibliographic reference list of these materials, including these two popular choices: *Read Two Books and Let's Talk Next Week: Using Bibliotherapy in Clinical Practice* (2000) by Maidman Joshua and DiMenna and *Rent Two Films and Let's Talk in the Morning: Using Popular Movies in Psychotherapy, Second Edition* (2001) by Hesley and Hesley (both books are published by Wiley). For further information about self-help books, mental health professionals may wish to consult *The Au-*

thoritative Guide to Self-Help Resources in Mental Health, Revised Edition (2003) by Norcross et al. (available from The 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-IV*. 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-IV* 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 Oppositional Defiant is provided at the end of this introduction.

INCORPORATING EVIDENCE-BASED TREATMENT INTO THE *TREATMENT PLANNER*

Evidence-based treatment (that is, treatment which is scientifically shown in research trials to be efficacious) is rapidly becoming of critical importance to the mental health community as insurance companies are beginning to offer preferential pay to organizations using it. In fact, the APA Division 12 (Society of Clinical Psychology) lists of empirically supported treatments have been referenced by a number of local, state and federal funding agencies, which are beginning to restrict reimbursement to these treatments, as are some managed-care and insurance companies.

In this fourth edition of *The Adolescent Psychotherapy Treatment Planner* we have made an effort to empirically inform some chapters by highlighting Short-Term Objectives (STOs) and Therapeutic Interventions (TIs) that are consistent with therapies that have demonstrated efficacy through empirical study. Watch for this icon as an indication that an Objective/Intervention is consistent with those found in evidence-based treatments.



References to their empirical support have been included in the reference section as Appendix B. Reviews of efforts to identify evidence-based therapies (EBT), including the effort's benefits and limitations, can be found in Bruce and Sanderson (2005), Chambless and colleagues (1996, 1998), and Chambless and Ollendick (2001). References have also been included to therapist- and client-oriented treatment manuals and books that describe the step-by-step use

4 THE ADOLESCENT PSYCHOTHERAPY TREATMENT PLANNER

of noted 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 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 their particular client.

In many instances, EBTs are short-term, problem-oriented treatments that focus on improving current problems/symptoms related to a client's current distress and disability. Accordingly, STOs and TIs of that type have been placed earlier in the sequence of STO and TI options. In addition, some STOs and TIs reflect core components of the EBT approach that are always delivered (e.g., exposure to feared objects and situations for a phobic disorder; behavioral activation for depression). Others reflect adjuncts to treatment that are commonly used to address problems that may not always be a feature of the clinical picture (e.g., assertive communication skills training for the social anxious or depressed client whose difficulty with assertion appears contributory to the primary anxiety or depressive disorder). 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 previous editions of this *Treatment Planner*, each chapter also includes the option to add STOs and TIs that are not listed.

Criteria for Inclusion of Evidence-Based Therapies

Not every treatment that has undergone empirical study for a mental health problem is included in this edition. In general, we have included EBTs 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 EBTs, such as Chambless and colleagues (1996, 1998) and Nathan and Gorman (1998, 2002). At minimum, this requires demonstration of efficacy through a clinical trial or large clinical replication series that have features reflective of 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). 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. Because treatment literatures for various problems develop at different paces, treatment STOs and TIs that have been included may have the most empirical support for their problem area, but less than that found in more heavily studied areas. For example, Cognitive Behavior Therapy (CBT) has the highest level of empirical

support of tested psychotherapies for Childhood Obsessive Compulsive Disorder (OCD), but that level of evidence is lower than that supporting, for example, exposure-based therapy for phobic fear and avoidance. The latter has simply been studied more extensively. Nonetheless, within the psychotherapy outcome literature for OCD, CBT clearly has the highest level of evidence supporting its efficacy and usefulness. Accordingly, STOs and TIs consistent with CBT have been included in this edition. Lastly, just as some of the STOs and TIs included in this edition reflect common clinical practices of experienced clinicians, those associated with EBTs reflect what is commonly practiced by clinicians that use EBTs.

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.

There does remain considerable debate regarding evidence-based treatment amongst mental health professionals who are not always in agreement regarding the best treatments or how to weigh the factors that contribute to good outcomes. Some practitioners are skeptical about the wisdom of changing their practice on the basis of research evidence, and their reluctance is fuelled by the methodological problems of psychotherapy research. Our goal in this book 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 their particular client. As indicated earlier, recognizing that there are interventions which practicing clinicians have found useful but that have not yet received empirical scrutiny, we have included those that reflect common practice among experienced clinicians.

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 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, clinician, and mental health community.

SAMPLE TREATMENT PLAN

OPPOSITIONAL DEFIANT

- Definitions:** Displays a pattern of negativistic, hostile, and defiant behavior toward most adults.
Often defies or refuses to comply with reasonable requests and rules.
Consistently is angry and resentful.
Often is spiteful or vindictive.
- Goals:** Replace hostile, defiant behaviors toward adults with respect and cooperation.
Reach a level of reduced tension, increased satisfaction, and improved communication with family and/or other authority figures.
Parents learn and implement good child behavioral management skills.

OBJECTIVES

1. Identify situations, thoughts, and feelings that trigger angry feelings, problem behaviors, and the targets of those actions.
2. Learn and implement calming strategies as part of a new way to manage reactions to frustration and defiance.
3. Identify, challenge, and replace self-talk that leads to anger and misbehavior with self-talk that

INTERVENTIONS

1. Actively build the level of trust with the client through consistent eye contact, active listening, unconditional positive regard, and warm acceptance to help increase his/her disclosure of thoughts and feelings.
2. Thoroughly assess the various stimuli (e.g., situations, people, thoughts) that have triggered the client's anger and the thoughts, feelings, and actions that have characterized his/her anger responses.
1. Teach the client calming techniques (e.g., muscle relaxation, paced breathing, calming imagery) as part of a tailored strategy for responding appropriately to angry feelings and the urge to defy when they occur.
1. Explore the client's self-talk that mediates his/her angry feelings and actions (e.g., demanding expectations

8 THE ADOLESCENT PSYCHOTHERAPY TREATMENT PLANNER

facilitates a more constructive reaction.

4. Learn and implement thought-stopping to manage intrusive unwanted thoughts that trigger anger and acting out.
 1. Assign the client to implement a “thought-stopping” technique on a daily basis to manage intrusive unwanted thoughts that trigger anger and acting out between sessions (or assign “Making Use of the Thought-Stopping Technique” in the *Adult Psychotherapy Homework Planner*, 2nd ed. by Jongsma); review implementation; reinforce success, providing corrective feedback toward improvement.
 5. Verbalize feelings of frustration, disagreement, and anger in a controlled, assertive way.
 1. Use instruction, modeling, and/or role-playing to teach the client assertive communication; if indicated, refer him/her to an assertiveness training class/group for further instruction.
 6. Parents learn and implement Parent Management Training skills to recognize and manage problem behavior of the client.
 1. Teach the parents how to specifically define and identify problem behaviors, identify their own reactions to the behavior, determine whether the reaction encourages or discourages the behavior, and generate alternatives to the problem behavior.
 2. Teach the parents how to implement key parenting practices consistently, including establishing realistic age-appropriate rules for acceptable and unacceptable behavior, prompting of positive behavior in the environment, use of positive reinforcement to encourage behavior (e.g., praise), use of calm clear direct instruction, time out, and other loss-of-privilege practices
- reflected in should, must, or have to statements); identify and challenge biases, assisting him/her in generating appraisals and self-talk that corrects for the biases and facilitates a more flexible and temperate response to frustration.

- for problem behavior (or assign “Switching from Defense to Offense” in the *Adolescent Therapy Homework Planner*, 2nd ed. by Jongsma, Peterson, and McInnis).
3. Assign the parents home exercises in which they implement and record results of implementation exercises (or assign “Clear Rules, Positive Reinforcement, Appropriate Consequences” in the *Adolescent Therapy Homework Planner*, 2nd ed. by Jongsma, Peterson, and McInnis); review in session, providing corrective feedback toward improved, appropriate, and consistent use of skills.
7. Decrease the frequency and intensity of hostile, negativistic, and defiant interactions with parents/adults.
1. Track the frequency and intensity of negative, hostile feelings and defiant behaviors and problem-solve solutions (or assign “Stop Yelling” or “Filing a Complaint” in the *Adolescent Therapy Homework Planner*, 2nd ed. by Jongsma, Peterson, and McInnis); implement plan toward decreasing frequency and intensity.
8. Identify what is wanted from parents and other adults.
1. Assist the client in becoming able to recognize feelings and wants, their connection to behavior, and how to express them in constructive, respectful ways.
 2. Assist the client in reframing complaints into requests for positive change (or assign the exercise “Filing a Complaint” or “If I Could Run My Family” from the *Adolescent Therapy Homework Planner*, 2nd ed. by Jongsma, Peterson, and McInnis).

DIAGNOSIS

313.81 Oppositional Defiant Disorder

ACADEMIC UNDERACHIEVEMENT

BEHAVIORAL DEFINITIONS

1. History of academic performance that is below the expected level, given the client's measured intelligence or performance on standardized achievement tests.
2. Repeated failure to complete homework assignments on time.
3. Poor organization or study skills.
4. Frequent tendency to postpone doing homework assignments in favor of engaging in recreational and leisure activities.
5. Positive family history of members having academic problems, failures, or disinterest.
6. Feelings of depression, insecurity, and low self-esteem that interfere with learning and academic progress.
7. Recurrent pattern of engaging in acting out, disruptive, and negative attention-seeking behaviors when encountering frustration in learning.
8. Heightened anxiety that interferes with performance during tests.
9. Parents place excessive or unrealistic pressure on the client to such a degree that it negatively affects the client's academic performance.
10. Decline in academic performance that occurs in response to environmental stress (e.g., parents' divorce, death of loved one, relocation, move).
