CHAPTER 2

Case Conceptualization

The first step when working with a child is to develop a case conceptualization. Case conceptualization facilitates the therapist's task of tailoring techniques to custom-fit a youngster's circumstances. The individual case conceptualization guides the choice of techniques, their pacing and implementation, as well as the evaluation of progress. Each case you face is different. Our task is to create a general conceptual framework that allows for maximum flexibility. In this chapter, we define case conceptualization, compare it with diagnosis and treatment planning, explore the various domains we consider important, and discuss the relationship among these domains.

When we supervise trainees, we find that case conceptualization is a hard sell. Nonetheless, Bieling and Kuyken (2003) argued that case formulation forms the "heart of evidence based practice" (p. 53). Moreover, Kendall, Chu, Gifford, Hayes, and Nauta (1998) emphasized that case conceptualization breathes life into any manual. Many new therapists want a "bag of tricks" and dismiss case conceptualization as an abstract exercise. Yet case conceptualization is one of the most practical tools they can have in their tool kit. Case conceptualization tells therapists when and how to use their tools.

Case Conceptualization: Once Is Never Enough

The case formulation is a dynamic and fluid process that requires you to generate and test hypotheses (J. S. Beck, 2011: Persons & Tompkins, 2007). You must continually revise and refine your picture of the child throughout the treatment process.

A hypothesis-testing attitude toward case conceptualization necessitates good data analysis skills. First, simply constructed conceptualizations

are generally the best approach (Persons & Tompkins, 2007). You will be weighing multiple variables—ranging from objective test scores to cultural context variables—and will be pulled to complex formulations. Yet we urge you to keep it simple.

Second, effective case conceptualization is propelled by open-mindedness. Rather than single-mindedly adhering to one perspective, we continually ask, "What's another interpretation of these data we have obtained?" You also need to hold onto explanations supported by data obtained from the client and be ready to discard hypothesis that are unsupported. Collaboration with the client facilitates case conceptualization. Sharing the conceptualization with children and their families provides a valuable sounding board for you; their reactions to the formulation likely will provide you with useful data.

Case Conceptualization and Treatment Planning

Treatment planning provides direction and specifies a path for clinical progress. *Treatment plans* detail the sequence and timing of interventions. Not surprisingly, effective treatment planning should be based on case conceptualization. As Persons (1989) rightly argued, case conceptualization drives intervention strategies, predicts obstacles to treatment, provides a way to negotiate therapeutic dilemmas, and troubleshoots unsuccessful treatment efforts.

Shirk (1999) lamented that treatment packages are often ingredients in search of a recipe. The case conceptualization process offers a recipe for putting together the various ingredients included in a treatment plan. For example, self-monitoring and self-instructional methods may be indicated in treating an aggressive child. The case conceptualization will not only tell the therapist what techniques to use at a particular time, but also guide him or her in adapting the techniques to fit the individual child. If the child is more concrete in his or her thinking, a visual aid such as an Anger Thermometer may be used. If the child is more abstract, a traditional rating scale might be used. Psychoeducational materials should be selected on the basis of a case conceptualization. For instance, printed materials are indicated for youngsters who have good reading skills. On the other hand, for children whose reading skills are poor, videos are useful.

Case Conceptualization and Diagnosis

Case conceptualization clearly differs from diagnosis. Diagnostic classification systems summarize the symptoms in general terms. Case

conceptualizations are personalized psychological portraits. Diagnostic classifications are atheoretical, whereas case conceptualizations are theoretically derived. Accordingly, diagnostic classifications tend to be descriptions rather than explanations. Case conceptualization offers a more explanatory hypothesis, explaining why symptoms emerge; how various environmental, interpersonal, and intrapersonal factors shape these symptom patterns; and what the relationship is between ostensibly discordant symptoms. Finally, case conceptualization is a broader clinical task than diagnosis. In fact, case conceptualization subsumes diagnosis, including it as a component but not overly weighting its importance.

Case Conceptualization: "Dressing Up" the Client Picture

The following section offers the multiple components that constitute a case conceptualization. If you simply review the parts, you may neglect the whole picture. As a way to simplify the case conceptualization process, we offer a "wardrobe" metaphor. Each component in the case conceptualization system is like a separate article of clothing. There are socks, shirts, skirts, shoes, hats, pants, and so on. When dressing, a person takes care to make sure a hat goes on the head and shoes are properly placed on the feet. Moreover, coordination of the separate clothing articles is commonplace. Synthesizing the various components of the case conceptualization process requires similar coordination. Each variable is matched with other aspects so that a coherent whole is formed from its parts.

Once the wardrobe components are sorted and categorized, a system for applying these concepts can be implemented. You have to know how to put on the clothes—for example, you have to put pants on one leg at a time. In this way, a theoretical model shapes a case conceptualization.

In cognitive therapy, relationships exist between the various elements in a case conceptualization. Clearly, the information-processing variables are pivotal. As articulated by the cognitive model, a child's behavior patterns are learned responses shaped by the interaction of environmental, intrapersonal, interpersonal, and biological factors. Moreover, the behaviors are embedded within a cultural and developmental context. Case conceptualization addresses all these aspects.

Synthesizing the various components into a coherent whole is difficult. Children and adolescents are complex human beings whose behaviors are multiply determined. Figure 2.1 presents the components and hypothesizes relationships between the variables. The presenting problem is at the center of the conceptualization. The case conceptualization begins with the presenting problem. The cognitive model addresses five symptom clusters: physiological, mood, behavioral, cognitive, and

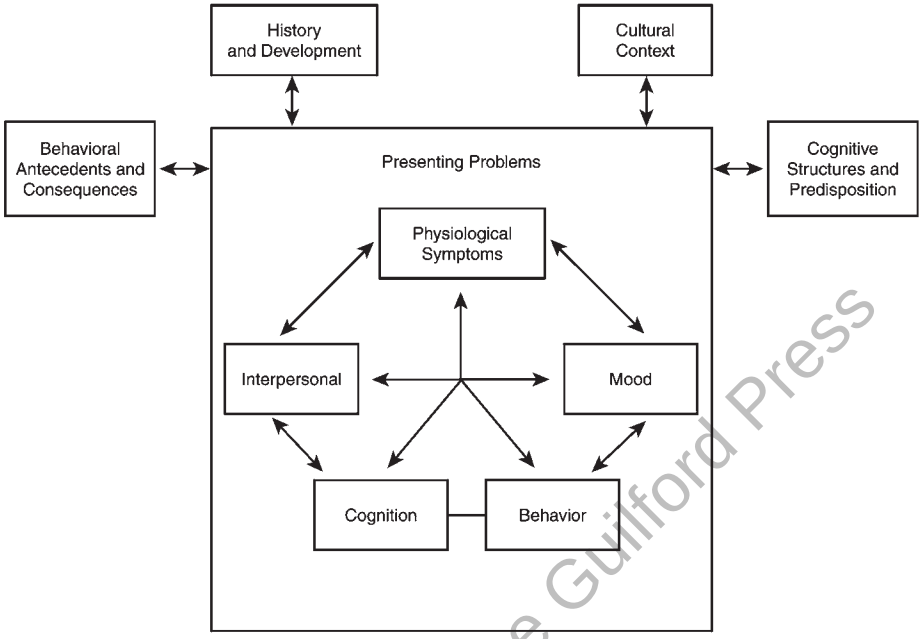

FIGURE 2.1. The relationship between the components of a case formulation.

interpersonal. Surrounding these core problems are four interrelated variables that influence one another: history and development, cultural context, cognitive structures, behavioral antecedents and consequences.

For example, a youngster's developmental and learning history clearly has an impact on his or her presenting problem, and this in turn shapes development and history. Suppose Andy is a shy, anxious child who avoids friends, school, and clubs. He fears rejection and believes he will only be safe if he stays near Mom and Dad. As a preschooler, he was behaviorally inhibited and had bad experiences at daycare. When he first started kindergarten, his mother and father became extremely anxious. All these elements contribute to his current problem. Additionally, due to his current anxiety and withdrawal, he is missing out on some important developmental opportunities like going to birthday parties and hanging out with buddies. In this way, the presenting problems and developmental history interact.

The other variables (cultural context, cognitive structures, behavioral antecedents and consequences) interact with the presenting problem in similar ways. Andy's escape response is negatively reinforced by his avoidance of anxiety. The continued escape and avoidance further support his beliefs that anxiety is dangerous, that he can't cope without his

mother's constant support, and that avoidance is the antidote to anxiety. His familial cultural context and environment may also support his anxiety. Suppose he lives in a violent neighborhood where safety is secured by close attachment to parents and home. Further, cultural beliefs regarding parenting (e.g., "A parent's job is to ensure the safety of the child. This safety is best achieved by keeping the child close by your side.") also determine behaviors.

Components of the Case Formulation

Presenting Problems

The first step is to define the presenting problem in a way that reflects the unique situation of the child and his or her family. We recommend being as specific as possible. Persons (1989) has suggested ways to transform general problems into discrete ones by dividing problems into their cognitive, physiological, behavioral, emotional, and interpersonal components. In this way, a personalized picture can be drawn.

For example, an 8-year-old girl presents with low self-esteem. "Low self-esteem" is a very vague, general term that does not give you a clear understanding of the specific difficulties this child faces. Through the interview and her self-report measures, your understanding of her experience of low self-esteem becomes clearer. The *behavioral* aspects included shying away from novel tasks and new people, crying, difficulty persisting with a frustrating task, and passivity. The *emotional* components included sadness, anxiety, and some irritability. Having one or two friends and being repeatedly criticized by her father represents the *interpersonal* aspects of her low self-esteem. When the child experienced these circumstances, she suffered several *physiological* reactions such as stomach cramps, headaches, and sweating. Finally, the youngster's *cognitive components* included thoughts such as "I'm no good at most things"; "People think I'm a jerk"; and "My dad thinks I'm no good." As Figure 2.2 illustrates, the vague presenting complaint has been transformed into more viable therapeutic issues. Treatment can now specifically target problem areas.

Test Data

Assessment is a key component in cognitive therapy. Many cognitive therapists rely on both interview data and information gleaned from assessment instruments. Most cognitive therapists use objective self-report measures and checklists. These instruments provide data on the presence of symptoms, as well as data on their frequency, intensity, and duration. The information culled from test data may be integrated with the client's verbal report and the therapist's clinical impressions.

GENERAL PRESENTING PROBLEM

Low self-esteem

PARTICULAR COMPONENTS

Behavioral: Shying away from novel tasks and new people, crying, difficulty persisting in a frustrating task, and passivity

Emotional: Sadness, anxiety, irritability

Interpersonal: One or two friends, repeated criticism by father

Physiological: Stomach cramps, headaches, and sweating

Cognitive: "I'm no good at most things. People think I'm a jerk. My dad thinks I'm no good."

FIGURE 2.2. Operationalizing low self-esteem.

Typical objective self-report instruments include the Children's Depression Inventory (CDI; Kovacs, 1992), the Screen for Child Anxiety Related Emotional Disorders (SCARED; Birmaher et al., 1997), the Revised Manifest Anxiety Scale for Children (RCMAS; Reynolds & Richmond, 1985), the Multidimensional Anxiety Scale for Children (MASC; March, 1997), the Beck Youth Inventories—Second Edition (BYI-II; J. S. Beck, A. T. Beck, Jolly, & Steer, 2005), the Hopelessness Scale for Children (Kazdin, Rodgers, & Colbus, 1986), and the Fear Survey Schedule—Revised (FSS-R; Ollendick, King, & Frary, 1989). The Beck Depression Inventory–II (BDI-II; A. T. Beck, 1996), the Beck Hopelessness Scales (BHS; A. T. Beck, 1978), and the Beck Anxiety Inventory (BAI; A. T. Beck, 1990) may be used with adolescents. Finally, the Achenbach Scales (ASCBA; Achenbach, 1991a, 1991b, 1991c), the Conners Parent Teacher Rating Scales—Revised (CRS-R; Connors, 2000), the Behavior Assessment Scale for Children–2 (BASC; Reynolds & Kamphaus, 2004), and the Swanson, Nolan, and Pelham Rating Scale (SNAP-IV; Swanson, Sandman, Deutch, & Baren, 1983) are good parent and teacher rating scales for externalizing disorders.

Some cognitive therapists may elect to use the Minnesota Multiphasic Personality Inventory for Adolescents (MMPI-A; Butcher et al., 1992) to assess personality dimensions. Projective techniques such as the Thematic Apperception Test (TAT; Murray, 1943), the Children's Apperception Test (CAT; Bellak & Bellak, 1949), the Roberts Apperception Test for Children (RATC; McArthur & Roberts, 1982), and the Rorschach Inkblot Test (Exner, 1986) are used by some cognitive-behavioral clinicians.

Regardless of the instrument employed, the initial test data provide a baseline for therapeutic work. Self-report measures may be periodically

readministered to evaluate treatment progress. The scores reflect severity of distress, acuity, and functionality. Accordingly, the test data augments interview data and clinical impressions. Decisions regarding initial treatment targets and future intervention strategies can be enhanced through the use of test data.

Cultural-Context Variables

A major influence on family practices is ethnocultural background (Cartledge & Feng, 1996b). Since ethnocultural context shapes family socialization processes, and since these family practices influence symptom expression, you should expect a child's clinical presentation and response to treatment to be influenced by his or her cultural background (Sue, 1998). Carter, Sbrocco, and Carter (1996) offer a useful theoretical framework for conceptualizing the way ethnicity influences symptom expression, treatment response, and help-seeking behavior. Although the model was developed for adult African American clients with anxiety disorders, the paradigm has implications for children and adolescents.

Carter et al. (1996) conceptualized clients along the dimensions of racial identity and level of acculturation. African Americans with a high level of racial identity who are highly acculturated have a firm sense of their own ethnic identity yet also accept the values of the dominant culture. Clinically, these individuals present with a high perception of personal control and an active problem-solving stance. Their symptom presentation will likely approximate the symptoms shown by their Caucasian counterparts. Carter et al. (1996) hypothesized that once these clients connect with a therapist who understands their symptoms and appreciates their ethnicity, they will stay in treatment and profit from clinical interventions.

African American clients who have a strong racial identity but low levels of acculturation will respond to treatment quite differently. These individuals have well-developed ethnic identities but ascribe to relatively few values embedded within the dominant culture. Carter and her colleagues claimed that these clients will recognize symptoms differently, attribute these symptoms to physical or spiritual causes, and likely manifest different symptoms than anxious Caucasian clients. Not surprisingly, these clients will initially seek assistance from medical professionals or clergy. Finally, Carter et al. (1996) concluded that although these clients may perceive anxious symptoms as signs that they are going crazy, they tend not to trust Caucasian mental health professionals. Accordingly, these individuals are likely to drop out of treatment early in the process.

"Culture," Cartledge and Feng (1996b) wrote, "is like a webbed system in which various aspects of life are interconnected. The various components of culture are not discrete but interactive. Kinship, economic,

and religious subsystems, for example, all affect one another and cannot be understood in isolation" (p. 14). Like other history and developmental variables, there are several domains you will want to sample in your case conceptualization (Brems, 1993; Sue, 1998). Considering the child's and family's level of ethnic identity and acculturation is a pivotal first step. Attitudes toward affective expression are also robust clinical variables (Brems, 1993).

Unique environmental circumstances may punctuate the lives of culturally diverse children. For example, poverty, oppression, marginalization, prejudice, and institutional racism and sexism differentially affect children from nonmajority cultures (Sanders, Merrell, & Cobb, 1999). Indeed, institutional prejudices will affect children's educational experiences. These attitudes and practices may contribute to inferior teaching, low expectations, and denigration of various individuals (Bernal, Saenz, & Knight, 1991). Indeed, minority status itself may represent a stressor (Carter et al., 1996; Tharp, 1991). These conditions may contribute to particular thoughts, feelings, and behavior patterns that are embedded in the problem expression. Forehand and Kotchick (1996) wrote that "because ethnic minority families of lower socioeconomic status experience stressors in their lives not typically present in the lives of middle-class European families, they may not respond in the same manner to established treatment techniques or maintain the gains for as long as families in the middle income range" (p. 200). For example, it is an unfortunately common occurrence that children of color are frequently "tracked" by clerks in retail stores. Greater levels of irritability and anxiety would be natural accompaniments to this stressful experience. Zayas and Solari (1994) wrote, "The cumulative effects of socioeconomic disadvantage and negative stereotypes felt by racial and ethnic minority families lead them to develop adaptive strategies based on their beliefs about what it means to be a member of an ethnic minority or racial minority group" (p. 201).

Consider the following example. Alex, the only Latino boy in his sixth-grade class in a suburban school, felt excluded and uneasy all year. One day a classmate reported that his collection of gel pens was missing. For no apparent reason, many children blamed Alex. Although he was later exonerated, Alex withdrew more into himself, his schoolwork suffered, and he ended up being referred to your clinical practice. Upon presentation, Alex seems quiet, sullen, emotionally restricted, and withdrawn; he avoids eye contact, appears suspicious, and acts like he has a chip on his shoulder. It would be easy to label this child as resistant. However, considering the hassles he has been experiencing in school, his behavior is totally understandable. He likely equates therapy with punishment and expects the therapist to blame, reject, and perhaps pigeonhole him into a biased stereotype.

Language clearly mediates attitudes, behaviors, and emotional expression. Tharp (1991) rightly noted that culture shapes linguistic courtesies and conventions. For instance, length of pauses, rhythm of speech, and rules for turn taking in conversation are culturally defined. For example, white children tell stories that are topic-centered and thematically cohesive with temporal references (Michaels, 1984, as cited by Tharp, 1991). African American children tell less topic-centered stories that are more anecdotal and topic-associative. Interestingly, the Caucasian audience saw the African American story as incoherent whereas the African American audience viewed the story as interesting and detailed. This finding suggests that youngsters will tell their "stories" in various ways and we, as therapists, need to shape our interventions accordingly.

Different cultural groups may hold varying beliefs regarding obedience to authority (Johnson, 1993). The way these families react to the therapist's "authority" shapes their response to therapy. For instance, for individuals whose culture dictates relative deference to authority figures, collaborating with and giving negative feedback to the therapist will be unsettling. Conversely, the therapist's direction will be expected and welcomed. Additionally, children may be expected to dutifully comply with all parental requests.

As you can see, cultural context issues can impact a youngster's clinical presentation and response to treatment. In Table 2.1, we provide a sample list of questions to highlight important issues. While this list is not exhaustive, it may direct your attention to some heretofore neglected areas and alert you to other points worth considering. Regardless of the question asked, an appreciation of the youngster's cultural context should be integrated within the case conceptualization.

TABLE 2.1. Sample Questions Addressing Cultural Context Issues

- What is the level of acculturation in the family?
- How does the level of acculturation shape symptom expression?
- What characterizes the child's ethnocultural identity?
- How does this identity influence symptom expression?
- What are the child and family thinking and feeling as a member of this culture?
- How do ethnocultural beliefs, values, and practices shape problem expression?
- How representative or typical is this family of the culture?
- What feelings and thoughts are proscribed as taboo?
- What feelings and thoughts are facilitated and promoted as a function of ethnocultural context?
- What ethnocultural-specific socialization processes selectively reinforce some thoughts, feelings, and behaviors but not others?
- What types of prejudice and marginalization has the child/family encountered?
- How have these experiences shaped symptom expression?
- What beliefs about oneself, the world, and the future have developed as a result of these experiences?

History and Developmental Milestones

Obtaining a personal and developmental history is standard clinical fare for most mental health professionals. Historical or background information yields data regarding the youngster's past learning and places the present complaints into an appropriate context. The frequency, duration, and intensity of the child's problems can be more soundly established.

Knowing how a child navigates developmental milestones also provides key information for case conceptualization. Typically, developmental delays will make a child more vulnerable to perceived criticism and lead to intolerance of negative affective states and possibly to depression. If the delays affect cognitive, emotional, or behavioral processing, the therapeutic approach may need to be modified. For instance, a child who has significant language and reading problems is unlikely to profit from sophisticated reading materials. Accordingly, simplification of the materials may be indicated. Patterns of emotional and behavioral dysregulation are amplified through considering developmental milestones and learning history. For instance, a pattern of behavioral and emotional dysregulation may be revealed by a child's chronic sleeping, eating, and toileting problems; by aggressive behavior with peers; or by poor adjustment to changes in routine. Constitutional or temperamental vulnerability factors likely interact with environmental factors to produce children's behavior.

Developmental and historical data also provide information regarding the child's caretakers. For example, the accuracy and completeness of the caretakers' recall of developmental information is revealing. What might it mean if a mother is virtually clueless regarding the child's developmental achievements? Perhaps the mother has a poor memory for events, but she also might be inattentive or lacking in concern. You might then inquire what was going on during these times. Was the mother depressed or drinking? Was she suffering through marital conflict? Therapists might also develop hypotheses regarding parents who recall the minute details of a child's life (e.g., day, time, and year of first pooping in potty). Are these parents simply detail-oriented or do they tend to be so overattentive and overinvolved that they psychologically "crowd" their child?

School and Peer Relationships

Work and relationships are generally major history-taking foci in adult interviews. Children's "work" is play and school. A youngster's play activities, clubs, sports, and hobbies are quite revealing. Does the child enjoy solitary, isolative activities? Competitive games? Fantasy games? Additionally, examining a child's peer relationships is fruitful. Who are the child's friends? Does the child have friends who are his or her own age?

Are they younger or older? How long do the child's friendships last? Are friendships arduously made but easily lost?

Gathering information on the youngster's adjustment to and performance in school is a key task. School is a place where children respond to demands, demonstrate productivity, and interact with others. How is the youngster's academic performance? What factors compromise academic functioning (e.g., learning disabilities)? Has performance declined? How does he or she get along with others? How does the child regulate his or her behavior in the classroom? How does the child respond to teachers' directives and commands? Has he or she ever been suspended or expelled?

Family Relationships

Family relationships and attachment processes also convey meaningful information. Knowing how the different family members interact and get along gives the therapist more information about the child's functioning. Moreover, it places the child's behavior within a family context, allowing the therapist to discuss the similarities and differences in the child's functioning in various circumstances. For example, is the child aggressive at school but not at home? Is the child clingy at home but not at school? Does the child respond more compliantly to mother's directives than to father's commands?

Collecting information on the disciplinary practices employed by parents is a vital task for clinicians. Therapists will need to know how desirable behavior is promoted and undesirable behavior is discouraged. What parenting or child behavior management strategies are employed? What are the parents' styles? Are they overcontrolling, indulgent, authoritarian, authoritative, permissive, unattuned, or inattentive? How consistently do they apply consequences? Do parents and caretakers agree on the behavior to be promoted or discouraged? Do they agree on disciplinary methods?

Previous Treatments

We also suggest checking on the youngster's previous treatment experiences. The type, duration, and response to treatment are useful data points. Similarly, family and personal medical information is critical in uncovering medical conditions that may exacerbate psychological problems or psychological disorders that may exacerbate medical conditions. For instance, any chronic medical condition will be a stressor for children and their families. Psychological issues regarding control and autonomy may affect compliance with medical regimens. Family illness may also be a significant issue for children. Children understandably worry about ill

caretakers. Not surprisingly, medical consultation is recommended in all these cases.

Substance Use

Substance use is also a major area for history taking. Illegal drugs, prescription medications, over-the-counter medicines, alcohol, household products (e.g., glue, aerosol products), cigarettes, laxatives, and even food items are just a few of the potential sources of substance abuse. Substance use and abuse clearly complicates symptom presentation. Moreover, youngsters tend not to be particularly forthcoming about their substance use. Nonetheless, therapists are strongly encouraged to examine possible substance abuse in the children and adolescents they treat.

Legal System

The child's involvement with the legal system should also be considered. Involvement with the juvenile court system or law enforcement agencies should be noted. Clearly, a youth's legal problems reflect overall problem severity. Additionally, consultation with legal authorities may be indicated.

We realize that while this is not an exhaustive list of clinical considerations, it is nonetheless a great deal to think about. We summarize some of the pivotal questions in Table 2.2 as an organizational guide.

Cognitive Variables

As briefly noted in Chapter 1, the cognitive variables in the case conceptualization process are organized in the hierarchical layers of cognitive products, cognitive processes or operations, and cognitive structures.

Automatic Thoughts

Automatic thoughts (cognitive products) reflect the explanations or predictions that accompany events and represent cognitive content. Automatic thoughts tend to be relatively easily accessible and can be readily identified through standard interventions. The automatic thought content often serves as the initial treatment target and provides clues regarding the core schema.

Schemata

Schemata (cognitive structures) represent core organizing beliefs or personal meaning structures (A. T. Beck et al., 1979; A. T. Beck Davis, &

TABLE 2.2. Important Areas in History Taking

Developmental milestones

- Were there remarkable delays in developmental milestones?
- Are there language and speech problems?
- How well does the child read?
- How well does the child write?
- When did the child sleep through the night? How would you characterize the child's sleeping patterns and habits?
- When was the child toilet trained? How did it go? What were the difficulties? Have there been many toileting accidents?
- How would you describe the child's eating patterns?
- How does this child characteristically respond to changes in his or her routine?
- What type of baby was he or she? Fussy? Colicky? Sweet disposition? Etc.
- Who has taken care of this child? Have there been disruptions or inconsistency in the caretaking?
- Has he or she ever been a victim of sexual or physical abuse?

School

- What is the child's academic performance like? Has there been a decline in performance?
- How does he or she get along with classmates? Teachers?
- What was his or her adjustment to school like? How are his or her mornings before school? How are his or her afternoons after school?
- Has the child ever been expelled? Suspended? Received detention?
- How is the child's school attendance?

Peers and activities

- What are the child's activities?
- Who are the child's friends?
- How long do the child's friendships last?
- Are the child's friendships arduously made but easily lost?

Family relationships

- What is the child's relationship with each caretaker? Sibling?
- What is the household climate like? Conflictual? Warm? Permissive?
- What is the relationship like between major caretakers?
- Has the child ever witnessed domestic violence?
- How is the child's behavior similar and different with each family member?
- How does the child's family relationships differ from his or her relationships with others?

Disciplinary practices

- What disciplinary techniques are used?
- What techniques work well and/or don't work well?
- What are the parents' styles?
- Do the parents agree on discipline?

(continued)

TABLE 2.2. *(continued)*

Medical conditions and previous treatment

- What medical/physical conditions are present?
- How do these medical conditions influence psychological functioning?
- How do the psychological conditions influence the medical condition?
- What has been the child's and family's response to past treatment?

Substance use and legal involvement

- What is the child's substance use?
- What is the child's use of laxatives, food, over-the-counter medicines? Household products?
- What is the extent of legal involvement?

Freeman, 2015). Schemata exist out of awareness, yet profoundly influence cognitive processes and content. Understanding youngsters' schemata provides insight regarding multiple clinical variables such as the changeability of automatic thoughts, interpersonal behavior, responsiveness to treatment, and probability of relapse.

Schemata work to maintain homeostasis (Guidano & Liotti, 1983; Padesky, 1994). Information that is consistent with the meaning structure is assimilated, whereas discrepant information is rejected or transformed so that it matches the schema. As Liotti (1987) aptly noted regarding this process, "Novelty is actively reduced to what is already known" (p. 93).

Cognitive Processes

Schemata are self-perpetuating. Young (1990) proposed three mechanisms that serve this self-perpetuating tendency. Schema maintenance processes preserve the cognitive structure through cognitive distortions and self-defeating behavior patterns. Recognizing the *cognitive distortions* embedded in youngsters' automatic thoughts facilitates more complete case conceptualization and intervention. For instance, personalization is well suited to the Responsibility Pie intervention discussed in Chapters 8 and 9. Time projection works well with emotional reasoning. Additionally, cognitive distortions mediate the way children view therapy and the therapist. For example, a child who frequently uses discounting may dismiss success in therapy and find it difficult to internalize treatment gains.

Young (1990) hypothesized that schemata also operate through schema avoidance. Schema avoidance can take three forms: cognitive avoidance, emotional avoidance, and behavioral avoidance. The purpose of schema avoidance is to prevent experiences that would question the schema's accuracy. In *cognitive avoidance*, the thoughts that trigger the schema are blocked. A good example is when you ask a distressed

youngster what is going through his mind at the moment of an intense mood shift and he responds with an "I don't know." Sometimes cognitive avoidance is indicated by the youngster's sense that her mind is blank (e.g., "Nothing is going through my mind."). For such clients, their thoughts are too painful, embarrassing, or shameful to identify. With *emotional avoidance*, instead of blocking the thoughts connected to the schema, the individual blocks the feelings associated with his or her thoughts. Young (1990) astutely remarked that self-mutilation (i.e., cutting or burning oneself) is often a function of emotional avoidance. The youngster may experience a prohibited feeling (e.g., anger) and then try to avoid the feeling by burning him- or herself with a cigarette lighter. Social isolation, agoraphobia, and procrastination are examples of *behavioral avoidance* (Young, 1990). In such cases, children do not perform behaviors that are related to the schema content. Since they avoid the behaviors, the schema content remains unquestioned.

Schema compensation is the last schema process. In schema compensation, the child acts in ways that are opposite to the schema content. For example, a boy may bully and mercilessly tease other children as a way to compensate for a schema reflecting weakness and a fragile sense of self. In the bully example, the boy does not have to deal with his perceived weakness and sense of inadequacy thanks to his threatening behavior. However, if the bullying and belittling fails, the youngster is ill equipped to manage his fragility.

A study by Taylor and Ingram (1999) suggests that negative cognitive schemata may contribute to children's depression in children as young as 8 years old. They concluded that "each time a negative mood state is encountered, high risk children may be developing, accumulating, strengthening, and consolidating the reservoir of information in the dysfunctional self-referent cognitive structures that will guide their views of themselves and how information is processed when adverse events evoke these structures in the future" (p. 208). Thus, schematic influence on children's psychological functioning may begin in children of elementary school age. However, schemata may not consolidate until adolescence (Hammen & Zupan, 1984). Therefore, appreciation of schema processes may be most pivotal in cognitive therapy with adolescents.

Behavioral Antecedents and Consequences

Behavioral responses are molded by stimuli that both precede and follow the behavior (Bandura, 1977, 1986). The classic A (antecedent), B (behavior), and C (consequences) behavioral paradigm nicely illustrates this process (Barkley, Edwards, & Robin, 1999; Feindler & Ecton, 1986). Antecedent and consequent determinants may be learned either vicariously (e.g., through observation) or by direct experience (Bandura, 1977, 1986).

Antecedents

Depending on the learning circumstance, antecedent stimuli may either directly elicit the behavior or simply set the stage for the behavior to occur. If the behavior is acquired through classical conditioning, certain stimuli have come to elicit emotionally charged behavior. In these instances, stimuli acquire the capacity to pull out an emotional response from the child. For example, suppose a demanding fifth-grade teacher slams his book closed every time he is about to announce a pop quiz. Suppose too that any quiz or test generates a variety of aversive physiological, emotional, and cognitive stimuli in a youth. Over time, through repeated pairings, the teacher's slamming of the book can elicit the same anticipatory anxiety in the youth as the quiz itself.

Antecedent stimuli "trigger" children's behavior. "Stressors" in children's lives are generally antecedent stimuli (e.g., parents' divorce, teacher's criticisms, peer's taunts). For example, antecedent stimuli are often recorded in the event column in a thought diary (described in Chapter 6), in subjective ratings of distress scales (described in Chapter 12), and on an ABC worksheet (described in Chapter 13).

Parental commands represent antecedent stimuli. Vague, indirect, hostile, and confusing parental directives rarely produce the desired behavior in a child. Rather, they often set the stage for noncompliance and contribute to coercive power struggles. Antecedent cues that set the stage for behavior are often called discriminative stimuli. Discriminative stimuli signal the child that the situation is right for reinforcement. When children selectively respond in the presence of discriminative stimuli and inhibit behavior in their absence, the behavior comes under stimulus control.

Consequences

Behavioral consequences refer to the stimuli that follow a behavior. Consequences determine whether the specific behavior is strengthened or weakened. Consequent stimuli that strengthen a behavior or cause it to occur more frequently or enduringly are called *reinforcers*. There are two basic reinforcement processes: positive reinforcement (adding something pleasant to increase the rate of behavior) and negative reinforcement (removing something unpleasant to increase the rate of behavior). A father who praises and hugs his son for getting a good grade is using positive reinforcement. A teacher who removes a penalty like extra homework due to her students' improved performance is using negative reinforcement to increase study habits.

Punishment decreases the rate of behavior. For example, a father who responds to his son's tantrums by giving him a time-out, denying

him rewards and privileges, or ignoring him is using punishment. Take the case of a mother who ignores her daughter's emotional expression, thereby punishing this affective expressiveness. Not surprisingly, the child learns feelings are bad and becomes emotionally constricted. Basic reinforcement and punishment procedures are described in greater detail in Chapter 15.

Reinforcers and punishers occur on schedules. Reinforcement schedules stipulate how much behavior is required, how long the behavior is required to persist, or how often the behavior must occur before it merits reinforcement. It is well known that behaviors established under intermittent schedules of reinforcement are quite enduring.

Planning and Thinking Ahead: Provisional Formulation, Treatment Plan, and Expected Obstacles

Provisional Formulation

The provisional formulation coordinates the components in a dynamic and interrelated way. The formulation paints a picture of the youngster's external environment and inner world. The presenting problems, test data, cultural context, history and developmental data, behavioral variables, and cognitive variables are analyzed and integrated. In this way, you create an individualized psychological portrait that allows you to tailor the interventions to each child's unique circumstances and styles. The key steps in a provisional formulation are summarized in WOW Box 2.1.

WOW BOX 2.1. Key Steps in a Provisional Case Formulation

- Define the presenting problems into discrete components.
- Integrate test data.
- Incorporate cultural context variables.
- Include meaningful historical and development milestones.
- Address cognitive structure (schema) and as well as schema processes (compensation, maintenance, avoidance).
- Mindfully identify behavioral antecedents (discriminant stimuli) and consequences (positive reinforcers, negative reinforcers, response cost procedures).

Anticipated Treatment Plan

The provisional formulation guides your treatment plan. Treatment plans vary from child to child since they must take into account each child's unique characteristics and circumstances. For instance, an anxious child who blushes, sweats, and has lots of muscle tension would probably benefit from relaxation training, whereas a worried child with ruminations and self-critical thoughts would not benefit from this kind of training. The formulation will inform you about when to use the conventional cognitive-behavioral techniques and when to creatively modify the traditional procedures. For example, a depressed child who has more developed verbal skills would profit from a reattribution done with paper and pencil whereas a less verbally sophisticated child may gain from a reattribution techniques done with arts and crafts.

Expected Obstacles

The route toward therapeutic progress is often bumpy. If you can anticipate the bumps or potholes on the road, you can swerve to avoid them or brace yourself for impact. The formulation helps you see the road ahead and predict obstacles. In this way, you can shape your treatment plan so you can negotiate therapeutic impasses.

For instance, if a child is perfectionistic, you might expect the child to procrastinate or avoid doing homework due to fears of failure. Or suppose you are treating an oppositional youngster whose parents are very inconsistent in their care. This child comes to therapy very irregularly. Since you know the parents inconsistently follow through on their own assignments, you will have advance warning to get plans in place to manage these difficulties.

Case Conceptualization Example: Tessa

Presenting Problems

Tessa is a 9-year-old African American girl who is being cared for by her mother and her aunt. She presents as a well-behaved but fearful and sad child. Her schoolwork consistently receives A's and B's. However, her teachers complain that Tessa is slow to complete her assignments and frequently requires considerable reassurance. She often cries in class during new assignments or during group projects. At lunch and recess, she wanders around the playground, sits by herself, or elects to stay in the classroom to read with the teacher rather than play with her classmates. More specifically, the physiological components of Tessa's problems include stomach aches, sweating, and headaches. Her mood symptoms are

marked by fear, anxiety, and sadness. Behaviorally, she cries frequently, is restless and fidgety, is slow to turn in work, and requests to see the nurse frequently. Interpersonally, she appears shy and withdrawn. Her cognitive components include automatic thoughts such as "I'm going to mess up and everyone will notice," "Everybody is waiting for me to mess up," "I'm not going to be OK at school without my mom," and "The other kids in class don't like me."

Test Data

Tessa completed the CDI and the RCMAS. On the CDI, Tessa obtained a raw score of 18, which suggests a moderate level of depression. On the RCMAS, her total score was 18, indicating moderate anxiety. She scored relatively high on subscales for worry and social concerns.

Cultural-Context Variables

Tessa's mother's income is quite limited. They struggle to make ends meet but they live above the poverty line. Tessa, her mother, and her aunt all belong to the same Baptist church. The church offers some social support to them. They have a few relatives in the area who occasionally visit and babysit. The family lives in a low-rent area where crime rates are relatively moderate. Tessa attends a predominantly Caucasian school and she is one of a few African American children in her grade. Both Tessa and her mother did not report specific instances of Tessa experiencing prejudice or racism. Her mother did say, "I tell her she has to be twice as good, well-behaved, and smart to compete with her white friends." Tessa's mother describes her daughter's teachers as "friendly and cooperative," but she says she gets a feeling that school personnel are walking on egg shells. "I think they are afraid or uncomfortable about dealing with me. I don't know why. Maybe they just aren't used to people like me."

Mother gives Tessa lots of "survival instructions." She warns her about walking home from the bus stop and gives her specific instructions on how to walk from her house to a nearby grocery store. "I don't want anybody to mess with her. When I was her age I could defend myself but Tessa is different. She takes things personally."

History and Developmental Milestones

Tessa reached and completed all her developmental milestones within normal age limits. In the past she is described as a serious and anxious child, but her mood symptoms have exacerbated within the last several weeks. Her mother, who is diagnosed with major depressive disorder and

takes Prozac, discloses that her own depression seems worse during the last few months.

Tessa has always been a good student. Her grades remain consistently good and she presents with no behavioral problems. As a toddler and preschooler, she attended daycare and preschool where she initially displayed some separation anxiety, but she subsequently adjusted to the school routine. Tessa regularly gets quite nervous the week before the first day of a new school year and seems worried on Monday mornings. She says she does not like waiting for the bus or riding on the bus. Sometimes she worries that her aunt will not pick her up at the bus stop. She recalls that her most embarrassing moment at school was when the other kids made fun of the gift she gave for a holiday grab-bag ("It's so small and cheap!").

Tessa plays soccer and baseball, and takes flute lessons. In her free time, she enjoys reading and watching television. She has a few friends in her neighborhood, with whom she plays typical childhood games. Tessa likes to play with younger children and take care of them. She rarely fights or argues with friends. She gets invited to birthday parties for her school friends but elects not to go. Her invitations in the last year seem to have decreased.

Tessa's father left when she was nine months old; she has not seen him since that time. Her mother and aunt get along well and generally agree on disciplinary practices. Tessa's mother claims that her sister thinks she is "babying" Tessa. Her mother reports that she is the "authority" in the house, but also discloses that she thinks she has been more lax in her discipline since she has been more depressed. Her primary disciplinary techniques are praise, hugging, time-out, and removing rewards and privileges. Mother says she does not believe in physical punishment because she was "whooped" as a child. She did not want to spank her daughter. Mother also reports she has not had much energy to do one-on-one activities with Tessa. She feels guilty about this and blames her tiring schedule and increasing depression for her low energy level.

Tessa does not use drugs or drink alcohol. She has no legal troubles. This is her first psychotherapy experience. Mother has seen a family practice physician for her medication but has never seen a therapist. Mother hopes Tessa will find "someone she can talk to and confide in" in therapy. Tessa is not quite sure what to make of coming to therapy.

Cognitive Variables

Tessa's automatic thoughts include beliefs such as "I'm going to mess up and everyone will notice," "Everybody is waiting for me to mess up," "I'm not going to be OK at school without Mom," "The other kids in class don't like me," "I have to be good so I don't tire Mom out," "The world

has lots of awful dangers," "I don't think I can protect myself," "I'm not as smart or strong as most other kids," "Being frightened means something bad will happen," and "I don't think I fit in." Her characteristic cognitive distortions include all-or-none thinking, personalization, overgeneralization, emotional reasoning, and labeling. Since Tessa is only nine, it is likely that her schemata are not fully formed. However, she may be vulnerable to developing core beliefs such as "I'm vulnerable and fragile in a critical and harsh world where others are unresponsive and judgmental," "Being different makes me an outcast in a world where others are smarter and stronger," "I must be constantly alert to all the dangers so I can avoid them," and "Mistakes are catastrophic in a critical world where others are critical and I am weaker than they are."

Behavioral Antecedents and Consequences

Transitions from home to school, especially on Monday mornings, are clear triggers for (antecedents to) Tessa's symptoms. Additionally, new assignments, group projects, critical feedback, and ambiguous situations such as recess stimulate her anxious and depressed feelings. Unresponsiveness by adult caretaking figures and other children (e.g., mother, aunt, teachers) also triggers beliefs such as "They don't care about me" or "They don't like me." Tessa's avoidance, withdrawal, and checking behavior on her assignments are not only elicited by these stimuli but are reinforced by relief from anxiety. Her checking is positively reinforced by her good grades and praise from Mom. Her reassurance seeking is also intermittently reinforced both positively and negatively. At times, she feels comforted by authority figures; the simple act of seeking reassurance provides anxiety relief. Her quiet behavior is reinforced in the classroom. Tessa's somatic complaints also have functional value. They elicit caretaking from others, which Tessa finds satisfying. Tessa's eagerness to please is also positively reinforced by others' approval.

Provisional Formulation

Tessa is a young African American girl who is experiencing primarily anxious and depressive symptoms. Her cognitions are marked by themes of fear of negative evaluation and self-criticism. Behaviorally, she responds to such threats through hypervigilance, reassurance seeking, and withdrawal from peers. Many of her psychological symptoms are translated into somatic symptoms. It is possible that Tessa fears negative evaluation by others if she is more emotionally expressive.

Certainly, environmental factors feed into the initiation, maintenance, and exacerbation of her distress. Both Tessa and her mother are aware of the racial differences between her and her classmates. Tessa has

likely internalized Mom's encouragement to "work twice as hard as her white friends." Therefore, she feels put on the spot to perform, compete, and fit in. These are a lot of strong feelings for a young child. Moreover, thoughts such as "Everybody is waiting for me to mess up" reflect her sense that she is on display. This propels her social anxiety. For a youngster who experiences such pressure in a context where people are walking on egg shells, reassurance is expected. Indeed, it is a way for Tessa to gage how she is doing.

Tessa sees herself as fragile in a critical and threatening world. In order not to be damaged, she withdraws and behaves extremely cautiously. Indeed, cautious behavior is adaptive in her neighborhood and at times with her classmates. However, because she is so cautious, her peers taunt and intimidate her. Mom also tends to be overprotective. The overprotection and peer teasing further reinforce her negative self-perceptions.

Anticipated Treatment Plan

1. Due to Tessa's high level of somatic complaints, relaxation training should be initiated (see Chapters 8 and 12 for this technique).
2. Pleasant event scheduling should be attempted to increase her level of positive reinforcement (see Chapter 11).
3. Cognitive interventions aimed at ameliorating her fears of negative evaluation should begin with self-instructional approaches and progress to techniques involving more rational analysis (see Chapters 8 and 11).
4. Care should be directed toward Tessa's attributions around her awareness of the racial differences between her and her classmates. If she is making self-damaging attributions, cognitive techniques such as reattribution procedures should be employed (see Chapter 11).
5. Problem-solving strategies should be taught to Tessa throughout the treatment process (see Chapter 11).
6. Cognitive techniques aimed at Tessa's view of herself as fragile should also be initiated (see Chapter 8).
7. Tessa's mother should be included in child-centered parent training to develop a contingency management program for therapy homework completion. Additionally, therapy should focus on helping Tessa's mother decrease her overprotectiveness and increase her consistency in responding to Tessa's needs (see Chapter 15). Care will need to be directed toward increasing consistency and communication between Tessa's major caretakers (i.e., mother and aunt).
8. Depending on Tessa's social skill level, social skills training in response to peers' teasing should be considered (see Chapters 8 and 11).

9. After Tessa has sufficiently acquired, practiced, and applied her skills, behavioral experiments should be collaboratively designed that will test Tessa's inaccurate predictions.
10. Ongoing collaboration with the teacher and other school personnel should be maintained.

Expected Obstacles

Tessa is an eager and motivated young client. Therefore, noncompliance is not expected to be an issue. However, Tessa does have a tendency to "overdo." Therefore, we should be alert to perfectionistic efforts at homework completion. Additionally, since Tessa is so eager to please and fears negative evaluation, we will have to watch out for signs that she is minimizing her symptoms or inhibiting dissatisfactions about the therapy. Finally, due to Tessa's strong written and oral expressive skills, we will have to be alert to the possibility that Tessa will initially provide intellectualized responses rather than emotionally present ones.

Working with Tessa's attributions regarding racial differences will be crucial. Helping Tessa to comfortably explore her thoughts and feelings about these issues without exacerbating her social anxieties will be difficult. Focusing on both the content and process issues in therapy (e.g., What is it like to talk about these thoughts and feelings? What is the danger in talking about these thoughts and feelings?) is important.

Parental work will also present challenges. Mother's level of depression will need to be monitored. If indicated, individual therapy for mother may need to be recommended. In this instance, attention to the cost of care is critical. Regardless, the child-focused parental work will need to be sensitive to mother's depression. For instance, pleasant activity scheduling may be an arduous task when Mom is depressed. Due to her depressed mother, attention may be inordinately focused on Tessa's vulnerabilities. Finally, Mom may find it difficult to marshal the psychological energy to respond to Tessa and increase her communication with her sister.

Consulting with the school may also present some obstacles. Establishing a partnership with Tessa's teacher is a good idea. We likely would coach the teacher on ways to help reduce Tessa's reassurance seeking and avoidance. Increasing the teacher's sensitivity to Tessa's anxiety would be another proper strategy.

Case Conceptualization Example: Tatiana

Presenting Problems

Tatiana is a 12-year-old European American female who lives with her mother and two younger sisters. At school, she is a model student. She is on

the distinguished honor roll (GPA = 99.9) and takes several gifted classes. Tatiana is president of the student senate, and participates in soccer, gymnastics, chess club, choir, and orchestra. However, at home, her behavior is a different matter. Her mother describes extreme noncompliance and oppositional behavior, noting, "It is impossible to get Tatiana to do anything around the house. When you do, she explodes and goes off on me." When she becomes angry at her mother, Tatiana hits, kicks, punches, and spits at her. She has thrown breakable objects at her mother (e.g., bowls, drinking glasses). At times, Tatiana is quite verbally abusive to her mother (e.g., "You dumb slut," "You miserable whore"). Tatiana's aggression is not limited to her mother. She is verbally and physically aggressive to her middle sister (e.g., breaking her toys, calling her stupid and retarded).

Test Data

Tatiana completed the SCARED and obtained a highly elevated total score (raw score = 41), indicating high levels of self-reported anxiety. More specifically, her Generalized Anxiety and Separation Anxiety subfactors were also well above threshold. Tatiana completed the CDI and obtained a raw score of 12, indicating the presence of self-reported depressive symptoms. Tatiana's negative mood factor was elevated. There was no endorsement of any suicidal ideation. A recent Weschler Intelligence Scale for Children–IV test (WISC-IV) revealed an IQ of 145.

Tatiana's mother completed the parental report version of the SCARED. Her score for Tatiana was well below clinical threshold. However, on the SNAP-IV, Tatiana's mother rated her daughter well above threshold on the Oppositional Defiant Scale.

Cultural-Context Variables

Tatiana's mother's income placed her squarely in the middle class. Tatiana's mother and her parents immigrated to the United States from Croatia 15 years earlier. Her mother speaks several languages and currently works as a paralegal. Tatiana's grandparents are wealthy entrepreneurs and serve as emotional and financial supports.

History and Developmental Milestones

According to her mother's report, Tatiana reached all her developmental milestones within normal limits. Tatiana's mother described her as "always being high-strung" and being "too spunky for her own good." The family history was quite remarkable. Tatiana's mother and father were divorced when she was 6 years old. Her father currently lives in

another state and suffers from bipolar disorder complicated by cocaine abuse. Prior to the separation and divorce, the marital relationship was marred by intense conflict and domestic violence. Tatiana witnessed several incidents where her father was hitting and physically intimidating her mother. Both Tatiana and her mother disclosed that Tatiana would try to get in between her mother and father to protect her mother (e.g., "I would try to push that big jackass out of the way but I couldn't."). Mother responded to Tatiana's rescuing behavior by telling her to stay out of the way and warned her to hide under her bed in her room. Tatiana interpreted this as her mother being bossy and dismissive (e.g., "She thinks she is the only one who can handle things. She's so stupid. She's the one who married that asshole. She is the one who has to be in control but I can handle things. I am not a baby.").

According to Tatiana's mother, Tatiana is not "a good big sister." She noted, "I think she resents them and competes for attention with them." Tatiana finds her siblings "annoying" and admitted, "Mom thinks they are angels but they're not. They don't respect me and they get away with everything." Tatiana collects a variety of dolls, stamps, and coins. She also keeps old ribbons, wrapping paper, and still has papers and projects from kindergarten. Moreover, Tatiana orders her books and CD's alphabetically. Her younger sister often "gets into" these things which angers Tatiana. Not surprisingly, Tatiana gets upset when her sister "messes up" her arrangement.

Tatiana is an exceptional student. She earns straight A's and is in gifted classes. She plays a variety of instruments. Tatiana is very popular with her peers. She also is on a travel soccer team and is a competitive gymnast.

This is Tatiana's first psychotherapy experience. She was seen by a pediatrician due to her mother's concern about her "explosive behavior." The pediatrician deferred the recommendation to prescribe medication, preferring to wait until a 6-month trial of CBT was initiated.

Cognitive Variables

Tatiana voiced automatic thoughts such as "I must be in charge," "My best ability is the way I control others," "Absolute perfectionism is my way to stay in control," "I must be the best always," "I must have positive attention from everyone," "Emotions are dangerous," "Having feelings means you are out of control," "Other people are unpredictable," "Others are unjustly punishing," "I have to strike out at others before they plan to attack me," "I must never be a victim," "Victims are weak and stupid," "The world is frightening," "I hate chaos," and "The world should work according to my rules."

Behavioral Antecedents and Consequences

Behavioral triggers for Tatiana included competitive situations, criticism, and perceived or actual coercion. Her aggressive behavior relieved an aversive internal experience of pressure. Tatiana's emotional avoidance was quite satisfying to her because it protected her from uncomfortable emotional states. When she received negative consequences for her noncompliant, aggressive, or overcontrolling behavior, her sense that others are punishing was confirmed.

Provisional Formulation

Tatiana's emotional life is characterized by anxiety. She reacts to anxious feelings in all-or-none ways, vacillating between fight and flight responses. Emotions are quite scary for her as they signal potential loss of control. Tatiana held the core beliefs that "I must remain in perfect and absolute control of everyone and everything in a hostile, chaotic, and victimizing world where people are deceitful, aggressive, and coercive."

Not surprisingly, Tatiana is quite vigilant, keeping a watchful eye out for signs of danger. Tatiana's aggression, while problematic, is likely secondary to her anxiety. She uses aggression instrumentally as a countercontrol strategy. Being in a real or perceived victim position is quite aversive and she aims to fight her way out of that position. Her imposition of rules and routines is a way to bring order to what she sees as an unpredictable world.

Anticipated Treatment Plan

1. Collaboration and therapeutic patience should be practiced in order not to rupture Tatiana's fragile sense of control. Moreover, Tatiana is prone to seeing others as deceitful and coercive so the therapist should ensure transparency in therapeutic processes.
2. Due to Tatiana's strong emotional avoidance, affective education should be gradually introduced to help her identify and tolerate small bursts of emotion (see Chapter 6 for techniques).
3. Behavioral interventions to increase frustration tolerance and anger management techniques should be applied to her "fight" responses.
4. Cognitive interventions should target Tatiana's absolutist demands for control and facilitate a genuine sense of self-control (see Chapter 8).
5. Session structure should be faithfully applied to increase Tatiana's belief in a more predictable world.
6. Tatiana's mother and sisters should be systematically introduced into treatment allowing the therapist to teach her mother more productive

child management techniques and giving Tatiana the opportunity to practice her acquired coping skills when potentially provoked by her sister (see Chapter 15).

7. After these above skills are acquired and applied, the psychological sequelae (hypervigilance, reaction to being in a victim role) associated with witnessing the domestic violence should be addressed.
8. During the later phase of treatment, conjoint sessions with mother are likely good options (see Chapter 15).

Expected Obstacles

1. Considerable behavioral and emotional avoidance should be expected from Tatiana due to her overvalued sense of control.
2. Tatiana's view of others as deceitful and coercive will influence her perception of treatment and the therapist. Care needs to be directed at maintaining collaboration and transparency. The alert therapist should keenly process Tatiana's perception of therapeutic work.
3. Work with the family will require balancing training mother in child management strategies with decreasing Tatiana's oversensitivity to control. The key will be increasing both Tatiana's and her mother's self-efficacy.

Case Conceptualization Example: Victor

Presenting Problems

Victor is a 13-year-old Latino boy who is referred due to his anxiety at school and noncompliance at home. He is an eighth grader who attends private parochial school, where the student body is nearly exclusively European American. He is a good student (GPA = 89) and athlete (football, lacrosse), but experiences considerable anxiety regarding school. He worries about giving oral reports and participating in class. He complains about stomach aches nearly every morning before school and frequently is slow to get ready to leave for school. Victor complains of sweaty palms and dry mouth at school. He rarely finishes his lunch in school, claiming he loses his appetite at school. Victor disclosed several automatic thoughts associated with his anxiety at school.

Test Data

Victor completed the CDI and obtained a minimal total score. However, on the SCARED, he obtained a very elevated total score (raw score = 45).

His Generalized Anxiety Disorder, Social Anxiety, Separation Anxiety, and School Anxiety factors were clinically elevated.

Cultural-Context Variables

Victor and his family are second-generation Puerto Rican Americans. Their church is a pivotal part of their lives. Victor is active in the church youth group and with the local Puerto Rican American community. He lives in a middle-class neighborhood that is primarily European American, but includes a moderate proportion of Asian American, African American, and Latino American families.

History and Developmental Milestones

Victor was his mother's third pregnancy. Her first two pregnancies sadly ended in miscarriages. However, his prenatal, postnatal, and neonatal periods were unremarkable, other than mild colic during the neonatal period.

Victor's family history is remarkable for his mother carrying a diagnosis of GAD. She describes herself as a constant worrier and an "overprotective" parent. Victor has a younger sister (age 6), with whom he enjoys a good relationship. Victor's father is employed as a middle manager in a large corporation. His father sees himself as a "troubleshooter" and a "problem solver" at work and home. He explained, "I like to get things done efficiently and well. Sometimes that is hard at home because Vic likes to do his own thing. His mama indulges him."

Victor has always been a good student who is well behaved at school. However, at the beginning of each school year, he experiences problems separating from his mother. He is well liked by his teachers and most peers. However, other peers hurl racial slurs at him at school and on the school bus. Both Victor and his mother describe the race-based teasing as persisting off and on for the past several years. His mother has informed the school and the school insists it has made various efforts at dealing with the problem with modest success. Victor's father tells him to "Man up" and "Just deal with people's ignorance." At times, his father has encouraged Victor to fight back physically ("Kick their asses and it will shut their mouths."). For his part, Victor does not want to fight ("I'm a thinker, not a fighter"; "I don't want to hurt anyone or get hurt."). Victor admits to feeling shamed by his father for these thoughts.

Victor's noncompliance and conflict at home is mainly directed at his father. He disclosed, "I can never get things done fast or good enough for him." He describes his father as "hypercritical and mean." His mother agreed that his father is very demanding and at times verbally harsh (e.g., "He doesn't realize Victor gets his feelings hurt easily. He's like me. . . .

He's sensitive."). Victor's father admitted he is very demeaning and somewhat critical but added, "Victor has got to learn that the world is cold for a mama's boy. He has to grow a thicker skin."

Victor is active in his church youth group as well as in sports and school activities (key club, student senate). He has a core group of friends who "chill out" together at each other's homes.

Cognitive Variables

Victor holds automatic thoughts such as, "I must keep my eyes open for danger," "I'm unwanted," "Nobody likes me," "Other kids think I am strange," "I don't belong," "I'm so different there must be something wrong with me," "My house is my safe place," "No one protects me," "Teachers don't care," and "If I speak up, I'll get in trouble."

Behavioral Antecedents and Consequences

The beginning of the school day prompts Victor's anxious feelings and thoughts. Moreover, the mere discussion of school, teasing, and the bus elicits Vic's worry and irritability. At home, Victor's anxiety is met with a calm and nurturing stance by his mother and looks of disapproval by his father. At school, when bullies sense his anxiety, their attacks intensify.

His father's commands and criticisms trigger his irritability and noncompliance. When Victor does not comply or gives "attitude" to his father, his father's criticism and demandingness intensify. Of course, a vicious self-perpetuating cycle ensues.

Provisional Formulation

Victor is challenged by significant anxiety and self-doubt. He holds a pernicious set of debilitating beliefs characterized by a sense that "I am a target because I am different, rejected, unwanted, and can't measure up in a world that is bullying, intimidating, and hostile. Others think I am weak and can't stand up for myself." Moreover, he likely equates difference with deviance. School represents a threat because he is the target of bullying and his response to the bullying elicits his father's belittling remarks. The paternal criticism makes his father an aversive stimulus, further reinforcing his sense of being an outcast and unwanted.

Anticipated Treatment Plan

1. Cognitive-behavioral family therapy appears to be a pivotal first treatment option. It should focus on increasing the father's understanding of Victor's experience and an appreciation of his role in

exacerbating Victor's symptoms. Attention should be directed at modifying Victor's sense that he is weak, unwanted, and does not belong (see Chapter 15).

2. Care will need to be directed at decreasing Victor's mother's overprotective behavior. The overcontrolling behavior likely undermines Victor's fragile sense of self-efficacy. When his father's behavior becomes less harsh and critical, his mother's behavior is likely to become more flexible (see Chapter 15).
3. School consultation should be initiated to identify the perpetrators of the teasing and enforce the no-tolerance-for-bullying rule at the school.
4. Individual work with Victor should include specific social skills to inoculate him against the deleterious effects of bullying, as well as traditional CBT interventions to manage his anxieties and depression (see Chapters 8, 11, and 12).

Expected Obstacles

1. Victor presents with doubts about his ability to measure up to others as well as beliefs of being fundamentally different from others. Therapeutic tasks need to be graduated in order to ensure Victor's initial success so his self-efficacy can be increased.
2. Both Victor's mother's and father's individual sets of beliefs will need to be identified and modified within the family's systemic context.
3. The therapist will need to be careful to make sure that the social skills training is emotionally meaningful. Consideration should be given to group CBT to build social skills.
4. The therapist will clearly need to adopt an advocacy role in school consultations and offer support to school personnel to stamp out the bullying.

Case Conceptualization Example: Jackson

Presenting Problems

Jackson is a 14-year-old European American boy who came to therapy carrying a diagnosis of Asperger syndrome and attention-deficit hyperactivity disorder (ADHD). He was prescribed Concerta and sertraline. Jackson is often targeted at school by his peers for teasing. He evidences poor social skills, idiosyncratic routines and rules, and eccentric behavior. He feels lonely and wishes for more friends. Jackson's motor skills are quite well developed, but he is reluctant to join teams due to his fears

of negative evaluation. He has various sensory sensitivities and becomes agitated when these sensory sensitivities are aroused.

Test Data

Jackson completed the CDI and the SCARED, obtaining very minimal scores. Both his parents completed separate versions of the SCARED. The maternal report revealed a score of 28 with clinically elevated thresholds on the Social Anxiety Scale. The paternal score was 32 with clinical elevations on the social anxiety and generalized anxiety disorder factors. Jackson's parents also completed the Gilliam Asperger's Disorder Scale (Campbell, 2005; Gilliam, 2001). Jackson's score revealed an overall elevation on the Asperger's Disorder Quotient as well as specific elevations on social interaction and cognitive patterns subscales.

Cultural-Context Variables

Jackson's family is European American and middle class. The family is not very religious, stating, "We are two-day-a-year Catholics. We go to church on Christmas and Easter." Jackson's father holds a bachelor's degree in science and is working on a master's degree to become a school administrator. His mother graduated from a local community college and regrets not continuing further in her education. Both parents value education.

History and Developmental Milestones

Jackson's developmental milestones were within normal limits. His language development is unremarkable other than some eccentric and quirky word use.

Jackson lives at home with his mother, father, and younger sister. His father is a high school physics teacher and his mother is a legal secretary. His father drinks regularly, battles bouts of depression, and is seen by his mother as "an introvert who hates to socialize." Mother is seen by Jackson as very nurturing and helpful, whereas he sees his father as kind of aloof: "He seems to be in his own world." Jackson's relationship with his younger sister is described as "good" but her blithe attitude "bugs" him. He finds her singing and various voices during doll play to be "annoying."

Jackson's father sees his behavior as due to his "arrogance." His mother is somewhat more accepting and Jackson tends to confide in his mother about his school and peer problems.

Jackson is in the eighth grade in a large suburban school. He is an outstanding student academically. However, his behavior is often disruptive in class and his poor social skills make the school environment quite anxiety-producing for him. Jackson is often reprimanded for his behavior

at school and ridiculed by his peers (who call him an "Ass-Troll"). He desperately wants to fit in with his peers and this sense of desperation prompts eccentric showing-off behavior. For instance, he walked up the stairs balancing only on the handrails during classroom changes (quite a feat!). Additionally, Jackson also is quick to point out any missteps by teachers. He explained this by saying, "Everybody says I am a know-it-all. But I don't think it is a problem because I am always right. I want to make sure the teacher is doing a good job." Finally, Jackson acts as a self-appointed class monitor, pointing out peers' misbehavior and failures to complete assignments.

Jackson generally engages in solitary activities such as riding his bike around the neighborhood, kicking a soccer ball in his backyard, playing with a pitch-back machine, watching TV, and playing video games. He is an avid reader particularly in the areas of his interest (e.g., history of LA Lakers basketball, astronomy). He avoids group activities and is reluctant to join in with his peers in his neighborhood.

Cognitive Variables

He holds various beliefs such as "Rules are meant to be followed," "My way is always right," "People must always do their best," "Feelings are strange," "I cannot allow myself to feel bad," "I can't stand feeling uncomfortable, "I am in charge," "Change is bad," "Other kids will never like me," and "I can't fit in."

Behavioral Antecedents and Consequences

Jackson experiences the urge to correct others when he believes they are providing misinformation. The urge is an aversive state and is reduced by correction. Thus, his "correcting behavior" is negatively reinforced. Social interactions are unsettling and anxiety-producing. Avoidance relieves this unpleasant emotional state and so is also conditioned by negative reinforcement. His retreat into solitary, self-absorbed, narrow interests is pleasurable, giving Jackson a sense of control.

Provisional Formulation

Jackson is a boy experiencing significant anxiety as well as difficulties with social interactions. His peer relationships are compromised by his egocentricity and rigid adherence to personal imperatives. He is governed by a core set of principles reflected by the sense that "I must be right and in control to have any chance of approval and success in an unfamiliar, foreign, and confusing world where people will never accept or approve of me."

Anticipated Treatment Plan

1. In order to address Jackson's interpersonal difficulties, social skills training should be initiated (see Chapters 8 and 14).
2. Cognitive restructuring should be directed at Jackson's overvalued sense of control and perfectionism (see Chapters 8, 12, and 14).
3. Jackson should acquire various frustration and distress tolerance skills (see Chapters 8, 11, 12, 13, and 14).

Expected Obstacles

1. Self-monitoring will likely be difficult for Jackson. Jackson will need multiple cues and help from his parents to complete homework assignments.
2. Jackson is a very concrete thinker so abstract tasks will need to be simplified.
3. Due to Jackson's concreteness, all interventions should have an experiential, here-and-now emphasis with a focus on developing productive action strategies.

Conclusion

Case conceptualization brings together the processes and procedures outlined in the following chapters. Each case is unique; the clinical application of the general techniques described must appreciate this uniqueness. By emphasizing case conceptualization, you avoid a "one-size-fits-all" clinical mentality. When you get stuck with your cases, refer back to this chapter and allow yourself to reconceptualize, redesign, and ultimately refresh your therapeutic work.

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