Case Studies in Individual Treatment and Assessment

When adults contemplate childhood, they often imagine an idyllic time of innocence and exploration. Unfortunately, for many children, life is fraught with stress. Biological and environmental factors contribute to the development of mental disorders in children, and many young people must struggle to achieve the developmental tasks that lead to a healthy life. It is crucial for mental health professionals from all disciplines to consider the common disorders affecting children.

According to the New Freedom Commission on Mental Health (2003), one in five children has a diagnosable mental disorder, and 1 in 10 young people experiences sufficient problems related to mental health that impact home, school, or community functioning. The National Institute of Mental Health (2013) notes that anxiety is among the most common mental health disorders in children and adolescents, with approximately 8 percent of young people affected. Attention-deficit hyperactivity disorder (ADHD) is another one of the most common reasons that children are referred for mental health services, and it is estimated by parent report that 10 percent of
children have received a diagnosis of ADHD (Centers for Disease Control and Prevention, 2010). Depression becomes more of an issue as children grow into adolescents. According to the New Freedom Commission on Mental Health (2003), depression affects as many as 1 in every 33 children and one in eight adolescents. Eating disorders, while not as prevalent, affect an inordinate percentage of teenage girls. An estimated 2.7 percent of female adolescents have an eating disorder (National Institute of Mental Health, 2010), but approximately 50 percent of teen girls express negative emotions about body image (Littleton & Ollendick, 2003). Roughly the same percentage of early-adolescent girls are dieting at any given time (Neumark-Sztainer & Hannan, 2000).

The statistics clearly indicate that children in our society are not living the carefree existence that we would like to imagine. And yet few texts concentrate on treatment of children’s mental disorders. When we treat children for physical ailments such as fever, we often use smaller amounts of the same medicine administered to adults. In children’s mental health, however, there is no downsizing of doses. Instead, practitioners must approach treatment with a very different perspective. A child’s unique physical, developmental, gender, social, and environmental factors must be considered carefully prior to and throughout the treatment process. It seems clear that all practitioners, whether they specialize in work with youth or with the broader population, must become acquainted with the common disorders of childhood and methods of helping young clients and their families.

The seven case studies in this chapter focus on individual assessment and treatment of common disorders in childhood and adolescence. Clearly, family plays a major role in childhood treatment, but this section primarily focuses on the child or adolescent developmental aspects of assessment and treatment as they overlap with family issues. Family-specific therapies are described in Section III.

In the first case study, Bogas relates the tale of a young boy with ADHD. The author describes the important processes of establishing rapport with the child, engaging and maintaining parental involvement in treatment, and working as part of a treatment team. Because of the practitioner’s extended treatment relationship with the family, we are privileged to follow the boy and his family’s progression in dealing with ADHD from childhood to young adulthood. In the second case study, Corcoran guides the family of a boy with behavioral problems through solution-focused therapy. She
clearly describes and demonstrates techniques such as identifying resources through the use of exceptions, using the miracle question, and employing scaling questions. The next case study paints a picture of a depressed African American adolescent girl. Gibbs describes the importance of considering the client's developmental stage, environmental issues, and sociocultural issues from the very beginning of the case and shares her insights about exploring the client as a person rather than as a problem.

The next four case studies focus on developmental issues in individual treatment in a variety of treatment settings. Crowley describes the treatment of a young man dealing with developmental life changes through a brief cognitive-behavioral therapy model. She discusses the role of the clinician in working from a strengths perspective and allowing the client's assets and needs to guide the treatment. Next, Sacco, Bright, and Springer provide an encounter with a young woman's beginning involvement with the juvenile justice system as a result of her marijuana use. They describe a staggered treatment approach using motivational interviewing and then cognitive-behavioral therapy to address her stage of awareness about her substance use. Next, Leibowitz and Robinson capture the complexity of working with a sexually abusive youth through a developmental understanding of his treatment needs. By conducting a thorough and ongoing developmental assessment of risk and protective factors, the therapists are better equipped to make empirically supported treatment decisions. Finally, Glick describes the use of motivational interviewing and cognitive-behavioral therapy in the treatment of a young man living in residential treatment. He describes the challenges of mandatory treatment and strategies that can engage a young person, in addition to those that will be more likely to push him or her away.

Each of these cases provides a window into the world of the practitioner and demonstrates the unique manifestations of common disorders of childhood, and subsequent assessment and treatment considerations. The emphasis on treating the individual child and the techniques that the practitioners employ to gain the trust and cooperation of their young clients merit special attention. These stories ring true because they are true (or composite) pictures of children's and adolescent's lives. Students and practicing professionals alike may profit from the glimpse into the treatment of these clients who experience some common disorders of childhood and adolescence.
REFERENCES


CASE STUDY 1-1 FROM CHILDHOOD TO YOUNG ADULTHOOD WITH ADHD

Susan Bogas

Working with a child diagnosed with ADHD involves treatment in the context of the family, with all the challenges and strengths that exist in a family system. This case highlights the developmental trajectory of ADHD and the flexibility required by the therapist in a unique portrayal of assessment and treatment progression from Nate’s childhood to young adulthood using a combination of structural family therapy and parenting techniques.

Questions for Discussion

1. How does the practitioner establish rapport with the youth with ADHD during the first session? Why does she delay gathering background information during the first session?
2. Why is it important for the parents to provide tight external controls for the client in this case study?
3. What is the length of the therapeutic relationship in this case study? Why? Could or should it be any different?
4. Why does the practitioner explore each parent’s childhood with them? How does that knowledge contribute to the treatment?
5. What is the important factor in finding a treatment team to work with a child with ADHD?
6. What was important about Nate’s parents coming to view art as “elemental to who Nate was”?
7. What was different about Nate’s experience of ADHD in childhood versus adulthood?

Nate, age 7, could not find his favorite army men. Ellen, his mother, told him to look in his closet. Like a wild creature springing from nowhere and without taking a step toward the closet, Nate burst into a frenzied campaign. He stomped around the room, kicking the furniture and toys in his path, and screaming as loudly as he could.
Nate’s sudden escalation from calm to rage, without warning and seemingly unprovoked, was all too familiar to Ron and Ellen, Nate’s parents. They did not know what made him react to an ordinary situation with such fury, and they could not predict when, and over what, an explosion would occur. They had learned, however, that there would be another incident and that there was no reasoning with Nate during such incidents. “When Nate is angry,” Ellen explained, “it’s as if he were possessed. His emotions come out very fast. He ‘spews’ . . . and has to go to his room to calm down, to regain control. He then comes down and feels remorseful.”

This was a typical event in the Barclay household at the time when Nate’s parents brought him to therapy. They were baffled by their third child’s total inability to tolerate frustration, to be patient, and to cope with the routines and challenges of daily life. The point had come when they knew they needed help.

I had known this family, which included three boys (John, 18; Peter, 15; and Nate, 7), for more than five years. I treated their oldest son for procrastination (which turned out to be ADHD), their next son for adolescent social issues, and the couple for marital issues. Ron, a tall, thin businessman, combines a curious, incisive mind with a fierce task-oriented mentality. Ellen, a stay-at-home mom, is bright, outgoing, and energetic. She has a gift for words and great warmth and humor.

Ellen read widely about attention problems in relation to her first son and began to be concerned about Nate when he was in kindergarten. Nate was always in motion. He asked to listen to storytime from under his desk. In first grade, he was in trouble a lot. At the end of first grade, the Barclays took Nate to a specially trained pediatrician, who administered a “neurodevelopmental” evaluation (developed by Mel Levine, M.D., an expert in attention and learning problems). The pediatrician diagnosed Nate with attention-deficit hyperactivity disorder (ADHD), but found no significant learning deficits, such as problems with memory, language, higher-order thinking, motor skills, or social ability.

**FIRST SESSION**

There was no hint of negativity or defiance in Nate at the first therapy session in my office. I didn’t even detect fidgetiness. Nate was tall, blond, and cute. He looked a bit wide-eyed and serious, as if he anticipated hearing a lot about how bad he was. As I chatted with him, asking about his friends and what they liked to do, he relaxed and told me that he loved playing with boys in his
neighborhood, especially on his trampoline. Once I sensed he was comfortable, I offered Nate the option of drawing at a table in a corner of my office. It was time to hear his parents’ concerns. I wanted to allow Nate to listen and to participate in the discussion, but also to have some distance from us. He made a beeline for the table, took a chair facing the wall, and began to draw.

Ron and Ellen talked about two key problems with which they struggled daily. First, Nate refused to sleep in his own room. Afraid to be alone, he slept downstairs where his parents were early in the evening and, later, beside their bed. They had no time for themselves. Second, he was extremely uncooperative. He opposed absolutely everything, refused to perform his routines and responsibilities, and defied directions and suggestions. His answer to everything was an emphatic and instant “No!”

Ellen, who handled Nate’s daily behavior, was at her “wits’ end.” Her stress was palpable. I decided to delay gathering background information or going over the evaluation they brought with them—steps I might have taken if the immediate situation was not so pressing. The priority was to deal in a practical way with the problems at hand. We turned to problem solving, leaving for later discussion the more theoretical questions about Nate’s ADHD, its etiology, and his particular nature. For the first session, my goal was to develop a map, or a structured plan, for each of the two presenting problems to be carried out by the family at home.

Nate had said earlier that he feared sleeping alone in his own room because someone could come in the window and “something bad will happen.” I asked Nate, who was busy drawing monster and animal-like figures with big teeth, what he thought about this. He said he was embarrassed about it. His two friends slept in their own rooms, although with brothers, and he would really like to sleep in his room. I was impressed by his candor and glad to hear he was motivated to change. I suggested an interim plan. Instead of Nate falling asleep in the same room as his parents, he would fall asleep in the next room. Nate would be in the dining room, with his parents in the kitchen. Each night that he complied, he would receive a small daily reward. If this was successful, then Nate would gradually move to falling asleep in his own room. Ron proposed moving Nate’s bed away from the window and closer to the door to allay his fears of someone coming in the window. He also proposed the ultimate “carrot”: When Nate was able to sleep most nights in his own room, he would be given an allowance, something he wanted very much because he associated it with his older brothers.
On the second issue, Ellen gave an example of Nate’s opposition to almost anything she asked him. “If I ask, ‘What do you want for breakfast? Pancakes?’ Nate’s typical response is ‘No.’ I try again. ‘Cereal?’ ‘No!’ ‘Waffle?’ ‘No!’ Finally, Nate will announce: ‘I want pancakes! Pancakes!’” Such interactions went on all the time and left Ellen worn out and exasperated.

Explaining further, Ellen astutely observed that her own disciplinary style was that of a negotiator. She operated with a win/win approach to situations. She knew that it did not come naturally to her to be firm, to draw the line, or to lay down the directives in black-and-white terms. Ron, by contrast, noted that he was firm and tough. However, he acknowledged that he became angry quickly and exploded when Nate did not comply.

To me, it was clear that the family’s authority system needed to be organized and tightened in order for Nate to develop better internal controls. Ellen and Ron had to learn to operate from a policy rather than reacting to their son’s behavior, either with appeasement or anger. I introduced them to the basics of setting limits and delivering consequences. My intervention, a combination of structural family therapy developed by Salvador Minuchin, Braulio Montalvo, and Jay Haley and the theories found in 1-2-3 Magic, a book by Thomas Phelan (1996), went like this:

The child has two choices—comply with the request or take the consequence. Lack of cooperation (refusing to make a choice) leads to a consequence. Devise ready-to-use short- and long-term lists of consequences.

Do not engage in conversation when setting limits (actions—such as losing a play date, going to his room, or suffering an “electrical black-out”—speak louder than words). Noncompliance with the direction or the consequences results in a time-out.

As I laid out the principles, Ellen recognized the difference between her approach to Nate’s behavior and what I was advocating. Her approach amounted to appeasement, and she needed to be an authority figure. Ellen said she thought that if she negotiated so that Nate got something he wanted and she got the behavior she wanted from him, then he would be motivated to cooperate. I explained to Ellen and Ron that the reason Nate needed an authority figure was that because of his ADHD with impulsivity and hyperactivity, he lacked the inner controls to contain his own behavior. He needed
Ellen, as his primary caretaker, and Ron to provide tight external controls so that he could (a) learn to function responsibly and (b) gradually develop stronger inner controls himself.

The other issue I stressed was that parents must become a team. Together they must learn the skills of conflict resolution; that is, how to compromise and come to an agreement about their policy toward Nate. I emphasized the following: Expectations and consequences for Nate must be clear and precise, and the presentation of these expectations is to be in a visual mode (preferably a chart, with pictures).

From our previous work together, I knew that this couple had a strong commitment to each other and to their children. I also knew there were some difficulties and disagreements between Ron and Ellen that would emerge and have to be dealt with if they were to make headway. I closed our first session with a warning intended to focus them on whether they, as parents, were presenting Nate with one message or two different messages. “If you two are not absolutely clear, meaning that you deliver one airtight message, and then absolutely consistent in setting expectations and carrying through on consequences, there will be no change.”

**TWO MONTHS LATER: ELLEN AT THE BREAKING POINT**

The next session excluded Nate in order to allow Ellen and Ron to speak candidly and at length about their concerns. Nate had responded somewhat to the structures related to sleep. He was beginning to sleep in his own room and to earn an allowance. However, he did backslide sometimes, and the issue was by no means solved. Nevertheless, the Barclays were pleased and relieved because following the step-by-step plan showed them that Nate could make progress if they provided him with appropriate structure. Nate was proud to join his brothers in earning an allowance, and the Barclays now had some time for themselves in the evening.

Ellen, however, continued to be extremely upset over Nate’s opposition to anything she asked him to do and the verbal attacks that followed. Tears overcame her as she described the ongoing obstacles that Nate presented to her every statement, request, or direction: “I hate you!” “You’re mean!” “You’re stupid!” “I wish you weren’t my mother!” “I hate this family!” “I hate my life!” These were just some of the things he had said to her. With a mixture of desperation and sadness, Ellen said, “He doesn't like me. He doesn't want to be around me.
Nothing I do works.” I felt the gravity of the situation. It was time to gain some perspective by gathering background information on Nate and on Ellen.

In Nate’s early history, there were extreme patterns. As an infant and even as a newborn, he did not tolerate being in a car seat. He had difficulty sleeping. At about nine months old, he started banging his head on the crib rail, the wall, and the floor when he was frustrated. Ellen actually had put a helmet on him to keep him from hurting himself. As a young child, Nate developed a pattern of hitting himself when he was angry, as well as hitting, kicking, and throwing objects. In short, Nate “acted in” as well as “acted out.” Hearing about those early and consistent patterns of very low frustration tolerance and of angry outbursts directed either inward or outward led me to suspect that these behaviors were hardwired in Nate—that is, biologically based and not the result of environmental factors such as quality of mothering or family dynamics. (It is, of course, impossible to completely sort out these nature versus nurture issues.)

Much to Ellen’s sadness, Nate never cuddled and, unlike his brothers, he did not climb into his parent’s bed in the morning. He did not like to be hugged and kissed. “Sometimes Nate has a shocking lack of empathy. He is often mean to the cat, which he loves,” she said. Yet each parent corroborated that Nate was an extremely social kid, choosing interaction over doing anything else. “Nate must have a play date. He’s insatiable about play dates,” Ellen said. Ron chuckled as he described how he would say to Nate: “C’mon, Nate, let’s go take out the garbage!” and Nate would enthusiastically accompany him. Nate indeed embodied an interesting mix of traits.

I explored Ellen’s history in a pointed way. I was searching for themes of conflict in her early life that related to what she was struggling with now. This is not to suggest that I doubted the reality of Nate’s outrageous behavior or how incredibly difficult the behavior was for Ellen to address. I intuited, however, that something else was operating here and that its roots were in Ellen’s past. I sought to identify times in Ellen’s experience when she felt inadequate to address a challenge and to determine whether Nate was evoking those same feelings in her.

**ELLEN**

Ellen was the third of three children. Bright, kind, and cheerful, she was viewed by her parents as the easy one, and she felt loved and cherished by both. Her brother, Rob, was eight years her senior and had learning
disabilities. Her sister, Carol, was five years older and had a difficult character—moody, angry, and demanding. Ellen, ever optimistic, constantly tried to win the affection of her big sister, but Carol was either mean to Ellen or dismissive of her. When Carol was unhappy, she often blamed Ellen. Ellen’s failure to get through to her sister left her with underlying feelings of loneliness and guilt.

When Ellen was 15, the sudden death of her father left her sad and aware of the precariousness of life. From this information, Ellen and I derived two key themes in her behavior. First, Ellen believed in the goodness of people. Second, she believed that she could get through to anyone if she just tried hard enough. The relationship with her sister reinforced in Ellen, as an adult, the tendency to assume the entire responsibility (and blame) for how a relationship was working and whether the other individual—her husband, son, or someone else—was pleased or displeased. She was left very vulnerable to feelings of blame, rejection, and abandonment.

Turning to the situation at hand, I asked Ellen to describe in detail how she was handling Nate and what methods she was using to get through a day with him. Her description revealed the enormous effort she was making to ensure that things worked for him. She was his coach, short-order cook, tutor, and cheerleader all wrapped in one. She prepared him for challenging situations, praised any product or sign of effort he made, structured tasks to be followed by fun activities, and, in general, made the things Nate found difficult or boring as palatable as possible. In one sense, this was excellent mothering—committed, creative, flexible, and loving—but it clearly was not effective. Nate’s anger was not contained. Ellen felt hurt, rejected, and burned out. Ron was deeply concerned about Nate’s continuously outrageous behavior and about Ellen’s growing despair, especially because he was frequently away on business.

Due to time constraints, I cut to the chase, focusing on Ellen’s immediate need for help. It was apparent that Ellen was failing to draw a line that Nate could not cross. She was allowing Nate to control the situation. I told her she needed to move in and set a limit at the moment his negativity began. I pointed out to her that, contrary to the situation with her sister, in which she had been little and could not take charge, here she was the adult, and she could take charge. I emphasized that she must learn to hold her ground and become a strong authority figure, firm and non-negotiating on the things Nate was required to do. As long as Nate perceived any possibility of getting
his way, he would not have to muster the internal controls necessary to comply with her expectations. If he sensed that she was trying to accommodate him, he would act out of his base instincts rather than exercise control. I went over the how-tos of setting limits and consequences, which I had laid out in the previous sessions.

A YEAR LATER

When I next met with Nate, Ron, and Ellen, Nate was 8 years old and repeating second grade because his parents felt he would profit emotionally and academically from the extra year. We began by discussing his academic progress. Ellen praised Nate’s teacher, Mrs. Turner, who combined firmness and structure with a real understanding of what Nate was struggling with. To discharge his excess energy, she allowed him to stand up during “quiet time,” when singing, and to deliver messages to the office. Academically, Nate was having some difficulty with reading and could not grasp mathematical concepts such as telling time or counting money. He basically did not “get” games. As the semester progressed, Mrs. Turner suggested that Nate needed more help, so the Barclays returned to the pediatrician who had first evaluated him. Based on the earlier diagnosis of ADHD, Nate was placed on a trial of Ritalin, a stimulant medication commonly used for ADHD. His parents and teacher immediately saw “a different child”—one who was calm, able to sustain his focus, and able to do his work. He stopped calling out and fooling around in the classroom and was able to control himself in the library. Mrs. Turner said that, for the first time, she saw Nate as able to be a “member of the team rather than captain.” Nate had previously demonstrated a pattern of being bossy with children his age.

Next we addressed Nate’s at-home behavior. “He’s negative, mean, and utterly insatiable, and he says ‘no’ to everything!” Ellen reported. She went on to say that she had become more structured and firm in setting limits and was not appeasing him as she had been. She was careful to make sure that pleasurable activities and rewards followed—but did not precede—Nate’s carrying through on responsibilities. Despite these efforts, the level of Nate’s hostility and opposition was still so intense that things felt very out of control to Ellen. However, she had found one method to stop Nate in his tracks. She called this her “drill sergeant” mode. Uncharacteristically,
she would speak to him in a loud and menacing tone of voice and say something mean, such as “your brother never did that,” which would upset Nate greatly. Although she said it went against her nature to be so mean, at present it was absolutely the only thing that made Nate stop being oppositional. While I did not view this method as functional for the long term, I did not intervene here because I saw Ellen as “in process” toward becoming a stronger authority figure. At this stage, she was finding, perhaps for the first time in her life, her own aggression, which she needed to access in order to stand up to her son’s aggression.

Nate was quite talkative when he joined us. After he told me that school was going well, I inquired about home life. “I worry that I shout too much. I’m going to grow up like pop,” Nate said, referring to Ron’s father, who was not well liked. Nate also admitted to being mean to his friends. I was again impressed by Nate’s candor and his ability to observe and show concern regarding his own behavior. He was maturing and developing self-awareness, and he was not identified with his angry behavior, which is to say he had not taken on the identity of an angry boy. I viewed this as a positive sign of emotional growth.

Our discussion for the remainder of the hour centered on several difficult topics and was open, honest, and nonjudgmental, although it was clear that Ron and Ellen were concerned about their son. Ellen brought up her discomfort with Nate’s play, which involved “never-ending death and destruction: traps, weapons, killing, spikes, war ships, and knives.” Ron, however, wondered whether Nate’s aggressive drawings and play might be helping him to deal with his own aggression. Ellen added that while Nate was well liked by his peers, he had a close buddy in school with whom he got into trouble for things such as laughing at a child who gave a wrong answer, keeping children out of a game, and other mean behaviors. I ended the session by having Ron and Ellen discuss (in front of Nate) the message that they wanted to give him about his mean behavior in school. Then, I asked them to discuss the subject with Nate. They took a clear stand: “Mean behavior toward kids in school is not appropriate, and we will not tolerate it! If and when it occurs, you will be given a very stiff consequence.”

Nate’s explosiveness continued over the next year, despite Ellen and Ron’s serious efforts to tighten their at-home structures. He exploded when he was asked to do things, when he was told he must go somewhere, and even with friends when he did not get his own way. Persistence of the problem led
Ellen, Ron, and me to develop even more airtight strategies, which included the following:

- **Minimizing spontaneous requests to Nate** (anticipate what is ahead for him, and schedule all responsibilities into the routine)
- **Scheduling his after-school obligations in detail** (violating 30 minutes, reading 30 minutes, homework 20 to 30 minutes; then, if everything is complete, he can play with friends)
- **No spontaneous buying** (in order to buy anything over $15, Nate must wait two weeks [with the request written and dated]; state “no buying” whenever leaving the house; and no spontaneous trips to McDonald’s)

Structure, structure, and more structure was the operating principle.

As the year progressed (Nate was now 9 years old), Ellen was being clear, straightforward, firm, and sometimes “furious” in her approach to Nate. She had learned to allow no deviation from the plans, schedules, and routines. “I sometimes grab him and make him look me in the eye. Then I tell him what I expect him to do.” She was, in short, giving Nate less space to act out his anger, and he was responding with somewhat better control, but there was still a long way to go.

**RON**

For a long time after Nate was diagnosed with ADHD, Ron did not accept the diagnosis. Thus, his approach to the situation was ambivalent. On the one hand, he learned about ADHD, especially through attending workshops with Ellen. In therapy, he worked with Ellen on strategies and limit setting. On the other hand, when Nate attempted to negotiate every direction or had a meltdown over something small, Ron became impatient and angry. He often exploded. Underlying Ron’s inappropriate reactions to Nate’s behavior was the belief that Nate could do it (if he really wanted to). Ron judged Nate as average “compared to what a child should be able to do in our household,” and he conveyed that to Ellen. He was disappointed in Nate for traits such as having to be first, refusing to share, showing limited curiosity, and making everything a struggle. What in Ron’s history contributed to his resistance to accepting Nate’s diagnosis and his rigid, judgmental approach to Nate?
“You are as good as your performance!” was the paradigm that Ron learned at an early age from his father. With a hint of sarcasm, he reported that he was a model son: “the best boy, the best scout, the best student.” Nevertheless, he felt absolutely no support for his accomplishments, nor acknowledgment from either parent that he had done well. His face registered pain when he admitted that he did not feel his parents took pride in him. He remembered, with sadness, his father pointing out things he admired in other people.

Ron was able to link his parents’ emotional coldness with certain aspects of himself. He noted, “I did not learn to give myself credit. I had no well-developed sense of self-respect and not much empathy.” The lack of support he experienced left him with significant feelings of inferiority. The result of these parental messages was an interesting mix of behaviors: Ron was a very hard worker, task oriented, and focused on accomplishment. He could also be a ruthless taskmaster who was devoid of empathy and compassion. His attitude in relation to his sons, all of them, was: “If I could do it (be a hard worker, oriented to tasks and accomplishment), then so can they.”

**NATE AS A PREADOLESCENT**

Beginning in mid-winter, when Nate was 10 1/2, the Barclays had a series of sessions spread over a year. Tremendous growth took place that year. In general, Ron and Ellen described Nate as developing better inner controls. He accepted the structures of the household and his own routines, although he did not do his after-school work without prompting. When he got angry, Nate would often comply with Ron or Ellen’s direction to take the industrial-strength bat and go hit the tree in the backyard or to jump on the trampoline. Nate was beginning to participate actively in his own recovery from anger. Instead of relentless arguing, begging, and manipulating to change the rules as he used to do, Nate was also learning to negotiate in an appropriate way. For example, “Rob is available to play. Can I practice 20 minutes instead of 30? I’m negotiating, mom.”

Nate continued to have serious episodes of opposition and rage, although they occurred less frequently. On one snow day, he was impossible all day. He refused to do two tasks that Ellen asked of him—read for 20 minutes and practice viola for 30 minutes. At the end of the day, Ellen broke down, sobbing. Then Nate calmed down and stopped being hostile. On another day,
Ron repeatedly told Nate to get ready for church: over and over Nate refused. Ron “bellowed.” Nate was shaken and complied. Ron cried.

During this period, when Nate was 11, something very significant happened. Ron stopped traveling and began to work from home. Having been away five days a week, now he was home all the time. This change in the family routine was central to what followed. Ron was happy to be at home and delighted to have the opportunity to improve his relationship with Nate. He had a growing awareness that his older sons viewed him as critical more than supportive. He was very unhappy about this and wanted a chance to “do it right this time.” Specifically, he wanted to move from taskmaster to a warmer, more supportive father-son relationship with Nate. However, he did not know how to reconcile this desire with his deeply internalized performance expectations.

As Ron spent time at home, his annoyance and impatience with Nate grew. He frequently exploded. Ellen and Ron argued about managing Nate. Gradually, it became clear that Ron resented Nate. He was mad at Nate. For what? For being flawed. For not being as right as his brothers. In Ron’s eyes, Nate was an underachiever (previously, Ron had the same belief about each of his other sons).

Being task oriented and a “doer,” Ron took the initiative to have Nate tested again. Ron wanted to be satisfied that he and Ellen had done everything possible to help Nate. He was also motivated by a desire not to do “mental combat” with Nate on homework for the rest of Nate’s time at home. This time Nate would be evaluated by a school psychologist for IQ (“to see what was under the hood”) and to clarify his learning weaknesses. The results indicated that Nate scored in the “high average” range. He achieved a “superior” score in verbal functioning and a “high average” score in perceptual motor skills. The evaluator found that because of Nate’s “attentional inefficiency” and impulsivity, he performed best in a highly structured situation. This validated the work Ron and Ellen were doing with him. Ron was pleased with the results; Ellen was not surprised. A turning point had been reached.

Ron’s view of Nate began to shift. He started to perceive Nate as capable rather than incapable. He struggled not to get so mad at Nate when he worked with him. He became Nate’s advocate rather than his critic. He spent time with Nate on both homework and fun activities. He was finally a true partner with Ellen in providing Nate with a solid foundation of support, along with tight structures and firm limits. Ron was fully on board regarding the parenting of Nate.
MEDICATION

Since Nate was 7 years old, when his second-grade teacher discretely suggested that medication might be helpful, he has been on one of the three most commonly used stimulant medications: Ritalin, Adderol, or Dexedrine. Early on, he only took medication for school. Later, Ellen learned that Nate dealt much better with his after-school responsibilities if he had a small dose at that time as well.

One might think that with the intensity and persistence of Nate’s anger and explosiveness, the family would have pressed for more treatment through medication. Actually, Ron attributes the fact that Nate was minimally medicated to Ellen’s tireless work with him. I agree and add that Ellen and Ron each confronted a core personality issue and, through doing so, expanded their capabilities to deal with Nate and with each other in constructive ways. The work that each one did had a powerful and very positive effect on Nate and his ability to make progress.

WHERE IS NATE AT AGE 13?

Perhaps the most compelling statement of where Nate was at age 13 was made by his father in my office in October 2001:

I continue to be impressed, astonished, at how, with patience and structure, modeling, explaining, trying not to get mad, he has been able to improve his own behaviors, which include responsibilities around the house, and his academics and music. He is at a point where he accepts his responsibilities. He is able to submit himself to the applied disciplines. An example of how far he has come is reflected in something he said to me recently: “Dad, would you help me get up early tomorrow because I didn’t get my reading done?” And he does it!

Does Nate take “no” for an answer these days? Ellen says he is still resistant and pushes back. She stated that they still must draw the line and be somewhat harsh at times, but “nothing like the old days.” And as for meltdowns, Ellen reported that what Nate has is an “instant flash” or “anger surge” that appears to be physical, lasts two or three seconds, and may involve “a door banging and a shoe (going) across the room.” Ellen feels that, even while it is going on, Nate knows that he should not be doing it. She even suspects that it’s not all right with him.
THE TREATMENT TEAM

Ron and Ellen handpicked their treatment team over the years, a “team without walls.” They feel that the team was, and is, essential to their progress. The team included the following people:

- Pediatrician (evaluation and medication)
- Family therapist (author)
- Teachers (especially Nate’s second-grade teacher)
- School psychologist (evaluation)
- Tutor (organizational and study skills)

An important factor in creating a team is finding professionals who share a common understanding of the problems as well as a desire to support the child and parents through various stages and challenges. Ron and Ellen used their team as needed. The team never met as a whole, although the pediatrician and I (the family therapist) shared information from time to time. Ellen feels that Mrs. Turner, Nate’s second-grade teacher, was an extremely valuable member of the team, because she had a powerful effect on his self-image. Having had a first-grade teacher who viewed him as misbehaving and made him spend a lot of time “on the mat,” Mrs. Turner’s appreciation of Nate changed his self-image from “bad and stupid” to “charming and capable.” In contrast to many other situations with a child who has behavior problems, however, I was not involved with Nate’s teachers, because his grades were mostly As and Bs, and his behavior problems were managed adequately by the teachers (with the cooperation of Ellen and Ron).

TREATMENT SUMMARY

Ellen and Ron embodied an interesting and powerful combination of strengths that served them extremely well during this course of treatment with Nate. They were committed to each other and to Nate. They had high expectations of improving things within their family. Ellen had high expectations (Ron was not as sure on this one) of getting through to Nate so that he could function responsibly and on a level close to his potential. Ron and Ellen took an active role in the therapeutic process, doing their homework, bringing in notes on incidents at home, reading
about various issues, and generating their own ideas and strategies. They were able to be introspective; that is, to look at themselves individually and as a couple and to open their minds to what they were feeling or doing that was not constructive or was even destructive. They worked extremely hard, and once they began, they trusted the process, and they trusted me as their guide.

The lesson for me here is that because the Barclays accomplished so much, they are an example of what it is possible to achieve. My concept of the changes that are attainable with a child who has serious behavior problems has expanded significantly. The consequence of this is that with other families, I will be stronger in communicating both a clear vision of what they can potentially accomplish and just what they have to do to achieve those ends. This is a significant contribution to my work.

There is another way that I have been impacted by the Barclays’ work. They demonstrated how parental intervention, when skillfully implemented, can shape very difficult, and probably biologically based, behavior. Having worked for 20 years with children who have biologically based problems and their families, I have generally observed and come to assume that serious symptoms often require a combination of medications. (I will note that at one point in the treatment, at my suggestion, Nate had a brief trial of Catapres, an antihypotensive medication sometimes used with ADHD and serious behavior problems. This medication was stopped because it took away Nate’s charm and ability to tell jokes.) It is to Ellen and Ron’s credit that Nate has been rather minimally medicated.

Families such as the Barclays teach therapists what is possible in the realm of changing human behavior and experience. As the Barclays gained from my skills and support, I gained from their ability to sustain their efforts until they were achieving what they desired.

**ELEVEN YEARS LATER**

**Recap**

In 2001, after several years of intensive family therapy, as well as many medical and educational interventions, Nate was showing clear signs of growth. Now 13 years old, he was taking significantly more responsibility for himself at home with both his schoolwork and his music. (In this family, each child is required to play a musical instrument.) Nate was still very
ADHD—distracted, disorganized, and having difficulty sustaining attention when he was not interested. His academics were most affected. Nevertheless, meltdowns and rages were fewer and typically lasted only a few minutes or seconds as compared with hours in the past! He was on daily medication, a stimulant, which helped him. Overall, Nate was showing more ability to self-regulate. His parents, Ellen and Ron, had learned to unite their management strategies and were confident they were on the right path. They decided to terminate family therapy.

A Teen Without a Direction

The rest of this story is an interesting one. As Nate progressed through middle school, academics became increasingly difficult for him. In eighth grade, it was apparent that Nate, according to Ellen, was “seriously challenged academically.” While Nate, as always, had friends and an active social life, he had very little motivation at school and no real engagement with his studies. Ron and Ellen realized they had to help Nate find a direction so he could make the best possible decisions about his life after high school.

When Ron and Ellen asked themselves the question, “What is Nate’s thing?”, they knew the answer instantly. From the time he could hold a pencil, Nate had been drawing. He drew everywhere: on his hands, arms, clothes, shoes, any surface he could find. Drawing got him through church, his brothers’ concerts, and anything where he was required to sit quietly. Nate’s special thing was art. Ron and Ellen saw him as someone who thought outside the box and was continuously and intensely engaged in drawing and making things.

For Ron and Ellen, the prospect of nurturing an artist was an entirely new direction. Their other two sons had taken more traditional paths. In college, one majored in business and the other in computer science. Opening their minds to the idea that their youngest son might be destined for a life in some aspect of the art world was a turning point in their parenting of Nate. They began to view art as elemental to who Nate was. And, with this important shift, they began to look for ways they could support Nate’s self-development by supporting his art. They had a direction and focus that felt right to them and could lead Nate to develop a clear sense of his identity, his strengths, and who he was internally and in the world.
Art as Focus

The first benefit from this shift in thinking was that Ron and Ellen agreed to let Nate take an art class every semester. This soon amounted to course overload, so they reluctantly decided to let Nate drop his foreign language course and maintain art in his schedule from then on. This was an important step in their efforts to support whatever would provide the best outcome for Nate.

As often happens with teenagers with ADHD, Nate refused to continue taking his medication. He had complained about taking the medication in elementary school (“it takes away my funny”), but now, squarely in adolescence, he decided he was “finished with meds,” that he hated them and the way they made him feel (“like an automaton”). His parents agreed, but said that if his grades began to fall, they would insist he take medication again. They backed him up with tutors, many tutors, and an especially strong one for math. Ellen also asked the tutors to work with Nate on study skills and project management in addition to subject content, because he would no longer accept this kind of help from his mother!

Still, Nate routinely lost things, forgot things, missed deadlines, and misplaced everything. Punishment and resulting negative consequences did nothing to improve the situation, so Ellen and Ron, in the spirit of “we need to help this boy just get through high school,” decided to become more proactive and more positive in their approach to helping Nate. When he left homework (or his viola or soccer gear) at home, they took turns getting things to school; at home, they worked together on problem-solving strategies with Nate, rather than letting him struggle and fail. They wanted Nate to feel that they were all on the same side of the table, solving problems together rather than being adversaries.

As they had learned with their first two sons, Ellen and Ron knew summer was an ideal time to further special interests, so they began to search for serious art programs for Nate. However, before letting him sign up for an intensive summer art program—a privilege that would require a good deal of independence and responsibility—they decided Nate needed some different lessons. During ninth grade, he had developed a rather negative, contentious attitude at home. When he became frustrated, which was often, his disrespect to his parents, especially his mother, was extreme and unacceptable. His organizational skills were not getting any better either.

So, in the summer after ninth grade, Nate’s parents enrolled him in a 35-day program with the National Outdoor Leadership School (NOLS), a nonprofit
program that focuses on environmental ethics, outdoor skills, and leadership training. To make it more attractive to Nate, they convinced the parents of his best friend to enroll their son as well. Together, the two headed west to the Grand Tetons. They trekked and camped in the mountains, and they participated in experiences such as “leave no trace” camping, where the group had to leave the site exactly as it had been found, showing respect for the environment, self-discipline, and responsible group participation. A highlight for Nate was leading a small group on a 24-hour wilderness expedition. Both boys returned with a more mature—and respectful—to the delight of their parents!

Following NOLS, the boys attended another national program, this one focusing on study skills and academic strategies, called SuperCamp. The three-week program, held on a college campus, helps teens develop personal strengths (communication strategies, unique abilities, goal setting, problem solving, conflict resolution, and so on) and ways to achieve academic success (study skills, time management, test-taking strategies, etc.). SuperCamp was an intense group experience, which required equally intense individual effort, but it was also fun. “It worked!” Ellen said, with a mixture of joy and relief. “Those two programs took that surly adolescent attitude right out of him!”

The 10th grade was a turning point for Nate. He got involved in the school’s art gallery (eventually becoming president of the gallery his senior year) and became more serious about his art. Ron and Ellen felt he was ready for an experience in the art world beyond the confines of school, so the following summer they enrolled him in an intensive studio art program at a New England prep school. He was in heaven! The program introduced him to a wide variety of studio art experiences—live model drawing, print making, sculpture, welding, the study of color—and confirmed his interest in, and commitment to, the serious study of art.

Nate’s high school years continued to be challenging and stressful, although he took increasing responsibility for what he had to accomplish. He still had angry outbursts when he got frustrated, and he still pushed back when given direction by one or the other parent, but, in contrast with the past, he basically did what he had to do. Ron and Ellen continued to partner with tutors and, as college became imminent, with an SAT coach and a college counselor, who helped them select the best matches for Nate. As Ron puts it: “We had Nate’s back!”

The summer after junior year, Nate went to the Rhode Island School of Design for a four-week intensive course. Students attended classes all day and
worked on their art in the studio at night. Nate’s evenings (sometimes well into the night) were spent painting and drawing, and he was in his element. He earned all As, and confirmed for himself and his parents that he was serious about pursuing a college degree in the Fine Arts.

Senior year brought the nightmare of college applications compounded by the distinct requirements of each school. Nate applied to four art schools. For each, he had to have an application and a portfolio. However, one school wanted slides, and another CDs. None used the generic online application. All of the essays were different. One school required an elaborate drawing of a bicycle, another required a self-portrait. Before submitting the carefully drawn portrait, Nate decided to show it to his former art teacher/mentor, who looked at it and told Nate it had to be redone because it had to be on white, not off-white paper. Nate drew a second self-portrait.

The process was a tremendous struggle. Nate had schoolwork to do on top of applications, and Ellen and Ron knew Nate needed their help to get the job done. It was an ordeal for all, but once again, Nate’s parents took the long view and collaborated with Nate to meet the deadlines successfully.

**Nate Is Growing Up**

All this effort paid off! Nate was accepted to three of the four schools to which he applied, and was waitlisted by the fourth. He chose to attend one of the leading art schools in the country, and he received a generous scholarship based on the quality of his portfolio.

Nate loved art school. He shared an apartment with other students but spent almost all of his time either in class or in the studio. He typically painted through the evening and into the night. The work was challenging and there was a lot of it. He struggled terribly with procrastination, and thus with meeting deadlines. Around the middle of freshman year, Nate decided to take meds again to help complete projects in a timely manner; he continued taking them as needed throughout his four years at college.

From time to time, Ellen would receive distress calls from Nate when he was overwhelmed and anxious about completing work and meeting deadlines. By then Ellen had been trained as an ADHD coach. She would go into coach mode with Nate, and together they would prioritize his assignments and work out a timeline to help him manage his substantial workload.
Nate graduated from college in May 2011 on the Dean’s List. He was immediately awarded a scholarship to do a five-week residency in an artist colony on Lake Michigan. This was a beautiful environment where creativity and the melding of genres was emphasized. Following this residency, Nate went to Myanmar (Burma), invited by a family friend who owns an art gallery in Yangon. There he painted, met young artists, and eventually taught English as a second language. After several months, in order to be able to lengthen his stay, Nate successfully figured out the logistics and took flights to Bangkok as necessary to renew his visa. All in all, Nate’s experience in Myanmar was invaluable in helping him develop independence, self-management, and life-management skills. When he arrived home after five months, his first observation was, “Wow! I still have everything I left with—my passport, my cell phone, my camera, my computer, my paintings!” Ellen described Nate’s growth during this period as a quantum leap.

After returning from Myanmar, Nate was hired for his first paid project. A Boston company involved with green energy contracted him to create a one- to two-minute stop-motion animation commercial. For the next five months, Nate spent every waking hour in his parents’ basement working. He created a lead character, a furry chipmunk, and built the set, a treehouse complete with working fireplace, chipmunk family portraits, easy chairs, and even an old record player. He shot all of the frames and spent weeks painstakingly editing. The finished product included 7,200 photographs! Nate had been fully engaged by this exciting project. Shortly after this project, Nick interviewed for a full-time animation job in NYC. He was the runner-up! He then found free-lance animation jobs; for example, one for a music video, another involving the promotion of a corporation. For almost a year he broadened his experience and strengthened his resume.

This brings us to the present. After a year of doing free-lance work, Nick was hired in NYC as a full-time animator for a major network in the social media world. Nick, who describes himself as a “fine artist turned multi-media animator,” is thrilled with his work and his life! He maintained a work schedule of 8 to 12 hours a day and delivered on deadline. Feedback from the company was very positive.

**DISCUSSION**

What can we learn from the Barclays? How did they facilitate Nate’s development from a 13-year-old middle-schooler who was angry and unmotivated
to a 24-year-old young man who knows who he is and is making meaningful strides toward a life centered on his passion? How can we apply these lessons to the treatment of children with ADHD whose families have more modest means, perspective, and resources? Finally, what are the most salient issues for the therapist to keep at the center of the treatment process? Let’s look first at some of the values and strengths Ron and Ellen showed in parenting Nate.

The significance of the role of love, and a secure attachment between parent(s) and child, cannot be overstated in raising any child, but when dealing with a difficult child who, at least some of the time, is difficult to like, it becomes critical. Parents of a child with ADHD must, with considerable support from the therapist, fight to maintain, or repair (after a destructive episode), their heart-connection with their child and his or her vulnerabilities. Remaining conscious of their child’s best qualities and abilities will sustain them as they deal with very difficult behavioral, attitudinal, and cognitive issues. Ellen and Ron learned to do this well.

When a parent–child attachment is ambivalent, or less than secure in some way, the difficulty of the treatment situation is compounded. In such cases, attention must be given to strengthening the parent–child relationship(s). On the one hand, engaging an insecurely attached parent in the process of discovering his or her child’s interests, strengths, and talents may be a natural pathway to strengthening the parent–child bond. On the other hand, an insecure attachment in a parent may signal an emotional, personality, addiction, or other problem in the individual adult. This adds significantly to the complexity of the situation. In short, the quality of the parent–child bond(s) is a central issue in the treatment.

Commitment on a number of levels—parent-to-parent, parent-to-child, and eventually child-to-self—was beautifully illustrated by the Barclay family. These parents took on and engaged with the problems their child was experiencing. This involved becoming active problem solvers within the treatment process. Love and a secure attachment are the foundation for change. A parent’s love for his or her child quite naturally leads to becoming proactive; for example, becoming educated about the problem(s), finding the appropriate professionals, and doing the very difficult emotional work of learning to detach from frustration and anger in order to turn destructive interactions into constructive ones. Nate’s story illustrates his parents’ commitment as they, again and again, were willing to do whatever it took to help their son achieve self-confidence and competence.
The story also illustrates how Nate gradually became proactive; that is, committed to himself as he applied himself passionately to one art program after another, and then to art school. Along with a deepening commitment to art, Nate was simultaneously growing more responsible and independent.

Acceptance of the nature and level of severity of the problem allows parents to immerse themselves in identifying their child’s needs and finding the right set of people to work with the child. Ron and Ellen accepted certain hard truths about Nate over time; for instance, that Nate had no interest in academics; that, despite lots of support and clever strategies, Nate’s angry outbursts and weak executive functioning persisted. By gradually accepting these and other realities, the Barclays learned to shift their perspective and travel a course that was more consciously shaped by Nate’s strengths, yet still took into account his weaknesses. Other strengths Ron and Ellen displayed included the following:

- The ability to communicate and collaborate with teachers, other educators, medical professionals and anyone they thought had a worthwhile idea
- Resourcefulness, which led them to research and locate programs and opportunities that would benefit Nate
- Problem-solving skills, which helped them analyze everything from the high school curriculum to which summer program would be most beneficial, to how to help Nate stay organized when he was away
- Flexibility and an openness to learning and being willing to change an approach or strategy until they found one that worked

A clear example of Ellen and Ron’s flexibility and good problem-solving skills is illustrated by the following story. When Nate was in grade school and the family was in therapy, Ron and Ellen worked intensely to function as a team. They set clear, explicit expectations, limits and consequences, and systematically enforced the consequences. Later, during high school, when the family was no longer in treatment, Nate continued to forget, lose, or misplace things. Consequences were clearly having no effect, so Ron and Ellen changed their approach dramatically. They dropped the consequences, which they felt were reinforcing an adversarial situation, and they adopted what they felt was a more positive approach. They supported Nate to do all that he could, and they gave him more help where he was weak, especially with executive functioning.
How can we apply these principles to our work with families of more modest means than the Barclays? A major turning point in this inspiring story is the discovery of Nate’s passion, which became a catalyst for growth and change. Any family, whether or not they have access to material resources, can and should discover that area where the child experiences enjoyment and shows even a moderate amount of interest and ability.

Not every child has a clear specialty, but every child has an area of relative strength. This can range from a sport to the arts, computers, building robots, a love of animals and nature, to having an imaginative or enterprising mind, and so on. A therapist must understand the power of identifying this strength. However undeveloped, discovering this special interest provides the seeds for potential growth. The creative energy from this special interest fosters the development of identity, spirit, hope, motivation, and the creation of goals, whether short-term or long-term.

Therapists working with families of low to moderate incomes must collaborate with parents and other professionals to find all available resources in the school and community that support the child’s interest. Most school systems in middle and high school offer art (which benefited Nate so much), a range of musical options, drama, wood and metal shop, and so on. After-school programs provide a wide range of activities, including sports, music (sometimes even a jazz band), drama, student government, a newspaper, and so on. Community resources can include programs sponsored by the public library, the YMCA or YWCA, and other local organizations. The community must be scoured tor opportunities during the school year and the summer. In addition, there are state and national programs available for young people. Most programs, whether public or private, offer scholarships. The key is to find the right program for the particular child. A well-informed therapist is in a strong position to guide parents to the opportunities and professionals they will need to undertake a successful search.

In conclusion, what are the salient issues for the therapist to keep central in the therapy process? The first issue is the attachment between parent(s) and child. There must be a strong, loving bond between parent(s) and a child in order for the parent(s) to persevere with the difficulties involved in effecting positive change. The therapist’s awareness of the quality of the bond(s) provides valuable information for developing an effective treatment plan.

Second, if attachment is the foundation for change, then making a commitment to action—that is, taking the necessary steps to solve a problem—follows
from this and is essential to the process. Once the Barclays accepted who Nate was, that he was creative but not academically oriented, all of their actions were organized to do what was necessary to support his artistic development. The case is a wonderful example of parents with strong love, acceptance, and a commitment to action helping their son reach maturity and a sense of wholeness. The therapist must know what it takes for a family to change and then support, and press, parents to do the hard work and to go the extra mile to accomplish their ends.

The third issue for the therapist to keep central in the treatment process is the identification of the child’s interest. When Nate’s artistic abilities were supported and he was happily engaged, he had a clear reason to put effort into the requirements that were less interesting but necessary for meeting his goals. Identifying a challenging child’s special area of interest gives parents and teachers the leverage they need to ensure that the child learns, for example, life skills, executive functions, and other things needed to become independent and to reach his or her potential. For Nate, living his life as an artist is everything. He might have found it on his own. However, without the early identification of art as critical to Nate’s development, in concert with his parent’s expectations that he apply himself and learn to function responsibly, Nate would not be where he is today.

REFERENCE

CASE STUDY 1-2 SOLUTION-FOCUSED THERAPY WITH CHILD BEHAVIOR PROBLEMS

Jacqueline Corcoran

Although solution-focused therapy shares with other family therapy models a focus on the contextual nature of behavior, its unique focus is on exceptions, times when the problem is not a problem (De Shazer 1988). The practitioner helps the family to identify resources used during exceptions and then shows the family how to amplify strengths and apply them to problem situations. With solution-focused interventions, people are led to imagine the future without the problem and then to develop concrete steps toward that view.

Solution-focused therapy was applied to the case example through the following techniques: assessment and engagement of the different client relationships, identification of resources through exceptions, the miracle question, and scaling questions.

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Questions for Discussion

1. What are the three main types of client relationships present in solution-focused therapy treatment? Which roles do parents usually engage in? Which roles do children engage in?
2. In reframing, the practitioner recognizes that “every problem behavior contains within it an inherent strength.” How does she reframe the child’s arguing behavior?
3. How and when does the practitioner engage the child in termination of treatment?
4. The practitioner acknowledges that children often use the default response of “I don’t know” when asked a question. What are some different strategies that can help get past this response?
5. If a family cannot supply an exception to the problem behavior—a time when things went well—what can the practitioner do to elicit some description of a positive situation to explore?
6. What is the difference between indirect and direct complimenting? With indirect complimenting, what must the client do?
7. What techniques can be used to help children make exceptions more concrete?
8. What is externalization, and how does it enable the client to approach problems less negatively?
9. How do the miracle question and scaling help clients clarify goals and solve problems?

Rubin Cruz, age 11, was referred by the school system because of difficulty with his teacher, who reported that he often refused to follow directions and complete his schoolwork. He provoked other students into talking with him and played class clown. He instigated arguments with the teacher and was in detention at least twice a week for these infractions. His mother, Anna Cruz, says that Rubin shows similar behaviors at home. He argues about doing chores and “everything else” and won’t follow his mother’s directions.

**ENGAGEMENT**

In solution-focused therapy, three main types of client relationships present in treatment: the customer (the voluntary client wanting to make changes), the complainant (the client who is more interested in change for another), and the visitor (the involuntary client who has been mandated to attend) (DeJong & Berg, 2007). When parents bring their child to treatment for behavior problems, two types of client relationships are typically present. Parents are the complainant type: they see their child as the problem and want change to come from the child. Joining with the complainant involves aligning with the client’s goals, asking coping questions, discovering previous solution-finding attempts, refraining, normalizing, eliciting details about the context, and rephrasing complaints as positive behaviors enacted in the present. These techniques are illustrated as follows with Rubin’s mother, Mrs. Cruz.

Children with behavior problems are usually engaged in the visitor relationship (Selekman, 1993, 1997). Generally less concerned about their behaviors than others (e.g., their parents, the school system, and the courts), children’s main goal is to terminate treatment. Engagement strategies with the visitor relationship include creating goals around the referral source requirements, allowing clients to take responsibility for their own change, and
asking relationship questions. Following the discussion of the engagement strategies with Mrs. Cruz, the joining techniques with Rubin are discussed.

**Engagement Strategies with Parents**

Parents can usually be engaged in a treatment approach that is explained as working with the child’s and family’s inherent strengths and that is limited in duration. The solution-focused practitioner also works to align treatment with the client’s goals. She collaborates with Rubin on how they will get his parents and the school “off his back” so that he will no longer have to come for treatment. At the same time, the practitioner shares the parent’s view that the focus should be on child behavior problems rather than on parenting skills.

Coping questions are another way to join with parents who complain about their child’s behavior problems. If complainants’ struggles are not validated, they will not readily engage in solution talk. The main purpose of coping questions, however, is to elicit from parents the skills, abilities, and resources they have used to manage difficulties with the child and other adversity (Berg & Kelly, 2000; Dejong & Berg, 2007).

For example, Mrs. Cruz was asked how she managed with the multiple stressors that afflicted her: a son who required frequent meetings with the school, full-time receptionist work at a state agency, and the unemployment of her husband because of an injury. In answer to coping questions (How do you manage? How do you cope? How do you find the strength to keep going?), Mrs. Cruz said that she was grateful for her family and loved her two boys and her husband, no matter what the problems. The practitioner learned from this conversation that Mrs. Cruz’s caring and gratitude for her family was a strength that she drew on to cope with adversity.

In the solution-focused model, clients are considered the experts on their own lives and are asked about what has and has not worked for them in the past (Bertolino & O’Hanlon, 2002). Mrs. Cruz stated that past problem-solving attempts included her husband spanking Rubin when he was younger, but she said, “He’s too big for that now.” Taking away privileges was another discipline method she and her husband used, but she said, “It gets to the point where Rubin’ll have everything taken away from him—the TV, the phone, trips to [a local amusement park]—there’s nothing left to take away, and he’s arguing all the time because he’s bored.” She then alluded to the counseling, “That’s why we have to come here, to find out other things we can do.”
The practitioner said she would hold off on making suggestions and telling the family what they must do because, first of all, “they must have already heard all that.” Mrs. Cruz agreed and said that Rubin’s new school counselor, Mrs. Crawley, told her that Rubin should have consequences for his actions, although taking away privileges seemed to have escalated the situation. The practitioner explained that the solution-focused approach would work with the strengths and resources of family members rather than telling them what they should do.

Reframing is a solution-focused technique in which the client is given credit for positive aspects of behavior that was previously seen as negative (Berg, 1994), with the recognition that every problem behavior contains within it an inherent strength (O’Hanlon & Weiner-Davis, 1989). In Rubin’s case, the practitioner laughed off Rubin’s constant attempts at arguing. When she responded in this way, he laughed as well, and she reframed these behaviors as demonstrating his “sense of humor.” At the same time that his attempts at arguing were being taken less seriously in session, his mother began to stop engaging in debates with him about his responsibilities. This new response pattern had the effect of reversing the negative cycle of arguing that Rubin and his mother previously shared.

The practitioner was also able to reframe Rubin’s arguing in another way. She said, “Rubin can always find the angle. He would really make a good lawyer. Have you thought about that, Rubin, becoming a lawyer?” Rubin said he had, especially when he saw the lawyer shows on TV. Then the conversation turned to what he needed to accomplish in school (currently in the sixth grade) to be prepared for a potential career as a lawyer.

Normalizing can also be used with complainants to depathologize concerns and present them instead as normal life difficulties (Bertolino & O’Hanlon, 2002; O’Hanlon & Weiner-Davis, 1989). Parents sometimes have expectations of their child that are beyond the child’s developmental stage, and they can become frustrated when these expectations are not met. When a parent is frustrated and places pressure on a child, some children are even less likely to perform new behavior. Normalizing might involve educating parents on what children at certain levels can do.

For parents of preteens, normalizing can center around aspects of the child’s developmental stage. For example, Mrs. Cruz complained about Rubin’s choice of clothing. He would then become more defiant and insist on wearing the clothes, they would argue, and she would feel even less positively
toward him. Although the practitioner could join with Mrs. Cruz by agreeing that Rubin's clothing style might seem distasteful to adults, she normalized the behavior by explaining that experimentation with nonmainstream clothing was part of a transitional phase typical of adolescence.

Solution-focused therapy concerns itself with the context of the problem, and the parent's behavior is part of this context. Inquiry about the impact of the child's behavior can be determined by asking the question, “How is this a problem for you?” (O'Hanlon & Weiner-Davis, 1989). When Mrs. Cruz was asked, “How is his wearing those clothes a problem for you?” she said that the clothing style made her son look like he belonged to a gang: “The first step, he looks the part; the next step, he's playing it.” She was asked if other youth in her neighborhood wore those kind of clothes but were not in gangs and performed well in school. Indeed, she had to admit, “all the kids wear that style these days, even the ‘good kids.’” The question “How is this a problem for you?” sometimes changes a parent's perspective about the problem, making them focus on the specific behaviors they would like to see changed rather than on aspects of the problem that have seemingly “taken on a life of their own.”

Parents who bring in their children for behavior problems usually catalog their children's negative behaviors. Similarly, Mrs. Cruz talked about Rubin's noncompliance at school, the frequent parent-teacher conferences, his lack of follow-through with rules at home, and his defiance. A key question then is, “What do you want to see instead?” with the practitioner working to identify the presence of positive behaviors. For example, rather than “not talking back” the goal becomes “following directions”; rather than “not fighting” the goal becomes “getting along with classmates.”

Once his mother clarified some desired outcomes, Rubin was asked, “What do you hear your mom say she wants you to do?” Rubin’s reply was, “I don’t remember.” In many instances, parents talk so long or in such a general manner that the gist of the message is lost, and the child is unable to reflect back his or her parents’ expectations. In these cases, parents are asked to repeat themselves. Through this process, parents learn to be brief and specific in their requests.

**Engagement Strategies with Children**

The child with a behavior problem is engaged in the goal of terminating treatment as quickly as possible with these opening questions: Whose idea
was it for you to come here? What do they need to see to know that you don’t have to come here anymore? (Selekman, 1993, 1997). In this way, young clients see that the practitioner is not invested in a long-term relationship and will work with them to obtain results and end treatment.

Rubin answered this line of questioning in the following way:

**Practitioner:** Whose idea was it that you come here?

**Rubin:** My teacher, I guess *(glances at his mother with a smile).* And maybe my mom, too.

**Practitioner:** What do they need to see to know you don’t have to come here anymore?

*Rubin seems a little taken aback by this question and is silent for a moment.*

**Rubin:** I don’t know.

**Practitioner:** Come on, I know you don’t want to keep coming here. What do you need to do so that they’ll be satisfied, and you don’t need to come anymore?

**Rubin:** To be good.

**Practitioner:** What does being good look like?

**Rubin:** Not fighting.

**Practitioner:** What will you be doing instead of fighting?

**Rubin:** Being good.

**Practitioner:** If I were seeing you through a video camera—*(mimes this action)*—what would I see you doing?

*Rubin laughs at the idea, but it gets him to think for a moment.*

**Rubin:** Well, in school, I won’t tell the teacher, “No!”

**Practitioner:** What will you do instead when she asks you to do something?

**Rubin:** I’ll just do it. I’ll sit there and just do my work.

In this example, the practitioner is persistent in getting the client to identify the specific behaviors that are required to end treatment as quickly as possible, a goal in which Rubin is invested. In solution-focused therapy, in addition to the view that clients are the experts on their own lives, clients are also allowed to come up with their own answers and solutions rather than having the practitioner lecture them “on what they must do.” However, Rubin, like many youngsters, used the default response of “I don’t know” to
reply to many of the practitioner’s subsequent questions. Several different strategies may be used at this point. The first is to allow silence (Berg, 1994). The child may then become uncomfortable and talk to fill the silence. (*Parents should be prevented from filling the silence themselves.*) The silence should not go on too long, because power struggles might result, and these inhibit rapport building. The second way to handle an “I don’t know” response is to rephrase the question (Berg, 1994) so that the client understands that the practitioner will persist until the question is answered. A third way to handle an “I don’t know” response is to use a relationship question.

Relationship questions ask clients to view themselves from the perspective of someone else (DeJong & Berg, 2007), a process that enables clients to understand the influence of their behavior on others and to view themselves from a more objective position.

Rubin was asked, “What do you think your mom (or teacher) would say needs to happen so you don’t have to come here anymore?” He still said he didn’t know, so his mother was asked, “He doesn’t seem to know, mom. What can you tell him about what he needs to be doing so he doesn’t need to keep coming back here?” After she gave her perspective on what should happen, Rubin was asked to repeat what he heard his mother say to make sure the expectations had been clarified into specific and concrete behaviors. Relationship questions are particularly helpful with involuntary clients who, perhaps because they are not interested in changing, do not know how they can change. However, they are often aware of what others would like for them to do. This perspective is tapped with solution-focused therapy by defining what goals need to be achieved so that treatment is no longer necessary.

**EXCEPTIONS**

One of the main interventions for solution-focused therapy is identifying exceptions, or times when the problem is not a problem (Bertolino & O’Hanlon, 2002; De Shazer et al., 1986; Selkman, 1993). Once the parent and/or the child identifies the desired behaviors, family members are asked about times when those behaviors have already occurred. People typically have become so immersed in their problems and in their expectation that counseling involves discussion of the problems (O’Hanlon & Weiner-Davis, 1989) that they are taken aback by questions about nonproblem times and
are sometimes initially unable to answer. Practitioners must allow space (time and silence) for family members to identify exceptions, perhaps using additional probing questions if they are still unable to answer.

For example, Mrs. Cruz was asked to consider a time when Rubin washed the dishes (his nightly chore) without an argument. She said, “No, he always argues.” When Rubin was asked if he could think of such an instance, he said, “I do the dishes all the time. It’s Joey (his brother) who doesn’t do them.”

“He doesn’t complain like you do,” Mrs. Cruz retorted. “You complain and argue about doing anything I want you to do.”

When people still struggle with finding exceptions, despite the attempts of the practitioner, questions can be asked about when the problem was less intense, frequent, or severe (O’Hanlon & Weiner-Davis, 1989). In this case, the practitioner said, “I know Rubin seems to do a lot of arguing. I wonder when he argued just a little bit or only made one comment and then did what he was supposed to do.”

In answer to this prompt, Rubin produced an instance from that week in which he said he didn’t want to do the dishes, and he had hardly eaten anything compared to all the other people in the family, so he wondered why he should have to clean up. Despite his grumblings and attempts to get out of the chore, he went ahead and did it.

Once an exception has been identified, the practitioner probes for what was different about the contextual details of the situation: who was there, when it happened, what was happening, and how it happened (DeJong & Berg, 2007). In this instance, Mrs. Cruz said she just ignored him; his argument was so “lame” that it was not worth responding to, and she went on talking to her husband, who also ignored Rubin. The practitioner paraphrased back to her, “So when you didn’t pay attention to his argument, he just went ahead and did it? What does that tell you about what you can do?” Mrs. Cruz was able to see that she could ignore some of her son’s attempts to engage her in debates.

If people still struggle with the request to find exceptions, examples of behavior in the session can sometimes be used. One time, Mrs. Cruz talked at length about a report from the teacher about Rubin’s noncompliance. Growing bored, Rubin started playing with an alarm clock in the office until it was finally in pieces. Realizing what he had done, Mrs. Cruz shouted at him to put it back together. After a pleased look at his handiwork, Rubin
began to replace the parts. The practitioner noted to Mrs. Cruz that he had followed her direction the very first time. Mrs. Cruz downplayed his compliance in this instance, saying, “It’s only because you’re here.” The practitioner reassured Mrs. Cruz that her presence did not necessarily command obedience, and she pushed Mrs. Cruz and Rubin to take credit for this exception.

Another example of exception finding involved Rubin’s intermittent tendency to get into fights at school. This example shows that clients often attribute their exceptions to entities other than themselves. Rather than accepting this view, the practitioner works with the client to take credit for what is different about the exception.

**Practitioner:** Tell me about a time when you avoided getting into a fight.

**Rubin:** I was in science.

**Practitioner:** What happened?

**Rubin:** This idiot threw a spitball at my head.

**Practitioner:** Then what did you do?

**Rubin:** I gave him a dirty look, told him he better watch it.

**Practitioner:** Then what happened?

**Rubin:** I turned back around and saw the teacher was watching.

**Practitioner:** What were you thinking?

**Rubin:** That I would get in trouble if I did something back. But I wanted to. Because he was still saying stuff. I don’t know why Mrs. Wymann didn’t hear him.

**Practitioner:** What did you do then?

**Rubin:** I just stayed turned around.

**Practitioner:** What were you telling yourself then?

**Rubin:** The teacher was still looking; I wasn’t going to do nothing.

As in this example, some children and adolescents give credit to people or entities outside of themselves. The practitioner must work to empower clients and help them take credit for the success: “Good, so you knew if the teacher saw you, you wouldn’t let yourself fight.”

Rubin said, “But if the teacher wasn’t there, I would have knocked the jerk’s face in.” “I’m sure you would have,” the practitioner said easily. “So what does that say about what you can do to avoid fights?” Rubin was eventually led to the response that he could make sure a teacher saw him when a
provocative situation developed, which would prevent him from responding in a way that got him in trouble.

Another central aspect in the context of children’s behavior includes the parent’s role in the interaction (O’Hanlon & Weiner-Davis, 1989): “What are you doing when your child is behaving?” Parents may realize, for instance, that they have given their children special attention or remained calm. In solution-focused therapy, the context of a behavior is seen as crucial. Problems do not reside as much in the individual as in the behavior patterns, which influence others to act a certain way. With child behavior problems, parents play a large role in this context.

COMPLIMENTING

Solution-focused practitioners pay a great deal of attention to complimenting clients and being vigilant for opportunities to praise (DeJong & Berg, 2007). For example, when Rubin took apart the clock in session, the practitioner praised him for his “mechanical abilities” and for following his mother’s direction to put the clock back together.

As a general guideline, indirect rather than direct complimenting should be used whenever possible and can be directed toward either parent or child. A direct compliment is when the practitioner praises the client: “You did a good job” or “I liked the way you said that.” An indirect compliment implies something positive about the client, but pushes the client to figure out the resources used to achieve success (DeJong & Berg, 2007): “How were you able to do that?” “How did you know that was the right thing to do or say?” Compliments are more powerful when clients generate them for themselves. When clients realize their own resources, change begins to occur.

For instance, Rubin was asked about his chores: “How did you manage to do the dishes when you find it such a drag?” Rubin answered, “I just did them.” He was then asked, “But how did you get yourself to do them when you didn’t want to?” He answered, “There was a TV show I wanted to watch, and I knew my dad wouldn’t let me go in there until I finished the dishes.” The practitioner, ever vigilant for exceptions, seized on this strategy as well, bringing it to the attention of Mrs. Cruz: “How did you come up with that idea, that he doesn’t get to watch TV until he’s done the dishes? That’s a great idea!” Mrs. Cruz admitted that her husband resorted to this tactic more
than she did, but that they didn’t use it as often as they could. Giving Rubin privileges when he did behave seemed to work much better than taking away privileges when he didn’t behave. In an attempt to expand on the exception, the practitioner asked, “How could you do more of that?” Although withholding privileges until Rubin had completed his chores seemed an obvious solution, Mrs. Cruz had not taken advantage of this strategy until the practitioner focused her attention on it.

The practitioner also worked to evoke more compliments from the parent to the child, because a solution-focused premise is “to change the viewing” as well as “the doing” (De Shazer, 1994). Rubin was asked, “What does your mom tell you when you’re doing a good job or doing what she wants you to do?” When Rubin had some difficulty with this question, Mrs. Cruz saw she did not often give Rubin credit for his positive behaviors.

When parents do praise their children in session, youth are asked to repeat what they have heard their parents say. In this way, the positive message is reinforced, and parents begin to realize the powerful effect their words have on their children. When parents have a more positive view of their children and communicate this, children tend to increase their positive behaviors, and the relationship between parent and child is enhanced.

**TECHNIQUES TO MAKE EXCEPTIONS CONCRETE**

Cognitively, young children have difficulty going into the past to retrieve exceptions (Selekman, 1997). Although parents can help them with this process, other techniques are needed to bring the material into more concrete and present focus. One way to do this is through the use of drawings to make exceptions more concrete (Selekman, 1997). Rubin enjoyed drawing a picture of himself in the classroom, sitting quietly doing his work and following his teacher’s directions. At the practitioner’s request, he displayed, with comic-strip bubbles, what would be said aloud and what he would be telling himself. He showed the teacher saying, “Rubin, do this, do that” and himself saying, “Yes, Mrs. Wymann.” In a thought bubble above his head, he wrote, “This work is boring, but I’m so smart I can finish it fast and then I can draw cartoons.”

Another way to help children apply the exceptions they have identified is to role-play situations, which makes their strategies concrete. A playful atmosphere is generated in session when children are asked to assign roles to
the therapist and to their parents. This sense of playfulness lightens up the negativity that surrounds problems and introduces new possibilities for behavior. Role-playing also forces members to take on new perspectives, which helps introduce new possibilities for behavior.

Rubin role-played a situation in which a classmate had tried to provoke him into a fight by calling him “Mexican.” He had previously handled the situation by hitting the classmate; a physical fight ensued, and both he and the other boy were suspended. Earlier, the practitioner had helped Rubin identify that humor was one way he could handle difficult situations. Rubin came up with a response in session (but said he would try to think of something better in the meantime): “That’s right, I’m Mexican and proud of it,” he said while smiling.

He enjoyed having both the practitioner and his mother play him in turn, with him acting as difficult as possible as the other boy. The practitioner complimented Rubin on making the role-play so challenging, mentioning that a lot of children just tell her that they would “walk away” from provocation without thinking through how difficult that would be and without rehearsal. Then when they are faced with a tense situation, they do not know how to enact the solutions they identified. She then had Rubin play the game Transgressions from the prior week. Rather than allowing the session to be overtaken by “problem talk,” the family can be re-oriented by asking, “How could the situation have been handled instead?” This discussion could also be followed by role-play so that new behavior choices are made more concrete. This process is much more productive than spending time with a family going over in detail problems that have already occurred.

The Miracle Question

People who have experienced a negative and stressful past may easily project this past into the future and assume that their lives will always be the same. The miracle question is one way that clients can begin to envision a more hopeful future (Cade & O’Hanlon, 1993). In the miracle question, clients are asked to conjure up a detailed view of a future without the problem: “Let’s say that while you’re sleeping, a miracle occurs, and the problem you came here with is solved. What will let you know the next morning that a miracle happened?” (De Shazer, 1988). Specifics are elicited about this “no problem”
experience so that clients can develop a vision of a more hopeful and satisfying future (DeJong & Berg, 2007). Rubin and his mother responded in the following way to the miracle question:

**Rubin:** I will want to get up in the morning.

**Practitioner:** What will you be doing to show you want to get up?

**Rubin:** I will jump out of bed.

**Mrs. Cruz:** Instead of me telling him over and over again that he has to get up now.

**Practitioner:** So what will your mom notice about you, Rubin?

**Rubin:** She would be really surprised if I just came into the kitchen already dressed. She would turn around to yell at me, and there I would be—right behind her. It would scare her.

**Practitioner:** What’s the next thing you would notice?

**Mrs. Cruz:** There wouldn’t be this big hunt for his homework. He would already have it together, and we would be ready to leave on time.

**Practitioner:** What would you notice, Rubin?

**Rubin:** My mom wouldn’t be all stressed out. She would be laughing and joking around with me.

The practitioner continued to elicit specific behavioral sequences for Rubin as he went to school in the morning, asking the question “What will your mom or teacher notice that you are doing or that is different about you?” to help him see the perspective of others and to demonstrate the influence of contextual factors.

Sometimes asking clients to envision a brighter future may help them to be clearer about what they want or to see a path to problem solving. By discussing the future in a positive light, hope can be generated, and change can be enacted in the present by the recognition of both strengths to cope with obstacles and signs of possibilities for change (Cade & O’Hanlon, 1993).

**Scaling Questions**

A more specific way to address future goals is through the scaling question intervention. Scaling questions involve ranking progress on goals on a 10-point scale (DeJong & Berg, 2007). Although scaling questions are
primarily used for goal setting, multiple interventions can be followed by this technique, including relationship questions, exception finding, complimenting, and task setting.

Scaling questions begin when family members are asked to identify the priority goal. In complainant-driven goals, child behaviors are the focus. The goal should be achievable (rather than perfection), limited to one setting (i.e., home or school), and involve the presence of concrete behaviors rather than the absence of negative behaviors.

Mrs. Cruz selected Rubin’s school behaviors as a priority, because they were the reason for the referral. Both Mrs. Cruz and Rubin were involved in developing the concrete indicators, which included “completing work without arguing,” “being respectful to teacher” (which was defined even further as accepting her directions by nodding and smiling), and “leaving the other kids alone.”

After the concrete indicators were formulated, Rubin was asked to rank his current functioning on a scale, with 10 defined as the behaviors listed above and 1 as “the day you called for the appointment.” Rubin ranked his current functioning as a 7 and said that he did a lot of the positive behaviors already. He was complimented for having made so much progress already (“Wow, you’re almost home free!”) and asked how he was able to achieve this level of success.

After some discussion of exceptions, Rubin was asked a relationship question about how his mother would rank him. He said a 6 and was shocked when his mother ranked him as a 2. Rubin was asked about his stunned reaction and to account for the disparity between his and his mother’s rankings. He said he couldn’t account for it; his mother was his biggest supporter. Asked to elaborate, Rubin said his mother was always behind him when no one else was and always encouraged him. The practitioner asked Mrs. Cruz, “Mom, did you realize he saw you this way?”

“No, I’m really surprised.” Mrs. Cruz then explained her ranking, “Rubin, you’ve been in detention at school twice a week practically all semester, and you’ve been suspended twice. I call that a 2, not a 7.” This seemed to get across to Rubin, as nothing else apparently had, that he needed to make improvements in his behaviors.

At this point, he was also asked relationship questions about other people impacted by his behavior, namely his father and his teacher. He estimated his father’s ranking of his behavior as a 5, which Mrs. Cruz agreed was a realistic
appraisal because she was the one who handled the calls from the school and the parent-child conferences.

Chastened by his mother’s ranking, Rubin ranked himself as a 2 from his teacher’s perspective. Opportunities for exceptions can develop even from low rankings: “A 2! You’ve already taken some steps. What have you been doing?” If clients give 1 as a ranking, then the client can be asked, “What are you doing to make sure it’s not getting any worse?” In this way, clients can still be given credit for the actions they are taking to overcome their problems.

Task setting follows from the scaling by asking children, “What needs to happen so that you can move one number up on the scale before the next time we meet?” Even young children grasp the ordinal nature of the scale, and they often find moving up on the scale quite reinforcing in itself. Children often come into subsequent sessions and proudly announce how they have advanced on the scale. Progress is tracked over time, so the scales serve as measures of goals. Scales make goals and the steps necessary to attain these goals concrete and specific.

**SUMMARY OF SUBSEQUENT SESSIONS AND TERMINATION**

Mrs. Cruz and Rubin attended a total of five sessions. Because Rubin improved steadily on his school behaviors, according to both Mrs. Cruz and his teacher, another solution-focused scale was developed for Rubin’s home behaviors. Part of his home behavior involved getting along with his 14-year-old brother, who was included in the last two sessions. Although a sixth session was scheduled, the Cruzes didn’t return for their appointment. When the practitioner called Mrs. Cruz, she said that the family didn’t need to come back because Rubin’s behavior was so much better.

**CONCLUSION**

This case study demonstrates the solution-focused model applied to child behavior problems. The emphasis of the techniques is on identifying and elaborating the strengths of clients and families rather than focusing on their deficits. In this way, the positive aspects of children’s behavior are highlighted, and the strategies they use are applied to problem areas.
REFERENCES


CASE STUDY 1-3 CRISIS INTERVENTION WITH A DEPRESSED AFRICAN AMERICAN ADOLESCENT

Jewelle Taylor Gibbs

Crisis intervention is often required with adolescents who have problems of substance abuse, violent behavior, eating disorders, or suicide attempts (Meeks & Bernet, 1990; Steiner, 1996). Adolescents who are referred to crisis intervention services are often admitted after an impulsive, self-destructive act that is precipitated by a major loss, disappointment, or narcissistic injury to their self-concept. The techniques of crisis interventions can be particularly effective with these adolescents because of their developmental stage, in which they often respond more positively to short-term, highly focused, problem-solving strategies (Aguilera, 1998).

Questions for Discussion

1. The practitioner considers developmental, environmental, and socio-cultural issues of the client’s case even before meeting with her. Why is this important?
2. The practitioner states that she explores the depressed adolescent client “as a person rather than a problem.” What is the strength of this approach?
3. How does the author’s understanding of the client’s developmental stage enhance the treatment process?
4. What factors may have influenced the client’s family doctor to diagnose her with an anxiety disorder instead of depression?
5. How does the crisis intervention model used here differ from longer-term therapy?

The case of Tanya, an African American female adolescent, provides an excellent example of using crisis intervention techniques to facilitate the resolution of her presenting problems, to restore her psychological equilibrium, and to strengthen her problem-solving skills. As Caplan (1964) pointed out, a crisis presents both a problem to be resolved and an opportunity for change. For adolescents who are in the process of rapid developmental changes, a crisis state may present an optimal opportunity to achieve a new personality.
synthesis, to develop more mature coping mechanisms, and to test out more constructive behaviors.

In analyzing this case, I applied a multidimensional conceptual framework that examines the adolescent in the context of her developmental stage, her environmental milieu, and her sociocultural background (Gibbs & Huang, 1998). This framework provides a comprehensive assessment of Tanya as a unique person, not just a typical client with a collection of symptoms and behavioral problems. Thus, Tanya's clinical symptomatology is viewed in the broader context of her adolescent developmental challenges, family background, cultural heritage and values, risk and protective factors, and support systems.

**CASE DESCRIPTION**

Tanya, a 16-year-old African American adolescent, was admitted to a psychiatric emergency service late one evening for taking an overdose of medication. Tanya was groggy, unresponsive, and unable to report what she had ingested. Her 18-year-old boyfriend, Marlon, had rushed her to the hospital after finding her semiconscious on the floor of her family's living room.

Marlon was able to supply some information about Tanya's background and recent history to the admitting nurse. Shortly after the recent death of her mother, Tanya had moved from the rural South to an urban industrial city in the San Francisco Bay area. She had moved in with her father, his second wife, and two younger half-sisters, aged 8 and 10.

Marlon reported that Tanya had been very unhappy with the transition from a small southern town where she had a close network of friends and relatives to a large metropolitan area where everything was strange and unfamiliar to her. She had transferred to a local high school but had been put back a grade because she was unable to do the work in 11th grade. Tanya complained that the other students made fun of her accent, her clothes, and her classroom behavior, so she hated to go to school. She also missed her church choir, her part-time job, and all of her friends. Furthermore, Tanya had also complained that her stepmother expected her to babysit her younger half-sisters and made her clean and cook after school, so she couldn’t work anywhere else. Her father seemed distant and preoccupied with financial problems, and she felt very isolated and lonely.
In recent weeks, Tanya had complained to her boyfriend about headaches, stomachaches, and insomnia. She had gone to the family doctor, who had prescribed some tranquilizer pills for her, but they only made her feel worse. According to the boyfriend, Tanya sometimes seemed very angry, got into screaming matches with her stepmother, was very irritable with him, and frequently stated that her life was a mess.

Her boyfriend was worried that Tanya may have accidentally taken too many of the tranquilizers after her father had said he couldn’t afford to send Tanya to visit her hometown relatives during her spring vacation. During the 48 hours following her admittance to the hospital, Tanya’s condition stabilized, and she confirmed much of this information in the psychiatric evaluation that was conducted before she was released from the hospital.

**ISSUES IN ASSESSMENT**

The following issues are relevant to an adequate assessment of Tanya’s case.

**Developmental Issues**

What is the impact of Tanya’s developmental stage on the recent problems she has been experiencing in family disruption, school adjustment, social relationships, and community transition?

**Clinical Issues**

What is the significance of Tanya’s somatic and affective symptomatology? What psychological state of mood do they suggest? Did the doctor who prescribed tranquilizers conduct an adequate and culturally appropriate assessment? Could there be alternative hypotheses about the underlying causes of Tanya’s symptoms? After she was hospitalized, what other questions should have been addressed in assessing her behavior and affect?

**Sociocultural Issues**

What social and cultural factors contributed to Tanya’s symptomatology? Did specific social and cultural institutions in the African American community provide protective factors for Tanya? What factors in her current social situation (and family situation) may have increased the risk factors for Tanya?
What changes have occurred in Tanya’s family and social environment in the past year that altered the balance between protective and risk factors in her psychosocial adjustment? In what ways could cultural factors potentially influence Tanya’s symptoms as well as her help-seeking behaviors?

CASE DISCUSSION AND ANALYSIS

Assessment of the Therapist’s Preparation and Self-Awareness

Because my first session with Tanya occurred the morning after she was admitted to a psychiatric emergency service for a suspected suicide attempt, I had only a few sketchy details about her from the notes on her medical chart. Before our initial interview, I thought it would be useful to think about three major factors that might have an important bearing on her case: developmental issues, environmental issues, and sociocultural issues. I also took a few minutes to think about my previous experience with similar cases of adolescents who had made suicide attempts of varying levels of severity, especially the few cases of African American suicide attempters I had seen or heard about. In fact, African American female adolescents, ages 15 to 19, have the lowest suicide rate of all race-sex groups in their age cohort, so it is a relatively rare occurrence. Although I had had direct clinical experience with only two previous cases of suicide attempters, I had conducted research on the phenomenon of African American adolescent suicide (Gibbs, 1998; 1999; Gibbs & Hines, 1989). Moreover, it was important for me to examine my own attitudes and knowledge about adolescent suicide so that I would be able to assess Tanya’s symptoms objectively but still communicate my concern and compassion for her current situation. As an African American female psychologist, I also had to be conscious of my impact on Tanya, who was young enough to be my own daughter and might easily misinterpret my interest and concern for the maternal nurturance that she had recently lost. On balance, I was also aware that the two major traits we shared—being black and female—could facilitate the development of open communication and trust in our initial session (Greene, 1993; Pinderhughes, 1989).

Assessment of Client

When I first saw Tanya in her hospital bed, I noticed that her affect was very sad, that she seemed very tired and listless, and that she avoided making eye
contact with me. These symptoms were all congruent with recovery from an overdose of tranquilizers, so they were neither unexpected nor idiosyncratic. After greeting Tanya and explaining who I was and my role in the hospital, I began to ask some very general questions about how she was feeling and what had happened to her, slowly and cautiously trying to assess her current mood and her understanding of what had precipitated her visit to the emergency room (Aguilera, 1998; Ligon, 1997).

Tanya began to cry copiously as she described the feelings of loneliness, hopelessness, and despair that had led her to take the pills. I spent considerable time reassuring her, expressing empathy about her losses and the changes in her life, and offering her the opportunity to share her deepest feelings, fears, and anxieties with me. She slowly managed to gain control of her volatile emotions and seemed greatly relieved to unburden herself to a supportive adult. However, the effort exhausted her, and she seemed to have little energy for a longer interview, so I promised that I would return later in the day after she had more time to rest and recover from the overdose. I had decided that it would be preferable to conduct the initial assessment interview when she was more rested, less emotionally fragile, and had had an opportunity to reflect on her feelings and her actions of the previous evening.

This decision bore fruit in our second session later in the afternoon, after Tanya’s parents (her father and stepmother) had visited and her condition had improved considerably. In fact, Tanya’s appearance and affect had markedly improved, and she was looking much more like a typical teenager, with her hair combed and braided in an intricate style, wearing a colorful robe brought by her parents, and listening to rock music on the radio. I was struck by these rather dramatic changes in Tanya’s affect and behavior, considering this a positive sign of her resiliency (Luthar, 1991; Rutter, 1987).

Tanya recognized me and greeted me with a wan, shy smile, but she seemed slightly embarrassed and began playing with the tassel on the belt of her robe. Again, I decided to proceed slowly and cautiously to build up her trust and to allay her anxieties about talking further with me. At this point, I did not review our previous conversation, but focused instead on learning about Tanya as a person rather than as a problem.

First, I explored developmental questions that would give me a better idea of her current developmental stage, how she was handling normative developmental tasks, and what concerns or issues she was currently facing. I noticed that she talked slowly and deliberately, with a distinct Southern accent.
(in contrast to my rather rapid Northern-accented speech); she also had a good vocabulary and expressed herself clearly and with appropriate affect.

Tanya described herself as an average person who liked sports, music, dancing, and going to the movies. She seemed sad again when she spoke of moving away from friends, missing her church choir and other activities, and not feeling really “at home” in the Bay Area. Tanya was disappointed in her schoolwork, because she had trouble keeping up with some of her classes, particularly math and science. She also complained that she was frequently teased by the African American girls in her school because of her conservative clothes and her Southern accent, but one or two girls had been friendly to her. Tanya’s smile returned when she described her boyfriend, one of several boys who had seemed interested in her, but she was worried because he had been pressuring her for sex lately, and she didn’t feel ready to have that kind of relationship with any young man.

As we talked about her relationships with her family, her peers, and boys and about her adjustment in school, Tanya’s responses were developmentally appropriate, and her strategies to cope with the challenges of transitioning from mid-adolescence to late adolescence appeared to be flexible and relevant to her particular social context (Erikson, 1959). Tanya was in the developmental stage of mid-adolescence, a period when peer relationships take on an increasing level of importance and when youth shift a major part of their interest (or “cathexis”) from family to friends (Petersen, 1988). This is also a period when belonging to a group in which you are valued and accepted is a major developmental task to be achieved, because it reinforces a positive identity, promotes the development of social skills, and allows for identity experimentation. During this crucial period, Tanya had lost a loving and nurturing mother through death, a group of supportive friends through moving, and a familiar school environment through transfer. All of these abrupt transitions caused major disruptions in her family relationships, her peer relationships, and her school environment. She had to adjust to a new family with a stepmother and new siblings, to a new school with different academic standards, to a new group of peers who were extremely critical and rejecting, and to a new community with unfamiliar norms, values, and opportunities for youth. Thus, developmentally, Tanya was facing several major challenges without the security and stability of a cohesive family and social systems to provide her with the support and nurturance needed to achieve a positive and constructive transition to adulthood. Without such support systems,
Tanya was at risk for the development of psychological and/or behavioral problems (Camasso & Camasso, 1986; Resnick & Burt, 1996).

Although it was clear that Tanya was experiencing some doubts and confusion about her traditional values and responding to some assaults on her self-esteem, she was able to distance herself sufficiently from the responses of her peers to evaluate her own priorities and preferences. On the other hand, I needed to explore in greater depth Tanya’s ambivalence about maintaining these values and behaviors in this new and different environment and to determine whether Tanya’s depression was related to an internal conflict over how to maintain her self-concept and enhance her self-esteem while fulfilling her social and sexual needs (Adelson & Doehrman, 1980; Gibbs, 1986).

A second major area of assessment was Tanya’s clinical symptomatology, ego strengths, coping and defense mechanisms, personality traits, level of self-awareness, and ability to manage her impulses (Meeks & Bernet, 1990; Petersen & Hamburg, 1986). Although Tanya’s family doctor had prescribed tranquilizers for her, I thought her symptoms reflected an underlying mood disorder of depression, perhaps masked by some overt signs of anxiety before she ingested an overdose of pills.

The variety of somatic and affective symptoms reported by Tanya can be interpreted in several ways (e.g., as signs of underlying anxiety or depression or as a mixed state of both anxiety and depression). In assessing Tanya, it is important to keep in mind that cultural factors do influence the expression of symptomatology. For example, an initial review of her symptoms may lead to a diagnosis of an anxiety disorder, as was determined by the doctor who prescribed tranquilizers for her. However, given the history of her recent losses and recent assaults on her self-esteem and identity, it is certainly conceivable that these symptoms reflect an underlying mood disorder of depression (Robbins & Alessi, 1985; Roberts, Roberts, & Chen, 1997).

Also helpful in evaluating Tanya’s symptoms is an awareness of the tendency of low-income African Americans, particularly those who are less well-educated, to express depression through somatization. It is also not uncommon for African American adolescents to express depression through anger, irritability, and acting-out behaviors; in fact, this is characteristic of many children and adolescents in general. The clinician should explore Tanya’s feelings about the death of her mother, the loss of her friends and church activities, and her demotion in school to determine whether she is masking underlying feelings of sadness, grief, and disappointment with
physical symptoms and angry outbursts. The symptoms may also represent a mixture of anxiety and depression, but it is important to determine whether one affect is dominant in order to develop an appropriate treatment plan.

Tanya had reported recent feelings of depression, frequent crying spells, feelings of helplessness and hopelessness, extreme lethargy and fatigue, loss of appetite, and insomnia, and these symptoms were consistent with a diagnosis of major depression because they had lasted more than one month. She had also expressed irritability with her friends, frequent arguments with her parents, and feelings of unworthiness and guilt, all of which supported a diagnosis of major depression (Meeks & Bernet, 1990).

Despite these recent symptoms, Tanya had a history of being well adjusted in her family, at school, and in the community where she had grown up. Although she described herself as “average,” she had reached the age of 16 without any major developmental or behavioral problems, according to her self-report. She appeared to have a well-integrated personality with an ability to manage her life reasonably well, to have satisfactory peer relationships, to have a set of moral values based on her strong religious beliefs, and to be engaged in a heterosexual relationship that was making her aware of the need for sexual decision making. She also had displayed signs of a subtle sense of humor and the ability to criticize her own behaviors, alternating with a sensitivity and vulnerability that was characteristic of her age. Tanya did not report any history of drug or alcohol use and stated that she had never had sexual intercourse, both of which probably reflected her religious upbringing.

Assessment of the Therapist’s Knowledge of the Client’s Background

In order to conduct a culturally sensitive assessment of Tanya, it is essential to have an understanding of her social and cultural background and current milieu. The clinician should evaluate the influence of Tanya’s religious beliefs and her Southern rural experiences on her beliefs about mental health and psychological symptomatology. The African American church has a profound influence on the values, beliefs, and norms of its members, particularly in rural Southern settings. Similarly, church membership and involvement in religious activities is known to be a significant protective factor for African American youth and their families, insulating them from many of the social problems of low-income communities. The extended family has also traditionally been a
source of support and a resource for positive development for African American youth (Boyd-Franklin, 1989; Lincoln & Mamiya, 1990; Pinderhughes, 1989).

It was important to discuss with Tanya how her recent transitions impacted these protective factors (i.e., the loss of a cohesive family unit, her church choir, and her supportive peer groups). Without these protective factors, Tanya may have experienced a sense of isolation, loneliness, and loss of self-esteem, all of which caused her to be at risk for psychological disorders (Camasso & Camasso, 1986; Luthar, 1991; Resnick & Burt, 1996).

In assessing Tanya, I was aware of the influence of her social and cultural background on her normative behaviors and values, as well as on the expression of her clinical symptoms. As a young African American female reared in the rural South, Tanya had probably been strongly influenced by the religious beliefs and values of her fundamentalist Christian church, as well as the folkways and traditions of her African American southern community, which was a tightly knit society of extended families, cohesive social support networks, and conservative values (Lincoln & Mamiya, 1990). Moreover, when members of these communities have emotional problems, the families usually seek help initially through elders, ministers, and medical practitioners rather than from mental health professionals (Neighbors, 1985). In that cultural milieu, the tendency for people to somatize when they feel emotional distress is reinforced because of the stigma among rural African Americans of admitting to any form of psychological disorder.

Tanya had made a giant leap from the rural South to the urban West, literally changing cultural environments overnight. This factor was very important in assessing her level of stress while adapting to a major metropolitan area with a faster-paced lifestyle, far more social freedom for adolescents, and far fewer social constraints on behaviors and relationships (Myers, 1989).

While I was evaluating Tanya’s clinical symptoms and her personality attributes, I was also assessing her strengths, her social supports, and the protective factors in her family and environment (Harrison, Wilson, Pine, Chan, & Buriel, 1990; Jessor, 1993). In some respects, Tanya was fortunate to have a new home with a father and stepmother who were successfully functioning adults who provided her with a stable and secure family life. Although she was unhappy about her added family chores and responsibilities, she was also pleased to be reunited with her father and to get to know her younger sisters better. This was an area that I would need to explore further, but Tanya clearly expressed a mixture of positive and negative feelings about
her family relationships. Similarly, she expressed some ambivalence about her relationship with her boyfriend, whom she viewed both as a major source of emotional support and as a source of potential danger in tempting her to abandon her moral standards. One of the major deficits in her life was the absence of strong female friendships, although she reported cordial relations with several of her classmates (Way, 1996).

Finally, the clinician should conduct a suicide assessment to determine the motivation behind the overdose of medication and the lethality of the intentional or unintentional behavior (Gibbs & Hines, 1989). If the clinician concludes that Tanya has, in fact, attempted suicide as a cry for help, this assessment would dictate some very specific interventions as a part of a comprehensive treatment plan for Tanya.

My overall assessment of Tanya was of a mid-adolescent female in transition to late adolescence who was basically well adjusted and coping successfully with her environment until her mother’s death precipitated a period of severe stress, which was exacerbated by an abrupt move to live with her father and his new family in a location quite geographically, socially, and culturally removed from her rural Southern community. When she experienced numerous difficulties in adjusting to her new family, new community, and new school, Tanya’s previous coping strategies failed her, and she experienced feelings of helplessness, hopelessness, and despair. When these feelings intensified, she experienced an episode of major depression, during which she impulsively ingested an overdose of tranquilizers, without a clear and deliberate plan to commit suicide.

**Pretherapy Intervention**

After I had collected sufficient information about Tanya to make the preliminary assessment that she was depressed but not psychotic or experiencing a toxic drug reaction, I suggested that it would be helpful to discuss with her some ways that she could handle her feelings better in the future and cope more effectively with her new family situation and all the changes in her environment. At that point, I was planning to engage Tanya in some immediate crisis resolution sessions before she left the hospital, and I was not certain that she would be able to return for any follow-up sessions (Ewing, 1978; Puryear, 1984).

Before I proceeded any further, I asked Tanya if she had ever had any counseling or any previous experience with mental health treatment of any
kind. When she said that she had not had any previous experience in therapy, I thought it was necessary and appropriate to offer her a brief explanation about therapy, emphasizing the opportunity for her to express her feelings and talk about her problems in an atmosphere of mutual trust and confidentiality. As I suspected, Tanya had some anxieties and fears about therapy, based on her lack of knowledge and exposure to it, but we were able to discuss her fears openly, and I was able to allay her anxieties about any potential stigma, discomfort, or embarrassment she might experience if she talked with me about her concerns. I also reassured her that one of the goals of our discussion would be to help her identify her strengths and her ability to cope with similar problems in the future. Tanya seemed considerably relieved but said she needed to rest and would prefer to have me return the following day.

Hypothesis Testing

After my second session with Tanya, I was able to establish some distance from our intense interactions and to think more about testing several hypotheses to develop a psychodynamic case formulation that would lead to a recommendation for an appropriate treatment plan (Perry, Cooper, & Michels, 1987).

I had arrived at a tentative conclusion that Tanya’s series of traumatic losses had resulted in a period of grief and anger that had not been recognized or addressed by her family. Tanya’s abrupt move to the Bay area to live with her father, new stepmother, and half-sisters exacerbated her feelings of helplessness and hopelessness, resulting in an episode of major depressive disorder. At the same time that her family was trying to mitigate the impact of her mother’s death, Tanya may have experienced the move as a sign of rejection and double abandonment by her Southern relatives, particularly because she was being uprooted from a secure and happy environment with close friends and strong community ties (Shapiro & Freedman, 1987).

The onset of Tanya’s depression was further aggravated by feelings that she was the target of scapegoating by her peers and criticism from her teachers. As she had recounted her mounting frustration with all of these stressful interactions, I noted that she had seemed particularly upset about her boyfriend’s initial request for sexual intercourse. That apparently was the incident that overwhelmed her fragile ego defenses and caused her to decompensate, precipitating the abortive suicide attempt. In fact, the overdose was
probably not an intentional suicide attempt, but more probably a cry for help, a signal to her family and her boyfriend that she felt out of control and unable to cope with these multiple demands and pressures (Gibbs & Hines, 1989; Robbins & Alessi, 1985).

Considering Tanya’s religious background and conservative upbringing, she may have consciously refused to engage in sexual relations with her boyfriend, but unconsciously experienced feelings of sexual desire that made her feel immoral and guilty. These ambivalent feelings could have created a sense of panic that interfered with rational decision making and judgment, allowing her impulses to propel her into self-destructive behavior.

Although the initial information from her boyfriend, parents, and Tanya herself supported this formulation, I planned to meet with her parents again to confirm my assessment of her case. I was aware that clients in crisis are not always the most reliable informants, and I also thought I needed more developmental and family information before I made a definitive formulation of Tanya’s behaviors and symptoms.

**Monitoring Therapist–Client Interactions**

In a crisis intervention situation, the clinician does not have the luxury of a week between sessions to analyze the case, develop the treatment plan, or consider various intervention options. Similarly, the phases of therapy are usually compressed into one to three sessions, depending on the length of the client’s hospitalization. Thus, the therapy focuses on encouraging the expression of feelings about the presenting problem(s), quickly restoring the client’s ego capacities, strengthening problem-solving skills, and developing a short-term treatment plan to address specific limited goals (Aguilera, 1998; Puryear, 1984).

I was aware of the time constraints in my third session with Tanya, which occurred on the morning of her second day in the hospital. Tanya seemed more relaxed, more alert, and considerably more animated after a day of rest and visits from her family and her boyfriend. I was particularly conscious of approaching Tanya with warmth, communicating my empathic understanding of her feelings, and projecting myself as a person who was genuinely concerned about her welfare. I also knew it would be important not to convey disapproval of her behavior, particularly because Tanya had a rather harsh superego and seemed to blame herself for many of the unfortunate things
that had happened to her. I noticed that she responded positively to me, seemed to enjoy talking with me, and was pleased that I knew and understood some of the factors in her background and life experiences that made her a unique person. These were all positive signs of a growing rapport that I could marshal in building the mutual trust and respect needed to facilitate a rapid resolution of her current crisis.

I also recognized some of my own feelings toward Tanya, who alternately evoked maternal and big sister feelings in me because she sometimes reminded me of my two adolescent sons, but as a first-born daughter with three younger siblings, I could also empathize with her role as the oldest daughter in her family. I was aware of the importance of monitoring these feelings of countertransference and not allowing them to influence my relationship with Tanya (Meeks & Bernet, 1990).

**Monitoring the Client’s Responses and Transference**

In responding to my efforts to help her, Tanya’s behavior had gradually changed from an initial shyness, embarrassment, and reluctance to engage fully in the relationship to a more open, less-defensive attitude and a more reflective style of communication. She expressed discomfort about discussing her relationship with her boyfriend, probably reflecting her anxiety about their ambivalent sexual relationship. At several points in our sessions, she expressed resistance by becoming unresponsive or evasive in responding to my questions. She seemed particularly unwilling to discuss her relationship with her stepmother and half-sisters, a topic that was the source of considerable tension in her family and was one of the precipitating factors in her current crisis (Shapiro & Freedman, 1987).

In her interactions with me, Tanya seemed to reach for my maternal instincts and to search for ways to identify with me. She wanted to hold my hand throughout each session when I tried to comfort her while she was crying and in such emotional distress. As she regained some control over her emotions, she showed more curiosity about me, asked me if I had any children, and thanked me several times for helping her to “feel better about myself.” Although it is not useful or appropriate to interpret transference or countertransference reactions in a crisis intervention treatment situation, it is important for the clinician to monitor these feelings and to use them to facilitate the restoration of the client’s functioning and the resolution of the crisis.
Goal Setting and Problem Resolution

In the third session with Tanya, I thought it was important to discuss some short-range goals and some longer-term goals before she was discharged from the hospital. We had previously set up an appointment with her parents for a family session later that afternoon before they took her back home, but I first wanted to develop some individual goals with Tanya.

Tanya and I agreed that there were three immediate and short-term goals: (1) getting treatment for her depression, (2) asking her parents to participate in some family counseling sessions, and (3) clarifying the boundaries of her relationship with her boyfriend. Because we had identified these three areas as major sources of Tanya’s current stress, we selected these areas as appropriate targets of intervention. I discussed referrals for psychiatric treatment and advised Tanya that the psychiatrist who had seen her in the emergency room had prescribed some antidepressant pills for her, so her medication would be monitored by her new therapist in consultation with the hospital psychiatrist (Aguilera, 1998).

Tanya was not sure her parents would agree to participate in family counseling, so we discussed other options, such as pastoral counseling, which might be more congruent with their cultural beliefs. She understood the importance of sharing her feelings with her parents and thought it would be helpful if she expressed her disappointment and feelings of frustration with her household responsibilities and lack of attention from her father, but she was also fearful of alienating her parents and becoming even more of a stepchild in the family. I reinforced Tanya’s desire to discuss her feelings with her family and emphasized that this crisis presented an opportunity for Tanya and her whole family to discuss their mutual feelings, hopes, responsibilities, and obligations, because although the family unit had really changed with her arrival, they had never really confronted the implications of those changes.

Tanya was also eager to discuss with her boyfriend, Marlon, her feelings about intimacy, her reluctance to engage in sexual relations until she felt that she was in a committed, premarital relationship, and her fears about pregnancy and sexually transmitted diseases. Although Tanya felt that Marlon was one of the most supportive people in her life, she also felt that he was causing her a great deal of emotional turmoil. Tanya realized that removing this turmoil would not only reduce her stress, but would perhaps enable her to explore other relationships.
We also explored some longer-term goals for Tanya to work toward when she was feeling stronger and in greater control of her environment. Tanya expressed a desire to become more active in her family’s church in order to feel more integrated into a familiar religious community. Tanya also wanted to be more assertive about developing friendships with two or three classmates who had been friendly and supportive of her when she first arrived. Finally, Tanya realized that it was time to “stop feeling sorry for myself” and to start thinking about her plans after her high school graduation.

By the end of this third session, I was pleased to see that Tanya had made remarkable progress in less than 48 hours after being admitted to the hospital for an overdose of tranquilizers. In setting some short- and longer-term goals for herself, Tanya had exhibited an ability to identify her problems, analyze some of the causes, marshal her motivation to recover, make rational plans, and develop realistic goals to improve her overall personal, social, and family functioning (Ligon, 1997; Puryear, 1984).

**Planning for Intervention**

Because Tanya was a 16-year-old dependent adolescent, it was important to involve her family in the assessment and treatment plan. I met with Tanya and her parents for a final session just before she was discharged early in the evening of her second full day in the hospital. I reported my evaluation of Tanya’s admitting symptoms and her current condition, emphasizing to her parents the severity of her depression but suggesting that the overdose of pills was really a cry for help rather than a serious suicide attempt. I then asked Tanya’s parents if they had any questions or comments before I recommended my treatment plan and follow-up for Tanya.

Tanya’s parents seemed very concerned about her behavior and eager to cooperate in facilitating her recovery. They both expressed relief that she had improved so swiftly and were eager to take her home, where they were planning a welcome home party with her two younger sisters. I used this as an opening to discuss Tanya’s relationship with her parents and sisters and quickly realized that this topic was difficult for them to address.

After I proposed my recommendation of individual treatment for Tanya and family counseling for the entire family, Tanya’s parents were enthusiastic about the individual treatment but more skeptical about family counseling. They responded that they would first like to initiate individual treatment for
Tanya and asked for a recommendation for an African American therapist in the community. They said they would talk to their minister and seek his advice about family counseling, and they did acknowledge the need for the family to discuss the changes brought about by Tanya’s inclusion in their household.

At the end of the session, I asked Tanya and her parents if they had any further comments or questions about Tanya’s problems, her treatment in the hospital, or her follow-up treatment. Tanya spoke first and thanked me for helping her to understand all of the things that had happened to her and to figure out ways to handle her problems better in the future. Her parents also were very gracious, thanking the hospital staff for “saving Tanya’s life” and thanking me for my support and concern for Tanya. As the family left, I sensed that they were hopeful that Tanya would continue to improve and that their relationship with her would improve. However, I also felt that this family needed to work out their issues as a family unit and to be more supportive of Tanya’s need to separate and individuate while still providing her with the nurturance and security to develop as an autonomous young adult.

**CASE SUMMARY**

This case of Tanya, a 16-year-old African American female who presented at a hospital emergency service with an overdose of tranquilizers, illustrates several developmental, sociocultural, and clinical issues in the assessment and treatment of a minority adolescent in a psychiatric emergency situation. Even in crisis intervention, the clinician should be mindful of cultural influences on symptomatology, behavioral norms and values, family and peer relationships, and adaptive behaviors. Most importantly, the clinician must make a very rapid assessment of the patient’s clinical symptoms, their severity, and the patient’s ability to cope with precipitating problems in the context of this broader conceptual framework.

In Tanya’s case, I was able to develop a dynamic formulation of her symptoms and their underlying causes fairly quickly, thus enabling me to facilitate her relatively rapid reintegration after an impulsive overdose of medication in an attempt to alert her parents and her boyfriend to the fact that she was overwhelmed by her current stresses. Tanya responded positively to several sessions of crisis counseling that focused on helping her to express
her feelings, to identify the sources of her emotional distress, to mobilize her problem-solving skills, and to restore her adaptive functioning. Fortunately, Tanya had several ego strengths, a supportive family, and a caring boyfriend, all of which suggested a positive prognosis for her recovery.

REFERENCES


CASE STUDY 1-4 WHAT A FEW CBT SESSIONS CAN DO: THE CASE OF A MOTIVATED YOUNG ADULT

Kathy Crowley

Brief treatment can assist a client to make progress on specific, well-defined treatment goals. Brief therapeutic work may be sufficient for the current state of the client, or it may lay a foundation for therapeutic work in the future. This case describes the use of cognitive-behavioral therapy (CBT) in an important transitional phase of development with a highly motivated young man.

Questions for Discussion
1. What was unique about this case, and how did these unique features impact treatment?
2. Describe Jake’s strengths.
3. How did the therapist know Jake was done, at least for now, with his work in therapy?
4. Is there anything about Jake’s case that you think needed follow-up?
5. Would you consider other resources or referrals for Jake?

THE INITIAL CONTACT

The initial phone call should have been the first tip that this case was going to be unusual. I had been in private practice for about two years, but had worked with teens for the past 20 years. It was not common for a high school student to call and make his own appointment. It turned out that “Jake” had just turned 18 the week prior to his call. He had purposefully waited until he could come in on his own. It would take a bit of in-depth conversation for me to really understand why that was so important to him. Jake needed an after-school appointment that would not interfere with his part-time job or athletic team’s schedule. We were able to find a time within a week, and the appointment was set. Jake was coming in alone to address “issues about school and being 18.”

In just the first call, I was able to identify a multitude of strengths and resiliency in this client. This was someone who knew things were not the way
he wanted, yet he seemed to have a vague notion that it would be possible for things to get better. He believed in himself and knew what things were important in his life. Having someone with multiple social support systems in place is always a plus at the time of intake. He already had positive connections around him. It appeared that there was tension within the family, as he was clear that no parent would accompany him to his first appointment. He had gathered the insurance information he needed, called for an authorization, and informed me that he would make the copayment on his own. This was a young man who was able to get things done. I was looking forward to the appointment.

In preparation for the appointment, I tried to collect my thoughts and begin an early case conceptualization about what I knew so far about Jake. It was evident there was family stress and some type of conflict or distance in his relationship with his parent or parents. I knew that he was a senior in high school and was expecting to graduate. The topic of grades had not come up at all, and because he was on a school athletic team, my initial assumption was that he had at least passing grades. I also knew that the school he attended had a strong drug testing policy and that athletes did not usually take the risk to use substances if they played a sport. These were two more areas of resiliency that would aid in his treatment. It was likely that there were at least some positive adults in Jake’s life between school, sports, and his part-time job. It was also likely that Jake was physically healthy and had access to resources like transportation, some finances to pay the copay, and his own cell phone to make the calls he needed to make to arrange this appointment. I felt well prepared to meet him and get started.

**FIRST APPOINTMENT**

Jake arrived a bit early for his appointment in order to complete the required paperwork. He presented as a tall, healthy, well-nourished, and good-looking young man. He appeared to be of mixed race and/or ethnicity, was well groomed, and very polite. When he entered my office, he did appear a bit nervous as he looked around to take in the environment. He settled into a chair, and his leg bounced for most of the session. Jake reported that he had already been accepted at a state university, and he was eager to finish the last few months of his senior year of high school. He reported that his grades were good and that his part-time job fluctuated between 10 to 20 hours per
week depending on his lacrosse team schedule. Jake was co-captain of the team and proud of his success in being chosen by his peers for this position.

Jake disclosed that his issue was with his girlfriend, Alice. He reported that they have been together for the past 18 months. Two weeks ago, she cheated on him at a party by kissing an acquaintance of Jake’s from the same high school. Some of Jake’s friends witnessed this and forced her to tell him. Now she has broken up with him to date the other person. Jake was heartbroken and feeling despondent over this loss. He reported difficulty with sleeping and eating since this occurred. He also went “partying” with a friend the day after she told him, which was very out of character for him, according to Jake. He knew that if he was caught drinking under age, he could lose his scholarship. Jake reported that he felt “desperate,” which led to his phone call for the appointment.

When asked to describe the relationship with his girlfriend when it was going well, Jake recounted a very intense and close relationship. He reported they would see each other daily before school, in school, and after school. They spent all of their free time together. He also reported that they had “gone on vacation” several times together, including to California and to Mexico. The level of commitment, as well as the quantity and quality of time together, sounded much more like a marriage than a high school relationship. Jake concluded this description by saying, “She means everything to me. She is the only family I have.”

At this point, Jake went on to discuss his family of origin. He was an only child, and his parents divorced when he was 10. When he was 12, his father completed suicide as a result of stress in his life and an inability to pay any child support, which lead to no contact with Jake. Jake reported that his father had been on the verge of losing his job. His father left him a note that said that his choice to end his life was the only way he could provide any support for Jake through the insurance benefit. After his father’s death, his mother fell apart emotionally. She was able to maintain her job, but she distanced herself from Jake and, according to Jake, “spent her free time trying to find a new husband.” Jake felt like he had been on his own since his father died and reported that he has lost respect for his mother. At the present time they were barely speaking to one another, although Jake still lived at home with her and was using insurance from her job to pay for his services.

Jake was aware that his relationship with Alice was intense because of his own home situation. He reported that she had troubles of her own and that
they were able to meet each other’s needs. His best friend had also been in a long-term relationship, and the two couples would celebrate holidays and travel together. Jake reported that all four of them were accepted to the same state university, which is located about two hours from where they currently attend high school. His friend’s family had a house there that the four of them were going to rent together. Since the breakup, Jake felt like he would need another plan about where to live, because he no longer wanted to live with his friend and his friend’s girlfriend.

Jake felt overwhelmed by his emotional response to these recent events. He wanted to find a way to manage his anger, hurt, disappointment, and uncertainty. At this point, I introduced and explained cognitive-behavioral therapy (CBT) to Jake. Jake was quick to catch on to the idea that thoughts, emotions, and behaviors are all connected. He could see how the influence of his environment and his physical reactions were also tied together. At the end of the first session, I gave Jake reading material about CBT and asked him to observe when he was most upset or overwhelmed and to notice what was happening internally as well as around him at that time. Conversely, he was also asked to notice when he felt included by others and had a feeling of being accepted.

Our initial plan was to address Jake’s thoughts that he is “unlovable” and that “the people I love leave me.” Because of Jake’s level of maturity and his ability to actively participate in setting his goals, we were able to complete a portion of a thought record in the first session. His statement that “the people I love leave me” was addressed, and together we identified evidence both for and against this belief. Jake was well prepared to provide a great level of detail about times when this was the case. He used his father, his mother, and his girlfriend as examples. However, he was unprepared for what he found when we did the “evidence that does not support the hot thought” section of the thought record. Jake had many people in his life who had been there for a long time. He had many friends, both male and female, who he had gone to school with since kindergarten. He was popular among his friends and had lost only a few friends over the years. Likewise, he was close to his high school and club lacrosse coaches and very close to his best friend’s parents. All of them had stood by him during his parent’s divorce and his father’s death. Most of these people knew his mother was not emotionally available to Jake, and they offered a great deal of support to him over the years. This activity brought tears to Jake’s eyes as he realized he was not as alone as he
had thought. He requested to have a few blank copies of the thought record so he could complete a “few more of these” between sessions.

This was a great end to a first session. Jake was very open to feedback and was eager to know that he was lovable. Jake had many strengths to utilize to assist in the therapeutic process. He had not told his friends that he was coming to counseling, but he told his coach. He was worried that he would be judged, but his coach supported the choice for Jake to attend some sessions. I knew this was going to be a client who would not need many sessions. He was highly motivated and would need clarification of his thought processes as well as some objective feedback and support to discover the many internal strengths he already possessed.

SECOND APPOINTMENT

Jake returned one week later. He brought the thought records back with him, but he had not completed them. He wanted to do the activity together, as he was concerned it might be “too difficult” for him to process on his own. He had thought about our discussion and had many examples of when he had been upset and overwhelmed that he wanted to discuss. Jake was able to select one particular example (See Table 1.1). He was able to note the impact of the circumstances on his thoughts, emotions, behaviors, physical reactions, and the environment. Jake was able to identify a situation when he was in the school cafeteria and saw Alice with her new boyfriend. As we worked our way through the thought record, he was very articulate, describing the event in great detail. He included who was there and how the environment of her being with someone else in front of all his friends escalated his thoughts, emotions, and physical reactions. He was proud of the fact that he did not have a negative behavioral response. He reported that his heart was racing and his palms were itching, but he knew he should not start a fight, despite his desire to do so. Jake reported that, in the moment, he knew that this would be the situation he most wanted to address at his next session.

As we progressed on the thought record, we hit a snag when we came to the “evidence that does not support the hot thought” section. He did not want to identify anything in this category. He explained that he was not exaggerating and that his “hot thoughts” were accurate. Using a sports analogy of how the members of the team all have a different perspective on what happens during a game, he came to see how even he could have a differing point
Table 1.1  Jake’s Thought Record

<table>
<thead>
<tr>
<th>Situation</th>
<th>Mood</th>
<th>Automatic Thoughts</th>
<th>Evidence Supporting the Hot Thought</th>
<th>Evidence Against the Hot Thought</th>
<th>Alternative/ Balanced Thoughts</th>
<th>New Rate for Mood</th>
</tr>
</thead>
<tbody>
<tr>
<td>I saw Alice in the cafeteria with her new boyfriend and she was kissing him right in front of me.</td>
<td>Anger 100%</td>
<td>I should fight him.</td>
<td>She dumped me for my “friend.”</td>
<td>My friends all say she was dumb to drop me.</td>
<td>Maybe the relationship was too intense.</td>
<td>Anger 70%</td>
</tr>
<tr>
<td></td>
<td>Embarrassed 80%</td>
<td>I can’t believe she left me for him.</td>
<td></td>
<td>Other girls are asking me out.</td>
<td>I don’t think she wanted to be so serious.</td>
<td>Embarrassed 25% (She’s the one who should be embarrassed.)</td>
</tr>
<tr>
<td></td>
<td>Lonely 60%</td>
<td>No one will stay with me.</td>
<td>I am still functioning without her now that 2 weeks have passed.</td>
<td>Other people still like me.</td>
<td></td>
<td>Lonely 20%</td>
</tr>
</tbody>
</table>
of view without the initial view being “wrong.” When we arrived at the end of the thought record and examined the “balanced thoughts” and re-rated his moods, he was genuinely surprised at how different he felt both emotionally and physically. This was different from the previous week, when the emotion we had addressed was sadness. Jake had more difficulty addressing his anger, and it was more of a challenge to see the “evidence against.” He asked if he could try another situation, but if we could do it “without the piece of paper.” Verbally we went through the same process of identifying a situation and going through the steps outlined on the thought record. Jake reported the same sense of relief after the next scenario was done. He suggested that he continue to practice this on his own. He did not want the paper, as he was worried that his mother might find it at home. He also wanted to be able to attempt to do this “in the moment.” We addressed the challenges that approach might create if he was angry, but he was motivated to give it a try.

THIRD AND LAST APPOINTMENT

Jake returned in one week. He reported that he had been doing this process in his head “almost daily.” Jake had memorized the categories so that he could do this on his own, anywhere, and at any time. He reported that he could do this in class and no one would know that he was working his way through the process. Jake reported that he was now sad that the relationship had ended, and he felt like he was grieving the loss of his future with Alice. He was no longer questioning his own worth regarding the end of the relationship. He again addressed his fear that he may be “unlovable” because of his family history. He reported this view changed over the past week when several girls expressed an interest in dating him. He expressed a possibility to have some dates, but he wanted to avoid a serious relationship because of planning a move in a few months to start school. Jake reported that he contacted the university and found out he could still get into a dorm. He had decided to enjoy college life without having to worry about the responsibility of sharing a house that would require yardwork, cooking, repairs, etc.

Jake felt that he would be able to apply his newly learned skills in various new situations that may arise in his future. We brainstormed when or why it might be difficult to use these skills and identified potential challenges that lay ahead for him. Jake set some goals for himself both for before and after he left for the university. One of his short-term goals was to try a thought
record regarding his relationship with his mother. He did not want to move out with any unresolved conflicts between them. Jake was done. He had been able to learn and apply the skills of CBT on his own in a variety of situations that allowed him to regain his confidence in his ability to manage his own life.

This was an unusual case in many ways. It is certainly not typical to have a teen come in with such a significant family history and get what he needed in only three sessions. Once Jake recognized all of the supports he did have in his life, he was able to really challenge the notion that he was unlovable. There were many people in his life who were not obligated to care about him, and yet they did. This really helped his view of himself and how he presently did—and in the future could—fit into the world.

This case was also different in that Jake had grieved the loss of his father but had not really grieved the loss of his mother as well. Although she was physically present, she was not really emotionally available to support him. As Alice broke away from him, Jake came to realize that he would have to address his relationship with his mother. He seemed to be able to see how she was suffering, and he was able to recognize that her actions were not a rejection of him, but they were all she could offer him at the present. I wish Jake would have been willing to have his mother join him to address these issues in family therapy, but Jake wanted to address this matter in his own way and in his own time. I think the success that Jake experienced in the course of therapy will be beneficial for him. If he has a need to return in the future, he will likely do so, without fearing the judgment of others or a sense of failure in himself.
CASE STUDY 1-5 THE CASE OF AUNDRIA: TREATING SUBSTANCE ABUSE DURING ADOLESCENCE USING CBT AND MOTIVATIONAL INTERVIEWING

Paul Sacco
Charlotte Lyn Bright
Janai Springer

This case focuses on social work intervention with an adolescent who has been arrested for marijuana possession. The social worker utilizes motivational interviewing (MI) and cognitive-behavioral therapy (CBT) techniques to engage this young woman to help her to consider making a change in her cannabis use.

Questions for Discussion
1. What challenges does the social worker face in helping this young woman to consider making a change in her marijuana use?
2. How are motivational interviewing and cognitive-behavioral approaches applied to this particular case?
3. How does the social worker develop a therapeutic alliance with the client?
4. What additional resources or supports might be useful to this client and her family?

AUNDRIA: AN INTRODUCTION

I first met Aundria, a 15-year-old sophomore in high school, at the local courthouse, where she was awaiting a court appearance for possession of marijuana and drug paraphernalia. This was her second arrest for these charges in a period of six weeks, and I could tell as I arrived that both Aundria and her mother Judy were terrified of what might happen. They were sitting on a wooden bench, waiting in silence for the judge to call their case. Aundria and Judy looked remarkably similar physically, with curly blonde hair and pale blue eyes. In the dimly lit hallway, both appeared tiny enough to disappear, small within the expanse of the courthouse hallway.
Upon arriving, I introduced myself to them and asked whether they were aware that Aundria’s juvenile probation officer, Vanessa Smith, was recommending to the judge that Aundria participate in outpatient substance abuse treatment as a condition of her probation. I explained that the judge would order Aundria to work with me and other substance abuse counselors for at least six weeks if this recommendation was accepted. Aundria nodded nervously, and her mother added, “I just don’t want her to get taken away.” It was clear from this early exchange that both this young woman and her mother were primarily interested in keeping her out of congregate care. What I did not know yet was the extent to which Aundria considered her use to be a problem, and her willingness to consider making changes.

Moments later the court called Aundria’s case, and we entered the courtroom together. Aundria’s probation officer and her attorney were already in the courtroom. The juvenile court judge invited Ms. Smith to report on the case. The probation officer explained that Aundria had been arrested for the first time six weeks earlier for possession of marijuana at her school; this incident led to her arrest and suspension from school. Based on her lack of prior arrests and agreement to participate in self-help groups for substance use, Ms. Smith placed Aundria on informal probation without involving the court. Because of her second possession arrest in such a short time, Ms. Smith felt that a more intensive response was needed. She recommended that Aundria be placed on formal probation and required by court order to participate in outpatient substance abuse treatment. At this point my role became clear to all involved. I was going to work with Aundria, and hopefully prevent her from having further problems with drugs. In the moment, I was aware that this would be a complicated process and would require that Aundria go through a process of evaluating her use and its consequences and consider what, if anything, she wanted to do about it. I was feeling daunted by this challenge, but hopeful that I could make a connection with this young person. Ms. Smith, a colleague and friend, nodded in my direction as she indicated that I was present in the courtroom and that I was willing to work with Aundria.

Throughout Ms. Smith’s testimony, Aundria’s eyes were downcast. It was clear that she was overwhelmed and wanting to be anywhere but standing in front of the judge. In the discussion that ensued, Aundria’s attorney indicated that Aundria and her mother were both in agreement with the
recommendation, because they believed that Aundria’s use of marijuana had become a problem for her. When asked if they wanted to make a statement, Aundria and Judy declined to do so. The judge then ordered that Aundria be placed on formal probation for six months, and that she successfully complete outpatient substance abuse treatment during that period. Judy and Aundria greeted the news from the court with a sigh of relief. They seemed pleased that Aundria would be able to undergo treatment on an outpatient basis and would continue with her normal school routine.

Following the hearing, we set a date the following week for an initial session and agreed that Aundria would begin treatment within two weeks. I asked Aundria and Judy to sign a release of information so that I could inform Ms. Smith about Aundria’s progress in treatment. Neither Aundria nor Judy said much, but both appeared to be in agreement with the plan.

In many ways, Aundria represents a typical adolescent who is entering treatment through the juvenile justice system. Almost half of all youth in juvenile detention facilities (45%) may have a substance use disorder from marijuana use, either alone or in combination with alcohol and/or other drug use (McClelland, Elkington, Teplin, & Abram, 2004). It is important to note that current evidence does not suggest that being court mandated for treatment is associated with worse outcomes, and it may even serve as an incentive to complete treatment (Coviello et al., 2013). Still, one challenge in working with youth such as Aundria is maintaining a balance between the roles of a social worker serving the client and of an agent with the responsibility to report back to the court. Also, with adolescents, the social worker has a responsibility to work with the parents, such as Judy, who should be incorporated into the helping process. Social workers should state clearly what information they will share with the court and with parents, and obtain releases of information. In the end, this transparency will help build a stronger therapeutic bond between the client and social worker. Being upfront with the client is only one component, though. The social worker must also respond nonjudgmentally; the social worker is responsible to report to the court, but she or he should avoid interacting with clients like a judge or parent. In my role, my goal was helping adolescents to develop their own ability to make decisions about using drugs in the context of arrests, court involvement, and family relationships.
Aundria and Judy arrived for our first meeting promptly. The purpose of this first meeting was to complete an initial psychosocial assessment. During the one-hour meeting, I talked with Aundria individually, and then met with mother and daughter together. In the session, I employed a developmental assessment process (Vernon & Clemente, 2005) to better understand Aundria’s use of substances in context, as well as her functioning in multiple areas.

I incorporated standardized measures, the Substance Abuse Subtle Screening Inventory (SASSI), Adolescent Version (Miller, 1985, 1999) and the CRAFFT (Knight et al., 1999). The SASSI is a masked assessment tool that can gauge risk of substance-related risk without asking overt questions about alcohol and drug use. It can be useful with adolescents in getting a sense of substance abuse risk among individuals who may not be forthcoming about their use. Its main shortfall is that the measure is copyrighted and fees apply for administration. The CRAFFT screen is an assessment that utilizes six questions in the form of an acronym (see Table 1.2). This is a useful screening tool for identifying probable substance abuse or dependence. Both of these assessment tools can be self-administered, so a client like Aundria can complete them before even meeting with the social worker. These instruments can then be used to inform the initial assessment.

Beyond these screenings, I asked Aundria about her use of alcohol and other drugs in addition to marijuana and her quantity and frequency of use of these drugs recently and over her lifetime. When I asked her these questions, I was mindful to adopt a nonjudgmental tone and asked about each

| C | Have you ever ridden in a car driven by someone (including yourself) who has been high or had been using alcohol or drugs? |
| R | Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in? |
| A | Do you ever use alcohol or drugs while you are by yourself? (alone) |
| F | Do you ever forget things you did while you were using alcohol or drugs? |
| F | Do your family or friends ever tell you that you should cut down on your drinking or drug use? |
| T | Have you ever gotten into trouble while using alcohol and drugs? |
drug separately (i.e., “How often do you drink alcohol?”). I avoided grouping all drugs together (e.g., “Do you use drugs?”) or asking the questions in a way that unintentionally communicates judgment (“You don’t abuse speed, do you?”). I asked about the context of recent use, such as where Aundria was and who she was with when use occurred, as I knew this could be important to prevent relapse. I also asked Aundria and Judy some questions about their family dynamics and history, and asked Aundria about her accomplishments and struggles in school, with friends, and in the community. Particularly among girls and women, struggles with substances are often related to experiences of trauma (Briggs & Pepperell, 2009), so I asked multiple questions about experiencing or witnessing violence.

One of the challenges with assessing and treating substance use in adolescents is distinguishing their symptoms from normal, or typical, adolescent behavior (Erk & Field, 2008). The majority of adolescents engage in alcohol (72%) or drug use (47%) by the end of high school (Johnston, O’Malley, Bachman, & Schulenberg, 2012), so although this behavior is risky, it is also normative to some degree. Therefore, I focused attention on what preceded and followed Aundria’s experiences with marijuana and other drugs, and I talked with her about the legal and other consequences she had encountered. It is important in working with adolescents to avoid simple rules-driven responses to use; instead, the focus should be on the individual. I took this approach with Aundria.

Results from the assessment indicated that drug and alcohol use had disrupted Aundria’s functioning in several important ways. Unlike most youth, her substance use had led to two arrests in a short period, indicating that marijuana use was impacting her ability to function in the community. Aundria also stated that her grades had worsened, and she was in danger of repeating the tenth grade. She acknowledged daily use of marijuana, including while alone, and described use of marijuana as a way to “feel better about myself” and “forget about my problems.” She also endorsed drinking on the weekends and one or two days during the week, but denied other drug use. Alcohol and marijuana are the most common substances used among adolescents (Conway et al., 2013), so Aundria’s use pattern was one I had observed with other clients. At least one of Aundria’s friends had expressed concern about the level of Aundria’s use, despite that friend also using marijuana on occasion. Aundria indicated that the majority of her friends were drug or alcohol users and that her boyfriend of six months was her primary supplier.
According to the SASSI results, Aundria had a high probability of substance abuse but a low probability of substance dependence.

Aundria’s mother provided valuable information on family history and dynamics. Judy blamed her divorce, 10 years earlier, from Aundria’s father on “drinking . . . just both of us drinking, every day, all the time. I thought I had it all together and could be a good mom to Aundria. I think [my ex-husband’s drinking] fueled my drinking, and I just wasn’t even thinking straight. Eventually I came out of the fog. I don’t know how, exactly, but I started to realize that my relationship with Aundria wasn’t what I wanted it to be. Her dad wasn’t willing to change, and I was. I packed her up and we left, moved in with my mom in Ohio.” Judy stated that neither she nor Aundria was in contact with Aundria’s father, and that she believed he was still a “heavy drinker.” I asked Judy about her own recovery, and she reported having spent 30 days in an inpatient facility immediately after moving in with her mother. During that time, Aundria was in the care of Judy’s mother. Since that time, Judy had attended Alcoholics Anonymous meetings and, despite “a few slips over the years,” said that she was proud to have received her one-year chip, marking a year of complete sobriety.

After hearing about this possible multigenerational pattern of use, I explored Aundria’s reactions and perceptions about what her mother had disclosed. She said, “I don’t think my mom and dad drinking had anything to do with me smoking weed. I do think I feel lonely sometimes, and I miss my dad and my grandma [who still lives in Ohio], and that’s part of the reason I smoke weed.” Aundria and her mother denied any history of violence or maltreatment beyond the alcohol abuse during Aundria’s early childhood.

From this assessment, I developed several hypotheses about Aundria’s substance use. As she acknowledged, she had experienced substantial losses and seemed to have little family support beyond her mother. It appeared that Aundria lacked sufficient ability to cope with her difficult feelings. Although she denied any influence, I suspected that her parents’ drinking had shaped her understanding of “normal” behavior and that she had internalized a belief that substance use was one way to handle problems. I believed that some of the temperamental risk factors that may have contributed to her parents’ alcohol problems could be present for her as well. I was concerned that her peer group, and her boyfriend in particular, reinforced her beliefs about cannabis use. I planned to address the thoughts that led to
her use of marijuana in our early sessions and to encourage her to develop new cognitions.

**INITIAL SESSIONS: AUNDRIA’S AMBIVALENCE**

I expected to meet Aundria again the following Monday, and we had arranged that Judy would transport her to my office after school that day. I was surprised and disappointed when Aundria did not arrive. I called her mother and left a message, but I did not hear from her until the next day, Tuesday. “Aundria was out all night,” she said. Judy’s voice sounded tired, but I noted a lack of surprise. “She came home around six this morning, and I’m sure she was high as a kite. She’s still sleeping now. I couldn’t get her to go to school. I don’t think she went to school yesterday, either.” I expressed to Judy my concern that Aundria’s use of marijuana was escalating and becoming more disruptive to her functioning. I explained that, furthermore, if Aundria could not engage in work with me, her probation officer or the judge might decide that a higher level of care, such as inpatient treatment, was required. Judy insisted that Aundria would benefit from outpatient work, and I agreed to reschedule our meeting for the next day.

One day later, I was relieved when Judy escorted Aundria to my office at the scheduled time. After Judy left, however, my enthusiasm dampened. Aundria presented as sullen and withdrawn. I asked a series of rapport-building questions about school, friends, and family, which generated one- or two-word replies. Aundria sat with her arms crossed, jiggled her foot, and looked up at the ceiling for the first several minutes. Addressing the missed appointment and my concerns about escalating use, however, elicited a much stronger reaction. Aundria exploded in a series of somewhat contradictory, but seemingly genuine, comments: “I do not have a problem. Marijuana is not a big deal. It’s not getting worse . . . I just freaked out and needed to get away. I don’t think the answer is for me to stop smoking.” For the first time, Aundria looked me in the eye and appeared invested in what she was saying. At this point, one might think that the best approach would be to confront Aundria with her recent arrests and set her straight about the negative impact of cannabis on her life. The problem with this tactic is that the social worker may come across as sounding much like Aundria’s probation officer or parent, unintentionally reinforcing client resistance.

Therefore, rather than confrontational techniques, I looked at this as an opportunity to build rapport and begin to establish a therapeutic alliance.
Using a motivational interviewing (MI) approach, I responded by listening seriously and carefully to what she was saying, summarizing and paraphrasing (e.g., reflecting that she disagrees with the current plan to reduce or eliminate her use of marijuana), and adopting an accepting rather than a judgmental attitude (Tevyaw & Monti, 2004). I used two techniques in particular from MI, “expressing empathy” and “rolling with resistance,” with a goal of helping her to think through her marijuana use and its role in her life (Rollnick & Allison, 2004, p. 109). Central to the practice of MI is the idea that motivation for changing a behavior like marijuana use would need to come from Aundria and could not be imposed on her (Rollnick & Miller, 1995). MI is a great approach for social workers, because it respects self-determination and builds the foundation of self-regulation, goals that are consistent with social work values. It should be noted that these MI approaches should not be considered a kind of trick that social workers do on clients, but an attitude toward working with young people that takes root in techniques (Miller & Rollnick, 2009).

Aundria was much more engaged during our next two sessions together. She arrived on time, focused attention on our conversation, and appeared open to discussion. I concentrated on “beginning where she was” and did not push her to acknowledge a problem with marijuana. Instead, I talked with her about her plans and goals for her life. She indicated that she wanted to be the first person in her family to attend college, she wanted to build a career in “business or finance or something,” and she wanted to “reunite with [her] grandma in Ohio.”

My rationale for this approach was to “develop discrepancy,” to use another MI term; my intention was to encourage her to think for herself about how daily marijuana use fit and did not fit into her goals for her life. To begin enhancing her motivation for work, I encouraged her to think about whether her use of marijuana was helping or hindering accomplishment of these goals and in what ways. She related that marijuana use had interfered with her educational accomplishments and that her grandmother “wouldn’t like it at all.” I reflected on our initial assessment session, during which Aundria had indicated that marijuana use helped her deal with feelings of loneliness and loss. I asked whether, in the long term, marijuana would increase or decrease these feelings. Aundria was quiet for a minute, and then said, “I always feel better when I smoke. Or, I feel less bad, anyway. But I think it also drives a wedge between me and my family.” Aundria and I went on to talk in great
detail about this response, that the cannabis use helped her in some ways but in other ways exacerbated the very problems she was attempting to resolve. In this session, another MI technique that I used was eliciting “change talk.” In the approach, I attended closely to statements made by Aundria that moved her toward changing her behavior, essentially applying selective reinforcement. In the words of a colleague, “What you pay attention to grows.”

**ACTION PHASE: USING CBT APPROACHES**

Beginning around the fifth session, I introduced Aundria to several approaches consistent with cognitive-behavioral therapy (CBT). This was based on the idea that through our earlier sessions, Aundria had reached the so-called Action stage (see Figure 1.1) of Prochaska and DiClemente’s Transtheoretical Model of Change (TTM; Prochaska & Di Clemente, 1982). First developed to describe smoking cessation, TTM is a theory that describes the processes people go through to make change in their lives. Aundria was ready to focus more on specific techniques for avoiding use and replacing cannabis use with other behaviors. If she was still ambivalent about her use, or flatly refused to quit her pot smoking, this would be a counterproductive endeavor.

![Figure 1.1](image-url)  
**Figure 1.1**  Prochaska and DiClemente’s Transtheoretical Stages of Change Model
Although many treatment options are available for adolescents who are experiencing problems with substances, CBT has substantial research evidence and long-standing practice wisdom supporting its success. In addition, because CBT comprises a wide variety of intervention strategies, it offers flexibility in dealing with the multidimensional determinants and impacts of substance use in adolescents. CBT is noted for its ability to help adolescents change the behaviors associated with drug use and increase the instances of positive behaviors that will counteract substance abuse patterns (Becker & Curry, 2008; Hogue & Liddle, 2009; Liddle, Dakof, Turner, Henderson, & Greenbaum, 2008; Tripodi, Bender, Litschge, & Vaughn, 2010). Strategies such as emotional regulation, making social support connections, anger management, coping skill building, and relapse prevention training are common components of CBT to address adolescent substance use.

Using a CBT approach, Aundria and I worked on changing her use behavior from three different vantage points, based on the cognitive triad of thoughts, feelings, and behaviors. During sessions, Aundria and I discussed the so-called automatic thoughts that were associated with her use. In 12-step nomenclature, these are often referred to as “stinking thinking” or ideas that lead to use. For example, Aundria discussed her belief that pot was the only thing that could help her to manage her painful feelings of loss and loneliness. In our work, we discussed finding ways of replacing these beliefs with more rational ones, and just as importantly, thoughts that will encourage different behaviors (Newman, 2004). Coupled with this approach, Aundria and I talked extensively about alternate ways for her to deal with these painful and difficult feelings in a way that did not make them worse. It is often helpful to engage clients in a strengths-oriented way to identify unique methods of coping that work for them, rather than imposing techniques on them. Still, curriculum materials offer a framework of potential options for coping (Jankowski, Rosenberg, Rosenberg, & Mueser, 2011).

On a more basic level, Aundria had the task of changing the “people, place, and things” associated with her use. This meant, first, getting rid of all drug-related paraphernalia and drugs from her house. This is more complicated than it may seem on its face, because ambivalence at times drives a client to keep a stash of drugs in the home “just in case.” It also meant jettisoning drug-oriented music and other media. Probably the most challenging aspect of these changes relates to the peer group, who ironically represented a bulwark against the loneliness that plagued Aundria. Rather than issuing
her an ultimatum, I talked with Aundria about ways that she could avoid particularly risky settings, and we scripted a conversation for her to use with her boyfriend about her desire to distance herself from use. We spent time in session discussing her concerns that this might hurt their relationship, and we conducted role-plays to support her ability to set boundaries with her close friends. We ended up trying a combination of avoiding situations where marijuana was used and working on skills for refusing drugs. These options included cognitive techniques such as “thinking through” the using to the end instead of just thinking about being high. Because she was being randomly screened for drugs, this thought process included the recognition that she would have to deal with the legal repercussions.

TERMINATION: REFLECTIONS ON WORKING WITH AUNDRIA

During the sessions that followed over the next four months, Aundria and I continued to monitor her urges to use drugs and worked together to plan ways of avoiding use. Nonetheless, these sessions were hardly limited to conversations about drug use. Aundria talked about her boyfriend and friendships, her disappointments and hopes for the future, and her struggles with her family. During the time that we worked together, her mother had relapsed in her alcohol use, which really shook Aundria’s determination to stay clean. She also made the decision to end her relationship with her boyfriend, as she discovered that drug use was the main thing that linked them. In the absence of marijuana, their relationship had crumbled. Aundria also had a “slip,” an episode of use, on at least two occasions, but she was able to stay connected with me and get back on track.

Aundria and I developed a written relapse-prevention plan during the end stage of our work together. We reviewed the skills she had learned and discussed additional resources (including 12-step programs, the school counseling office, and a crisis hotline) that would be available to her at no cost and no need for a referral. I emphasized that these resources were not just about drug use but also sources of support for dealing with difficult emotions. I further encouraged Aundria to consider Alateen to help her manage her feelings related to her mother’s not-always-successful efforts to maintain sobriety.

Two overarching conclusions can be gleaned from my work with Aundria. The first is that, to achieve and maintain sobriety, young people like Aundria
have to make changes in almost every area of their lives during a period of development (adolescence) when change is constant. We have the obligation as social workers to respect the challenges young people like Aundria face. The second is that relapse is the norm, not the exception, in working with youth who have drug and alcohol problems. After six months, Aundria completed her probation successfully, and our work together ended. Because I did not work with her again, I do not know whether she started to use again, but I am confident that the use of collaborative MI and CBT techniques means that if she needed help again, she would start with some tools already in her toolkit.

REFERENCES


CASE STUDY 1-6 A DEVELOPMENTAL APPROACH TO WORKING WITH SEXUALLY ABUSIVE YOUTH

George Stuart Leibowitz
Susan L. Robinson

Working with youth who have sexually abusive behaviors requires considerable expertise to address the complexity of contributing factors and safety concerns. This case provides an introduction to this complexity through the assessment and treatment of a 14-year-old boy, highlighting the developmental and contextual considerations.

Questions for Discussion

1. How do risk assessment tools and an understanding of static and dynamic risk factors associated with sexually abusive behavior inform treatment planning and recommendations? Which dynamic risk factors are apparent in Joshua’s case?

2. How does developmental contextual theory and social learning inform social work practice with youth who have sexually harmful behaviors? What developmental pathways are evident in this case?

3. What do you think was Joshua’s motivation for offending? Consider level of force, modus operandi, and victim selection.

4. How are co-occurring mental health issues (such as ADHD) and the effects of traumatic stress related to offending behavior? What are the implications for treatment?

5. How does the practitioner establish therapeutic alliance and simultaneously address complex trauma/PTSD and offending behavior in Joshua’s case? How might the practitioner work with this youth and draw from his strengths and resiliencies?

6. What are callous-unemotional traits, and what specific challenges might they present in treatment?

7. What types of modalities might be effective when working with sexually abusive youth?
INTRODUCTION

Working with youth who have sexually abusive behaviors is a complex undertaking for the social work professional. Effective practice with this population requires understanding the etiological factors and the psychosocial context contributing to sexual offenses; incorporating current advancements in the field is critical to implementing community-based prevention and intervention approaches (Kaufman, 2010; Ryan, Leversee, & Lane, 2010). Advancements include the research on complex trauma and maltreatment among adolescents who are involved in the juvenile justice system (Ford, Chapman, Connor, & Cruise, 2012; Maschi & Bradley, 2008). Neurodevelopmentally informed approaches to working with sexually abusive adolescents underscore that early adversity and trauma impact the brain and behavior (e.g., Longo, Prescott, Bergman, & Creeden, 2013). Additionally, the recidivism research and empirical findings regarding the validity of risk assessment tools in predicting future offenses (Prescott, 2006; Reitzel & Carbonell, 2006; Viljoen, Elkovitch, Scalora, & Ullman, 2009; Worling, Littlejohn, & Bookalam, 2010) must be considered, as well as practice frameworks delineating the family and social context in which sexual abuse occurs.

Sexually abusive behavior among juveniles encompasses hands-on, non-assaultive, and hands-off offenses that include child-on-child sexual harassment, rape, incest, exhibitionism, and voyeurism (Rich, 2003; Ryan et al., 2010). Differentiating which sexual behaviors are developmentally appropriate and which ones are harmful is also part of negotiating the terrain of assessment and therapeutic practice. The heterogeneity of sexually abusive youth dictates that careful consideration is rendered in developing a comprehensive and individualized treatment plan to best meet their developmental needs and offending behaviors.

Of the 14,500 juvenile arrests for sex offenses, other than rape and prostitution, 47 percent involved youth under age 15, and juveniles were responsible for 15 percent of forcible rapes (Puzzanchera, 2009). The number of adolescents involved in the legal system for sexually abusive behavior increases at age 12 and plateaus after age 14. Early adolescence is the peak age for offenses against younger children (Finkelhor, Ormrod, & Chaffin, 2009). Moreover, sexual victimization has been found to have the greatest impact on subsequent sexual offending and sexual fantasy in developmentally sensitive periods (ages 3 to 7), when children rapidly acquire inhibition skills and
cognitive flexibility (Grabell & Knight, 2009). These findings illustrate the importance of early intervention, as well as the need to account for the differences in the developmental trajectories between youth who offend against children and their counterparts (i.e., delinquent youth and sexually abusive youth who offend against peers; Leibowitz, Burton, & Howard, 2012; Netland & Miner, 2012; Seto & Lalumière, 2010).

As the following case study of Joshua (age 14) demonstrates, offense-specific treatment should consist of multiple modalities to best address the youth’s individual and family needs, which include cognitive-behavioral therapy (CBT; Carpentier, Silovsky, & Chaffin, 2006), family-based interventions, and trauma-informed approaches. This case study also illustrates the importance of a comprehensive psychosexual evaluation and understanding of the developmental and contextual antecedents to sexual harm (e.g., childhood adversity and co-occurring mental health issues), as well as the challenges associated with enhancing motivation, the development of self-regulation capacities and skills building, and addressing risk and promoting protective and resiliency factors in clinical practice. Additionally, in light of research linking trauma, callous-unemotional traits (CU; includes lack of empathy and risk taking), and disinhibition/impulse control among sexually abusive youth (e.g., Knight & Sims-Knight, 2004; Lawing, Frick, & Cruise, 2010; Netland & Miner, 2012), the case highlights strategies for addressing the presence of these traits in treatment. The case study focuses on practice with male adolescents who have sexually harmfully behavior, which may not generalize to females, who have specialized assessment and treatment needs (see Robinson, 2006).

CASE STUDY

Demographics and Sex Offense History

Joshua is a 14-year-old Caucasian male in the ninth grade, who was referred by the Department of Children and Families for an ongoing assessment of his level of risk to the community and treatment needs following a substantiation for sexualized behaviors toward a 6-year-old girl in a previous foster home. Joshua’s modus operandi (tactics used to gain sexual compliance) included bribes, telling the girl to pull down her pants, exposing his penis, and giving her toys if she “kissed his privates.” He told the young girl that he would give her necklaces and toys if she complied.
Joshua acknowledged that he told the victim not to tell and stated the abuse may have occurred once or twice, and consequently, he does not believe she was harmed by his actions. Joshua maintained that he does feel shame talking about the abuse, and he initially denied bribing the young girl. He indicated that when he is around younger children, he sometimes experiences sexual urges, and he stated, “sometimes I need to be away from little kids.” Joshua attributed the emergence of these urges, and his overall underlying anger, as related to physical, sexual, and emotional victimization by his parents (discussed in the family section).

There were ongoing reports of Joshua having inappropriate sexual behavior with other younger girls beginning at age 9 (exhibiting “subtle” behaviors, as well as more intrusive touching behaviors) when Joshua lived with his biological parents, and with same-age or younger boys, involving fondling (their penises). His victim selection appears diverse (in age and gender), and his offense patterns are associated with high levels of impulsivity. Additionally, social workers and therapists have described his tendency to minimize his behavior and to exhibit low empathy following his actions. Joshua has a history of downloading hard-core pornography, and he has stolen the credit card numbers of foster care providers to pay for the images. The sexual evaluation revealed a history of frequent masturbation to pornographic material, involving younger male and female children, and with same-age females. Deviant sexual arousal/sexual drive and preoccupation is an important consideration for treatment, and is strongly supported as a risk factor (Worling, 2012; Worling et al., 2010).

Joshua also has an extensive history of nonsexual offenses, including animal cruelty, destruction of property, stealing, fire-setting, and verbal and physical aggression toward younger children and adults, including social workers and treatment providers.

**Family History**

Joshua is the second child born to Joan and Bob, who divorced when he was 4 years old. His siblings, Jill (17) and younger sister, Tracy (12), are living with a foster family, and they have sporadic contact. He reported being closest to Tracy, and that he would like to regain contact with his biological father “someday.”

Joshua recalled that he was exposed to domestic violence, and he was physically, sexually, and emotionally abused by his mother (e.g., belittling
him, slapping him on the face, and touching him on the genitals when he was 4 years old, in front of male partners who also sexually abused him). He reported that his father was also abusive, and he recalled being harshly disciplined with a belt and forced to “drink soap.” Additionally, his maternal grandmother (with whom Joshua and his sisters were initially placed) physically abused him and his siblings. Joshua was initially reluctant to discuss this trauma history, and he reported that his memories are sometimes vague and that he “checks out.” In treatment, he has begun to address his trauma history, his feelings of betrayal, and his anger toward his parents (particularly toward his mother) as contributing factors toward his own abusive behavior.

**Mental Health Concerns, Strengths, and Clinical Issues**

Joshua cited his strengths as “being smart, creative, and a motivated student.” He also seems to possess the capacity for good social skills, has some insight, and can do well in a structured treatment program. He has an Individualized Education Program (IEP), and teachers noted he has difficulty with empathy and peer rejection, but nevertheless he shows a degree of academic competence. He often tries to make positive connections with others, and he has several friends and teachers who provide him with support. Joshua indicated he was sometimes proud of the fact that he can “read other people,” although he acknowledged being sarcastic and “mean” to his younger sister.

Joshua’s mental health issues include several diagnoses, including post-traumatic stress disorder (PTSD; e.g., avoidance, flashbacks) and attention-deficit hyperactivity disorder (ADHD), for which he is taking stimulant medication (e.g., Concerta). In addition, he scored high on Inventory of Callous and Unemotional Traits (ICU; Frick, 2004), a 24-item measure with three independent dimensions of behavior: Uncaring, Callousness, and Unemotional. Joshua did not endorse depression, but on one occasion in the past he was hospitalized for threatening to hurt himself (no current attempts). Joshua also had elevated scores on *The Adolescent Dissociative Experiences Scale-II* (A-DES; Armstrong, Putnam, Carlson, Libero, & Smith, 1997), which indicated he might utilize dissociation (e.g., derealization, depersonalization, absorption, and imaginative involvement) as a defensive strategy, which is consistent with complex trauma. There is no reported history of substance abuse.
Case Studies in Individual Treatment and Assessment

Treatment Considerations

Joshua is currently in the custody of the Department of Children and Families, and he resides in a group home that is staffed by social workers who are trained in working with youth who have sexually harmful behaviors. As a result of conduct problems in previous therapeutic foster home placements, including assaulting staff members and sexual aggression toward other foster children, Joshua has experienced several changes in placement. However, he is responsive to his current treatment team.

A psychosexual evaluation was completed (the process of conducting evaluations is described as follows), which included several assessment tools, such as risk instruments designed for sexually abusive youth and mental health and trauma measures, in order to determine the structure and level of care he required. In addition to addressing risk and promoting healthy sexual behaviors, there are family systems issues such as how Joshua would be impacted by having contact with his biological family.

ETIOLOGICAL THEORY, TYPOLOGIES, AND DEVELOPMENTAL PATHWAYS

The causes and etiology of adolescent sexual offending can be understood as multifactorial, with diverse pathways to sexual aggression. Adolescence is a period associated with social and emotional skill development and experimentation with a variety of behaviors that include sexual exploration and sensation and pleasure seeking (Ryan et al., 2010). Social workers should evaluate the context in which sexualized behaviors occur, and caution should be exercised to avoid pathologizing normative behaviors. Moreover, it is important to consider that sexual offenses committed by youth do not fit the profile of the adult pedophile or that of a predatory sex offender (Finkelhor et al., 2009), in that their arousal patterns are not fixed. Clinical case studies highlight a range of characteristics and behaviors among sexually abusive youth, including sexual arousal patterns and fondling over or under clothes, preforming oral or vaginal sex on younger children, and boundary violations with peers.

In considering the case of Joshua, research indicates that sexual perpetration can be placed within a framework of adolescent development that explains a range of motivations, some of which overlap with developmental pathways to delinquent behaviors. Some researchers have tested a specialist
perspective in which youth with risk factors for sexual abuse differ from others with general illegal behavior (Wanklyn, Ward, Cormier, Day, & Nelson, 2012). In Joshua’s case, he exhibited several sexual and nonsexual offending behaviors, and nonsexual offenses are considered important in psychosexual assessment. In a recent meta-analysis, it is noteworthy that the delinquency explanation of sexually abusive behavior was not supported, and important group differences have been found, such as sexually abusive youth experienced increased victimization in the family, sexual victimization, atypical sexual interests, and social isolation (Seto & Lalumière, 2010), all of which are evident in Joshua’s case. Generally, theories of adolescent sex offending include an investigation of several pathways, including neuropsychological deficits and exposure to criminogenic environments that are characterized by abuse and neglect (Burton, Duty, & Leibowitz, 2011; Longo & Prescott, 2006; Moffitt, 1993).

Theory building regarding sexually abusive behavior should occur in a developmental framework (Letourneau & Miner, 2005; Ryan et al., 2010) such that the range of similarities and differences between sexually abusive youth and other youth involved with the juvenile justice system—and relevant static and dynamic risk and protective factors—are incorporated into interventions. The biological, cognitive, social, emotional, and familial differences need to be considered. Developmental contextual theorists (Ryan et al., 2010) focus on the interaction of the person’s developmental status and the context of life experiences that shape functioning, and the reciprocal interplay between the youth and the various systems in which the youth is embedded, such as family, peers, neighborhood, and school. The implications for prevention are that social workers should target early developmental stages in a young person’s life to prevent sexually abusive behavior. Contextual refers to the youth’s view of the world based on his or her experiences, and the beliefs and perceptions of the youth.

**TRAUMA AND VICTIMIZATION**

The findings of research testing etiological models of sexual aggression found that, for some youth, sexually harmful behavior may involve recapitulation of earlier sexual victimization, supporting social learning theory (Burton & Meezan, 2004; Burton, Miller, & Shill, 2002). Joshua describes his abusive behavior as related to his own victimization at the hands of caretakers.
Moreover, sexually victimized youth with sexually harmful behavior have been found to experience more severe developmental antecedents and behavioral challenges compared with other youthful offenders (Burton, Leibowitz, Eldredge, Ryan, & Compton, 2011; Leibowitz et al., 2012), and sexually victimized sexual offenders were found to experience high levels of trauma, sexual arousal, early-onset aggression, early exposure to pornography, and greater personality disturbances (Burton, Duty, & Leibowitz, 2011). In a large-scale study following 2,759 sexual abuse victims, Olgoff, Cutajar, Mann, and Mullen (2012) confirmed that sexual victimization in males older than age 12 can be a risk factor for future abusive behavior, whereas other studies indicate that a history of sexual abuse predicted sexual recidivism but not general recidivism among sexually abusive youth (Mallie, Viljoen, Mordell, Spice, & Roesch, 2011).

In terms of etiological theory and developmental pathways, childhood maltreatment and trauma have been widely implicated in studies as preceding both socioemotional disturbances such as anxiety, PTSD, and depression, and antisocial behavior. Moreover, sexually abusive youth more frequently have experienced complex trauma and are a polyvictimized group, which includes multiple types of trauma including neglect, compared with nonsexual offenders (Ford et al., 2012; Jonson-Reid & Way, 2010 Van Wijk et al., 2006). Complex trauma is associated with the experience of chronic or multiple traumatic events, resulting in impairment in attachment, biology, affect regulation, and dissociation (Cook et al., 2005). Childhood trauma is associated with both undercontrolled (dysregulation and impulsivity) and overcontrolled behavior. Maltreated youth may show rigidly controlled behaviors (e.g., resistance to change and compulsively compliant behavior) or they can, alternatively, exhibit aggression, sexualized behavior, and oppositional defiance resulting from reenactment of traumatic experiences (Cook et al., 2005). Marshall and Barbaree (1990) advanced a theory of sexually abusive behavior in which early abuse and neglect could contribute to the development of sexually aggressive tendencies, and adolescents who have been sexually victimized have been found to have different developmental pathways to offending than do nonabused sexual offenders (Cooper, Murphy, & Haynes, 1996). Historically, etiological explanations of male adolescent sexual aggression typically include the victim-to-victimizer model (Freeman-Longo, 1986; Ryan & Lane, 1997), in which an understanding of sexually harmful behavior involves the intergenerational transmission of violence based on childhood victimization.
Joshua experiences feelings of betrayal, which in this case involved intra-familial abuse perpetrated by caretakers, and can result in dissociation, including forgetting and lack of awareness of the betrayal in order to preserve the attachment (Becker-Blease, DePrince, & Freyd, 2011). Dissociation is an adaptive response to trauma among adolescents, including depersonalization, forgetting, and splitting memories of abuse from awareness in order to survive. Researchers have found that youth with sexually harmful behavior may be higher dissociators than delinquent youth (Friedrich et al., 2001; Leibowitz, Laser, & Burton, 2011). Joshua appears to have utilized dissociation as a defensive strategy to survive the impact of abuse, as indicated earlier.

**STATIC, STABLE, AND DYNAMIC FACTORS**

To gain a comprehensive understanding of the relevant risk factors in the case of Joshua, the research delineating actuarial (associated with developing risk assessments that predict sexual recidivism) and dynamic (or changeable) risk factors is crucial for building effective interventions and for clinical assessment of sexually abusive youth (Ryan et al., 2010). These include the following:

- **Static factors** (historical, unchangeable), such as family of origin, early life experiences, and abuse and neglect
- **Stable factors** (life spanning/less changeable), such as difficult temperament, executive functioning and intelligence, and chronic PTSD
- **Dynamic factors** (changeable/can be observed and moderated in treatment), such as thoughts, feelings (mood disorders), showing empathy and remorse, impulsivity, and overall behavior

Measuring progress in treatment is based on an assessment of dynamic factors. Circumstantial dynamic risk factors that fluctuate and must also be addressed in treatment include social isolation (one important risk factor for sexually abusive youth). In terms of balancing risk reduction with health promotion, Gilgun (2006) draws from resiliency research to include protective factors related to good outcomes in youth, such as prosocial efforts (e.g., desire to do no harm), emotional expressiveness, and the quality
of family and peer relationships, all of which are central to Joshua’s treatment plan.

**RISK AND PROTECTIVE FACTORS**

There are several well-known risk factors for adolescent delinquency that include impulsivity, anger management issues, and ADHD impacting executive functioning (see Mulder, Brand, Bullens, & Van Marle, 2010). Some youth with sexualized behaviors with co-occurring ADHD were noted as internalizing negative feedback, engaging in problematic self-talk, experiencing self-esteem issues, and having trouble with verbal and written directions, resulting in “giving in” to oppositional behavior (Hopwood, 2013). In the case of Joshua, he has a diagnosis of ADHD, but his behavioral concerns (sexual and nonsexual) also appear characteristic of underlying complex trauma symptomatology, which include impairments in attachment and affect regulation (Cook et al., 2005; Ford et al., 2012). Therefore, the development of strong positive attachments and bonds as protective factors against nonviolent recidivism is an important component of treatment with Joshua (the research is equivocal regarding protective factors that reduce the likelihood of sexual reoffending; Spice, Viljoen, Latzman, Scalora, & Ullman, 2013).

Among sexually abusive youth, Worling and Langstrom (2003) found that the risk factors supported for sexual recidivism include deviant sexual interests, prior criminal sanctions for sexual assaults, selection of a stranger victim, past sexual offenses against two or more victims, a lack of intimate peer relationships/social isolation, and incomplete offense-specific treatment. Parks and Bard (2006) found that the Impulsive/Antisocial Behavior scale of the Juvenile Sex Offender Assessment Protocol (J-SOAP-II; Prentky & Righthand, 2003) and the Interpersonal and Antisocial factors of the Psychopathy Check List—Youth Version (PCL:YV; Forth, Kosson, & Hare, 2003) were significant predictors of sexual recidivism. Worling & Curwen (2001) concluded that Antisocial/Impulsive and Unusual/Isolated subgroups of offenders were at a higher risk for both sexual and nonsexual recidivism, which is particularly salient in Joshua’s case. Other research has shown the following risk factors to be predictive of sexual reoffense: prior sexual offending (Langstrom, 2002; Langstrom & Grann, 2000); the selection of a stranger victim (Langstrom, 2002; Smith & Monastersky, 1986); two or more victims (Langstrom, 2002; Langstrom & Grann, 2000) and total number
of victims (Rasmussen, 1999); the J-SOA5 sexual drive/preoccupation scale (Hecker, Scoular, Righthand, & Nangle, 2002); and a self-reported sexual interest in children (Worling & Curwen, 2000). Several of these risk factors should be considered in safety and treatment planning with Joshua.

**CALLOUS-UNEMOTIONAL TRAITS, TRAUMA, AND DISINHIBITION**

Knight and Sims-Knight (2003) tested the hypothesis that histories of abuse combined with personality predispositions among adolescents produced latent traits predicting sexual aggression: an arrogant/deceitful personality; “callous-unemotional” traits (CU; e.g., lack of remorse and empathy); impulsivity/antisociality; and sexual preoccupation. Disinhibition may explain PTSD-related impulsivity and aggression. Failure of inhibition appears related to traumatic stress disorders, and antisociality among youthful offenders and impulsivity have been commonly cited as characteristics of sexually abusive youth (Barbaree & Marshall, 2006). Marshall and Marshall (2000) found that among these adolescents, disinhibition can allow them to sexually abuse others. Joshua exhibits these characteristics and pathways, which are important considerations for intervention.

Lawing, Frick, and Cruise (2010) found that after controlling for impulsivity/antisocial behaviors, adolescent sexual abusers with high CU traits on the Inventory of Callous-Unemotional Traits (ICU) had more victims and used more violence. Research shows that CU traits are a unique risk factor associated with aggression/offending among adjudicated youth, and that targeting both affective and cognitive vulnerabilities, and intervening early to promote empathy development, may enhance clinical interventions (Stickle, Kirkpatrick, & Brush, 2009). These considerations are incorporated into the recommendation for working with Joshua that follow. Moreover, incorporating Joshua’s psychosocial context, with a focus on relationship development, is central to good outcomes (see summary box).

**PSYCHOSEXUAL EVALUATIONS**

Conducting assessments with sexually abusive youth is one of the most challenging responsibilities for social workers, psychologists, and professionals in related fields.
Psychosexual evaluators are called on to be attentive to the multiple domains associated with a youth’s functioning and developmental/contextual factors. A comprehensive psychosexual mental health evaluation was completed on Joshua, which includes a clinical interview with youth and current caretakers and consultation with professionals/past treatment providers, review of collateral information, psychological testing, and the use of risk assessment instruments that are appropriate for use with sexually abusive males. Assessment of risk, protective factors (including traumatic sequelae), strengths, and amenability to intervention are part of the assessment, as are recommendations for treatment, supervision, and risk management.

It is important to note that there are no empirically validated risk assessment tools, but there are sex offense instruments that assess the likelihood of attenuated or elevated risk based on both static and dynamic factors (Prescott, 2006). These include the J-SOAP-II (Prentky & Righthand, 2003), which is designed to be used with males ages 12 to 18 who have been adjudicated for sexual offenses, as well as nonadjudicated youths with a history of sexually coercive behavior. The instrument has four subscales, two major historical (static) domains that are of importance for risk assessment, Scale 1: Sexual Drive/Sexual Preoccupation and Scale 2: Impulsive and Antisocial Behavior, as well as the two major dynamic areas that could potentially reflect behavior change, Scale 3: Clinical/Treatment and Scale 4: Community Adjustment. Another commonly used instrument with sexually abusive youth, the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR; Worling & Curwen, 2001), is an empirically guided tool for youth between ages 12 to 18, consisting of 25 risk factors falling into five categories: (1) Sexual Interests, Attitudes, and Behaviors; (2) Historical Sexual Assaults; (3) Psychosocial Functioning; (4) Family/Environmental Functioning (high stress levels); and (5) Treatment (i.e., practicing realistic safety/treatment plans).

Because Joshua has an extensive range of conduct disturbances, the usual risk assessments to solely assess sexual domains (i.e., the J-SOAP-II or ERASOR) were considered in Joshua’s evaluation. Choosing instruments that also assess nonsexual crimes is important to obtain a clear picture of the trajectory and risk in both domains. Additionally, the Structured Assessment of Violence Risk in Youth (SAVRY; Bartel, Borum, & Forth, 2002) was utilized as a means to assess his future risk of violence (sexual or nonsexual). It is intended to assist in assessing risk in adolescents between the ages of 12 and 18. The SAVRY comprises 24 risk items (historical, social/contextual,
and individual/clinical) that are drawn from the existing research and professional literature on adolescent development and on violence and aggression in youth. Protective factors are also assessed.

Given the rapid developmental changes during adolescence, the estimate of risk should be reevaluated every six months and following any significant social, environmental, familial, sexual, affective, physical, or psychological change. Joshua has some protective factors mitigating his risk, such as his current personal/social supports, an absence of self-harm, current lack of involvement with delinquent peers (which may result from his controlled environment), and an absence of substance-use difficulties, yet these mitigating factors may not outweigh his risk factors. Given his pattern of violent and nonviolent offending, his early exposure to violence in the home, his early caregiver disruptions, peer rejection, poor coping skills, negative attitudes, risk-taking/impulsivity, anger management problems, low empathy/remorse, and ADHD difficulties, Joshua is currently viewed as moderate to high risk to engage in violent behavior (sexual and nonsexual). Because there appears to be a strong relationship between Joshua’s sexual reactivity and abusive-ness, and his sexual victimization history, this history also appears relevant to increasing his risk level.

Summary of Considerations for Working with Youth with Sexually Harmful Behaviors

1. Sexually abusive youth are a heterogeneous group with a variety of developmental, attachment, personality, and mental health considerations.
2. The etiology of sexually abusive behavior is multifactorial, and several pathways lead to sexual aggression.
3. Assessment and treatment should be an ongoing process, should be sensitive to developmental changes in the youth, and should be based on a developmental perspective, incorporating static, stable, and dynamic risk factors (Ryan et al., 2010).
4. Developmental/contextual approaches include a consideration of multiple developmental antecedents, including a history
of sexual, physical, and emotional abuse and social learning or “modeling,” in which an adolescent learns sexually abusive behavior (from peers, caretakers, and/or pornography; Burton & Meezan, 2004).

5. Youthful sexual abusers are not the same as adult sex offenders, and they do fit the profile of pedophiles. There are differences in terms of amenability to treatment, mental health issues, and the conceptualization of “deviant sexual interests” (i.e., youth are not as “habituated”).

6. Sexually harmful behavior is not explained by general delinquency theories, but nonsexual crimes are important to address in treatment. Differences between youth with sexual offenses and delinquent youth include atypical sexual interests and greater sexual victimization and social isolation (Seto & Lalumière, 2010).

7. Treatment should address risk and protective factors, be family-based where possible, and draw from treatment areas derived from using appropriate sex-offense-specific risk assessment instruments. Sexual recidivism among sexually abusive youth is relatively low, and offense-specific treatment can be effective and reduce recidivism (Carpentier & Proulx, 2011).

8. Treatment approaches for complex trauma (Cook et al., 2005; Ford et al., 2012) are integral to working with youth with sexual and nonsexual offenses.

CASE CONCEPTUALIZATION SUMMARY AND TREATMENT RECOMMENDATIONS

Joshua is a 14-year-old male with some notable assets. He can exhibit good social skills, presents as articulate, is responsive in his current placement, and seems to enjoy school. His developmental pathway to antisocial behavior appears to be based on a combination of his individual vulnerabilities (e.g., temperament) and the early psychosocial context in which he was raised (witnessed domestic violence, experienced physical and sexual victimization). Given his combined types of aggression and emotional
functioning, he is more likely to develop persistent antisocial behavior, as opposed to a youth who only possesses the impulsivity inherent with emotional undercontrol. Although his prognosis may appear guarded, he is still young, and it is hoped he can make the gains necessary to lead a law-abiding and constructive life. The combination of intensive treatment in a structured (i.e., residential) setting has shown to result in some decrease in callous-unemotional traits as well as behavioral improvements (Caldwell, Skeem, Salekin, & Van Rybroek, 2006; Caldwell, McCormick, Umstead, & Van Rybroek, 2007).

Despite his strengths, his affective, interpersonal, and behavioral disturbances are considerable and appear to be related to negative sequelae associated with complex trauma. Complex trauma occurs when a child has experienced multiple developmentally adverse traumatic events, resulting in a loss of core capacities for both self-regulation and interpersonal relatedness, as is strongly evident in this case. Joshua’s early life was characterized by exposure to domestic violence and substance abuse, physical abuse, sexual abuse, and maternal and paternal abandonment. His internal working model consists of a fairly positive view of himself but a negative view of others, resulting in a dismissive attachment style. His elevated view of himself seems to function as a compensatory strategy from his early trauma insults and interpersonal/affective deficits.

Given his challenges in social cognition, Joshua’s therapy includes learning to process social information so he can appropriately encode, interpret, and respond to social cues. This can be done with cognitive-behavioral therapy (CBT) skills training and restructuring techniques that address his negative attitudes about sexuality and relationships. Generally, CBT targets negative coping strategies and distortions associated with sexually abusive acts among youth and often incorporates relapse-prevention techniques. Carpentier, Silovsky, and Chaffin’s (2006) research supports the use of short-term CBT for children with sexual behavior problems. After a 10-year follow-up, those authors found significantly fewer future sex offenses compared with other modalities. Programs based on CBT approaches that include individual and group therapy modalities (Marshall & Burton, 2010) address issues of denial, teach the sex abuse “cycle,” encourage the development of victim empathy, and help reduce defense mechanisms so that gains in treatment can be made (Rich, 2003; Ryan et al., 2010). It is noteworthy that multisystemic therapy (MST) has been recommended for
sexually abusive youth given findings that it is ineffective to treat youth in isolation of the various interrelating systems in which they are embedded. In a randomized control trial, Letourneau and colleagues (2009) found that MST resulted in reductions in sexual behavior problems, delinquency, and out-of-home placements.

Drawing from multisystemic approaches, engaging Joshua in reparative work and demonstrating accountability with the victims and their families (if possible) may also be indicated in this case, as he is working on perspective-taking and understanding the ways in which his behavior impacts others in general, in light of his own victimization. Trauma-informed work in a structured setting that includes his family (i.e., with his sisters and other caregivers) can increase protective factors, address experiences of betrayal trauma, and improve self-control.

To address problems with internal motivation, motivational interviewing (MI; Miller & Rollnick, 2002) and skills building strategies can be effective, which include the following:

- A *motivational phase* designed to help Joshua recognize the need for change and to become motivated to engage in treatment
- A *skills-building phase* to teach him the skills necessary to overcome or adapt to deficits (e.g., consider potential negative consequences of behavior)
- A *generalization and maintenance phase* designed to enhance the use of skills over time and situations (as described in Stickle & Frick, 2002).

Throughout these phases, it is important to address his history of complex trauma, including chronic exposure to violence, attachment difficulties, and feelings of betrayal concerning his biological family. Trauma-focused cognitive-behavioral therapy (TF-CBT) shows promise in addressing traumatization among children with PTSD secondary to exposure to domestic violence (Cohen, Mannarino, & Iyengar, 2011), which addresses in vivo desensitization to trauma reminders and utilizes conjoint sessions with caregivers in addressing traumatic narratives. Additionally, restructuring negative self-talk (secondary to ADHD), which may also involve stimulant medication, and helping Joshua succeed in activities that interest him should be part of interventions. Increasing his capacity for organization, attention, and problem solving may reduce his anxiety. Joshua may also
struggle with transitions and new environments (e.g., to a new residential program or foster placement), and he may be at risk for association with a negative peer group.

In addition to safety planning around Joshua’s exposure to pornography, sexual arousal control and regulation should be a central part of the therapy, given Joshua’s urges toward younger children, which he acknowledges. Caution should be exercised in using certain aversion therapies and sexual reconditioning procedures with youth; it is likely the case with adolescents that arousal control in general (i.e., higher levels of autonomic arousal) may be the primary treatment issue (Longo et al., 2013). Moreover, emerging hypersexuality and impulsivity should be addressed through individualized treatment specifically tailored to adolescents. This intervention should also focus on his risk for nonsexual offenses, boundaries, improving emotional awareness, signaling behavior (methods for expressing his needs), peer relationships, safety planning, and self-care, which would also help achieve increased stability. Targeting both cognitive and affective vulnerabilities may enhance clinical interventions.

CONCLUSION

This case study utilized a development/contextual perspective to explore the relationship between a history of maltreatment and subsequent sexually abusive behavior in an adolescent who exhibits the sequelae of complex trauma, including impairments in attachment, affect regulation, empathy, and dissociation. Social workers should take into account that working with youth who have sexually abusive behavior entails developing a knowledge of etiological theory, resiliency, methods of psychosexual evaluation, effective interventions that address complex trauma among youth involved with the juvenile justice system, and the current research on stable and dynamic risk factors. Additionally, social workers should consider social justice issues in working with this population. Specifically, iatrogenic legal policies, such as community notification and registration requirements, can have negative unintended consequences with sexually abusive youth (Letourneau & Miner, 2005; Zimring, 2004). These consequences can range from educational discrimination to ostracism and stigma, and therefore the importance of developmentally appropriate, differential responses should be underscored.
REFERENCES


CASE STUDY 1-7 EFFECTIVE INTERVENTIONS FOR ADOLESCENT CONDUCT DISORDER IN RESIDENTIAL TREATMENT

Jamie L. Glick

Engaging adolescent clients in treatment and establishing a therapeutic alliance is an ongoing therapeutic effort. The combination of motivational interviewing and CBT techniques used in this case demonstrate the constant nature of engagement in each phase of treatment with this young man in residential treatment.

Questions for Discussion
1. Why does the author believe a confrontational approach is ineffective?
2. In what ways did the motivational interviewing and CBT techniques work together to support change in Anthony?
3. How do you see different funding sources influencing treatment choices? What can we do as social workers to impact this issue for our clients?

INTRODUCTION

The role of the social worker is vast and continues to grow as the needs of the people within our society evolve. One area of social work that has grown is the use of social workers within the juvenile justice system. According to Shufelt and Cocozza (2006), 65 percent to 75 percent of youth involved with the juvenile justice system have at least one diagnosable disorder, and more than 60 percent meet the criteria for three or more disorders. In the current economic climate, this number will likely only increase. According to a report by the National Alliance on Mental Health (Honberg, Diehl, Kimball, Gruttadaro, & Fitzpatrick, 2011), the two major sources of funding for mental health services are Medicaid (46 percent in 2007) and monies from the state general funds that are allotted to mental health services (40 percent in 2007). Both funding sources received significant cuts in the last few years, and they are expected to receive even more in the future. With these massive cuts, the responsibility to take care of mental health needs will merely shift
to other sources, one of which includes the juvenile justice system. Mental health clinicians, including social workers, will need to be prepared to meet these clients’ needs and have the appropriate skill sets to treat this difficult population.

The following case study involves the treatment of a youth in the juvenile justice system. It will first look at how to respond to resistant clients using motivational interviewing (MI) skills. Clients in the juvenile justice system are generally mandated to participate in treatment, which often has a negative influence on their motivation and engagement. Many of these clients also do not trust the system or have mental health factors that influence their ability to connect with others, such as attachment disorders or past trauma. This case study highlights how using MI can reduce these clients’ resistance and increase their motivation for change.

In order to identify the appropriate treatment interventions, the social worker must first conduct a thorough and accurate assessment. In the juvenile justice field, there is a large emphasis on providing treatment that will reduce the risk that the client will continue to commit crimes. The second section of this case study focuses on the assessments that are often used in the juvenile justice field and the rationale for these assessments.

The last section of the case study focuses on cognitive-behavioral therapy (CBT) as a framework for counseling high-risk youth. It uses the case study as a guide to illustrate how CBT can be utilized to assist high-risk youth in changing their thinking and belief systems about high-risk behaviors. It also discusses skill building as a CBT intervention to teach prosocial skill development.

**CASE STUDY**

Anthony was referred to residential programming by the state’s department of juvenile corrections. He received a criminal charge of first-degree assault when he was involved in a fight at school. He caused a significant injury to the other student who was involved. He had previously been on probation for theft and gang involvement.

The residential program in which Anthony was placed is a male-only facility that houses 225 male residents ranging from 14 to 20 years of age. The facility is an open campus, as it does not have walls around the perimeter or locked doors to the rooms. At this facility, youth have the opportunity to go
to school, learn vocational skills, play high school sports, and participate in group and individual cognitive-behavioral treatment. Placement in this program was an opportunity for Anthony to show that he could be successful in a normalized environment, as opposed to being in jail where he would sit in a cell most of his day and become further institutionalized.

He was referred to me after being involved in several fights while in the residential placement. The residential staff had become concerned for the safety of Anthony, along with the safety of the other residents. They made the decision that if he was involved in one more fight, he would be referred back to the state’s department of juvenile corrections. Anthony had been involved in group therapy, but he was not responding well to this type of treatment. The treatment team decided to attempt to engage Anthony in individual therapy.

In looking at Anthony’s clinical history, he had most recently lived with his grandmother. He had some contact with his mother, but she was in and out of treatment centers for her drug addiction. Anthony had a difficult upbringing that involved several social service referrals for neglect. He also witnessed domestic violence against his mother on several occasions. His most recent diagnoses included conduct disorder and anxiety.

**FIRST SESSION**

When I met Anthony for the first time, he was separated from the main population and was in the school’s disciplinary program. This separation was a result of the recent fights that he had been involved in. He was an African American male who was 6 feet, 2 inches tall with an athletic build. He had a few bruises on his face from a recent fight. In observing his facial expressions and body language, one could make the assumption that he hated the world and anything in it. When introducing myself to Anthony, I could immediately see the skepticism on his face. He came into my office, sat down, and glared at the floor. I began my typical routine, discussing my role as a therapist along with explaining confidentiality. Anthony looked up at me and stated, “Do you think that I care about any of this shit?”

At this point I realized that Anthony was in crisis, and the normal routine would have to be delayed. Anthony was an involuntary client, but he could refuse to meet with me at anytime. My goal for this session went from completing the initial paperwork to getting Anthony to come back to see me.
MOTIVATIONAL INTERVIEWING

When dealing with a client who is displaying some resistance, I typically use motivational interviewing (MI) techniques to break down some of the barriers and to deal with the resistance. MI is a nondirective approach that was originally developed for work with addictions, but its use has broadened within many fields (Burke, Arkowitz, & Dunn, 2002). It provides a framework to talk to clients about change, and it has been found to be effective with handling resistant clients who are at the point of not wanting to make change (Miller & Rollnick, 2002).

One of the primary goals of MI is to enhance intrinsic motivation for change (Miller & Rollnick, 2002). Research suggests that the most long-term change occurs when the client is internally motivated to change. In other words, the desire and reasons for change come from within the client as opposed to outside pressures (Ryan & Deci, 2000). This is accomplished by allowing the client to be responsible for change.

In my initial interaction with Anthony, it was apparent that he was resistant to change or any discussions about change. In order to make any progress, the resistance would first have to be addressed. According to the MI research, there are four types of resistance: reluctance, rebellion, rationalization, and resignation (Miller & Rollnick, 2002). When working with a resistant client, it is important to understand what type of resistance you are dealing with, so that you can respond in the appropriate way. In my case, I was dealing with a client who was in the rebellion stage.

Miller and Rollnick (2002) suggest two categories of skills for interacting with resistant clients. The first phase involves reflective listening by using simple, amplified, or double-sided reflections. Simple reflections are merely repeating back to clients what you heard them say. This skill allows clients to feel heard. Amplified reflections involve repeating back what you heard them say in an exaggerated form. By doing this, clients often decrease their argument and draw out some of their uncertainty about change. Double-sided reflections repeat back what the clients said while emphasizing their ambivalence.

The next phase involves other skills that move past reflections: shifting the focus, reframing, agreeing with a twist, and emphasizing personal choice and control. Shifting the focus involves changing the subject to remove clients from a distraction or barrier preventing them from making progress toward change. Reframing takes what clients have stated and puts a more positive
meaning on it. Agreeing with a twist begins with a form of reflection but with a reframe that moves clients in the direction of change. Lastly, emphasizing personal choice and control reminds clients that they are responsible for change. Following is an illustration of how these skills can be used in a paraphrased example of our first conversation:

**Therapist:** Anthony, it appears that something is bothering you.
**Anthony:** I want to get the hell out of your office and out of this program. You guys are not going to change me. I have been this way for a long time. I am just being me.
**Therapist:** It sounds like you don’t like it here. *(simple reflection)*
**Anthony:** No, I don’t, but it doesn’t matter because I am never going to be able to leave.
**Therapist:** That has to be frustrating to be somewhere you don’t like and feel that you are stuck. *(simple reflection)*
**Anthony:** I just feel that no matter what I do, it is not good enough. I do a lot of good things too.
**Therapist:** You feel that no one ever acknowledges the good things you do. *(amplified reflection)*
**Anthony:** Most of the time they don’t. I am not as bad as they make me out to be. I just want to quit.
**Therapist:** You do the right thing some of the time, but with everything going on you just feel like quitting. *(double-sided reflection)* What would be the benefits to giving up?
**Anthony:** Well, all the people who say I can’t do it would be right.
**Therapist:** That is true, you would prove those people right, but how would it help you? *(agreeing with a twist)*
**Anthony:** It wouldn’t, but I have tried to change for a long time and look where I am.
**Therapist:** Even though you haven’t always had successes you kept trying, and that shows a lot of persistence. *(reframing)*
**Anthony:** I really do want to make the right decisions. I need to be home with my family.
**Therapist:** It is your choice if you want to make some changes. You have complete control over that. I couldn’t control it if I wanted to. Like you mentioned earlier, no one here is going to change you. That is up to you. *(emphasizing personal choice and control)*
**Anthony:** I need to change something. I can’t spend another holiday away from my family, but the staff keep picking on me.

**Therapist:** That would be frustrating to have the staff picking on you, but can we spend a few minutes discussing what changes would help you to get home to your family? *(shifting the focus)*

**Anthony:** Yeah, I need to be with them.

In this conversation, Anthony began with a very confrontational attitude and communicated that he only cared about getting out of my office. In a matter of a few minutes, Anthony began to let go of his resistance and became open to discussing change. When Anthony stated he only cared about getting out of my office, I could have responded in a confrontational manner. This would have only increased his resistance. I also could have told him that he doesn’t have to be here and that he can leave at any time. This would probably have led to him walking out. Instead, by using reflective listening, showing empathy, and emphasizing personal choice and control, I was able to keep him engaged in the conversation long enough to begin discussing change.

**CONFRONTATIONAL STYLES**

In working with resistant clients, I have seen counselors use a variety of approaches with mixed results, but I have observed one approach that almost never works and often increases resistance. This approach is a confrontational, in your face, “let me tell you what you need to do” approach. In speaking with counselors who utilize a more confrontational approach, they have stated that they choose to utilize this type of counseling style for the following reasons:

- “In order to change them, I need to speak their language.”
- “They respect me more when I talk to them like this.”
- “I get faster results this way.”
- “You have to break them down to the point of crisis before you can have a breakthrough.”

I have yet to find any research to support any of these comments. What I often observe in these situations are clients becoming more escalated and
either shutting down or becoming more confrontational themselves, and on some occasions physically aggressive. In a study by Miller, Benefield, and Tonigan (1993), a directive-confrontational style produced twice the resistance and only half of the desired behaviors as that of counselors who used a supportive, client-centered style.

Counselors who are more confrontational in their approach often are able to get the client to comply with basic rules and expectations. In residential settings or criminal justice settings, the counselor sees this as a win because achieving compliance can be a difficult task. This compliance often reinforces the counselors’ beliefs that their confrontational style has been effective. A client may begin following basic rules or directives, but one should not confuse basic compliance with change. Just because a client has become compliant to basic rules and expectations does not mean the client has made long-lasting change. The client has merely adapted to external pressures to comply; however, when those external pressures are removed, the client often reverts back to his or her old behaviors. In order for long-lasting change to occur, the client has to be intrinsically motivated to change.

Assessment

Anthony was in the criminal justice system, and the state’s juvenile correction department was funding his placement. A difficult reality in the field is that the funding source has a significant influence over treatment based on its agenda. When a youth enters the correctional system, the primary goal shifts to decreasing the risk that the youth will go back into the community and commit crimes, or reoffend. Therefore, the main goal for treatment interventions with Anthony needed to focus on areas that would reduce his risk to reoffend.

An array of assessments measure a client’s risk to reoffend, along with treatment domains that have an impact on criminal behavior. These risk assessments have evolved over the years. Currently, fourth-generation risk assessments are the most reliable indicator of the risk to reoffend (Andrews, Bonta, & Wormith, 2011). Fourth-generation risk assessments separate risk into two categories: static and dynamic. Static risk factors are those that do not change. An example of a static risk factor is family history of criminal behavior. Dynamic risk factors can change and should be the focus of treatment interventions. An example of a dynamic risk may be the client’s peer
group. If a client has a negative peer group, for instance, then risk reduction would include the client choosing a less risky peer group.

Fourth-generation risk assessments also focus on domains that the results of research indicate have an impact on reoffending. Research that was conducted by Andrews and Bonta (1998) identified eight major risk factors associated with the reasons why people commit or recommit crimes, with the first four identified as having the largest risk:

1. Antisocial and procriminal attitudes, values, and beliefs
2. Procriminal associates and the isolation from prosocial people
3. Temperament and personality factors such as being impulsive, adventurous, and pleasure seeking
4. History of antisocial behavior
5. Family factors such as family criminality, or lack of caring and cohesiveness
6. Low levels of educational, vocational, or financial achievement
7. Lack of prosocial leisure activities
8. Abuse of drugs and alcohol

In the case of Anthony, these risk factors were measured using a fourth-generation risk assessment entitled Positive Achievement Change Tool (PACT). The results of this assessment indicated that Anthony had a high risk to reoffend. His risk to reoffend was significant, because research indicates that high-risk individuals require a higher dosage of treatment in order to have an impact on recidivism. The assessment also revealed that the domains that should be targeted for treatment are Attitudes/Behaviors, Current Relationships, and Mental Health.

The domain of Attitudes/Behaviors scored as high risk because Anthony answered questions that indicate that he thinks there is nothing wrong with his negative behavior. Also, he is highly criminal in his thinking patterns and belief systems. In order to get a more accurate understanding of his thought patterns, I had Anthony complete the How I Think Inventory (HIT). The HIT is an assessment that measures the cognitive distortions of self-centered, blaming others, minimizing/mislabeling, and assuming the worst. It also measures the behavioral referents of opposition-defiance, physical aggression, lying, and stealing. The results of this assessment indicated that Anthony had significant cognitive distortions in the area of minimizing/mislabeling.
He also scored clinically significant in the behavioral referents of physical aggression and opposition-defiance.

The domain of Current Relationships scored as high risk because he answered questions that indicate he has a negative peer group. He reported being involved with the Crip gang. He reported not having either prosocial friends or any positive mentors in his life.

The domain of Mental Health scored as high risk because of a previous diagnosis of anxiety and a rule-out of post-traumatic stress disorder. In his history, it was indicated that he used to take Prozac, but Anthony indicated that he does not take any medication currently. He also reports that he does not struggle with the symptoms of anxiety anymore. Anthony completed the Trauma Symptom Checklist for Children (TSCC-A) in order to get information about any trauma symptoms that he may be experiencing as a result of witnessing violence in the home and in the community. These results indicated that Anthony was experiencing a few trauma symptoms, such as difficulty sleeping and hypervigilance. The Behavioral Assessment for Children 2 (BASC-2) was also completed to rule out any other behavioral or emotional issues. There were no significant findings from this assessment.

**TREATMENT**

The first few sessions with Anthony were spent building rapport. As mentioned before, most youth in the juvenile justice system are slow to build trust. Therefore, there needed to be more time dedicated to building this rapport in the beginning. Because Anthony was in residential programming, we were able to participate in some activities that are typically not available in traditional counseling settings. For example, for our second session I took Anthony out to the basketball courts, and we shot baskets together as we talked. For our third session, we walked around the campus and got to know each other while we walked. Throughout this time, I continued to use motivational interviewing to have discussions about change. It was important for Anthony to have an increased motivation to change before we began discussing the “how” of change. In order to do this, I used an MI skill of developing discrepancies in order to process through Anthony’s ambivalence to change. This skill involves guiding the client through a process of discussing the discrepancy between his current behaviors and important goals or values (Miller & Rollnick, 2002). In this case, Anthony valued being with his family, and
it was important that he be there for them. At the same time, Anthony was participating in behaviors that were keeping him away from his family. In this nondirective approach of MI, it was important for Anthony to come up with the arguments for change rather than the arguments coming from me. Through asking the right questions, reflective listening, expressing empathy, and enhancing self-efficacy, Anthony was able to get to a point where he realized that he needed to change and had built some confidence that he could change.

**COGNITIVE-BEHAVIORAL MODEL**

When Anthony had developed motivation to change, I introduced the cognitive-behavioral therapy model. Cognitive therapies focus on conscious thought processes as a way of understanding and influencing current and future behaviors (Beck, 1979). Cognitive-behavioral therapy, as it is referred to now, is a very common therapeutic approach that is used in a wide array of fields. Cognitive-behavioral interventions and their application in juvenile justice settings have been researched extensively, and the results consistently show that programs that utilize cognitive-behavioral interventions and focus on crimonogenic needs are the most effective in reducing recidivism (Latessa, 2006).

When using cognitive-behavioral interventions with clients, I first teach the client the basic concepts of cognitive-behavioral therapy. With Anthony, I used the whiteboard in my office to show him how thoughts, feelings, and behaviors are all connected. I first begin by using an everyday example that does not stir up significant emotions. I use a generic example so that the client does not personalize the example and so that emotions do not cloud the client’s ability to learn. With Anthony, I used an example of someone cutting in front of him in line. With Anthony, we discussed this situation along with his thoughts, beliefs, and emotions involved in the situation. The primary goal of this exercise was to help Anthony understand how his thoughts influence his emotions and behavior. In going through this exercise for the first time, we moved slowly so that Anthony could clearly see this connection. Table 1.3 provides a summary of Anthony’s responses.

Anthony completed this first exercise slowly, as he was learning it for the first time. He struggled mostly with the section where he had to identify beliefs. This is common as most youth have difficulty even describing what
Table 1.3  Anthony’s Initial Thought Record

<table>
<thead>
<tr>
<th>Situation: A brief, unbiased description of the event</th>
</tr>
</thead>
<tbody>
<tr>
<td>One of my peers cut in front of me in line.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Automatic Thoughts: Immediate thoughts that came to mind when this situation occurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>He has no right to do that.</td>
</tr>
<tr>
<td>Who does he think he is?</td>
</tr>
<tr>
<td>There is no way that I can let him get away with this.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Belief/Attitude: Belief systems or attitudes that influenced your thoughts in this situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>People will take advantage of you if you let them.</td>
</tr>
<tr>
<td>Everyone is trying to get ahead no matter the cost.</td>
</tr>
<tr>
<td>If you let one person push you around, everyone will.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feelings: What would be your feelings if you had the above thoughts and beliefs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger</td>
</tr>
<tr>
<td>Frustration</td>
</tr>
<tr>
<td>Nervousness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action: If you had the above thoughts, beliefs, and feelings, what is likely your response?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cuss the peer out</td>
</tr>
<tr>
<td>Threaten the peer</td>
</tr>
<tr>
<td>Push my way in front of the peer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome: If you participated in the above actions, what could be the outcome?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal altercation</td>
</tr>
<tr>
<td>Get in trouble with the staff</td>
</tr>
<tr>
<td>It could lead to a fight</td>
</tr>
</tbody>
</table>

a belief system is. In order to assist with the learning process, Anthony and I processed through this exercise using several other examples. Because the goal of this exercise was for Anthony to learn the link between his thoughts and his behavior, we also discussed a few situations that would elicit positive thoughts, emotions, and outcome. At the end of the session, I had Anthony describe to me what he learned from the exercise. This assisted me in determining if the goal of the session was accomplished and if Anthony made the connection between how behaviors are influenced by thoughts. Because Anthony appeared to have learned the material, I provided him with a worksheet to practice going through this process using a real-life situation of something that happens before the next session.

In our next session, we began by reviewing the homework. Anthony had completed the homework, which indicated to me that he was engaged in the
therapeutic process. After reviewing the homework, it was clear that Anthony understood the connection between thoughts and behavior. The next step of the process was to begin cognitive restructuring. This process involves replacing maladaptive thoughts with more productive thoughts (Meichenbaum, 1985). In order to do this, Anthony would have to spend a lot of time thinking about his thinking. Anthony and I discussed the importance of changing thinking and belief systems. Anthony had formed thinking habits and belief systems that were well established. Therefore, it was stressed that change would be gradual and would involve a lot of practice and intentionality. Anthony would have to slow down situations so that he could spend more time in his thoughts to assist him in making better decisions. He would have to form new thought habits that are less risky and more prosocial. This process is not easy; therefore, I taught Anthony a couple of skills to assist with the process.

The first skill that I taught Anthony was testing the evidence (TOE), which involves the client evaluating the facts of a situation and collecting evidence to either support or negate current thoughts. TOE is a useful skill to test overgeneralizations, faulty conclusions, and unfounded beliefs (Friedberg & McClure, 2002). This skill should be used if you are confident that there is significant evidence to counter current thoughts or beliefs. In the example of the peer cutting in front of him in line, Anthony may look at the evidence and determine that the peer was looking the other way, so it’s possible that he didn’t see him. He may also remember that he has a good relationship with the other youth, which would provide further evidence that he may not have done it on purpose. Many of the high-risk youth with whom I have worked, including Anthony, assume the worst of others’ intentions. This skill can be helpful for providing information that is contrary to initial thoughts. This skill involves the client asking, “Is this thought realistic?”

Another skill I taught to Anthony was encouraging him to look at alternative explanations for situations, or reattribution. Reattribution involves encouraging the youth to look at other possible explanations, influences, or causes for a situation (Friedberg & McClure, 2002). This can be helpful when youth overpersonalize their roles in situations. This skill involves asking the question, “Are there other factors that need to be considered in this circumstance?”

Anthony was also taught patterns of maladaptive thoughts, also referred to as thinking errors, so that when he begins to go down this road of thinking,
he can stop this thought process and begin to replace it with more adaptive thoughts. The most common thinking errors that I have seen for high-risk youth include the following:

- **Minimizing/mislabeling**—Minimizing their role in situations or putting an inaccurate label on a situation
- **Assuming the worst**—Always assuming the worst-case scenario will occur
- **Catastrophizing**—Often believing that the situation is far worse than it really is
- **Blaming others**—Always blaming other people or situations for an outcome of a situation

Lastly, I taught Anthony that, when evaluating his thoughts, he needs to ask if his current thoughts are helpful in the situation or if his current thinking is making the situation worse. This skill can be helpful when the youth feels justified in his current thought process and is struggling to let go of these thoughts. Anthony was taught to ask himself four questions when evaluating his thoughts:

1. Are my thoughts realistic?
2. Are there alternative explanations for the situation?
3. Am I using a thinking error?
4. Are my thoughts helpful in this situation?

We began processing through situations that Anthony has experienced or may experience in the future so that he could practice changing his thoughts and beliefs. As an illustration of this process, we used the first situation that we practiced in the previous session. Table 1.4 depicts Anthony’s new thoughts, beliefs, and feelings.

After completing the cognitive restructuring exercise, Anthony received a practice assignment to use a real-life situation to process through his automatic thoughts and to change these thoughts to those that would lead to a less risky outcome. The next few sessions focused on cognitive restructuring and involved a lot of practice using real and anticipated experiences. When learning any new skill, it is important to practice in order to increase the chances that the skill will be replicated in a real-life setting. We focused specifically on his thought processes and belief systems.
Anthony had a few belief systems that he had developed that were influencing his thoughts and ultimately leading to him getting into trouble. For example, one of his maladaptive belief systems was “I have to fight in order to earn people’s respect.” Because thoughts are so influenced by beliefs, we had to address this belief before we could move forward. In order to do this, I went back to the motivational interviewing technique to help guide Anthony to begin changing these belief systems. As mentioned earlier, guiding Anthony to come to this conclusion on his own as opposed to telling him was much more effective and likely to lead to longer-lasting change.

Through the process of cognitive restructuring, Anthony was beginning to make changes in his thought processes and belief systems. He was also beginning to make progress in his behavior in the program. He had been promoted to the next level in the program, and the staff were reporting significant changes in his attitude and behavior. Because Anthony was making progress in his thinking, we decided to move to his behavior and discuss
specific skills that will help him to navigate situations with which he often struggles.

**SKILL BUILDING**

Skill building involves teaching prosocial skills to the client using psychoeducational material (Friedberg & McClure, 2002). Many skill-building curriculums are designed for group settings, but I have found skill building to be an effective individual therapy model. I begin by having a discussion about the skill with the client. The goal of this initial conversation is for the client to understand the importance of the skill. During this process we discuss when the skill would be used, along with the possible outcomes if the skill was not used correctly. After teaching the skill, we go over each step of the skill to ensure that the client has a clear understanding of each of the steps. For steps that involve thinking, the client is asked to verbalize his or her thoughts so that the counselor can be involved in the client’s thought process. Next we role-play the skill. I usually role-play first to show the client what the skill looks like and to decrease anxiety about role-playing. Lastly, the client practices the skill using role-plays and other graduated practice while I guide the client and provide feedback on the acquisition of the skill. After the client masters the skill in practice sessions, the client can experiment with the skill in real-life situations.

Throughout the therapeutic process, we were able to identify several skills that Anthony was struggling with, which then became the focus of several of our sessions. Following the format mentioned in the previous paragraph, we were able to discuss these skills and allow Anthony the opportunity to practice them in session first and then in the residential milieu. The skills that we used were from *The Prepare Curriculum* (Goldstein, 1999). The skills that we focused on were as follows:

- Knowing Your Feelings
- Expressing Your Feelings
- Understanding the Feelings of Others
- Avoiding Trouble with Others
- Keeping Out of Fights
- Responding to Persuasion
- Dealing with Group Pressure
Anthony benefited from all of these skills, but the skill that he benefited from the most was *Keeping Out of Fights*. Anthony had changed his thoughts and belief system about fighting and no longer wanted to be involved in fights. Teaching the skill of how to keep out of fights was the last step in assisting Anthony with making this change.

I first began by going over the skill, which utilized four steps:

Keeping Out of Fights (Goldstein, 1999)

1. Stop and think about why you want to fight.
2. Decide what you want to happen in the long run.
3. Think about other ways to handle the situation besides fighting.
4. Decide on the best way to handle the situation and do it.

We began by discussing the skill and each specific step to ensure that Anthony had an understanding of each step. The first step involved Anthony taking a few quick seconds to ask himself why he wants to fight. This step was helpful to Anthony because he was very impulsive, and this allowed him to slow things down. In the second step, Anthony would think about the long-term consequences. Anthony was very motivated to go back into the community and be with his family, so this step was crucial for keeping Anthony out of fights. If he was able to think about his family and how being involved in fighting would keep him from his family, this would have a significant influence on his behavior. This third step encourages Anthony to think about other ways that he can handle the situation. Anthony identified that he could walk away, cuss the peer out, or tell the peer that going home is more important than fighting him. While cussing the peer out is not the most prosocial option, it is less risky than getting involved in a fight. The last step is to pick one and do it, so I allowed Anthony to keep that as an option. For the last step, Anthony stated that he would try to walk away in those situations.

After discussing the steps, we role-played scenarios that may come up where the skill would have to be used. I role-played a scenario so that Anthony could see the skill in action. Anthony played the role of a peer with whom he had a conflict and wanted to fight. I went through the steps, and then we discussed afterward. Anthony was able to give me feedback on how he thought I did, but more importantly he now had a visual of the steps. Anthony was then able to practice the step. We role-played three different
scenarios. With each scenario, Anthony went through each skill step and ended by acting out the decision that was made. Anthony was coached through the steps and then given feedback on how he did with the steps. Anthony also had opportunities to evaluate his own performance. With each role-play, Anthony got better at the skill. In the last role-play, Anthony was able to go through the role-play without looking at the steps.

This same process was followed with the other steps that Anthony practiced. He was challenged to use the skills outside of the therapy session. His staff were informed of the skills that he was focusing on so they could assist with helping Anthony to identify when the skill could be used. In therapy, we were able to discuss how Anthony applied the skills in real-life situations. Using these situations, Anthony was able to review how he handled himself and make adjustments when necessary. Anthony got progressively better at each skill, which led to him making better decisions.

**OUTCOME**

Anthony was able to successfully complete treatment. He had a few setbacks along the way, but with each setback, we were able to use it as a learning experience. He was not involved in any more fights while at the residential facility. Anthony continued to show changes in his thinking and behavior throughout treatment. While he was in the residential setting, he was also able to get caught up in school and participate in the Junior Reserve Officers’ Training Corps (JROTC) program. After returning to his family, he completed his high school diploma, and a few months later he enlisted in the military.

**CONCLUSION**

The goal of this case study was to highlight the primary interventions that are effective in working with high-risk youth. These interventions included motivational interviewing, cognitive-behavioral therapy, and skill building. MI was utilized to decrease Anthony’s resistance and increase his motivation to change. It was also used to assist Anthony in changing some of his anti-social belief systems. CBT assisted Anthony with changing his thoughts and beliefs, along with recognizing some of his negative thinking habits. Lastly, skill building gave Anthony essential skills to navigate everyday situations
that he encountered. It should be noted that other interventions were also used to assist Anthony throughout his treatment. Some of these interventions included medication management to assist with stabilizing his mood, trauma focused-cognitive-behavioral therapy to address some of the trauma that Anthony had experienced earlier in his life, and family therapy to re-build Anthony’s relationship with his grandmother.

There were some challenges in my work with Anthony. One of the challenges involved Anthony periodically disengaging in individual therapy. This often happened as Anthony began to show success in the program. In these cases, I would bring my observations to Anthony’s attention. As Anthony was close to transitioning from the placement, he stated that he thought he might not need therapy anymore because he felt he made the changes that he needed to make. Anthony was provided with the autonomy to make this decision, because I felt it was important for him to take the lead in our relationship. Also, I believe it showed that Anthony was developing confidence that he could make the changes that he needed to be successful in the community. It was not easy for me to terminate therapy, because I had developed a strong therapeutic bond with Anthony, but I had to begin my own termination process as it was in the best interest of the client.

Another challenge included the racial and cultural differences between Anthony and myself. As a Caucasian male, I understand that my race and gender may be a distraction or barrier to a successful therapeutic relationship with an African American client. When I discussed this topic with Anthony, he communicated that it was not an issue for him, but I kept this possible barrier in mind throughout treatment by practicing in a culturally competent manner. Westbrooks and Starks (2001) provide recommendations for culturally competent practice specifically with African American individuals and families. The recommendations that were most helpful to me when working with Anthony are:

- Adopting a role of willingness to learn and be led—a true student of the partnership model
- Allowing and validating appropriate expressions of anger from clients
- Respecting the client’s right to reject “help” (p. 112)

In discussing this case study, it is important to understand that Anthony’s treatment took place in my office but continued outside of my office in the
therapeutic milieu of the residential placement where he lived. Anthony made significant breakthroughs in individual therapy, but it was complemented with a therapeutic milieu that also focused heavily on cognitive-behavioral interventions and skill building. Anthony was able to have the concepts learned in therapy reinforced outside of therapy. This relationship allowed for a fluid learning process for Anthony and expedited the therapeutic process.

REFERENCES


