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Rationale for *Clinical Case Studies*

An Editorial

The most important issue with respect to the single case is that the greatest innovation in psychotherapeutics has sprung from its application. Just to name a few of the innovators who have used the case method, consider Sigmund Freud, Victor Frankl, Carl Rogers, Arnold Lazarus, Joseph Cautela, Aaron Beck, Joseph Wolpe, Don Meichenbaum, David Barlow, Andrew Salter, and more recently, Francine Shapiro with EMDR treatment. Hence, there is a very long tradition, including Ivan Pavlov and B. F. Skinner. Indeed, there is no group comparison study that has truly led to innovation in this field; to the contrary, I would contend that most innovation comes by way of the single case in which maximum flexibility allows the clinician to test new hypotheses as new data accrue.

In developing the rationale for *Clinical Case Studies* (CCS), a number of salient issues needed to be answered before proceeding and finding a suitable publisher. Major concerns considered were the quality of writing and scholarship when presenting case study material, overall quality control, need for this publication outlet, acceptability in the professional and academic community, the heuristic value for students, and reaction from libraries.

Frequently, the model for scholarly writing in our field is the careful detailing of a completed research study. However, presenting a research report is no guarantee that scholarship or writing will be carried out at a high level. As editor of several more traditional journals, my fellow editors and I are able to attest to that fact. Second, looking at this from a different perspective, I do believe that there will be numerous academes and their students who will write up their cases and submit them to CCS. The reason that they have not in the past is clear; there is no comprehensive outlet. Coming back to the first point, how, then, will we ensure quality control? My answer to this question is the format that will be followed. Authors are required to adhere rigidly to this format. Such format will, in a sense, force the author to think clearly, theoretically, and empirically while providing the reader with detail of the intricacies of the clinical situation. Therefore, we will not simply have a random mélange of unfiltered cases. With very careful editorial monitoring, the clinician will impart to the reader his or her thought processes with respect to the formulation of the case, how it fits into the theoretical scheme, how it was assessed, and how the various strategies were implemented and modified as a result of the client's changing presentation. The objective is to demythologize and make pub-

lic to the reader what really transpires in the clinical process, *but not simply the sanitized version*.

I daresay that the aforementioned format is not typical of case reports that most reviewers have seen. We are not simply talking about a carelessly written paper of “my favorite case or treatment.” Before acceptance, each paper will be carefully massaged to ensure not only readability but also comprehensiveness of the exposition of the clinical issues, relationship to the extant research and clinical data, and its heuristic value.

Incidentally, in our survey of clinicians, teachers, and clinical academicians, my colleagues uniformly have indicated the need for such a publication. Perhaps they like to say yes to me! However, I think that the real reason is that there is no one journal outlet devoted to exposition of cases. There are cases that will be presented occasionally in *Psychotherapy*, *American Journal of Psychotherapy*, *Journal of Behavior Therapy and Experimental Psychiatry*, *Behavior Modification*, and others, but these are scattered. Indeed, despite their obvious clinical and educational value, there has been a bias against publishing more comprehensive single-case analyses. However, as someone who has written two books on *Single Case Experimental Designs* with David Barlow and edited four casebooks and one in press (second edition), I do know that there is considerable but unfulfilled interest. Moreover, in addition to the obvious clinical audience, there is a plethora of students and their supervisors (cross disciplinary) who could make extensive use of this kind of publication outlet, especially given the growing number of professional schools of psychology in this country. If my analysis of the need is correct (given how often students and other clinicians will ask, How did you implement such and such technique that you used with the given client, and what was your thinking behind the various clinical decisions that you made?), then the libraries, as well, would have to conclude that CCS has significant educational merit.

CCS is a multidisciplinary journal that is directed to practitioners, teachers, and students of psychotherapy. It publishes case reports of therapeutic interventions across the age spectrum (child and adolescent, adult, older adult). Papers on individual therapy, couples therapy, and family therapy are considered, as well as those that focus primarily on interesting and challenging assessment cases. In addition, case series that present direct and systematic replications will be considered.

Manuscripts that articulate various theoretical frameworks (behavioral, cognitive-behavioral, gestalt, humanistic, psychodynamic, rational-emotive therapy, and others) will be welcomed. All manuscripts adhere to the following format:

Abstract

1. Theoretical and research basis
2. Case introduction
3. Presenting complaints
4. History
5. Assessment
6. Case conceptualization (this is where the clinician's thinking and treatment selection come to the forefront)

7. Course of treatment and assessment of progress
8. Complicating factors (including medical management)
9. Managed care considerations (if any)
10. Follow-up (how and how long)
11. Treatment implications of the case
12. Recommendations to clinicians and students
13. References

Papers will emanate from numerous disciplines, including clinical psychology, counseling psychology, psychiatry, social work, and psychiatric nursing. Manuscripts that highlight innovative therapeutic strategies or existing therapeutic strategies applied to novel problems will be given preference. The emphasis, however, will be on clear communication to the reader as to the conceptualization of the case, reasons for the ensuing selection of treatment, how treatment difficulties were dealt with, and recommendations to clinicians and students who are seeing similar clients and patients. Manuscripts are reviewed for the heuristic value of the case. We also underscore the course of treatment and assessment of progress and include actual dialogue where relevant.

In conclusion, I believe that CCS has an outstanding Editorial Board that will ensure high quality of presentation to our readership. I truly think that this journal will fill the proverbial gap in the literature and trust that colleagues and students will agree.

Michel Hersen
Editor

Treatment of Obsessive Thoughts and Cognitive Rituals Using Exposure and Response Prevention

A Case Study

JONATHAN S. ABRAMOWITZ

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Abstract: This case study describes the application of cognitive-behavioral therapy by exposure and response prevention (EX/RP) to a young man with obsessive-compulsive disorder (OCD) involving primarily obsessional thoughts and mental rituals. Although patients with primarily cognitive OCD symptoms have been previously considered treatment resistant, novel approaches to EX/RP have been developed and validated. Successful treatment of such symptoms requires a thorough and informed assessment. The theoretical and empirical basis for these procedures is described, along with a cognitive-behavioral analysis of the problem. The course of treatment, use of assessment data, and recommendations to clinicians are also discussed.

Keywords: obsessive-compulsive disorder, mental rituals, cognitive-behavioral theory, obsessional thoughts, case study.

1 THEORETICAL AND RESEARCH BASIS

Obsessive-compulsive disorder (OCD), once thought to be an uncommon psychiatric condition, is now known to affect about 1 in 40 adults in the United States (Rasmussen & Eisen, 1989). Similar rates have been reported worldwide (Angst, 1994). Whereas the cardinal symptoms of OCD are (a) *obsessional thoughts* (e.g., fears of contamination) that give rise to anxiety and (b) *compulsive rituals* (e.g., repetitive hand washing) performed to reduce anxiety, researchers have identified a subgroup of patients reporting obsessions without observable rituals (e.g., Baer & Minichiello, 1990; Rachman, 1971, 1976). Individuals with this symptom pattern, often called “pure obsessionals,” have historically been considered especially resistant to behavioral treatment methods

AUTHOR'S NOTE: I wish to thank Stacy Abramowitz, Martin E. Franklin, and David F. Tolin for their assistance at various stages in preparing this report. Address correspondence to Jonathan S. Abramowitz, Mayo Clinic, 200 First St. SW, Rochester, MN 55905; e-mail: abramowitz.jonathan@mayo.edu.

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(Jenike 1993) and are, therefore, distinguished from those with overt rituals (e.g., washing and checking). Moreover, the purely cognitive symptoms displayed by these patients present a monumental challenge to clinicians inexperienced with assessing and understanding this problem. In this article, I present the case of a young man with severely distressing obsessional thoughts but no overt compulsive rituals. His successful treatment using cognitive-behavioral procedures derived from recent conceptualizations of obsessional problems (Salkovskis, 1999) is described. Moreover, the therapeutic mechanisms hypothesized to underlie the observed clinical changes are highlighted.

The term *pure obsessional* suggests that patients with this form of OCD suffer only from obsessional thoughts. However, Salkovskis (1999) has synthesized research from several areas to elucidate a cognitive-behavioral model of obsessional problems that involves two processes: (a) anxiety-evoking thoughts and (b) efforts to reduce this anxiety. The model starts with the idea that practically everyone experiences intrusive, upsetting thoughts at various times (Rachman & de Silva, 1978). Thus, the difference between normal intrusive cognitions and clinical obsessions lies not in the occurrence or content of the thought itself but in the person's appraisal of the thought. Accordingly, an obsessional pattern occurs if unwanted thoughts are appraised as meaning that the person may be, may have been, or may come to be responsible for harm or its prevention (Rachman, 1993; Salkovskis, 1999).

Not surprisingly, this type of responsibility appraisal leads to anxiety or distress and the motivation to control or neutralize the upsetting thought. Strategies of thought control may include (a) thinking through whether a thought is really true, (b) replacing the "bad" thought with a "safe" or "good" thought, or (c) attempting to suppress the bad thought altogether. Newth and Rachman (2001) recently suggested that concealing obsessional thoughts is yet another strategy of thought control. Although these mental rituals or neutralizing strategies result in the short-term reduction in obsessional distress, they are ultimately counterproductive for three reasons. First, they serve to increase preoccupation with intrusive ideas. Second, because neutralization strategies function as an escape from feared thoughts (which are harmless), the patient is prevented from learning that intrusive thoughts are not actually indicative of harm. Finally, because these strategies are negatively reinforced by the reduction in distress they engender, they become a habitual way of coping with intrusive thoughts. Thus, mental neutralization strategies serve to maintain obsessional problems.

From a functional analytic perspective, Salkovskis's (1999) idea that two cognitive phenomena are present in individuals with obsessional problems (anxiety-evoking thoughts and anxiety-reducing thoughts) parallels cognitive-behavioral conceptualizations of OCD with overt compulsions. That is, obsessional thoughts evoke anxiety, and purposeful ritualistic behavior is performed to reduce anxiety. This leads to the hypothesis that cognitive-behavioral treatment procedures that are effective for OCD with overt compulsions would also be effective (with modifications) in the treatment of patients with only mental rituals. In both cases, reducing OCD symptoms requires demonstrating that (a) obsessional situations do not pose a real threat, and (b) anxiety/distress can be

reduced without performing specific rituals or neutralizing behaviors (Kozak & Foa, 1997). Consistent research has demonstrated that repeated and prolonged exposure (confrontation with anxiety-evoking situations and thoughts) and response prevention (resisting urges to perform compulsive behaviors; for a detailed treatment manual see Kozak & Foa, 1997) are highly effective in reducing OCD symptoms (Franklin, Abramowitz, Kozak, Levitt, & Foa, 2000).

In our OCD treatment program at Mayo Clinic, we employ a modified exposure and response prevention (EX/RP) program when treating patients with no overt rituals. This therapy is based on the model described above and includes the following components: First, assessment and planning involves identifying intrusive thoughts, discussing how they are appraised by the patient, and identifying situations that evoke the thoughts. An emphasis is placed on identifying attempts to control or neutralize these thoughts. Next, patients are taught about the cognitive-behavioral conceptualization of obsessional problems (described above) and given a rationale for EX/RP. A hierarchy of situations and intrusive thoughts for exposure is then developed.

In the treatment phase, patients practice repeated and prolonged confrontation with anxiety-evoking intrusive thoughts, as well as with situations that evoke these thoughts. This kind of exposure often takes the form of verbalizing the thought/idea into a tape recorder and listening repeatedly. Patients are taught to include the most distressing elements of the thought. In addition, neutralizing behaviors are identified, and the patient is instructed to refrain from them. The patient is encouraged to allow the unpleasant thought to remain in consciousness.

2 CASE INTRODUCTION

“AF” (not the actual initials), a 19-year-old Asian American male in his first year as a university student, was referred to our unit by a psychologist at the university counseling center, who recognized his complaints as OCD symptoms. Mr. F denied any previous psychological treatment. Although he reported achieving excellent grades in school, he recently had lost interest in his studies and was missing classes due to feeling depressed. Mr. F said that although he was an avid basketball player, for the past several weeks he had lost interest in playing sports.

3 PRESENTING COMPLAINTS

At his initial evaluation, Mr. F described the presence of unwelcome, yet recurrent, intrusive thoughts. These included unwanted impulses to yell curse words during classes or musical performances, stab others while using knives, and look in the direction of peoples’ genitals. Mr. F was especially bothered by intrusive thoughts concerning

nonconsensual sexual intercourse with a particular female friend of his, “Mindy.” The patient noted that these thoughts were “unlike him” and said he had never taken and would never take such action. Nevertheless, AF was extremely fearful that he *might* act on such thoughts. For example, he ruminated about how such violent acts could be committed with relatively little effort or planning. Mr. F also described physical symptoms of anxiety, such as frequent indigestion, headaches, chest pain, and sleep loss.

A pretreatment semistructured interview using the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) (Goodman, Price, Rasmussen, Mazure, Delgado et al., 1989; Goodman, Price, Rasmussen, Mazure, Fleischmann et al., 1989) and symptom checklist indicated that Mr. F met the diagnostic criteria for OCD (Diagnostic and Statistical Manual of Mental Disorders, 4th edition [DSM-IV]; American Psychiatric Association, 1994). His main obsessions were the aggressive thoughts and impulses as described above. Additionally, Mr. F worried that he was a bad person with evil tendencies because he entertained these thoughts and seemingly could not control them. Although he was unable to identify any overt compulsions, Mr. F described mental rituals such as reviewing his thoughts and reasoning or reassuring himself that he was not an evil person. Mr. F also met the diagnostic criteria for a major depressive episode, but these complaints were clearly secondary to his OCD. When not anxious, Mr. F recognized that his obsessions were somewhat bizarre and that he most likely would not act on them; that is, he had generally good insight into the senselessness of his OCD symptoms.

4 HISTORY

Mr. F was born and raised in an upper-middle-class community outside of a large northeastern city. Until his enrollment at the university, he lived with both of his biological parents, who had been born in China. Mr. F considered himself a religious Christian with strong moral values. He reported an outstanding high school academic record and participation in numerous athletic and scholarly extracurricular activities. Mr. F also reported satisfaction with his social life. He denied previous abuse of alcohol or illegal drugs.

Mr. F noted that his obsessional problems began about a year prior to treatment when he experienced unwelcome and upsetting thoughts about killing his parents in their sleep. Similarly, he recalled driving with his mother and thinking that he could easily drive off the road and kill them both. Mr. F said that he found such ideas extremely troubling and often tried desperately to dismiss them, yet often had difficulty doing so. He often would sit in his room thinking about ways he could be careful so as to prevent his thoughts from influencing his actions. As the repulsive thoughts recurred, Mr. F became worried that he possessed tendencies to impulsively commit violent and immoral acts. Importantly, he reported that such thoughts and ideas were repugnant and that he had never acted, nor felt any desire to act, on them.

5 ASSESSMENT

Thorough assessment is critical for case formulation and development of a successful cognitive-behavioral treatment plan. Therefore, we discuss the therapist's functional assessment of Mr. F's anxiety-related thoughts and behaviors in detail. Following this, we describe how the case was conceptualized, leading to the choice of treatment procedures. Because OCD is characterized by anxiety-evoking thoughts as well as purposeful efforts to reduce this anxiety, assessment focuses on identifying these specific phenomena. Importantly, OCD is a heterogeneous condition; thus, the nature of these symptoms varies widely from patient to patient. Discussion of situations avoided by the patient as well as appraisals of intrusive thoughts are also important in gaining a functional assessment of OCD-related symptoms.

First, the therapist inquired about situations in which Mr. F experienced obsessional thoughts. Mr. F reported that using knives, reading or hearing about violent crimes, and going to the study lounges on the balcony of his university dormitory often evoked obsessions. He also said that when in the company of Mindy, he had unwanted thoughts of forcing her to engage in sexual intercourse. Seeing his roommate sleeping evoked thoughts of stabbing him. Additional sources of anxiety included using e-mail and attending certain classes or performances.

Next, the therapist assessed Mr. F's appraisals of his unwanted intrusive thoughts. Mr. F said that the thoughts were highly threatening and that he was particularly concerned he might act on them. He felt it was immoral and disrespectful to have such thoughts and also reported feeling guilty for thinking sexual thoughts. The following dialogue from Session 2 illustrates Mr. F's inflated sense of responsibility associated with his obsessional thoughts:

- JA: What do you think it means that you have these sexual thoughts about Mindy?
 AF: I know I shouldn't have them, but maybe deep down I really want to force her to have sex with me. I'm scared there's a part of me that's evil.
 JA: Well, have you ever acted on any of the thoughts before?
 AF: No, but I am very careful to make sure I don't do anything crazy.
 JA: And if you weren't so careful, what is the probability that you'd do something terrible?
 AF: Probably high. Why else would I have these thoughts? If people could only read my mind, they would think I was some perverted, evil person.
 JA: So, even though you have never actually acted on these thoughts, you see yourself as evil and perverted just because you have the ideas, am I right?
 AF: I wonder about that a lot. I'm usually a nice guy who respects people. Then I start to worry, "What kind of sick person thinks about these things," you know? I feel so guilty.

The therapist also asked Mr. F about situations he avoided because of the thoughts. Mr. F reported that he had been avoiding knives, especially when around others (i.e., at meals), because of thoughts of stabbing people. He had also stopped going to his dormitory's study lounge because it was located on a balcony and evoked thoughts of throwing himself over the ledge. He had become increasingly isolated from his friends and began missing classes on a regular basis because of fears he might yell curse words in class. Due to his fears of sending inappropriate e-mail messages, Mr. F had disconnected his own computer. Finally, Mr. F said he avoided looking in the direction of peoples' genital areas because of sexual thoughts this evoked.

Next, the therapist introduced the concepts of *neutralizing* and *mental rituals* and inquired about strategies that Mr. F used to control his unwanted thoughts. Mr. F described several types of rituals. First, he reported "testing" himself when he had urges to yell curse words in public places. This involved subvocally whispering the curse word. He also described "mentally reasoning" about the possibility that he would commit the acts he obsessed about. This ritual involved reviewing previous actions to restore confidence that he had never acted this way in the past and was of good moral character. Mr. F said that on some occasions, he had spent up to 3 hours sitting alone engaged in this type of thinking.

Assessment also included administration of several interview and self-report measures of OCD, depression, and anxiety. To reduce bias, a clinical psychologist not otherwise involved in Mr. F's treatment administered these measures. The following instruments were used to assess overall symptom severity before, during, and after treatment.

Y-BOCS (Goodman, Price, Rasmussen, Mazure, Delgado et al., 1989; Goodman, Price, Rasmussen, Mazure, Fleischmann et al., 1989). Used to measure OCD symptoms, the Y-BOCS is a semistructured clinical interview that also includes a 10-item severity scale. Obsessions and compulsions are rated separately, yielding two subscores (range 0-20) that are added to produce a total score (range 0-40). Symptoms are rated on a 5-point Likert-type scale from 0 (*no symptoms*) to 4 (*severe symptoms*). Items include (a) time spent on symptoms, (b) interference, (c) distress, (d) resistance, and (e) control over symptoms. Efforts to neutralize or reduce obsessional anxiety (e.g., mental rituals) were rated on the compulsions subscale. The Y-BOCS has satisfactory psychometric properties and has been found sensitive to treatment effects (e.g., Goodman, Price, Rasmussen, Mazure, Delgado et al., 1989; Goodman, Price, Rasmussen, Mazure, Fleischmann et al., 1989).

Beck Depression Inventory (BDI) (Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961). The BDI is a 21-item self-report scale that assesses the severity of affective, cognitive, motivational, vegetative, and psychomotor components of psychological distress. Scores of 10 or less are considered normal; scores of 20 or greater suggest the presence of

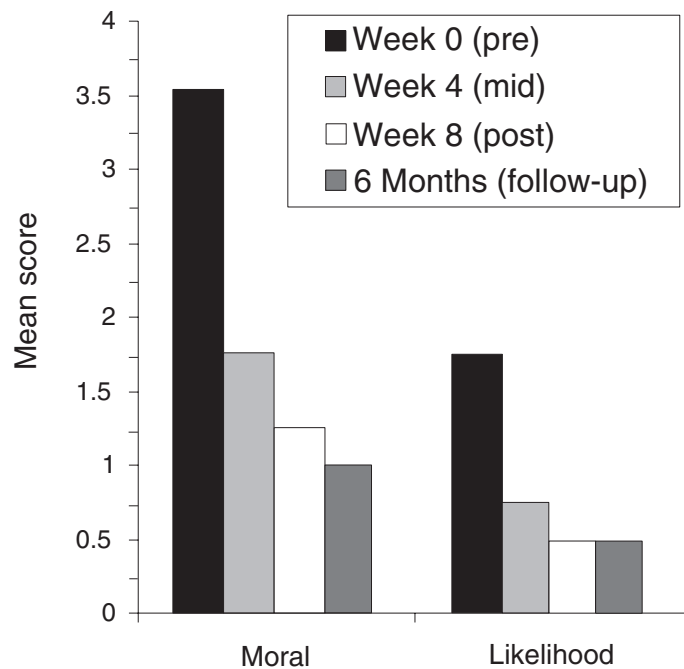


Figure 1. Pretreatment, Midtreatment, Posttreatment, and Follow-Up Scores on the Thought-Action Fusion Questionnaire Subscales

clinical depression. The BDI has been shown to have excellent reliability and validity (Beck, Steer, & Garbin, 1988) and is widely used in treatment outcome research.

Revised Thought-Action Fusion Scale (TAF) (Shafran, Thordarson, & Rachman, 1996). This is a 19-item self-report measure of the degree to which a person believes that unwanted thoughts about disturbing events (a) are the moral equivalent of the actions they describe and/or (b) make the event more probable. Each item (e.g., "When I think unkindly about a friend, it is almost as disloyal as doing an unkind act.") is rated on a scale from 0 (*strongly disagree*) to 4 (*strongly agree*). The TAF includes two subscales: Moral (12 items) and Likelihood (7 items) that possess high internal consistency (Cronbach's alphas = .95 and .96, respectively). Summed totals for each subscale are divided by the number of items so that scores on each subscale range from 0 to 4.

Thought Control Questionnaire (TCQ) (Wells & Davies, 1994). This is a 30-item self-report questionnaire that assesses the use of five strategies for managing intrusive thoughts. Five subscales, which correspond to the thought control strategies, include (a) distraction, (b) social control, (c) worry, (d) punishment, and (e) reappraisal. Each item represents a method of thought control (e.g., "I try to think of something else.") and is rated on a 4-point Likert-type scale from 1 (*never use*) to 4 (*almost always use*). Each of the five subscales is composed of six items. Internal consistencies of the five subscales

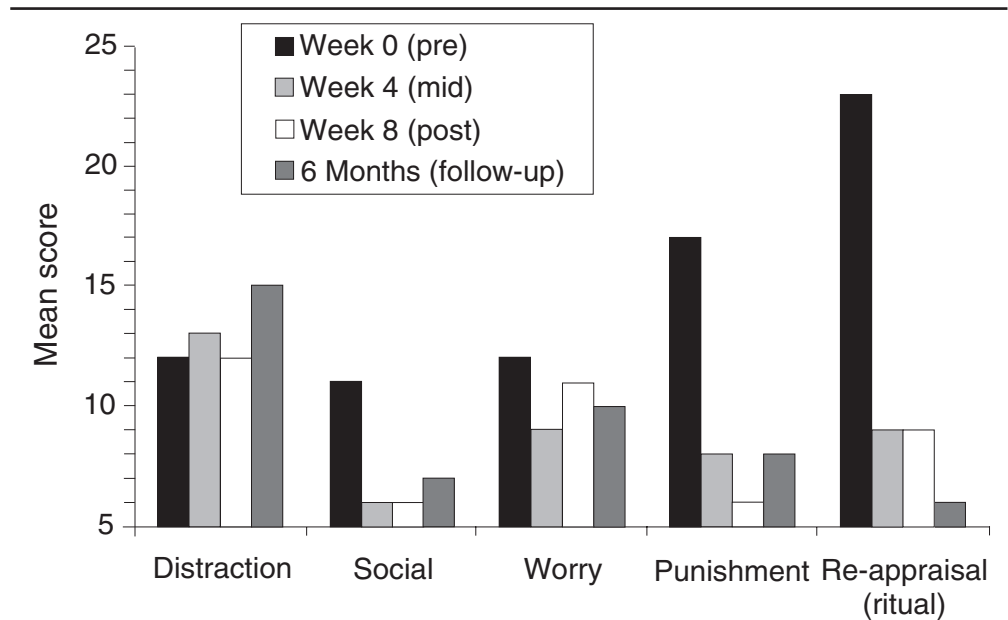


Figure 2. Pretreatment, Midtreatment, Posttreatment, and Follow-Up Scores on the Thought Control Questionnaire Subscales

range from .64 to .83 (Wells & Davies, 1994). Amir, Cashman, and Foa (1997) found that individuals with OCD used worry, punishment, and reappraisal strategies more often than nonpatient controls.

At the start of each session, the therapist rated the following symptoms:

1. Fear of intrusive thoughts. This was rated on a scale from 0 (*none*) to 8 (*severe*).
2. Avoidance. The degree to which Mr. F was avoiding situations associated with unpleasant intrusive thoughts was rated from 0 (*never avoids*) to 8 (*invariably avoids*).
3. Neutralizing (rituals). Daily time spent performing neutralizing behaviors (e.g., rationalizing the meaning of unpleasant thoughts) was assessed on a scale from 0 (*none*) to 8 (*30 times or over 2 hours per day*).

6 CASE CONCEPTUALIZATION

Mr. F's complaints were conceptualized based on the cognitive-behavioral model of obsessional problems described above. Assessment data were used to examine hypotheses about this conceptualization. His intrusive thoughts, however unpleasant, were considered normal stimuli that occur in 90% of the population at large (Rachman & de Silva, 1978). The excessive fear and anxiety associated with such thoughts, however, was thought to occur due to catastrophic misinterpretations of the thoughts' presence and significance (e.g., "The thoughts mean I am an evil person."). In support of this conceptualization were Mr. F's pretreatment TAF data, which indicated strong beliefs that

TABLE 1
Scores on Measures of Obsessive-Compulsive and Depressive Symptoms at Each Assessment

<i>Symptom and Measure</i>	<i>Assessment</i>			
	<i>Week 0 (pre)</i>	<i>Week 4 (mid)</i>	<i>Week 8 (post)</i>	<i>6 Month</i>
Yale-Brown Obsessive Compulsive Scale total score (0-40)	28	15	7	7
Obsessions (0-20)	14	9	5	5
Compulsions (0-20)	14	6	2	2
Beck Depression Inventory	18	4	1	3

unacceptable thoughts were somehow linked to inappropriate actions, particularly from a moral standpoint (see Figure 1).

Mr. F's avoidance of situations that evoked the thoughts was seen as a method of preventing intrusions and related distress. Similarly, neutralizing rituals were seen as methods of escape from intrusive thoughts already in progress. Mr. F's pretreatment TCQ scores (see Figure 2) were consistent with the presence of OCD and the hypothesis that he was using punishment, worry, and reappraisal (ritual) strategies (Amir et al., 1997). Because avoidance and mental rituals were effective in reducing distress in the short term, Mr. F resorted to them whenever intrusions occurred. However, in the long term, their use prevented Mr. F from discovering that his intrusive thoughts, although unpleasant, were harmless and not foreboding of violent or inappropriate actions. Thus, passive avoidance and active neutralizing were actually maintaining the catastrophic misinterpretation of harmless intrusive thoughts. Furthermore, fear of the thoughts was increasing Mr. F's attention and preoccupation with them.

Foa and Kozak (1986) have suggested that reduction of pathological fear requires confrontation with the feared stimulus along with presentation of corrective information, that is, that disastrous consequences do not occur. Therefore, the conceptualization described above leads to exposure as a primary treatment procedure. Repeated and prolonged exposure to situations that evoke intrusive thoughts, as well as to the thoughts themselves, will help Mr. F discover that such thoughts are not dangerous. Exposure is thought to weaken the misappraisal of such intrusions and break anxiety/fear responses to having such thoughts (Foa & Kozak, 1986). However, Mr. F must also curtail cognitive neutralizing because these strategies maintain beliefs that intrusive thoughts are harmful. Thus, response prevention is instituted to help weaken the associations between having to neutralize to reduce anxiety.

7 COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

An intensive time-series design (Barlow, Hayes, & Nelson, 1984) was used to examine the effects of treatment. Treatment consisted of a two-session measurement-only

period to assess the severity and stability of symptoms, followed by a 13-session treatment phase and a 6-month follow-up measurement-only period. Treatment sessions occurred twice weekly over 8 weeks, and the severity of Mr. F's fear, avoidance, and rituals was assessed at each session. Comprehensive assessments of overall symptom severity were conducted at pretreatment, midtreatment, and posttreatment. At pretreatment, Mr. F's score on the Y-BOCS was 28, which is indicative of severe OCD symptoms. Scores on both the obsessions and compulsions subscales were 14. His BDI score was 18, suggesting moderate depressive symptoms (see Table 1).

During the first two sessions (information gathering and education), the therapist collected information about Mr. F's OCD symptoms and his history and provided a cognitive-behavioral conceptualization of OCD and an explanation for how OCD symptoms are weakened by EX/RP (described above). In vivo and imaginal exposure were conducted during Sessions 3 through 15. One session was scheduled toward the beginning of each week and the other toward the end of each week. Homework practice was assigned for days when there was no session. Instructions to refrain from ritualistic or neutralizing behaviors (ritual prevention) were also given. Telephone contacts were scheduled for 1 day between sessions. The purpose of phone contacts was for Mr. F to check in with the therapist and for the therapist to make any necessary corrections in the performance of exposure practices. The final session included a thorough assessment and discussion of methods Mr. F could use to maintain his treatment gains.

After taking a general history, the therapist introduced the cognitive-behavioral model of obsessional problems, as described above. To normalize the presence of such thoughts, the therapist showed examples of intrusive thoughts from OCD and non-OCD participants in Rachman and DeSilva's (1978) article. Several types of misinterpretations of thoughts common in OCD were discussed (e.g., thought-action fusion [Shafran et al., 1996]; responsibility [Salkovskis, 1999]), and examples relevant to Mr. F's symptoms were provided. Evidence that thoughts are not necessarily linked to actions was then collected by having Mr. F perform a brief experiment in which he was asked to think about performing certain actions (e.g., getting out of his chair) yet to refrain from doing them. Mr. F was asked to explain how he was able to refrain, despite thinking about performing the action.

Next, the therapist described how neutralizing strategies maintain erroneous interpretations of unwanted thoughts. This discussion included an explanation of research demonstrating that attempts to suppress a thought paradoxically lead to an increase in the frequency of that thought (e.g., Wegner, Schneider, Carter, & White, 1987). To illustrate and further normalize this phenomenon, Mr. F was asked to not think of a pink elephant. When the patient subsequently reported numerous pink elephant thoughts, the therapist pointed out the difficulty people have in suppressing their thoughts. The therapist also discussed with Mr. F how attempts to suppress unwanted thoughts were backfiring—specifically, that they result in more thoughts, as well as the illusion that the thoughts are uncontrollable.

TABLE 2
Mr. F's Planned Exposure Treatment Hierarchy

<i>Exposure Session</i>	<i>Situation or Thought</i>	<i>Subjective Units of Distress Scale Score</i>
1	Look at people's genital area	55
2 and 3	Go to study lounge on dorm balcony; think about jumping	55
4 and 5	Think about curse words in inappropriate places	65
6	Use knife in presence of others	65
6	Place knives around dorm room freely	70
7 and 8	Think about stabbing someone with knife in hand	85
9 and 10	Wish for accidents to loved ones	85
11 and 12	Rape thoughts	93

Once Mr. F understood this conceptualization, the therapist introduced the concepts of EX/RP as procedures to reduce obsessional thinking and the urges to perform rituals. Exposure was described as a way of weakening the association between unpleasant thoughts and distress by demonstrating that the thoughts are not harmful. Response prevention was explained as a strategy for weakening the connection between having to perform mental rituals to reduce anxiety or distress. It was also highlighted that EX/RP was intended not to curtail unpleasant thoughts per se (indeed, everyone has the occasional unpleasant idea) but rather to change Mr. F's interpretation of the thoughts. A written summary of this treatment rationale was provided to the patient for his further review.¹

Mr. F and the therapist developed a hierarchy of situations and thoughts to be confronted both in real life (in vivo) and in imagination. Items to be confronted first were those that evoked relatively little distress. Moderately distressing situations and thoughts were confronted next, followed by the most distressing situations by the eighth treatment session. The level of distress evoked by a given situation was assessed by Mr. F using the Subjective Units of Distress (SUDS) scale, with a rating from 0 (*no anxiety*) to 100 (*intense anxiety*). Mr. F agreed to confront these situations and remain exposed until the obsessional distress had decreased significantly (a substantial decrease in SUDS) despite not ritualizing or performing any neutralizing behaviors. Table 2 presents the initial exposure hierarchy and corresponding SUDS ratings.

Early hierarchy items included glancing in the direction of people's genital area and going to the dormitory balcony while thinking about jumping off. Mr. F practiced these situations with the therapist before trying them on his own (homework). Mr. F recorded his SUDS level on a homework chart every 10 minutes during exposure practice. In-session observations and inspection of completed homework forms indicated that Mr. F's anxiety levels were decreasing both within and between exposure sessions. The patient was extremely successful with abstaining from his ritualistic and/or neutralizing behaviors.

At the fourth session, Mr. F reported that although his fears of looking at peoples' genitals had decreased, those of impulsively forcing Mindy to have sexual intercourse

were becoming worse. In particular, he was fearful of impulsively sending this woman an e-mail message in which he described raping her. Because of these fears, Mr. F disconnected his computer and avoided using his e-mail account. A problem arose in which Mr. F thought that if he simply sent such an e-mail to Mindy and asked her to erase it without reading it, the fear of sending this message would disappear. This obstacle is described more fully in the Complicating Factors section below.

By the sixth treatment session, Mr. F was confronting exposure situations rated as moderately difficult. These included planning to yell curse words during classes (but not actually yelling), placing knives out in his dorm room, and reconnecting his personal computer to the Internet. During the seventh session, Mr. F wrote a vignette about losing control and stabbing unsuspecting people. This thought was then read aloud into a tape recorder and played repeatedly until his distress had substantially decreased (about 20 minutes). Next, the therapist gave Mr. F a large butcher knife and instructed him to imagine the vignette he had taped. At first, Mr. F became uncomfortable, saying he was concerned about losing control and stabbing the therapist. He held the knife gingerly at first but soon was able to use a firm grasp. The therapist turned his back and asked the patient to wave the knife in the air. Mr. F was then taken to an office with a confederate who was working on his computer. The patient was instructed to wave the knife in the air and think his obsessional thought (but not stab the confederate!). The therapist left the room after 5 minutes, and after about 20 minutes, Mr. F reported no longer worrying about losing control. Mr. F's SUDS levels had decreased substantially, and he could raise the knife to the (brave) confederate's back while saying out loud, "I could kill you right now." When this exercise was repeated at the subsequent session, Mr. F reported virtually no distress. An excerpt from the subsequent discussion about this dramatic exposure follows:

JA: So, when we started this you were scared your thoughts of stabbing people would turn you into a raging maniac. What happened during the exposure?

AF: I didn't stab anyone.

JA: Right, even though you were purposely thinking about it. Plus, your anxiety subsided. How do you explain that?

AF: I didn't want to stab anyone, so I didn't. Just like in my room, I have some knives lying around, but I'll never use them to hurt [roommate].

JA: So, what does that tell you about your thoughts and your actions?

AF: You're right. *I* decide what I'm going to do and not do. If I don't want to stab someone, I'm not going to do it. The thought of doing it is just a thought, like a "brain hiccup."

JA: How strongly do you believe what you just told me?

AF: Pretty strongly, like 80 to 90%.

JA: Good. As long as you keep thinking that way, you'll find yourself paying less and less attention to the thought when it comes up since it's not a threat anymore.

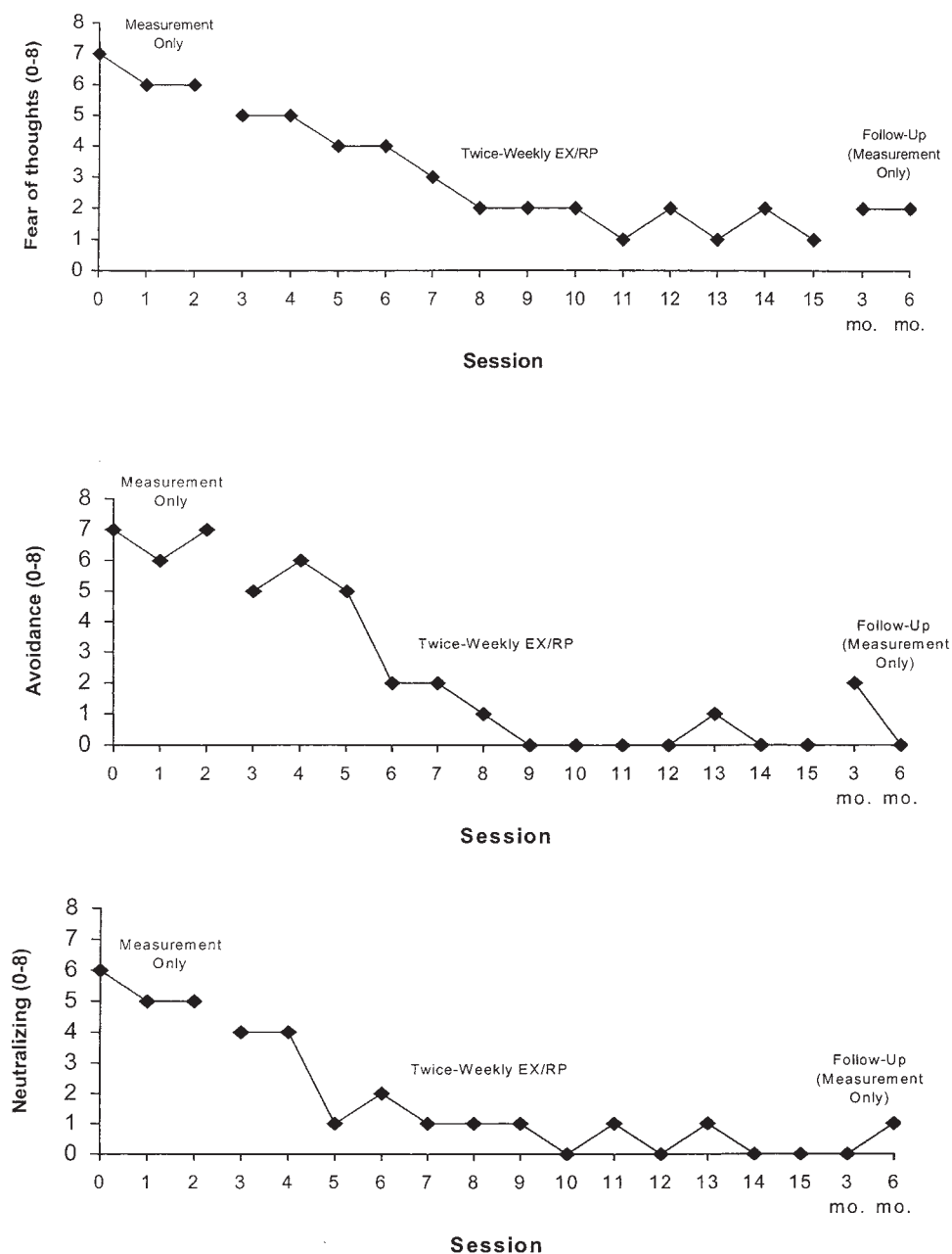


Figure 3. Therapist Ratings of Mr. F's Fear of Intrusive Thoughts, Avoidance, and Rituals at Each Treatment Session and at Follow-Up

The midtreatment assessment occurred after 4 weeks of therapy. Table 1 shows the decreases in Y-BOCS and BDI scores. Figures 1 and 2 show decreases in TAF and thought control strategies of punishment and reappraisal. Figure 3 shows decreases in fears of thoughts, avoidance, and time spent performing neutralizing behaviors. In con-

cert, these data suggest improvement in major symptoms as well as changes in some of the cognitive processes hypothesized to underlie OCD.

The knife exposures were significant in Mr. F's treatment course because after Session 8, he began designing and practicing exposure on his own. Mr. F knew that he had to purposely let himself think unpleasant thoughts when they arose and prove to himself that he would not act on them. In the remaining sessions, time was devoted to intrusive fears of impulsively sending explicit e-mails to his friend Mindy. Mr. F practiced by actually typing an explicit message as if to send it but refraining from pushing the "send mail" button on the mail program. He even put his hand over the keyboard and told himself to send the message yet was able to refrain, thus demonstrating the control he had over his actions. His distress decreased with repeated practice in the therapist's office as well as in his dorm room.

The majority of OCD patients who undergo EX/RP report at least minimal obsessional symptoms that remain at the end of treatment (Abramowitz, 1998), and Mr. F was no different. The final session included a discussion of the importance of continuing exposure to obsessional thoughts or situations to prevent the return of symptoms. Potential high-risk situations were identified, and Mr. F was given suggestions for how to implement EX/RP on his own. In addition, the difference between *lapse* and *relapse* was discussed, and Mr. F was told to expect periodic lapses (particularly when under more stress) during which he would have to use the skills learned in cognitive-behavioral treatment to maintain treatment gains. Mr. F's posttreatment total Y-BOCS score (Table 1) indicated only subclinical OCD symptoms. He had substantially reduced his fears of thoughts, avoidance patterns, and neutralizing behaviors as rated by the therapist (Figure 3), and his BDI score indicated that he was no longer depressed. These scores were consistent with Mr. F's verbal reports. His interest in socializing had returned, and he had stopped avoiding classes, performances, and other situations in which his obsessive thoughts were cued. TAF and TCQ scores indicated that changes in cognition had occurred as a result of EX/RP. These final results were discussed with Mr. F, and follow-up visits were scheduled for 3 and 6 months later.

8 COMPLICATING FACTORS

Mr. F's course of treatment was generally smooth. He grasped the cognitive-behavioral conceptualization of OCD but at first did not appear to understand the rationale for using EX/RP treatment procedures to weaken these symptoms. This presented a problem in the fourth treatment session when Mr. F insisted that if he simply sent an e-mail to Mindy and asked her to delete it without reading it, his unwanted fears about sending such a message would pass. During a discussion of this possibility, the therapist pointed out that this idea was inconsistent with EX/RP because it would reinforce the use of avoidance rather than exposure to decrease anxiety. The potential negative consequences of this idea (e.g., losing a friend, sexual harassment) were also considered. Mr. F

was unhappy with this outcome and discontinued Session 4 early. The following day, the therapist contacted Mr. F by telephone to assess the future of treatment. Mr. F had decided not to take the ill-advised route he had suggested and instead returned to the therapist and agreed to continue with treatment as planned.

This potential stumbling block illustrates the mistaken idea that avoidance is the best route to overcoming OCD. Mr. F wanted to send the e-mail message to Mindy because he thought it would rid him of further intrusive fears of impulsively sending the message. However, avoidance is an ineffective coping strategy because it reinforces the belief that obsessional thoughts are threatening. Moreover, the cognitive-behavioral hypothesis of OCD posits that such intrusive ideas are normal and almost certainly would resurface again at some point (Salkovskis, 1999). Thus, given that such thoughts do not cause one to act immorally, a more efficient solution is to weaken the fear associated with such thoughts, that is, via EX/RP. As this complication and its management reveals, it is critical that patients have a clear understanding of the rationale for employing EX/RP.

9 FOLLOW-UP

Mr. F was seen approximately 3 months after completing the 8-week EX/RP program. Between the end of therapy and follow-up, he had continued to practice self-exposure to his unwanted thoughts, especially those of sending inappropriate e-mail messages. He reported practicing at times when he was having intrusive thoughts. In addition, he had been quite successful in resisting urges to perform behaviors to neutralize intrusive thoughts. At follow-up, Mr. F reported occasional unwanted thoughts; however, they evoked only minor levels of distress. He also reported being able to remind himself that these cognitions, although strange, were meaningless and would not lead to inappropriate behavior. One concern that arose was Mr. F's anticipation that he might experience intrusive thoughts concerning his family while at home during the upcoming summer vacation. Mr. F and the therapist discussed techniques that could be used to keep any such thoughts from becoming problematic. The cognitive-behavioral conceptualization of obsessional problems (Salkovskis, 1999) was discussed again in detail, as well as the rationale for using exposure to unpleasant thoughts. Possible exposure situations were planned, and Mr. F was also instructed to telephone the therapist as needed.

The 6-month follow-up visit occurred soon after Mr. F had returned from his summer vacation. Y-BOCS, BDI, and symptom ratings (Table 1 and Figure 3) suggested that both obsessive-compulsive and depressive symptoms had remained at a subclinical level. Mr. F's verbal report was consistent with these data. He reported having some intrusive thoughts over the summer but that he was able to use the skills he had learned during therapy to circumvent having to resort to many rituals or avoidance. At this point, the patient was told to contact the therapist should he run into further difficulty but was otherwise dismissed from the treatment program.

10 TREATMENT IMPLICATIONS OF THE CASE

OCD is a heterogeneous condition, and treatment outcome studies of this disorder typically include samples of patients with various types of symptoms (e.g., checking, washing). With the exception of compulsive hoarding (e.g., Hartl & Frost, 1999), treatments for particular OCD presentations (e.g., scrupulosity) have remained largely unexamined. Patients without overt rituals (pure obsessionals) have previously been considered impervious to cognitive-behavioral treatments (Jenike, 1993). This case study is one of the few detailed demonstrations of the treatment of obsessive thoughts using EX/RP. Whereas previous research in this area has been scarce, results from these reports have been encouraging, indicating the generalization of cognitive-behavioral techniques to this subset of OCD patients (e.g., Freeston et al., 1997; Ladouceur, Freeston, Gagnon, Thibodeau, & Dumont, 1995; Salkovskis & Westbrook, 1989). Future treatment studies of this specific subgroup of OCD patients should use group designs in which EX/RP is compared with other forms of cognitive-behavior therapy (e.g., thought stopping) or medications, as has been done with OCD patients showing both obsessions and overt rituals (e.g., Kozak, Liebowitz, & Foa, 2000).

This case study is also the first to examine changes in cognitive phenomena hypothesized to underlie obsessional problems (e.g., Rachman, 1998; Salkovskis, 1999). Mr. F showed reductions in both the moral and likelihood aspects of thought-action fusion. In addition, he showed decreases in the use of punishment and reappraisal (mental neutralizing) as methods of controlling his intrusive, unwanted thoughts. Instead, he began allowing such thoughts to exist in his mind while reminding himself that they will not cause him to carry out violent or immoral actions. Importantly, these changes in cognition occurred in the absence of formal cognitive therapy (e.g., cognitive restructuring). Whether EX/RP causes changes in cognition that in turn reduce fear of intrusions, urges to neutralize, and use of problematic thought control strategies cannot be determined from this single-case design. However, it is clear that such phenomena change, along with symptom severity, as a function of EX/RP. Future treatment studies should include measures of underlying cognitive processes hypothesized to play a role in OCD to more closely examine mechanisms of change during EX/RP.

A distinctive feature of cognitive-behavioral therapy is the acquisition of new knowledge and skills. Skill acquisition assumes active patient participation in regard to relevant treatment-related assignments. Such assignments, often practiced as homework, are a hallmark of cognitive-behavioral therapy in general and EX/RP in specific. Patients cannot be expected to fully employ their newly learned skills (e.g., exposure) to overcome fear if they do not practice or practice solely in the therapist's office. Thus, compliance with treatment instructions, both in and out of the session, is a central and necessary mechanism for generalization and therapeutic change. Mr. F was able to execute assigned homework practice on a consistent basis. Verbal reports of compliance were supported by the completion of homework forms and by his performance in session.

11 RECOMMENDATIONS TO CLINICIANS AND STUDENTS

In contrast to the predominant view that OCD patients without overt compulsive rituals suffer singly from obsessions (as the term pure obsessionals would suggest), the EX/RP program used to treat Mr. F was based on a conceptualization of obsessional thinking that identifies two distinct phenomena: (a) intrusive thoughts or ideas that *evoke* anxiety and (b) mental or behavioral strategies performed to *reduce* anxiety. In addition, this conceptualization involves normal processes and behavior (e.g., intrusive thoughts, thought suppression, coping mechanisms to reduce anxiety) rather than implicating cognitive deficits or brain dysfunction. This assumption of normality, which can (and should) be demonstrated to patients, is often reassuring to individuals who fear their OCD is a "brain disease."

The success of treatment procedures based on the model described above highlights the importance of a detailed functional assessment of patients with obsessional thoughts. These individuals present a challenge in differentiating between cognitive phenomena that are anxiety evoking and those that are anxiety reducing. Such an assessment is made even more difficult by the heterogeneous nature of OCD. Clinicians may gain useful information by asking patients about their appraisals and beliefs concerning unwanted unacceptable thoughts. In addition, it is important to ask what patients do about their unwanted thoughts. If efforts to neutralize are reported, these may be considered analogous to overt compulsive rituals. On the other hand, if patients report that their thoughts are not anxiety evoking, or there is no reason to neutralize, it raises the question of whether OCD is the appropriate diagnosis.

Providing a clear and compelling model of OCD and rationale for treatment to patients is also extremely important for successful EX/RP. After all, these treatment procedures are, by definition, anxiety provoking. Patients who have a conceptual model for understanding their own difficulties, as well as knowledge of how and why exposure works to decrease these problems, will be much more likely to comply with the often-difficult treatment instructions. Research suggests that understanding the rationale for using EX/RP was significantly related to effectiveness of treatment (Abramowitz, Franklin, & DiBernardo, in press). In our treatment program, we often illustrate, for patients, idiosyncratic models of the relationships between their symptoms, anxiety, and factors maintaining their anxiety. Diagrams are also used to show how EX/RP procedures weaken associations between thoughts and anxiety and the importance of explaining the conceptualization and rationale.

Finally, this case study highlights use of psychometrically validated symptom measures in clinical care. Responses on measures of thought control strategies and thought-action fusion were used to further illustrate to Mr. F the cognitive biases he had that contributed to the persistence of his obsessional symptoms. Changes in these phenomena were observed during therapy. In addition, the regular assessment of symptom severity allowed the therapist and Mr. F to quantify the degree of success and identify whether symptoms had returned during the follow-up period. Especially in this era of managed

health care, demonstrating outcomes of empirically validated treatment is important. Thus, whether in training clinics, private practice, or academic settings, the use of measures to collect patient data and track treatment outcome data cannot be emphasized enough.

NOTE

1. Copies of handouts we provide to patients are available from the author.

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Treatment of Kleptomania Using Cognitive and Behavioral Strategies

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Abstract: Little research exists examining the treatment of kleptomania, particularly in men. This case study illustrates the treatment of a male client with kleptomania in which depression, suicidal ideation, and potential legal complications were present. Strategies included covert sensitization, behavioral chaining, problem solving, cognitive restructuring, and use of homework. On completion of treatment, symptoms of depression and kleptomania had decreased significantly. At 16-week follow-up, the client reported continued remission of kleptomania and depressive symptoms. Treatment complications are discussed, and recommendations to clinicians are made.

Keywords: kleptomania, cognitive behavioral therapy (CBT), depression, case study.

1 THEORETICAL AND RESEARCH BASIS

There exists little empirical research on the treatment of kleptomania (Goldman, 1991), perhaps in part because there is much debate regarding how to classify and treat symptoms. For example, some researchers have likened kleptomania to theft and refute the notion that there are psychological components involved (Bresser, 1979, as cited in Wiedemann, 1998). Others view kleptomania as part of an “affective spectrum disorder” (McElroy, Hudson, Pope, & Keck, 1991) and cite research linking it to depression and anxiety. Still other researchers tend to classify kleptomania as more of an obsessive-compulsive disorder, citing evidence that persons with eating disorders often display kleptomania symptoms (Tynes, White, & Steketee, 1990). Finally, some researchers view kleptomania as part of a substance-unrelated addiction (Wiedemann, 1998), along the lines of pathological gambling. At times, the terms *compulsive shoplifting* or *compul-*

AUTHORS' NOTE: The client's name and identifying information were changed to preserve confidentiality. The authors wish to thank “Jay,” without whom there would be no article.

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sive stealing appear interchangeable with the term *kleptomania* (e.g., McElroy, Hudson et al., 1991; Murray, 1992), resulting in some confusion about the diagnostic criteria used in various studies. The *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) (DSM-IV) (American Psychiatric Association, 1994) classifies kleptomania as an impulse control disorder in which the essential feature is a recurring failure to resist impulses to steal items, even though those items are not needed for personal use or their monetary value (Criterion A). The individual experiences an increasing sense of tension just prior to the theft (Criterion B) and feels pleasure, gratification, or relief when committing the theft (Criterion C). The stealing is not committed to express anger or vengeance, is not done in response to a delusion or hallucination (Criterion D), and is not better accounted for by conduct disorder, a manic episode, or antisocial personality disorder (Criterion E).

Historically, kleptomania has been considered a disorder mainly seen in White upper- and upper-middle-class women (Abelson, 1989; Goldman, 1991; McElroy, Hudson et al., 1991). With few exceptions (Sarasalo, Bergman, & Toth, 1996; Wiedemann, 1998), comparatively little is known about men or individuals of lower economic status with kleptomania symptoms and how treatment may differ based on these variables (e.g., Goldman, 1991, 1992; Murray, 1992). Criterion A from the DSM-IV is an example of how examining mainly those in the upper economic status may bias both diagnosis and treatment of kleptomania. Criterion A presumes that the individual would otherwise have adequate income to pay for the stolen items and may be an artifact of studying mainly upper-class sufferers. For example, a report of 20 cases of kleptomania (McElroy, Pope, Hudson, Keck, & White, 1991) found that 90% of kleptomania patients, all of whom were of lower economic status, did use the stolen items.

There is some research that suggests there are gender differences in controlling shoplifting behaviors (Tibbetts & Herz, 1996); thus, it is plausible that there may also be gender differences in the treatment of kleptomania. Moreover, much existing research about the treatment of kleptomania has been retrospective and uncontrolled and has failed to identify patients' thoughts or associations just prior to the theft (Goldman, 1991). In addition, most available research focuses on describing kleptomania, with very few reports of successful treatment and little attempt at long-term follow-up (Goldman, 1991; Murray, 1992). Within the treatment literature, there are two case reports of women with kleptomania who were successfully treated with covert sensitization (Gauthier & Pellerin, 1982; Glover, 1985). Gauthier and Pellerin (1982) specifically recommended use of kleptomania-specific consequences for the aversive events in the covert sensitization exercise rather than images of nausea or vomiting, which is the usual recommendation (e.g., Cautela, 1966; Glover, 1985). Use of antidepressant medication—specifically, selective serotonin reuptake inhibitors (SSRIs)—is inconclusive, as it has been shown to be both effective (McElroy, Keck, Pope et al., 1989, as cited in Goldman, 1991) and ineffective (Davis, 1979; McConaghy & Blaszczyński, 1988) in the treatment of kleptomania. This article illustrates the successful treatment and longitudinal follow-up of a male client presenting with symptoms of kleptomania.

2 CASE INTRODUCTION

This case illustrates the treatment of kleptomania, or compulsive stealing, in which depression, suicidal ideation, and potential legal complications were present. Kleptomania symptoms were treated with cognitive and behavioral procedures. The client (he will be referred to by the pseudonym “Jay”) was a 39-year-old White, married man who was self-referred to the clinic. Jay lived with his wife and was an active parent to his 14-year-old son from a previous marriage. The client reported a long history of shoplifting and petty theft since the age of 6 years for which he had never suffered legal consequences. Approximately 1 year prior to treatment, he was fired for embezzlement from his job at which he had worked for several years, which opened up the possibility of serious legal consequences. Subsequent to getting fired, Jay became depressed and was put on SSRI by a physician. He reported having a bad reaction to this SSRI, and during this period he experienced severe depression and suicidal ideation with a plan, a means to carry out this plan, and intent to do so. He was switched to another SSRI, which he felt worked better and alleviated much of his depression; however, his concern regarding the severity of his recent depression and suicidal ideation led him to seek treatment. At the start of treatment, he was still taking the SSRI.

3 PRESENTING COMPLAINTS

Jay presented with complaints that he was “constantly fighting the urge to take things” from work as well as from stores (Criteria A) and that these compulsions had led to severely decreased self-esteem and depression over the past several years. He had also experienced suicidal ideation over the past several months. He reported some sense of increasing tension prior to committing the theft (i.e., if he did not give in to the impulse, he felt an increase in tension) (Criterion B), he felt some sense of gratification and/or pleasure while committing the theft (Criterion C), the act of stealing was not done out of anger or in response to a hallucination or delusion (Criterion D), and his symptoms were not better accounted for by conduct disorder, mania, or antisocial personality disorder. He described his behaviors as “compulsions to steal,” and more often than not he stole things that he could use. Jay had experienced depressive episodes off and on throughout most of his life and wanted assistance with reducing the likelihood that he would relapse into a major depressive episode again in the future, as he had observed his compulsions to steal intensified when he was feeling depressed. He expressed concern that his continued kleptomania behaviors would eventually lead him to get caught, which might then lead to a recurrence of suicidal ideation, imprisonment, and the end of his marriage. He also reported that he had nightmares about 2 to 3 times per week. He had shoplifted 1 week prior to his intake (an electronics item), and prior to that he had not shoplifted in several months. Throughout therapy, his previous job did not pursue legal action, and at the time of the writing of this article, this was still true.

4 HISTORY

Jay grew up in a rural environment along with his three siblings. He reported that at a young age, he engaged in minor vandalism (e.g., tearing up mailboxes), set a forest fire, shoplifted, and took money from "the family jar." His parents would discipline him physically in a way that might be considered abusive by today's standards. He was never sexually abused and never engaged in use or abuse of alcohol or other substances. He described himself as a mediocre student due to his lack of interest in school. After a few community college courses, he left school and joined the armed forces, where he served 4 noncombat years. During that time, he became active on the football team and described incidents in which he would become somewhat physically aggressive with others outside of the football games. He married after leaving the armed forces, and he and his first wife had a child together. They divorced but maintained an amicable relationship due to their mutual interest in their son. His son lived with his ex-wife and stayed with him and his current wife on alternating weekends and one weekday per week. He had a close relationship with his current wife, and both she and he were close with his son. He described having a good, although somewhat superficial, relationship with his parents and siblings. He described himself as an otherwise socially conscientious person and felt embarrassed about his kleptomania behaviors. Possibly due to his embarrassment, he had few close friends and, with the exception of his wife, preferred to maintain a friendly, but distant, relationship with his colleagues, acquaintances, and friends. He reported experiencing symptoms of depression periodically throughout his life and had one prior episode in which he experienced suicidal ideation during his late teens. Jay had minor medical problems, including mild hypertension and carpal tunnel problems, which were being addressed by his primary care physician and were not the focus of therapy.

5 ASSESSMENT

In addition to clinical observations, standardized assessments were given immediately before and after treatment and at several weeks posttreatment. Each assessment included the Beck Depression Inventory (BDI) (Beck, Steer, & Garbin, 1988), Beck Anxiety Inventory (BAI) (Beck, Epstein, Brown, & Steer, 1988), and Improvement Scaling (IMS) (Smith, Cardillo, Smith, & Amezaga, 1998). Jay also completed the IMS during each session. Each of these measures is described below.

MEASURES

BDI. The BDI is a 21-item self-report measure of depression that has high reliability and validity. The BDI is routinely used in studies of depression and has been used with several impulse control disorders.

BAI. The BAI is a 21-item self-report inventory for measuring the severity of anxiety. The BAI has good reliability and validity and has been used in a large number of studies across diagnostic boundaries.

IMS. The IMS is a self-report measure of individual patient change and treatment effectiveness. The IMS has been shown to have adequate reliability and validity. Because the therapist's and client's ratings were virtually identical at all rating intervals, Jay's ratings were used in this report. As was protocol at the clinic, the treatment plan and goals were developed during the fourth session. The goals as developed in collaboration between the therapist and Jay were to be able to resist impulses to shoplift/steal, identify cognitive and behavioral triggers of kleptomania, and successfully employ cognitive and behavioral preventative strategies to avoid recurrences of kleptomania behaviors. The criterion for successful achievement of these goals was agreed on by both therapist and client as a period of 6 to 12 weeks of kleptomania-free behavior and was based, in part, on the number of sessions available for treatment. The IMS scale was as follows:

- 0 = Extremely poor functioning as demonstrated by at least one incident of shoplifting/stealing.
- 25 = Poor functioning as demonstrated by picking things up with a plan and an intent to steal but not following through with the plan.
- 50 = Moderate functioning as demonstrated by planning a course of action but not following through with stealing the merchandise/item.
- 75 = Good functioning as demonstrated by reduction in the number of thoughts and impulses about stealing and no incidents of stealing behaviors.
- 100 = Extremely good functioning as demonstrated by having no impulses, thoughts, or behaviors regarding stealing for a period of 6 months or greater.

6 CASE CONCEPTUALIZATION

Although Jay had a long history of kleptomania and depression, he had not been faced with negative consequences of kleptomania until he was fired from his job. This served as a motivation for entering treatment. Subsequent to being fired, Jay experienced severe suicidal ideation and depression, diminished self-esteem, and poor self-efficacy regarding his ability to parent. The thought of continuing to act on his compulsions to steal became more ego-dystonic, and he decided to seek treatment. As a way of coping with the ego-dystonia, he had cut himself off socially and had no close friends. He had conflicted views of himself, on one hand as an "upstanding, socially conscientious citizen and loving husband and parent" and on the other as "a no-good thief; the black sheep of the family."

We conceptualized this case as both one of an impulse control disorder (e.g., he was unable to control his mind's impulse to devise a plan almost instantaneously) and as an addictive-type disorder (e.g., risk of relapse was high; it had become a means of coping

with depression and frustrations; stealing had short-term gains with serious long-term negative consequences). In addition, he had poor problem-solving skills (e.g., identifying thoughtful, inexpensive gifts to give his family and feeling compelled to give expensive gifts; feeling "less than" compared to his siblings, feeling angry at where he was in life financially given his intelligence and age), which made it difficult for him to independently generate alternative behaviors to stealing.

We decided that a cognitive-behavioral approach might be most beneficial. Although existing literature is limited, the studies that do exist appear to favor use of cognitive and behavior therapy, including covert sensitization, in the treatment of kleptomania (e.g., Gauthier & Pellerin, 1982; Murray, 1992; Wiedemann, 1998). For example, based on his study of 12 patients diagnosed with kleptomania, Wiedemann (1998) proposed the following:

One primary task of diagnosis and therapy [of kleptomania] is therefore to determine and scrutinize the individual and environmental precipitants, in order to analyze factors contributing to symptom development and maintenance, and functions of stealing behavior, and to resolve them in co-operation with the patient. (p. 75)

This recommendation appeared to be best accomplished with the use of cognitive and behavior therapy, as the main goals are to identify the antecedent cognitions and behaviors, emphasize the consequences of the problematic symptoms, and generate positive alternative cognitions and behaviors.

Jay had good access to his cognitions immediately preceding the event as well as several minutes/hours/days prior, and he was able to identify several behaviors that appeared to precede a stealing event/compulsion. As Jay's kleptomania cognitions, impulses, and behaviors decreased, his self-esteem increased, and other unrelated positive behaviors also showed an increase (e.g., increased closeness with wife, improved work performance, more confidence in self as a good parent and role model), and unrelated negative behaviors showed a decrease (e.g., he became less competitive with his son).

During the course of treatment, Jay's IMS scores showed a marked increase with consistently maintained gains (i.e., achievement of therapy goals) until his relapse at Session 5 of Treatment Episode 2 (see Figure 1). After the relapse, he returned to his prior high level of goal maintenance, and this remained so at the 16-week telephone follow-up. As expected, Jay's BDI scores decreased from 15 at pretreatment to 9 at posttreatment, showing a decrease in depressive symptoms (see Figure 2). Interestingly, Jay's BAI scores increased from a score of 0 at pretreatment to a score of 4.5 at posttreatment (see Figure 2). Instead of viewing this negatively, as his reported level of anxiety was still quite low, we considered this a sign of improvement. Ostensibly, use of covert sensitization, functional analysis, behavioral chaining, and problem solving should increase the patient's awareness of his actions, cognitions, and behaviors as well as

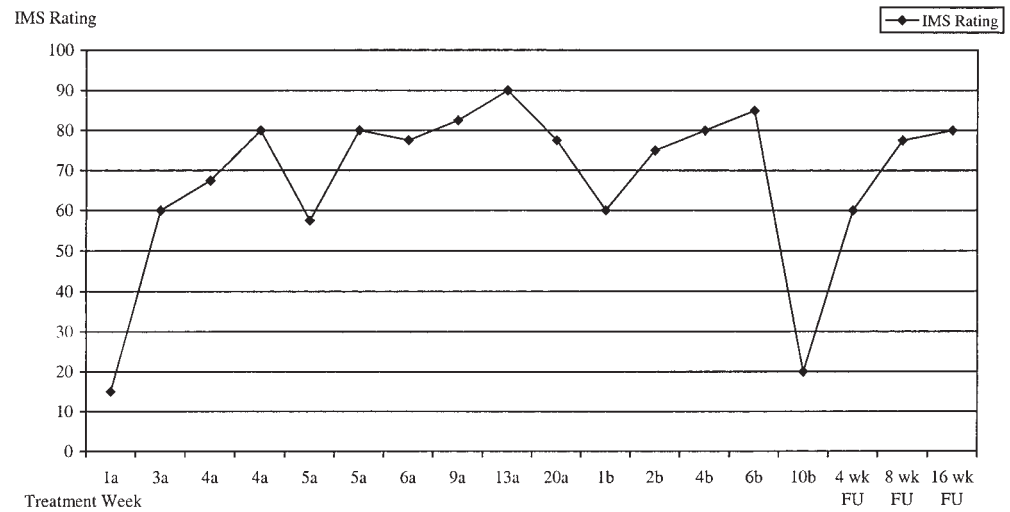


Figure 1. Client's Improvement Scaling (IMS) Ratings Across Treatment Weeks and at Follow-Up
NOTE: a indicates first treatment episode; b indicates second treatment episode; FU indicates follow-up.

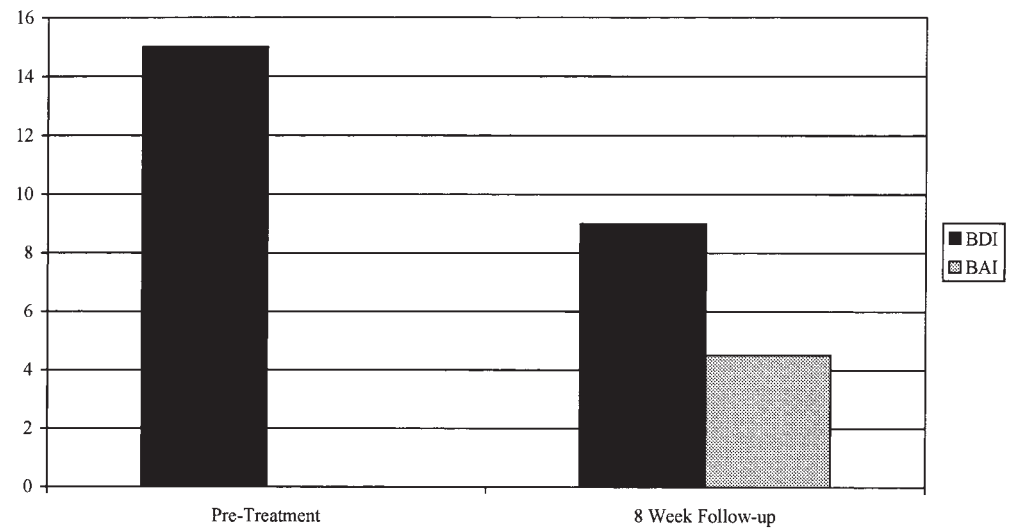


Figure 2. Beck Depression Inventory (BDI) and Beck Anxiety Inventory (BAI) Scores at Pretreatment and Follow-Up

the consequences of each. This, in turn, might increase his anxiety somewhat by causing him to be more cognizant of the antecedents and consequences to the kleptomania symptoms and thus increase his level of anxiety to some degree.

7 COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

Jay was treated by the first author, a predoctoral intern, under the supervision of the second author, a licensed Ph.D.-level clinical psychologist who specializes in behavior therapy. The second author conducted the initial intake interview, and 9 days after the intake Jay began treatment with the first author. Jay was initially treated for a total of 12 50- to 70-minute sessions over a period of 5 months. He was seen twice per week for the 1st month, once per week for the 2nd month, and once per month for the remaining 3 months. During this time, behavioral and cognitive strategies were used to decrease Jay's stealing impulses, ruminations, cognitions, and behaviors. Strategies included covert sensitization, behavioral chaining, problem solving, cognitive restructuring, and homework (e.g., use of behavioral cues, practicing of covert sensitization, tracking of cognitions). Each week, Jay and the therapist used the IMS to rate his current progress. Toward the end of therapy, relapse prevention, including the abstinence violation effect (e.g., Larimer, Palmer, & Marlatt, 1999) was discussed. At the termination of therapy, Jay was encouraged to reenter therapy in the future if he felt the need for additional, or "booster," sessions to maintain his current progress and avoid a relapse of kleptomania behaviors and/or depressive symptoms. Approximately 3 months later, Jay called the clinic to request additional therapy to address what he thought might be a relapse of depressive symptoms as well as an increase in intensity but not frequency of stealing compulsions. He was seen by the same therapist-supervisor combination for an additional six 50-minute sessions over a period of 4 months; the first 3 sessions were twice per month, and the remaining 3 sessions were once per month.

TREATMENT SESSIONS

During the first session, additional information was gathered about Jay's symptoms and general functioning. Educational information about kleptomania, impulse-control disorders, and non-substance-addictive disorders was provided. The rationale for the use of behavior therapy including covert sensitization was presented, and a functional analysis (Kanfer & Saslow, 1965) of his stealing behaviors was conducted. A more comprehensive functional analysis was developed over the first four sessions and revealed that antecedents to his stealing behaviors often involved cognitions such as "I'm smarter than others and can get away with it;" "They deserve it;" "I want it;" "I don't want/have to pay for it;" or "I want to prove to myself that I can do it," which were precipitated by financial, family, and work stressors or feelings of depression. Prior to the theft, he reported that his mind "calculated plans" and that it was both difficult to stop the planning process and disengage from completing the stealing act ("a build-up of tension" would result from ignoring this impulse). Behavioral chaining revealed the following behavioral antecedents to his stealing behaviors: wearing a heavy jacket or wearing an untucked long-sleeve shirt over a T-shirt and jeans, both of which allowed him to be able to put items under his

clothing; going to one store with a previous store's shopping bag; and shopping at "easy target" stores (i.e., low-level security; stores in which he is familiar with the layout); and window shopping or browsing without having specific shopping goals or a time limit. He also reported that he was more likely to steal when he was feeling depressed.

Things that reduced the likelihood of kleptomania behaviors included his trying to develop a conscience (e.g., "stealing increases prices for everyone," "stealing makes me a lousy father") and going shopping only when his wife or son was with him. We discussed other behavioral strategies he might use to avoid relapsing into kleptomania, including making himself go into another store, holding his wife's or son's hand while shopping, avoiding "desirable" parts of the store (i.e., the computer section), or making the manager aware of him (i.e., by saying something to the manager on entering the store). He often felt guilty several minutes to hours after completing the theft and had thoughts such as, "I'm just a thief" or "I'm a bad [or weak or defective] person." This was discussed as having potentially deleterious effects on his treatment, as research has indicated that among shoplifters, individuals who experience stable, global feelings of shame (e.g., "I'm a bad person") are more likely to continue stealing, whereas those who experience situation-specific feelings of shame (e.g., imagining getting caught stealing when one is an otherwise good person) are more likely to stop (Tibbetts, 1997).

At the beginning of each session, Jay was asked to rate his progress for the past week according to the IMS ranking scale developed in collaboration with the therapist. Covert sensitization exercises were conducted during the third, fifth, and seventh sessions. For covert sensitization, Jay recounted the details of recent scenarios in which he felt compelled to steal (e.g., in a store or at work) for about 20 to 30 minutes per session, using a different scenario for each session. During the treatment session, Jay was instructed to imagine the event as vividly as possible, with his eyes closed, "as if it were happening now" and to describe it out loud in the present tense. He was encouraged to include as many details as possible (e.g., the type, size, location, and layout of the store and item to be stolen), along with the thoughts, emotions, and physical sensations he felt. Jay would describe his thoughts and behaviors in detail, then would go on to describe the consequences in detail (e.g., being caught, the police being called, being handcuffed, being put in the police car while others watched, having to call his wife from jail, her anger and disappointment, having to explain to his son what he did, having others ridicule his son due to his actions, sitting in jail with other criminals, standing before a judge, losing his marriage, and having parents, neighbors, and coworkers find out about the arrest). He would become visibly upset during these exercises as noted by wringing of his hands, hands rubbing his head and face, tearfulness, and looks of distress on his face. The following is a composite of a covert sensitization exercise conducted during a therapy session, with details changed to protect confidentiality:

I'm in the store, heading towards the aisle where they display computer disks. I can't believe they charge so much for these. I think to myself, I want them but I shouldn't have to pay that much; the company is wrong. I'm looking around, knowing that security in this store is

weak, and don't see any managers. I place the disks in my pocket, then pick up a pack of pencils and go to the register to pay for them. As I leave the store, a security guard approaches me and taps me on the shoulder, and I feel my heart sink as I know I've been caught. He tells me they caught me on video surveillance and have already called the police. When the police arrive they handcuff me and shove me into the police car and my head hits the door and I begin to bleed. On the ride downtown, I realize that I was supposed to pick up my son after his soccer game, and I try to hold back tears because I dread having to tell him why I can't pick him up . . . the guilt is horrible. I feel like a hypocrite; when he tells small lies I get on him and now he and all his friends in school and all the neighbors are going to find out what I've done. What will he think of me? . . . Oh, god—my wife. I don't know how much longer she is going to understand. I love her so much . . . what if this was the last straw and she leaves me? I can't make that phone call, but I know I have to. We can't afford this; we're going to go deeper into debt. I can't believe I messed up like this.

Jay would continue on, describing the feel of the jail cell, the thoughts and emotions that went on during the phone call to his wife, and his feelings as he stood before the judge with his family in the courtroom. Throughout the exercise, his voice would become shaky, and he would become tearful and appear emotionally distraught. After the exercises, Jay would discuss his thoughts and emotions about the exercise with the therapist. Each time, he reported feeling "pretty distressed" during the exercise and that it felt like realistic representations of possible scenarios should he get caught stealing. Each week, Jay was instructed to elicit a covert sensitization scenario and the feelings associated with it whenever he felt a strong urge to steal something and also to practice at home.

To facilitate treatment gains, supplemental behavioral strategies were discussed and implemented as part of treatment. One such strategy included disclosing his history of kleptomania to his wife and a close friend. The risks and benefits of this strategy were discussed thoroughly with Jay (e.g., friend telling others and not liking him anymore versus learning his friend and wife accepted him and were supportive of his efforts to change). This strategy provided evidence for Jay that he was not a globally bad person and allowed for a reduction in the global feelings of shame he felt about himself. This disclosure exercise appeared to encourage him to become more socially connected to his wife and friends, possibly because it replaced his global feelings of shame with situation-specific feelings that are more conducive to increased self-esteem (Abramson, Metalsky, & Alloy, 1989) and decreased incidents of stealing behaviors (Tibbetts, 1997). During several sessions, Jay described his desire to steal as sometimes being a competitive feeling, such as, "I'm smarter than they are and so will show them by getting away with this." Other areas in which this competitive nature bothered him were discussed (e.g., never letting his son win a game) and addressed with behavioral homework (e.g., allowing his son to win at least half of the next several games).

Jay reported that behavioral interruption/incongruent activities (e.g., stopping to write down a thought, taking out a picture of his son or wife) were helpful in that they distracted him from the thought and planning of stealing and made it easier to implement preventative strategies (e.g., covert sensitization). Jay's wife attended the eighth session, and she was educated as to the treatment process and the role she might play in Jay's treat-

ment. For example, she agreed to the strategy of Jay calling her from a store or from work if he felt a compulsion to steal. The risks of integrating his wife into the treatment were also discussed and addressed (e.g., “nagging” leading to decreased marital satisfaction was to be avoided). Toward the final sessions of therapy, Jay reported that he felt his self-esteem was improving, and as a result he was increasing his parenting responsibilities, as he was feeling less like a “hypocrite” when parenting his son. The final two sessions of therapy were held after the holiday season, normally a high-risk time of year for Jay. Jay reported no incidence of stealing and a substantial decrease in the number and intensity of stealing compulsions/cognitions. At the last session, Jay reported that he continued to use these techniques, although in a less structured manner and for briefer periods of time than in the treatment phase. Jay had not had another incidence of stealing since 3 weeks prior to beginning therapy, the longest period of time in his memory that he was able to refrain from stealing.

Three months later, Jay called to reinstate therapy due to what he thought was a relapse of depression. During the first session, Jay reported that he had stopped taking his SSRI about 3 weeks prior and began experiencing depressive symptoms without suicidal ideation for about 1 week prior to reentering therapy. Education regarding discontinuation effects of SSRIs (Coupland, Bell, & Potokar, 1996) was given during the session, and Jay was instructed to monitor his depressive symptoms over the next week. During the second session, Jay reported a remission of all depressive symptoms. The next two therapy sessions were held 4 weeks apart, and Jay reported no recurrence of depressive or kleptomania symptoms. At the fifth session, Jay reported that he had had a relapse of kleptomania and had shoplifted once during the past 4 weeks. Behavioral chaining was used to help him identify the relapse triggers, which included family and financial stressors, remaining in a high-risk store for a long period of time, and avoiding the use of behavioral cues (e.g., pictures of wife and son) and behavioral strategies (e.g., calling wife). Jay reported that he felt extremely guilty about this event although the item remained in his possession. The importance of not being positively reinforced for stealing by keeping the item was discussed, and Jay agreed to choose the method of disposing of the item (e.g., throwing the item away). A covert sensitization exercise was employed, and the abstinence violation effect was discussed so that Jay would be able to view this as a slip and maintain hope of success rather than as a relapse causing global shame and feelings of hopelessness. The final session was spent reviewing the cognitive and behavioral strategies he had learned and continuing education regarding the abstinence violation effect, discontinuation effects, and relapse prevention.

8 COMPLICATING FACTORS

Initially, the therapist and supervising psychologist had difficulty making a differential diagnosis between antisocial personality disorder and kleptomania based on Jay's

history of antisocial-like behaviors. This is not an uncommon problem when attempting to make a differential diagnosis of kleptomania, particularly among male patients presenting with some criteria for antisocial personality disorder (Sarasalo et al., 1996). However, because therapy was self-initiated rather than mandated and because Jay appeared sincerely interested in changing his behaviors, we opted to err on the side of positive thinking. Indeed, as the sessions continued, particularly after meeting his wife, it appeared that we had made an accurate diagnostic decision.

9 MANAGED CARE CONSIDERATIONS

At the facility in which the treatment was provided, it was strongly recommended that a maximum of 12 sessions be allotted per client per therapy episode, and we adhered to this recommendation. This appeared beneficial to Jay in that he reported it helped his motivation to achieve as much as possible within and between each session and gain maximum benefit from each one.

10 FOLLOW-UP

A final follow-up was conducted by telephone by the therapist 4 months after completion of his second episode of treatment. At posttreatment and at the 4-month follow-up, Jay reported that he had become more confident and reported that whereas previously he would avoid social contacts because of shame at being a thief, he had become more socially active (e.g., confided more in friends, joined athletic groups). He had increased his parental responsibilities and was spending more time with his son. He had also been given a promotion at work. He reported that he rarely thought about shoplifting, and when the thought did occur, it had none of its previous overwhelming intensity.

11 TREATMENT IMPLICATIONS OF THE CASE

This case illustrates the efficacy of covert sensitization, behavioral chaining, problem solving, and cognitive and behavioral strategies in the treatment of kleptomania in a man of middle to lower economic status. It is important to note the conducting of a thorough functional analysis to determine the most efficacious use of the covert sensitization scenario, as well as the treatment of peripheral problems (e.g., depression, lowered self-esteem, negative global stable thoughts of self, decreased socialization, low sense of self-efficacy as a parent). Also, it is important to educate clients regarding the potential for discontinuation effects of antidepressants to prevent a belief that a relapse is occurring.

12 RECOMMENDATIONS TO CLINICIANS AND STUDENTS

It is recommended that clinicians conduct a thorough functional analysis over several sessions and maintain the ability to change hypotheses regarding diagnosis and treatment based on this continuing new updated information. To allow the client to feel that his or her needs are being addressed in a personal manner, be sure to examine other aspects of the client's life affected by his or her presenting problem behaviors and examine the treatment's effects, if any, on these areas as well. Assist clients in constructing a covert sensitization scenario that best addresses their particular compulsions. It is advised that the clinician not stop the covert sensitization exercise when the client's anxiety increases but rather carry out the exercise to a predetermined endpoint (e.g., in jail or at the conclusion of a court trial). Due to the anxiety-provoking nature of the covert sensitization exercise, it is also important to leave several minutes at the end of the session for a debriefing and cooling off period. Clinicians should provide information about abstinence violation effects to minimize feelings of failure and provide follow-up and booster sessions if needed in the future. Finally, clinicians should educate clients regarding their potential for experiencing discontinuation effects of antidepressants to prevent beliefs that a full relapse of depression or anxiety has occurred.

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Client Readiness for Change, Cultural Concerns, and Risk Taking

A Multimodal Case Presentation

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Abstract: This is a straightforward case in which several interrelated components nevertheless called for specific therapeutic attention. Matters pertaining to racial discrimination, cultural limits, and readiness for change had to be factored into the treatment trajectory. The anxiety, depression, and self-denigrating tendencies that had brought the client to therapy called for careful timing, some audacious advice, and several standard cognitive-behavioral procedures.

Keywords: multimodal therapy, thorough assessment, sociocultural transplantation, underentitlement, outlandish strategy.

1 THEORETICAL AND RESEARCH BASIS

The methods of assessment and therapy I call “multimodal” (Lazarus, 1997) are fundamentally a broad-spectrum, cognitive-behavior therapy approach to assessment and treatment. Hence, its theoretical framework is primarily social- and cognitive-learning theory (Bandura, 1977, 1986; Rotter, 1954). As Bandura (1986) underscored, social-learning theory posits testable developmental factors (e.g., modeling, observational and enactive learning, the acquisition of expectancies, operant and respondent conditioning, and various self-regulatory mechanisms). Although drawing on effective methods from any discipline, the multimodal therapist does not embrace divergent theories but remains consistently within social-cognitive-learning theory. The virtues of *technical eclecticism* (Lazarus, 1967, 1992; Lazarus, Beutler, & Norcross, 1992) over the dangers of *theoretical integration* have been emphasized in several publications (e.g., Lazarus, 1989, 1995; Lazarus & Beutler, 1993). The major criticism of theoretical integration is that it inevitably tries to blend incompatible notions and only breeds confusion.

Many psychotherapeutic approaches are trimodal, addressing affect, behavior, and cognition (ABC). The multimodal approach provides clinicians with a more comprehensive template. By separating sensations from emotions, distinguishing between

images and cognitions, emphasizing both intraindividual and interpersonal behaviors, and underscoring the biological substrate, the multimodal orientation arrives at seven discrete but interactive modalities. These are behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drugs/biological factors. The first letters yield the convenient acronym BASIC I.D. By assessing a client's BASIC I.D. one endeavors to "leave no stone unturned."

The elements of a thorough assessment involve the following range of questions:

- B:* What is this individual doing that is getting in the way of his or her happiness or personal fulfillment (self-defeating actions, maladaptive behaviors)? What does the client need to increase and decrease? What should he or she stop doing and start doing?
- A:* Which emotions (affective reactions) are predominant? Are we dealing with anger, anxiety, depression, or combinations thereof, and to what extent (e.g., irritation versus rage; sadness versus profound melancholy)? What appears to generate these negative affects—certain cognitions, images, interpersonal conflicts? And how does the person respond (behave) when feeling a certain way? It is important to look for interactive processes—what impact do various behaviors have on the person's affect and vice versa? How does this influence each of the other modalities?
- S:* Are there specific sensory complaints (e.g., tension, chronic pain, and tremors)? What feelings, thoughts, and behaviors are connected to these negative sensations? What positive sensations (e.g., visual, auditory, tactile, olfactory, and gustatory delights) does the person report? This includes the individual as a sensual and sexual being. When called for, the enhancement or cultivation of erotic pleasure is a viable therapeutic goal (Rosen & Leiblum, 1995).
- I:* What fantasies and images are predominant? What is the person's self-image? Are there specific success or failure images? Are there negative or intrusive images (e.g., flashbacks to unhappy or traumatic experiences)? And how are these images connected to ongoing cognitions, behaviors, affective reactions, and so forth?
- C:* Can we determine the individual's main attitudes, values, beliefs, and opinions? What are this person's predominant shoulds, oughts, and musts? Are there any definite dysfunctional beliefs or irrational ideas? Can we detect any untoward automatic thoughts that undermine his or her functioning?
- I.:* Interpersonally, who are the significant others in this individual's life? What does he or she want, desire, expect, and receive from them, and what does he or she, in turn, give to and do for them? What relationships give him or her particular pleasures and pains?
- D.:* Is this person biologically healthy and health conscious? Does he or she have any medical complaints or concerns? What relevant details pertain to diet, weight, sleep, exercise, and alcohol and drug use?

The foregoing are some of the main issues that multimodal clinicians traverse while assessing the client's BASIC I.D. A more comprehensive problem identification sequence is derived from asking most clients to complete the Multimodal Life History Inventory (Lazarus & Lazarus, 1991). This 15-page questionnaire facilitates treatment when conscientiously filled in by clients as a homework assignment, usually after the initial session. Seriously disturbed (e.g., deluded, deeply depressed, highly agitated) clients will obviously not be expected to comply, but most psychiatric outpatients who are rea-

sonably literate will find the exercise useful for speeding up routine history taking and readily provide the therapist with a BASIC I.D. analysis.

In multimodal assessment, the BASIC I.D. serves as a template to remind us to examine each of the seven modalities and their interactive effects. It implies that we are social beings who move, feel, sense, imagine, and think, and that at base we are biochemical-neurophysiological entities. The seven modalities are by no means static or linear but exist in a state of reciprocal transaction.

A patient requesting therapy may present any of the seven modalities as his or her entry point. Affect: "I feel sad and am often anxious for no good reason." Behavior: "I have a nail-biting habit, and I also can't quit smoking." Interpersonal: "My daughter and I are not getting along." Sensory: "I have a lot of pains that my doctor says are all due to tension." Imagery: "I can't get the picture of my cousin's funeral out of my mind, and I often have upsetting dreams." Cognitive: "I know I expect too much from myself and also judge others too harshly, but I can't seem to help it." Biological: "I don't get enough exercise, and I also suffer from high blood pressure."

It is more usual, however, for people to enter therapy with explicit problems in several modalities: "I have all sorts problems. I feel angry with a lot of people, and I worry too much and often end up feeling depressed. I also compulsively check things. Like at work, I go over stuff again and again, quite needlessly." When addressing clients' problems, whenever feasible, treatments of choice are employed based on empirically supported methods (see Chambless, 1995; Wilson, 1995).

RESEARCH

The seven-point BASIC I.D. template arose out of follow-up inquiries that suggested more durable outcomes when traversing clients' BASIC I.D. rather than the usual trimodal ABC (Lazarus, 1989). Williams (1988), in a carefully controlled outcome study, compared multimodal assessment and treatment methods to other approaches in helping children with learning disabilities. Clear data emerged in support of the multimodal procedures. Kwee (1984) conducted a treatment outcome study on 84 hospitalized patients suffering from obsessive-compulsive disorders or phobias, 90% of whom had received prior treatment without success and 70% of whom had suffered from their disorders for more than 4 years. Implementing multimodal treatment regimens resulted in substantial recoveries and durable 9-month follow-ups. This has been confirmed and amplified by Kwee and Kwee-Taams (1994). Herman (e.g., 1992a, 1992b, 1994) has conducted a good deal of research into the reliability and validity of various multimodal assessment instruments and their applications to several areas and clinical conditions.

Nevertheless, multimodal treatment is so broad based, so flexible, and so personalistic that tightly controlled outcome research is virtually impossible. Clinical

evidence, rather than hard data, confirms the clinical impression that covering the BASIC I.D enhances outcomes and follow-ups.

2 CASE INTRODUCTION

I will present a case that touches on cultural and strategic issues in addition to various specific treatment methods that were applied. Another component addresses the degree of risk taking a therapist might consider maximally helpful in assisting a client to attain explicit goals.

3 PRESENTING COMPLAINTS

A 33-year-old computer consultant whom we will call Rashni, complained that over the past 4 months he had felt depressed and anxious a good deal of the time. His dysphoric emotions had coincided with a job transfer that brought him into daily contact with a highly critical male supervisor.

4 HISTORY

Rashni, a most personable and well-spoken gentleman, was born in India and had emigrated to the United States with his parents and two older brothers when he was 3 years of age. Life in America had not been easy for Rashni and his family due mainly to racial discrimination. Nevertheless, he and his brothers received a good education, were happily married (to women of their family's choosing), and had coped rather well.

He described his 9-year marriage as "very good." He had two sons, aged 7 and 5, who presented no problems. He had a flare for mechanical issues, loved working with computers, and graduated with honors in computer science. His work as a computer consultant consisted of advising large corporations on their technological needs, installing hardware, and keeping the various devices in good repair.

Problems arose when a new supervisor was appointed to his unit, a man who was apparently overbearing, domineering, and officious and who interfered with Rashni's work. "He knows very little about the technical issues," Rashni declared, "yet he demands that I run by him every decision I make." His former supervisor was described as efficient, knowledgeable, helpful, and a pleasure to work with. His previous supervisor had received a promotion 4 months prior to Rashni's initial interview with me. Soon after the new supervisor arrived, Rashni became tense, anxious, depressed, and unable to sleep through the night.

One might inquire, what factors probably lay behind his symptoms and problems? I have learned to be very tentative about making etiological pronouncements, but in

Rashni's case, certain elements seem reasonably obvious. His parents and other role models were anything but exemplars of assertiveness. They belonged to a religion that emphasized nonviolence to a rather extreme degree. Most of his relatives struggled with their sociocultural transplantation from India. He described several members of his extended family as fearful and dysphoric (suggesting a possible genetic diathesis in this direction), and temperamentally, Rashni seemed to have a rather labile autonomic nervous system.

5 ASSESSMENT

Rashni's completed Multimodal Life History Inventory (Lazarus & Lazarus, 1991, 1998) revealed four significant issues:

1. He was unsure about continuing in his present occupational track. "Perhaps I am capable of bigger and better things," he wrote.
2. Although he and his wife lived in an integrated community, teenage hooligans who had thrown stones at their car and painted ethnic slurs on the front door of their cottage persecuted them.
3. Rashni was extremely prone to self-abnegation and self-denigration.
4. He was the youngest family member, and his parents and older brothers seemed unusually exploitative and made many demands on him and his wife.

Rashni complained that "anxiety attacks" would descend on him "from nowhere." He stated that lately, even while watching television at home, he sometimes felt excessively anxious for no apparent reason. A tracking sequence (Lazarus, 1989) in which he was asked, the next time he became anxious, to examine the immediate antecedents suggested that he followed an imagery-sensory-cognitive pattern. Mostly, he said, a vague image wherein he saw himself as the recipient of censure or rebuke would trigger shortness of breath, perspiration, and tachycardia, at which point he would aggravate matters by condemning himself for being so emotionally labile.

6 CASE CONCEPTUALIZATION

Three immediate treatment objectives were the following:

1. to teach him how to assuage and control his anxiety,
2. to enable Rashni to acquire and adopt a generally more assertive *modus vivendi*, and
3. to alter, via cognitive restructuring, his self-denigrating penchant.

Anxiety management techniques such as relaxation, deep breathing, and coping imagery were easy for Rashni to adopt. He had been meditating for several years and also practiced yoga. I simply encouraged him to add some standard cognitive-behavioral

methods to his repertoire. Thus, tension-relaxation contrasts were introduced as were mental pictures wherein he imagined himself disputing critical statements aimed at him while also using positive self-talk to mitigate his anxiety. He was asked to use these methods as homework assignments and reported that they were fairly helpful in lessening the frequency and intensity of his anxiety attacks.

But when I tried to address his other problems, we reached an impasse. It soon became evident that Rashni was by no means ready to embark on the development of assertiveness skills. In some respects, he was what Prochaska and DiClemente (1986) termed "precontemplative." He often questioned whether it was necessary for him to receive therapy, and when specific actions were suggested (such as trying to be more assertive), he became extremely resistant: "Perhaps I should go and think matters over for a few months." But when we addressed his career conflicts, discussed options, and weighed various pros and cons, he remained interested and essentially contemplative. Consequently, after implementing the foregoing anxiety management techniques, therapy for the next 9 or 10 sessions remained mainly exploratory and supportive. His central conflict seemed to be straightforward. He was a bright, capable, rather ambitious individual who aspired to complete an MBA (he already had many credits that he had obtained at evening classes). He expressed a desire to make headway in business-related ventures, but he was also struggling with powerful feelings of underentitlement.

Part of the problem, to my way of thinking, was that he belonged to a religious sect that preached a passivist philosophy. We had been meeting at weekly intervals for almost 4 months, and we had focused on his issues of personal entitlement, career options, and the impact of his formative years. He continued to mention his unfair and overcritical supervisor and alluded to needless chores that his family imposed on him. It remained counterproductive for me to offer anything more than person-centered reflections. ("It must be very annoying and frustrating to be treated that way.") He then arrived for a session feeling acutely distressed. On two separate occasions, four teenage hooligans had stood outside his home chanting ethnic slurs while his wife, through their dining room window, pleaded with them to go away. They had also painted "Go back to India!" on his garage door. The police to whom they had reported these incidents were unsympathetic and said that unless the teenagers were caught in the act, nothing could be done. On one occasion when Rashni had called the police during an ongoing harassment, the perpetrators ran away when they saw the police car coming. After that event, matters remained quiet for about a month, after which they started up again. Given the fact that Rashni and I had developed a good relationship, it seemed opportune to finally step outside the purely contemplative mode and assess whether he was now ready for action.

I pointed out how much I admired and identified in part with his religious convictions that emphasized the need to avoid harming all living creatures. (Rashni was, of course, a strict vegetarian and refused, quite literally, even to kill a fly.) Nevertheless, I argued that this did not countermand the development of an assertive lifestyle or prevent him from protecting his personal property. "If you can't care for your wife and yourself like a man living in America," I said paradoxically, "perhaps you should listen to those

hooligans and return to India.” Rashni asked, “What would you do in my place?” I answered, “I know exactly what I would do.”

Rashni had mentioned that he sometimes went target shooting at a local rifle range. He owned a rifle and a large revolver. I said that the next time the hooligans came round, if I were in his shoes, I would act like a madman and come rushing and screaming out of the house brandishing the revolver. At first he was amused, but when he saw that I was serious, he said that my suggestion was outrageous. He feared that his adversaries would retaliate in kind or report him for pointing a firearm at them. “I think you could talk your way out of that situation,” I said, and added, “But bullies don’t usually react that way.” To my astonishment, Rashni came to the next session and reported that he had carried out my prescription to the letter. “Those kids scattered. . . . I’ve never seen anybody run so fast.” He said that one of them yelled, “Look out, that guy’s gone crazy!” and somebody else shouted, “Can’t you take a joke?” Obviously, I had taken a professional risk by making such a suggestion, but after Rashni carried out his “homework assignment,” the hooligans, as he later put it, “disappeared from sight.”

After carrying out what he called my “outlandish but most effective suggestion,” Rashni seemed to be generally buoyed up. This finally paved the way for us to embark on assertiveness training vis-à-vis his supervisor at work. He took well to role-playing, role reversal, and the empty chair technique. Interestingly, before Rashni had the opportunity to implement the scripts we had rehearsed, his supervisor quit his job. His new supervisor turned out to be a most congenial person, and Rashni soon received a promotion and raise.

7 COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

At this juncture, I had worked with Rashni for more than 6 months (more than 20 sessions of therapy). When comparing Rashni’s present affective state to the way he had been feeling 6 months earlier, there were many areas of improvement. His anxiety and depression had been resolved. His self-abnegation was no longer in evidence, and he had mastered several assertive interpersonal skills. Hooligans were no longer tormenting him and his family, and he was generally optimistic and upbeat.

8 COMPLICATING FACTORS

Like many Indians whom I have known and treated, the family interactions were, clinically speaking, off limits. It is simply not done to talk back to one’s elders. As the youngest family member, it would remain his lifelong obligation to take orders from his parents and brothers. Readiness for change in this domain was simply not in the cards.

I was disappointed that Rashni did not have the opportunity to put his newfound assertive skills into effect, although I was heartened to learn that when one of his work

associates pressured him to undertake assignments that he considered ill advised, Rashni was willing and able to stand his ground.

9 MANAGED CARE CONSIDERATIONS

Fortunately, we were not constrained by managed care considerations, as Rashni preferred to pay for my services privately. Metaphorically, the long runway we had to taxi down before he was airborne (i.e., embark on assertiveness training and seriously challenge his self-downing cognitions) would have exceeded most limits imposed by HMOs and insurance companies. It makes no sense to impose a 6-session limit on a man whose precontemplative mind-set rendered him anything but ready for change in many dimensions of his being. I would say that it took about a dozen sessions before adequate rapport and trust had been developed.

10 FOLLOW-UP

I was able to conduct a follow-up telephone interview more than 3 years later. (I had been receiving Christmas cards from him over the years.) Rashni had completed his MBA degree and was gainfully employed as the section head of a large pharmaceutical company. He claimed to feel positive about himself and his life in general. He stated, "Since I took your crazy advice, I have never looked back." We both chuckled and agreed that sometimes a bit of craziness goes a long way toward achieving sanity.

11 TREATMENT IMPLICATIONS OF THE CASE

Some who have read articles and books on multimodal therapy incorrectly assume that in every case, slavish attention is given to the entire BASIC I.D., whereas, as this case exemplifies, one traverses all the modalities to reveal the major issues that call for modification. Clients who are more disturbed than Rashni inevitably yield a profile with many more problem areas.

In many ways, this case is straightforward, but there are several choice points that warrant discussion. One of the earliest issues was how best to manage his unwillingness to consider assertiveness training and other self-affirming procedures. My decision to coast along with him in an extended rapport-building sequence paid off.

When he made mention of his acute distress over the behavior of the neighborhood hooligans, there were two obvious treatment paths: (a) remain sympathetic and supportive and hear him out, or (b) take a chance and offer an out-of-the ordinary solution. My sense was that Rogerian empathy and reflection would only bolster the impasse, whereas if I encouraged a direct *action* sequence, there was a far greater likelihood of

constructive change. I had not anticipated that Rashni would act on my recommendation so quickly. It cemented our rapport and enabled our alliance to develop and grow.

12 RECOMMENDATIONS TO CLINICIANS AND STUDENTS

Practitioners need to realize that purely verbal methods (e.g., interpretation, reflection, and cognitive disputation) are seldom as robust in achieving change as methods that prompt immediate action. When clients discuss their problems, my main response is, "Let's see what you can *do* about it."

I would ask clinicians and students to think along the seven-dimensional BASIC I.D. model and see if it enhances their ability to ferret out significant issues that can then be addressed. When therapy falters, they may find—as do my colleagues and I, who think in multimodal terms—that by traversing the BASIC I.D., elements that were overlooked or had not come to light are apt to emerge. Thus, when a stalemate is reached, I quickly ask myself what I know about the client's salient behaviors, affective responses, sensations, and so forth. By so doing, I may realize that I lack information in one or more modalities. By then focusing on these areas, more often than not I learn new facts about the client that enables me to work more effectively.

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The Case of Ms. A

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Abstract: Object relations theory focuses on the intense relationship between child and parent and how the internalized objects from childhood influence one's emotions, thoughts, and behaviors in adult life. The case of Ms. A demonstrates the integration of Margaret Mahler and Donald Winnicott's contributions to object relations theory regarding conceptualization and treatment. The case study vividly explains and illustrates the application of Winnicott's concepts of the good-enough mother; holding, mirroring, and the true and false self; as well as Mahler's rapprochement crisis and issues concerning separation and individuation. Ms. A was treated individually over the course of 1 year for treatment of her depression, anxiety, and dependent character traits.

Keywords: object relations theory, separation-individuation, false self, holding environment, good-enough mother, psychodynamic model.

1 THEORETICAL AND RESEARCH BASIS

A psychodynamic conceptual model will be used in the case of Ms. A, integrating the theories of Margaret Mahler and Donald Winnicott and their contributions to object relations theory. Object relations theory emphasizes how the main objects (parents, typically the mother) in the very young child's world have been experienced, how certain aspects of those objects (good and bad) have been internalized, and how these unconscious images live on and exist in the adult's life and relationships (McWilliams, 1994). These internal object representations determine a person's feelings, beliefs, expectations, fantasies, and views of themselves and others (Horner, 1991).

Object relations theorists focus on the importance of a nurturing and supportive relationship with the primary caretaker. A confirmation of love and acceptance in the early mother-child relationship will affect an individual's self-worth, trust in oneself and others, and resilience in the face of conflict (Kernberg, 1984). Traumatic childhood conflict or deficits in nurturance and acceptance in the early mother-child relationship will lead to feelings of ambivalence toward the mother (Mahler, 1972), the development of a poor self-view, low self-esteem, and an increased vulnerability to depression (Winnicott, 1954/1996a). The case of Ms. A demonstrates the development of these internal dynamics and their effect on all future relationships.

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Mahler focuses on the infant's first 3 years, which she describes as a gradual process of separation and individuation (Levine, 1996a). Mahler describes an ever-changing relationship between infant and mother. During the first few weeks of life, the infant is in the phase of normal autism, also referred to as primary narcissism, in which he is minimally aware of the world beyond his body (Mahler, 1968). In the second phase, symbiosis, the mother and infant are seen as being a dual unit. During the subphases of differentiation and practicing, the mother is needed for emotional support and energizing as the infant experiments with physical separation. Next is the critical subphase of rapprochement followed by object constancy (Mahler, Pine, & Bergman, 1975).

The rapprochement subphase begins about the 15th month of life with the development of the rapprochement crisis extending from 18 to 24 months of age (Mahler et al., 1975). According to Mahler et al. (1975), during this phase of life, the child begins to see the mother as a separate person who is not always available to meet every need. This development leads to an increase in separation anxiety, feelings of helplessness, and depressed mood associated with the fear of losing the object (mother) and, more important, losing the object's love, support, and approval.

The child struggles with his ambivalence regarding the need to be separate and the need to be involved and nurtured by the mother. A struggle occurs within the child to incorporate his love and anger felt toward the mother and the struggle to be able to view the mother as having good and bad qualities, the defense of splitting. Splitting develops in the rapprochement phase to help the child reduce the anxiety associated with his ambivalence and maintain his self-esteem (McWilliams, 1994). By splitting the object into two parts, the internalized "good" object becomes protected from one's anger directed toward the "bad" object (Bacal & Newman, 1990).

During this period, it is crucial that the mother be consistently emotionally available, nurturing, warm, and accepting of the child. A failure in providing such *holding* behaviors will lead to a fear of feeling states, development of increased anger toward the love object, and a continuous search by the child to gain the acceptance and approval from others that he was denied from the mother (Mahler et al., 1975). The failure of needed responsiveness and emotional understanding on the part of the object will lead to the child's inability to achieve object constancy, separate from the object, and become autonomous (Bacal & Newman, 1990). Furthermore, Mahler (1966/1994) stated that lack of acceptance by the mother results in low self-esteem and an increase in aggression and anger within the child, which are then directed against the self, resulting in feelings of helplessness and depression.

Winnicott believes that the child's development is a maturational process whose quality is determined by the responsiveness of the mothering figure toward the child (Bacal & Newman, 1990). According to Winnicott (1960/1965d), "there is no such thing as an infant . . . the infant and mother come together to form a unit" (p. 39) (similar to Mahler's concept of symbiosis). Crucial to his theory is the idea of the "good-enough mother" (Winnicott, 1960/1965d) in the early child's life. The good-enough mother is one who is emotionally available, comforting, and supportive. She is free of narcissistic

concerns and is able to act as a safety net, encouraging exploration and growth. The mother must be protective, consistent, and able to assess and attend to the child's emotional needs. These qualities and characteristics of the mother-child relationship are referred to as "holding" or the "holding environment" (Winnicott, 1965c).

Holding is determined by the mother's ability to empathize with and meet the needs of the infant. This ability derives from a state of primary maternal preoccupation (Winnicott, 1956/1996b), or a state of heightened maternal care and empathy. With adequate holding by the mother, the infant will be able to be alone (physically and psychologically) and develop a healthy boundary between self and not self. With failure in a proper hold and mothering, the ability to be alone will be compromised (Winnicott, 1958/1965a). Also encompassed in the concept of holding is that of mirroring (Winnicott, 1967). Winnicott emphasized the importance of the child's experience of being seen. This is accomplished through the mother's facial responses, which communicate recognition of the infant's emotional experience, uniqueness, and creativity. Specifically, the infant experiences and internalizes aspects of himself by seeing his mother's face. By not retaliating, rejecting, or moralizing, the object becomes a separate, permanent, and usable source of security and comfort in the child's world (Bacal & Newman, 1990). Furthermore, the mirroring function of the mother encourages the development of a sense of self or the *true self*.

Winnicott further discussed the impact of deficient mothering or holding in relation to one's development of a true self and a *false self*. With an adequate maternal environment that provides empathy, security, nurturance, and acceptance, the true self will develop (Winnicott, 1960/1965b). The true self is the core and center of a child's own personality (Scharff, 1996). However, if the mother does not provide the holding and protection needed, a false self develops that covers and protects the true self (Winnicott, 1960/1965b). The false self is a quality of the personality that is overly compliant to environmental demands and overly reactive to the mother's needs and that of others, consistent with character pathology. The false self dominates in everyday life by facilitating relatedness to others, attempting to gain from others the holding and mothering qualities of which they were deprived. Winnicott (1950s/1989) posited that the false self is a "defensive organization that helps the child adapt and relate in their environment while at the same time hiding the true self and ensuring that it will not be exploited or done away with" (p. 43). In sum, the failure of the mother to hold or provide good-enough mothering impedes the development and expression of the true self. This results in a compliant false self (Winnicott, 1954/1996a) and later difficulty with separation and individuation (Grotstein, 1996).

2 CASE INTRODUCTION

Ms. A is a 24-year-old, divorced Caucasian woman, referred to the community mental health center by student services at a local community college. She was seen for

intake, which consisted of a clinical interview conducted by the therapist, in September of 1998. Ms. A is the eldest of two children. At the age of 20 months, she suffered significant burns in a house fire, which left visible scars all over her body. Ms. A reported that when this event occurred, she and her mother were the only ones in the house. According to the patient, her mother initially ran out of the house, leaving her behind. By the time her mother realized what had happened, Ms. A had already been burned by the fire. The patient's father blamed the mother for the fire and the patient's burns and continues to harbor resentment toward the mother. However, Ms. A claims that she forgave her mother.

3 PRESENTING COMPLAINTS

Ms. A presented with complaints about having "no control" over her life due to "new issues." The patient appeared sad and dejected and cried throughout the evaluation. She reported moderate depressive symptoms that included experiencing a dysphoric mood nearly everyday, occasional crying spells, insomnia, feelings of guilt, low self-esteem, poor concentration, loss of appetite, fatigue, feelings of hopelessness, and anhedonia. Ms. A expressed that she had been experiencing thoughts about death but denied any suicidal plan or intent. Ms. A also reported symptoms of anxiety that included chronic worry and frequent headaches.

At intake, Ms. A described herself as one who would always keep her emotions and feelings inside. She described herself as having to "wear a mask" when interacting with others because she does not want to "burden" people with her feelings and problems. Ms. A stated that others tend to perceive her as a strong person who rarely gets upset. She went on to refer to herself as the "yesser," which she described as an individual who "always says yes when they really want to say no." The patient admitted that she very much wants to be reassured by others and have someone to lean on. She described herself as an extremely neat, organized, and perfectionistic individual who can be stubborn at times. Ms. A stated that she was seeking services because she was greatly overwhelmed by her life. Ms. A also expressed a desire to regain some control over her life as well as an understanding of the nature of her problems and the difficulties in her relationships.

4 HISTORY

Ms. A described her childhood and early home environment as sad and full of conflict between family members. Ms. A described her mother as cold, manipulative, unstable, unloving, and unsupportive. She expressed that she could never talk about her emotions or feelings with her mother and that her family did not openly discuss their problems. Throughout her childhood and into adolescence, the patient was "disciplined with the hand" by her mother. If she did not adhere to her mother's rules, her mother

would inflict pain or ignore her completely. Ms. A expressed that she would rather be subject to physical pain and punishment than to receive the silent treatment from her mother; she could not bear the loneliness and isolation that the silent treatment would bring. The patient stated that her mother had never hit her brother or been physically abusive toward him. The last time Ms. A was hit by her mother was when she was 18 years of age. Ms. A's mother has a history of two suicide attempts (slit wrist, pills) and was diagnosed with bipolar disorder in 1994.

According to the patient, the father took a passive and distant role in her upbringing and was often not home. Despite presenting her father in a withdrawn and emotionally distant light, Ms. A stated that her father is her "hero" and that she "idolizes" him. She claimed that the reason he was rarely home was because he was busy holding several jobs to financially support the family because her mother was not contributing. For this reason, Ms. A referred to her father as a dedicated and strong man. Ms. A described her relationship with her father as close and reported spending a lot of time with him during her childhood when he was home. Her mother was continually jealous of her relationship with her father. The patient's mother would make hurtful comments such as, "You love your dad more than me" and "How can you love your father when he is never around for you?" When further describing her relationship with her father, Ms. A expressed his tendency to perceive her as flawless and perfect. She stated that he placed a tremendous amount of pressure on her to be this way.

In regard to her parents' relationship with one another, Ms. A indicated that there was a high level of conflict, anger, neglect, and abuse. Ms. A recalled several memories when her mother and father threw household objects, verbally abused, or completely ignored one another. The patient stated that she was often the mediator of her parents' conflicts and was thrown into the mother role at a young age. As the posing mother, Ms. A often found herself doing the laundry, cooking, cleaning, and taking care of her younger brother in his times of need.

Ms. A sided with her father when describing her parents' poor relationship. She stated that although her mother and father were not physically or emotionally involved, she knew that her father was still happy because he would tell her that he was taking care of his happiness when he was not home. Ms. A believed that this meant that her father was seeing other women on the side. This was "okay" with the patient given her mother's behavior and emotional presentation throughout their marriage. Ms. A's parents planned on divorcing once both children were out of the house. However, Ms. A needed to move back home for financial reasons, and she expressed feeling guilty and responsible for now prolonging her parents' marriage.

Ms. A was married at the age of 20 years. She stated that one of the reasons she married so young was to escape the fighting in the house. Before getting married, Ms. A and her husband had agreed that she would withdraw from college and get a job while her husband finished his B.A. degree. After his schooling was finished and Ms. A no longer needed to support her husband, she would go back to school and pursue her career. In

following this plan, Ms. A agreed to sacrifice her own hopes, dreams, and goals to meet the wants and needs of her husband.

Ms. A's marriage did not go as planned and was short-lived. Their 3 years of marriage were riddled with abuse and neglect. As the marriage quickly deteriorated, Ms. A's husband dropped out of college. He started abusing marijuana, alcohol, and cocaine. He cheated on her and stole her money, jewelry, and credit cards. During some heated arguments, her husband hit her and once even pulled a gun on her. In January of 1998, Ms. A divorced her husband. This was a difficult decision for her, as she was the first in her family to do so. Despite their abusive marital history, Ms. A expressed a desire to go back with her ex-husband, and she had reestablished contact with him at the time of the intake. The patient sacrificed her wants and needs for her husband but never received her promised opportunity in return.

In June of 1998, only 6 months after her divorce, Ms. A became engaged to a gentleman that she claimed to be madly in love with. The engagement was terminated in July of 1998. Ms. A stated that she was unsure of the cause of the breakup and assumed that they had "rushed into things." Shortly after this event, Ms. A moved back home to live with her parents for financial reasons. This was emotionally devastating for her; she felt that she had accomplished very little in her life and was now back to the beginning.

In July of 1998, after her broken engagement and move back home, Ms. A started experiencing depressive symptoms for the first time. In August of 1998, the patient reenrolled at a local community college in an attempt to pursue her dream of becoming a registered nurse. Ms. A reported being excited and anxious about starting college again. She stated that she was overwhelmed by the workload and concerned about performing at a level of excellence. The patient also felt that the added stress of living with her parents would affect her ability to perform in school.

Ms. A has a history of poor social relationships throughout her life. At the time of intake, she reported having only two people in her life that she could call close friends. She stated that these two women, whom she has known since childhood, had always been there for her in her times of need. However, she felt that they could have been more compassionate at times. When describing her social life in general, Ms. A stated that she had never gotten along well with females. She described most women as "bitchy" and "superficial." The patient reported that she had always gotten along better with men than with women and therefore favored relationships with men.

Ms. A presented for treatment in September of 1998. She denied ever experiencing any depressive feelings or symptoms prior to July of 1998. This was Ms. A's first experience with therapy.

5 ASSESSMENT

Ms. A presented as an attractive, slim, well-groomed, and appropriately dressed woman. She appeared profoundly sad and cried throughout the entire clinical interview.

Ms. A was verbal, responsive, cooperative, and open to discussing information. She was alert, socially appropriate, and maintained good eye contact. She was oriented to person, place, time, and situation. Reality testing appeared to be intact. Her speech was logical, clear, and coherent. Ms. A's estimated intelligence was average. Immediate, recent, and remote memory appeared to be intact. Judgment was questionable due to a history of poor and unstable interpersonal relationships. Ms. A denied a current or past history of experiencing any hallucinations or delusions. She described her mood as depressed and lonely with appropriate affect for the situation. Ms. A reported suicidal thoughts and thoughts of death but denied plan or intent. She denied homicidal ideation and reported no history of alcohol or substance abuse. Ms. A's strengths include her intelligence, motivation for treatment, good sense of humor, and psychological mindedness.

6 CASE CONCEPTUALIZATION

At 20 months of age, which falls within Mahler's rapprochement subphase, Ms. A was severely burned in a house fire when left under her mother's protection and care. This event is seen as the source of Ms. A's core conflict with her primary mothering figure. The fire occurred during a period of her early life when Ms. A was beginning to view her mother as a separate object with increasing fears of losing her mother's love, acceptance, and approval. She harbored ambivalent feelings relating to her need to be autonomous and her need to be nurtured by her mother. Ms. A's subjective experience of being left alone and burned in the fire was internalized as her mothering object being seen as unresponsive, absent, and rejecting. Ms. A experienced this event as occurring due to her ambivalence and growing independence from her mother. The mother, sensing her child's growing independence, may have acted on an unconscious wish to hurt and punish her child for not meeting *her* (the mother's) needs and wishes. Thus, Ms. A learned that to receive love and approval from her mother, and eventually others, she needs to sacrifice her own needs and desires.

Ms. A defended against her overwhelming ambivalence, guilt, and anxiety by splitting her mother into two parts. The mother became a "bad" object and a "good" object, with Ms. A identifying with the good object. The good object became Ms. A's internal mothering image, which was used to protect her mother from her anger and hostility. Furthermore, by identifying with the good object, Ms. A maintained her self-esteem and self-worth during a time when she felt unloved and abandoned.

Through her childhood years and adolescence, Ms. A was further deprived of the nurturance and support one needs to develop into a strong, resilient, and independent individual. Ms. A described her mother as cold, manipulative, and emotionally unavailable. At a time in her life when mother and child are to act as one, Ms. A experienced her mother as adversarial. Her mother withheld empathy and availability, depriving the patient of a mirroring object to help her understand and gain value in her own emotions, uniqueness, and experiences. Ms. A often stated that she was not allowed to express her

true feelings or concerns and was encouraged to express only positive emotions. The lack of a good-enough mother, holding, and mirroring deficits were internalized as loss and abandonment and led to a failure of the completion of the separation-individuation process. Furthermore, Ms. A now feels bound to her mother with the continuous struggle to gain her acceptance and love.

Out of her unnurturing environment came the development of a false self, which Ms. A referred to as a mask. The false self hides Ms. A's true self, inner potential, and true emotional experiences. She fears that exposing her true inner self will lead to further abandonment and rejection. Ms. A's false self is dependent and overly compliant with others in an attempt to gain the love, acceptance, approval, and support she was deprived of as a young child. Ms. A's false self dominates her relationships with others as her main need is to find the good-enough mother in another individual, filling the void and emptiness left by her mother. Ms. A described herself as the yesser—as a person who always needs to appear strong and in control. She believes that if she denies other's requests and does not appear emotionally strong, that others will reject her as her mother did.

Ms. A described a childhood in which her mother was physically abusive toward her but not her brother. This resulted in Ms. A internalizing a part of herself as bad and her mother as not loving her. Fostering feelings of worthlessness and guilt, Ms. A turned to her father for emotional support. Ms. A described her relationship with her father as close and stated that she idolized him. This idealizing of her father was her attempt to bolster her self-esteem and self-worth by identifying with him, filling the void left by her mother's unavailability. However, in Ms. A's relationship with her father, he expected her to be perfect and flawless. Ms. A internalized his expectation, believing this was how she was to appear and behave, viewing other people as making similar expectations and perceptions of her.

Ms. A's parents' poor relationship resulted in her feeling the need to take on the mother role, depriving her of a childhood. She often mediated her parent's conflicts and was left to provide and care for her brother due to her mother's irresponsibility and unavailability. Angry about being placed in this role, it communicated to her that her value relied on what she would sacrifice and do for others. Taking on the mother role was also Ms. A's attempt to gain some control and bring stability to her life.

Ms. A's growing frustration and disappointment in her family led her to marriage at a young age. Apparent in her marriage was the influence of her internalized mother images and expectations. She believed that she must put her husband's needs before hers to gain his love and approval. Fearing abandonment and further loss by expressing her true feelings about the marriage, Ms. A tolerated 3 years of physical and emotional abuse by her husband. Due to the strong sense of rejection and loneliness she experienced when alone, Ms. A quickly became involved with another man after her divorce. Ms. A's short-lived engagement to this gentleman was a failed attempt on her part to quickly find another person to fill the void and emptiness she felt as a result of her divorce. These events were emotionally and psychologically devastating for her and began the deterio-

ration of her already fragile and damaged ego structure, the failing of her defenses, and the onset of her depression.

Other areas in Ms. A's social life were also a source of struggle and frustration for her. Ms. A has difficulty establishing and maintaining meaningful relationships with others. She has difficulty trusting others, specifically women. Ms. A finds security and comfort in her relationships with men. However, when involved in relationships with men she feels she needs to appear strong and always happy (her false self). Academically, Ms. A believes that she always needs to achieve the highest grades, as nothing else is tolerated in her family. If she is to bring home anything less than an A, she feels she will lose the love and acceptance of her parents. Ms. A's beliefs and expectations about her behavior and relationships are influenced by the internal images of her parents from her childhood. These images place a tremendous amount of pressure and anxiety on her to act and behave in a certain manner. By having to be something she is not, anger broods within her that is suppressed. However, her current emotional life stressors led to her defenses failing, resulting in the manifestation of her depressive symptoms.

In sum, Ms. A's early childhood experiences and relationships were internalized as object loss, which increased her vulnerability to disappointment and loss, feelings of helplessness, and low self-esteem (Luborsky et al., 1995). Being deprived of nurturance, harmed in a fire, and stripped of her childhood all facilitated anger and rage directed at Ms. A's love objects. However, the guilt associated with these feelings was too painful for Ms. A to experience and understand, so she internalized the anger and denied its existence. Freud (as cited in Jacobson, 1971) believed that anger directed inward rather than being expressed outward is the leading factor in depressed patients. Ms. A's depression can be seen as a result of her anger, the fantasy of destroying her love object, and her inability to resolve her ambivalence.

7 COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

Treatment consisted of 32 individual sessions from September 1998 to July 1999. For the purpose of discussing its course, the therapy will be divided into three phases: beginning (Sessions 1-11), middle (Sessions 12-23), and end (Sessions 24-32).

The beginning of therapy focused on setting the frame and establishing a safe, warm, nonjudgmental environment. This was communicated to Ms. A through empathic listening and by not reacting to her experiences and beliefs in a critical or rejecting manner. In our very first session, Ms. A came to therapy neatly dressed, wearing makeup, and appeared to be in a euthymic mood. When queried as to why she seemed happy, she stated that she had spoken with her ex-fiancé, who said he missed her. This made Ms. A feel accepted and loved. Attention and reassurance from others easily influenced her mood and affect and briefly hid her sadness. This would become apparent to the therapist throughout the course of treatment. Ms. A very much wanted the therapist

to accept and approve of her, as with all her relationships, which was also why she presented at the first session with the facade of being emotionally well and happy.

We began to discuss her relationship with her ex-fiancé and the reasons for their breakup. Ms. A's emotional presentation abruptly changed while discussing this relationship, and she began to cry, which she would do during all of the sessions in the beginning of therapy. Ms. A was very open from the start and demonstrated some insight into her difficulties. She stated that she was unsure if it was her ex-fiancé that she missed or just that she missed being with someone, having someone to lean on, and having a sense of security.

The focus of the initial session shifted to Ms. A's relationship with her mother. She expressed that the onset of her tears sparked thoughts of her mother, which angered her. She stated, "my mother always manipulated me by crying." Ms. A then shared how she has had difficulty saying no to others, especially her mother. Through exploration of their relationship, she expressed how her mother would hit only her and treated her differently than her brother. She experienced this as rejection, and it made her feel like the "bad child." The therapist often asked Ms. A how she felt being treated this way by her mother, in an attempt to begin to focus Ms. A on, and get her to think about, her inner feelings. During the first session, Ms. A sadly stated, "My parents make me feel like I can't have my own emotions." The patient and therapist explored this statement and its origins. This produced information about how Ms. A felt like the family mediator growing up and how she hates conflict.

Ms. A continually associated her problems and shortcomings back to her mother. She discussed her difficulty with experiencing joy and pleasure in her life, stating she felt "guilty for having fun." Inquiry into the origins of her guilt revealed that her mother would say hurtful things to her as a child whenever she did something enjoyable. This marked the first time the therapist attempted to help Ms. A begin to see how her current behavior is influenced by her past experiences.

Throughout the sessions, the therapist listened empathically, which allowed Ms. A to tolerate her anxiety about discussing her experiences and feeling states. The therapist often mirrored Ms. A's emotional states, helping her to recognize and accept her feelings. Furthermore, by doing so, the therapist communicated acceptance of the patient and the importance of her true feelings. Ms. A had a tendency to report the feelings and thoughts of others regarding the experiences and choices she had made in her life. The therapist worked to shift her away from the perceptions of others and refocus her on her own feelings and beliefs instead. Early in treatment, this shift was difficult for Ms. A. However, gradually she learned that the therapist was only interested in and cared about Ms. A and how she felt. This encouraged the patient to think similarly and become more concerned about her own feelings, as she would slowly become acquainted with her true self.

During the next several sessions, Ms. A continued to express her feelings of loneliness and desire to have someone take care of her. While focusing on her feelings of loneliness, abandonment, and rejection, Ms. A expressed suicidal thoughts. She denied plan

and intent, and the therapist assisted her in identifying reasons to live. Ms. A expressed with a sense of guilt that her thoughts would often drift to her abusive ex-husband. She would say that when she feels lonely, she wants desperately to call him and even contemplated going back to him. When discussing her relationship with her father, Ms. A used only positive words to describe him. She expressed how she looks up to him and how much she idolizes him for everything he has sacrificed for his family.

Throughout the beginning phase of therapy, Ms. A only once brought up the fire in which she was burned as an infant. While exploring her feelings about this event, she expressed forgiveness toward her mother stating, "It wasn't her fault." Regarding her physical scars, Ms. A claimed that they did not upset her, and the men she has been with have rarely commented on them in a negative manner. However, the therapist noted that Ms. A would quickly change the topic when discussing the fire, specifically when broaching her feelings toward her mother regarding the event. This signified that Ms. A was not ready to explore these deep, painful emotions at this early time in the therapy and could not tolerate the guilt and anger that she would likely feel as a result.

The focus of the middle phase of treatment concentrated on the release of Ms. A's anger, her relationship with her parents, and her dependency needs as they relate to her current relationships. This phase of treatment involved the patient searching within herself, as she would begin to recognize the painful emotions and thoughts she possessed. It was crucial for the therapist to remain consistent, empathic, and nonrejecting, as this communicated that Ms. A's true feelings and beliefs were acceptable to the therapist. Ms. A would then come to understand that she could express and accept her true self without the fear of being rejected by others. The goal was for this acceptance of the self to generalize to her relationships beyond the therapeutic interaction.

Ms. A demonstrated a shift in her affect during this phase of treatment. When discussing painful experiences and relationships, she no longer expressed sadness, but her affect was flooded with increased anger. Discussions about her mother focused on her lack of nurturance and how the mother's failure to be a parent prompted Ms. A to take on the mother role and grow up too fast. When exploring her feelings regarding this relationship, Ms. A would state, "I hate her for not being there for me when I needed her." However, statements such as this one would produce overwhelming guilt for Ms. A, which she would shortly after attempt to undo by saying, "But don't get me wrong, I still love her." Ms. A would share with the therapist how she only wanted to know that her mother loved her and was proud of her. More importantly during these times, in an attempt to facilitate the separation process, the therapist would ask the patient if she was proud of herself. The goal here was for the patient to become able to emotionally reward herself and not depend on her mother or anyone else to validate her accomplishments and choices.

Being able to express and accept her true feelings more readily, Ms. A also began to demonstrate anger and disappointment in her father as well. Discussions focused on how Ms. A believed that she must be perfect in all areas of her life and perform at a level of excellence. The patient was encouraged to discover the origins of these beliefs by

exploring her early relationship with her father. When doing so, she would express how “tiring and emotionally draining” it was for her to live her life on a “pedestal of excellence.” This caused Ms. A great anxiety and worry, specifically when it came to her performance in college, which was already difficult for her. She was concerned that if she did not achieve A’s in most or all of her classes, she would be disappointing her parents, resulting in being rejected and losing their love and acceptance.

During the next several sessions, Ms. A’s idealizing transference and dependency on the therapist became more evident. The relationship between the patient and therapist began to be explored early in this phase when Ms. A brought to session a letter she had written her ex-husband regarding her feelings for him and plans for the future. Ms. A expressed a desire to read the letter to the therapist in the hope of gaining the therapist’s approval of the letter and her feelings. Furthermore, she expressed a desire for the therapist to mail the letter, as she did not want to take the responsibility for her own feelings and actions. Ms. A’s fantasy was that the therapist (ideal father or the father she wished she had) would rescue her from her guilt and pain.

The therapist and patient explored her reasons for bringing the letter to session, her growing dependency on the therapist, and how her behavior in therapy related to her relationships with others in her life. Discussions concerned the exploration of how Ms. A strives for reassurance, approval, and care from her relationships, including the therapeutic relationship. In the sessions that followed, Ms. A slowly began to understand why she needed these reactions from her relationships and how they related to what she was deprived of as a child. Further discussion focused on how Ms. A believed the only way she could gain acceptance and love from others was to sacrifice her own needs, dreams, and happiness for that of others.

In the latter part of this phase, Ms. A decided to apply to the nursing program at the college she was attending. This decision was very exciting for the patient, and her excitement was mirrored by the therapist. This marked the first time Ms. A decided to pursue her own goals and interests without concern for how others felt. The therapist and patient strongly focused on Ms. A’s happiness regarding this event, and for the first time in therapy she expressed that she began to feel an increase in self-esteem.

Early in the final phase of treatment, Ms. A came to session one day in a euthymic mood, with “great news” to report. After holding onto the letter she had written to her ex-husband for 3 weeks, Ms. A stated that she finally mailed the letter. Focusing on her emotional state, we discussed what this event meant regarding Ms. A becoming more assertive, expressive, and stronger. More important, Ms. A was showing indications that she was becoming more confident in expressing her inner self by doing what she (true self) wanted to do without a fear of being rejected by others.

Ms. A demonstrated other signs of progress during this phase of treatment as well. Regarding a new intimate relationship with a coworker, Ms. A was gradually beginning to express frustration and unhappiness. She stated that she felt the relationship was not a partnership and that he was not concerned enough about her dreams and needs. The therapist and patient discussed how in the past she would have been content to just be in

a relationship with someone. However, that was no longer satisfying for Ms. A, and she terminated the relationship toward the end of treatment. We discussed the significance of the termination of the relationship and how it demonstrated that Ms. A was growing as a person. She was now more concerned with her own happiness and goals and was placing her own needs before the needs of others. Progress was further demonstrated in relation to the grades Ms. A received at college. Ms. A reported that she had received a C on a final in one of her nursing classes and a C+ for the course. Contrary to how Ms. A would have reacted to these grades in the past, she was “thrilled” to receive her C. She was able to recognize the hard work and effort she put into the class and felt proud to receive this grade. Ms. A demonstrated here that she was now able to reward herself for her accomplishments and not worry about meeting other people’s (parents) expectations.

Although Ms. A did demonstrate significant gains and changes in her life, several aspects of her personality still remained intact. Regarding Ms. A’s dependency and feelings of self-worth, she still continued to seek reassurance and approval from others, despite ending the relationship with her boyfriend. Furthermore, how she felt about herself still largely depended on whether she was in a meaningful relationship or on another individual’s giving her attention and communicating care and affection toward her. Despite being able to recognize the hurtful patterns of behavior in her relationships, Ms. A stated toward the end of treatment, “That’s okay if I need to depend on others, I am happy enough that my life is back to normal for me.”

8 COMPLICATING FACTORS

The therapist began discussing termination with Ms. A 3 months before its occurrence. An abrupt shift in the transference occurred when she was initially informed of the termination date. The therapist went from the idealized, all-caring father to the hurtful and abandoning father. She stated, “Oh no, you too are just like all the other men in my life who have hurt me, and now I have to be mad at you, too.” Feeling guilty about her remarks and in fear of offending the therapist, she then stated, “Just kidding, I am just going to miss you and enjoyed spending time with you.”

After this session, a deeper exploration of Ms. A’s feelings toward the therapist occurred and would continue until the end of the treatment. The therapist and patient explored her initial reaction of anger and abandonment about termination and how it related to her relationship with her father and other men in her life. Sessions were also spent discussing the patient’s dependency on the therapist. The therapist helped Ms. A understand that she, not the therapist, was responsible for her gains in therapy.

Evaluation of Ms. A’s progress and growth made during therapy revealed that she had made significant improvements in some areas with minimal improvement in others. Regarding her depression, Ms. A described her mood at the end of treatment as mostly happy with some periods of sadness. Her concentration improved, and crying spells and headaches were less frequent. She reported experiencing more restful sleep and

increased energy and motivation. Her medical report substantiated these positive findings. Having recently been accepted to the nursing program at her college, Ms. A was now hopeful and excited about her future and the possibility of achieving her goals. Furthermore, Ms. A was able to balance a stressful school schedule with the demands of the new waitressing job she started toward the end of therapy. Personally, Ms. A now described herself as a “stronger” individual. She stated that she was more comfortable expressing her feelings and thoughts, although she still had the urge to say yes to others at times. Ms. A reported an increase in self-esteem and, more important, self-acceptance.

When Ms. A initially presented for treatment, she was highly enmeshed in her family. She was greatly affected by her parent’s beliefs and feelings, compliant, always trying to please them. At termination, Ms. A demonstrated considerable improvement in separation and individuation from her family. Her main priority was now satisfying her own goals and needs, as demonstrated by her decision to pursue the career of her choice. Furthermore, Ms. A was able to reward herself for her hard work and accomplishments, with less concern about how others felt (e.g., when she received a C on her nursing final). Ms. A demonstrated an improved ability to express her feelings of anger, frustration, and sadness with a greater awareness and understanding. She now put herself and her goals before those of others and realized that she did not have to sacrifice her own desires for others (parents, boyfriends) to approve and accept her (she was able to terminate an unfulfilling relationship with a coworker). All of these improvements contributed to the emergence and expression of Ms. A’s true self.

There are several criticisms regarding the therapy. Ms. A’s dependency and search for approval from others was deeply ingrained and required a longer and more intensive form of therapy than what was provided. Sessions twice a week would have been more beneficial and led to a stronger transference with which to analyze and work. Aware that the therapy time was limited, the therapist would press at times and push the patient in an attempt to help her gain insight and improvement more readily. Given that this was a patient from the therapist’s first practicum placement, more training dealing with transferences and greater comfort with the use of silence would have allowed the therapist to work with the patient more effectively and at her pace.

9 MANAGED CARE CONSIDERATIONS

Ms. A was treated in a manner considered ethical by the American Psychological Association (1992). She was informed at intake that the therapist was a doctoral student in his second year of training. Issues regarding confidentiality and privacy were discussed. Ms. A consented to the audiotaping of her sessions for the educational purposes of this therapist. Ms. A was informed that the therapist was supervised by a licensed clinical psychologist.

The therapist must be aware of the impact of the patient and therapist variables on the therapeutic process. Significant diversity issues included gender, religion, and ethnic

differences. Gender differences may have contributed to the patient's difficulty discussing sexual issues with the therapist. Appreciation for and knowledge about the patient's religious and ethnic beliefs allowed the therapist to be more understanding of the patient's feelings of guilt regarding divorce and her family disapproval of therapy. Overall, these diversity issues were considered, and this therapist did not have any indication that they hindered treatment.

10 FOLLOW-UP

On termination, Ms. A was encouraged to continue with therapy. Although she was reluctant to begin therapy with a new therapist, she was willing to be transferred. She stated that she would decide whether to continue at a later time. Despite attempts to make the termination process easier for Ms. A, she increased the frequency of cancellations, demonstrating that ending therapy was difficult for her. This behavior was the patient's way of coping with the loss and distancing herself from the therapist.

The therapist continued to follow up with Ms. A throughout the first 6 months following termination. She was contacted over the phone twice the first month posttermination, once the second and third month, and one last time at 6 months posttermination. Confirming what this therapist believed would happen, Ms. A decided not to continue with therapy and transfer to another therapist. She stated that she was doing very well emotionally, with no reemergence of her depressive symptoms. Ms. A reported that she still experienced headaches but with much less frequency. At 3-month follow-up Ms. A continued to function at a high level, still being able to balance her stressful work and school schedules. Interpersonally, Ms. A remained single, reporting less of a need to be with another person. This was very encouraging for Ms. A, as she expressed concern about quickly immersing herself in another relationship after termination of therapy. At the 6-month follow-up, Ms. A continued to demonstrate her gains from treatment with increased self-reliance and minimal depressive symptomatology.

11 TREATMENT IMPLICATIONS

Ms. A is an individual who does not openly express her feelings and thoughts in fear of how others will react to her if she does. The suppression of her painful emotions and fantasies serves two purposes: (a) She presents herself in a positive manner, which will increase her chances of being accepted and liked by others; and (b) she avoids the guilt and anger that is experienced due to her lack of understanding of her emotions, thoughts, and behavior.

Winnicott (as cited in Levine, 1996b) stressed the importance of the therapist being trustworthy, reliable, and consistent in the therapy. In therapy, the therapist becomes the good-enough object and provides the patient with a safe holding environ-

ment (Winnicott, as cited in Glickauf-Hughes & Wells, 1995), one of which Ms. A was deprived as a child. This enables the patient to feel open to expressing and exploring all of her emotions and thoughts without the fear of being rejected or criticized. In addition, it will enable the patient to embrace difficult feeling states rather than fear them (Bacal & Newman, 1990).

The therapist's attitude should be nonjudgmental, nondirective, and permit the patient to determine what is discussed during the therapeutic session. Empathic responses (Mahler, as cited in Levine, 1996a) allow for frustration and anxiety to remain at a tolerable level and facilitate the resolution of the rapprochement crisis by rewarding independence. Mirroring (Winnicott, as cited in Glickauf-Hughes & Wells, 1995) should be used to help the patient feel understood and to validate her inner feelings. Treatment focused on assisting the patient in expressing her anger toward her caregiving objects (mother and father) and facilitated individuation and autonomy. This goal can be accomplished by frequently refocusing the patient inward to search for her inner desires, needs, and beliefs. By doing so, the patient began to gain an understanding of who she is, and her true self began to emerge. For therapy to be effective, the therapist must continually focus and refocus the patient on the true self (Winnicott, 1954/1996a).

An additional aspect of therapy is the concentration on the relationship between patient and therapist. This relationship should be explored in relation to the patient's current interpersonal relationships, behavior, and past experiences. The goal is to gain insight into how the patient's world of internalized objects is influencing her current relationships. This will lead to healthier interpersonal relationships for the patient. Overall, the hope is for Ms. A to develop a stronger sense of self, increased individuation and autonomy, and decreased depression by developing the ability to express and accept her anger, guilt, and painful experiences.

12 RECOMMENDATIONS TO CLINICIANS AND STUDENTS

When using an object relations approach, it is recommended that the individual initially research the literature on this topic to gain a good understanding of the theory and its principles. This will help the therapist to better understand and relate to the patient, facilitating a strong therapeutic alliance. In addition, one should also possess a strong knowledge of transference and countertransference issues, their impact on the course of therapy, and how the analysis of the transference can lead to self-growth and change. Without an understanding of and an appreciation for the dynamics that exist between the therapist and patient, one may do more harm than good for the patient. It is crucial that the therapist is comfortable using silence. It is recommended that future therapists become more aware of the impact silence can have during a therapy session. In the case of Ms. A, silence was highly valuable as it provided her time to reflect, experience her true feelings as they were occurring in session, and free associate.

In our opinion, of utmost importance regarding the case of Ms. A is that of unconditional acceptance of the patient by the therapist. In doing so, this enables patients to learn how to accept themselves and all their internal positive and negative emotions and thoughts, ultimately leading to greater emotional stability, insight, and self-acceptance. When working with a patient with a character disorder, more intense therapy is often needed to facilitate change. Therefore, it is recommended that therapy continue beyond the 1-year time that was used in the case of Ms. A. Furthermore, sessions should be increased from one time weekly to twice weekly. If frequency and duration were increased, we believe that Ms. A would have demonstrated a greater emergence of her independence, and she would likely be more resilient in the face of conflict or future periods of loneliness. In addition, it is recommended that psychological testing be used early in the course of treatment, as doing so will provide valuable information about the patient, which the therapist can use effectively in the therapy.

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Case Study of the Assessment and Treatment of a Youth With Multifunction School Refusal Behavior

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Abstract: School refusal behavior is a common problem among children and adolescents and can lead to serious short- and long-term consequences if not addressed. Although recent treatment outcome studies have targeted youth who refuse to go to school for one specific reason (e.g., anxiety, attention), very little information is available on youth who refuse school for two reasons, and no information is available on youth who refuse school for three reasons. This article reports on the successful treatment of a 12-year-old boy who received prescriptive treatment for multifunction school refusal behavior. The treatment was assigned in accordance with a set assessment strategy designed to identify the primary reasons why a particular child refuses to attend school.

Keywords: school refusal behavior, assessment, treatment.

1 THEORETICAL AND RESEARCH BASIS

School refusal behavior refers to youth who have difficulties attending classes or remaining in school for an entire day. The behavior covers children and adolescents who are completely or partially absent from school, those who display morning misbehaviors in an attempt to stay out of school, and those who experience great distress about attending school and who issue pleas to miss school in the future (Kearney & Silverman, 1996). School refusal behavior is present in about 5% to 28% of school-aged children, is seen equally in boys and girls, and is prevalent in many types of families of different incomes (Kearney, 2001). Serious short-term and long-term problems can develop as a result of extended school refusal behavior, including distress, family conflict, social alienation, academic problems, delinquency, and school dropout, among others.

A key aspect of school refusal behavior is its heterogeneity; youth with school refusal behavior display a wide range of internalizing and externalizing behavior prob-

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lems. Common internalizing behavior problems include anxiety, depression, somatic complaints, fear, fatigue, and withdrawal. Common externalizing behavior problems include noncompliance, verbal and physical aggression, clinging, refusal to move, tantrums, and running away from home and school. In many cases of school refusal behavior, a confluence of these symptoms is evident. Such confluence is often difficult to sort, however, a fact that has led some researchers to develop assessment and treatment strategies for this population based more on the function rather than the form of behavior.

Kearney and colleagues (Kearney & Albano, 2000; Kearney & Silverman, 1996) have devised a functional classification, assessment, and treatment model for youth with school refusal behavior. In this model, youth are hypothesized to refuse school for one or more of the following reasons: (a) to avoid stimuli that provoke a sense of general negative affectivity (i.e., distress, anxiety, depression), (b) to escape aversive social and/or evaluative situations (e.g., tests, recitals, peer interactions), (c) to obtain attention from significant others (e.g., parents), and/or (d) to pursue tangible reinforcement outside of school (e.g., sleeping, playing with friends). The first two conditions refer to youth who refuse school for negative reinforcement or to avoid something aversive in the school building. The latter two conditions refer to youth who refuse school for positive reinforcement or to obtain something positive outside of school.

Kearney and Silverman (1993) devised the School Refusal Assessment Scale to measure the relative strength of these functional conditions for a particular case of school refusal behavior. Parent and child versions were constructed, and ratings from both are combined with other assessment data to determine the strongest function. Kearney and Albano (2000) developed prescriptive treatment strategies for each function that are assigned and tailored individually to a particular client.

For youth who refuse school to avoid stimuli that provoke negative affectivity, prescriptive child-based treatment involves psychoeducation about anxiety, anxiety/avoidance hierarchy development, somatic control strategies (e.g., relaxation, rebreathing), and gradual reexposure to the school setting. For youth who refuse school to escape aversive social and/or evaluative situations, prescriptive child-based treatment includes psychoeducation, anxiety/avoidance hierarchy development, modeling and role-play, cognitive restructuring, and gradual reexposure to the school setting. For youth who refuse school for attention, prescriptive parent-based treatment includes contingency management, establishment of routines, modification of parent commands, and, in some cases, forced school attendance. For youth who refuse school for tangible reinforcement outside of school, prescriptive family-based treatment includes contingency contracting, communication skills training, peer refusal skills training, and, in some cases, escorting the child to school and classes.

Preliminary treatment studies have demonstrated that prescriptive treatment based on function is effective for this population (Chorpita, Albano, Heimberg, & Barlow, 1996; Kearney & Silverman, 1990, 1999). However, these studies evaluated youth who

were refusing to attend school for one particular function. Very little work has been done to address youth who refuse school for multiple reasons. For example, it is not uncommon for a child initially to refuse school due to something unpleasant at school but then to enjoy the amenities of home life and refuse school to stay home as well. In addition, many adolescents home from school for long periods of time become nervous about the prospect of returning to new peers, teachers, and classes. In each case, the child is refusing school for both negative and positive reinforcement.

The purpose of this article is to describe and discuss a recent case of school refusal behavior that was motivated and maintained by several (three) functions. The presenting symptoms, assessment strategy, and treatment elements are covered in detail. In doing so, an overall strategy for assessing and treating this population is made available. A key aspect of this strategy is to engage in a thorough assessment of the functions of school refusal behavior and prescribe treatment that specifically addresses each of the functions.

2 CASE INTRODUCTION

Jordan (not his real name) was a 12-year-old White male referred to a specialized university-based clinic for youth with school refusal behavior and anxiety disorders. He was referred in the first week of October of the academic year, with school having been in session for 6 weeks. Jordan was referred by his parents and his school counselor, all of whom had been increasingly exasperated with his behavior during the past month and especially in the past 2 weeks. The initial assessment session was attended by Jordan and his mother, "Mrs. J." Jordan's father was regularly out of town on business during the week and did not attend the assessment or therapy sessions. He did, however, consult with the therapist via telephone.

During the initial assessment process, Jordan appeared sullen and subdued. He replied to all questions put to him but was guarded in his answers and not fully sure of why he was at the clinic. He was polite and respectful but also eager to leave the interview and begin work on his questionnaires (see Assessment section). During his work on the self-report measures in another room, Jordan was much more animated as he spoke with a female undergraduate student. He completed all of his questionnaires quickly and spoke to the student about his friends, family, school, and life events.

Mrs. J. was also subdued but politely and efficiently answered the interview questions put to her. She was occasionally apologetic for her son's behavior and also slightly embarrassed at her inability to get Jordan to school. Moreover, she expressed a fear that returning Jordan to school would cause him long-term harm and was confused about what steps to take next. Consent was secured to speak with school officials, and Mrs. J. indicated that she would be happy to know what they said. The assessment session lasted about 90 minutes and was followed 1 week later with a consultation session.

3 PRESENTING COMPLAINTS

Jordan reported that he currently had a number of anxiety-based physical symptoms when attending school. Most prominent among these were shaking and nausea, although other symptoms such as accelerated heart rate, muscle tension, crying, difficulty breathing, and fidgeting would occur. These symptoms tended to begin early in the morning and worsen in intensity up to the point where Jordan had to get on the bus. The symptoms were so severe at this point (reportedly a 10 on a 0-10 scale) that Jordan was forced to return home. On returning home, his anxiety symptoms quickly abated and remained low until the following morning. This cycle would continue each school day but not on Saturday or Sunday.

Jordan also reported several anxiety-based cognitive symptoms. Specifically, he reported a strong fear of getting into trouble in class, making mistakes on homework, getting poor grades, and being late to school or class. Jordan said he worried constantly in the morning, and previously when at school, that he would somehow get into serious trouble for various innocuous acts (e.g., talking at school, handing in work not according to procedure). He also stated that he always tried to do his best and worried that he would not always be able to do so (he was highly perfectionistic). Part of his worry stemmed from the greater amount of homework he faced in his new middle school. Jordan was concerned that he would not be able to finish his work and therefore would get into trouble. This worry was unfounded, however, as Jordan was traditionally a fine student and one who continued to carry A and B grades despite his absences.

During the past 2 weeks when not in school, Jordan also reported more difficulty sleeping, paying attention to others, and concentrating on his work. Most of this was the result of not going to school, a scenario that did bother Jordan because he knew the importance of his education and because he felt guilty about the effects of his behavior on his mother. He did report a desire to return to school but insisted that his anxiety precluded full-time attendance at this point. He was open, however, to an initial part-time schedule combined with anxiety-reduction strategies.

Mrs. J. reported other symptoms that were present in Jordan, including occasional vomiting of breakfast (medical conditions had already been ruled out). She also said she had to pick up Jordan from school one day several weeks earlier because of his difficulty breathing while there. She reported that Jordan often complained of his teachers and amount of homework, particularly regarding his early morning classes in first, third, and fourth periods. Mrs. J. also complained of Jordan's behavior during the day while home. After finishing his homework in the morning, following several prompts, Jordan would talk to his mother, play with his dog, watch television, visit with younger friends, and play on the computer. Mrs. J. expressed concern that Jordan was becoming quite accustomed to the pleasurable activities available to him at home.

4 HISTORY

Jordan stated that he attended classes without difficulty for the first 4 weeks of school. At that point, however, he got into trouble for talking in one class. Specifically, the teacher of that class singled him out and reprimanded him before his classmates. The event was reportedly quite humiliating for Jordan, who had never gotten into any trouble during elementary school. He said he felt extremely embarrassed and anxious following the event and into that evening. The following day, Jordan prepared for school as he normally would and strode to the bus stop. At that point, however, he was unable to board the bus due to overwhelming feelings of anxiety. He then walked home and was allowed to stay home during that day by his mother. On subsequent days, the same event happened, and Mrs. J. acquiesced to her son's strong demands that he not be sent to school.

After several days of this scenario, Mrs. J. began to plead with her son to attend school and discussed different ways of reintegrating him. Specifically, she warned him of impending consequences (e.g., legal, academic, social) and gave comfort in an effort to persuade Jordan to go back to school. These discussions were successful only in convincing Jordan to complete his schoolwork (retrieved by his mother) and to continue to practice a musical instrument he had just starting learning to play in band. Otherwise, he steadfastly refused to attend school and had now been absent for 2 straight weeks. In addition, Mrs. J. reported that Jordan was dawdling more in the morning, reluctantly getting dressed, and trying to sleep later. He also attended to his schoolwork in a slower fashion each day and seemed to be growing accustomed to a lackadaisical schedule at home.

5 ASSESSMENT

Assessment consisted of structured diagnostic interviews, behavioral questionnaires, daily ratings, and discussions with school officials with Mrs. J.'s permission. Child-based measures included the Anxiety Disorders Interview Schedule for Children (child version) (Silverman & Albano, 1996), State-Trait Anxiety Inventory for Children (Spielberger, 1973), Children's Manifest Anxiety Scale (Reynolds & Paget, 1983), Fear Survey Schedule for Children-Revised (Ollendick, 1983), Daily Life Stressors Scale (Kearney, Drabman, & Beasley, 1993), Children's Depression Inventory (Kovacs, 1992), Social Anxiety Scale for Children-Revised (La Greca & Stone, 1993), Piers-Harris Self-Concept Scale (Piers, 1984), Negative Affectivity Self-Statement Questionnaire (Ronan, Kendall, & Rowe, 1994), and School Refusal Assessment Scale (child version) (Kearney & Tillotson, 1998).

These child-based questionnaires were chosen and are commonly used to assess youth with school refusal behavior because of the frequency of internalizing symptoms

in this population. The instruments are standardized and excellent measures of many covert problems that may go undetected in an interview due to a youngster's reluctance to admit personal or potentially embarrassing information. The data can also be used in comparison with reports from other parties (e.g., parents, teachers) to form an overall impression about the function of school refusal behavior.

Parent-based measures included the Anxiety Disorders Interview Schedule for Children (parent version) (Silverman & Albano, 1996), Child Behavior Checklist (Achenbach, 1991), Family Environment Scale (Moos & Moos, 1986), and School Refusal Assessment Scale (parent version) (Kearney & Tillotson, 1998). These instruments were chosen to assess externalizing problems as well as family dynamics that are commonly linked to specific functions of school refusal behavior (see Kearney, 2001; Kearney & Silverman, 1995). The data are also used in combination with other reports to derive an overall functional profile.

Data indicated that Jordan met criteria for no formal *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV) diagnosis (American Psychiatric Association, 1994), although he did meet criteria for subclinical generalized anxiety disorder. The only criterion that prevented a full diagnosis was time, as Jordan displayed the requisite symptoms for less than 6 months. Data from the anxiety and negative affectivity questionnaires indicated moderate but not severe levels of discomfort. This is not necessarily unusual, however, in a child who has not been attending school for some time and whose anxiety level is therefore low. Jordan's endorsement of school-related items on the Fear Survey Schedule for Children-Revised was also moderate (e.g., "some" fear of "having to go to school"). Of particular fearfulness was "not being able to breathe," an anxiety symptom about which Jordan seemed most concerned. In addition, his level of self-esteem was good and his level of depression low.

Mrs. J. reported moderate levels of internalizing and externalizing behavior problems, although these were tempered as well by Jordan's nonattendance over the past few days. Family Environment Scale data revealed elevated cohesion, achievement orientation, and active-recreational orientation scores in addition to low conflict and moral-religious emphasis scores. The family was described by Mrs. J. and by school officials as hard driving and achievement oriented, which may have contributed to Jordan's perfectionistic nature.

Data from the School Refusal Assessment Scale indicated that Jordan was primarily refusing school for three reasons: avoidance of stimuli that provoke negative affectivity, attention, and tangible reinforcement. His combined (child and parent) profile scores for the four functions described earlier were 3.50, 0.80, 3.17, and 3.05. Only the second function, escape from aversive social and/or evaluative situations, did not seem relevant. In a recent treatment outcome study, profile scores within 0.50 points of one another were considered equivalent (Kearney & Silverman, 1999). Therefore, Jordan's school refusal behavior was considered to be maintained by three functions. In essence,

Jordan was refusing school because of the anxiety he faced while there but also to enjoy the many amenities, tangible and intangible, available at home.

A discussion with school officials was not overly informative because the academic year was young and Jordan was not yet well known. He was generally described as a good student and a polite youth but also one who seemed overly conscientious at times. His class schedule was obtained, and his counselor indicated that this could be changed if necessary, albeit with changes in teachers and times. Jordan's more demanding classes (i.e., English, math, reading) were in the morning prior to lunch, whereas his more enjoyable classes (i.e., computer, science, band) were in the afternoon. School officials also agreed to participate in a part-time schedule whereby Jordan would be gradually reintroduced to school and be allowed to attend at odd hours.

6 CASE CONCEPTUALIZATION

When addressing youth with school refusal behavior, it is best to digest all of the available assessment information to form an opinion about what motivates or maintains the behavior. This process may start by examining profiles from the School Refusal Assessment Scale. As noted above, Jordan appeared from his profile to be refusing school for multiple reasons. However, these ratings only provide an initial hypothesis about why a child is refusing school. Case conceptualization must continue by examining data that confirm or disconfirm this original hypothesis.

In Jordan's case, several pieces of information supported the idea that he was refusing school to avoid negative affectivity. Both he and his mother reported that Jordan had physical and cognitive symptoms of worry, and his avoidance of getting on the bus was clear. Still, other factors disputed this scenario. For example, Jordan had no prior history of school refusal behavior and met no formal criteria for an anxiety disorder. In addition, scores on his self-report measures of anxiety were only moderate. However, the therapist decided that Jordan was indeed refusing school to avoid negative affectivity on the basis of several facts. First, Jordan was clearly sincere in describing his anxiety symptoms and had said that they had escalated so quickly because his father was no longer available during the week to personally talk to him. Second, daily ratings of distress were high, indicating that Jordan was nervous about attending the clinic and the prospect of returning to school.

Other data also supported the idea that Jordan was refusing school for attention and for tangible reinforcement. He clearly enjoyed talking to his mother and spending time with her during the day. In addition, he had access to, and enjoyed, various play options at home and in his neighborhood. Some factors disputed this idea, such as the fact that Jordan was generally compliant in other areas and had few externalizing behavior problems. Still, the therapist concluded that Jordan was indeed refusing school for attention

and tangible reinforcement on the basis of several facts. First, Jordan's relationship with his mother was close and somewhat overdependent. The two clearly spent a lot of time together in the father's absence and had grown accustomed to supporting each other. In addition, Mrs. J. had essentially acquiesced to Jordan's desire to play during school hours once his schoolwork was completed.

Prescriptive treatment in a functional model of school refusal behavior is assigned on the basis of the strongest maintaining variables of the behavior. Because Jordan's school refusal behavior was maintained by several (three) factors, a complex treatment strategy was constructed. This consisted of (a) anxiety-reduction strategies with a particular focus on controlling Jordan's hyperventilation, (b) gradual reexposure to the school setting, (c) parent training in contingency management, and (d) restriction of activities during school hours.

7 COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

Treatment lasted four sessions, and assessment of progress was made via daily ratings and actual school attendance. During Treatment Session 1, Jordan was educated about the nature of anxiety, its three response systems (cognitive, physiological, behavioral), and his individual pattern in the morning and at school. Jordan would typically experience somatic anxiety symptoms first, which would then stimulate cognitive worries about getting into trouble or being late to class. These physiological and cognitive symptoms would gradually increase and peak at the point of boarding the bus, at which time behavioral avoidance was displayed. Other scenarios were covered with Jordan as well, such as entering the school building, speaking to others in class, and moving from class to class. Jordan was able to comprehend his pattern of anxiety and was able to provide more detailed examples of the scenario when it occurred during the day.

The next step was to stem the somatic anxiety symptoms, and this was done via breathing retraining and tension-release relaxation of key muscle groups. Jordan practiced breathing in slowly through his nose and out through his mouth to control his hyperventilation. In addition, to address his stomach, Jordan tensed this area, held it tight for 5 seconds, and released it. The therapist and Jordan practiced this several times and then worked on secondary muscle groups such as the face and legs. Jordan was instructed to practice these techniques at least twice per day and during any stressful situations.

Jordan was also asked to choose three periods of school that were least problematic for him. He indicated that his afternoon classes of computer and band were his favorites, although they sandwiched science class, which was less preferred. Jordan was asked if he could attend computer and band class but sit in the library during science class. He agreed to try this part-time schedule and was encouraged to practice his somatic control exercises when entering school.

Session 1 also involved work with Mrs. J., who supported the part-time schedule and was able to secure a relative to take Jordan to school midday. In addition, Mrs. J. agreed to establish a consequence system to be implemented based on Jordan's level of compliance. If Jordan attended school during the mandated times without difficulty, he would be allowed to play with friends and enjoy the amenities of home at night as if he had attended a full day. If Jordan did not attend school as mandated, however, his privileges would be revoked and he would have to spend time in his room completing schoolwork or engaging in reading or some other academic activity. In addition, Jordan's morning time at home was restricted to schoolwork and band practice.

The therapist also counseled Mrs. J. regarding her statements made to her son as well as the morning routine. Specifically, Mrs. J. was to refrain from any attempts to comfort Jordan or persuade him to attend school. Instead, she was asked to allow the consequences to work and abstain from any extra verbal or physical attention. Should Jordan engage in any excessive reassurance-seeking behavior, such as asking the same questions repeatedly, Mrs. J. was to ignore these and refocus her son toward schoolwork and attendance. Mrs. J. was also educated about the anticipated positive effects of this therapy program and that no long-term negative discomfort was expected. She was also encouraged to allow the family relative to take Jordan to school and to downplay any farewell scenes with her son. Finally, Mrs. J. was instructed to rigorously maintain the morning schedule so that Jordan would arise and prepare for school as if he were starting first period on time. Dawdling was linked to consequences as well.

Between Sessions 1 and 2, Jordan was reluctant to attend school, and school officials delayed the procedures for 2 days (see Complicating Factors section below). He did, however, prior to Session 2, attend school for three periods on each of 3 days. The period between computer and band was spent in the library. During Session 2, Mrs. J. reported that the consequences had been administered accordingly. In addition, she was able to modify her statements to nudge Jordan to school and maintain the morning routine. Jordan reported enormous discomfort (rating of 9) on the first day back to school and was primarily concerned that he would be late to class and get into trouble. He arrived at school in plenty of time, however, reducing his anxiety considerably. In addition, Jordan was able to control any physical symptoms of anxiety because they were at a manageable level. He knew, for example, that the end of the school day was near and that the classes he was attending were his most comfortable. Work in this session concentrated on his worries, and these were allayed via basic cognitive restructuring. His next homework assignment was to attend lunch and science class, thus keeping him in school from 10:54 a.m. to the end of the day.

At Treatment Session 3, Jordan reported that he was able to meet the homework assignment and reported anxiety levels around 4 or 5. This was significant as it indicated that Jordan was habituating to the school setting, thus driving his anxiety ratings down. As part of his psychoeducation process, Jordan was informed that anxiety levels tend to

decline as one practices a situation more and gains mastery over it. Examples specific to his life (e.g., learning a musical instrument) were raised to reinforce this point. Previous procedures were implemented, and Jordan was instructed to add two more classes to his schedule. He chose his first and third period classes and was allowed to stay in the library during second period if he wished. Over the next week, Jordan was able to complete this assignment. Treatment Session 4 consisted of reinforcing the procedures that had been taking place, and Jordan was instructed to add his second period class and to ride the bus to and from school. He was able to accomplish both goals, and daily ratings of distress ranged from 0 to 1 each day. Treatment was terminated during a brief Session 5 as attendance and anxiety remained at acceptable levels.

8 COMPLICATING FACTORS

One complicating factor in this case was Jordan's very high anxiety on the first day back to school. Even though Jordan was only required to attend three periods and two classes, he called the therapist that morning to say that he was unsure he could go. It is not unusual for the first scheduled time back to school to be the most difficult part of therapy for a youth with school refusal behavior. Often, this difficulty is in the form of high anxiety, but it can also mean the child is deliberately worsening his or her misbehavior to gain further attention or tangible rewards. A key feature of treatment at this stage is to adopt a general rule that no backsliding should be allowed. For example, if a child makes it to school grounds but cannot bring himself or herself to enter the school building, parents or others should remain with the child until anxiety dissipates. Although difficult, a return home, or backsliding, should be avoided so as not to reinforce inappropriate behavior. In some cases, this means staying with the child for several hours in the school parking lot, but this option will facilitate treatment much more than a return home. In similar fashion, once a child is attending two classes at school per day, this should be the minimum attendance required each day until a more detailed schedule is implemented.

In Jordan's case, encouragement from the therapist and his mother was sufficient to impel him to attend school for two classes on the first day. In other cases, very gradual exposure is needed. For example, it may take several hours or days for a child to enter a school building, but small steps forward are key in this situation. Many times, including Jordan's case, these small steps lead to faster and more substantial gains later.

Events in Jordan's case were further complicated by a delay in the treatment plan by school officials. The school counselor who had originally agreed to the procedure backtracked and said that a full conference with the dean and attendance officer would be necessary prior to approval. This delayed treatment for 2 days and inadvertently reinforced Jordan's absenteeism. This scenario reveals the importance of working closely with all relevant school officials and being sure that any plan (e.g., partial reintegration,

schoolwork sent home) be conducted with their full cooperation. In many cases, cooperation from school officials is key to resolving a child's school refusal behavior.

9 MANAGED CARE CONSIDERATIONS

Although no significant managed care considerations applied to Jordan's case, such considerations do apply to many cases of youth with anxiety disorders and school refusal behavior. One such consideration is a focus on brief, solution-focused therapy. Because of the emphasis on limited sessions in managed care, treatment of school refusal behavior usually must be abridged and condensed. Short-term treatment manuals for this population are available (Kearney & Albano, 2000), but clinicians should be aware of the need to impart much information in a short period of time. Second, the era of managed care has tended to create a greater reliance on drug therapy compared to psychotherapy. In fact, treatment guidelines for youth with anxiety disorders tend to be pharmacologically focused (American Academy of Child and Adolescent Psychiatry, 1993). However, a close examination of drug treatment outcomes studies for youth with anxiety and/or school refusal behavior has revealed mixed results or positive results if combined with behavioral procedures (see Kearney & Silverman, 1998, for review). Clinicians are encouraged to explore a full range of psychotherapeutic options, including those described here, for this population.

Third, primary care providers may tend to downplay or fail to support reimbursement for a behavioral problem (i.e., school absenteeism) that is not formally part of the *DSM-IV* or in need of immediate medical attention. School refusal behavior is potentially as debilitating a condition as any formal mental disorder, however, and this should be conveyed to managed care administrators. Fourth, managed health care tends to emphasize cheaper and more readily available resources than licensed psychologists. This is unfortunate given that the treatment of school refusal behavior is often a delicate issue that benefits most from substantial, intensive, and complex psychological treatment. Finally, preventative care is sometimes trivialized in a managed health care system, despite the fact that early detection and amelioration of school refusal behavior in youth at risk for absenteeism would save enormous resources.

10 FOLLOW-UP

Follow-up with Jordan 1 month later indicated continued progress and no school refusal behavior. In addition, duress at school was minimal. This is consistent with treatment outcome data from other studies (Chorpita et al., 1996; Kearney & Silverman, 1990, 1999). Prescriptive treatment for school refusal behavior tends to be more effective

in the long run compared to a generic treatment approach that targets the entire population. This is likely due to the individual attention given to a certain case and because factors other than anxiety (e.g., attention, tangible reinforcement) are considered and addressed.

11 TREATMENT IMPLICATIONS OF THE CASE

Jordan's case is the first in the literature that involves the assessment and treatment of a youth whose school refusal behavior was maintained by three functions. His successful treatment implies, at a very preliminary level, that a prescriptive therapy approach is effective for detailed and complex cases of school refusal behavior. His case also indicates that the concurrent use of multiple prescriptive treatments is feasible and perhaps desirable in this situation. In particular, the combined prescriptive treatment approach mandated that both Jordan and his mother be intimately involved in therapy, and this combined effort appeared key to resolving the case. In many instances of school refusal behavior, family participation in therapeutic homework assignments increases compliance, supervision of the child, and easing of pressure from school officials. What remains unclear, however, is which of Jordan's treatment ingredients was most effective. Future casework and research will need to determine which aspect of prescriptive treatment is best for youth with multifunction school refusal behavior.

12 RECOMMENDATIONS TO CLINICIANS AND STUDENTS

When addressing cases of school refusal behavior maintained by multiple functions, several things should be kept in mind. First, the behavior will be likely referred to as an urgent one by parents and school officials, and many different hypotheses about the cause of the problem will be offered. As a result, great care should be taken during the screening and scheduling process to listen to all relevant parties and determine the true urgency of the situation. In some cases, for example, an immediate return to school is unnecessary.

In related fashion, a comprehensive assessment should be conducted regarding not only the forms but also all the functions of the behavior. Knowing why a particular child is refusing school will advance treatment of the case immeasurably, especially if the functions are prioritized and addressed by strength. A common scenario in this population is for children to report one main function and for parents to report another. In this scenario, the clinician must weigh the statements made by each party, rely on his or her own observations and third-party information, and consider several explanations. For example, it is possible that two or more functions are truly influential to the case, and it is possible that one or more parties is uninformed about the child's school refusal behavior.

A comprehensive assessment that relies on multiple methods and multiple sources of information is usually critical in cases of school refusal behavior.

Clinicians should also keep in mind that treatment sessions for youth with multifunction school refusal behavior will tend to be lengthy, intense, and frequent. In addition, clinicians should be prepared to receive calls at different times of the day. In Jordan's case, for example, it was not unusual for him to contact the therapist via e-mail and telephone calls early in the morning prior to school. Clinicians should be aware of the often-dire nature of these cases and the severe disruption that it causes family members who often want the problem resolved as quickly as possible.

Clinicians also have to carefully decide the timeline for returning a child with multifunction school refusal behavior to school. In contrast to traditional dictates regarding this population, an immediate return to full-time attendance is often not preferable. This is especially the case for youth with high levels of anxiety as well as those with long histories of school refusal behavior. In addition, educating children about their condition and soliciting their input regarding its resolution is important and should precede any reintegration. In other cases, gradual work toward a part-time schedule as the final goal may have to be considered. In very chronic cases, alternative methods of education (e.g., night courses, vocational classes) may have to be pursued.

The treatment of youth with multifunction school refusal behavior is a challenging one but one that can be successfully completed with a comprehensive assessment process and a complex prescriptive treatment strategy. Clinicians are encouraged to be innovative when treating this population and to be persistent in addressing extremely difficult cases. In addition, therapists should remain aware of the rapid advances in this field with respect to assessment and treatment.

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Dialectical Behavior Therapy for Suicidal Adolescent Inpatients

A Case Study

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Abstracts: Dialectical behavior therapy (DBT) is an empirically supported treatment for chronically parasuicidal adult women with borderline personality disorder. It has recently been modified for use with other psychiatric disorders and populations. In this article, the authors briefly review the theoretical and research basis for the use of DBT with parasuicidal adolescent inpatients, and a case study is presented. The case study includes a DBT case formulation, and its application to the inpatient management of a chronically parasuicidal adolescent is described. This adolescent had significant difficulties engaging in treatment and required use of DBT commitment strategies, which are reviewed. The authors also describe (a) the use of a stage theory of treatment, (b) the application of Linehan's biosocial theory, (c) use of behavioral analysis of parasuicidal behavior, and (d) dialectical treatment of this patient. Finally, 1-year follow-up data on this patient are presented.

Keywords: dialectical behavior therapy, suicide, adolescents, hospitalization.

1 THEORETICAL AND RESEARCH BASIS

Dialectical behavior therapy (DBT) is a theoretically grounded and empirically supported psychotherapy originally developed by Linehan (1993a, 1993b) for chronically parasuicidal women with borderline personality disorder (BPD). DBT integrates traditional cognitive-behavioral approaches with Eastern philosophy and meditation practices and shares elements with psychodynamic, client-centered, gestalt, paradoxical, and strategic approaches (Koerner, Miller, & Wagner, 1998). There is now empirical data supporting use of DBT with chronically parasuicidal women with BPD in both inpatient (Bohus, Haaf, Stiglmayer, Pohl, Bohme, & Linehan, 2000) and outpatient set-

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tings (Koons et al., 1998; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). As well, DBT has been modified for use with patients with substance abuse (Dimeff, Rizvi, Brown, & Linehan, 2000), histories of domestic violence (Fruzetti & Levensky, 2000), and antisocial personality disorder (McCann, Ball, & Ivanoff, 2000). Recently, DBT has been applied across a range of age groups, including adolescent inpatients (Katz, Guneseckara, Cox, & Miller, 2000; Katz, Guneseckara, & Miller, in press), adolescent outpatients (Miller, Rathus, Linehan, Wetzler, & Leigh, 1997), and geriatric populations (Lynch, 2000). In this article, we will briefly review the theoretical basis for DBT and will describe its application to the treatment of a parasuicidal adolescent inpatient. DBT for parasuicidal adolescent inpatients (Katz et al., in press) uses an expanded application of DBT, modified from treatment of patients with BPD to parasuicidal adolescent inpatients with or without BPD.

Linehan (1993a) proposed a biosocial theory of BPD. She purports that BPD develops when a child who is biologically vulnerable to difficulties regulating emotions is placed in environments that are perceived as pervasively socially toxic, or "invalidating environments." Biologically vulnerable children are described as more sensitive to emotional stimuli, experiencing more intense emotional reactions, and taking longer to return to a baseline level of arousal. An invalidating environment is one that pervasively trivializes, blames, rejects, and attributes socially unacceptable characteristics to an individual's cognitive, behavioral, and emotional responses despite the fact that the responses make sense in terms of facts, inferences, accepted norms, or in terms of long-term goals (Koerner, Miller, & Wagner, 1998). This can contribute to the cognitive distortions that often "fan the flames" of emotion in emotionally vulnerable individuals. The effects of the invalidating environment are ongoing in adolescents who are often still living in this environment in contrast with adults who are coping with their past experiences having lived in the environment.

Transaction of emotional vulnerability and an invalidating environment leaves individuals with BPD with dysfunction in up to five domains. According to Linehan (1993a), the central problem for BPD patients is (a) emotional dysregulation. Difficulties with emotional dysregulation contribute to four other domains of dysfunction, including (b) interpersonal dysregulation, (c) self-dysregulation, (d) cognitive dysregulation, and (e) behavioral dysregulation. DBT skills training addresses the five domains of dysfunction using corresponding behavioral skills modules (Linehan, 1993b).

2 CASE INTRODUCTION

This case has been sufficiently disguised so that identification will not be possible. Diane was a 16-year-old female from a rural area who presented to a pediatric emergency room having taken a potentially fatal overdose of acetaminophen. She had taken the

overdose impulsively after an argument with an older sibling. She also endorsed ongoing suicidal ideation.

3 PRESENTING COMPLAINTS

When seen in the pediatric emergency room, Diane was deemed to be stable enough for admission to a psychiatric ward. She had one previous admission to this unit approximately 1 year prior to her current presentation. After admission, she developed numerous medical sequelae requiring transfer to a pediatric ward for in-patient pediatric medical stabilization. She was stabilized over approximately 2 days; however, transfer back to psychiatry was still indicated. The patient was transferred to a different psychiatric unit and was very angry about not returning to the original unit.

4 HISTORY

Diane's first psychiatric contact occurred approximately 1 year prior to this presentation. She presented at that time in a similar manner, having taken an overdose. She was psychiatrically hospitalized for many months. She had been diagnosed with major depressive disorder and borderline personality features based on clinical interviews. She had been treated with an antidepressant during her inpatient stay. However, at the time of discharge, she declined outpatient treatment. At that time, she reported a history of parasuicidal behavior including cutting and burning that continued at times during her first inpatient stay. She also attempted to strangle herself a number of times during that admission. These behaviors continued after discharge and up to this admission. For the period between this admission and her last admission, she reported cutting herself at least 100 times, frequently burning herself, and taking three overdoses. Diane stated that over the 2 months prior to her current admission, she had been having symptoms consistent with a recurrence of her major depression and that this had interfered with her school performance and day-to-day functioning.

Diane did not have a significant history of substance abuse. Initially, she denied a history of physical abuse, although she later acknowledged that her father had seriously physically assaulted her in the past. This included being thrown into a wall resulting in a significant physical injury. Assaults tended to occur in the context of extremely heated family arguments and domestic violence. She also acknowledged a third-party sexual assault when younger. Family history was significant for an older sibling having been psychiatrically hospitalized with similar difficulties. There had been long-standing difficulties in her parents' marriage. At no time did she present with psychotic symptoms. She did not have any significant history of medical problems.

5 ASSESSMENT

Diagnostically, based on clinical interviews, Diane presented with a history consistent with a recurrence of major depression and ongoing evidence of borderline personality features. At the time of admission, her 13-item Beck Depression Inventory score was 28 and her Reynolds' Suicidal Ideation Questionnaire–Jr. score was 82. She had engaged in 143 parasuicidal behaviors in the year prior to admission. There were also parent-child relational problems. She was deemed to warrant inpatient psychiatric care for the stabilization of her acute suicidality and for reassessment of her condition. Consideration was to be given to pharmacotherapy of what appeared to be a recurrence of her major depressive disorder. Inpatient adolescent DBT uses pharmacotherapy on an as-needed basis.

To arrive at a DBT-based case formulation, it is necessary to conduct a behavioral chain analysis of the events leading up to her emergency room presentation. This allows for a detailed understanding of the emotional and cognitive events that precipitated the suicide attempt. A behavioral chain analysis involves a line of questioning designed to elicit a detailed account from the patient of the events of the day that led up to the suicide attempt. It involves a review of the day to identify the problem behavior (in this case, the self-harm episode) and the presence of vulnerability factors that predisposed the patient to suicidality. As well, the precipitating event is reviewed. Once the problem behavior is identified and the vulnerability factors are delineated, the specific thoughts and feelings (related to the precipitating event) that drove the problem behavior are analyzed. Links between the thoughts, feelings, and behaviors are sought to build a chain from the initiation of the process to its conclusion with the problem behavior and its contingencies. Thus, the final step is the recognition of the consequences of the behavior. This detailed assessment allows the therapist to identify each point at which the patient could have engaged in an alternative behavior that may have produced positive change and averted the conditions that led to the problem behavior (Koerner & Linehan, 1997).

6 CASE CONCEPTUALIZATION

There are five sets of theoretical concepts that provide the underpinnings to DBT case formulation and that may be applied to parasuicidal adolescent inpatients: (a) stage theory of treatment; (b) biosocial theory of the etiology and maintenance of BPD; (c) learning principles and ideas from behavioral therapy; (d) common behavioral patterns of BPD and dilemmas created by the dialectical nature of these patterns, which interfere with efforts to change; and (e) dialectical orientation to change (Koerner & Linehan, 1997). Diane's problematic behavior is formulated in the context of these five concepts to guide construction of hypotheses and planning of interventions to remedy the prob-

lem behavior. We will first review these five concepts and then illustrate their application to Diane's presentation.

Stages of Treatment: Behaviors to Target

In DBT, a stage model of treatment is used. The extent of disordered behavior determines what treatment tasks are relevant and feasible (Koerner & Linehan, 1997). In DBT for parasuicidal adolescent inpatients, the treatment targets are further modified from standard DBT (Linehan, 1993a) based on these principles (Katz et al., in press). The first stage of treatment with all DBT patients is pretreatment in which the patient and therapist agree on treatment goals and mutual commitment to treatment. In DBT for parasuicidal adolescent inpatients, following pretreatment there is only one stage of treatment, and its primary targets are to (a) decrease life-threatening behaviors prompting admission or delaying discharge, (b) decrease behaviors that interfere with outpatient therapy or current inpatient therapy, (c) decrease behaviors disrupting the inpatient unit, and (d) increase core mindfulness and distress tolerance skills, which are crucial to enabling and maintaining outpatient therapy.

Biosocial Theory: The Central Role of Emotion Dysregulation

As discussed above, Linehan (1993a) conceptualizes BPD as a result of the transaction between an invalidating environment and an individual who is biologically vulnerable to emotion dysregulation. Thus, disordered behavior is conceptualized as a consequence of emotional dysregulation, an attempt to modulate emotion, or both. In DBT for parasuicidal adolescents with or without BPD, the biosocial theory is used to understand parasuicidal behavior. In particular, it is the transaction of emotional factors (whether biologically attributed to inherent emotionality or triggered by major depressive disorder) with the experiences of invalidation (from others or the self) the individual has experienced that contribute to the understanding of the function of the behavior. Behavioral principles translate these general ideas into specific hypotheses about the patient (Koerner & Linehan, 1997).

Theory of Change: Learning Principles and Behavior Therapy

In DBT, disordered behavior in patients with BPD is viewed as a result of deficits in capabilities as well as problems of motivation. To specifically understand the problem behavior, a behavioral chain analysis is used to analyze the specific antecedents and consequences that maintain the behavior. Absence of skilled performance may be due to (a) the patient not having the skills necessary to navigate the situation, (b) problematic

contingencies, (c) emotional responses blocking more skillful responses, and (d) faulty beliefs and assumptions inhibiting effective behavior (Koerner & Linehan, 1997).

BPD Behavioral Patterns and Dialectical Dilemmas

To successfully treat primary targets, other (secondary) behavioral patterns may also need to be targeted. Linehan (1993a) has distilled patterns of behavior organized into dialectical poles that are frequently evident in BPD. This perspective orients the therapist to behavioral patterns that may compromise treatment if not directly treated (Koerner & Linehan, 1997).

The first of these dialectical patterns is emotional vulnerability and self-invalidation. Emotional vulnerability refers to the intense suffering experienced during emotion dysregulation. Self-invalidation occurs when the patient responds to her behavior (or the absence of needed self-generated behavior such as emotion control) as invalid, which can lead to a blocking of emotional experience. The intense discomfort of either experience results in an oscillation between experiencing vulnerability and invalidation of the emotional experience (Koerner & Linehan, 1997).

The second set of dialectical patterns is active passivity and apparent competence. Active passivity is the tendency to respond to problems passively. Apparent competence is a description of the behavioral responses that influence observers to overestimate and overgeneralize response capabilities.

The third set of dialectical patterns is unrelenting crisis and inhibited grieving. Unrelenting crisis refers to a self-perpetuating behavioral pattern in which the individual with BPD both creates and is controlled by incessant crises. Inhibited grieving is an involuntary, automatic avoidance of painful emotional experiences (Koerner & Linehan, 1997).

Following up on Linehan's work, Rathus and Miller (2000) have proposed dialectical dilemmas and secondary treatment targets for adolescents and their families. The dialectical dilemmas they have identified in working with adolescents and their families are excessive leniency versus authoritarian control, normalizing pathological behaviors versus pathologizing normative behaviors and, finally, forcing autonomy versus fostering dependence. They provide secondary treatment targets designed to achieve a synthesis between the polarities inherent in each dialectical dilemma.

Dialectics of Change: Philosophical Guiding Principles

In DBT, dialectics shifts attention from the patient alone to the context within which the patient interacts. The formulation, from a dialectical perspective, is not of the individual *per se* but rather the relationships between the patient, the patient's community, the therapist, and the therapist's community.

DBT CONCEPTUALIZATION OF DIANE'S PRESENTATION

In Diane's case, the formulation revealed that she had been experiencing a recurrence of her major depression for approximately 2 months that had left her thinking of suicide more intensely for the past 4 days (vulnerability factor). The depression was having significant effects on her schooling and functioning. She was highly judgmental of herself in this context (self-invalidation and emotional vulnerability). On the day of the overdose, she was at heightened vulnerability to emotional dysregulation (above her core biological predisposition) secondary to the difficulties related to the depression and got into an argument with her sibling, who called her judgmental names (precipitating event involving invalidating comment). Diane had difficulties accepting her own emotional vulnerability, and in the context of this argument and judgmental comment, she began to judge herself for her own emotionality (self-invalidation and emotional vulnerability). This intensified her emotional dysregulation, leading to her finding it unbearable. Not knowing what else to do (skills deficit), she took an overdose to terminate her feeling state. She was brought to the emergency room and was accompanied by her mother, which she found supportive (positive contingency).

7 COURSE OF TREATMENT, ASSESSMENT OF PROGRESS, AND COMPLICATING FACTORS

PRETREATMENT

On transfer back to psychiatry, her consultation obtained in the emergency room was reviewed by the psychiatrist and an initial case formulation done. Diane appeared to be a candidate for DBT based on her presentation, and the initial interview was conducted using the stage theory of treatment. Thus, the initial contact was viewed as pretreatment, and the focus was on establishing commitment to treatment and agreement on goals.

In the initial interview, Diane was very angry about not returning to the ward she had been on previously. She began the interview saying, "f— you, I want to see Dr. Smith" (the psychiatrist on the other ward). In an attempt to engage her in a dialogue when emotionally dysregulated, Diane was validated regarding her anxiety and discomfort on the new ward and that her request for transfer would be taken seriously. It was explained that there were no beds on the other ward but that Dr. Smith would be asked if a bed was going to be available shortly; otherwise, a treatment plan would need to be worked out for her on the current ward. Later that day, it became apparent that transfer was not going to be possible. When informed of this, Diane stated, "If that's the case, then I won't talk to anybody, I'm fine now [apparent competence], and I want to be discharged."

At this time, DBT commitment strategies (Linehan, 1993a) were used in an attempt to obtain Diane's commitment to treatment. Once again, she was validated for how hard it is to begin treatment with a new team and that it is scary to open oneself up to hope when she had been through a number of difficult previous treatments. Next, a meeting with her parents the following day to arrange discharge was agreed on. However, it was suggested that DBT might be helpful (selling commitment strategy, Linehan, 1993a) but that it would be entirely up to her. She could choose the next day to be discharged (she was denying suicidality for 2 days) but nothing had changed or been accomplished, and DBT might facilitate her returning home with more skills for coping with emotional dysregulation (freedom to choose and absence of alternatives strategy, Linehan, 1993a). Diane agreed to consider it and to look through the skills-training manual, but she was still planning to be discharged the next day.

At the time the discharge meeting was scheduled to occur, Diane refused to attend and instead stayed in her bed crying (active passivity contrasting with apparent competence demonstrated with earlier request for discharge). The psychiatrist met with the parents and discussed the situation and explained that Diane was insisting on leaving and could not (and should not) be held in hospital against her will. However, as she would not attend the meeting, it was agreed that the psychiatrist would meet with her one last time and, using commitment strategies, try to engage her in treatment. In meeting with Diane, the same strategies as described above were used and the same material restated (validation of fear, freedom to choose, and absence of alternatives) in addition to the application of additional commitment strategies. A dialectical approach using a paradoxical technique for obtaining commitment was balanced with a cheerleading technique (devil's advocate vs. cheerleading, Linehan, 1993a). In meeting with the patient in her room, after validating her, the patient was told that she clearly thought that it was too hard for her to stay for DBT and that it was understandable (devil's advocate). It was stated that maybe now was not the time. However, it was also emphasized that the psychiatrist felt that she was capable of it at some point, otherwise it would not have been offered in the first place (cheerleading). Throughout this time, the patient remained on her bed crying. The psychiatrist continued to dialogue with Diane for approximately 10 minutes to allow her time to process the situation and then stated that a decision was required and that her initial request for discharge would be honored unless she stated otherwise. As the psychiatrist was leaving the room to arrange discharge, Diane stated, "All right, I'll stay for DBT" and proceeded to spend the remainder of the evening in bed. Diane was told that it was fabulous that she was staying and that the staff looked forward to working with her in DBT.

STAGE 1 TREATMENT

Stage 1 of treatment targets behaviors described above in the section on the application of the stage theory of treatment. The structure of the inpatient adolescent DBT

program has previously been described (Katz et al., in press). It involves a daily skills-training group that lasts from 45 to 75 minutes. In the group, Diane was taught skills to address the deficit areas described above. This consists of mindfulness skills to help her identify emotional dysregulation and stabilize her sense of self. Distress tolerance skills (e.g., distraction techniques and self-soothing techniques) were taught to facilitate crisis management. Interpersonal skills were taught to remedy social deficits, and emotional regulation skills were taught to help her more effectively regulate her mood.

Diane also attended individual psychotherapy sessions twice per week with the psychiatrist to review a weekly diary card and conduct behavioral analyses of maladaptive events recorded on the diary card. The sessions were structured using the treatment target hierarchy for parasuicidal adolescent inpatients described above. In Diane's case, a focus was maintained on factors that may have compromised her motivation and on her chronic parasuicidality. This led to multiple behavioral analyses that elicited a pattern of parasuicidality in the context of emotional dysregulation triggered by judging herself for her own emotional vulnerability. For example, Diane had one parasuicidal behavior on the ward during her admission (this was her only parasuicidal behavior during her admission). Specifically, she tried to strangle herself but was not harmed. This occurred during a period when the psychiatrist was away for 2 days at a conference. The event was triggered when she became dysregulated by the emotional dysregulation of another patient. She began to judge herself for her sensitivity and felt hopeless about ever having control over her emotions. On the psychiatrist's return, a behavioral analysis was conducted, and the judging and self-invalidation was targeted using cognitive restructuring techniques to encourage practicing nonjudgmental forms of thought. As well, a solution analysis was integrated to provide alternative coping strategies for emotional dysregulation.

The dialectical approach encourages viewing the individual as part of the whole, thus family assessment and treatment are an integral part of DBT for parasuicidal adolescents. In fact, in outpatient adolescent DBT, the skills training is conducted in multifamily skills-training group (Miller et al., 1997). In Diane's case, her parents' ongoing antagonism toward each other made it impossible to have all family members attend family therapy. Meetings were held at admission and discharge to discuss principles of DBT and the utilization of skills training. This was the maximum amount possible in this situation, although it was recognized as less than optimal.

The ward milieu itself offers a number of interventions. Diane's nurse was available to provide consultation to her on the utilization and generalization of skills. Meetings with her nurse occurred on an as-needed basis but followed the same hierarchy as directed by the treatment targets. She was able to approach her nurse for consultation in managing her emotions on a number of occasions after upsetting events. When she went out on pass, she knew she could call the ward if she become dysregulated and consult with her nurse on the skills necessary to manage the situation (this was never required). To facilitate staff functioning, the inpatient staff attends a biweekly DBT therapist consultation group to enhance therapist capabilities and motivation to treat effectively. The

staff psychiatrist who is also the provider most experienced in DBT leads this meeting. This meeting is critical to allow for consistent compassionate and effective interventions with these adolescents who can often try the patience and skills of even the most experienced staff members.

In summary of her treatment course, Diane reluctantly engaged in DBT and required frequent use of commitment strategies to keep her in treatment. During the early part of her hospitalization, she engaged in one parasuicidal behavior. She completed the program without further incident. Thus, she met her Stage 1 targets of reducing life-threatening behaviors, did not engage in therapy-interfering behaviors, and was not engaging in egregious behaviors on the ward. She also completed her skills training with good intellectual acquisition of skills. During the course of her admission, she presented with depressive symptoms that warranted a trial of an antidepressant, and fluoxetine was initiated.

8 MANAGED CARE CONSIDERATIONS

This patient was managed within the Canadian health care system, and as such, there were no managed care considerations in her treatment. Within the Canadian health care system and in accordance with its principles, her care was paid for by the universal health care system. There were no restrictions with regard to the nature or duration of her treatment or what kind of follow-up treatment for which she would be eligible.

9 FOLLOW-UP

Diane was discharged and referred to an outpatient adolescent clinic for medication management and psychotherapy. She attended only briefly and then discontinued the psychotherapy, although she continued her fluoxetine for 10 months. As part of an ongoing outcome study of inpatient DBT, Diane was contacted at 1 year following her discharge. At that time, her 13-item Beck Depression Inventory score had gone from 28 at the time of admission to 5 at 1 year. As well, her score on the Reynolds' Suicidal Ideation Questionnaire-Jr. had gone from 82 at the time of admission to 17 at 1 year. Her parasuicide count in the year prior to admission had been 143 and in the year after had declined to 113. She had one emergency room visit during the year related to suicidal ideation but had not been rehospitalized during the year. Of note, at the time of phone contact, she had been off medication for 2 months and had not harmed herself in 2 months.

10 TREATMENT IMPLICATIONS OF THE CASE AND RECOMMENDATIONS TO CLINICIANS AND STUDENTS

This case serves to demonstrate the utility of the application of DBT to the management of parasuicidal adolescent inpatients. These patients present with multiple serious problems that all beg to be addressed at the same time. DBT structures the treatment approach and facilitates coordination of delivery of inpatient treatment. Specifically, it provides treatment strategies that can be used effectively to address serious problems such as parasuicidal behavior. The inpatient staff addresses the patients' needs in a hierarchical manner and remains focused on the most serious behavior. The dialectical balancing of acceptance and change ensures that the patient feels validated throughout the process yet is grounded by the structure of DBT. There is now preliminary evidence that DBT may reduce maladaptive behaviors on adolescent inpatient units (Katz et al., 2000). At the core of the effectiveness of this treatment is a comprehensive understanding of the application of Linehan's biosocial theory and the recognition that maladaptive behaviors are largely the result of emotional dysregulation and its sequelae.

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