AdulTs in television sitcoms and drama

The cases of Jack Bauer, Sophia, George Lopez, Lieutenant Commander Data, and Jack McFarland

Preview: Popular culture themes

In this section, you will meet a cast of characters who have reached into our living rooms (and hand-held digital devices) directly from the world of television. Each as unique and different from the others as is humanly possible, these characters of television sitcom and drama have richly storied lives and offer us a glimpse into the fundamental struggles of the adult experience. Now that the troubling and angst-ridden years of childhood and adolescence are well behind them, they face challenges that are anchored firmly in the present but that have significant impact on their futures.

This particular group of characters varies considerably in age, race, culture, and sexual identity. It is important to consider how these different contextual features are represented on television. For instance, the depiction of the elderly has evolved from stubbornness, eccentricity, and comical foolishness to respectability, affluence, wisdom, and clever wit (Bell, 1992); however, the full range of diverse characteristics of this age group has yet to be represented. Similarly, although there is greater diversity in the representation of different racial and ethnic groups in prime-time television, questions remain as to whether the roles and actions of these characters are a fair representation or simply perpetuate stereotypes (Graves, 1999).

Although television comedy is clearly designed for laughs, and dramas centering on crime, police, or the legal system titillate, provoke, and shock us, it is important for counselors to consider whether or not the depictions of mental illness are accurate and fair (Hyler, 1988; Hyler, Gabbard, & Schneider, 1991). And finally, although television shows like Ellen, Will & Grace, Modern Family & and Glee have invited conversations around lesbian, gay, bisexual, and transgender (LGBT) issues (Hart, 2000; Quimby, 2005), here too, we must be careful as counselors and consumers to carefully assess these shows for their potential to misrepresent the homosexual and gay experience as well as to perpetuate prejudicial attitudes.
With regard to the specific characters in this section, Jack Bauer, star of the long-running Fox real-time, action-drama series *24*, has kept audiences riveted to their televisions and on the edge of their seats for 7 years, has won numerous awards, and has challenged us to rethink our beliefs about good and evil. Recently ended, the series promises to film reincarnations, and the character of moral vigilante Jack Bauer has permeated our national consciousness. In our presentation, Jack struggles with Posttraumatic Stress Disorder (PTSD), Bereavement, and Antisocial Personality Features. Through her caustic wit, octogenarian Sophia Petrillo has wrought her brand of truthful terrorism more provincially as one of the stars of television’s *The Golden Girls*. Sophia has endeared herself to audiences of all ages by her willingness to share her perceptions of the world as she sees it. In our presentation, Sophia struggles with Dementia of the Alzheimer’s Type. George Lopez, star of the largely Hispanic-ensemble television show of the same name, helps us to better understand the Mexican American experience through cleverly crafted one-liners and a glimpse into not-so-middle America with a twist. George Lopez went on to briefly host a late night talk show aptly titled *The George Lopez Show*. In our presentation, George struggles with an Adjustment Disorder and Acculturation Problems. Android Lieutenant Commander Data of the Star Trek franchise’s *The Next Generation* perennially wrestles with the same question as Pinocchio and the Velveteen Rabbit—what does it mean to be a “real person”? Originally appearing on all 178 episodes of the acclaimed series, the character of Data has also starred in many of the *Star Trek* movies that followed the ending of the television series. In our presentation, Data struggles with Major Depressive Disorder, Amnestic Disorder, and Identity Problems. And finally, there is Jack McFarland, the way-out-of-the-closet costar of the risqué and risk-taking television show *Will and Grace*. Jack’s flamboyant character gave us an opportunity to reflect on some very serious issues with a laugh thrown in for good measure. Although the character of Jack ended with the show, he continues to open our eyes to issues of social and sexual justice. In our presentation, Jack struggles with Major Depressive Disorder and Attention-Deficit/Hyperactivity Disorder.

The characters in this section have brought us to our knees in laughter, pushed us to our emotional extremes, and given us opportunities to exercise our imaginations. Sophia Petrillo, Jack McFarland, and George Lopez lead everyday lives, much like those of you and me, and for that reason are relatively easy with which to identify. They neither battle international terrorists nor fly through the galaxy in futuristic spacecraft. That is the province of Counter-Terrorism Unit (CTU) special agent Jack Bauer and Starfleet’s Lieutenant Commander Data. Although these characters differ in such fundamental ways, from demography to their television story plots, they also experience very similar internal dramas that are not always funny and that center on mortality, the need for security and safety, the desire for connection—both inside and outside of the family, and answers to basic existential questions such as “Who am I?” “What is the meaning of life?” and “How do I fit into the world?” Jack Bauer, Sophia Petrillo, George Lopez, Lieutenant Commander Data, and Jack McFarland will help you answer many important questions about the human condition and the thin line that separates normalcy and pathology.

**Appraoches to Learning**

As you learn about this group of characters, pay attention to:

- How women with counseling problems are presented on TV compared with men.
- The manner in which the plight of older people and those with age-related declines are depicted in popular media.
- Whether or not racial stereotypes pervade or are reinforced in television sitcoms and dramas.
- The difference between the ways that gender, sexuality, and race are portrayed in popular media, and particularly on television, and in your own clinical and personal experience.
Introducing the Character

Jack Bauer is the central figure in the 20th Century Fox television action/drama series, 24, which first aired in 2001. This series was produced collaboratively by Imagine Entertainment, 20th Century Fox Television, Real Time Productions, and Teakwood Lane Productions. It has been directed by numerous individuals, most prominently Jon Cassar and Brad Turner.

Jack Bauer is a highly intelligent, militarily adept, and fiercely loyal patriot who, from the outset of the series, is depicted as a skilled, persistent, and when necessary, brutally aggressive field agent of the CTU. At the start of each season, Bauer and his comrades are presented with a seemingly impossible challenge that involves thwarting both domestic and international terrorist plots. Doing so (in real-time, and hence the title of the series) brings him in direct contact with those who stop at no cost in order to wreak havoc and chaos on organized society and to bring death to as many innocent victims as possible. Although surrounded by a team of highly effective tacticians, technophiles, and warriors, it is Bauer who always seems to be the ultimate point-person in a heart pounding, countdown race to stave off biological, chemical, and nuclear Armageddon.

Over the course of Bauer’s relationship with CTU, we see a man capable of seemingly limitless pain tolerance, physical endurance, and capacity to emotionally distance himself from all around him in order to complete his missions. Although revered by his fiercely loyal colleagues and trusted by presidents with the fate of the nation, Bauer is nevertheless persecuted by the “moral majority” who argue that the pursuit of liberty and safeguarding freedom from harm do not justify the use of violence and torture—both of which are powerful social and political issues in today’s real world. Thus, he is often a target of the mainstream military and the political Right, and as such, can be truly effective only as a rogue agent who is ultimately disaffected and disdained by those who rely upon him. He suffers his losses silently, and in spite of ongoing efforts to lead a “normal” life, which includes a relationship with his daughter Kim, he is bitter, alienated, and tragically alone. The following basic case summary and diagnostic impressions describe what we portray as Jack’s clinically significant negative reactions to his exposure to traumatic events in which he is subjected to threats of capture, serious injury, and death.

Meet the Client

You can assess the client in action by viewing clips of Jack Bauer’s video material at the following websites:

- http://www.youtube.com/watch?v=5CJ8OIdIrj0 A day in the life of Jack Bauer
- http://www.youtube.com/watch?v=kBzwPvaBYWE Jack at work

Basic Case Summary

Identifying Information. Jack Bauer is a 43-year-old white male who works as a field agent for a covert governmental paramilitary agency through which he is regularly involved in life-threatening, high-stakes missions. Mr. Bauer was casually attired and unshaven, and appeared visibly fatigued, irritable, and impatient throughout the assessment.

Presenting Concern. Mr. Bauer was mandated to attend counseling by his superior, Bill Buchanan, who was concerned with what he described as his agent’s “volatility, emotional exhaustion, and imminent burnout.” On further inquiry, Buchanan said he noticed that since his last mission several months ago, Jack Bauer seemed “different.” In this context, Mr. Buchanan noted that his agent had begun to
drive out of his way to avoid the scene of his last capture and torture, to leave meetings when the capture topic was brought up, seemed less able to rally his subordinates, and instead spends most of his work time in his private office. Buchanan said “I’ve seen this before. I’ll bet he’s having nightmares, too, but you’d never get him to admit it!”

By comparison, Mr. Bauer denied that his behavior has changed and indicated that he was “more than capable” of handling job stress, the losses he has experienced in the course of his duties, and that he did not need to “see a shrink!” Noting that exhaustion, physical and emotional stress, exposure to threats, and loss were a routine part of his job description, Mr. Bauer added that he “just needed to rest.”

**Background, Family Information, and Relevant History:** Jack Bauer was born in Santa Monica, California, the older of two children to parents who separated during his early infancy. Mr. Bauer and his brother Graem were raised by their father, Phillip, an industrialist who believed in corporal punishment, absolute obedience to authority, and fostering competitiveness between the siblings, who Mr. Bauer reports did not get along. Mr. Bauer was a highly competitive and successful athlete during his formative years. He described himself as somewhat of a loner who reached out very selectively to others, but only minimally to his father, with whom he had a distant relationship. He had no contact with his mother after the marital dissolution. Following his graduation from the University of California, Los Angeles (UCLA), Mr. Bauer married Terri, with whom he had a daughter, Kim. Prior to completing his master’s degree in criminology and law from the University of California, Berkeley, Mr. Bauer entered the military. Military records indicate that as a military professional he revealed a cadre of skills and abilities that quickly propelled him through the ranks and into a series of covert affiliations and operations. Success in the field garnered him great respect and the reputation of being a fiercely intelligent, yet lethal combatant who stopped at nothing to accomplish his missions. Over the past several years, Mr. Bauer has experienced several significant life stressors, including directly witnessing the death of his wife at the hands of a formerly trusted coworker; becoming alienated from his daughter, who, he admits found it impossible to maintain a relationship with him; and developing a growing distrust of anyone around him for fear that he would be betrayed. In the course of his services, Mr. Bauer has also lost numerous colleagues, experienced betrayal, and been confronted by a deep sense of guilt over his inability to save the President of the United States, David Palmer, from assassination. Mr. Bauer has submitted to annual mandatory evaluations by CTU staff psychologists who have consistently recommended, but have never mandated, ongoing counseling.

**Problem and Counseling History:** From the outset of the meeting, Mr. Bauer made it quite clear that he was not interested in counseling and was only “following orders.” He offered little eye contact, spontaneous information, and only the briefest of responses to questions, particularly those aimed at discerning feelings about himself, the job, and the losses he has encountered. Mr. Bauer was oriented in all spheres, seemingly had intact memory for both remote and recent events, and was capable of expressing himself articulately when interested in doing so. His anger at being mandatorily referred was palpable as was his seeming willingness to say whatever needed to be said in order to convince the examiner that he was “alright.” At times, he expressed himself through expletives when it seemed that he was not being understood by the examiner. Mr. Bauer described himself as a historically self-reliant individualist who has learned the hard way that it is wise neither to trust nor get close to others.

Mr. Bauer described difficulties falling and remaining asleep, graphic and disruptive dreams in which he failed to protect loved ones from harm, as well as occasional and seemingly random intrusive and similarly themed images during his waking hours. Although he expressed a deep commitment to the importance of his work,
he also expressed remorse over the job-related losses, including his wife, Terri, at which time he quickly choked back tears. He did admit that “sometimes I just don’t care what the future holds. Who cares about tomorrow when yesterday and today sometimes are so bad?” When the subject of his last mission was introduced, he first said he could not recall anything special about it, and then quickly changed the topic.

Mr. Bauer endorsed no regrets for the multitude of job-related killings he has committed nor did he question the morality of his behavior. However, he wondered aloud if a “normal” relationship with his daughter would ever be possible or if he would ever be able to enjoy a bond with his newly born grandson, Trevor. At that point in the interview, Mr. Bauer’s cell phone rang and he indicated the need to quickly depart.

Goals for Counseling and Course of Therapy to Date. In a brief follow-up webcam conversation from an undisclosed location, Mr. Bauer indicated that he was appreciative of the time spent during the interview and that he “got enough out of it to hold me over.” He denied having significant bereavement issues or feelings of depression or anxiety, but did express an interest in making his sleep more efficient and eliminating both the nightmares and intrusive memories that “get in the way of doing my job.” In that context, he expressed concern that some of his current symptoms could lead to his forcible retirement from active duty.

Mr. Bauer agreed to return for a follow-up interview pending his next assignment, which he hoped would be a domestic one. The primary goals of the follow-up interview will be (a) to confirm clinically significant symptoms of PTSD in the areas of re-experiencing the trauma, avoidance of traumatic stimuli, and increased arousal; and (b) improve Mr. Bauer’s motivation for counseling to address these issues and issues and grief and loss.

<table>
<thead>
<tr>
<th>Diagnostic Impressions</th>
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<tbody>
<tr>
<td><strong>Axis I.</strong> 309.81 Posttraumatic Stress Disorder, Chronic</td>
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<tr>
<td>V62.82 Bereavement</td>
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<tr>
<td><strong>Axis II.</strong> Antisocial Personality Disorder Features</td>
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<tr>
<td><strong>Axis III.</strong> None</td>
</tr>
<tr>
<td><strong>Axis IV.</strong> Problems with primary support group—Death of wife, discord with daughter</td>
</tr>
<tr>
<td>Occupational problems—Difficult work conditions, severe job stress</td>
</tr>
<tr>
<td><strong>Axis V.</strong> GAF = 60 (at evaluation)</td>
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<tr>
<td>GAF = 70 (highest level past year)</td>
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**Discussion of Diagnostic Impressions**

Jack Bauer was mandated to counseling by his superior based on concerns that he was showing signs of burnout that had become more noticeable since his last paramilitary assignment. His superior officer was concerned that he was avoiding the locations near the scene of his most recent mission as well as his recent mission as a topic of conversation; was having nightmares in which he re-experienced
aspects of the mission; and appeared fatigued. Jack Bauer disclosed that he did, in fact, have difficulties maintaining sleep; and had nightmares and, occasionally, waking images of his traumatic experiences. During the interview, he displayed angry outbursts and expressed a lack of aspirations for the future. As discussed in the case, he recently experienced paramilitary capture and torture. Previously he experienced many events during which he, someone for whom he was professionally responsible, or his wife, was in danger or actually killed.

The predominant feature shared by all of the diagnosable conditions found in the Anxiety Disorders section of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* is the presence of increased arousal, excessive worry, or other signs of anxiety that cause distress or impairment, including panic. Among these are Acute Stress Disorder and PTSD, both of which, by definition, occur only in the aftermath of or as a result of a traumatic life event. This case describes what we portray as Jack Bauer’s clinically significant negative reactions to his exposure to the traumatic experiences of capture, serious injury, and threat of death.

Mr. Bauer experienced an event characterized by threat to his physical integrity (he was held against his will), subjected to painful torture and physical injury, and threatened with serious physical damage or possibly death. His reactions included horror. These characteristics meet the *DSM-IV-TR* definition of a traumatic event. Following the most recent of these events, he has been re-experiencing the event during nightmares and waking flashbacks. He has been avoiding places (the site near the capture and torture of his most recent mission) reminiscent of the event and avoiding the topic, and he talks about the future without his lost wife in a foreshortened manner. He has signs of anxiety, including sleep disruption and angry outbursts. According to the case timeline, Mr. Bauer’s symptoms have been present for several months. These factors indicate a diagnosis of PTSD. Because symptoms have persisted more than 3 months, the specifier, Chronic, is warranted.

Differential diagnoses might include Acute Stress Disorder and Adjustment Disorder. However, Acute Stress Disorder allows for a maximum duration of symptoms of 1 month, whereas PTSD fits when symptoms have lasted beyond 4 weeks. Whereas Adjustment Disorders are negative reactions to any sort of life stressors, in this case, Mr. Bauer has experienced exposure to multiple extreme stressors meeting the diagnostic definition of trauma, and his reactions conform to the specific constellation of symptoms characteristic of PTSD and Acute Stress Disorder, which go beyond the general criteria set for Adjustment Disorder.

On Axis II, problematic personality disorder features and defenses can be listed even when they do not reflect a diagnosable Personality Disorder, if these personality characteristics are important to understanding the client’s functioning and are maladaptive for the person. We provided the notation, Antisocial Personality Disorder Features, to describe aspects of Mr. Bauer’s pattern of behavior characterized by “reckless disregard for safety of self” and “disregard for, and violation of, the rights of others” (APA, 2000a, p. 706).

Further, along with all the various diagnosable disorders, a multiaxial diagnosis also lists Other Conditions That May Be a Focus of Clinical Attention. The client concerns contained in this section (appearing at the end of the *DSM-IV-TR*, following all of the diagnosable disorders) are not diagnosable mental disorders according to the *DSM* classification system; instead, they sometimes are client problems that are a focus of counseling but not a part of the individual’s diagnosable mental disorder. Mr. Bauer’s grief reactions, or Bereavement, are in this category.

To wrap up the diagnosis, Jack Bauer’s important family and occupational psychosocial stressors are emphasized on Axis IV, and on Axis V his functioning is represented by GAF...
scores indicating, at present, moderately serious symptoms that are causing moderate impairment in social and occupational functioning, and earlier in the year, functioning characterized by mild symptoms and some difficulties in social and occupational functioning. The information on these axes is consistent with the diagnostic information on Axes I and II describing Jack Bauer’s situation.

**CASE CONCEPTUALIZATION**

The counselor who met Jack Bauer for his mandated evaluation collected as much information as possible about the problems for which he was referred. Mr. Bauer’s counselor first used this information to develop diagnostic impressions. His concerns were described by PTSD and Bereavement, along with Antisocial Personality Features. Next, his counselor developed a case conceptualization. Whereas the purpose of diagnostic impressions is to describe the client’s concerns, the goal of case conceptualization is to better understand and clinically explain the person’s experiences (Neukrug & Schwitzer, 2006). It helps the counselor understand the etiology leading to Jack Bauer’s posttraumatic concerns and the factors maintaining these. In turn, case conceptualization sets the stage for treatment planning. Treatment planning then provides a road map that plots out how the counselor and client expect to move from presenting concerns to positive outcomes (Seligman, 1993, p. 157)—ideally, assisting Jack to reduce or eliminate the problematic trauma reactions and related concerns that led to his referral.

When forming a case conceptualization, the clinician applies a purist counseling theory, an integration of two or more theories, an eclectic mix of theories, or a solution-focused combination of tactics to his or her understanding of the client. In this case, Mr. Bauer’s counselor based his conceptualization on a purist theory, Cognitive Behavior Therapy. He selected this approach based on his knowledge of current outcome research with clients experiencing PTSD and related symptoms (Bradley, Greene, Russ, Dutra, & Westen, 2005; Bryant et al., 2008; Foa & Keane, 2000). Cognitive Behavior Therapy also is consistent with this counselor’s professional therapeutic viewpoint.

The counselor used the Inverted Pyramid Method of case conceptualization because this method is especially designed to help clinicians more easily form their conceptual pictures of their clients’ needs (Neukrug & Schwitzer, 2006; Schwitzer, 1996, 1997). The method has four steps: Problem Identification, Thematic Groupings, Theoretical Inferences, and Narrowed Inferences. The counselor’s clinical thinking can be seen in Figure 10.1.

**Step 1: Problem Identification.** The first step is Problem Identification. Aspects of the presenting problem (thoughts, feelings, behaviors, physiological features), additional areas of concern besides the presenting concern, family and developmental history, in-session observations, clinical inquiries (medical problems, medications, past counseling, substance use, suicidality), and psychological assessments (problem checklists, personality inventories, mental status exam, specific clinical measures) all may contribute information at Step 1. The counselor “casts a wide net” in order to build Step 1 as exhaustively as possible (Neukrug & Schwitzer, 2006, p. 202). As can be seen in Figure 10.1, the counselor collected clinical data about Jack Bauer’s trauma events (death of wife, death of colleagues, torture), anxiety symptoms (poor sleep, startle reactions), re-experiencing symptoms (nightmares, etc.), avoiding behaviors, feelings of grief and loss and regret, anger and hostility, suspicion and disregard for others, and history with a strongly authoritarian father. His counselor collected as much detail as possible about Mr. Bauer’s posttraumatic symptoms—and went further to assess related concerns such as his antisocial personality features, bereavement, and daughter relationship, as well as relevant history pertaining to his development experiences with his father.
Step 2: Thematic Groupings. The second step is Thematic Groupings. The clinician organizes all of the exhaustive client information found in Step 1 into just a few intuitive-logical clinical groups, categories, or themes, on the basis of sensible common denominators (Neukrug & Schwitzer, 2006). Four different ways of forming the Step 2 theme groups can be used: Descriptive-Diagnosis Approach, Clinical Targets Approach, Areas of Dysfunction Approach, and Intrapsychic Approach. As can be seen in Figure 10.1, Jack Bauer’s counselor selected the Descriptive-Diagnosis Approach. This approach sorts together all of the various Step 1 information about the client’s adjustment, development, distress, or dysfunction “to show larger clinical problems as reflected through a diagnosis” (Neukrug & Schwitzer, 2006, p. 205).

The counselor grouped together Mr. Bauer’s (a) trauma experiences and various symptoms of anxiety, avoidance, and re-experiencing into the theme of “PTSD”; (b) feelings of grief and loss, teariness, and blame and regret regarding his wife’s death into the theme of “bereavement”; and (c) his anger, suspicion, alienation, disregard, and violation regarding self and others into the theme, “antisocial thoughts, feelings, and behaviors.” His conceptual work at Step 2 gave the counselor a way to begin understanding and thinking about Mr. Bauer’s areas of functioning and areas of concern more clearly and meaningfully.

So far, at Steps 1 and 2, the counselor has used his clinical assessment skills and his clinical judgment to begin meaningfully understanding Jack Bauer’s needs. Now, at Steps 3 and 4, he applies the theoretical approach he has selected. He begins making theoretical inferences to interpret and explain the processes or roots underlying Jack Bauer’s concerns as they are seen in Steps 1 and 2.

Step 3: Theoretical Inferences. At Step 3, concepts from the counselor’s selected theory, Cognitive Behavior Therapy, are applied to explain the experiences fueling, and the mechanisms maintaining, Mr. Bauer’s problematic thoughts, feelings, and behaviors. The counselor tentatively matches the theme groups in Step 2 with this theoretical approach. In other words, the symptom constellations in Step 2, which were distilled from the symptoms in Step 1, now are combined using theory to show what is believed to be the psychological etiology of Mr. Bauer’s current needs (Neukrug & Schwitzer, 2006; Schwitzer, 2006, 2007).

According to Cognitive Behavior Therapy (Beck, 1995, 2005; Ellis, 1994; Ellis & MacLaren, 2005), irrational thinking, faulty beliefs, or other forms of cognitive errors lead individuals to engage in problematic behaviors and to experience negative moods and attitudes. As can be seen in Figure 10.1, when the counselor applied these Cognitive Behavior Therapy concepts, he explained at Step 3 that the various issues noted in Step 1 (witnessing trauma, avoiding and re-experiencing, anxiety, grief feelings, anger and suspicion, etc.), which can be understood to be themes of (a) PTSD, (b) bereavement, and (c) antisocial features (Step 2), are rooted in or caused by a collection of faculty beliefs that it is better to “just live with” these negative symptoms, avoid confronting his traumatic history, and avoid confronting his guilt and grief—and that all people must be regarded with suspicion and attack. These faulty beliefs are fully spelled out in Figure 10.1.

Step 4: Narrowed Inferences. At Step 4, the clinician’s selected theory continues to be used to address still-deeper issues when they exist (Schwitzer, 2006, 2007). At this step, “still-deeper, more encompassing, or more central, causal themes” are formed (Neukrug & Schwitzer, 2006, p. 207). Continuing to apply Cognitive Behavior Therapy concepts at Step 4, Mr. Bauer’s counselor presented a single, deepest, most-fundamental cognitive error, which he believed to be most explanatory and causal regarding Mr. Bauer’s current psychotherapeutic needs: the deepest faulty core belief that “I am a man and therefore responsible to serve and protect with disregard for my own feelings, relationships, or safety—and any other attitude shows
Figure 10.1  Jack Bauer’s Inverted Pyramid Case Conceptualization Summary: Cognitive Behavior Therapy

1. IDENTIFY AND LIST CLIENT CONCERNS

<table>
<thead>
<tr>
<th>Concern</th>
<th>Reaction</th>
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<tbody>
<tr>
<td>Witnessed death of wife</td>
<td>Feelings of grief and loss</td>
</tr>
<tr>
<td>Witnessed death of colleagues</td>
<td>Teariness about loss of wife</td>
</tr>
<tr>
<td>Victim of torture</td>
<td>Self-blame</td>
</tr>
<tr>
<td>Victim of additional traumas</td>
<td>Anger toward others</td>
</tr>
<tr>
<td>Sleep difficulties</td>
<td>Suspicion of others</td>
</tr>
<tr>
<td>Fatigued</td>
<td>Alienated from daughter</td>
</tr>
<tr>
<td>Easily startled or angered</td>
<td>Reckless disregard for safety of self</td>
</tr>
<tr>
<td>Angry/hostile in session</td>
<td>Disregard for, violation of, others’ rights</td>
</tr>
<tr>
<td>Cursing in session</td>
<td>Highly authoritarian father</td>
</tr>
<tr>
<td>Avoids trauma in conversation</td>
<td>Strong sense of duty</td>
</tr>
<tr>
<td>Inability to recall trauma</td>
<td>Strong competitiveness</td>
</tr>
<tr>
<td>Waking flashbacks</td>
<td></td>
</tr>
<tr>
<td>Nightmares</td>
<td></td>
</tr>
<tr>
<td>Graphic dreams of regret at failing to protect</td>
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2. ORGANIZE CONCERNS INTO LOGICAL THEMATIC GROUPINGS

1. Posttraumatic stress disorder (trauma, re-experiencing, avoiding, anxiety)
2. Bereavement
3. Antisocial thoughts, feelings, and behaviors

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

Faulty Beliefs

1. It is better to just live with the anxiety symptoms, re-experiencing of events, and other effects than it is to confront my reactions to trauma.
2. It is better to avoid thinking about my traumas than to confront them.
3. It is better to avoid my guilt about putting my wife in danger than to confront my grief.
4. All other people are potentially dangerous so I must be suspicious and ready to attack first in all circumstances.

4. NARROWED INFERENCE: SUICIDALITY AND DEEPER DIFFICULTIES

Deepest Faulty Core Belief

I learned that I am a man and therefore responsible to serve and protect with disregard for my own feelings, relationships, or safety. Any other attitude shows unmasculine weakness and therefore means I am a complete failure as a man, a person, a father and husband, and a professional.
unmasculine weakness and therefore would mean that I am a complete failure as a man, a person, a father and husband, and professional” (see Figure 10.1). When all four steps are completed, the client information in Step 1 leads to logical-intuitive groupings on the basis of common denominators in Step 2, the groupings then are explained using theory at Step 3, and then, finally, at Step 4, further deeper explanations are made. From start to finish, the thoughts, feelings, behaviors, and physiological features in the topmost portions are connected on down the pyramid into deepest dynamics.

The completed pyramid now is used to plan treatment, during which Mr. Bauer and his counselor will attempt to resolve his faulty core beliefs and to improve his overall functioning.

**Treatment Planning**

At this point, Mr. Bauer’s clinician at the CTU Covert Counseling Center (CTUCCC) has collected all available information about the problems that have been of concern to him and his supervisor. Based upon this information, the counselor developed a five-axis DSM-IV-TR diagnosis and then, using the “inverted pyramid” (Neukrug & Schwitzer, 2006; Schwitzer, 1996, 1997), formulated a working clinical explanation of Mr. Bauer’s difficulties and their etiology that we called the case conceptualization. This, in turn, guides us to the next critical step in our clinical work, called the treatment plan, the primary purpose of which is to map out a logical and goal-oriented strategy for making positive changes in the client’s life. In essence, the treatment plan is a road map “for reducing or eliminating disruptive symptoms that are impeding the client’s ability to reach positive mental health outcomes” (Neukrug & Schwitzer, 2006, p. 225). As such, it is the cornerstone of our work with not only Mr. Bauer, but with all clients who present with disturbing and disruptive symptoms and/or personality patterns (Jongsma & Peterson, 2006; Jongsma, Peterson, & McInnis, 2003a, 2003b; Seligman, 1993, 1998, 2004).

A comprehensive treatment plan must integrate all of the information from the biopsychosocial interview, diagnosis, and case conceptualization into a coherent plan of action. This plan comprises four main components, which include (2) a behavioral definition of the problem(s), (2) the selection of achievable goals, (3) the determination of treatment modes, and (4) the documentation of how change will be measured. The behavioral definition of the problem(s) consolidates the results of the case conceptualization into a concise hierarchical list of problems and concerns that will be the focus of treatment. The selection of achievable goals refers to assessing and prioritizing the client’s concerns into a hierarchy of urgency that also takes into account the client’s motivation for change, level of dysfunction, and real-world influences on his or her problems. The determination of treatment modes refers to selection of the specific interventions, which are matched to the uniqueness of the client and to his or her goals and clearly tied to a particular theoretical orientation (Neukrug & Schwitzer, 2006). Finally, the clinician must establish how change will be measured, based upon a number of factors including client records and self-report of change, in-session observations by the clinician, clinician ratings, results of standardized evaluations such as the Beck Depression Inventory (Beck, Steer, & Brown, 1996), or a family functioning questionnaire, pre-post treatment comparisons, and reports by other treating professionals.

The four-step method discussed above can be seen in Figure 6.1 (p. 109) and is outlined below for the case of Jack Bauer, followed by his specific treatment plan.

**Step 1: Behavioral Definition of Problems.** The first step in treatment planning is to carefully review the case conceptualization, paying particular attention to the results of Step 2 (Thematic Groupings), Step 3 (Theoretical Inferences), and Step 4 (Narrowed Inferences). The identified clinical themes reflect the core areas of concern and distress for the client, while the theoretical and narrowed inferences offer clinical speculation as to their origins. In the case of Jack, there are three primary areas of concern. The first, “posttraumatic stress disorder,” refers to the
psychological effects of torture and witnessing the death of his wife and colleagues, including waking flashbacks, nightmares, avoidance of and general inability to recall trauma-related memories. The second, “bereavement,” refers to feelings of grief and loss, teariness about his wife, and self-blame, along with sleep difficulties, fatigue, and being easily startled. The third, “antisocial thoughts, feelings and behaviors,” refers to his anger, suspicion, and violence toward others along with his reckless disregard for his and others’ safety and rights. These symptoms and stresses are consistent with the diagnosis of PTSD and Antisocial Personality Features and Bereavement (APA, 2000a; Bradley et al., 2005; Critchfield & Smith-Benjamin, 2006).

Step 2: Identify and Articulate Goals for Change. The second step is the selection of achievable goals, which is based upon a number of factors, including the most pressing or urgent behavioral, emotional, and interpersonal concerns and symptoms as identified by the client and clinician, the willingness and ability of the client to work on those particular goals, and the realistic (real-world) achievability of those goals (Neukrug & Schwitzer, 2006). At this stage of treatment planning, it is important to recognize that not all of the client’s problems can be addressed at once, so we focus initially on those that cause the greatest distress and impairment. New goals can be created as old ones are achieved. In the case of Mr. Bauer, the goals are divided into three prominent areas. The first, “posttraumatic stress disorder,” requires that we help Mr. Bauer to relieve the symptoms of posttraumatic stress and verbalize an understanding of how these symptoms develop. The second, “bereavement,” requires that we help him to appropriately grieve his losses and improve his overall daily functioning. The third, “antisocial thoughts, feelings and behaviors,” requires that we help Mr. Bauer to resolve his negative perceptions of and reactions to other people, eliminate his antisocial urges and behavior, and resolve his thoughts about conspiracy theories.

Step 3: Describe Therapeutic Intervention. This is perhaps the most critical step in the treatment planning process because the clinician must now integrate information from a number of sources, including the case conceptualization, the delineation of the client’s problems and goals, and the treatment literature, paying particular attention to empirically supported treatment (EST) and evidence-based practice (EBP). In essence, the clinician must align his or her treatment approach with scientific evidence from the fields of counseling and psychotherapy. Wampold (2001) identifies two types of evidence-based counseling research: studies that demonstrate “absolute efficacy,” that is, the fact that counseling and psychotherapy work, and those that demonstrate “relative efficacy,” that is, the fact that certain theoretical/technical approaches work best for certain clients with particular problems (Psychoanalysis, Gestalt Therapy, Cognitive Behavior Therapy, Brief Solution-Focused Therapy, Cognitive Therapy, Dialectical Behavior Therapy, Person-Centered Therapy, Expressive/Creative Therapies, Interpersonal Therapy, and Feminist Therapy); and when delivered through specific treatment modalities (individual, group, and family counseling). In the case of Mr. Bauer, we have decided to use Cognitive Behavior Therapy (Beck, 1995, 2005; Ellis, 1994; Ellis & MacLaren, 2005), which has been found to be highly effective in counseling and psychotherapy with adults who experience the symptoms of PTSD (Bradley et al., 2005; Bryant et al., 2008). The approach relies on a variety of cognitive techniques (reframing, challenging irrational thoughts, and cognitive restructuring) and behavioral techniques (reinforcement for and shaping of adaptive behavior, extinction of maladaptive behaviors, systematic desensitization, and exposure with response prevention) (Ball et al., 2006; Frank et al., 2005; Milkowitz, 2008). Additionally, Mr. Bauer will undergo a course of eye movement desensitization and reprocessing (EMDR), which has been found to be particularly useful in addressing the physiological and emotional symptoms of post-traumatic stress (Shapiro, 2002, 2005). Mr. Bauer’s grief and loss issues will be addressed through an eclectic variety of empirically supported techniques, including narrative remembering, cognitive restructuring, and group bereavement counseling (Bradley et al., 2005; Bryant et al., 2008; Neimeyer, 2000; Servaty-Seib,
2004; White, 2007), while his antisocial attitudes and behaviors will be addressed through cognitive restructuring.

**Step 4: Provide Outcome Measures of Change.** This last step in treatment planning requires that we specify how change will be measured and indicate the extent to which progress has been made toward realizing these goals (Neukrug & Schwitzer, 2006). The counselor has considerable flexibility in this phase, and may choose from a number of objective domains (psychological tests and measures of self-esteem, depression, psychosis, interpersonal relationship, anxiety, etc.), quasi-objective measures (the DSM-IV-TR’s Axis V GAF scale; pre-post clinician, client, and psychiatric ratings), and subjective ratings (client self-report, clinician’s in-session observations). In Mr. Bauer’s case, we have implemented a number of these, including pre-post measures on the Clinical Anger Scale (Snell, Gum, Shuck, Mosley, & Hite, 1995), post measures of GAF functioning in the mild range (>70), clinician observation of prosocial attitudes and behavior, and acceptance of losses with reduced guilt over them.

The completed treatment plan is now developed through which the counselor and Mr. Bauer will work through the traumatic loss of his wife and colleagues and develop and implement plans for eliminating his antisocial thoughts, feelings, and behaviors. Jack Bauer’s treatment plan follows and is summarized in Table 10.1.

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### TREATMENT PLAN

**Client:** Jack Bauer

**Service Provider:** CTU Covert Counseling Center (CTUCCC)

**Behavioral Definition of Problems:**

1. *PTSD*—Psychological effects of torture and witnessing the death of his wife and colleagues, including waking flashbacks, nightmares, avoidance of and inability to recall trauma-related memories

2. *Bereavement*—Feelings of grief and loss, teariness about his wife and self-blame, along with sleep difficulties, fatigue, and being easily startled

3. *Antisocial thoughts, feelings, and actions*—Anger, suspicion, and violence toward others along with his reckless disregard for his and others’ safety and rights

**Goals for Change:**

1. *PTSD*
   - Relieve the symptoms of posttraumatic stress
   - Verbalize an understanding of how the symptoms of PTSD develop

2. *Bereavement*
   - Appropriately grieve the losses of his wife and colleagues
   - Improvement in overall daily functioning and mood
3. Antisocial thoughts, feelings, and actions
   - Resolve negative perceptions of and reactions to other people
   - Understand the relationship between his negative feelings about herself and toward others
   - Eliminate antisocial behavior
   - Resolve thoughts about conspiracy theories

THERAPEUTIC INTERVENTIONS:
A moderate-term course of individual Cognitive Behavior Therapy, including EMDR along with bereavement counseling (6–9 months)

1. PTSD
   - Participate in imaginal and in vivo exposure with response prevention to elements of traumatic events
   - Practice thought-stopping for unwanted and intrusive recollections
   - Modify irrational thoughts about the trauma and his perceived role
   - Learn skills of EMDR to reduce emotional and physiological reactivity to trauma recollections
   - Participation in trauma-focused group therapy, including relaxation training
   - Discuss and implement relapse strategies for PTSD symptoms

2. Bereavement
   - Understand the stages of bereavement
   - Verbalize feelings and thoughts related to losses
   - Refute irrational beliefs and guilt about his role in the loss
   - Use narrative remembering techniques to maintain healthy connection to lost loved ones
   - Attendance in bereavement group
   - Bibliotherapy for grief and loss issues

3. Antisocial thoughts, feelings, and actions
   - Identify and understand origin of “injustice schema” and its effects on his interpersonal functioning
   - Explore history of antisocial behavior and its effects on his self-image and relationships
   - Plan for restitution to known victims
   - Practice trusting others through disclosure of personal feelings of vulnerabilities

OUTCOME MEASURES OF CHANGE:
The resolution of his posttraumatic stress symptoms, improved overall mood, reconciliation of losses, elimination of antisocial thoughts, feelings, and actions, and overall improved adjustment and functioning in his daily life as measured by:

- Client report of improved overall daily functioning, including sleep, appetite, and energy level
- Pre-post improvement on the Clinical Anger Scale (CAS)
- Post measures of GAF functioning in the mild (>70) range
- Client report and clinician observation of reduced antisocial thoughts and attitudes
- Clinician observation and client report of prosocial thoughts and behavior
- Absence of arrests for antisocial behavior and illegal acts for a period of 1 year
- Clinician observation of improved mood, accompanied by reduced guilt over losses
Table 10.1  Jack Bauer’s Treatment Plan Summary: Cognitive Behavior Therapy

<table>
<thead>
<tr>
<th>Goals for Change</th>
<th>Therapeutic Interventions</th>
<th>Outcome Measures of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PTSD</strong></td>
<td><strong>PTSD</strong></td>
<td><strong>The resolution of his posttraumatic stress symptoms,</strong> <strong>improved overall mood,</strong> <strong>reconciliation of losses,</strong> <strong>elimination of antisocial thoughts, feelings, and actions,</strong> <strong>and overall improved adjustment and functioning in his daily life as measured by:</strong></td>
</tr>
<tr>
<td>Relieve the symptoms of posttraumatic stress</td>
<td>Participate in imaginal and in vivo exposure with response prevention to elements of traumatic events</td>
<td>Client report of improved overall daily functioning, including sleep, appetite, and energy level</td>
</tr>
<tr>
<td>Verbalize an understanding of how the symptoms of PTSD develop</td>
<td>Practice thought-stopping for unwanted and intrusive recollections</td>
<td>Pre-post improvement on the Clinical Anger Scale (CAS)</td>
</tr>
<tr>
<td>Bereavement</td>
<td>Modify irrational thoughts about the trauma and his perceived role</td>
<td>Post measures of GAF functioning in the mild (&gt;70) range</td>
</tr>
<tr>
<td>Appropriately grieve the losses of his wife and colleagues</td>
<td>Learn skills of EMDR to reduce emotional and physiological reactivity to trauma recollections</td>
<td>Client report and clinician observation of reduced antisocial thoughts and attitudes</td>
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<tr>
<td>Improvement in overall daily functioning and mood</td>
<td>Participation in trauma-focused group therapy, including relaxation training</td>
<td>Clinician observation and client report of prosocial thoughts and behavior</td>
</tr>
<tr>
<td><strong>Antisocial thoughts, feelings, and actions</strong></td>
<td>Discuss and implement relapse strategies for PTSD symptoms</td>
<td>Absence of arrests for antisocial behavior and illegal acts for a period of 1 year</td>
</tr>
<tr>
<td>Resolve negative perceptions of and reactions to other people</td>
<td><strong>Bereavement</strong></td>
<td>Clinician observation of improved mood, accompanied by reduced guilt over losses</td>
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<td>Understand the relationship between his negative feelings about himself and toward others</td>
<td>Understand the stages of bereavement</td>
<td></td>
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<tr>
<td>Eliminate antisocial behavior</td>
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