Evaluation of a multi-modal treatment approach for adjudicated youth

Jennifer K. Swingle
Rowan University

Let us know how access to this document benefits you - share your thoughts on our feedback form.

Follow this and additional works at: https://rdw.rowan.edu/etd
Part of the Psychology Commons

Recommended Citation
https://rdw.rowan.edu/etd/1243

This Thesis is brought to you for free and open access by Rowan Digital Works. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of Rowan Digital Works. For more information, please contact LibraryTheses@rowan.edu.
EVALUATION OF A MULTI-MODAL TREATMENT APPROACH FOR ADJUDICATED YOUTH

by

Jennifer K. Swingle

A Thesis
Submitted in partial fulfillment of the requirements of the Master of Arts Degree of The Graduate School at Rowan University
May 1, 2004

Approved by ___________________________

Date Approved 5/4/04

© 2004 Jennifer K. Swingle
MINI ABSTRACT

Jennifer K. Swingle
EVALUATION OF A MULTI-MODAL TREATMENT APPROACH FOR
ADJUDICATED YOUTH
2003/04
Dr. Janet Cahill
Master of Arts in Mental Health Counseling

The purpose of this study was to investigate the effectiveness of multi-modal treatment on an adolescent with comorbid mental disorders in residential treatment using a case study. The results of this study suggests that using the multi-modal approach, the client made significant improvements in levels of depression and aggression.
ABSTRACT

Jennifer K. Swingle
EVALUATION OF A MULTI-MODAL TREATMENT APPROACH FOR
ADJUDICATED YOUTH
2003/04
Dr. Janet Cahill
Master of Arts in Applied Psychology

The purpose of this case study was to examine the effectiveness of multi-modal treatment on an adolescent with comorbid mental disorders in residential treatment using a case study format. The subject of this study was a 16-year-old girl who suffers from Reactive Attachment Disorder, Conduct Disorder and Borderline Personality Disorder as well as multiple traumatic incidents in her childhood. For the purpose of this study, she was seen over a nine-month period. Major emphasis was on reducing aggression and depression and on increasing client participation in treatment. Depression and maladjustment were pre-tested and post-tested using the Beck Depression Inventory II and the Behavior Assessment System for Children. The Minnesota Multiphasic Personality Inventory-Adolescent and the Trauma Symptom Checklist were used pre-treatment to assess specific areas of psychopathology. Overall, the self-report questionnaires concluded that extreme caution must be used in interpreting the results, but that the client made improvements post treatment.
ACKNOWLEDGEMENTS

I would like to thank Dr. Cahill for her dedication and kindhearted spirit throughout the writing of this thesis. Without her cooperation this thesis would not have been possible. I would also like to thank Dr. Yurak for helping with the tedious task of revising this paper.

A special thanks goes to my family and fiancé for all their encouragement and support throughout my education.

Finally, I would like to thank the subject who not only participated in this study, and openly shared her experience, but also taught me about bravery and candor.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter I</td>
<td>Psychosocial Assessment</td>
<td>1</td>
</tr>
<tr>
<td>Chapter II</td>
<td>Review of other Assessments</td>
<td>22</td>
</tr>
<tr>
<td>Chapter III</td>
<td>Differential Diagnosis</td>
<td>26</td>
</tr>
<tr>
<td>Chapter IV</td>
<td>Literature Review</td>
<td>33</td>
</tr>
<tr>
<td>Chapter V</td>
<td>Normative Practice and Outcomes</td>
<td>48</td>
</tr>
<tr>
<td>Chapter VI</td>
<td>Outcomes</td>
<td>60</td>
</tr>
<tr>
<td>Chapter VII</td>
<td>Comparison of Best and Practice Normative Practice</td>
<td>65</td>
</tr>
<tr>
<td>Chapter VIII</td>
<td>Summary and Conclusions</td>
<td>69</td>
</tr>
<tr>
<td>Chapter IX</td>
<td>References</td>
<td>70</td>
</tr>
</tbody>
</table>
Chapter 1

Psychosocial Assessment

Presenting Problem

According to the Client

Lady X, a 16-year-old African American girl, states that her current problem is that she is residing in a residential treatment facility. Although she admits that she has bouts of depression, as evidenced by her sleeping patterns, loss of energy and loss of pleasure in most activities, she feels as though she would be happier and that her life would be fine if she were to live on her own and take care of herself. Lady X was having trouble falling asleep, staying asleep, and had frequent nightmares, before her medications were changed recently. Currently she is sleeping better but claims frequent dizziness. She reports having decreased energy and little interest in associating with others. She often states that she feels she is evil and that no one should want to be friends with her. She is easily agitated and moody. Recently she has stated feeling extremely hopeless about her situation and often finds it difficult to think about anything further than the present. She feels as though the treatment facility treats her unfairly and that the staff members are not looking out for her best interests.

In recent weeks the client has disclosed that she feels physically unsafe in the treatment facility, and she is often guarded because she feels as though she can trust no one. She avoids forging friendships with other residents and states that she does not want to let others know her business for fear that they will emotionally hurt her. Her reasons
for feeling physically unsafe include people knowing the code to the outside door and residential staff walking off the wing in the middle of the night. She also states that she has difficulties dealing with silence in and of itself, as well as the instability of our country as a whole.

Lady X believes that she has some internal struggles such as depressive feelings. She states that she has been depressed since she was approximately four or six years old. The depression coincides with the time she witnessed her father’s death and when sexual abuse began by her aunt’s boyfriend. When asked if there has ever been a time when she did not feel depressed, she states that there is not, but there are times when the depression is better. She states that some days are “good days” where she is happy, others are “bad days” where she is either feeling depressed and cries often, or when she is angry and is enraged by everything from how someone looks at her to what there is to eat for lunch. She reports that lately she is feeling more depressed. This may be a side effect of the change in her medication from Risperdal to a higher dose of Seroquel. It may be possible that because her anger is beginning to subside, the depression that was often masked underneath is now surfacing. When depressed, Lady X tends to threaten to commit suicide to gain the staff’s attention and to convey how sad she is feeling. However, she states that she does not actually want to kill herself and does not have an actual plan to do so. She states the same is true for why she has self-mutilated. She feels that these have been the most effective ways to help others understand how deep her pain is. Many of the problems Lady X has she externalizes and blames on others. She has stated that the reason she is residing in the facility is because her mother does not have a stable place to
live. However she states that the reason she was admitted was because she violated her probation by cutting off her electronic monitoring device.

**Presenting Problem(s) from the perspective of others.**

People close to Lady X believe that she has trouble controlling her anger, and that she has behavioral problems related to feelings of anger. She is often defiant, truant, and verbally abusive. Within the treatment facility, Lady X often believes that the rules should not apply to her, and she should have her own level system instead of having to follow the level system used for the other residents. Most recently she has been verbally aggressive toward senior administration at the treatment facility, as well as threatening physical harm to other residents. Lady X has a history of violence and getting in physical altercations (often involving knives) before she was admitted to the treatment facility. On her birthday this year, she threatened to kill a staff member after she felt as though the staff was making fun of her. She claims the staff member kept picking on her until she could not take it anymore and “blew up.” It is unclear as to the exact events surrounding the situation, as Lady X is always suspicious and defensive, and the staff member has been warned in the past about verbally harassing clients. After going AWOL and returning on her own the client and staff were still at odds, and the staff decided to press changes against her due to feeling physically threatened by her. The staff reported that this is the second time Lady X has threatened to kill her, and this time, Lady X specifically warned a staff member that when she least expects it, she will stab her in the back of the neck. In fits of rage the client resorts to using inappropriate language and becomes disrespectful to others. She freely curses at staff and administration and throws
things when she feels as though she is right and others are wrong. Tears of anger, rage, disappointment, and hopelessness usually follow the angry outbursts. Lady X often covers her depression by being aggressive, but on rare occasions when she lets her guard down to staff, she can talk about her depression and how it is affecting her. Most often however, when she is feeling extremely depressed she will avoid talking to others and will stay in her room all day.

Prior Efforts to Address the Problem

Due to her inability to obtain and maintain secure trusting relationships the attempts made at psychological treatment for her trauma seem to have been superficial and short-lived. The client states that therapy has never helped her, and she believes her medication makes her feel more depressed. Because the client’s medications were reduced in late August due to weight gain and lactation her mood and attitude have significantly declined. However, the client is unable to appreciate this and insists the medication makes her worse. The client was recently switched from Risperdal to Seroquel, and the dosage is slowly being increased to find the ideal level for the client. The client has stated that the minute she walked in the treatment facility she did not feel physically safe. However, she was unable to put her finger on the exact reason why. It has only been recently she has openly stated this fear, as well as the extreme desire to be discharged from the facility.
Family of Origin Including Household Compositions

Lady X has a long history of running away and shoplifting. Although these problems are not currently being exhibited, they play a large role in the reason she is in the treatment facility. The client states that she previously ran away to avoid family "issues."

Lady X is the second oldest of four children born to her mother and father. She also has two older maternal half-siblings. She has four sisters and one brother. Currently Lady X’s 13-year-old sister is also residing in the same treatment facility dealing with her own anger problems. Before Lady X was removed from her mother’s home she was living with three of her younger sisters, as well her maternal brother, her mother, and her stepfather, whom her mother married when the client was thirteen. The client’s biological father was murdered by her aunt in 1990.

The client reports that her stepfather was physically abusive to her and never liked him. One of the two occasions that she can remember involved her stepfather being angry with her and physically threw her out the door. The first occasion she can remember he was angry because the children were sitting outside because they did not have a key to get inside the house. The other instance she admits that she probably deserved to be punished because she was talking “trash” about her stepfather. She states that after the abuse she avoided him for a while, and he left her alone. She states that he was often verbally abusive calling her “no good,” “a whore,” and other derogatory names. However, she states that now that she does not live with him, she no longer hates him. In addition two of her sisters claimed he had sexually abused them. The sexual abuse was substantiated, and her stepfather was jailed from January 2002 to July 2003. When asked,
Lady X states that she does not believe that her stepfather sexually abused her younger sisters and feels as though her older sister may have alleged the abuse to get their stepfather in trouble. However, she does question why her one sister gets so physically upset when her stepfather's name is mentioned and does not completely rule out that he may have abused her one sister.

The client reports a strained relationship with her mother and stepfather. In addition, she states that she has trouble living with her sisters at times. Although she has trouble getting along with her mother and sisters at times because they are so much alike, there is also a strong sense of understanding each other because of everything they have been through together. Lady X states that her family used corporal punishment. Among the people who beat Lady X are her mother, her stepfather, and her older sister. She states that her mother often used curtain rods and belts to beat her when she did not do what she was supposed to do. She states that after her mother beat her, she would run around and do everything that she did not do before that her mother had asked her to do. However, once she got older and was able to take the pain, she states that she would show little reaction to the beatings so her mother stopped beating her and instead started yelling at her. She stated that although she got punished and would subsequently do what her parents asked, she states that the punishment had no long-term effect. She states that she would often misbehave or not follow directions repeatedly. Lady X spoke of one incident in which her older sister beat her and banged her head against the wall when Lady X did not comply with one of her orders. She states that when she told her mother about her sister's abuse, her mother beat her sister. Although she states that this is not how she wishes to punish her children, she is often aggressive when attempting to control her
younger sister in the treatment facility. She feels as though this is the only way to control her sister and feels as though sometimes it was the only way her family was able to control her in the past.

Reunification in the home is not being sought. The client has recently stated that her mother is “missing” and that she has not talked to her. Due to Megan’s Law, the children will not be allowed to live with their mother if she continues to have a relationship with her husband. However, the client states that her mother recently told her that she is seeking a divorce from her husband. Because her mother has trouble maintaining a stable residence, it is unlikely that her children would be reunited with her regardless of her marital status.

Lady X began acting out at approximately age eleven. At this time she admitted to her mother that she was sexually abused by her aunt’s lover from the ages six through eleven years. The client states that when she told her mother, her mother beat her. Although this was traumatic for Lady X, she now believes that her mother beat her out of guilt for not being there for her or realizing what was happening. Her mother reported the alleged sexual abuse to the Division of Youth and Family Services (DYFS), however, a previous psychological report states that her mother doubted the allegations. She and her mother did not talk about the abuse after that. Her mother was not very supportive of the client in dealing with the sexual abuse. She did see a therapist about the abuse, but her mother had little involvement. When questioned as to whether Lady X believes her Aunt knew about the sexual abuse, she says that she thinks her Aunt probably did know about the abuse. Lady X recalled a day when she was laying next to her Aunt’s lover naked in bed when her aunt came in the room she said, “When’s it my turn?” Lady X does not
blame her aunt for the abuse and they “get along” now. She states that her aunt has at least one drink a day and may be an alcoholic.

The client states that her mother was not at home a lot and that she was always out working to support the family. The client and her siblings had little supervision growing up. Lady X states that her mother would not give the children the key to the house so they were often left outside from after school until when their mother got home around 7:00 pm. She believes that her mother was negligent in raising her, stating that her mother often went out at night to clubs and bars and enjoyed the social life. Lady X reports remembering her mother coming home drunk and “making them laugh.” She states that her mother was not a “mean drunk.” She does not believe that her mother was, nor is, an alcoholic. Due to her own extracurricular activities, Lady X’s mother was of little support for her growing up. Lady X states that she had no one in her life that was supportive of her and often had to depend on herself.

It is important to note that at the age of four years, Lady X witnessed the murder of her father by her aunt, when her aunt stabbed her father over negligent childcare. This is not the same Aunt whose boyfriend sexually abused the client. DYFS reports state that after learning that one of his children had fallen off of the roof while in their Aunt’s care, a physical altercation ensued resulting in the stabbing which killed Lady X’s father. Lady X states that she often misses her father and feels as though she was robbed of having a father figure in her life. Although family members have told her that her father beat her mother and had drug addictions, she still wishes that she grew up having her father in her life. The witnessing of this tragic event, in addition to early sexual abuse, has
undoubtedly affected Lady X's schemas in regards to the world being an unsafe place, and affects the way she has conducted herself currently, as well as in the past.

Since the age of eleven years, Lady X has resided in three other residential facilities, as well as foster care. The client lived on the streets for approximately nine months, during which she suffered a rape by a man she knew, and had frequent physically abusive sexual relationships with older men.

Lady X's sister and grandmother are also a significant part of the family unit, although they do not live in the household. Lady X reports that her grandmother was verbally abusive to her in the past, however, she states that currently she talks to her quite frequently to get the family gossip. Lady X reports that her grandmother is a recovering alcoholic who has recently become sober within the past few years. Lady X’s older sister lives on her own with a physically abusive boyfriend. Although Lady X desires to visit her sister’s home on the weekends, her physical safety must be taken into account.

Lady X reports that she does not want to visit her mother on weekends due to her mother’s lack of stability, as well as her inability to care for her. Lady X is very protective of her family and although she has a strained relationship with them at times, she does report loving them very much. Family therapy was being conducted at the treatment facility until about August 2003 when Lady X, her sister, and their mother ended a session in a substantial argument. Lady X reports being angry that her mother will not take responsibility for the fact that she was a negligent parent. Lady X’s mother visits her daughters a few times a month on visiting day at the treatment facility but is hesitant to resume family therapy as she states she does not have a car and has to rely on others for transportation. Lady X’s mother has stated that she is going through a lot of her
own problems such as being evicted, juggling her job and school, as well as problems with her other daughters, which are preventing her from becoming fully engaged in her daughters’ therapy. It is unclear as to whether her mother is currently dealing with a substance abuse problem.

It is clear to see that Lady X appreciates her mother’s visits and loves her very much. Lady X admitted telling her mother during a recent visit that she was sorry for everything she had put her through. However, Lady X is realistic in her views of her family and states that she needs a mother figure right now, and she knows that her mother cannot be that person. She has stated that when she gets older and can take care of herself, she believes that she and her mother will have a better relationship. She attributes this to the fact that she and her mother are very similar and share a lot in common, but that at this point in her life she wants a mother figure that can take care of her, and she knows that her mother cannot provide that kind of support. The client states knowing that she often looks to older adults as parent figures, but ultimately they let her down because they cannot fill the void her parents have left.

Drugs/Alcohol or other Addictive Behavior

Lady X reports having abused marijuana and trying alcohol in the past. The client is not currently using any of these substances, but when she was living on the street she was smoking marijuana everyday. She states that her cousin would buy it for her because the drug dealers would harass her and try to flirt with her. She and her male cousin, who was a year older than her, would indulge in the substance together daily. Lady X reports that all the members of her family indulge in alcohol quite frequently. Her mother drank a
lot and the client saw her drunk every couple months. She states she saw her Aunt drink
everyday, and that her grandmother was an alcoholic and is only recently in recovery.

When she was young she snuck into her brother’s room and drank a bottle of Hennessey.
She remembers getting very ill from this and throwing up. A few years ago she drank a
40 oz. bottle of beer at a party with peers and got sick. She states that she has only drank
alcohol those two times, and she will not drink due to getting sick from it in the past.

However, she does feel as though she will probably smoke marijuana when she returns to
living outside the facility. She does not feel guilty about it, and no one had ever annoyed
her about her drug use while she was on the street. She states that she did not receive any
ill effects from using marijuana, which is why she prefers it to alcohol. She has never
gotten caught using marijuana. She states that although she does not have much contact
with her father’s side of the family, she states that she knows that many of them indulge
in illegal drugs.

Developmental

Lady X’s father was abusing cocaine at the time of her conception. However,
Lady X’s mother reports no difficulties during her pregnancy or during her daughter’s
birth. She reportedly reached all the developmental milestones at appropriate ages as a
child. She reports being a quiet child that kept to herself but was very watchful of others.

There is no known head trauma or apparent neurological problems. However, she had a
tumultuous childhood with multiple caregivers. She experienced early trauma related to
physical, sexual, and verbal abuse, as well as well as witnessing the murder of her father.
Lady X states that she can remember her father’s murder, exactly what her father wearing that day, and that her mother was screaming as he was bleeding.

**Medical and Psychiatric History**

Currently Lady X is having trouble sleeping and reports depressive feelings, as evidenced by feeling sad and crying often. However, she states sometimes she wakes up in a really good mood, but she never knows when those days are going to come. She is currently prescribed Seroquel, Zoloft, Allegra, and Aviane. She had been prescribed Risperdal, Depakote, and Ortho Cyclen in the past. Until July the client was prescribed 1.00 mg of Risperdal. However, due to weight gain and lactation, the dosage was reduced to .25 mg of Risperdal, then changed to Seroquel. Lady X is currently stabilized on these medications. Her aggression and outbursts of anger have reduced greatly since starting Seroquel.

At the age of fourteen years Lady X experienced a traumatic miscarriage of her five month-old fetus. She reportedly had the child in an ambulance, and the child survived for less than an hour. Lady X wanted to have the child and reported being very depressed after the miscarriage but received no treatment for her depression.

Lady X has participated in self-mutilation on the top of her forearm twice. She claims she did this to gain the staff’s attention and to express how much she hated being in the residential facility. She reports the night she cut herself she was so upset that she did not feel the pain until the following morning, however when she woke up, she claims there was blood all over her shirt and sheets. Lady X reports staging an apparent suicide attempt tying a pillowcase around her neck. In another example of parasuicidal behavior
Lady X states she pretended to strangle herself with her wrist shackles during a court session. Lady X has a pattern of threatening suicide or harming herself in some way to gain attention and to express how angry and unhappy she is. The client often has suicidal ideation, however, currently reports no specific plans to commit suicide. In the past some of her suicidal ideation revolved around thinking about hanging herself from the small ceiling sprinkler in her room. A suicide assessment was completed with the client, and the client reported that she did not really want to commit suicide, but that she is very unhappy and wants to be anywhere but the residential facility. Many of her episodes of acting out have admittedly been to try to get herself removed from the program and placed at another facility. However, the facility has a “no reject, no eject” policy, and administration would like her to stay at the facility.

The client reported auditory hallucinations of her father “telling her things” in the past, as well as a history of “blackouts” when she gets angry or into physical altercations. However, when asked about them now, she states that she lied about both accounts.

Lady X has received regular medical and dental checkups, as well as psychiatric visits when needed.

Lady X does not know very much about her family’s psychiatric history, but does state that her mother has been depressed for as long as she can remember. Lady X seems to believe that her mother’s depression is a result of her father’s murder and the subsequent murder of her older siblings’ father two weeks later. Her mother had also been sexually abused when she was a child. Lady X has no information on any other family members’ psychiatric history.
Past psychological reports have stated that due to early trauma in her life, she displays varied symptoms associated with Post Traumatic Stress Disorder, Reactive Attachment Disorder, Bipolar Disorder Conduct Disorder, Oppositional Defiant Disorder, and Depressive Disorder.

Educational and Job History

Lady X is currently enrolled in her residential treatment facilities’ school program. She is working though her 10th grade school year. She currently wants to be enrolled in an outside school and often finds excuses to avoid daily schooling within the facility. Past extensive educational testing has shown that she has an IQ of 81 with potential above this level. She has severe visual motor perceptual dysfunction. Broken down her IQ scores are:

- Fluid IQ 75
- Crystallized 75
- Memory 83
- Composite 75

These scores put Lady X in the “borderline” range of cognitive abilities.

When tested on her basic skills of reading, writing, and mathematics skills, her skills were comparable to that of at individual at grade 2.8 from the normative sample. She reportedly had a three-year span after 6th grade where she did not attend any specific school on a consistent basis due to frequent relocations. In terms of strengths, Lady X has strong visual memory skills. She enjoys artistic tasks such as creating things such as quilts and pillows.
In regard to work history, Lady X has worked as a babysitter for a year at one of the programs she attended, and she worked at McDonalds for two months. Currently Lady X is working as a babysitter after school for parents who are taking classes. She takes great pride and joy in this ability to earn money and be needed.

Social Supports and Pattern of Relationships

Lady X appears to have very little social support. Her mother is currently unstable and unwilling to engage in the client’s therapy process. Although the client has many siblings, they are all dealing with major issues of their own and are unable to provide stable support for the client. Lady X’s younger sister who resides with her at the facility is often more of a cause of distress for the client than a support due to her sister’s outrageous anger problems. However, the client does warmly state that her sister often tucks her in and kisses her goodnight before bed.

Lady X has a pattern of unstable relationships. A community member who taught at the residential facility’s summer arts program has taken an interest in mentoring Lady X. The two became close quite fast, however, Lady X pulled away quickly when she learned that the mentor could not fulfill her every need. She refused to speak to her for some time, often forgetting why she was angry with her. She has admitted that she was beginning to feel as though this woman could replace her mother and that frightened her. The client has a history of pushing people away before they could have the chance to push her away. This represents a pattern of extremes of idealization and devaluations. After repeated advice from her mother and therapist, Lady X has begun to accept this mentor back into her life at a much slower pace than before.
Although she lives in a facility and is surrounded by many other residents her age, Lady X keeps to herself quite often. She has recently avoided trying to make friends, but there are many residents who try to make friends with her. She often states that she does not know why they try to be her friend because she does not like anyone, she thinks they are all immature, and she thinks she is evil. She has stated that she likes to sit in her room alone and not be bothered. She questions her faith in God, but believes in the devil. She believes that she can see things happen before they do, and she feels bad things that are going to happen (such as death). After beginning to attend school outside the facility a few months ago, Lady X has made more friends and seems to positively interact with others more frequently.

She has had frequent sexual relationships in the past with older men who used her for sex. She states that while she was living on the streets many of them wanted her to live with them and wanted to take care of her. However, most recently she was involved with another resident about her age. She states that he had met her family, that everyone really liked him, and that he understood her. However, he was removed from the program after playfully attempting to sodomize a male resident with a broomstick. After he was removed Lady X went into a fit of anger and sadness and threatened to commit suicide. He continues to write her letters and wants to be with her, however, she states that while at the program he was very controlling and sometimes physically abuse. She states that he would raise his voice and push her if he did not agree with something she did. She states that in return she would push him back. She states that she knows the relationship was unhealthy and does not want to put herself back in that situation. There is currently a
new resident who is romantically interested in her, but she is adamant about wanting nothing to do with him. These relationships illustrate her pattern of affective instability.

In regard to her sexual behavior, Lady X has a pattern of poor judgment and immature decision-making. This represents a pattern of self-destructive and impulsive behavior. Since she began consensually having sexual intercourse at the age of thirteen years, she never used birth control, although she knew about it. When her mother found out she was having sexual intercourse, she told her she was going to bring her to Planned Parenthood and have Lady X put on the pill, but Lady X states her mother never brought her there.

Following the episode of her boyfriend being discharged from her current residential program, Lady X declined to see her therapist any longer, claiming that she was never there for her enough and did not care about her. She is currently seeing a student therapist who can devote more time to her needs. However, she is constantly trying to seek out other therapists to see her. She engages in frequent attempts to gain attention from the staff. This includes escalating relatively minor problems into more serious ones that have greater likelihood of getting the attention of the staff.

While in the treatment facility she will seek out support from anyone who will listen. She seeks out anyone from residential staff, to therapists, to administrative staff. When these problems are not dealt with to her liking she often goes into a fit of rage, storming out, yelling, and cursing. Again, these behaviors illustrate her affective instability and her pattern of intense and unstable relationships.
Situational Stressors

Within the past 6 months two major stressors have affected the client. The first was her stepfather’s release from jail. Not only did his release upset her due to her anger with him, but, if her mother decided to try to reconcile her relationship with him Megan’s Law prohibits the client and her sisters from being able to live with her mother again. Ultimately the client felt as though her mother chose a man over her children, which is a pattern that has seemed to be consistent throughout her lifetime. Recently Lady X has received news that her mother is looking to divorce her husband. When asked how she feels about this, she states that she does not really care, but that she wants her mother to be happy. In addition, within the last three months, the client no longer has the constant support of her boyfriend who used to reside in the treatment facility with her. Ultimately she feels as though she has lost everyone. This reinforces her fear of abandonment. These events came at a time when her medication was also decreased, leading to increased bouts of depression and angry outbursts.

Coping Mechanisms and Strengths

Lady X copes with stress with externalizing behaviors. She states that she lets it build up inside her until it “busts,” resulting in her angry outbursts. She has a pattern of having difficulty in controlling her anger. She previously ran away to avoid her problems, but she has not recently engaged in runaway behaviors or substance abuse, which were past coping mechanisms. Lady X has also reported claiming blackouts and staging suicide attempts to avoid punishment and to gain attention in the past. More recently, Lady X reported spending time alone as a way to calm down and think about things. She
claims music is a mechanism that helps her deal with problems and everyday stressors. She enjoys engaging in artistic projects to help brighten her room. She claims that the only good part about the program is that she has her own room, which she takes great pride in. However, she claims the white walls drive her crazy so she tries to decorate her room to make it less stark. She also takes great pride in cooking for the other residents in the facility.

Lady X sees herself as a strong individual who can take care of herself but wants others to care about her. Although she knows she is depressed, she has trouble relating the problems she has in everyday residential life to her anger. Although she craves attention from staff and therapists to fulfill her needs, she is only partially engaged in wanting to help herself in treatment. By doing this, Lady X may be using her attention seeking behavior in an effort to avoid abandonment. Lady X believes that her problems cannot be solved in therapy, and her anger is rooted in her placement at the facility rather than from previous life experiences. Her motivation to attend sessions is often to talk about staff and residents who have “wronged” her in someway. However, Lady X is very talkative and will answer any question the therapist will ask. She can be very insightful and has a good attitude when talking to the therapist. She was very interested in being a part of this thesis and was excited to complete the sometimes lengthy self-assessment measures. She enjoys the interview questions and is extremely forthcoming in her answers.

Lady X has poor insight regarding her problems. Lady X does not believe that most of the problems she encounters are due to her. She instead blames them on other people and the program itself. Although many of her experiences can be blamed on
others, there are many interpersonal obstacles she can work on herself. However, she does not believe that there are many things that she needs to change about herself. A reason she cites for not wanting to take medication is that she wants to be the real her and not let medication get in the way of who she really is. She states that she does not want to make friends, and she would be happy being alone for the rest of her life. She infrequently can think past the current moment and has few goals for herself. Recently she irrationally stated that she thinks she is never going to get out of the treatment facility and cannot do anything to help herself get out. She stated that she is giving up, and she is simply going to take one day at a time and see what happens. She states she does not care what happens to her anymore. Positive coping mechanisms are exhibited at times when she decides to sit by herself or take a walk. She has begun to express her problems in the form of letters and petitions rather than yelling. Most often, however, she retreats to her room and sits in the dark. She claims that she “sees better in the dark than the light.” Overall, Lady X has found coping mechanisms that have been functional in the past, however, she could benefit from more adaptive mechanisms.

Other Agencies Involved

Lady X has a parole officer due to past arrests for running away, fighting, and shoplifting. Her parole officer recently became more involved with the client since her threat to kill a staff member.

Due to an extensive history with DYFS Lady X has been in multiple treatment facilities and received both individual and family therapy. Her treatment has mainly consisted of cognitive behavioral therapy intertwined with a residential level system to
help with anger management. This has not seemed to be successful in changing her
behavior in the long-term. According to past records, Lady X has been evaluated multiple
times and the need for more extensive treatment for her PTSD symptoms has been
recommended. However, it is not evident that she has received adequate treatment for
these symptoms. Although Lady X has some symptoms associated with PTSD, she seems
to suffer more from long-term neglect and an overall traumatic upbringing.
Chapter 2

Review of Prior Assessments

Psychiatric-

A Board Certified Psychiatrist evaluated Lady X approximately a year and a half ago.

The findings of this assessment reported that Lady X has a “preload of early experience of trauma,” as well as the experience of “disrupted education and delayed identification of a learning disorder.” The assessment reports Lady X as having a presentation of depressive and posttraumatic symptoms complicated by a borderline personality organization. Her symptoms of mood reactivity, hopelessness and self-destructive behaviors are perpetuated by the continuing change of her environment and legal problems. The assessment relayed that her continued running away despite consequences, her socialization problems, lack of trust, and pervasive hopelessness were reported as concerns. The findings reported that Lady X was suffering from Post Traumatic Stress Disorder, Major Depressive Disorder, Oppositional Defiant Disorder, Learning Disorder NOS, and Borderline Personality Disorder. Recommendations were that the client be admitted to a residential facility, given appropriate medications, individual therapy, family therapy, educational assistance, and medical follow-ups.
Lady X was also evaluated approximately a year ago by a psychiatrist at a residential facility.

The findings of this assessment were that the client displayed symptoms of Conduct Disorder, Reactive Attachment Disorder, and Depressive Disorder NOS. The assessment also states that Lady X exhibits Antisocial and Borderline traits and suffers from Dyscalculia, as well as Borderline Intellectual functioning. A traumatic and unstable early childhood were also mentioned as significant factors in Lady X’s life. Recommendations included a residential treatment facility and psychopharmalogical treatment. It is possible that appropriate rapport was not established during this evaluation. Therefore some of the conclusions may have been based upon incomplete information because Lady X was not cooperative during this evaluation.

Educational-

Lady X was evaluated two years ago by a learning specialist.

Lady X was evaluated several different times due to ongoing academic and behavioral difficulties. In 2002 Lady X was found to have an IQ of 81 points, which is in the low average range of intelligence. Despite this score, this report states, “there appears to be potential above this level.” Several different tests were administered to assess Lady X’s intellectual functioning. On the Computer Optimized Multimedia Intelligence Test (COMIT) Lady X received a score of 75 in both Fluid IQ and Crystallized IQ and a score of 83 in memory. Her composite IQ score was 75. Although Visual Memory was strong for Lady X, Auditory Memory was found as a weakness.
Lady X was also tested in the area of distraction, and her profile matched closely with a person who suffers from ADHD. The assessment concluded that the “chances are 77/100 that Lady X has an attention deficit disorder.” It is also noteworthy to mention that when tested in social skills, Lady X seemed to show a lack of knowledge of implied meanings in a variety of verbal and visual prompts. Her “poor lack of attention to detail combined with poor social awareness may lead to inappropriate behaviors because of lack of attention to environmental cues.”

When discussing achievement measures, the Woodcock-McGrew-Werder Mini Battery of Achievement was used. Lady X scored in the “very low range” of score in all the basic skills areas including Reading, Writing, Mathematics, and Factual Knowledge. Her basic skills are comparable to that of a 2nd or 3rd grader when in fact she is in the 10th grade.

In regard to sensory motor skills Lady X scored in the “suspicious range,” which may indicate developmental or neurological deficits related to the central nervous system. Complex reasoning ability, procedural learning, decision-making, planning, and problem solving ability were found to be poor on the Tower of Hanoi Test. “Those who do poorly are said to have dysfunction or damage to the frontal lobes in a region of the brain that is involved in executive functions.” In addition, her low word scores on the Stroop Test may be indicative of “a brain injury causing pure dyslexia.” On the Category Test Lady X’s high degree of errors indicated “extreme mental confusion to the degree that she fails to grasp even rudimentary aspects of complex tasks.”
Overall, previous assessments indicate that due to severe psychological trauma and possibly physical trauma, Lady X suffers from severe psychological and educational impairments.

Lady X was evaluated 3 months ago by another learning specialist.

Lady X was evaluated by the child study team at the request of the New Jersey Superior Court. Educational testing was completed, and the self-assessments used were the Beery-Buktenica Developmental Test of Visual-Motor Integration and the Woodcock-Johnson Achievement Tests-Form A.

In regard to her reading abilities, Lady X scored equivalent to someone between a 6.3 and 10.9 age range. This shows delays of between five to ten years. Her strongest area was in Oral Comprehension, and her weakest was in Spelling of Sounds. In regard to her mathematical abilities, Lady X scored equivalent to someone between a 9.7 and 11.3 age range. Her weakest was that of Quantitative Concepts, which requires knowledge of mathematical concepts, symbols, and vocabulary. In regard to written language, Lady X scored equivalent to someone between a 9.10 and 16.3 age range. Her strongest area appears to be in her writing sample, where the client is not penalized for basic skill errors such as spelling, but rather, scored on quantity of expression.

Overall, Reading appears to be her weakest area and math her strongest. Written skills fall between these two areas. Her average scores were 8.10 age equivalent for broad reading skills, 11.0 age equivalent for broad math skills, and 10.5 age equivalent for broad written language. Compared to others her age level, Lady X is considered to performing in the low to low-average range.
Chapter 3

Differential Diagnosis

Axis I 312.82 Conduct Disorder, Adolescent Onset Type-Severe
313.89 Reactive Attachment Disorder of Infancy and Early Childhood-Inhibited Type
Rule Out Post Traumatic Stress Disorder by history
Rule Out Adjustment Disorder with Mixed Disturbance of Emotions and Conduct

Axis II 301.83 Borderline Personality Disorder

Axis III HPV - Cancerous Cervical Lesions

Axis IV Chaotic home setting, sexual abuse, emotional abuse, physical abuse, legal problems, neglect, relationship conflicts, social environment pressures, deficient primary support group, educational problems

Axis V GAF = 40

Lady X presents with symptoms of Conduct Disorder for many reasons in excess of the criteria listed in the DSM-IV. She often threatens and intimidates others and initiates fights. In the past she has used a knife when threatening others. Although she currently has not physically approached anyone with a weapon, she has threatened to kill a staff member by stabbing her in the neck. She often thinks about using pencils as
weapons due to the inaccessibility of other dangerous weapons. Lady X frequently lies to
obtain goods or favors or to avoid obligations. Although she does not always outright lie,
she often manipulates people to give her what she wants. This is often seen when she
attempts to get staff to give her things that other clients are not allowed, such as treats,
excursions, and privileges when she is not on levels. She has a way of telling her own
version of the truth to get out of violations she receives. She also has a history of
shoplifting that she has been arrested and charged for. Moreover, Lady X has a history of
running away for long periods of time and living on the street. Six months was the
longest period of time Lady X ran away for. When she was living at home she was often
defiant of the rules and expectations set for her by her mother and stepfather. Running
away and being placed in several residential treatment facilities and foster homes has
cause Lady X to miss a great deal of school, leading to academic impairment. In
addition, her misbehavior has led to numerous problems with family members and
caregivers. Combined with these criteria, a diagnosis of Conduct Disorder, Adolescent
Onset is warranted. She was given a severe specifier due to numerous criteria being met.

A diagnosis of Reactive Attachment Disorder was given because Many of Lady
X’s symptoms appear to root from early childhood experiences of neglect. Her basic
emotional and physical needs were often not met due to her mother’s absence in the
home and her father’s death. Lady X experienced sexual abuse at a young age that was
not properly dealt with. Lady X claims that her mother beat her when she told her about
the abuse, and reports show that her mother doubted her daughter’s allegations. Lady X
did not receive support during this traumatic time. In addition, her stepfather was at times
physically abusive. Family members were also often verbally abusive towards Lady X.
As she grew up, Lady X developed disturbed social relatedness. She often kept to herself and was very watchful of others. She currently exhibits the same responses, especially when she does not know someone well. She is extremely skeptical of others and at times exhibits extreme reactions. An example of this was she was recently in the kitchen cooking when a man came through the back door. She perceived the look on his face as being threatening, and although he told her he was there to fix the refrigerator, she preceded to run around the entire building and make a scene. Even after she returned to the kitchen with a staff member and was assured of the man’s purpose, she was still skeptical and unbelieving. She was able to process that this reaction was due to fear of danger in the past and admitted that her reaction was extreme but genuine. In addition Lady X is very skeptical of those around her. She is slow to warm to others and to trust others, however, once she does, she places a lot of importance on them. She often will attempt to get them to fulfill all her needs, and when they can no longer do this or deny her something she will avoid them. She also often seeks out other people for help but, when she is really depressed and angry she refuses to talk to anyone. These patterns of behavior seem to be at least in part due to the neglect she received as a child, leading to a diagnosis of Reactive Attachment Disorder of Infancy and Early Childhood, Inhibited Type.

Post Traumatic Stress Disorder was ruled out due to Lady X’s accounts that she does not experience flashbacks of the tragic event of her father’s death. Although she can vividly remember the day and the event, these thoughts do not pop into her mind at inappropriate times, but rather, only when she decided to think about them. In addition, she does not have recurrent dreams about the event, nor does she experience intense
physical distress when she thinks about them. Although Lady X has experienced various traumatic events in her childhood, such as the murder of her father, rape, and neglect, none of them elicit reactions in her extreme enough to be considered Post Traumatic Stress Disorder.

Due to various other disorders and inconclusive testing, Attention Deficit Hyperactivity Disorder was ruled out. Her problems with attention in the classroom may be due to personal problems with the teacher, not understanding the material, or stress related to other problems she is experiencing. In addition, a learning disorder diagnosis was deferred due to conflicting testing scores and the statement that Lady X has "potential above" her scores as stated by the learning specialist. It is suspected that Lady X has educational deficits in all areas of learning due to her spotty school attendance, however it is unknown whether any biological basis explains any cognitive impairments.

Although Lady X is only 16 years old she presents with a clear pattern of behavior consistent with a diagnosis of Borderline Personality Disorder. Lady X has a history of unstable and intense relationships with others that alternate between idealization and devaluation. There have been numerous examples of this pattern while Lady X has been in the residential treatment facility. She has done this with boyfriends, therapists, and mentors. She has held certain people in such high regard, relying on them to provide her both emotional support and to fulfill her physical needs. However, at the first sign these people will let her down in even the slightest way she retreats and blames them for many of her troubles. This is a major pattern in dealing with her mother, a person she loves and wants to rely on to meet her needs, but is consistently let down by. Her pattern of unstable relationships is related to frantic efforts to avoid real or imagined
abandonment. Lady X pulls away and creates chaos when she feels as though she will be abandoned. This was evidenced in how she dealt with her recent birthday. To avoid the let down of no one making a big deal out of her birthday she created chaos by threatening to kill a staff member so that she could get herself in trouble and would have a reason to explain why no one did anything special for her birthday.

In addition, Lady X often participates in suicidal threats, gestures, and self-mutilating behavior. She recently stabbed herself in her thigh with a pair of scissors she was hiding and threatened to commit suicide by hanging herself from the sprinkler on the ceiling. She also suffers from affective instability, one hour being angry, depressed, and suicidal, to the next hour singing with other girls in the shelter. This is often also seen when she engages in angry outbursts with staff when she does not get her way. However, her intense anger usually subsides in less than a day. This is combined with the diagnostic criteria of suffering from inappropriate and intense anger. Lady X periodically engages in temper tantrums and angry outbursts when she does not get her way. They often include storming out of rooms, slamming doors, cursing at staff, and throwing objects around a room. Moreover, Lady X states that she suffers from chronic feelings of emptiness. She often feels alone in the world and that no one understands her. She feels as though no one is supportive of her, and she has to rely on herself when she has problems. Lady X displays impulsivity in her decisions to engage in illegal substances such as marijuana and her decisions in regard to sexual activity. Lady X has a history of engaging in unsafe sex with older men and using sex as a way to get her basic needs met such as shelter and food. Lady X may suffer from stress related paranoid ideation. This may explain her feelings of being unsafe in the treatment facility and her thoughts that
she cannot trust anyone. Combined, these symptoms create significantly more than the
minimum criteria needed to diagnose Lady X with Borderline Personality Disorder.

Although Lady X presents with Adjustment Disorder with Mixed Disturbance of
Emotions and Conduct or for Adjustment Disorder with Mixed Anxiety and Depressed
Mood, these diagnoses were ruled out after much deliberation. Although moving to the
residential treatment facility has caused Lady X stress, she had previously presented with
Conduct Disorder. Although she blames the treatment facility for her unhappiness, she
admits to being depressed all her life. Moreover, it seems that the stress of being admitted
to the treatment facility may have simply exacerbated her symptoms of Borderline
Personality Disorder rather than creating new symptoms that she may not have otherwise
been diagnosed with.

In regard to medical conditions, Lady X suffers from the Human Papillomavirus
(HPV), which shows that she has pre-cancerous cervical lesions. She is under the close
care of a doctor for this condition.

There are many environmental factors that have influenced Lady X’s
development and her current situation. Lady X’s chaotic home setting with her family has
influenced her life probably more than anything else. Seeing her father murdered, being
sexually, emotionally and physically abused, and living with many caretakers has
changed the way Lady X views the world and has no doubt caused much of the distress
she has experienced and caused the relationship conflicts she has today with her family
members. Her legal problems of shoplifting and threatening to kill people probably come
from her drive to protect herself and to take care of herself. While she was on the run
from home, Lady X was confronted with a group of peers and negative influences that
may have pressured her into drugs and other illegal activity. Lady X has no one stable in her life to provide her with a supportive and safe environment to flourish. This kind of environment will be essential for Lady X if she hopes to live a more positive lifestyle than she has in the past.

In summary, Lady X was given a GAF score of 40. This score represents major impairment in functioning in several areas. These areas include impairment in school behavior and academics, interpersonally with peers and staff, impaired family relationships, as well as impaired judgment, thinking, and mood. Lady X has the capability to improve her functioning with the help of positive peer influences, proper medication, and possibly the restoration of family therapy.
Chapter 4

Literature Review

Borderline Personality Disorder

Several controlled studies have concluded that Dialectical Behavior Therapy (DBT) is effective in reducing symptoms of Borderline Personality Disorder (BPD) (Katz, 2000; Katz & Cox, 2002; Koerner & Linehan 2000; Koerner and Linehan, 2002; Linehan, 1993; Oldham, 2002; Paris, 2002; Robins, 2002; Stenhouse & Van Kessel 2002; Stone, 2000; Trupin, Stewart, Beach, & Boesky 2002). Dialectical Behavior Therapy is a cognitive-behavioral treatment approach that combines a broad array of cognitive and behavior therapy strategies such as skills training, exposure based techniques, cognitive modification, contingency management, problem solving with validation, mindfulness practices, reciprocity, and a main focus on the patient-therapist relationship (Linehan, 1993, Stone, 2000). Dialectical Behavior Therapy was originally developed as a treatment for chronically suicidal individuals but has since evolved to treat patients who suffer from Borderline Personality Disorder with different degrees of severity and a variety of symptoms (Koerner & Linehan, 2000, 2002).

Dialectical Behavior Therapy serves five functions. These functions include enhancing clients’ capabilities, improving client motivation to change, ensuring new capabilities generalize to the natural environment, structuring the environment in ways essential to support clients’ and therapists’ capabilities, and enhancing therapists’ capabilities and motivation to treat patients effectively (Koerner & Linehan, 2000).
The differences between traditional cognitive behavior therapy and Dialectical Behavior Therapy is that the latter focuses more on specific aspects of the Borderline client’s personality that need improvement, such as suicidality and commitment to therapy. In addition, DBT requires the therapist to assess clients’ skills in areas such as regulating emotions, tolerating distress, responding appropriately to interpersonal conflict, managing behavior in ways other than self-punishment, and the skills to observe, describe, and participate without judging (Koerner & Linehan, 2002). The five categories of skills are labeled as Core Mindfulness Skills, Interpretation Effectiveness Skills, Emotion Regulation Skills, Distress Tolerance Skills, and Self-Management Skills. If a client possesses weakness in any of these skills, DBT incorporates skills training to help improve these skills. Dialectical Behavior Therapy also differs from many treatment approaches in that it requires a high level of validation for the client from the therapist. During validation therapists are encouraged not challenge clients, but rather, align with them. Validating is executed by communicating to clients that their responses makes sense, are relevant, meaningful, justifiable, and effective while adding another way of thinking about the statement. Koerner and Linehan, (2002 p. 154) describe this as a “yes, but....” dialogue. This requires the therapist to be empathetic to clients and the clients to feel as though they are being supported, but adds an additional educational element. This treatment recommendation is similar to that of the therapeutic alliance that is stressed in all psychotherapy treatment approaches and is especially important in treating patients with BPD due to repeated relationship instability outside of the therapeutic setting.

Dialectical Behavior Therapy provides flexibility in treatment for both the treatment provider and the client and creates a “dialectical persuasion” (Koerner &
Linehan, 2000, p. 152). Koerner and Linehan describe this persuasion when the therapist highlights the clients’ inconsistencies in their thoughts, actions, and beliefs. The therapist serves as a coach to help clients develop a more complete perspective that coincides with their values.

Dialectical Behavior Therapy is the most empirically supported treatment for outpatient Borderline Personality Disorder, showing efficacy in reducing trait anger, suicidal ideation, hopelessness, and depression (Robins, 2002). In addition, DBT has reduced rates of parasuicidal behavior in adolescent juvenile offenders in both outpatient and inpatient treatment, leading researchers to believe that DBT is generalizable across settings and populations (Katz, 2000; Trupin, Stewart, Beach, & Boesky 2002). In a study by Trupin, Stewart, Beach and Boesky, DBT was most effective when matched to appropriate behavior problems such as suicidality, aggressiveness, and non-compliance and implemented with intensive training. However, due to lack of component analysis studies, evidence suggests that additional research is needed to delineate the specific components within DBT that contribute to outcomes (Koerner & Linehan, 2000, 2002). In addition, “additional research is needed to confirm the long-term effects of Dialectical Behavior Therapy” (Koerner & Linehan, 2000, 2002, p. 164).

Dialectal Behavior Therapy does not insist that it must be used alone as a sole treatment therapy. Psychotherapy can be combined with pharmacotherapy to help treat specific symptoms of Borderline Personality Disorder (Clarkin, Yeomans, & Kernberg, 1999; Egan, 1986; Stone, 2000; Koerner & Linehan 2002; McGlashan, 2002; Paris, 2002; Tyrer, 2002). However, pharmacotherapy is widely seen as a temporary or minimal improvement in the treatment of Borderline Personality Disorder. Borderline patients are
often prescribed several drugs such as antidepressants, mood stabilizers, neuroleptics, and benzodiazepines to treat symptoms separately. However, the majority of improvements seem to show solely in impulsivity rather than treating the overall affective instability that patients with BPD suffer from (Paris, 2002).

Psychoeducation, such as multiple family group treatment (MFG), is another approach suggested with some empirical support (Whitehurst, Ridolfi, & Gunderson, 2002; Blum, Pfohl, St. John, Monahan & Black, 2002). The goal of treatment is to improve factors, such as communication within the family, that increase the likelihood of relapse for patients with BPD. The three main goals of therapy are to educate the family about BPD, to teach skills to help with problem solving, and to develop a working alliance (Whitehurst, Ridolfi & Gunderson, 2002). Masterson and Rinsley (1975), as discussed in Whitehurst, Ridolfi and Gunderson’s article, (2002 p. 344), considered borderline psychopathology “resistant to correction unless changes were made in the person’s primary social milieu, which for many patients is the family.” Whitehurst, Ridolfi and Gunderson (2002) cited many studies that concluded that patients with BPD often come from families in which parents have a history of neglect or uninvolvment. (Frank & Paris, 1981; Gunderson, 1980; Gunderson & Zanarini, 1989; Links, Steiner, & Huxley, 1998; Soloff & Millward, 1983; Zanarini, 1997). A study from McLean Hospital “showed that parents of teens with BPD were less aware of their child’s feelings and self image than were parents in a comparison group composed of families with teens having other personality disorders” (Whitehurst, Ridolfi & Gunderson, 2002; Young & Gunderson, 1995 p. 346). Psychoeducation is important and helpful for families who are attempting to understand what family members with BPD are experiencing.
Psychoeducation can foster better communication between those suffering from BPD and their family members.

Whitehurst, Ridolfi & Gunderson (2002 p. 361) report that results from their investigation using Multiple Family Group Therapy indicated that participants made “desirable changes” such as reduced hospitalizations and diminished destructive acts. However, it is important to note that their study was conducted using a small sample size with no control group. Additional empirical research is needed before making conclusions about the effectiveness of MFG. Psychoeducation and Multiple Family Group Therapy are limited when using it as the sole treatment approach in helping a patient suffering from BPD.

Another approach is Systems Training for Emotional Predictability and Problem Solving (STEPPS), a cognitive systems-based group treatment for outpatients suffering from BPD. It combines system-based cognitive behavioral therapy with group skills training and Psychoeducation. Although there has been some systematic data collection with STEPPS participants, a pool of 52 subjects participated in a STEPPS program for 16 months. Self-report measures, such as the BEST, the PANAS, and the BDI, were administered to assess the degree of impairment the subjects suffered from. Those who participated in the STEPPS program “experienced a significant decrease in symptoms” associated with BPD as measured by the BEST, PANAS, and the BDI. (Blum, Pfohl, St.John, Monahan, & Black, 2002 p. 306). Although preliminary data show that the DBT-like STEPPS program is well accepted by both clients and the therapists delivering the treatment, additional studies are needed to replicate the efficacy of this treatment (Blum, Pfohl, St. John, Monahan & Black, 2002).
Stone (2000) suggests in his review of clinical guidelines for psychotherapy for those suffering from BPD that variables such as educational, socioeconomic, and cultural background, as well as chronological age, may affect how clients react to different therapies. There is no guarantee that any one therapy will work for every person. Although many treatments may promise to show improvement for those suffering from Borderline Personality Disorder, Dialectical Behavior Therapy is the most recognized and empirically supported treatment.

*Reactive Attachment Disorder*

There are few empirically supported studies that address treatment for Reactive Attachment Disorder (RAD). Research has shown that supportive, expressive therapy for individuals, as well as their family, is helpful for those suffering from RAD (Tibbits-Kleber & Howell, 1985; Hanson & Spratt, 2000; Hayes, 1997; Shiperis, 2003; Taylor, 2002; Wilson, 2001). The basis of supportive therapy is because the child has failed to establish trusting, intimate bonds with a caregiver; therapy can help to build a bond between the therapist and the client in a safe environment. The therapist needs to be open to trying different techniques with the client to find those, which the client feels most comfortable, and allow for open communication. Clients should be encouraged to express their anger or distrust in order to “free up” their energy to “get beyond their trauma” (Hayes, 1997 p. 358). Often, less intimidating environments than psychotherapy offices should be sought to help the client feel more at ease while the therapeutic alliance is being formed. For younger children this may include activities such as play therapy or story telling (Hayes, 1997). These often can be the clients’ homes, schools, or a favorite
places they have. The therapist needs to be patient because clients with Reactive Attachment Disorder do not trust others. The goals of therapy are to develop self-control, personal boundaries, communication skills, self-identity, understanding natural consequences, and reinforcing reciprocity and nurturing (Wilson, 2001).

Family therapy is also beneficial in helping the client and the family to learn how to form healthy attachments. The therapist helps to facilitate open communication and a supportive environment. The therapist works with the child’s caretakers to teach appropriate, empirically based parenting skills such as behavior management skills and effective coping skills. For younger patients, family treatment is based on education about normal child development (Tibbits-Kleber & Howell 1985). The therapist is also responsible for taking steps to ensure the child is in a nurturing and supportive home environment (Hanson & Spratt, 2000; Sherpis, Renfro-Michael, & Doggett, 2003). Often children with RAD are in foster care or for some other reason removed from their biological parents. In these cases, it is important that the foster parents and caregivers be educated about the child’s needs and how to effectively work to help in during treatment. Foster parents should be educated about “the attachment cycle and the subsequent development of disordered attachment” (Wilson, 2001 p. 47). Foster parents should be encouraged to participate not only in the child’s psychological treatment but also in the school setting due to common comorbid developmental delays. This holistic approach leads to an overall supportive environment.

There are more controversial treatment approaches that are being researched such as Eye Movement Desensitization and Reprocessing (EMDR) and Holding Therapy. The basis of using EMDR as a treatment for children who suffer from RAD is that the EMDR
treatment can help alleviate anxiety caused neglectful and abusive situations the child suffered as and replace the anxiety with positive cognitions about feeling safe in their current environment (Taylor, 2002). Eye Movement Desensitization and Reprocessing combined with supportive therapy may be beneficial to clients suffering from RAD. However, at this time there is little empirical research to support this treatment. In a case study the EMDR technique was used along with family therapy, marital therapy, as well as education and supportive counseling. A follow-up was implemented for one year. At the end of the year the client’s mother reported that the client had improved and had made “big steps in such a little time” (Taylor, 2002 p. 479). Taylor (2002) reported that EMDR should not be used as the sole treatment in helping clients with RAD, and traditional psychotherapy should be stressed before and after EMDR is implemented. Tinker and Wilson (1999) describe case studies in which they successfully use EMDR with clients as well.

Holding Therapy, also known as “the coercive technique” or “rage reduction therapy” (Hanson & Spratt, 2000, p. 142), is an even more controversial technique that involves physical holding of the child by the therapist to “elicit the child’s inner rage” (Wilson, 2001 p 49). This therapy was created in the 1970’s and has been viewed with skepticism since (Wilson, 2001). The goal of this therapy is to attempt to recreate a bonding cycle that is similar to that of a parent and infant by having the child endure annoyances such as poking, tapping, or tickling by the therapist until eventually they “surrender and break down” (Wislon, 2001, p.49). When they break down, they are then given to their caretaker for an opportunity to attach (Hanson & Spratt, 2000). Wilson (2001, p. 38) cites Fahlberg (1990), citing “significant progress in reducing destructive
behaviors, strengthening attachments and increasing emotional expression following holding therapy.” However, this kind of treatment has little empirical research and there is no empirical research to support that it is more effective than more traditional therapies such as supportive therapy. Others have stated that holding therapy can be “cruel, unethical, and potentially dangerous” (Wilson, 2001; James, 1994, p. 43). In one study (Achenbach, 1993; Randolph & Myeroff, 1998; Wilson, 2001) at the Attachment Center at Evergreen a treatment group and control group were compared. Those in the treatment group showed “significant decreases in aggression and delinquency as measured by the Child Behavior Checklist, whereas the controls showed no change” (p.44) Researchers concluded “holding therapy in combination with intensive parenting counseling was effective in reducing problem behaviors” (Wilson, 2001; Randolph & Myeroff, 1998, p. 43). A second study by the same researchers containing 25 subjects reported “significant improvements in behaviors for 76% of the sample” (p. 45). These are significant results, but due to the small amount of participants in the study, conclusions should be made conservatively. Yet another study by Lester (1997) combined holding therapy with sensory stimulation and parent counseling. Researchers indicated an improvement in attachment patterns.

All these studies must be interpreted with caution. None of the studies use holding therapy alone, and all the studies have small sample sizes. Two of the studies lacked a control group, as well as a lack of placebo control (Wilson, 2001). Due to the scant empirical research found on holding therapy it should be avoided as a first or second line of treatment.
Although there is no concrete evidence that Holding Therapy can harm a child, Wilson (2001) quotes James (1994 p. 43) as that Holding Therapy is “degrading, brainwashing, belittling, and forces the child into submission.” There are other less invasive, more empirically validated ways that should be used to treat RAD.

**Conduct Disorder**

Several controlled studies have concluded that Multisystemic Therapy (MST) is effective in reducing symptoms of Conduct Disorder (Brown, Henggeler, Schoenwald, Brondino, & Pickrel, 1999; Carr, 2000; Cottrell & Boston, 2002; Keiley, 2002; Luk, Service, Staiger, Mathai, Wong, Birleson, & Adler, 2001; Mpofu & Crystal, 2001; Phares, 2003; Reed & Sollie, 1992). Multisystemic Therapy, which borrows its treatment modality from family systems and social learning theories, combines strategic and structured family therapy, parent training, marital therapy for parents, supportive therapy related to interpersonal problems, and social skills training among other treatments (Cottrell, 2002). In addressing multiple aspects of the client’s life, MST aims to improve all areas of family functioning and reducing conduct-disordered behavior (Henggeler, Melton, Smith, Schoenwald & Hanley, 1993; Brown, Swenson, Cunningham, Henggeler, Schoenwald & Rowland, 1997; Reed & Sollie, 1992). The client and the family, as opposed to the therapist and the treatment team, are accountable in MST for achieving targeted goals (Brown, Swenson, Cunningham, Henggeler, Schoenwald, & Rowland, 1997). Multisystemic Therapy works within a “social-ecological framework” which allows therapists and clients to use empirically supported traditional treatments in real-life settings. Therapists who work within an MST framework use the client’s naturalistic
setting to conduct the therapy. In using MST the client and therapist work within the client’s “system” to problem solve and find methods to manage everyday stressors. While these unique factors require extensive training, it gives MST therapists more flexibility and freedom to use their personal strengths and creativity to treat individual families (Brown, Swenson, Cunningham, Henggeler, Schoenwald, & Rowland, 1997).

In a study conducted with juvenile offenders, 84 participants were randomly divided into two groups. One group was given “treatment as usual” through services provided by the Department of Youth Services, while the other group was assigned to a family preservation group that used MST as the treatment of choice. The average treatment for both groups lasted approximately 13 weeks (Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993). A 2.4-year follow-up study using Department of Youth Services records examined information about the participants regarding client re-arrest rates. Re-arrest rates were lower for the MST group (20%) than the youth receiving traditional services (39%). In addition, of those who were re-arrested, the mean time between treatment and re-arrest for the MST group was 56.2 weeks, whereas the mean re-arrest time for those in the traditional services group was 31.7 weeks (Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993). Results show that MST is more effective than traditional community services when considering at re-arrest rates. Limitations of this study include no information regarding incarceration rates as a result of the arrests, as well as a high number of re-arrests. Future programs using MST as the treatment modality need to focus on enhancing the effectiveness of the treatment (Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993).
Multisystemic therapy has been tested in schools due to research consistently showing that when parents are involved in their children's education, student's performance is increased and they are more likely to graduate than children whose parents are uninvolved in their education. (Brown, Henggeler, Schoenwald, Brondino, & Pickrel, 1999). Results of a study conducted on youths with multiple serious problems indicated that MST was effective in increasing school involvement and producing long-term effects among the adolescents (Brown, Henggeler, Schoenwald, Brondino, & Pickrel, 1999; Hawkins & Weiss, 1985; Rodick & Henggeler, 1980; Schoenwald, Henggeler, Brondino, & Donkervoet, 1997). In addition, after implementation of MST parents reported, "significant decreases in conduct problems, immature behavior and association with delinquent peers," closer relationships between the child and parent, and closer relationships between the parents. In addition, parents noted increased involvement among adolescents in family discussions. (Reed & Sollie, 1992; Henggeler, Rodick, Hanson, Watson, Borduin, & Urey, 1986).

Family Focused Therapy (FFT), a form of treatment that borrows its theory from systemic therapy, is similar to MST. Therapy is focused on the family system and how it affects the individual, but, unlike MST, does not focus on outside factors. Although parent training is effective when treating families with young children, it is important to include the entire system as the child gets older and problems become more complex (Cottrell & Boston, 2002). Cottrell and Boston (2002) state that meta-analysis of systemic and family therapies generally conclude that family therapies "have positive effects," but that they "often have methodological flaws." There is a need for more well-designed studies to better distinguish the aspects of systemic family therapy that are effective in
treating children suffering from Conduct Disorder (Cottrell & Boston, 2002). Cottrell and Boston (2002) cite Hazelrigg, Cooper, and Borduin (1987) and Markus, Lange, and Pettigrew (1990) in concluding, “family therapy has a positive effect post treatment.” In the same study, family therapy was found to be more effective than no treatment controls and moderately better than alternative treatments (Cottrell & Boston, 2002). “Early studies of FFT demonstrate its effectiveness in reducing adolescent offending behavior” (Cottrell & Boston, 2002; Alexander & Parsons, 1973; Parsons & Alexander, 1973, p.578). Family Focused Therapy follow-ups into early adulthood have revealed that improvements in adolescents with conduct disorder were maintained (Cottrell & Boston, 2002; Gordon, Graves, & Arbuthnot, 1995). However, additional research articulates that the therapeutic alliance may account for almost half of the variability in outcome (Cottrell & Boston, 2002; Alexander, Barton, Schiavo, & Parsons, 1976).

Carr (2000) suggests that less severe cases of Conduct Disorder be treated through functional family therapy, moderate cases through multi-systemic therapy, and severe cases treated through multisystemic therapy combined with temporary therapeutic foster family placement. Although MST is an effective treatment for Conduct Disorder, many of the clients suffering from CD are in residential or foster care placement, which may have a negative impact on treatment simply due to the already disrupted attachment to family and friends (Keiley, 2002; Santos, Henggeler, Burns, 1995; Liddle, Rowe, Dakof, & Lyke, 1998). Because of the disruption in attachment the child proceeds to suffer and negative affect regulation escalates, creating “negative affect cycles of conflict” (Keiley, 2002; Johnson, 1996; Magai, 1998). In addition, children have increased contact with “deviant peers and continuing academic failure, which factor into the maintenance not
treatment of Conduct Disorder” (Keiley, 2002, p. 485). It is important to address the interruption of attachment before adolescents are released from incarceration or residential placement to help them reestablish the bonds they had with family and friends and to address the relationships they would like to have with these people. In addition, Keiley (2002) discusses the problem that although the client is being treated in residential placement, the environment that partly caused the child’s disorder is not improved. To address this concern Keiley (2002) developed an eight week Multiple Family Group Intervention (MFGI) as was discussed in the treatment of Reactive Attachment Disorder above. Multiple Family Group Intervention was used with a group of incarcerated adolescents and their parents before discharge and was found effective in decreasing adolescents “externalizing and internalizing behaviors and increasing functional affect regulation and attachment for adolescents and parents” (Keiley, 2000; Keiley, Liu, & Robbins, 2000 p.489).

Psychopharmacological studies have been sparse and only account for approximately 5% of the research done on conduct disorder in the last 20 years. (Mpofu, 2002 p.13). The use of psychostimulants and antidepressants has been shown to be effective in treating children with conduct disorder (Frick & McCoy, 2001; Mpofu, 2002). The basis for using stimulant medication on children suffering from conduct disorder is that “all behavior has a neuropsychological basis and that CD in particular is thought to be the behavioral manifestation of abnormalities in the neurochemical functioning of the central nervous system” (Mpofu, 2002; Gray, 1987; Quay 1993; Stein, Towey, & Hollander, 1987 p.9). “The serotonin-norepinephrine receptor inhibition effect of antidepressants contraindicates the synaptic serotonin-dopamine deprivation that has
been associated with aggressiveness" (Quay, 1993; Mpfou, 2002). By treating children with conduct disorder with medication, symptoms associated with often comorbid ADHD, ODD, and depression (such as impulsiveness, aggressiveness, and poorly regulated behavior) are managed (Balon, 2003; Frick & McCoy, 2001; Mpfou, 2002; Phares, 2003). Stimulants such as Ritalin, Dexedrine, and Cylert were found to be effective in treating children with CD and comorbid depression and ADHD, but, not as strongly evidenced in children who suffer from CD alone (Mpfou, 2002; Kutcher, 1989; Phares, 2003). Lithium carbonate, as well as anticonvulsants, have shown mixed results in treating children and adolescents with conduct disorder (Mpfou, 2002; Phares, 2003). There are inconsistencies in the research for all the psychopharmacological treatments suggested for CD, and caution should be used when treating CD with psychopharmacological treatment.

Overall, residential placement, group therapy, and individual therapy have not been proven effective in treating conduct disorder (Mpfou, 2002; Kazdin, 1996; Lipsey, 1992; Phares, 2003). After comparing the research between different interventions for Conduct Disorder, Multisystemic Therapy is the most encompassing to treat all different aspects that cause, as well as maintain, the disorder and its symptoms.
Chapter 5
Normative Practice/Outcomes

Treatment was conducted at an inpatient behavioral management facility for youth ages ten through eighteen. Client and therapist met one hour per week for nine months. Residents work through a level system, in which their good behavior earns them rewards. The level system includes the following levels: Freshman, Sophomore, Junior One, Junior Two, Senior One, Senior Two and Graduate. Good behavior is defined as being respectful towards staff and peers, doing your assigned chores, attending school on a regular basis, participating in daily activities with other residents and participating in individual as well as group therapy. The level system begins with “freshman” level and works through “graduate level.” Each week the residents have the opportunity to move up a level if their behavior meets the standards for the next level. Rewards as the clients move up the levels, include, additional monetary allowance, extended free time to spend in their rooms, the privilege to have a radio or TV in their room, a later bed time, Friday outings with the group, family outings, overnight home visits, and the opportunity to order snacks at night.

Residents also have the opportunity to move down a level or several levels if their behavior during the previous week is contrary to the level they are on. Reasons a client may lose their level would be if they attempt to AWOL, if they are disrespectful to staff (i.e.: cursing, not following directions) or if they break a law (i.e. not attending school, smoking or doing drugs while on home visits or at school or assaulting another client or
staff). Although the agency creates guidelines on how many levels a client should be dropped for certain infractions, clinical staff determine how many levels a client should lose depending on their behavior history and severity and circumstances surrounding their current misbehavior.

Inconsistent program implementation is often a problem in cases such as Lady X’s. Due to discrepancy in staff perceptions of misconduct, reprimands are often altered depending on the client. If a client has been on consistent high levels, and is involved in a physical altercation, staff often are hesitant to drop their levels. However, if a client is on a low level their levels seem to be consistently dropped. Because Lady X is consistently on a high level, she is less likely to get her levels dropped, again showing inconsistent implementation of the rules. An additional problem in Lady X’s case was that she often believed she would escape punishment due to her perception that she is more mature than others and should be treated differently. This perception is sustained by the way staff treat her (i.e.: allowing her privileges other residents are not permitted). Due to these inconsistencies and her history of angry outbursts, when Lady X is reprimanded for her behavior by a loss in levels, she becomes resistant and reacts in an unpredictable and often volatile manner. Lady X often uses manipulative behavior directed towards staff members to allow her privileges she has not earned. Due to inconsistencies discussed earlier, she is often successful in manipulating the levels therefore she does not benefit from the therapeutic intent of them.

Regardless of clients’ levels, they are always permitted to participate in individual therapy, group therapy, family therapy and are allowed to visit with their families if their family comes to the shelter on visiting days. Lady X has participated in weekly individual
therapy since her admittance over a year ago. Since then, she has seen three individual therapists. The inconsistency in having one therapist has been difficult for Lady X, given her diagnosis of BPD and her attachment problems.

The goal of therapy during this case study was to implement a multi-modal approach to inpatient therapy. Lady X and the therapist met weekly for one hour over a nine-month period. Client and therapist identified several areas of focus in the client’s life that needed improvement. These included improving interpersonal skills, academics and family relationships. Using a supportive–expressive framework, as well as Dialectical Behavior Skills the therapist and client worked on goals including, reducing her outbursts of anger and aggression, improving her communication and social skills, improving her relationship with family members, setting academic goals and basic life skills in preparation for independent living. During individual sessions, the therapist often challenged the client to take another perspective, as she is egocentric and repeatedly loses sight of her goals when has a bad day and is feeling depressed. An example of this is reminding the client of her desire to go to college and become a successful lawyer when she feels like she hates school and wants to drop out.

Lady X was partially successful in her goal of increasing social relationships. The therapist and client were able to build a therapeutic alliance and the client was engaged in therapy for the 9 months they worked together. Although the client has attachment problems and suffers from BPD, the supportive–expressive techniques used in individual therapy may have helped build the therapeutic alliance. Lady X also has formed a friendship with another resident. The two are able to confide in one another and trust each other to help work through stressful situations. By building female friendships,
Lady X will have the chance to experience a better sense of self in regards to self-confidence and sense of worth. In addition, she will form a social support system for herself rather than having to rely on her distressed family. By using a DBT Interpersonal Effectiveness skill of balancing wants-to-shoulds ratio the client learned to expect less from others in relationships and was less demanding. Therefore, she was able to build relationships with others and have fewer unreasonable expectations of them. In the past Lady X expected staff, her therapist, teachers and friends to fulfill needs that her parents were not fulfilling. Lady X now is more conscious of her expectations of others and is able to understand others' limitations.

Family therapy was also conducted to help Lady X reach her goal of establishing a more supportive relationship with her mother. While Lady X’s mother sporadically made time for family sessions, she was inconsistent in setting time aside to come in for family sessions or to visit her daughter during visiting hours. Lady X claims that she often sees her mother on the weekends during her home visits at her sister’s house, but that they often get in arguments. Lady X and the therapist worked together to help the client examine the reasons for the arguments, and find more adaptive ways to deal with her frustration over her mother’s inconstant parenting. Lady X and her mother have recently begun talking on a more intimate level and sharing their feelings and weaknesses rather than fighting. However, Lady X’s mother has not consistently been involved in family sessions. In Lady X’s situation, family sessions are imperative to help her effectively communicate with her mother and to begin to heal past hurt and resentments she has towards her mother. Although DBT skills of Interpersonal Effectiveness such as
balancing priorities versus demands directed towards the client’s mother, may have been helpful in family therapy, they were not addressed due to minimal family sessions.

Although Lady X is usually compliant in taking her medications, she states that she believes her medication makes her feel more depressed. Currently, Lady X is taking the following medications:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seroquel</td>
<td>50 mg</td>
<td>QHS</td>
</tr>
<tr>
<td>Zoloft</td>
<td>50mg</td>
<td>QAM</td>
</tr>
<tr>
<td>Hydroxyzine Pamoate</td>
<td>50mg</td>
<td>PRN</td>
</tr>
<tr>
<td>Allegra</td>
<td>30 mg</td>
<td>QHS</td>
</tr>
<tr>
<td>Aviane</td>
<td>1 pill</td>
<td>QHS</td>
</tr>
</tbody>
</table>

The client’s Risperdal medication was reduced in late August, due to weight gain and lactation, but her mood and attitude significantly declined. This was to be expected, as Risperdal helped control her moods and her anger. The client was then switched from Risperdal to Seroquel in October and her anger management skills have improved.

Lady X also takes Zoloft to help alleviate her feelings of depression. She states that she is always depressed even though she is on medication, but some days are worse than others. It is hypothesized that if the client discontinued the Zoloft, her depression would be markedly worse, due to her depression in the past when the dosages of Zoloft were lower. The psychiatrist has decided not to try another medication as most days, the client does not appear markedly depressed. One of Lady X’s goals is to be knowledgeable about her medications and be compliant with taking them. If she feels there is a problem with her medications she will ask to see the psychiatrist and discuss
her concerns about the medications with him. The client and therapist work together in individual therapy and cognitive restructuring is used to help client with her depressive feelings. An example of this is helping the client to see how much progress she has made and all of the possibilities for her future, (i.e. college, living independently, a job) rather than looking at her failures and dwelling on the negative aspects of her family and her past. In addition, DBT Emotion regulation skills were implemented to help client feel competent in what she is doing to help herself rather than acting passive and helpless in improving her situation.

Another goal Lady X worked on was anger management. Through supportive expressive therapy, education on relaxation techniques and cognitive behavioral techniques, Lady X has increased her anger management skills. Although at times she had trouble controlling her emotional reactivity in stressful situations, Lady X was usually able to discuss the situation with the therapist and diffuse her anger. Currently, Lady X is better able to handle frustrations by taking a brief walk, using breathing exercises, and thinking about the consequences of her actions. Her favorite exercise is taking a brief walk and removing herself from the situation. Although this is successful in helping her to deal with frustrations at school, it often causes her trouble within the facility due to strict AWOL violations for leaving the building. Lady X will need to continue to work on this goal and explore other efficient skills to help deal with anger frustration in situations she cannot escape (i.e.: child care and at work). DBT skills of being more mindful of her current emotion but “leaving” her emotion and acting opposite to how she feels while staying in the same physical place may be helpful for the client.
Another of Lady X’s goals was academic. This goal includes, attending school on a daily and consistent basis and maintaining average or above average grades. The therapist worked to help the client start a school program outside the residential facility. Although Lady X was initially satisfied with this arrangement, she has recently begun to resist school by feigning illnesses to stay at the facility. When she does attend school, she often leaves class and does her work in the library to avoid other students in the class. Lady X claims she does her work but often states that she feels as though she is failing. The therapist and client have worked together to assess the positives and negatives of the school she currently attends in comparison with other schools. Therapist uses confrontation with the client to address her attempts to feign illnesses to avoid school as well as other unwanted circumstances and the pattern of avoidance this has created in her life. Although the client has partially met this goal, stating that she wants to graduate high school and go to law school, at times she becomes overwhelmed and hopeless, refusing to go to school or do her work. The therapist often reminds client of her academic goals to help client look at her future rather than minor day-to-day incidents. DBT techniques such as building mastery and self-respect were implemented. The therapist worked with the client in helping her to see how many successful people fail time and time again before achieving success, reinforcing the need to be persistent when working towards goals. This is often successful but more work is needed to help client stabilize her pattern of school inconsistency. Pre-Intervention Assessment Testing

The MMPI-A, administered as a pre-intervention assessment measure, showed a slightly elevated level of depression as well. She endorsed items supporting sadness, fatigue, crying spells and self-deprecatory thoughts as well as feelings of loneliness,
pessimism and uselessness. However, the validity of the test is questionable due to an elevated L (Lie) scale, indicating the client responded as being unrealistically virtuous, and demonstrating an unwillingness to disclose personal information. Lady X may be experiencing more or less depression than indicated on the MMPI-A.

The MMPI-A clinical scales profile supported that Lady X has problems with acting out behaviors, social naiveté, lack of insight, and weak self-control. In addition, the scales supported Lady X’s behaviors of blaming others for her difficulties, being moody, argumentative and resentful. The somatization scale was elevated and supports the hypothesis that Lady X uses vague somatic complaints as a defensive style when she encounters stressors such as punishment or to manipulate situations in her favor. This kind of behavior has been seen recently to avoid school.

When analyzing the supplementary scales, Lady X has elevated scores on the Hysteria (Hy) and Psychopathic (Pd) subscales. These subscales take into account somatization, inhibition of aggression, lassitude-malaise, family discord, authority problems, as well as social and self-alienation, all of which Lady X suffers from.

The Interpretive Report from the MMPI-A states that “a clinical profile configuration, which includes Hy and Pd, is the second most frequently occurring well-defined two-point code among adolescent girls in treatment settings. Approximately 6% of girls in mental health and alcohol/drug treatment programs have this clinical profile.” In addition, the MMPI-A interpretive report states that Lady X “appears to have some skill in interpersonal situations, although she lacks genuine warmth and may manipulate other for her own gains, possibly through intimidation.” This is seen quite often in her residential placement, as Lady X fluctuates between charming and aggressive depending on her
needs. The MMPI-A clinical scales profile and interpretive report suggest that Lady X is not a good candidate for traditional psychotherapy, but rather may be more responsive to a behavior management approach.

Lady X was also administered the Trauma Symptom Checklist for Children (TSCC) as a pre-intervention assessment measure to assess Post Traumatic Stress symptoms as well as depression. Although she did not score out of the average range for depression, on the TSCC, she answered “Sometimes” when asked about “Wanting to hurt myself.” However, the TSCC shows that Lady X answered in a slightly “hyperresponsive” manner and that she may have over responded as a cry for help. The common link between the BASC and the TSCC hypothesizing Lady X is responding with a cry for help is congruent with her behaviors in the treatment facility. She often feels like she has no control over her future and wants others to change her situation. Lady X is not specifically being treated for depression in individual therapy, as her depression is an underlying reaction to other stressors and diagnoses.

9-Month Treatment Plan

The following is a recent treatment plan that was updated to show Lady X’s progress.

**NEED #1: Behavioral**

**Statement of Need**

Reduce level of aggression and symptoms of depression.

**Treatment Goal(s) Related to Need**
Lady X will take all medications as prescribed on a daily and consistent basis. In addition, she will learn the uses for the medications and increase her awareness of the effects they have on her. She will request a consultation with the prescribing psychiatrist if she feels she needs and adjustment in medication. Client will also meet with her individual therapist weekly to work on aggression and depression using supportive expressive therapy as well as Dialectical Behavior Therapy techniques (i.e.: Core Mindfulness Skills and Emotion Regulation Skills).
Using Emotion regulation skills, client will learn to “get active” and do things that make her feel competent rather than acting passive.

**NEED #2: Behavioral**

**Statement of Need**
Reduce the intensity and frequency of hostile and defiant behavior towards adults and peers.

**Treatment Goal(s) Related to Need**
Lady X will demonstrate improved frustration-tolerance and anger management skills learned in individual by using relaxation techniques as well as cognitive strategies for controlling anger. Lady X will use emotion regulation skills learned in DBT such as learning cues to identify emotions, being mindful of her current emotion and acting opposite to the current emotion to “leave” the situation. This skill will require the client to distract herself from the situation by doing something nice rather than ruminating about what makes her angry.
**NEED #3: Family**

**Statement of Need**

Reach a level of reduced tension and conflict in the family via improvement of coping skills and communications.

**Treatment Goal(s) Related to Need**

Decrease the frequency of negative and defiant interactions with mom and explore expectations for their future relationship. These goals will be worked on through supportive expression and multisystemic therapy. Client and mother will work together in family therapy to improve communication. Dialectical Behavior techniques, i.e. interpersonal effectiveness skills such as balancing priorities versus demands and attending to relationships will be implemented.

**NEED #4: Academic**

**Statement of Need**

Attend full day school daily and on a consistent basis as well as maintain average or above academic level for the school year.

**Treatment Goal(s) Related to Need**

Lady X will attend school on a daily and consistent basis. Lady X will complete all school assignments and homework, as well as, study for all quizzes and tests to ensure average or above average grades. Using a multi-systemic therapy approach, individual therapist will work with school administration to help client succeed in school. Therapist will work with client and use the DBT interpersonal technique of overcoming obstacles to help client overcome difficulties in school.
Need # 5: Social

Statement of Need

Develop the social skills necessary to enhance the quality of interpersonal relationships.

Treatment Goal(s) Related to Need

Increase recognition of positive and negative peer influences as well as friendships. Lady X will work with therapist on Dialectical Behavior Therapy skills for Interpersonal Effectiveness.
Lady X was administered the Beck Depression Inventory II (BDI-II) in the beginning of treatment with the current therapist. This measure was given to assess the severity of Lady X’s depression. Lady X scored a 17, which falls in the “mild” range for depression. She was again administered the BDI II nine months later and she scored a 1 which falls in the non-depressed range. It is hypothesized that the client is “faking good” as this is a dramatic change from her previous self-assessment score on the BDI-II. She was also administered the Behavior Assessment Scale for Children (BASC) Adolescent form. Lady X’s F score on both the pre-treatment and post-treatment BASC suggests the test be interpreted with caution, as the client may have randomly responded to the questions, may have had trouble reading or understanding them or responded in such a way as a cry for help. However, Lady X responded exactly the same pre and post-treatment to all the F Index questions. The F-index questions that Lady X responded “False” to were, “My mother and father help me if I ask them to,” “I enjoy making new friends” “I enjoy meeting others” and “I am a dependable friend.” The consistency of the answers in both tests, in combination with clinical interviews, attests to Lady X’s distress, and her problems with attachment.

Lady X’s score on the depression scale showed “Clinical Significance” with a score of 74, which put her in the 95th percentile for depression. At this time, per clinical interviews, Lady X was experiencing loneliness, hopelessness and an overall pessimistic
view of her future. Nine months later, Lady X was administered the BASC again and had a T score of 46, which put her in the 51st percentile. Post treatment, the client shows, an “Average” level of depression, which shows an increased level of hopefulness about her future.

The BASC self report assesses the clients school maladjustment was well as clinical maladjustment. At the pre treatment assessment point, the client had average feelings regarding school but had an at risk attitude towards teachers, endorsing items such as “teachers do not understand me” “my teachers want way too much” “most teachers are unfair” and “teachers mostly look for the bad things that you do.” She did not positively indorse items such as “my teacher cares about me” or “my teacher is proud of me.” Nine months later in the post treatment, BASC, scores in “Attitude to teachers” showed that Lady X endorsed items that put her in the “Average” range. Although she did not endorse the statement “My teacher understands me” she did endorse items such as “My teacher cares about me” and “My teacher is often proud of me.” The difference in her attitude towards teachers may be accounted for by her change in schools and teachers since pre-testing as well as her increased overall positive attitude towards school and her current goal of graduating from high school.

In regard to clinical maladjustment, at the beginning of treatment with the current therapist, on the BASC, Lady X displayed elevated “At-Risk” levels on the scales of “Locus of Control” and “Social Stress.” In regard to “Locus of Control,” Lady X’s endorsement of statements such as “I can’t seem to control what happens to me,” “my parents blame too many of their problems on me,” “what I want never seems to matter,” “I get blamed for a lot of things I don’t do,” and “people expect too much from me,”
support statements she makes in individual therapy about feeling like she can not change anything and that no matter what she does things don’t change. The BASC manual p. 60 states that adolescents with a high locus of control “tend to believe that even when behaving as expected, they will not be rewarded systematically or appropriately.” Those with low scores on this scale perceive that they have control over their own successes and failures. Concordant with interviews, Lady X believes that she has little control over her situation, indicating congruence with her high score on the Locus of Control scale. This statement is consistent with how Lady X might feel in the treatment facility when she is inconsistently rewarded.

Nine months later, post treatment testing showed a significant change in “Locus of Control” scale scores. Lady X only endorsed the statement that “I get blamed for things I can’t help.” Although Lady X may still feel slightly out of control, this would be an average response for an adolescent who is not permitted to make all of her own decisions. Lady X’s responses post-treatment are consistent with recent clinical interviews and her current perception that she has more control over her successes and failures than she once perceived herself to have. Lady X’s lower score post-treatment may indicate a lower sense of helplessness than she once had and that she blames less on others. In addition, in the past few months Lady X has been more consistently rewarded for expected behavior (i.e. going home on weekends if on levels and being denied weekend visits when she gets in fights).

Regarding Social Stress, Lady X scored in the “Clinically Significant” range with a T score of 71 (96th percentile) as she endorsed statements such as, “people act as if they don’t hear me,” “other people are against me,” “I feel really stressed out,”
and "other people always find things wrong with me." Her score indicates that she may be emotionally unpredictable. These statements support Lady X's actions in regard to isolating herself from others in unsuccessful attempts to cope with stressors. Nine months later the BASC showed a significant decrease in social stress. Lady X had a T score of 41 (23rd percentile) and scored in the Average range. This score may indicate increased coping mechanisms and a greater ability to increase positive interactions with peers.

In addition, Lady X's anxiety level fell from the "Average" range to the "Low" range. This too may be an indication of improved coping mechanisms and a better sense of control over her future.

Pre-treatment testing did not raise concerns about the "Atypicality" scale however, Lady X scored in the high average range with a score of 58 which is in the 79th percentile. High "Atypicality" scale scores may indicate confused thought processes or an inability to control behavior. Post-treatment testing, Lady X scored 41 which put her in the 19th percentile. Although Lady X scored "Average" in both pre and post testing there is a significant improvement in "Atypicality."

On the Adaptability Scales, Lady X also exhibited significant positive change. Both "Relationship with Parents" and "Self-Esteem" increased. Although Lady X's current "Relationship with Parents" T Score of 37 is still below what is considered "Average" it indicates mild to moderate disturbed relations with parents as opposed to her past clinically significant score of 21 which indicates severe family problems and possible alienation. "Interpersonal Relations" scale scores remained the same in the "Average" range. "Self-Reliance" scores remained the same and continued to indicate below average self-confidence. The BASC manual (p. 62) states that the T score of 30 on
both pre and post treatment testing indicate a possible “difficulty facing life’s challenges (especially emotionally difficult ones) and a tendency to repress unpleasant thoughts or feelings.” This is consistent with Lady X’s actions and how she copes with problems. In future therapy it would be important to address these issues and work on helping Lady X seek additional appropriate supportive means to express emotions, thoughts and feelings. In addition, it is important to address her inability to face challenges and aid her in finding ways to cope with challenges and address them head on.

Overall, Lady X shows improvement in the clinical and adaptive scales of the BASC as well as the BDI-II. However, although her scores seem reliable on the BASC, there is indication that her score on the BDI-II is misrepresentative of her true self. Her attempt at “faking good” may be due to wanting to please the therapist or to avoid perceived negative consequences for not improving in therapy.
Lady X suffers from Conduct Disorder, Reactive Attachment Disorder and Borderline Personality Disorder. In order to treat all of these disorders, many different treatment modalities are needed. For the purposes of this study, the therapist used a multi-modal approach so that aspects of each disorder could be treated in the 9-month time period.

Several controlled studies have concluded that Multisystemic Therapy (MST) is effective in reducing symptoms of Conduct Disorder (Brown, Henggeler, Schoenwald, Brondino, & Pickrel, 1999; Carr, 2000; Cottrell & Boston, 2002; Keiley, 2002; Luk, Service, Staiger, Mathai, Wong, Birleson, & Adler, 2001; Mpofu & Crystal, 2001; Phares, 2003; Reed & Sollie, 1992). In addressing multiple aspects of the client’s life, MST aims to improve all areas of family functioning and reducing conduct-disordered behavior (Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993; Brown, Swenson, Cunningham, Henggeler, Schoenwald, & Rowland, 1997; Reed & Sollie, 1992). During this case study, Lady X received treatment aimed at improving several problem areas. Some of these included, relationships with family, school achievement, peer relationships, self-care skills, and self-regulation.

Although several aspects of multi-systemic therapy were implemented, others were not. Multisystemic Therapy works within a “social-ecological framework” which
allows therapists and clients to use empirically supported traditional treatments in real-life setting. Therapists who work within an MST framework use the client’s naturalistic setting to conduct the therapy. Due to institutional policy, family therapy was not implemented in the home, as often the case in multi-systemic therapy. In-home therapy may have been effective in helping Lady X’s family participate in her treatment, as they had limited transportation, which created barriers to their participation.

In addition, although MST is an effective treatment for Conduct Disorder, many of the clients suffering from CD are in residential or foster care placement, as Lady X is, which may have a negative impact on treatment simply due to the already disrupted attachment to family and friends (Keiley, 2002; Santos, Henggeler, & Burns, 1995; Liddle, Rowe, Dakof, & Lyke, 1998). Because of the disruption in attachment, the child proceeds to suffer and their negative affect regulation escalates, creating “negative affect cycles of conflict (Keiley, 2002; Johnson, 1996; Magai, 1998). Although residential placement is not the ideal treatment setting for Lady X, she is in placement, as her mother does not have a stable and safe environment for lady X to return to. Weekend home visits to her sister’s house have helped Lady X develop and maintain a relationship with her siblings and mother. However, Lady X’s sister’s house is not being considered as an option for Lady X due to instability. Currently, Lady X is on a waiting list for Independent Living which provides a less restrictive environment and requires the client to take more responsibility for self-care.

Lady X also suffers from Reactive Attachment Disorder. Although there are few empirically supported treatment studies, research has shown that supportive, expressive therapy for the individual as well as their family is helpful for those suffering from RAD
(Tibbits-Kleber & Howell, 1985; Hanson & Spratt, 2000; Hayes, 1997; Shiperis, 2003; Taylor, 2002; Wilson, 2001). The basis of supportive therapy is that because the child has failed to establish trusting, intimate bonds with their caregiver, therapy can help to build a bond between the therapist and the client in a safe environment. The therapist needs to be open to trying different techniques with the client to find those that the client feels most comfortable with and allow for open communication.

During the 9 month treatment the therapist used supportive-expressive therapy with the client to build a therapeutic alliance. Through the supportive expressive framework, the client was able to work on sensitive issues in a safe environment. During preparation for termination, the client claimed to feel a strong bond with the therapist. Therapist and client are working together through supportive expressive therapy to terminate in a healthy way so that the client does not feel abandoned once again.

Although supportive-expressive techniques were used with the client, they were not successfully implemented with her family. If Lady X’s family was more involved in her treatment these techniques may have been implemented more successfully and fully to help the client make progress in building relationships with others.

Borderline Personality Disorder is a difficult mental illness to treat. However, several controlled studies have concluded that Dialectical Behavior Therapy (DBT) is effective in reducing symptoms of Borderline Personality Disorder (BPD; Katz, 2000; Katz & Cox, 2002; Koerner & Linehan 2000; Koerner and Linehan, 2002; Linehan, 1993; Oldham, 2002; Paris, 2002; Robins, 2002; Stenhouse & Van Kessel 2002; Stone, 2000; Stenhouse & Van Kessel, 2002; Trupin, Stewart, Beach, & Boesky, 2002). The five categories of skills in DBT are labeled as Core Mindfulness Skills, Interpretation...
Effectiveness Skills, Emotion Regulation Skills, Distress Tolerance skills and Self-Management Skills. It is imperative to align with the client and build a therapeutic alliance.

The therapist attempted to use skills found in Linehan’s Skill Training Manual for Treating Borderline Personality Disorder (1993). The therapist was able to implement aspects of all of the 5 skill categories but was unable to implement all details of the skills due to training and time restraints. Best practice would suggest implementing the skills found in Linehan’s manual as close as possible to gain the best results. However, it is important to remain flexible when working with the client and to focus on their needs rather than implementing every skill to a tee.

Overall, the therapist was able to implement aspects of best practice to treat Lady X. Due to her vast needs, it would be impossible to implement every aspect of best treatment for Lady X, but the therapist should attempt to follow empirically supported treatments as closely as possible to help Lady X continue to make progress.
Chapter 8

Summary and Conclusions

Lady X has a history of trauma and distress. Currently she is being treated with the most effective care possible for the resources available. However, Lady X will continue to progress as she moves towards more independent living and continues to receive individual therapy. It would be of great benefit to Lady X to be a participant in family therapy if they are able to become more involved in her treatment process.

Overall, lady X made significant improvements in reducing her anxiety, depression, and social stress. In addition she was able to improve her self-esteem and self-reliance. These improvements will help Lady X as she matures, to function successfully on her own without having to depend on others to meet her needs. Lady X has goals and hopes for the future, which shows improvement from 9 months ago when she felt she had little control over her future. Lady X has overcome many obstacles and continued to make progress to positively adapt to her environment. She will continue to need support to help her maintain the gains she has made but is increasingly become more self-reliant.
Chapter 9

References


