

Case #1

Amanda

Diagnosis: Social Phobia

Amanda's case is difficult to diagnose because she shows symptoms of both Social Phobia and Separation Anxiety Disorder. First, Amanda demonstrates a disruption in her everyday functioning. The formation of peer relationships in her neighborhood and her school is essentially nonexistent. When confronted with feared situations, Amanda responds with tears, avoidance, and somatic symptoms, such as her vomiting on the school bus. The interaction, and seeming dependence, of Amanda and her mother calls into question the diagnosis of Separation Anxiety Disorder. However, no indication is given by Amanda or her parents that the child is worried that her mother is in any danger. In addition, Amanda is able to act appropriately, and without fear, when interacting with her church friends and her relatives. Therefore, the diagnosis of Separation Anxiety Disorder must be ruled out.

According to the DSM-IV, social phobia is to be diagnosed under the following conditions:

- A. Excessive fear when the individual is exposed to a situation in which he or she will be observed or scrutinized by others; the individual believes he or she may be embarrassed
- B. Confronting the feared situation almost always leads to anxiety; in the case of children, this anxiety may manifest itself as crying, freezing, tantrums, or shrinking from unfamiliar people
- C. The individual is aware that the fear is excessive; however, children may not meet this criterion
- D. The feared situation is avoided or endured with intense anxiety
- E. Daily functioning is significantly disrupted
- F. Duration of at least six months in children
- G. Symptoms are not better accounted for by another disorder or a general medical condition and are not caused by the effects of a drug
- H. If a general medical condition or disorder is present, the fear in condition A. is not related

While Amanda's case should properly be diagnosed as Social Phobia, her mother's overinvolvement with her daughter and the strict rules that both parents have instituted seem relevant to Amanda's overall functioning. Therefore, it was determined that therapy would consist of weekly sessions with Amanda, weekly sessions with Amanda's parents, and monthly sessions with the family. The parents, at first resistant to being seen, were convinced that therapy could help them learn ways to help Amanda.

During the individual sessions with Amanda, the therapist began in a playroom. During the first week, Amanda spent the entire time playing with the Barbie doll she had brought with her. During subsequent sessions, Amanda was not allowed to bring any toys into the playroom with her. Starting with the second session, Amanda began to play more freely with the toys and developed a trusting relationship with the therapist. At this point, the therapist began using the dolls to stage common school and play scenes in which Amanda might find herself. On one occasion, Amanda and the therapist acted out a scene in which a child vomits in the middle of lunch. Amanda's doll immediately helped the sick doll and became her friend.

In the sessions with Amanda's parents, the therapist began exploring the rules in the house. It quickly became evident that both parents had been brought up with strict rules and considered themselves strict, but good, parents. The therapist steered discussion into how the strict rules they grew up with affected their peer interactions. At first, Amanda's father and then Amanda's mother began discussing how they felt different from their peers and how, at times, this had made their life very difficult. Over the course of the first month, both parents began to question whether they needed to be quite as strict with Amanda, especially as she was beginning to get older.

At the first family session, the therapist was pleased to see that although Amanda sat next to her mother, she was not sitting on her mother's lap. In addition, Amanda was wearing blue jeans and a t-shirt. Amanda proudly told the therapist she had made a new friend at school, Kristie, and that she had been invited over to Kristie's house. Mrs. Anderson reported that she was somewhat concerned about Amanda going to Kristie's house and had not yet given permission. At this point, the therapist asked under what conditions Mrs. Anderson might feel comfortable. After discussion, it was agreed that Mrs. Anderson would call Kristie's mother and take Amanda to Kristie's house. Amanda was quite pleased with these results and was willing to discuss other household rules. By the end of the first family session, the parents had agreed to allow Amanda to ride her bicycle in the street as long as she was with another child or an adult and wore her helmet. In addition, she would be allowed to play with two of the children in the neighborhood whose parents the Andersons knew and trusted.

Over the course of the next six months, therapy progressed slowly but

well. After two months, the therapist was able to obtain permission from the Andersons to contact Amanda's teacher. Mrs. Osborne, Amanda's teacher, was pleased to learn Amanda had been seeing a therapist and reported that she had been quite concerned about Amanda based on the reports she had received from Amanda's kindergarten teacher. However, Mrs. Osborne only had to send Amanda home twice because of crying. On both occasions, Amanda had also shown some signs of illness such as an upset stomach, which allowed Mrs. Osborne to tell the other children Amanda was crying because her stomach hurt, not because she was a "crybaby." Both of these incidents occurred during the first month of school. Despite this, Mrs. Osborne had noticed that the other children seemed to tease Amanda more frequently than other children and that Amanda was more isolated than any other child. However, a new child, Kristie, had entered the school approximately ten weeks before. Amanda had immediately made friends with her when the other children held back. Since Kristie was fairly popular now, Amanda had received less teasing. Academically, Mrs. Osborne reported that, while Amanda would probably never be a straight-A student, she worked hard and was able to earn Bs in all subjects.

At six months, the parent sessions were terminated. The family sessions continued to be part negotiation and part monitoring of previous issues. Amanda's sessions continued to focus on modeling difficult situations.

At the end of eight months, both the parents and Amanda felt comfortable terminating therapy. While Amanda was still not allowed to listen to modern music, the rules in the family seemed more appropriate to Amanda and her parents. Even more important, Amanda was able to ride the school bus without significant anxiety or any somatic complaints. In addition, she and Kristie had successfully weathered three fights and were still best friends. Amanda reported that she still hated math but felt that recess and gym, at least, were fun.

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Case #2
Anne

Diagnosis: Major Depressive Disorder

Rule Out: Borderline Personality Disorder

Anne is not unlike many children and adolescents whose symptoms may suggest more than one disorder. Whereas Anne's cult involvement may appear to be a red flag and the focus of her problems, the underlying low self-esteem and depressive symptomatology must be addressed. Anne's diagnosis reflects the seriousness of these underlying symptoms. This diagnosis must be made due to Anne's psychomotor agitation, difficulty sleeping, loss of interest or pleasure in activities previously enjoyed, diminished ability to concentrate, unexplained weight loss, and failure in school. In addition, her self-mutilation and possible identity problems clearly suggest the need to rule out Borderline Personality Disorder in future therapy sessions.

According to the DSM-IV, Major Depressive Disorder is diagnosed when the following five criteria are met:

- A. Five or more of the following symptoms must be present nearly every day for a period of two weeks, represent a change from previous functioning, and must include either 1 or 2 below:
 1. Depressed mood (can be irritable in children or adolescents)
 2. Loss of interest or pleasure in all or almost all activities
 3. Weight loss when not dieting or an increase or decrease in appetite
 4. Insomnia or hypersomnia
 5. Objectively observed psychomotor agitation or retardation
 6. Fatigue or loss of energy
 7. Feelings of worthlessness or excessive or inappropriate guilt
 8. Difficulty thinking or concentrating, indecisiveness
 9. Suicidal ideation, with or without a plan, suicide attempts
- B. Symptoms must not meet criteria for a Mixed Episode

- C. Symptoms must lead to clinically significant impairment or distress in social, occupational, or other important areas of functioning
- D. Symptoms must not be directly caused by a general medical condition or by the direct physiological effects of a substance
- E. Symptoms must not be better accounted for by bereavement

Discussion

After the initial session, Anne's mother, Ms. Newsome, was brought back into the office. The therapist explained that Anne was suffering from depression. The therapist went on to reassure Anne's mother that although Anne's behavior may have seemed bizarre, Anne was not crazy. However, the therapist also stressed Anne's situation was very serious, and needed to be treated as quickly and effectively as possible. On the basis of this discussion, it was agreed that Anne would be seen weekly for cognitive-behavioral therapy. The therapist explained to Ms. Newsome that continual assessment of Anne's condition would be made to avoid missing any additional developments. Ms. Newsome asked about prescribing an antidepressant for her daughter. This option was discussed at length. Although some clinicians have used antidepressants with children and adolescents, this is still somewhat controversial because these drugs were developed for and tested on adults. Following this discussion, Ms. Newsome agreed to first attempting to treat her daughter without the use of drugs.

A cognitive behavioral treatment program was developed to address Anne's problem areas. The program involved fourteen twice-weekly sessions that focused on teaching methods of relaxation, increasing pleasant events, controlling irrational and negative thoughts, and increasing social skills and conflict resolution skills. In addition, the therapist included critical discussions of various religions because of Anne's interest in Satanism.

As a result of continued assessment during the program, the therapist was able to rule out Borderline Personality Disorder. Anne did not demonstrate the identity problems inherent in this personality disorder. By the end of the third week of therapy, Anne had ceased her involvement in Satanism, had cut her hair to one length and stopped dyeing it, removed her make-up, and was no longer dressing in black. Over the course of the next four weeks, Anne began to show more affective expression, more interest in school and her friends, and was able to laugh about her self-mutilation.

At the end of the treatment program, Anne contracted with the therapist for twelve additional sessions to discuss her feelings about her parents' divorce. These sessions continued to be structured around the original treatment plan but with more focus on helping Anne express her feelings about negative events and find constructive ways of dealing with these emotions.

CASE 3 *Jimmy*

Diagnosis: Attention Deficit Hyperactivity Disorder

Diagnosing a child with Attention Deficit Hyperactivity Disorder (ADHD) is a task that requires careful consideration. Over the past ten to fifteen years, this disorder has become the common cold of childhood psychopathology. Therapists and parents need to be careful not to assume a child is truly suffering from ADHD on the basis of a teacher's or a parent's report. It is critical to remember that the DSM-IV requires documentation of symptoms in at least two separate settings. Physicians also need to be very careful not to diagnose a child as suffering from ADHD based solely on a parent's subjective reports of their child's behavior. A careful assessment of the child by a qualified psychologist is the first step to successfully ameliorating the problems associated with this condition. In the present case, there was clear documentation of Jimmy's problems in the home, in the therapist's office, and in the school. Frequently, however, cases are not as clear as the case of Jimmy. Many children with ADHD can perform extremely well in the therapist's office, as this type of one-on-one contact enables them to focus their activity in a more acceptable manner. Because of this, a school or home visit may be critical to accurately diagnosing a child with ADHD.

According to the DSM-IV, ADHD is only diagnosed when the following conditions and/or symptoms are present:

- A. Symptoms leading to impairment present before the age of seven
- B. Documented impairment in two or more settings
- C. Clear evidence of clinically significant impairment in social, academic, or occupational functioning
- D. Symptoms do not occur exclusively during the course of another mental disorder
- E. Either 1. or 2. below:
 - 1. Child must exhibit six or more of the following symptoms of inattention that have persisted for at least six months and are maladaptive and are not developmentally appropriate

Case 3 Jimmy

- a. Poor attention to detail; makes careless mistakes in schoolwork, work, or other activities
 - b. Difficulty sustaining attention
 - c. Fails to listen even when spoken to directly
 - d. Fails to complete work or instructions, but not as a result of a lack of understanding or oppositional behavior
 - e. Organizational difficulties
 - f. Often avoids, dislikes, or is reluctant to engage in tasks requiring sustained mental activity
 - g. Often loses things
 - h. Easily distracted
 - i. Forgetful
2. Child must exhibit six or more of the following symptoms of hyperactivity or impulsivity that have persisted for at least six months and are maladaptive and are not developmentally appropriate

Hyperactivity

- a. Often fidgets or squirms in seat
- b. Can't sit for long periods of time; gets out of seat
- c. Often runs about or climbs excessively in inappropriate situations
- d. Difficulty playing or engaging in leisure activities quietly
- e. Often "on the go" or described as "driven by a motor"
- f. Often talks excessively

Impulsivity

- g. Blurts out answers before the question has been completed
- h. Difficulty awaiting turns
- i. Often interrupts or intrudes on others

Discussion

Given the extensive literature on the treatment of this disorder (see for example, Engeland, 1993), the therapist decided that a combination pharmacological and behavioral treatment approach would be most effective in this case. These treatments appear to work well in combination and provide both immediate relief of the symptoms and long-term reinforcement of positive behavior. This approach was also viewed as one that would be most acceptable to Jimmy, his parents, and his teacher. While this should never be a prime consideration in treatment selection, it is fortunate when the most effective approach also happens to be one which would have high acceptance for the participants in the program.

With the parents' approval, Jimmy's physician was contacted and appraised of Jimmy's diagnosis of ADHD. After discussion of Jimmy's symp-

CASE 4 *Randall*

Diagnosis: Oppositional Defiant Disorder
Attention Deficit Hyperactivity Disorder

Rule Out: Conduct Disorder

In Randall's case, the biggest considerations in terms of diagnosing involve his previous diagnosis of ADHD and the possibility of Conduct Disorder. Randall was taking his Ritalin throughout the assessment process. It is the belief of Randall, his teachers, and his parents that his behavior was worse when he did not take his medication. Taking Randall off the medication at this time does not seem warranted. However, Randall's present behavior does not confirm ADHD. In looking at the criteria for a diagnosis of ADHD (see Case 3, Jimmy), Randall fails to meet these criteria. It is not unusual for children to exhibit both ADHD and Oppositional Defiant Disorder, however, and, in the absence of being able to assess Randall without the presence of Ritalin, this diagnosis appears to make the most sense. Likewise, Randall shows similar behavior to that needed for a diagnosis of Conduct Disorder (see Case 5, Scott). However, the level of Randall's behavior is not as aggressive nor as confrontational as seen in Conduct Disorder. Many psychologists believe that Oppositional Defiant Disorder is simply a less severe form of Conduct Disorder.

It might seem odd that Randall was essentially compliant with the requests of the examiner in light of his behavior at school and in the home. However, clinicians frequently note that children exhibiting these symptoms are more likely to experience problems with adults and children they know well.

Randall's behavioral problems most closely follow the criteria of Oppositional Defiant Disorder, which are outlined as follows:

- A. Characterized by a pattern of behavior, of at least six months' duration, including negativistic, hostile, and defiant behavior in which four (4) or more of the following are included:

1. Frequently loses temper
 2. Frequently argues with adults
 3. Actively defies or refuses to comply with the demands of adults
 4. Frequently annoys people on purpose
 5. Frequently blames others for his or her own mistakes
 6. Frequently annoyed by others
 7. Frequently angry or resentful
 8. Frequently spiteful or resentful
- B. These behavioral problems lead to clinically significant disruptions in daily functioning

Discussion

The use of a parent-training approach was determined to be the best choice for Randall and his parents. Parent training has been found effective in cases of Oppositional Defiant Disorder and was acceptable to Randall's parents. Individual psychotherapy was considered but rejected because of the high relapse rate associated with this approach.

The Ellises joined a parent-training group, led by the psychologist, that focused on the use of behavioral strategies and psychoeducational in nature. Parents in the group are taught specific behavioral techniques that increase the likelihood of maintaining control of the child. Gradual shaping of the child's behavior to be more age-appropriate is accomplished through the use of a behavioral monitoring and reward program.

The Ellises selected Randall's hitting as one of the first behaviors they wished to address. Rather than spanking Randall each time he hit one of his siblings, a plan was developed involving loss of privileges. The most important activities and personal items of Randall were identified. Each time Randall hit one of his siblings, one of these activities or items were lost for one day. The Ellises were enthusiastic during the development of the plan but, after the first week, reported that the implementation of the plan was more work than they had expected. Other group members were able to share with the Ellises the eventual positive outcomes they had experienced by adhering to the plan despite the increased effort. Over the course of the next seven weeks, Randall decreased his hitting in the home significantly. Additional problematic behaviors were addressed one at a time. The therapist discovered that the Ellises tended to be quite strict with their children. At some points, the Ellises were encouraged to reevaluate their rules and to allow Randall more autonomy. During this time, increased chances for positive interactions between Randall and his parents, individually and together, were also planned.

The problems Randall was having at school also needed to be ad-

dressed. The therapist, along with the school psychologist and Randall's teacher, developed a behavioral plan for use during the school day. The most disturbing behaviors to the teacher were the class disruptions (including passing gas and head banging), rude comments, and Randall's loud tone of voice. Both the school psychologist and the teacher acknowledged that they would threaten Randall with expulsion but did not actually expel him. It was decided that in-school suspension would be used instead of the threat of expulsion. A plan was developed allowing the teacher to give Randall three blue cards each day. If Randall received three blue cards, he would immediately be sent to the principal's office where he would complete the remainder of his school work in an isolated room. If the third blue card was given after 2 P.M., Randall would spend the entire next school day in the isolated room. On days when Randall received fewer than three blue cards, Randall would be allowed to choose a book from the teacher's collection of books that were given to children for positive behavior.

Randall was skeptical of the program when it was explained to him. On the first day, he earned all three blue cards within twenty minutes. When asked to go to the principal's office, Randall knocked his desk over and stomped out of the room. On the next day, Randall again earned all three blue cards within thirty minutes. This time he quietly left the room when requested. On the third day of the program, Randall did not earn his third blue card until after lunch. He became visibly upset when the teacher gave him the third card and left the room before the teacher could ask him to do so. On the fourth day, Randall earned only two blue cards. Once school was over, the teacher allowed Randall to select a book. Randall spent close to fifteen minutes shifting through the stack of books until he finally made his decision. When he came to school on the fifth day of the program, Randall told his teacher that he had already read the book and asked if there was a sequel. Over the course of the next four months, Randall was able to earn a book approximately two times a week for the first nine weeks and then about three times a week for the remainder of the year. One unanticipated side effect of the program was that other children began to ask Randall which books they should choose to check out in the library. At the end of the school year, Randall continued to antagonize many of the girls in his class by making rude noises and poking them in the back or arm. His rudeness toward the teacher and the number of class disruptions decreased drastically. In addition, Randall's grades improved to all Bs and Cs.

At the end of the sixth grade, Randall was demonstrating more appropriate behavior both at home and at school. During the summer, Randall's Ritalin was discontinued. Randall and his parents reported no increase in problems as a result of the discontinuation of the medication over the summer. A meeting was held with Randall, his parents, the therapist, and the physician to discuss whether Randall should be placed back on Ritalin at the start of seventh grade. Randall would be changing schools for seventh grade, enter-

ing the local junior high. Although Randall was somewhat apprehensive about his ability to perform well at school, he agreed to a four-week trial of no medication. During these first four weeks, the Ellises reported to the therapist their observations of Randall, brought in Randall's school work, and reported on their first parent-teacher conference. The Ellises reported that Randall continued to bump girls in the hallway but had made several new friends on the school newspaper. His teachers reported that Randall exhibited no unusual behavior and one teacher could not remember which child Randall was. Randall's school work showed a consistent pattern of Bs. At the end of the four-week period, it was decided, with Randall's agreement, that medication would be discontinued until further notice. Over the course of the year, the Ellises continued to attend parent-training group sessions aimed at improving their skills at addressing individual behaviors. Randall achieved Bs in the seventh grade and was not sent to the principal's office even once during the year. The Ellises discontinued attending the parent-training group sessions during the summer after Randall completed the seventh grade. The therapist did not receive any further information about Randall.

CASE 5 *Scott*

Diagnosis: Conduct Disorder, Childhood-Onset Type, Mild

Scott's current diagnosis must be Conduct Disorder because of his symptoms, which included intimidating the other children and stealing their money, repeated lies to avoid obligations, and running away from home. Given that Scott demonstrated at least one of these criteria before the age of ten, childhood-onset type was specified. At this point, Scott's conduct disorder can be said to be mild because his behavior has caused only minor harm to others. His fire setting, if allowed to continue, may eventually lead to a change from mild to moderate.

According to the DSM-IV, conduct disorder is diagnosed when:

- A. The behavior leads to clinically significant impairments in social, academic, or occupational functioning, and
- B. A pattern of behavior is seen in which the basic rights of others are violated or major age-appropriate social norms or rules are violated. This must be objectively demonstrated by the presence of three or more of the criteria listed below within the past twelve months. In addition, at least one of the criteria listed below must have been present within the past six months:
 1. Aggression to people or animals
This may include:
 - a. Bullying or threatening others
 - b. Initiating physical fights
 - c. The use of a weapon that might cause serious harm to another (e.g., a knife)
 - d. and e. Physical cruelty to people or animals
 - f. Forcing sexual activity on another
 - g. Stealing while confronting the victim
 2. Destruction of property
This may include:
 - a. Deliberately setting fires with the intention of causing serious damage

- b. Deliberately destroying others' property (other than fire setting)
- 3. Deceitfulness or theft
This may include:
 - a. Breaking into someone's house, building, or car
 - b. Frequent lies to obtain privileges or goods, or to avoid responsibilities
 - c. Stealing items of little to no value without confronting the victim
- 4. Serious violations of rules
This may include:
 - a. Staying out at night despite parental warnings, beginning before adolescence
 - b. Running away from home overnight at least twice or once if for a lengthy period of time

Discussion

While the therapist saw Scott's case as potentially salvageable, Scott's parents were not willing to pursue therapy past the initial evaluation. Scott was placed in a boarding school for "troubled boys" in another state. After three weeks at this school, Scott was expelled for burning down the dorm. Fortunately, none of the students were injured. Charges were pressed against Scott and he was sent to a group home for delinquent boys. He remained at this home for three months before he and two older boys ran away. The three were caught a few days after leaving the home when they attacked a homeless man, stealing his money (\$4.85) and beating him. As a result of this crime, Scott was sent to a detention facility until his eighteenth birthday. The therapist heard no further information about Scott.

In recent studies, several effective methods of treating children with problems such as Scott's have been identified. If a child is identified with Oppositional Defiant Disorder (a milder form of Conduct Disorder that typically precedes the development of Conduct Disorder), parent-training programs and cognitive-skills training programs used in combination have been found to effectively reduce problematic behavior (see, for example, Kazdin, 1995).

Once these children reach adolescence or become chronic juvenile offenders, the parent-training approaches do not appear to be as successful. One exception to this might be the functional family therapy developed by Alexander and his colleagues (e.g., Morris, Alexander, and Waldron, 1988). In this approach, behavioral-social learning and cognitive-behavioral and family-systems perspectives are combined in a focus on the interpersonal processes of the family.

Once the child has entered the juvenile system, most experts consider incarceration to be the least favorable approach because it seems to lead to higher recidivism rates. Alternatives might include restitution, intensive pro-

bation supervision, and wilderness programs. Restitution involves the youth being required to pay money or perform community service for the victim or the community. Intensive probation supervision includes more frequent supervision by a probation officer, the involvement of the family, and involvement of other social services such as job training. Wilderness programs have become quite popular as a result of their focus on individual development and group cooperation. Unfortunately, these alternatives to institutionalization have not been adequately evaluated.

The Teaching Family Model (Fixsen, Wolf, & Phillips, 1973) is one community-based program that has led to considerable research. In this behaviorally oriented program, youths live in a house with two trained teaching parents. While in the program, the adolescents show marked improvement. Unfortunately, once they leave this structured environment, the gains they have made are frequently lost.