Part I.
Assessment and Case Conceptualization
INTRODUCTION TO HOLISTIC CBT ASSESSMENTS

This manual provides an organized system to address the complexities of young adolescents. The adolescent often has had multiple pathways to his/her problematic behavior. The traditional methodology of CBT/relapse prevention typically fails to take into account the underlying psychodynamics that play into the individual’s acting-out. Problem behaviors are often the result of a convergence of Axis I mental illnesses and Axis II personality disorders for individuals with childhood histories of deprivation and abuse. The Case Conceptualization Method, (CCM) broadens CBT’s traditional focus on cognition distortions and thinking errors to gain a more holistic understanding of the adolescent, while addressing specific unhealthy problem behaviors.

Although many assessment measures are used in the responsibility and treatment program, there are three structured interview assessments that play a predominant role in the CCM used in this manual. The three instruments must be delivered in the following order:

- Typology Survey (TS).
- The Fear Assessment-Revised (FAR).
- Core Beliefs Questionnaire (CBQ).

These assessments have been used in treatment-research in several studies (Apsche, Ward & Bailey, 2003,2004). Some of these studies can be obtained in a refereed online journal at the following web-site: www.behavior-analyst-online.org. Please look in the on-line Journal of the Behavior Analyst Today, Volumes 4.4, 4.3, 4.1 and 3.4 and The International Journal of Behavior Consultation and Therapy, Volumes 1.1, 1.2, 1.3, 1.4 for more detailed information.
ASSESSMENT GUIDELINES

Assessment is interpersonal and interactive: Accurate comprehensive assessment is the key to gaining a clear conceptualization of each individual client. Unlike other psychological tests, the three assessment instruments described here are interactive and interpersonal in nature. The assessment instruments are not given to the client to complete on their own. Therapists are expected to administer the assessments verbally in a face-to-face, interactive interview.

Before the assessment: Therapists should be familiar with the specific instructions for each assessment instrument before administering it to a client. Therapists can view available training videotapes, practice using the instruments, and score practice administrations in order to gain confidence and competency.

Before meeting with the client, the clinician should first review the client’s records to gain familiarity with the client’s psychosocial history, abuse history, psychosexual history, and current treatment issues. If possible, the clinician is also encouraged to interview collateral sources for additional information, such as a parent, sibling, primary caretaker, spouse or significant others, who know the client well.

Administration environment: It is important to have an atmosphere conducive to the proper administration of the assessment. A quiet room is useful to minimize distractions and promote a sense of privacy and safety for the client.

Informed consent: The client should be given an opportunity to consent to the assessment. Inform the client of the process that will be taking place during the assessment sessions. (Depending on the individual’s cooperativeness and level of functioning, it may require several sessions to complete the assessment instruments.)
It is important to explain the nature of the assessment and its purpose before beginning. The clinician can enlist the client’s cooperation by letting him know that he can better help himself by providing the requested information because he is the best expert on himself.

**Guidelines for assessment sessions:** The following guidelines should be followed when administering the particular assessment instruments for the CCM as described in this manual:

- Explain the purpose of the assessment to the client before beginning the process.
- Explain the kinds of questions you will be asking, i.e., “I am going to ask you some questions about your past in order to learn more about you.” Tell the client to inform you if he begins to feel uncomfortable or tired because the structured questionnaires/interview can be a somewhat lengthy process. If necessary, the assessments can be completed in segments over several sessions.
- It may be beneficial to begin the assessments with questions which are less threatening or emotional for the client. For example, you could ask questions referring to physical abuse before those referring to sexual abuse. Be aware of the comfort level of the client. It is okay to periodically ask the individual how he is doing, since clients are often hesitant to tell you that they feel uncomfortable.
- Maintain an open conversation while administering this assessment. Allow clients to ask questions and talk without interruption. It will encourage the client to speak more freely and this will facilitate more details and more candid information. Once the therapist begins the assessment, all responses should be recorded in the space provided on the structured questionnaire/interview forms.
- Whenever possible, the clinician should use real life examples to make the assessment experience more personally meaningful and relevant to the individual client.
- Therapists should endeavor to complete all questions, even if some items seem irrelevant. This information is essential for completing the Case Conceptualization that will guide future therapeutic interventions.
**THE CORE ASSESSMENTS BATTERY**

**Typology Survey**

The first assessment instrument is the Typology Survey, (TS). It consists of twelve sections, which are completed through a combination of structured clinical interview, chart review and, when feasible, collateral interviews with parents, siblings, primary caretakers or significant others. The information gathered in these twelve domains of assessment is reflected in the elements of the integrated interdisciplinary assessment process (as described in the Operations Manual, Section III.E.) and may be obtained from multiple members of the treatment team representing their disciplinary domains of specialization (psychology, nursing/medical, recreational, educational/vocational, etc.).

I. **Identifying information:** Fill in the client’s name, date of birth/age, ethnicity, and date of admission.

II. **Family information:** Relevant information regarding the client’s family of origin. Include whether the client lived with an adoptive, foster, or biological family. It is important to identify any young children who were also in the home and their gender. This information may have future importance in determining home visit eligibility, others safety, and discharge planning/placement.

III. **Substance abuse:** Relevant substance abuse history. If the client has a serious substance abuse problem or history, the clinician may choose to refer the client to another team member with chemical dependency treatment expertise.
IV. Medical: Relevant medical history, including childhood head trauma, central nervous system damage, and/or maternal drug/alcohol use during pregnancy. These are all known to have adverse effects on a person’s ability to function effectively.

V. Educational/vocational: Relevant educational history and functioning, including any vocational or prevocational training, special education status, academic goals, and any vocational or independent living training.

VI. Emotional: Relevant history regarding suicidal, homicidal, and escape ideation, gestures and/or attempts. Include sleep, appetite, mood, bedwetting, fire setting, cruelty to animals, and previous treatment history (e.g., outpatient counseling, client programs, hospitalization, substance abuse, psychiatric treatment, etc.).

VII. Physiological: Describe one situation during which the client became angry, then identify each physiological change that the client experiences, and finally rank the responses in the order in which they occur.

VIII. Interpersonal relationships and sexual history: Relevant interpersonal history and sexual history. Include what the client likes to do for fun and what the client typically did during free time. Sexual history is important to gain an understanding of the client’s sexual habits, preferences, and deviancy. Many times clients do not recognize that what they consider to be normal consensual experiences are abusive behaviors.

IX. Abuses: Fill in the worksheet. Include the other’s name and relationship to abuser; the ages of the client and other at the time of the abuse; number of times the abuse occurred; description of the abuse; how the client got the other to go along with the abuse; how the client was caught; and any related criminal charges. If there are multiple known others, the therapist should photocopy the worksheet section and repeat this section for each major identified other.

X. History of physical and sexual abuse: Fill in the worksheets, one for physical abuse and one for sexual abuse. Include the abuser’s name and relationship to client; ages of the abuser and the client at the onset of the abuse; duration of the abuse; number of times the abuse occurred; description of the abuse; how the abuser got the client to go along with the abuse; how the abuse was discovered;
what was done about it; if the abuse had been reported; and the outcome of
reporting the abuse. If the abuse has not been reported, consult a senior clini-
cal supervisor and state regulations on reporting, and report the abuse as
appropriate.

XI. History of other abuse: Identify history of emotional abuse. Emotional abuse is
defined as poor treatment of a child, such as calling the child names or making
statements that the child is worthless, a bad person, deserves to be abused, will
never amount to anything, etc. It is important to address if the abuse had been
reported and what the outcome of the reporting was. Neglect is defined as fail-
ing to provide and/or care for a child. This can be in terms of food, shelter,
clothing, attention, love, lack of parenting, etc. In the final part of this section
include any other traumas experienced by the client, such as the death of a
loved one or friend, having one’s life threatened, witnessing any violence, fam-
ily stresses, gang involvement, and any survival skills the client needed and
used to survive in his/her home environment.

XII. Expectations of treatment: Include what the client would like to do differently
after discharge; goals the client has for the next year; willingness to be involved
in family therapy; and what the client would like to be different about himself.
It is also useful to assess the client’s initial level of commitment to treatment.
These questions will help to establish a foundation for treatment.
The Fear Assessment – Revised

The second assessment instrument is the Fear Assessment-Revised, (FAR). It is administered after completion of the Typology Survey. It is a 60-question assessment exploring the fears of a given individual, which provides insight into the client’s underlying traumas. Each “fear” is something that can be endorsed as “sometimes,” “almost always,” or “always,” or not endorsed as “never.” FAR is important for completing the “Fear/Avoids/Core Beliefs Correlation” component of the Case Conceptualization.

The FAR is designed to be completed in a collaborative manner. It is not intended to be a typical pen and paper psychological test, but is an interactive and collaborative gathering of personal information that will be vital to conceptualizing the case and designing an individualized treatment plan for the client.

First step: Therapist ratings of the client’s fears: Based on the therapist’s review of the client’s records, and any behaviors seen, verbalized, and documented, the therapist should go through the FAR and endorse each fear that he/she suspects or believes to be valid for the client. This is done before administering the FAR to the client.

Note: The therapist should not endorse fears that the client might be expected to endorse. Rather, the therapist is only identifying fears that the therapist believes would be true for the client. The therapist can differentiate his/her responses from the client’s responses by highlighting or circling each fear item with a different color ink.

Second step: Interviewing the client: The goal is to prompt the individual to disclose as much information about their fears and traumas, while being mindful of the
client’s level of comfort in sharing emotional information. Attempt to help the client feel comfortable as possible. Begin the assessment interview by first explaining the types of questions that will be asked (i.e., “I am going to ask you some questions about how you feel about certain situations”) and explaining the scale of possible responses, (i.e., “Tell me if you fear this sometimes, almost always, always, or never.”) Each “fear” is something that the client can endorse as “sometimes,” “almost always,” or “always.” Or, the client may not endorse the fear by responding “never.”

Some helpful guidelines for conducting the FAR interview: clients vary in their ability to understand and respond accurately to the assessment. If the therapist encounters some of the following challenges, he/she may use the corresponding techniques for a better outcome.

1) **Discomfort with the rating scale:** Some clients find the number scale too restricting. In this case, it can be useful to begin by asking if the fear is present or not. If the client endorses the fear as present, then the therapist can identify the frequency or intensity of the fear. For others, it can be helpful to describe the scale a little differently as a choice of “never, sometimes, almost always, or always.”

Keep in mind that disclosing fears causes clients to feel vulnerable and embarrassed. It is therefore natural for clients to sometimes protect that vulnerability by reporting fears as occurring sometimes or even never. If you notice that the client is predominantly responding with “never” and/or “sometimes,” it may be helpful to review the fears that were highlighted when you completed the assessment prior to administering it to the client. It is important for you to explore fears that you believe to be true. Share your reasons for believing the fear to be true with the client and discuss the discrepancy between his/her response and your belief.

2) **Concrete responding:** Some clients process questions in a very concrete fashion and thus may fail to endorse a given fear simply because they are not feeling the fear right now or recently. It is important to explain that fears can come and go. It may be helpful to explore scenarios to help the client identify if the fear is present during specific times. The goal is to identify major fears that the client has experienced over his/her life as a whole. Sometimes clients will require prompting or clarification of terms to help them to accurately endorse their responses.
3) **Prior treatment effect:** Some clients feel that they have improved as a result of prior treatment and therefore they are less bothered by former fears. As a result, they may tend to under-endorse the presence of fears. In this case, the clinician should clearly instruct the client to answer as he felt prior to treatment. Again, the goal is to identify major fears that the client has experienced over his/her life as a whole. In addition, you may phrase the fear questions in the past tense: “How often have you felt afraid of...?”

4) **Defensive responding:** If the client reacts strongly to the word “fear,” the therapist may use substitute words that are less threatening or more comfortable for the client, such as anxious, nervous, bothered, uncomfortable, hard time, difficulty, dread, upset, etc. For example, the therapist can ask if the client “worries” or has “difficulty” with ____? Or “Does ____ ever bother you?”

5) **Confusion and/or indecision:** Some clients get “stuck” and can’t decide how to rank their endorsement of a fear. Or they may be confused by the question. Here it can be especially useful to use real life examples and/or scenarios, etc. For example, fear item #48 reads as “Fear of someone standing too close to me.” The therapist can help to clarify or explain this item, for example, by suggesting a real-life situation where, “You are standing on the corner near your house and all of a sudden someone comes up behind you. Do you feel anxious, worried, nervous, etc.?” Or the therapist may rephrase a confusing or difficult-to-answer item. For example, question #6 reads as “Fear of closed rooms.” The therapist could suggest that, “It’s getting dark; it’s hygiene time; staff directs you to go to the shower. What is your level of fear, worry or anxiety?”

**Third step:** Exploring differences in therapist and client endorsements: The therapist should explore any fear that he/she believed would be true for the client, which the client did not endorse. If necessary, the therapist can explain or discuss the reasons why he/she highlighted the fear. This is important! If the client does not endorse a fear that you have highlighted, spend time clarifying what the fear means and how the client’s behavior suggests that he endorses it. Explain the context and/or meaning of the fear. However, don’t try to persuade or coerce the client into endorsing a given fear. Simply clarify the meaning of the type of fear and explore its possibility with the client.
**Fourth step:** Examining the response pattern for further exploration: During and after administration of the FAR, the therapist should be looking at the pattern of responses. Resistant and/or severely abused clients will tend to provide predominantly “never” or “sometimes” responses. These clients do not want to be seen as vulnerable and will therefore, attempt to protect themselves by not endorsing fears which they perceive as exposing them. In order to obtain better results, the therapist should consider how they could re-visit some of these items in a less defensive way, which may encourage a more forthcoming response. Then the therapist can continue the process in a subsequent interview.

**Fifth step:** Review endorsement of “Personal Reactive – External” Fears: There is a subset of items on the FAR, which are clinically salient and should be examined. The “Personal Reactive-External Fears” is a subscale of the FAR consisting of the following items: (Numbers correspond to the worksheet.)

1) Fear of trusting anyone.
2) Fear of trusting males.
3) Fear of trusting females.
4) Fear of trusting a relative.
12) Fear that I did something wrong.
21) Fear of someone knowing the secret.
23) Fear no one will believe me.
24) Fear I have no one to talk to.
27) Fear of being caught.
28) Fear that people will know by looking at me, I’ve done something wrong.
30) Fear that I am sick and they will find out.

“Personal Reactive External” is a subscale of the FAR. Individuals who endorse these fears tend to emotionally overreact in an instant to perceived threats. In turn, this extreme internal reactivity blocks or disables the ability to use cognition to maintain control (this is latter described as “emotional dysregulation”, see Section I.4.A.). Endorsement of any of these fear items can therefore be clinically significant, and endorsement of many of these fear items is indicative of an individual who may present serious behavioral challenges in the treatment milieu.

In most cases, the therapist should prioritize Personal Reactive-External Fears at the top of the treatment hierarchy because they typically manifest themselves in behavioral outbursts that can be violent and/or disruptive to treatment.
Do’s and Don’ts of administering the FAR:

DO
• Ask for training or a demonstration of how the questionnaire is administered.
• Be relaxed and patient.
• Take your time (use several sessions if necessary).
• Make eye contact when appropriate.
• Be observant.
• Give scenarios.
• Be supportive.
• Clarify fear items with the client and give examples as needed.

DON’T
• Read the assessment verbatim to the client.
• Give the assessment to the client to complete by himself.
• Move too fast through the assessment.
• Answer for the individual.
• Lead the individual to answer.
• Coerce the client to endorse a given fear.

Core Beliefs Questionnaire

The third assessment instrument in the sequence of assessments is the Core Beliefs Questionnaire (CBQ). The CBQ is a 209-question assessment used to gather a succinct understanding of a client’s beliefs or thought processes. (The CBQ-Short Version has 96 items and is designed for use with lower functioning clients.)

Both versions of the CBQ offer the therapist an opportunity to gather valuable information concerning beliefs endorsed by the client. Beliefs endorsed on this assessment are necessary to complete the Fear/Avoids/Core Belief Correlation component of the CCM.

The CBQ is administered in a very similar fashion as the FAR described above. Likewise, the therapist can apply the same techniques if he/she encounters problems during the assessment interview, such as concrete responding, prior treatment effects, defensiveness and indecisive responding.

Like the FAR, the CBQ is designed to be completed in a collaborative manner. It is not intended to be a typical pen and paper psychological test, but is an interactive and collaborative gathering of information that will be vital to conceptualizing the case and designing an individualized treatment plan.
First step: Therapist ratings of the client’s beliefs: Based on the therapist’s review of the client’s records, and any behaviors seen, verbalized, and documented, the therapist should go through the CBQ and endorse each belief that the individual suspects or believes to be valid for the client. This is done before administering the CBQ to the client.

Note: The therapist should *not* endorse beliefs that the client might be expected to endorse. Rather, the therapist is only identifying beliefs that the therapist surmises would be true for the client. The therapist can differentiate his/her responses from the client’s responses by highlighting or circling each belief item with a different color ink.

Second step: Interviewing the client: The goal is to prompt the individual to disclose as much information about their core beliefs, while being mindful of the client’s level of comfort in sharing emotional information. Attempt to help the client feel comfortable as possible. Begin the assessment interview by first explaining the types of questions that will be asked (i.e., “I am going to ask you some questions about your beliefs about yourself and the world”) and explaining the scale of possible responses, (i.e., “Tell me if you believe this sometimes, almost always, always, or never.”)

State each belief in turn and ask the client if it is something that he believes. The goal is to identify core beliefs that the client has held over their lives as a whole.

Therefore it is crucial to explain that the client is being asked if the client ever endorsed the belief. They may no longer hold that belief presently or at the time of the assessment. But the therapist is seeking core beliefs over the lifespan. The therapist can explain that such beliefs may only be conscious during times of conflict or strong emotion. The therapist is encouraged to offer real-life examples of situations to explore each belief with the client. It can be helpful to explore scenarios to help the client identify if the fear is present during specific times or situations.

Some helpful guidelines for conducting the CBQ: clients vary in their ability to understand and respond accurately to the assessment. If the therapist encounters some of the following challenges, he/she may use the corresponding techniques for a better outcome.

1) Discomfort with the rating scale: Some clients find the number scale too restricting. In this case, it can be useful to begin by asking if the belief is present or not. If the client endorses the belief as present, then the therapist can
identify the frequency or strength of the belief. For others, it can be helpful to describe the scale a little differently as a choice of “never, sometimes, almost always, or always.”

Keep in mind that disclosing beliefs causes clients to feel vulnerable and embarrassed. It is therefore natural for clients to sometimes protect that vulnerability by reporting beliefs as occurring sometimes or even never. If you notice that the client is predominantly responding with “never” and/or “sometimes,” it may be helpful to review the beliefs that were highlighted when you completed the assessment prior to administering it to the client. It is important for you to explore beliefs that you believe would be true. Share your reasons for believing the fear to be true with the client and discuss the discrepancy between their response and your belief.

2) **Concrete responding:** Some clients process questions in a very concrete fashion and thus may fail to endorse a given belief simply because they do not affirm the belief right now or recently. It is important to explain that beliefs can come and go. It may be helpful to explore scenarios to help the client identify if the belief is present during specific times. The goal is to identify core beliefs that the client has held over their lifespan. Sometimes clients will require prompting or clarification of terms to help them to accurately endorse their responses.

3) **Prior treatment effect:** Some clients feel that they have improved as a result of prior treatment and therefore had changed or abandoned certain beliefs. As a result, they may tend to under-endorse the presence of beliefs. In this case, the clinician should clearly instruct the client to answer as he had believed prior to treatment. Again, the goal is to identify core beliefs that the client has affirmed over their life as a whole. In addition, you may phrase the belief questions in the past tense: “How often have you believed that...?”

4) **Defensive and/or indecisive responding:** Some clients get “stuck” and can’t decide how to rank their endorsement of a particular belief. Or they may be confused by the item. Here it can be especially useful to use real life examples and/or scenarios, etc.

**Third step:** Exploring differences in therapist and client endorsements: The therapist should explore any belief that the client surmised would be true for the client, which the client did not endorse. If necessary, the therapist can explain or discuss the rea-
sons why the individual highlighted the belief. This is important! If the client does not endorse a belief that you have highlighted, spend time clarifying what the belief means and how the client’s behavior suggests that he endorses it. Explain the context and/or meaning of the belief. However, don’t try to persuade or coerce the client into endorsing a given belief. Simply clarify the meaning of the belief and explore its possibility with the client.

**Fourth step:** Examining the response pattern for further exploration: During and after administration of the CBQ, the therapist should be looking at the pattern of responses. Resistant and/or severely abused clients will tend to provide predominantly “never” or “sometimes” responses. These clients do not want to be seen as vulnerable and will therefore, attempt to protect themselves by not endorsing beliefs which they perceive as exposing them. In order to obtain better results, the therapist should consider how the client could re-visit some of these items in a less defensive way, which may encourage a more forthcoming response. Then the therapist can continue the process in a subsequent interview.

**Do’s and Don’ts of administering the CBQ Interview:**

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<th>DO</th>
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<td>• Ask for training or view demonstration of how the questionnaire is administered.</td>
<td>• Read the assessment verbatim to the client.</td>
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<td>• Take your time (use several sessions if necessary).</td>
<td>• Give the assessment to the client to complete by himself.</td>
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<tr>
<td>• Review assessment prior to administration and highlight beliefs endorsed by client’s behavior and/or his/her/hertory documented in the chart.</td>
<td>• Move too fast through the assessment.</td>
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<td>• Clarify each belief with the client and give examples as needed.</td>
<td>• Answer for the individual.</td>
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<td>• Lead the individual to answer.</td>
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<td>• Coerce the client to endorse a belief.</td>
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Fifth step: Scoring and interpreting the CBQ: Find the scoring key for the CBQ and circle all belief items endorsed as “always” in the first set, “almost always” in the second set, “sometimes” in the third set, and “never” in the fourth set.

The therapist then transfers the total number of responses in each set of the scoring key to the Profile Chart, which corresponds to each of the DSM-IV-TR Axis II Personality Disorders (Beck, Freeman, et al, 2004). Consider how well the result fits your diagnostic view of the individual based on the individual’s behavior, the interview and information from his/her records. Does it correspond with an existing Axis II diagnosis in the client’s prior record and give further support to that diagnosis? Or does it suggest a different personality diagnosis that may have been previously overlooked or ruled out? Discuss the results with other professionals, your clinical supervisor, and/or psychiatrist.


**CASE CONCEPTUALIZATION**

**Case Conceptualization Method and “Emotional Dysregulation”**

The CCM described here is an empirically based method. It is intended to provide the blueprint for treatment for each individual client.

To effectively use this methodology of holistic (CBT), it is necessary to complete the CCM at the very start of treatment. The CCM is then integrated, and may be further refined or modified, as needed, during the course of treatment. As the CBT addresses the dysfunctional cognitive system, the CCM is intended to integrate emotional dys-function and deep personality issues into the overall therapeutic process.

Ideally, the CCM should be completed by the primary therapist before the client embarks on his/her personal therapeutic work in A Client Workbook of Skills to Learn and the overall treatment program. Of course, it can be valuable for the therapist to share and discuss findings and diagnostic hypotheses about the client with the treatment team, clinical peers and the individual clinical supervisor while developing the case conceptualization. Subsequently, the therapist will be actively using the CCM in treatment as the individual monitors and reviews the individual’s ongoing therapeutic work in the client workbook chapter by chapter.

One of the most crucial features of this CCM is that it provides a framework for understanding and addressing the client’s “emotional dysregulation.” Emotional dysregulation occurs when a disordered individual is presented with a perceived (or actual) threatening situation and reacts with such intense and overwhelming emotion that it completely overrides the client’s cognitive controls. Many acting-out adolescents suffer from emotional dysregulation because nearly all have severe
underlying personality disorders, mental illness, substance abuse disorders and/or histories of severe childhood abuse and neglect.

The term “emotional dysregulation” derives from both (1) Linehan’s (1993) concept of the emotional dysregulation that occurs in Borderline Personality Disorder and other severe personality disorders, and (2) the characteristics of Reactive Conduct Disorder as described by Dodge, Lochman, Bates and Pettit (1997). The clinical populations described by each share the same problem of excessive emotional reactivity and histories of childhood abuse and neglect.

Linehan (1993, 1996, 1997) sees individuals with Borderline Personality Disorder as analogous to burn patients whose slightest movement can cause profound pain. “Because the individuals cannot control the onset and offset of internal or external events that influence emotional response,” Linehan argues that the burn other’s experience becomes a “nightmare of intense emotional pain” and a struggle to regulate themselves to avoid or minimize pain episodes.

"Emotional dysregulation" occurs when a disordered individual is presented with a perceived (or actual) threatening situation and reacts with such intense and overwhelming emotion that it completely overrides his/her cognitive controls.

As applied here, the intensity of the adolescent’s emotional pain or reactivity overrides the rational cognitive processes that are needed to make sense of the situation and choose an appropriate response. When the adolescents perceive a threat, they immediately overreact emotionally – with such suddenness and intensity – that they lose “cognitive” control, that is, the ability to pause and realistically access the situation and choose an appropriate behavioral response.

Similarly, Dodge et. al., (1997) argue that there are two subtypes of aggressive conduct-disordered individuals: The “Proactive” subtype uses aggression in a goal-directed fashion to obtain a benefit or reward, while aggression by the “Reactive” subtype comes from intense emotional reactivity – they emotionally dysregulate. Koenigsberg, Harvey, Mitropoulou, Antonia, Goodman, Silverman, Serby, Schopick and Siever (2001) also found that many types of aggression (as well as suicidal threats and gestures) are associated with emotional dysregulation.
Key Components of the CCM

For present purposes, the CCM provides the framework to assess and treat the emotional dysregulation that characterizes the adolescent and integrates this understanding into more targeted and effective treatment. The ultimate goal is to both (1) enable the individual to disconnect or de-activate the Fear/Avoids/Core Beliefs that trigger emotional dysregulation, while (2) learning to apply cognitive behavioral techniques to maintain control and behave appropriately – specifically, by correcting cognitive distortions and challenging negative core beliefs.

The clinician will employ three forms to organize their findings from the assessment into a clear case conceptualization of the individual’s fundamental issues and begin the development of a targeted treatment plan to target those issues:

1. The Conglomerate of Beliefs and Behaviors (COBB) Form.
2. The Fears/Avoids/Core Beliefs Form.
3. The Treatment Plan Development Form.

The following schematic shows the procedure for using the results of the assessment to develop the case conceptualization and treatment plan for the individual client.

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<th>Step 1: Complete assessments</th>
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<tr>
<td>Typology Survey</td>
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<td>Fear Assessment</td>
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<td>Core Beliefs Questionnaire</td>
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<th>Step 2: Use results for conceptualization of the case:</th>
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<tr>
<td>Enter most dominant fears into Fears/Avoids column of Fears/Avoids/Core Beliefs Form.</td>
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<tr>
<td>Enter most dominant core beliefs into beliefs column of Conglomeration of Beliefs and Behavior Form.</td>
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<tr>
<td>Enter most dominant core beliefs into beliefs column of Fear/Avoids/Core Beliefs Form.</td>
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<th>Step 3. Use case conceptualization for treatment planning:</th>
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<tr>
<td>Consolidate the foremost dysfunctional core beliefs and fears and enter them into first column of Treatment Plan Development Form, then begin identifying appropriate targets for therapeutic change across several domains.</td>
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**Conglomerate of Beliefs and Behaviors Form**

The Conglomerate of Beliefs and Behaviors (COBB) Form is used by the clinician as a component of the Case Conceptualization. The COBB identifies individual behaviors that correspond to particular core beliefs (which in turn correspond to particular Axis II personality disorders). In other words, the COBB is used to elucidate the connections between particular beliefs and the emotional dysregulation that follows, which can help the clinician to better target therapeutic interventions for that individual. The goal is to teach the client to recognize how their core beliefs and fears can activate their emotional dysregulation and behavioral dysregulation (i.e., aggression and acting out).

The term “conglomerate” refers to the fact that the great majority of adolescents who act-out have features from a variety of personality disorders. A “pure” example of an Axis II personality disorder is rare. Thus, in the example below, the individual holds many strong fundamental beliefs that are characteristic of the Borderline Personality Disorder (which could be seen as the client’s “primary” personality disorder), but he also has strong core beliefs that are indicative of Dependent, Avoidant, Antisocial and His/hertrionic Personality Disorders. This client, like many, has a “conglomeration” of personality disorders.

The Conglomerate of Beliefs and Behaviors is best done in collaboration with the client so that the clinician can accurately identify those core beliefs, which are the most powerful and influential beliefs driving the abuser’s problematic behaviors (e.g., emotional dysregulation). The client’s unhealthy core beliefs are then “prioritized” in a hierarchical fashion according to the greatest strength and importance of the given belief for the individual.

Below is a sample of a COBB completed for one individual. It is illustrative of the fact that many acting-out adolescents have a “conglomeration” of personality disorders and it also shows how core beliefs translate into dysfunctional behavior. Thus, in the example below, the client is fundamentally convinced that, “Everyone betrays my trust…always.” This core belief results in active avoidance of relationships and deficient ability to engage in meaningful relationships. In turn, the clinician applies this knowledge of the client to the Case Conceptualization and the targets of individualized treatment.
<table>
<thead>
<tr>
<th>CORE BELIEFS</th>
<th>CORRESPONDING BEHAVIOR(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borderline Personality Disorder beliefs</td>
<td></td>
</tr>
<tr>
<td>1. Everyone betrays my trust…always.</td>
<td>1. Doesn’t trust people or engage in relationships.</td>
</tr>
<tr>
<td>2. If I trust someone today, they will betray me later…always.</td>
<td>2. Reserved, distanced, and blunted in relationships.</td>
</tr>
<tr>
<td>3. Whenever I hope, I will become disappointed…always.</td>
<td>3. Gives up and becomes negative at any “bump” or disappointment.</td>
</tr>
<tr>
<td>4. When I am angry, my emotions are extreme and out of control…always.</td>
<td>4. Dysregulates, displays anger quickly.</td>
</tr>
<tr>
<td>5. When I hurt emotionally, I do whatever it takes to feel better…always.</td>
<td>5. Will clown or “mess around,” or disengage.</td>
</tr>
<tr>
<td>7. I try to control my feelings and not show my grieving, loss, sadness, but eventually it comes out in a rush of emotions…always.</td>
<td>7. After disturbing family phone calls, becomes angry and aggressive.</td>
</tr>
<tr>
<td>8. In relationships, if the other person is not with me, then they are against me…always.</td>
<td>8. Vacillates through all or nothing thinking.</td>
</tr>
<tr>
<td>Dependent Personality Disorder beliefs</td>
<td></td>
</tr>
<tr>
<td>1. If I am not loved, I am unhappy…always.</td>
<td>1. Emotions vacillate between extremes of idealization and devaluation.</td>
</tr>
<tr>
<td>2. I am helpless and cannot make it on my own…always.</td>
<td>2. Sadness, anger.</td>
</tr>
<tr>
<td>Avoidant Personality Disorder beliefs</td>
<td></td>
</tr>
<tr>
<td>1. I am inadequate; I will do whatever I must to hide it…always.</td>
<td>1. Distances self, anger and aggression.</td>
</tr>
<tr>
<td>2. I would rather do anything to avoid failing because I cannot succeed…always.</td>
<td>2. Anger, outbursts, emotional dysregulation (but accepts responsibility for his/her sexual abusing behaviors).</td>
</tr>
</tbody>
</table>
### Antisocial Personality Disorder beliefs

<table>
<thead>
<tr>
<th>1. Unless you have videotape of me, you cannot prove I did it…always.</th>
<th>1. Denial of small areas of responsibilities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. If he/she can’t take care of himself, they get what they deserve…always.</td>
<td>2. “Borrows” items and possessions from other clients.</td>
</tr>
</tbody>
</table>

### Histrionic Personality Disorder beliefs

<table>
<thead>
<tr>
<th>1. I am so exciting others want to be around me…always.</th>
<th>1. Inflated opinion of self.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. When I am bored, I need to become the center of attention…always.</td>
<td>2. Displays anger, silliness.</td>
</tr>
<tr>
<td>3. If I act silly and entertain people, they won’t notice my weakness…always.</td>
<td>3. Acts silly in groups and other tense situations.</td>
</tr>
</tbody>
</table>

### Fears/Avoids/Core Beliefs Form

The completion of the COBB can be completely before, after, or simultaneously with the completion of the Fear/Avoids/Core Beliefs Form. Using the results of the Fear Assessment, the clinician works collaboratively with the client to determine the fears that are foremost in strength and importance for the client. The clinician then enters this hierarchical list of main fears into the left column of the Fear/Avoids/Core Beliefs Form. Next, the clinician infers what the client will seek to avoid for each respective fear. This is usually a straightforward process. Fear of heights avoids high places. Fear of anger avoids confrontation with others. For each fear, the clinician enters the “corresponding avoid” into the middle column.

Given your knowledge of the client’s strongest and/or most frequent fears, ask yourself what sort of behaviors would be likely to be seen in treatment sessions and the client milieu in general. If a given client is afraid of being alone in dark rooms from dusk to dark, what would you expect he may avoid or have difficulty with? Why? Thus, for example, a client who fears being alone in dark places is more likely to avoid dark places and dark rooms, have strong emotional reactions to “time out” or seclusion rooms, cling to staff or peers during dusk/nightfall, and/or show more problematic behaviors during the evening and night shift.
Understanding the fear-avoidance relationship will help provide insights into many of the problem behaviors in which the client engages. It may also suggest the beginnings of a planned program of incremental “exposure” to fear stimuli as part of the treatment plan.

Finally, the clinician works creatively to “match” the foremost negative core beliefs (derived originally from the Core Belief Questionnaire or summarized on the COBB) with the respective fear/avoid. Thus, in the example below, the client’s greatest fear of “failing” causes him to avoid trying new things. This fear/avoid “matches” well with the Core Belief that “I am inadequate and must hide my inadequacy.” Similarly, his/her great fear of “hurting someone physically” suggests problems with interpersonal trust and avoiding relationships. This matches well with the core belief that “If I trust someone, they will betray me.”

<table>
<thead>
<tr>
<th>Fears/Avoids/Core Beliefs Form (sample)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fears</strong></td>
</tr>
<tr>
<td>Failing.</td>
</tr>
<tr>
<td>Hurting someone physically.</td>
</tr>
<tr>
<td>My anger.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>No one will believe me.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Something is wrong with me.</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Note: In most cases, the therapist should prioritize Personal Reactive-External Fears at the top of the treatment hierarchy because they typically manifest themselves in behavioral outbursts that can be dangerous and/or highly disruptive to the overall therapeutic milieu. As noted earlier, individuals who endorse these fear items may be especially prone to “emotional dysregulation” (See Section I.3.A.). The subscale items include fears of:

1) trusting anyone.  
2) trusting males.  
3) trusting females.  
4) trusting a relative.  
12) that I did something wrong.  
21) of someone knowing the secret. 

23) no one will believe me.  
24) I have no one to talk to.  
27) of being caught.  
28) that people will know by looking at me, I’ve done something wrong.  
30) that I am sick and they will find out.

**Treatment Plan Development Form**

After completing the Conglomerate Beliefs and Behaviors Form and Fears/Avoids/Core Beliefs Form, the clinician will already have formed a much clearer and precise understanding of the client’s personality type and core issues, which will enable them to begin to design individualized targets of treatment. The overall goal of treatment is to help the client learn to recognize how these negative core beliefs can be activated at any time throughout the client’s lifetime and each individual must be proactive in continually challenging and de-activating these fundamental, powerful fears, avoids, and beliefs.

The clinician begins by entering the prioritized unhealthy core beliefs and fears into the left column. For each unhealthy belief, the therapist then enters the corresponding healthy belief into the second column. Thus, the unhealthy belief that “I am inadequate” leads to therapeutic interventions that will work to reinforce the healthy belief that “I am adequate,” and the irrational fear that “I will always fail” leads to interventions that will work to reinforce the healthy belief that “I can take a risk and I can succeed.” The following columns of the Treatment Plan Development Form then apply the key issues in treatment across various domains of the entire treatment program experience. Thus the third column specifies desired treatment targets in the domain of healthy thinking, the fourth column targets the domain of healthy alternative behaviors, the fifth column targets the domain of therapy sessions and the
The sample Treatment Plan Development Form shows how clarity about fundamental dysfunctional core beliefs is translated into a multi-faceted, integrated array of therapeutic interventions that reinforce healthy core beliefs and behavioral competency.

<table>
<thead>
<tr>
<th>Current unhealthy core belief</th>
<th>Desired healthy core belief</th>
<th>Healthy alternative thoughts</th>
<th>Alternative strategies to compensate</th>
<th>Treatment targets in therapy sessions</th>
<th>Treatment targets in client milieu</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I trust someone today, they will betray me later.</td>
<td>I can trust some people some times.</td>
<td>If others disagree, they may not be against me.</td>
<td>I will take small steps and measure others...trust level.</td>
<td>I can trust my therapist sometimes.</td>
<td>I will try to trust one specific member of the unit staff other than therapist.</td>
</tr>
<tr>
<td>I am inadequate and must do anything to hide it.</td>
<td>I am adequate. I can manage feelings of incompetence.</td>
<td>I can take a risk at trying new things and I may succeed or not.</td>
<td>I accept others’ faults; they accept mine.</td>
<td>I can allow myself to feel adequate with my therapist.</td>
<td>Take a risk of expressing something important in peer therapy group.</td>
</tr>
<tr>
<td>When I’m angry, I always lose control.</td>
<td>My anger can be managed.</td>
<td>I can deactivate my anger. I can remove myself from the situation. I can pause and think it over first.</td>
<td>I can identify triggers for anger and the early physiological indicators of my anger. I can identify cognitions to counteract catastrophizing.</td>
<td>Practice self-control through imagined exposure to triggers, experiencing physiological indicators and applying cognitive restructuring.</td>
<td>Identify common triggers in various situations in a client’s life. Attend to physiological cues of anger – when where, what. Use voluntary time out with staff support.</td>
</tr>
<tr>
<td>When I get hurt, I want to hurt others.</td>
<td>When I get hurt, I can manage the emotional pain I feel.</td>
<td>Use journaling to practice rational thinking strategies.</td>
<td>Explore most sensitive areas of hurt in safety of individual sessions.</td>
<td>Identify and monitor various situations in client’s life where experience hurt.</td>
<td></td>
</tr>
</tbody>
</table>
Guidelines for Case Conceptualization

This cognitive-behavioral case conceptualization model combines the problem solving model of Nezu, Friedman, Haynes (1998) and Beck’s (1996) traditional model of cognitive conceptualization. To complete the case conceptualization, you should use Socratic questioning – that is, never accept any assumptions about the client unless they are supported by some solid evidence, some empirical data. Repeatedly ask yourself, “If so... then what,” and continue to question. You are like a detective looking for clues. In this case, the clues are the innermost fears and core beliefs that shape and drive the client’s behavior.

There are three ways to complete a case conceptualization: On your own, indirectly with the client, or directly with the client. The preferred method is direct collaboration with the client, but this may not always be possible.

On your own:
This is the best method for therapists who are just beginning to learn how to complete case conceptualizations. The therapist should follow the instructions in this manual, complete the forms as best you can, and then use available training and supervision to gain mastery of the techniques and methodology of case conceptualization.

Indirectly with the client:
This approach may be recommended for use with uncooperative clients who have great difficulty in feeling, processing, managing, and/or acknowledging emotions. In this method, the therapist can complete some or all of the sections with the client without directly stating that you are completing a case conceptualization. It is done as if you are simply discussing the material as part of an individual therapy session. While the client is processing a particular situation, belief, thought, feeling, etc., the therapist can encourage him to identify core belief(s) that were activated.

Once a core belief has been identified, ask the client to recall an experience when he was younger during which the belief was activated, or to describe a recent or current situation in which the belief was activated. Discuss the client’s understanding of what triggered the belief in the current situation and the recalled situation. While talking, you can fill out the COBB Form and the Fears/Avoids/Core Beliefs Form.
You can also collaboratively review any of the Thought, Feeling and Behavior Self-Report sheets (see Chapter 1 of the Client Workbook) with the client and ask him to identify what fears were triggered and what he was avoiding. More than likely, these will be the same or similar in the current and recalled situations. The self-report worksheets can be used as a visual representation of what you are processing in the session. Or you can suggest real-life situations that will help the client to identify behaviors, inner physiological changes, emotions, and thoughts, etc. Explain how the power and quickness of the emotional response make it especially difficult for him to try to “stop and think” or use cognitive behavioral “impulse control” techniques as he may have been taught previously. This is very validating for the client. Often, a client with “emotional dysregulation” problems is encouraged to discover that there is a reason for their frustrated inability to manage their anger more effectively, and he wants to know more about the concept and how he can gain better self-control.

**Directly with the client as a collaborative effort:**
Complete all sections of the case conceptualization as a totally collaborative effort with the client. This is similar to the second method, although offers the client the opportunity to begin learning about themselves and gain validation and control over some difficult thoughts and feelings.