

Case 1 Terry Hogan

The Avoidance Trap: Developing a Case Formulation

THE AVOIDANCE TRAP

Terry's fourth-grade teacher is concerned due to her progressively declining grades. Terry was in a bike accident in the third grade and was thrown from the bicycle, causing a separation of the cartilage from the rib cage. This very painful condition resulted in Terry missing several weeks of school and ultimately repeating the third grade. Terry was assessed 4 months ago and the psychological assessment revealed intellectual functioning to be in the average range (range 87–100), with academic functioning at a mid-Grade 3 level in all areas (standard score range 85–87). Terry did not qualify for special education assistance since the school district used the discrepancy criterion of 2.5 standard deviations difference between intellectual level and academic

standard scores, which would require academic standard scores to be well below current levels. However, academic concerns have continued to escalate, and Terry is becoming more and more vocal about disliking school. There are frequent complaints of stomachaches, and there is often a refusal to eat lunch. In the past 5 months, Terry has been absent for 17 days and tardy on 16 occasions. The school is requesting further assessment to clarify the nature of the problems. During the follow-up assessment, Terry completed a number of self-report scales (depression, anxiety, personality), and scores indicate clinically significant elevations for all internalizing scales, including depression, anxiety, and somatization.

After reading the case of Terry Hogan, ask yourself the following question: Does Terry suffer from a significant mental illness? According to a recent study based on data from the 2016 National Survey of Children's Health, approximately 16.5% of children between the ages of 6 and 17 have a treatable mental disorder (Whitney & Peterson, 2019), so the chances are approximately 1 in 6 that Terry does. However, unlike children who have disruptive behavior disorders, Terry's symptoms are not readily apparent, which leads to the other part of the statistic in the study by Whitney and Peterson (2019), which is that nearly half of the children who suffer from a mental disorder do not receive treatment from a mental health professional. How can the clinician determine the nature and severity of Terry's problems? What are the essential questions that need to be addressed?

Since a clinician's theoretical perspective can influence decisions, it is very important that clinicians are aware of their own theoretical biases in forming their opinions. Looking at a case through a set of theoretically colored lenses can affect all aspects of information processing, from hypothesis testing to treatment. The influence of theory on practice will become increasingly clear as *case formulations* are constructed from various theoretical viewpoints and applied to the case of Terry Hogan. The following exercise will provide a step-by-step look at how a case formulation would be developed and applied to this case.

Stage 1: Problem Identification: A Question of "What." At this stage, the clinician must ask the question, "What is Terry's problem?" However, this is often more complicated than it looks. For example, although Terry's poor academic progress was the initial concern, a very different set of problems eventually unfold that provided increased insight into the high rates of absenteeism and an increasingly negative attitude toward school.

Stage 2: Problem Interpretation/Understanding: A Question of "Why." At this stage of the process, the clinician draws on information from Terry's developmental and family history to provide a snapshot of Terry's history that can provide vital information regarding potential genetic factors that may suggest a vulnerability to some manifestations of behaviors (family pathology) or circumstances (family or school history), which might add to understanding how the problem evolved and what is maintaining the problematic behavior. At this point, it is also important to address any risks or protective factors that might help explain conditions that could exacerbate or moderate the problem. An understanding of the different theoretical perspectives can add to the depth and breadth of the analysis and hypothesis, and the ability to integrate information from these sources can contribute to our overall understanding and success in developing interventions based on the underlying dynamics involved.

Stage 3: Treatment Formulation: A Question of "How." Ultimately, our understanding of Terry's problem will help to inform treatment efforts regarding how to best address the problem based on our knowledge of evidence-based treatments that are most successful in dealing with problems of this nature. It will also be very important to integrate plans for monitoring and evaluating the effectiveness of the treatment plan in order to make any necessary changes.

Case Formulation: Applications to the Case of Terry Hogan

With the first goal of case formulation in mind, return to the initial description of Terry Hogan and reread the scenario with the following questions in mind:

1. What are Terry's main problems?
2. What is Terry's primary problem? Why has the problem developed (*precipitating factors*) and what is causing the problem to persist (*maintaining factors*)?

3. What other information is needed to respond to the above questions? Is Terry a boy or girl? Read the scenario again to see if you can find the answer. Risk factors for males and females can be different, so Terry's gender may also be a factor in determining targets for intervention (Box C1.1).

BOX C1.1 THINKING OUT LOUD

Although Terry is struggling academically, the initial assessment suggested that lack of academic progress was not due to lack of ability (intelligence was in the average range) but some

other factor that was contributing to her lack of performance (production). Terry said that she disliked school. Could lack of performance be attributed to lack of motivation, interest, and effort?

Based on the information to date, pinpointing the problem is not an easy task. In order to understand the problem, it is necessary to delve into the information and focus on behavior patterns that are most likely to yield relevant insights into Terry's difficulties. Based on the latest assessment results, the psychologist records the following impressions:

During the follow-up assessment session, Terry seemed even more agitated than she had been previously. She appeared pale and had dark circles under her eyes. When asked about school, she said that things were worse than before (referring to 4 months ago). Her younger sister, Lilly, is now in the same grade and even though they are in different classrooms, her younger sister is a constant reminder of her failure. Terry said the family was living with her grandparents until last week. She said her grandfather gets "too angry" at her and yells a lot. Just before they moved out, her grandfather had taken the belt out to hit her and she ran out the front door and down the street. She said she did not care if she was hit by a car, it was better than being hit by him. When asked about her absenteeism, Terry said that she felt sick a lot. She also mentioned that her back hurt because she had been sleeping on a sofa bed that has a bar across the middle that digs into her back at night and wakes her up, so she cannot sleep very well.

Her mother is a waitress who works long hours some nights. Since they are no longer living with her grandparents, Terry and her sister now go to the restaurant to eat their dinner and then walk home with their mother when she is finished with work. She said that the restaurant can be noisy, so it is hard to do her homework. Terry's father is a truck driver and is often away. When asked about friends, Terry said she used to have some friends, but when she repeated the third grade, they would not play with her anymore because she was only a third grader. Terry's favorite pastime is

watching TV. She said that she liked to watch Disney movies because “they always have a happy ending, not like most things.”

Reason for Referral

Although the original reason for referral was academic concerns, it is becoming increasingly apparent that academic problems are more a symptom than a cause of Terry’s difficulties. Further investigation is necessary in order to probe different hypotheses and provide an opportunity to develop case formulations from different theoretical perspectives. Information on family history, which would usually be obtained at the beginning of the case, is still lacking, since Terry’s mother has not yet met with the school psychologist.

Assessment Results

Terry’s responses to the Revised Children’s Manifest Anxiety Scale (RCMAS-2) indicated significant levels of social anxiety (feelings of isolation from peers and feelings of inadequacy compared to other girls her age). On the Child Depression Index (CDI-2), scores for total depression, negative mood, ineffectiveness, and anhedonia were all in the clinically significant range. There were indications of suicidal ideation, although Terry stated that she “would not do it.” Although responses to the Personality Inventory for Youth (PIY) revealed a valid profile (nondefensive), there were also indications of a potentially exaggerated response profile. Responses indicated little pleasure derived from academics and school-based activities, high scores for distractibility and concentration problems, and tendencies to be irritable and impatient. Terry admitted to having problems with compliance issues and following the rules. She endorsed many somatic complaints often associated with anxiety and depression (frequent headaches, stomachaches, dizziness, fatigue), placing her score on the somatic scale in the clinically significant range. Terry’s profile suggested that when psychologically distressed, she tended to show physical responses, such as feeling ill, loss of appetite, and sleep disturbance. Responses to the family dysfunction scale revealed that she was unlikely to view her home as a source of satisfaction and instead saw home as conflicted and fragmented. Responses suggested a troubled relationship with her parents, who she describes as argumentative, frequently absent, and in disagreement with each other. Responses indicated that one or both of her parents might drink to excess or demonstrate other signs of less than stable emotional adjustment.

Terry’s teacher completed the Behavioral Assessment System for Children (BASC-2), a rating scale of behavioral and emotional problems in children. Unfortunately, the parent version of the scale had not been returned to the school, despite several calls. Similar to Terry’s responses, her teacher also confirmed clinically significant concerns on all internalizing scales, including total internalizing problems, depression, anxiety, somatization, learning problems, and withdrawal (tendency to evade others and avoid social contact).

Based on the assessment results, the psychologist had a growing concern that Terry was experiencing many symptoms of depression, anxiety, and somatization. However, why these problems were occurring and seemingly escalating could only be speculated until there was contact with Terry's family. The school psychologist made several attempts to contact Mrs. Hogan.

Several weeks later, Mrs. Hogan agreed to meet with the school psychologist to discuss the assessment results. She provided a brief family history and answered most of the questions asked, although she was guarded in her responses. She explained that they had been living with her father for the past little while to ease financial burdens. She said he could be stubborn at times and blamed it on the Irish heritage. Her great-great-grandparents had emigrated from Northern Ireland at the time of the potato famine (mid-1800s) and worked as cheap labor in the United States, as did many who settled in America. She said that she had kept the name *Hogan*, not taking her husband's name, because the name means "warrior" and she was a fighter. After these comments, she added, "I don't know why Terry does not live up to her name. She's a whiner and complainer; she's no warrior."

Shortly into the interview, Mrs. Hogan announced that the family was relocating to Tennessee at the end of the week to live with her sister's family, which would place them closer to her husband's new truck route. When the assessment results were discussed, Mrs. Hogan became very defensive and stated that Terry was pretty good at pulling the wool over people's eyes, implying that Terry had the psychologist "fooled." She said that living with Terry had been difficult since the day she was born. Terry was an irritable baby who never slept well and was always a fussy eater. She was a clingy baby who cried every time her mother left her, so it was hard to find sitters who would look after her. She said that Terry was a selfish child who only thought about herself. She wished that Terry could be more like her sister, Lilly, who was easy to get along with and had many friends. On the other hand, Terry was moody, irritable, and difficult to please; she often walked around with a "chip on her shoulder." Mrs. Hogan said that unfortunately, Terry took after her father, who was the same way, especially when he was drinking. When asked about family history for depression, Mrs. Hogan said she suspected that her husband might be "down in the dumps" sometimes, especially when he would start drinking. However, with the truck driving job, drinking was no longer an option. Mrs. Hogan admitted to having financial problems and blamed Terry's willful and disobedient attitude for getting them "booted out" of Terry's grandfather's place. She explained that her father (Terry's grandfather) had always had problems controlling his temper and that Terry would "mouth off" and cause him to lose his temper. She described Terry as a complainer who often said that she was not feeling well to get out of doing chores or helping around the house. As a result, her sister often had to carry twice the load.

The psychologist emphasized her concerns about Terry's emotional well-being and her symptoms of depression and recommended that Mrs. Hogan find a counselor for Terry when they arrived in Tennessee. However, Mrs. Hogan felt that would just

encourage Terry to feel sorry for herself and make it worse. The psychologist requested permission to send the reports to Terry's new school, and Mrs. Hogan reluctantly agreed (Box C1.2).

BOX C1.2 THINKING OUT LOUD

Applying theory to case formulations: The psychologist has now amassed information from several sources and can begin building hypotheses regarding Terry's internalizing problems (depression, anxiety, and somatization). The

following case formulations will provide an increased understanding of how the problem can be conceptualized from a variety of theoretical perspectives.

Case Formulation: Five Different Perspectives

The following section is devoted to case formulations developed from five different theoretical frameworks: biological, behavioral, cognitive (social cognitive), psychodynamic/attachment, and parenting/family systems.

Case Formulation Based on the Biological Perspective

Terry's family history may be positive for depression (father) and if so, then she would have an increased risk (20%–45%) for developing depressive symptoms (Rutter, Silberg, O'Connor, & Simonoff, 1999). Imbalanced levels of serotonin, norepinephrine, and possibly dopamine and acetylcholine have been associated with depression in adults (Thase, Jindal, & Howland, 2002). Abnormalities in the gene responsible for transporting the neurotransmitter serotonin (5-HTT gene) have been linked to increased risk for depressive disorder (Caspi et al., 2003; Hecimovic & Gilliam, 2006). Caspi et al. (2003) found that children who inherited the short allele of the serotonin transporter (5-HTT) were more likely to respond to stressful events with symptoms of depression and suicidal ideation than peers who did not inherit the short allele.

Cortisol is a hormone that is released by the hypothalamic–pituitary–adrenal system (HPA) in times of stress. High cortisol levels can result in heightened sensitivity to threat that have been linked to increased risk for depression (Pliszka, 2002).

Studies of the neurophysiology of emotion regulation are based on the need for positive resolution of fearful experiences to allow for the development of self-soothing behaviors in response to fear and anxiety (Siegel, 1999). Results of a recent neuroimaging study have found that the anterior cingulate cortex (ACC), which is activated

during physical pain, is also activated in response to distress caused by social exclusion and rejection (Eisenberger, Lieberman, & Williams, 2003). The researchers suggest that these neural connections may be part of the social attachment survival system to promote the goal of social connectedness. These results help explain Terry's feelings of physical pain in response to her emotional loss and rejection.

Although the impact of genetic and environmental effects (*genotype–environment interaction: GEI*) on childhood anxiety and depression has been well established (Franić, Middeldorp, Dolan, Ligthart, & Boomsma, 2010), until recently, less emphasis had been placed on examining how these factors combine to influence outcomes. Silberg, Rotter, Neale, and Eaves (2001) found that adolescents who had genetic ties to anxiety and depression and experienced negative life events or *adverse life experiences (ACEs)* had an increased risk for anxiety and depression compared to adolescent females with genetic vulnerability who did not experience negative life events. Results even more relevant to Terry's case were findings from a study by Feinberg, Button, Neiderhiser, Reiss, and Hetherington (2007) who found that as parent negativity increased, so did the risk for depression. The finding was consistent with results obtained by Hicks, DiRago, Iacono, and McGue (2009) demonstrating that as negative environmental factors increased (mother, father, and child relationship issues; problems with achievement, stressful life events, and negative peer affiliations), symptoms of anxiety and depression also increased.

Therapeutic implications: Although medical management is common in the treatment of depression in adults, approximately 30%–40% of children with depression do not respond to medical treatment (Emslie et al., 1997). Fluoxetine (Prozac) is the only medication that has been approved by the FDA for use with children 8 years of age and older. Results of a 6-year-long investigation with adolescents found that combined treatment using antidepressants and cognitive behavioral therapy (CBT) was superior to CBT alone (Apter, Kronenberg, & Brent, 2005). However, in 2006, the FDA issued a *black box warning* (the highest level of caution) for antidepressant medications potentially increasing depression and suicidal behaviors in youth and young adults up to 25 years of age (Box C1.3).

BOX C1.3 THINKING OUT LOUD

Does the benefit outweigh the risk? Based on results of their exhaustive review of clinical pediatric trials between 1988 and 2006, Bridge

et al. (2007) conclude that not taking prescription medication for depression places children at greater risk than taking the medications.

Case Formulation Based on the Behavioral Perspective

From a behavioral perspective, principles of operant conditioning can be very helpful in understanding how Terry's symptoms of depression, often manifested in claims of "not feeling well," have become ingrained in a repetitive pattern of avoidance behaviors. When Terry initially stated that she was "not feeling well," it is likely that responses included increased attention from those around her (*positive reinforcement*) and an opportunity to escape from doing chores (*negative reinforcement*). Either way, feeling sick was reinforced with a positive outcome, thereby increasing the likelihood for the behavior to be repeated in the future. *Positive reinforcement* involves the addition of a reward (e.g., when you feel sick, I will comfort you and nourish you), while *negative reinforcement* involves the removal of a negative situation. *Negative reinforcement*, not to be confused with punishment, is rewarding because it involves the removal of a negative situation (e.g., if you are sick, you do not have to do chores or go to school). Negative reinforcement has sometimes been called *escape* because it allows one to escape a negative consequence.

In the Introduction, *coercion theory* (Patterson, Capaldi, & Bank, 1991) was discussed as it relates to social learning theory (a spin-off from the behavioral perspective). Coercion theory can help explain how Terry and her mother have established a negative cycle of interaction patterns. Parents who eventually yield to a child's escalating and demanding behaviors serve to *positively reinforce the child's misbehavior*. In this case, Terry's feeling sick has resulted in numerous absences from school, which allows her to escape from a situation she wants to avoid (*negative reinforcement*). In addition, as far as the communication pattern is concerned, when Terry is allowed to play the "sick role," the behavior is reinforcing for Terry (escapes going to school) and her mother (Terry stops whining and complaining). Therefore, the parent learns that giving in will stop the demands and whining (negative reinforcement), while the child learns that increased demands result in parent compliance (*positive reinforcement*). Since positive and negative reinforcement serve to strengthen behaviors, parent and child become locked in to an escalating and never-ending battle.

Therapeutic implications: Based on behavioral analysis, the payoff for Terry feeling ill has been an ability to escape negative situations, such as doing chores around the house or having to attend school, where she is failing academically and socially. In developing a behavioral program, goals would be to increase her sense of academic and social competency at school in an attempt to reduce her need to escape from a negative situation. At home, reintroduction of chores should be done in a way that requires a sense of responsibility but is also inherently rewarding, for example, preparing dessert for the family. Terry and her sister should have a chore list that is negotiated between them in the presence of their parents, with a list of rewards (e.g., allowance, privileges) that can be earned and traded at the end of each week as compensation for completion of required tasks.

Through the use of behavioral tools such as knowledge of schedules of reinforcement and objective observation techniques, behavior intervention plans can be developed, monitored, and modified to assist with behavioral change. Rewarding obedience with attention and praise; issuing demands that are clear and age appropriate; and providing consistent follow-through would strengthen Terry's compliant behaviors while increasing her self-confidence and breaking the cycle of avoidance behaviors. Building on earlier successes has proven to be a source of motivation in increasing compliance with more difficult tasks later on (Ducharme & Popynick, 1993).

The *Parent Management Training – Oregon Model* (PMTO) discussed in Chapter 1 is well suited in Terry's case and could provide the necessary training to assist her mother in reducing coercive parenting practices and increasing positive parenting by focusing on the use of positive reinforcement, appropriate limit setting, monitoring/supervision, interpersonal problem-solving, and emotion identification and regulation (Dishion, Forgatch, Chamberlain, & Pelham, 2016).

Case Formulation Based on the Cognitive Perspective

Terry's cognitive framework for social interaction places her at risk for social rejection (Dodge, Bates, & Pettit, 1990). If Terry is overly sensitive to rejection, then she is likely to misinterpret ambivalent social situations as hostile and rejecting or what has come to be known as the *hostile attribution bias*. Recently, Beauchaine, Strassberg, Kees, and Drabick (2002) found that parents of children with poor relationship skills were especially deficient in providing solutions to issues of noncompliance, especially when required to do so under pressured conditions. The authors recommend the need for treatment plans to target the underlying processes of negative attribution bias and affect regulation, which they suggest are the pivotal factors that drive coercive parenting patterns. Mrs. Hogan's communication pattern with Terry demonstrates *high expressed emotion (EE)*, a negative, critical, and disapproving interactive style. Such communication styles have been found to increase the risk for psychopathology in vulnerable family members (Nomura et al., 2005).

Therapeutic implications: CBT seeks to facilitate positive integration of thoughts and behaviors. For Terry, CBT would focus on how Terry's faulty belief system contributes to feelings of negative self-worth and avoidant behaviors. Social cognitive treatment might involve role-play in areas of social cue awareness and the underlying processes that contribute to the development of prosocial behavior, such as secure attachment, social perspective taking, empathy, and self-control. Parent training using CBT methods would focus on negative attributions, emotion regulation, and, ultimately, on increasing effective strategies for more positive communication. One possible program to enhance communication between Terry and her mother is the Seattle Program, which was developed by Speltz and colleagues (Greenberg & Speltz, 1988; Speltz, 1990). This parent training program uses cognitive behavioral methods to assist families of children with insecure attachment which is discussed next. The program focuses on

communication breakdown in the parent–child dyad and emphasizes the need for better “negotiation skills.” The four-phase intervention program includes components of parent education, reframing of the child’s behaviors within a developmental framework, limit setting and problem prioritizing, and communication/negotiation skills.

Case Formulation Based on Psychodynamic and Attachment Perspectives

On a psychodynamic level, Terry’s internalizing problems would be represented as the internal manifestations of unconscious conflicts stemming from an imbalance in the underlying personality structure. In Terry’s case, her mother’s rejection could represent a symbolic loss resulting in feelings of depression and feelings of guilt and self-blame for driving her mother away. Freud would interpret the loss within the context of unmet needs (lack of parental nourishing) during the oral stage. This pervasive sense of loss can result in feelings of emptiness and withdrawal from social contact, which can increase symptoms of depression. Individuals may remain overly dependent on others, feel unworthy of love, and have low self-esteem (Busch, Rudden, & Shapiro, 2004). In addition, Terry’s somatic complaints may be interpreted as tendencies to translate psychic pain into physical pain.

Ego psychologists might suggest that Terry’s insecurities result from a lack of resolution of the rapprochement phase in the separation individuation process. In this phase, the toddler is faced with awareness of separation, separation anxiety, and conflicting desires to stay close to the mother. Normally, the process of gaining greater independence and self-identity is facilitated by the parent, who performs the dual role of remaining emotionally available while gently encouraging the push toward greater independence (Settlage, 1977). However, as Terry’s mother was not emotionally available for her, theory would predict that conflicts between autonomy and dependence would be repeated throughout development, especially in vulnerable times (Kramer & Akhtar, 1989). Successful resolution of the conflict at this stage is achieved through the development of an internal representation or model of the parent–child relationship that can sustain separation due to the securely developed ego. To ego theorists, the focus is on consolidation of the ego, while for attachment theorists, the focus is on the relationship (Fonagy, 1999).

From an attachment perspective, the degree of security/insecurity inherent in primary attachment relationships provides *internal working models (IWMs)* or templates for all future relationships (Ainsworth, Blehar, Waters, & Wall, 1978; Belsky, 1988; Bowlby, 1982). While *secure attachments* can be a protective factor, *insecure attachments* may place the child at increased risk for developing problems. Terry’s avoidant behaviors may be the result of IWM based on an early *anxious attachment* evident in an *avoidant attachment pattern*. It is likely that Terry’s mother was, at times, withdrawn and emotionally unavailable, and at other times harsh, emotionally charged, and highly punitive (negative and highly critical). Within this context, Terry’s avoidance behaviors may serve to manipulate and regulate caregiver proximity and attentiveness. Through

the use of avoidant techniques, Terry can shield her sensitivity to her mother's harsh and rejecting responses. It has been suggested that these maladaptive behaviors may fit with the overall schema of family dysfunction (Marvin & Stewart, 1990). Terry's IWM is likely to evolve around avoidance and withdrawal to shield her from fears of rejection. Within this framework, parent-child dyads can be thrust into a hostile/helpless pattern, with one member of the dyad being the hostile aggressor and the other member becoming the passive, helpless, and overwhelmed recipient (Lyons-Ruth, Bronfman, & Atwood, 1999).

Insecure attachments can develop for a variety of reasons, including child characteristics (e.g., difficult temperament) and characteristics in the immediate environment, such as parenting style (Belsky, 1999). In Terry's case, there is strong evidence to suggest that both factors are highly interrelated. Greenberg, Speltz, DeKlyen, and Endriga (1993) incorporate four factors in their risk model for behavioral disorders, all of which are evident in the case study of Terry: *insecure attachment*, *atypical child characteristics*, *ineffective parenting*, and *family environment*. Although quality of attachment can be seen as a risk or protective factor in its own right, living in an environment that contains multiple risk factors (low socioeconomic status, family stress, parent maladjustment, etc.) also increases the likelihood of developing an insecure attachment (Belsky, 1997).

Socially, maladaptive attachment patterns can also undermine social orientation and subsequent prosocial competencies. Terry's lack of social reciprocity and withdrawal from social contact preclude strong social motivation at this point in her life. For Terry, the social world is a hostile territory that she would rather escape from than attempt to cope with. On the other hand, there is evidence that children with early secure attachments are more socially oriented and compliant and have better developed abilities to regulate their emotions (Ainsworth et al., 1978; Greenberg, 1999).

Therapeutic implications: Depending on the therapist's psychodynamic orientation, the therapeutic process might focus on the individual child (working through internal conflicts in play therapy), the parent (helping a parent resolve his or her own childhood conflicts and traumas), or the parent-child dyad (conjoint play therapy). In Terry's case, all three approaches would be appropriate—initially engaging Terry and her mother in individual therapy sessions and ultimately bringing them together in conjoint play therapy sessions. Psychodynamic developmental therapy for children (PDTC) is a relatively recent advancement in psychodynamic therapy developed by Fonagy and Target (1996). Although the approach is psychodynamic in origin, principles of social information processing (social cognition) are used to assist children in linking thoughts to feelings and behaviors (*reflective processes*). A PDTC therapist might provide *corrective experiences* through play therapy and the use of metaphor to assist Terry in replacing self-damaging feelings with increased positive views (Box C1.4).

BOX C1.4 THINKING OUT LOUD

Secure attachments can lead to better understanding rather than avoidance of negative emotions (Laible & Thompson, 1998). Terry demonstrates very few coping skills to effectively deal with negative emotions or negative information. Thompson (1999) suggests that “lessons

learned” in attachment relationships may be instrumental in defining expectations in such areas as how others react when the child is experiencing difficulties coping with stress, anxiety, or fears.

Case Formulation Based on Parenting Style and Family Systems Perspectives

The *authoritarian parenting style* is a controlling and harsh style of interacting that is lacking in warmth and often predictive of *avoidant attachment patterns* (Rubin, Hymel, Mills, & Rose-Krasnor, 1991). Baumrind (1991) found four different *parenting styles*, based on the amount of structure and warmth parents provided. The *authoritative parenting* approach (high structure and high warmth) has been associated with the best child outcomes. Children raised in a household that uses authoritarian parenting practices may demonstrate aggressive and uncooperative characteristics, while those whose parents are *uninvolved* or *permissive* may respond with more negative traits due to the lack of structure. Based on an avoidant attachment pattern and authoritarian parenting practices, Terry may have developed her tendency to feel overwhelmed by any emotional demands placed on her, or feel unable to cope with challenges in her environment, and respond by withdrawing and avoiding uncomfortable situations.

Family systems theory represents a variety of approaches that are unique to the traditional psychological focus on individual differences. Family systems theory, instead, looks at the family unit at the primary source for assessment and intervention. Within Terry's family constellation, we see that Terry's mother has aligned with Lilly (the good daughter) and has used this system of *triangulation* to shift the balance of power toward her and against Terry. The family also tends to have a combination of very loose boundaries (mother shares too many intimate details with Terry) but rigid boundaries regarding how much Terry can share with the family. Terry has also been flagged as the “problem child,” a stereotype that allows Terry's mother to *detour* her focus (Terry is the problem, rather than to acknowledge other problematic issues in the family, such as marital conflict, father absenteeism, and financial concerns).

Treatment implications: Beauchaine et al. (2002) found that parents who used ineffective and harsh methods of discipline associated with the authoritarian parenting style often had children who demonstrated poor relationship skills and did not have a good

ability to generate alternative solutions to problems. Parents and children were especially deficient in providing solutions to issues of noncompliance, especially when required to resolve these issues under pressured conditions. Beauchaine et al. (2002) suggest the need for treatment plans to target the underlying processes of *negative attribution bias* and poor affect regulation, pivotal factors that drive coercive parenting patterns.

Within the family systems approach, the therapist would attempt to observe family interactional patterns as they emerge in the family situation. The goal would be to restructure the family interactions toward more positive growth and change. In Terry's case, the therapist would likely focus on repositioning the balance of power and on improved problem-solving and communication between family members. As far as communication style, the main style of communication in this household best fits a description of *high EE*, a communication style that is hostile, critical, and prone to emotional overinvolvement (EOI). Families with communication styles high in EE attributes tend to be more rigid, have more intense and negative verbal exchanges that are often conflicted and oppositional in tone, and have been associated with relapse of psychiatric symptoms in individuals who are vulnerable to stress. As such, communication styles that are high in EE attributes are often considered within a *diathesis-stress model* as an environmental stressor that can exacerbate or precipitate mental distress in individuals with a given genetic vulnerability (Hahlweg et al., 1989; Hooley & Hiller, 2000; Wuerker, Haas, & Bellack, 2001).

Integrating Theoretical Perspectives: A Transactional Ecological Biopsychosocial Framework

The Case of Terry Hogan: A Brief Summation

Our case formulations for Terry Hogan have provided increased awareness of how different theoretical perspectives can contribute to an overall understanding of the nature and seriousness of her depressive symptoms. For Terry, risk factors evident on several levels of Bronfenbrenner's model (Bronfenbrenner & Morris, 1998) have added to the severity of her problems. At the individual level, Terry's difficult temperament was a poor fit for her mother's impatient, inherently negative, and hostile approach to parenting (authoritarian parenting style). At a biological level, it is possible that Terry inherited a genetic vulnerability to depression. Terry's poor relationship with her mother and isolation from her peers have added to her feelings of being ineffectual, culminating in a sense of *learned helplessness*. Her tendencies to use withdrawal and avoidance, likely patterned after an avoidant attachment relationship, have successfully allowed her to escape from situations of discomfort (school and chores) by claiming to be feeling ill, which has resulted in these patterns being negatively reinforced, thereby increasing and strengthening this avoidant behavior pattern. Risks in the immediate environment, *microsystem* (home and school), *exosystem* (financial stress), and the overall cumulative effect of her experiences, *chronosystem*, suggest that Terry is in

serious need of intervention. Her mother has focused on Terry as the “problem child,” allowing her to ignore major problems in the marital relationship. In addition to these underlying dynamics, Terry is at increased risk for major depression and possibly a suicide attempt because of the presence of a multitude of risk factors. It is unknown whether her recent move to Tennessee will provide a more stable environment with increased support from her aunt’s family or begin a spiral that leads to increased symptoms of depression and increased risk for suicide.

POST-CASE QUESTIONS

At the end of every case, you will find a series of post-case questions that are intended to assist you in consolidating the information from the case with information provided in the Introduction to Chapter 1, Appendices, and any outside readings that may be suggested.

1. Terry’s family seems to have a history of depression. From a biological perspective, what are the potential dynamics that might be involved in inheriting the risk for depressive symptoms? What are some of the positive and negative issues and implications regarding medical management of depression symptoms for Terry, based on the research findings regarding children her age and given the family dynamics?
2. Terry’s lack of compliance may be explained from a behavioral perspective by using the ABC paradigm (antecedent, behavior, consequence). How would coercion theory explain the dynamic of escalating aversive responses between Terry and her mother? Develop a behavioral intervention plan to assist Terry and her mother with her noncompliant behaviors.
3. Terry and her mother often engage in communication that is high in “expressed emotion.” From a cognitive perspective, this communication style has been associated with a number of negative outcomes. Explain how this dynamic works and apply this to exchanges between Terry and her mother. What suggestions would you have for improving the interactions?
4. Explain how Terry’s attachment history and attachment pattern can be used to better understand the underlying dynamics in this case. Be sure to include information on attachment from the Introduction to Chapter 1, regarding the ecological developmental framework (Greenberg, 1999) and Strathearn’s (2011) work on neurobiological factors influencing maternal responsiveness.
5. The authoritarian parenting style can often result in an avoidant attachment pattern. Explain how this applies to Terry’s case. Beauchaine et al. (2002) suggest the need for treatment plans to target the underlying processes of negative attribution bias and poor affect regulation that may develop from harsh parenting styles. How would you address these issues therapeutically in Terry’s case and what do you see as your biggest challenges to being successful?
6. Using Brofenbrenner’s ecological transactional model as a framework, discuss the risks and protective

factors that exist for Terry given the dynamics in her case.

7. Suggested individual or group presentation activity: The principal has called a parent–school meeting to discuss concerns about Terry’s progress and her future. Assign roles to individuals who will role-play important individuals in Terry’s life and how they would interact in this situation. Develop important

questions for each of the players who can add information to the case. Some of the casting members might be Terry, Terry’s mother, Terry’s father, Terry’s grandfather, Terry’s teacher, the psychologist, and any other individual that you feel might contribute to an understanding of the case and assist with developing an overall case formulation and treatment plan.

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