

***One Flew Over the Cuckoo's Nest's* Chief Bromden**

Introducing the Character

In Ken Kesey's 1962 book, *One Flew Over the Cuckoo's Nest*, the Native American character Chief Bromden narrates a story about life in a state psychiatric facility. The book was later made into an Academy Award-winning movie of the same title starring Will Sampson as the Chief and Jack Nicholson as protagonist Randle Patrick McMurphy (Zaentz, Douglas, & Forman, 1975). Actor Will Sampson was a significant choice for the role because he, himself, is a Muscogee-Creek Indian. Interestingly, there are differences between the book's and movie's storylines and portrayals of Chief Bromden. In the book, the Chief narrates the story, which chronicles the psychiatric misadventures of R. P. McMurphy, a fellow patient with antisocial personality features who feigns mental illness in order to avoid going to prison for statutory rape. In the movie, on the other hand, the Chief is an imposing 6-foot, 7-inch, 350-pound, mountain of a man who feigns mutism and has elected to remain silent since being hospitalized. The title phrase, "one flew over the cuckoo's nest," is a line from a children's rhyme Chief Bromden's grandmother sang to him as a child; "flying over the cuckoo's nest" means to go too far over the line, as McMurphy and other characters seem to do as the plot unfolds, and of course, the "cuckoo's nest" is a slang term for a psychiatric hospital.

Over the course of the story, McMurphy helps the Chief regain his self-respect and liberates him from his self-imposed silence; meanwhile, McMurphy, himself, unsuccessfully attempts to topple the oppressive power structure of the psychiatric facility, which is headed by clinical director Nurse Ratched. Following a long tradition of negative popular culture portrayals

of mental health professionals, Ratched's character is satirically presented in stereotype as a tyrannical, demeaning, punitive, and emasculating institutional psychiatric nurse. In fact, Ratched is so threatening that when Chief Bromden feigns being "deaf and dumb" in the movie version, it is as a defense, in order to become somewhat invisible, like a fly on the wall, and thereby avoid the troubles and harassment that other patients experience at the hands of Nurse Ratched, her henchmen, and society's various persecutors.

As the story nears its conclusion, McMurphy attempts one last, especially egregious but unsuccessful, assault on the power structure of the facility, rallying the patients together in revolt against the ward's system. After he led the failed patient uprising, Nurse Ratched arranges for McMurphy to be treated with a lobotomy procedure, leaving him in a vegetative state.

McMurphy's downfall, however, rallies Chief's Bromden's inner resources and empowers the Chief to escape from the institution and its (stereotypically) horrid conditions. The story is about injustice, abuse of power, as well as the social and racial politics that have combined to imprison and disenfranchise both McMurphy and Bromden. The following basic case summary and diagnostic impressions present our construction of Chief Bromden's mental health concerns at a time when we imagine him to have been recently discharged from inpatient psychiatric care; we focus on the complex symptoms of a long-standing schizophrenia spectrum disorder and, secondarily, alcohol use disorder we think he may have experienced.

Basic Case Summary

Identifying Information. "Chief" Bromden is a 37-year-old Native American male who identifies himself as a Columbia Indian of the Pacific Northwest. He was recently discharged from an Oregon state psychiatric hospital, where he resided for 15 years. Since his discharge, he has been

living in government-subsidized housing and attending the day treatment program at the Oregon Bridge Center. Bromden prefers the sobriquet “Chief.” Chief Bromden’s appearance at the center was appropriate and consistent with regional Native cultural norms.

Presenting Concern. During the first week of his daytime stay at the Oregon Bridge Center, Chief Bromden was interviewed by the director of intake services. Written medical and psychiatric historical notes also were available. The client sat quietly and passively as his file was reviewed, and he offered very simple and direct answers about his 15-year stay at the psychiatric hospital and his memory of the life events leading to his hospitalization. He volunteered that he was attending the Bridge Program as a condition of discharge and his goal was to manage his long-standing mental health problems so that he could remain living independently. Chief Bromden presents a history of increasingly prominent symptoms of a schizophrenia spectrum disorder, first suggested in childhood and adolescence and fully emerging in young adulthood and adulthood.

He also voluntarily raised concerns about his use of alcohol to manage his symptoms. He said he had recently lost his best friend, R. P. McMurphy, was despondent, and had twice visited a bar on the outskirts of town in order to “get my head right.” However, he chose not to drink and instead walked the streets for hours before being picked up by the police and escorted home. He said that he was “afraid that if I pick up the bottle again I will have to surrender my spirit that I have only recently reacquired.” Chief Bromden appears to have experienced Alcohol Use Disorder at times during his life cycle.

Background, Family, and Relevant History. Chief Bromden was born and raised on Indian tribal lands surrounding the Columbia River in the Pacific Northwest region of the United States. His father was a Native American tribal chief, Tee Ah Millatoona, and his mother was an Anglo

school teacher, Mary Louise Bromden. Bromden's most prominent memories of childhood and adolescence are predominantly negative ones. He recalls being exposed at an early age to his father's difficulties and what Bromden called "humiliations" attempting to work with the U.S. government on behalf of his tribal people. Bromden recalled this as diminishing his father as an idealized male role model. Chief Bromden similarly recalls perceiving his Anglo mother as being "emasculating" and "belittling" toward his father and his father's culture. Chief Bromden recalls that throughout childhood, he felt emotionally abused at having to take his mother's "white" last name rather than his father's. Further, he recalls that his mother "berated my father to submit" by selling his tribal lands to enable the construction of hydroelectric dams on the Columbia River. Positive highlights of his childhood and adolescence primarily revolved around playing high school football, which he said allowed him to travel and see cities and areas other than the one in which he grew up.

Problem and Counseling History. During the childhood and adolescent time period described above, Chief Bromden appears to have experienced an early hallucination, viewing his mother as growing taller and taller until he perceived her to be "twice as tall as my father." He remembers feeling angry and remorseful about his father's use of alcohol and believed his father had "shrunk" from alcohol abuse and emasculation by Chief's mother and the white establishment. Likewise, he appears to have experienced an early delusion of being "invisible to white men." Following childhood and adolescence, Chief Bromden was enlisted in the U.S. Army and fought in World War II. This period provided structure and purposefulness for the client. It also appears to have been a time period during which his mental health concerns more fully emerged. Over this young adult time period and into adulthood, he appears to have begun to experience prominent, resilient, well-defined delusions and hallucinations. His primary delusion was a firm

belief in an entity he referred to as the “Combine,” which he described as a mechanized matrix or industrial complex. According to his delusion, the “Combine” machine is “huge,” efficient, and well-organized, and its purpose is to control human thought and behavior. For example, it can insert fear or other emotions into individuals. Further, it is staffed by smoothly operating workmen. Along similar lines, his primary hallucinations were auditory ones of hearing the Combine in operation: gears turning, machines chugging, and a “rhythm” like a “thundering pulse.” He sometimes confused his delusion and hallucinations pertaining to the Combine with hydroelectric dams.

Following discharge from the Army as a result of his continued symptoms and use of alcohol, Chief Bromden was occasionally incarcerated in local jails and subsequently remanded to hospitalized psychiatric care. During this period, his delusions and hallucinations continued as described above. He also experienced visual hallucinations of a “fog machine” operated by the Combine being used to cloud the air inside the psychiatric ward and the delusion that the Combine arranged for the death of a fellow patient. In addition, he developed a new delusional narrative in which he perpetrates a “mercy killing” on a fellow patient who recently has undergone a lobotomy procedure and then violently escapes from the hospital ward.

Although some symptoms persist, over the course of his hospitalization Chief Bromden experienced a reduction in delusions and hallucinations. At the time of his discharge, he reported no longer seeing the fog or having the fog machine delusion; by comparison, he reports currently “seeing the world and seeing myself more clearly.” He also reported in the current interview that he understood his narrative about his hospital uprising and escape to have been a delusion (but added: “But it’s all true even if it didn’t happen”).

Goals for Counseling and Course of Therapy to Date. Successful mitigation of symptoms via antipsychotic medication and milieu therapy during 15 years of hospitalized treatment recently resulted in the patient’s discharge into independent living on the conditions that he reside in government-subsidized housing for community psychiatry patients and attend daily treatment at a bridge program. The primary goal is to develop a plan for supportive and life-skills counseling consistent with the following diagnostic impressions:

Diagnostic Impressions

295.90 (F20.9) Schizophrenia, Multiple Episodes, Currently in Partial Remission; 303.90 (F10.20) Alcohol Use Disorder, Moderate, in Early Remission

Other factors: V62.4 (Z60.5) Target of (perceived) adverse discrimination or persecution—Ethnic discrimination; V62.22 (Z65.5) Exposure to disaster, war, or other hostilities—History of exposure to war (WWII), V60.6 (Z59.3) Problem related to living in a residential institution—History of extended psychiatric hospitalization;—parental discord.

Discussion of Diagnostic Impressions

Chief Bromden came to the Oregon Bridge Center day treatment program following discharge from inpatient hospitalization to address symptoms of Schizophrenia. Secondarily, Chief presented problems with alcohol use.

The *DSM-5* section “Schizophrenia Spectrum and Other Psychotic Disorders” contains a variety of mental disorders featuring delusions, prominent hallucinations, disorganized speech, disorganized behavior, or catatonic behavior. Included in this section are schizophrenia spectrum

disorders (Schizophrenia, Schizophreniform Disorder, and Schizoaffective Disorder), Delusional Disorder (Erotomanic, Grandiose, Jealous, Persecutory, Somatic, and Mixed), and several other psychotic disorders (Brief Psychotic Disorder, Schizotypal (Personality) Disorder, and psychotic disorders that are due to substance use or another medical problem).

Chief Bromden presented a long-standing history characterized by the complex features of Schizophrenia. During adolescence, the Chief experienced periods during which he had visual hallucinations (seeing his mother grow extraordinarily tall and his father shrink) and delusions (being invisible to white men) without other prominent symptoms. Providing these periods each lasted less than 6 months, during childhood and early adolescence, he probably was experiencing Schizophreniform Disorder.

During young adulthood and adulthood, Chief began experiencing persistent delusions (belief in the thought- and behavior-controlling “Combine” machine; belief in the story of his escape from the “Cuckoo’s Nest”), auditory hallucinations (hearing the Combine rhythmically chug), and visual hallucinations (of a fog-making machine). His social functioning was impaired, he drank alcohol with problematic consequences, and his behavior led to being jailed on occasions. Taken together, Chief experienced a pattern of characteristic psychotic symptoms (delusions and hallucinations), with social dysfunction, lasting beyond 6 months. Further, there is no evidence of mood symptoms (suggesting a diagnosis of Schizoaffective Disorder or Depressive Disorder With Psychotic Features) or that his symptoms were the direct consequence of another medical condition or substance use, or any history of Autism Spectrum Disorder or another childhood Neurodevelopmental Disorder. Therefore, the diagnosis is Schizophrenia.

After his initial episode, he experienced a long pattern during which there were periods of intense delusions and hallucinations, and in between these intense periods, other periods during

which the hallucinations subsided and intensity of the delusions greatly reduced but did not completely disappear. In addition, Chief did not present with an acute episode at the time of his interview at the Oregon Bridge Center. Therefore, the longitudinal course specifier used is Multiple Episodes, Currently in Partial Remission.

Schizophrenia is a challenging diagnosis. Several differential diagnoses might be considered. There must be no evidence that the client's or patient's symptoms are the direct consequence of another medical condition (e.g., Psychotic Disorder Due to Another Medical Condition) or substance use (e.g., Substance/Medication-Induced Psychotic Disorder). Criteria regarding characteristic schizophrenia spectrum symptoms, psychosocial dysfunction, duration, and exclusionary considerations all must be considered. One suggested resource for new clinicians is Noll's *The Encyclopedia of Schizophrenia and Other Psychotic Disorders* (2007). Based on our clinical evidence, Chief Bromden's history best matched the complex criteria for Schizophrenia.

Further, differential diagnosis requires effectively understanding the client's concerns. Accurately identifying and describing the counseling presentations of Native American clients may require the counselor's special attention (Garrett, 1999). Native cultural norms regarding extraordinary auditory and visual experiences, narrative presentation, use of silence and space, issues of social isolation, and other cultural considerations sometimes must be differentiated when making a diagnosis (Garrett, 1999; Garrett & Pichette, 2000).

Secondarily, Chief Bromden also reported a history of problematic alcohol use. The Substance-Related and Addictive Disorders of the *DSM-5* comprise all of the Substance Use Disorders and Substance-Induced Disorders (Intoxication, Withdrawal, and substance-induced

disruptions in mood, sleep, and sexual function) related to the use of 9 classes of drugs (including alcohol), medications, and toxins.

Chief reported a history of drinking alcohol to the point of intoxication, leading to his occasional arrest. He continued his drinking despite his awareness of this ongoing problematic consequence. Therefore, the diagnosis is Substance Use Disorder and, more specifically, Alcohol Use Disorder. Alcohol Use Disorder with a more severe specifier (i.e., Severe) might be a reasonable differential consideration; however, Chief's use pattern meets the criteria for the less severe diagnosis of Moderate, rather than the more severe diagnosis. Another differential consideration is whether Chief Bromden was engaged in nonproblematic social or recreational drinking, which would not require a diagnosis; however, his use met the criteria for a maladaptive pattern of substance-related behavior resulting in negative life consequences (Inaba & Cohen, 2000)—namely, recurrent use leading to recurrent substance-related legal problems—and therefore warranted a diagnosis indicating clinical significance. Chief Bromden reports having better current control over his drinking behavior; if symptoms diminish, in the future this diagnosis might no longer be applicable.

To round out the diagnosis, Chief's critical psychosocial stresses are emphasized in the "Other factors" section. This additional information is consistent with the primary mental health diagnoses.

Case Conceptualization

During Chief Bromden's first week at the Oregon Bridge Center, the intake services director obtained current and historical information about the symptoms and consequences leading, at this point, to Chief's inpatient discharge and admission to the day program. Included among the intake materials were a thorough history, past medical and psychological records, interviews, and

observations. Based on the intake process, the intake services director developed diagnostic impressions, confirming previous diagnoses describing Chief Bromden's symptoms as a schizophrenia spectrum disorder, along with alcohol use disorder. Next, a case conceptualization was developed. Whereas the purpose of diagnostic impressions is to *describe* the client's concerns, the goal of case conceptualization is to better *understand* and clinically *explain* the person's experiences (Neukrug & Schwitzer, 2006). It helps the clinician understand the etiology and process of the schizophrenia and related symptoms the Chief was experiencing. Case conceptualization sets the stage for treatment planning. Treatment planning then provides a road map that plots out how the therapy team at the day center and the client expect to move from presenting concerns to positive outcomes (Seligman, 1993, p. 157)—helping Chief Bromden continue controlling the symptoms of Schizophrenia, maintain daily functioning, and continue reduced reliance on alcohol.

When forming a case conceptualization, the clinician applies a purist counseling theory, an integration of two or more theories, an eclectic mix of theories, or a solution-focused combination of tactics, to his or her understanding of the client. In this case, the intake director based his conceptualization on psychotherapeutic integration of two theories (Corey, 2009). Psychotherapists very commonly integrate more than one theoretical approach in order to form a conceptualization and treatment plan that will be as efficient and effective as possible for meeting the client's needs (Dattilo & Norcross, 2006; Norcross & Beutler, 2008). In other words, counselors using the psychotherapeutic integration method attempt to flexibly tailor their clinical efforts to “the unique needs and contexts of the individual client” (Norcross & Beutler, 2008, p. 485). Like other counselors using integration, Chief's clinician chose this method because he had not found one individual theory that was comprehensive enough, by itself, to address all of the

“complexities,” “range of client types,” and “specific problems” seen among his everyday caseload (Corey, 2009, p. 450).

Specifically, the director of intake services selected an integration of (a) Cognitive Behavior Therapy and (b) Cognitive Remediation Therapy. He selected this approach based on Chief Bromden’s chronic, long-standing experience of Schizophrenia and related symptoms and his own knowledge of current outcome research with clients experiencing these types of concerns (McGurk, Twamley, Spitzer, McHugo, & Mueser, 2007; Pfammatter, Junghan, & Brenner, 2006; TARRIER & Bobes, 2000). According to the research, Cognitive Behavior Therapy is one treatment approach indicated when assisting clients to address their psychotic and other schizophrenia spectrum symptoms and the distress these symptoms cause (TARRIER & Bobes, 2000; TARRIER et al., 2001; Turkington, Kingdon, & Weiden, 2006), whereas an integrated approach emphasizing Cognitive Remediation Therapy is indicated to strengthen their cognitive abilities and reduce the losses in neurocognitive functioning they often experience (Wykes & Reeder, 2005; Wykes et al., 2003).

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

Chief Bromden's Inverted Pyramid Case Conceptualization Summary: Psychotherapeutic Integration of Cognitive Behavior Therapy and Cognitive Remediation Therapy

1. IDENTIFY AND LIST CLIENT CONCERNS

History of diagnosis of Schizophrenia	Positive high school football & travel experience
History of inpatient hospitalization	Positive army enlistment experience
Early visual hallucination of towering mother	History of alcohol use leading to jail
Prominent delusions of Combine	History of jail plus symptoms leading to hospitalization
Auditory hallucinations of Combine gears	Native American upbringing
Visual hallucinations of Combine fog machine	Multicultural parents (Anglo mother, Native father)
Delusion of Combine killing inpatient	Recalls father primarily as humiliated in tribal actions with U.S. government
Delusion of narrative of mercy killing and escape	Recalls father primarily humiliated and belittled by mother
Currently without prominent symptoms	Recalls with regret father's selling of tribal land for hydro dams
Currently recognizes escape narrative as delusion	
Currently sober and compliant with treatment	

2. ORGANIZE CONCERNS INTO LOGICAL THEMATIC GROUPINGS

- Schizophrenia, Paranoid Type, Episodic With Interepisodic Symptoms (with influences of family and cultural context)
- History of Alcohol Abuse (resulting in jail and other negative consequences)

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

Psychotherapeutic Integration

Cognitive Behavior Therapy

- Client must learn to distinguish hallucinations from actual visual and auditory events
- Client must learn to distinguish delusional narratives from actual reality
- Client must reinforce importance of taking medications, complying with treatment, and coping with obstacles

Cognitive Remediation Therapy

Now that the client's psychotic symptoms have subsided, he may continue to experience neurocognitive deficits that can interfere with his coping

4. NARROWED INFERENCES: SUICIDALITY AND DEEPER DIFFICULTIES

Psychotherapeutic Integration

Cognitive Behavior Therapy

Despite the biological basis of the client's symptoms, he can use cognitive behavioral practices to manage their effects and reduce their consequences

Cognitive Remediation Therapy

Despite the neurocognitive deficits resulting from the client's schizophrenic disorder, with extensive, focused practice he can regain better attending, reasoning, and memory skills

Step 1: Problem Identification. The first step is Problem Identification. Aspects of the presenting problem (thoughts, feelings, behaviors, physiological features), additional areas of concern besides the presenting concern, family and developmental history, in-session observations, clinical inquiries (medical problems, medications, past counseling, substance use, suicidality), and psychological assessments (problem checklists, personality inventories, mental status exam, specific clinical measures) all may contribute information at Step 1. The counselor “casts a wide net” in order to build Step 1 as exhaustively as possible (Neukrug & Schwitzer, 2006, p. 202). As can be seen in the figure, the intake director identified not only Chief Bromden’s prominent history of schizophrenia spectrum symptoms (delusions, hallucinations, and negative symptom consequences) and problems resulting from alcohol use, but also positive past experiences (high school football, military service), parental and family dynamics, and sociocultural context—all of which were important to describing Chief Bromden’s clinical situation.

Step 2: Thematic Groupings. The second step is Thematic Groupings. The clinician organizes all of the exhaustive client information found in Step 1 into just a few intuitive-logical clinical groups, categories, or themes, on the basis of sensible common denominators (Neukrug & Schwitzer, 2006). Four different ways of forming the Step 2 theme groups can be used: Descriptive-Diagnosis Approach, Clinical Targets Approach, Areas of Dysfunction Approach, and Intrapsychic Approach. As can be seen in the figure, the intake director selected the Descriptive-Diagnosis Approach. This approach sorts together all of the various Step 1 information about the client’s adjustment, development, distress, or dysfunction “to show larger clinical problems as reflected through a diagnosis” (Neukrug & Schwitzer, 2006, p. 205).

The director made a straightforward grouping of all of Chief’s various affective, cognitive, and physiological symptoms of Schizophrenia—plus the family and cultural contexts

that seemed to influence the nature and content of his delusional narratives and hallucinations; he noted all of these together under “Schizophrenia.” Likewise, he grouped Chief’s problematic alcohol use and its consequences under “History of Alcohol Use Disorder.” The counselor’s conceptual work at Step 2 gave him a way to think about Chief’s functioning and concerns more insightfully.

So far, at Steps 1 and 2, the director of intake services has used his clinical assessment skills and his clinical judgment to begin critically understanding Chief Bromden’s needs. Now, at Steps 3 and 4, he applies the theoretical approach he has selected. He begins making theoretical inferences to explain the factors leading to Chief’s issues as they are seen in Steps 1 and 2.

Step 3: Theoretical Inferences. At Step 3, concepts from the counselor’s theoretical integration of two approaches—Cognitive Behavior Therapy and Cognitive Remediation—are applied to the experiences causing, and the mechanisms maintaining, Chief Bromden’s functioning. The counselor tentatively matches the theme groups in Step 2 with this theoretical approach. In other words, the symptom constellations in Step 2, which were distilled from the symptoms in Step 1, now are combined using theory to show what are believed to be the underlying processes or psychological mechanisms of Chief Bromden’s current needs (Neukrug & Schwitzer, 2006; Schwitzer, 2006, 2007).

First, Cognitive Behavior Therapy was applied primarily to Chief Bromden’s needs regarding his prominent schizophrenia spectrum symptomology. According to Cognitive Behavior Therapy (Beck, 1995, 2005; Ellis, 1994; Ellis & MacLaren, 2005), irrational thinking, faulty beliefs, or other forms of cognitive errors lead individuals to engage in problematic behaviors and experience their behavioral consequences. As can be seen in the figure, when the

intake director applied these Cognitive Behavior Therapy concepts to Chief Bromden's Schizophrenia, he explained at Step 3 that the various issues noted in Step 1, which can be understood in Step 2 to be a theme of recurrent Schizophrenia with contextual influences, lead to inferences that the client must (a) learn to distinguish hallucinations from actual visual and auditory events; (b) learn to distinguish delusional narratives from actual reality; and (c) reinforce the importance of taking medications, complying with treatment, and coping with obstacles (Bustillo, Lauriello, Horan, & Keith, 2001; Pfammatter et al., 2006; Rector & Beck, 2002).

Second, Cognitive Remediation Therapy was applied primarily to Chief Bromden's needs regarding declines or deficits in neurocognitive functioning, which sometimes results from long-standing Schizophrenia and prolonged treatment (Wykes & Reeder, 2005). As also can be seen in Figure 12.3, when the director applied these concepts, he additionally inferred at Step 3: Now that the client's psychotic symptoms have subsided, he may continue to experience neurocognitive deficits that can interfere with his coping (Wykes et al., 2003; Wykes & Reeder, 2005).

Step 4: Narrowed Inferences. At Step 4, the clinician's selected theory continues to be used to address still-deeper issues when they exist (Schwitzer, 2006, 2007). At this step, "still-deeper, more encompassing, or more central, causal themes" are formed (Neukrug & Schwitzer, 2006, p. 207). Chief Bromden's counselor continued to use psychotherapeutic integration of two approaches.

First, continuing to apply Cognitive Behavior Therapy concepts at Step 4, the director of intake services presented a single, deepest theoretical inference that he believed to be most fundamental for Chief Bromden from a cognitive behavioral perspective: Despite the biological

basis of the client's symptoms, he can use cognitive-behavioral practices to manage their effects and reduce their consequences. Second, continuing to apply Cognitive Remediation, the director presented a single, deepest theoretical inference that he believed to be most fundamental for Chief Bromden from a cognitive rehabilitation perspective: Despite the neurocognitive deficits resulting from the client's Schizophrenia Spectrum Disorder, with extensive, focused practice he can regain better attending, reasoning, and memory skills. These two narrowed inferences, together, form the basis for understanding the Chief's current counseling situation.

When all four steps are completed, the client information in Step 1 leads to logical-intuitive groupings on the basis of common denominators in Step 2, the groupings then are explained using theory at Step 3, and then, finally, at Step 4, further deeper explanations are made. From start to finish, the thoughts, feelings, behaviors, and physiological features in the topmost portions are connected on down the pyramid into deepest dynamics.

Treatment Planning

At this point, Chief Bromden's clinician at the Oregon Bridge Center has collected all available information about the problems that have been of concern to him and the psychiatric team that performed the assessment. Based upon this information, the counselor developed a *DSM-5* diagnosis and then, using the "inverted pyramid" (Neukrug & Schwitzer, 2006; Schwitzer, 1996, 1997), formulated a working clinical *explanation* of Chief Bromden's difficulties and their etiology that we called the *case conceptualization*. This, in turn, guides us to the next critical step in our clinical work, called the *treatment plan*, the primary purpose of which is to map out a logical and goal-oriented strategy for making positive changes in the client's life. In essence, the treatment plan is a road map "for reducing or eliminating disruptive symptoms that are impeding the client's ability to reach positive mental health outcomes" (Neukrug & Schwitzer, 2006, p.

225). As such, it is the cornerstone of our work with not only Chief Bromden, but with all clients who present with disturbing and disruptive symptoms and patterns (Jongsma & Peterson, 2006; Jongsma et al., 2003a, 2003b; Seligman, 1993, 1998, 2004).

A comprehensive treatment plan must integrate all of the information from the biopsychosocial interview, diagnosis, and case conceptualization into a coherent plan of action. This *plan* comprises four main components, which include (1) a behavioral definition of the problem(s), (2) the selection of achievable goals, (3) the determination of treatment modes, and (4) the documentation of how change will be measured. The *behavioral definition of the problem(s)* consolidates the results of the case conceptualization into a concise hierarchical list of problems and concerns that will be the focus of treatment. The *selection of achievable goals* refers to assessing and prioritizing the client's concerns into a *hierarchy of urgency* that also takes into account the client's motivation for change, level of dysfunction, and real-world influences on his or her problems. The *determination of treatment modes* refers to selection of the specific interventions, which are matched to the uniqueness of the client and to his or her goals and clearly tied to a particular theoretical orientation (Neukrug & Schwitzer, 2006). Finally, the clinician must establish how change will be measured, based upon a number of factors, including client records and self-report of change, in-session observations by the clinician, clinician ratings, results of standardized evaluations such as the Beck Depression Inventory (Beck & Steer, 1990) or a family functioning questionnaire, pre-post treatment comparisons, and reports by other treating professionals.

The four-step method discussed above can be seen in the text and is outlined below for the case of Chief Bromden, followed by his specific treatment plan.

Step 1: Behavioral Definition of Problems. The first step in treatment planning is to carefully review the case conceptualization, paying particular attention to the results of Step 2 (Thematic Groupings), Step 3 (Theoretical Inferences), and Step 4 (Narrowed Inferences). The identified clinical themes reflect the core areas of concern and distress for the client, while the theoretical and narrowed inferences offer clinical speculation as to their origins. In the case of Chief Bromden, there are two primary areas of concern. The first, “Schizophrenia, Multiple Episodes, Currently in Partial Remission,” refers to his history of diagnosis of Schizophrenia and inpatient hospitalizations, early visual hallucination of a towering mother, prominent delusions and hallucinations of the “Combine,” delusions of mercy killing and escape, and currently being without prominent symptoms. The second, “Alcohol Use Disorder,” refers to his history of episodes of excessive alcohol use and incarcerations. Many of Chief Bromden’s symptoms, particularly his alcoholism, can be contextualized within the sociopolitical oppression of American Indians (Diller, 2007). These symptoms and stresses are consistent with the diagnosis of Schizophrenia, Multiple Episodes, Currently in Partial Remission; and Alcohol Use Disorder (APA, 2013).

Step 2: Identify and Articulate Goals for Change. The second step is the selection of achievable goals, which is based upon a number of factors, including the most pressing or urgent behavioral, emotional, and interpersonal concerns and symptoms as identified by the client and clinician, the willingness and ability of the client to work on those particular goals, and the realistic (real-world) achievability of those goals (Neukrug & Schwitzer, 2006). At this stage of treatment planning, it is important to recognize that not all of the client’s problems can be addressed at once, so we focus initially on those that cause the greatest distress and impairment. New goals can be created as old ones are achieved. In the case of Chief Bromden, the goals are divided into

two prominent areas. The first, “Schizophrenia, Multiple Episodes, Currently in Partial Remission” requires that we help Chief Bromden to control (or eliminate) his active psychotic symptoms through medication compliance, distinguish between hallucinations/delusions and reality, improve his social skills and problem-solving, remediate neurocognitive deficits, including working memory, executive functioning, attention, and processing speed and increase his goal-directed behaviors. The second, “Alcohol Use Disorder,” requires that we help Chief Bromden to recognize the relationship between alcohol use and sociopolitical oppression of the American Indian, recognize the relationship between alcohol use and psychotic symptomatology, identify social, behavioral, emotional, physiological, and cognitive triggers for alcohol use, develop effective coping strategies to eliminate reliance upon alcohol, and establish a sustained recovery from the maladaptive use of alcohol.

Step 3: Describe Therapeutic Interventions. This is perhaps the most critical step in the treatment planning process because the clinician must now integrate information from a number of sources, including the case conceptualization, the delineation of the client’s problems and goals, and the treatment literature, paying particular attention to *empirically supported treatment* (EST) and *evidence-based practice* (EBP). In essence, the clinician must align his or her treatment approach with scientific evidence from the fields of counseling and psychotherapy. Wampold (2001) identifies two types of evidence-based counseling research: studies that demonstrate “absolute efficacy,” that is, the fact that counseling and psychotherapy work, and those that demonstrate “relative efficacy,” that is, the fact that certain theoretical/technical approaches work best for certain clients with particular problems (Psychoanalysis, Gestalt Therapy, Cognitive Behavior Therapy, Brief Solution-Focused Therapy, Cognitive Therapy, Dialectical Behavior Therapy, Person-Centered Therapy, Expressive/Creative Therapies, Interpersonal Therapy, and Feminist

Therapy); and when delivered through specific treatment modalities (individual, group, and family counseling).

In the case of Chief Bromden, we have decided to use a two-pronged “integrated” approach composed of Cognitive Behavior Therapy and Cognitive Remediation Therapy. Cognitive Behavior Therapy (Beck, 1995, 2005; Ellis, 1994; Ellis & MacLaren, 2005) has been found to be highly effective in counseling and psychotherapy with adults who experience the symptoms of Schizophrenia (McGurk et al., 2007; Pfammatter et al., 2006) and Alcohol Use Disorder (Longabaugh & Morgenstern, 1999). The approach relies on a variety of cognitive techniques (reframing, challenging irrational thoughts, and cognitive restructuring) and behavioral techniques (reinforcement for and shaping of adaptive behavior, extinction of maladaptive behaviors, systematic desensitization, and exposure with response prevention) (Ball et al., 2006; Frank et al., 2005; Milkowitz, 2008). Specific techniques drawn from this approach will include identification of and desensitization (imaginal and in vivo) to triggers of behavioral, emotional, and physiological stress that precipitate psychotic reaction; identification and refutation of irrational (and delusional) thoughts about the “Combine” and conspiracies; cognitive restructuring and reframing of thoughts related to oppression and conspiracies; and in vivo shaping and reinforcement of appropriate social behavior.

The second component of treatment will be Cognitive Remediation Therapy, which employs an array of tasks designed to address and improve the client’s cognitive functioning in areas that contribute to the positive and negative symptoms of Schizophrenia Spectrum and Other Psychotic Disorders (Wykes & Reeder, 2005; Wykes et al., 2003). Techniques drawn from this model will include verbal and computerized exercises designed and proven to strengthen many of the cognitive skills that are deficient in Schizophrenia, including executive control

(reasoning and problem-solving), verbal and visual working memory, social cognition, and speed of processing.

Step 4: Provide Outcome Measures of Change. This last step in treatment planning requires that we specify how change will be measured and indicate the extent to which progress has been made toward realizing these goals (Neukrug & Schwitzer, 2006). The counselor has considerable flexibility in this phase and may choose from a number of objective domains (psychological tests and measures of self-esteem, depression, psychosis, interpersonal relationship, anxiety, etc.), quasi-objective measures (pre-post clinician, client, and psychiatric ratings), and subjective ratings (client self-report, clinician's in-session observations). In Chief Bromden's case, we have implemented a number of these, including client self-reported alcohol abstinence, a pre-post improved measure on the Alcohol Use Inventory (Horn, Wanberg, & Foster, 1990), client self-report of absence of psychotic symptoms, counselor observation and client self-report of improved social functioning, medical evidence of no psychiatric hospitalization for 6 months, and rehabilitation center report of improved functioning on measured areas of cognitive functioning.

The completed treatment plan is now developed through which the counselor and Chief Bromden will work together to reduce the impact of his Schizophrenia Spectrum symptoms, to assist him with his alcohol use, and to improve his overall functioning. Chief Bromden's treatment plan is as follows and is summarized in the table that follows.

TREATMENT PLAN

Client: Chief Bromden

Service Provider: Oregon Bridge Center

BEHAVIORAL DEFINITION OF PROBLEMS:

1. Schizophrenia, Multiple Episodes, Currently in Partial Remission—History of diagnosis of Schizophrenia and inpatient hospitalizations, early visual hallucination of a towering mother, prominent delusions and hallucinations of the “Combine,” delusions of mercy killing and escape, and currently being without prominent symptoms
 2. History of Alcohol Use Disorder—Repeated episodes of alcohol abuse leading to jail (currently in remission)
-

GOALS FOR CHANGE:

1. Schizophrenia, Multiple Episodes, Currently in Partial Remission

 - Control (or eliminate) his active psychotic symptoms through medication compliance
 - Distinguish between hallucinations/delusions and reality
 - Improve social skills and problem solving
 - Remediate neurocognitive deficits (working memory, executive functioning, attention, and processing speed)
 - Increase his goal-directed behaviors
2. History of Alcohol Use Disorder

 - Recognize the relationship between alcohol use and sociopolitical oppression of the American Indian
 - Recognize the relationship between alcohol use and psychotic symptomatology
 - Identify social, behavioral, emotional, physiological, and cognitive triggers for alcohol use

- Develop effective coping strategies to eliminate reliance upon alcohol
- Establish a sustained recovery from the maladaptive use of alcohol

THERAPEUTIC INTERVENTIONS:

A moderate-term course of individual Cognitive Behavior and Cognitive Remediation Therapy (6–9 months)

1. Schizophrenia, Multiple Episodes, Currently in Partial Remission

-
- Psychoeducational group counseling around social skills, medication compliance, and positive symptom management
 - Identification of and desensitization (imaginal and in vivo) to triggers of behavioral, emotional, and physiological stress that precipitate psychotic reaction
 - Identification and refutation of irrational (and delusional) thoughts about the “Combine” and conspiracies
 - Cognitive restructuring and reframing of thoughts related to oppression and conspiracies
 - In vivo shaping and in vivo reinforcement of appropriate social behavior
 - Cognitive tasks (verbal and computerized) to strengthen executive control (reasoning and problem-solving, verbal and visual working memory, social cognition, and speed of processing)

2. History of Alcohol Use Disorder

-
- Discuss feelings of oppression and their

relationship to drinking

- Do a cost-benefit analysis of drinking and sobriety
- Develop a list of behaviors, attitudes, and feelings involved with use and relapse
- Identify and refute thoughts that precipitate the perceived need to drink
- Identify bodily and physiological states that lead to drinking
- Practice stress-management techniques, including breathing, progressive muscle relaxation, and meditation and plan for use in daily life
- Develop and establish rituals that enhance sobriety
- Attendance in alcohol support group
- Co-create a relapse contract and long-term plan for abstinence

OUTCOME MEASURES OF CHANGE:

The immediate reduction, and eventual elimination of, psychotic symptomatology, awareness of the role of racial oppression in his life, alcohol abstinence, and long-term adaptive functioning as measured by:

- Client self-reported alcohol abstinence
- Pre-post improved measure on the Alcohol Use Inventory
- Client self-report of absence of psychotic symptoms
- Counselor observation and client self-report of improved social functioning

- Medical evidence of no psychiatric hospitalization for 6 months
- Rehabilitation center report of improved functioning on measured areas of cognitive functioning

Chief Bromden's Treatment Plan Summary: Psychotherapeutic Integration of Cognitive Behavior Therapy and Cognitive Remediation

<i>Goals for Change</i>	<i>Therapeutic Interventions</i>	<i>Outcome Measures of Change</i>
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<p><u>Schizophrenia, Multiple Episodes, Currently in Partial Remission</u></p> <p>Control (or eliminate) his active psychotic symptoms through medication compliance</p> <p>Distinguish between hallucinations/delusions and reality</p> <p>Improve social skills and problem solving</p> <p>Remediate neurocognitive deficits (working memory, executive functioning, attention, and processing speed)</p> <p>Increase his goal-directed behaviors</p> <p><u>History of Alcohol Use Disorder</u></p> <p>Recognize the relationship between alcohol use and sociopolitical oppression of the American Indian</p> <p>Recognize the relationship between alcohol use and psychotic symptomatology</p> <p>Identify social, behavioral, emotional, physiological, and cognitive triggers for alcohol use</p> <p>Develop effective coping strategies to eliminate reliance upon alcohol</p> <p>Establish a sustained recovery from the maladaptive use of alcohol</p>	<p><u>Schizophrenia, Multiple Episodes, Currently in Partial Remission</u></p> <p>Psychoeducational group counseling around social skills, medication compliance, and positive symptom management</p> <p>Identification of and desensitization (imaginal and in vivo) to triggers of behavioral, emotional, and physiological stress that precipitate psychotic reaction</p> <p>Identification and refutation of irrational (and delusional) thoughts about the “Combine” and conspiracies</p> <p>Cognitive restructuring and reframing of thoughts related to oppression and conspiracies</p> <p>In vivo shaping and in vivo reinforcement of appropriate social behavior</p> <p>Cognitive tasks (verbal and computerized) to strengthen executive control (reasoning and problem solving, verbal and visual working memory, social cognition, and speed of processing)</p> <p><u>History of Alcohol Use Disorder</u></p> <p>Discuss feelings of oppression and their relationship to drinking</p> <p>Do a cost-benefit analysis of drinking and sobriety</p> <p>Develop a list of behaviors, attitudes, and feelings involved with use and relapse</p> <p>Identify and refute thoughts that precipitate the perceived need to drink</p> <p>Identify bodily and physiological states that lead to drinking</p>	<p><u>The immediate reduction and eventual elimination of psychotic symptomatology, awareness of the role of racial oppression in his life, alcohol abstinence, and long-term adaptive functioning as measured by:</u></p> <p>Client self-reported alcohol abstinence</p> <p>Pre-post improved measure on the Alcohol Use Inventory</p> <p>Client self-report of absence of psychotic symptoms</p> <p>Counselor observation and client self-report of improved social functioning</p> <p>Medical evidence of no psychiatric hospitalization for 6 months</p> <p>Rehabilitation center report of improved functioning on measured areas of cognitive functioning</p>
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	<p>Practice stress-management techniques, including breathing, progressive muscle relaxation, and meditation and plan for use in daily life</p> <p>Develop and establish rituals that enhance sobriety</p> <p>Attendance in alcohol support group</p> <p>Co-create a relapse contract and long-term plan for abstinence</p>	
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