# *The Breakfast Club*'s Claire

## Introducing the Character

Claire Standish is the main female character in the coming-of-age movie *The Breakfast Club* (Hughes, 1985). Although Hollywood had a history of ensemble movies, *The Breakfast Club* was one of the first to feature a cast of adolescents—who, in this case, became known as the "Brat Pack," which was loosely modeled after the "Rat Pack" of the 1950s and 1960s. The film takes place over an 8-hour period during the weekend detention of an improbable group of teenagers, featuring Claire Standish, "the Princess"; Brian, "the Brain"; Andy, "the Athlete"; Allison, "the Basket Case"; and John Bender, "the Criminal." Over the course of the day they are forced to spend with one another, the five students—each representing a different familiar faction commonly found among American high schools' varied and divided social demography—come to learn about each other, to question the rigid stereotypes that divide them, and to gain a deeper awareness of themselves. In so doing, they unite as a singular and powerful emerging group of young adults who hopefully will go on to question and challenge the prevailing biases and misconceptions about adolescents in society. Building on our impressions of Claire's character portrayal, the following basic case summary and diagnostic impressions present symptoms we believe she may have been experiencing in the areas of eating-related concerns, substance use, and impulse control.

## Basic Case Summary

*Identifying Information.* Claire Standish is a 17-year-old female senior at Shermer High School in Shermer, Illinois, who resides with her parents in a socioeconomically upper-class suburb of Chicago. Claire was referred to this independent practice, Great Lakes Clinical Associates of Chicago, following concerns raised by her school counselor. She was brought in by her father.

She was dressed appropriately, with obvious meticulous attention to peer-group fashion conventions regarding hair, makeup, and dress. She appeared the appropriate weight for her height.

Claire is highly accomplished with above-average academic grades and PSAT scores as well as social successes, including student council president, honor council representative, prom committee, and prom queen candidate. According to referral notes, she maintained good discipline and performance until several weeks ago; then, on March 24, 1984, she served 1 day of in-school Saturday detention for skipping school to go shopping with friends. As a result of the attention focused on her behavior leading up to, during, and following her detention, several additional behavioral concerns were raised.

*Presenting Concern.* Claire came to her school counselor's attention on several occasions following her 1-day detention. On the first occasion, a school security guard identified Claire as one of several students repeatedly found smoking marijuana under the football field bleachers during lunch breaks. A school janitor confirmed that he had suspected from odors and debris he found that she had also smoked marijuana in the school building during her Saturday detention. Because there was no definitive evidence, a note was made in her school records, and Claire was found in the cafeteria as assigned during subsequent lunch periods.

On the next occasion, the same security guard reported that she had overheard Claire vomiting in the girls' bathroom on several occasions; however, Claire denied this as well as any health problems. When consulting with her father, the school counselor learned that the father also had heard her vomiting in the bathroom at home, but "assumed that's what girls do when they are 17, right?"

The father also noted that he thought she seemed overly preoccupied with her eyebrows and eyelashes and arm hair, which all seemed to be becoming sparse. Again he said his perception was that "that's what teenage girls do."

*Background, Family Information, and Relevant History.* Claire has one older brother, an adult who has graduated from college and is an architect who lives in urban Chicago. Her father is a highly successful physician who is chief of radiology at Sherman Hospital in Elgin. Her mother does not work outside the home; she participates in a large number of charitable efforts throughout the Midwest region. In spite of their

respective successes, Claire's parents described a historically weak marital relationship and poor communication with their children. Regarding medical histories, her mother has been in treatment as an outpatient and inpatient for alcohol abuse and prescription-drug dependence on an ongoing basis over the past 10 years. Both parents are highly recognized patrons of the arts and humanitarian efforts and perceived to be community leaders.

Regarding school history, reports indicate that Claire has been consistently recognized for her above-average academic performance, leadership in school, extracurricular organized activities, social success among her peers, and skill as both a gymnast and cheerleader throughout her elementary, middle school, and high school years. It is unclear whether Claire's presenting concerns have been present for some time but overlooked, or alternatively, have emerged only in the past year.

*Problem and Counseling History.* Claire has been seen three times with the goals of conducting an extended assessment and establishing a therapeutic alliance. She appeared quite resistant during the initial meeting, with a special concern that her parents would have access to her records. A working agreement was established among Claire and her father that although her attendance at counseling sessions will be reported to her father, no information about session contents will be shared without Claire's permission (within the "normal" limits of confidentiality). Claire also is aware that suspension from school might result should she not pursue counseling as agreed. Her concerns appear in three areas.

First, Claire admits to regular marijuana use during and immediately after school. She reports that her use began only recently, in March, but admits that she is aware her use has resulted in late papers and missed homework. At the same time, she has said that "it doesn't really matter, because my teachers always give me a break." She is aware that she risks school suspension at this late point in her school career and responds that "I'm coming to counseling, and they'll leave me alone." She also admits she has begun associating with unfamiliar boys of peer age and boys in their early 20s "so I can bum some pot. All you have to do is flirt a little to go home with a few free joints!"

Second, when queried about being suspected of vomiting regularly at home and in the school bathroom, Claire at first was silent. Later, apparently feeling greater trust, she admitted that she vomits after eating to avoid weight gain "maybe once every week or two." By her report, she also occasionally ("I don't know, maybe once a month") steals her mother's laxatives for use to prevent weight gain. When confronted about these behaviors, Claire explained that "this way I can eat all I want sometimes and keep my nice body. And you know what, when my body looks nice in my clothes and I'm kind of extra thin, I feel hotter and better than any of my friends. I know I'm going to win prom queen and staying nice and thin is why. Plus I just feel better. So it's not really a problem. I know what I'm doing."

Third, although Claire denies recognizing any problems associated with pulling her eyelashes, eyebrows, or arm hair, she did readily admit to pulling out hair and said that she "needs the relief sometimes after dealing with my mom, especially when she's been at the club drinking." She characterized these behaviors as "only when I feel like it, they're under total control and I don't want to talk about them anymore. Besides, thin eyebrows look great." By observation, she appears to have very few eyelashes and on one occasion, an exposed arm appeared to display areas bare of hair that were not the result of cosmetic attention.

Claire has agreed to participate in ongoing sessions at least through the end of her high school year.

*Goals for Counseling and Course of Therapy to Date.* The primary goals at this point are to clarify diagnostic impressions; maintain and increase client motivation for change; and determine a treatment plan appropriate for the 6 weeks remaining in the school year or, alternatively, solicit the client's agreement to continue counseling through the summer until the start of college. An associated goal is to obtain Claire's permission for the clinician to obtain her father's at-home observations of her eating and compensatory weight management and hair-pulling behaviors. Treatment modalities may include individual, family, and/or group interventions.

## Diagnostic Impressions

305.20 (F12.10) Cannabis Use Disorder, Mild; 307.59 (F50.8) Other Specified Feeding or Eating Disorder (Purging Disorder); 312.39 (F63.2) Trichotillomania

(Hair-Pulling Disorder).

Other factors: V61.20 (Z62.820) Parent-Child Relational Problem

---

## Discussion of Diagnostic Impressions

Claire was referred to a private practitioner at the Great Lakes Clinical Associates of Chicago by her school counselor, who was worried about several domains of Claire's functioning. Claire's school counselor believed that she may have been experiencing concerns found in each of these three areas: substance use, eating-related concerns, and impulse control.

Each section of the *DSM-5* classification system contains a group of diagnoses that share qualitatively similar symptoms or features. For instance, the Substance-Related and Addictive Disorders section contains all of the Substance-Use and Substance-Induced Disorders (Intoxication, Withdrawal, and substance-induced disruptions in mood, sleep, and sexual function); the Feeding and Eating Disorders section contains several diagnoses that all are characterized by severe disturbances in eating, weight management, and body perceptions (Pica, Rumination Disorder, Avoidant/Restrictive Food Intake Disorder, Anorexia Nervosa, Bulimia Nervosa, Binge-Eating Disorder, and Other or Unspecified Eating Disorders); and the Obsessive-Compulsive and Related Disorders section contains clinical problems related by preoccupations with the body or environment and repetitive acts or thoughts in attempt to control the body or environment (e.g., Body Dysmorphic Disorder, Hoarding Disorder, and Excoriation—skin-picking—Disorder).

The counselor's first concern pertained to Claire's substance use. On several occasions she was suspected of smoking marijuana on school grounds, which led to disciplinary notes in her school records and could lead to further disciplinary actions. Her use continued even after her knowledge that she was under special scrutiny following a day of in-school suspension. In other words, her marijuana use comprises a maladaptive pattern in which she continues smoking despite her knowledge of negative consequences at school and potentially in other areas of her life such as social and family relationships. In such cases the diagnosis is a Substance Use Disorder, and more exactly, Cannabis Use Disorder.

A reasonable differential consideration may be Cannabis Use Disorder with a Moderate specifier; however, Claire's use pattern and number of symptoms meet the criteria for the less severe specifier, Mild, rather than the Moderate or Severe specifiers that indicate increased psychosocial disruption from cannabis use. Another differential consideration is whether Claire is engaged in nonproblematic experimental or social or recreational use of marijuana, which would not require a diagnosis; however, her use meets the criteria for a maladaptive pattern of substance-related behavior resulting in negative life consequences (Inaba & Cohen, 2000)—namely, recurrent use leading to problems with major role obligations at school—and therefore warrants a diagnosis indicating clinical significance.

The counselor's second concern pertained to Claire's eating and weight-management behaviors. On several occasions, she was overheard vomiting at home as well as in the girl's bathroom on a day that she was not ill with a gastrointestinal problem. Claire also admitted in her sessions that she vomits for weight management a few times a month. Likewise, she admitted to occasionally using her mother's laxatives for weight management. Further, in her session she described an overly close relationship between her overall feelings about herself and her perceptions of her body and appearance. The primary symptoms are recurrent, inappropriate behavior to compensate for eating in order to prevent weight gain, occurring less frequently than twice weekly, without any report of binge-eating, and with self-evaluation unduly influenced by body considerations. In such cases, when the behaviors do not meet the full criteria for a specified eating disorder, the diagnosis is Other Specified Feeding or Eating Disorder. The *DSM-5* lists several suggestions for this diagnosis, related to patterns of behavior, including disordered eating of lower-frequency and specifically, Purging Disorder. Purging Disorder is characterized by self-induced vomiting (not following a binge eating episode) and laxative abuse to control weight or shape (APA, 2013).

Other Specified Feeding or Eating Disorders (sometimes also referred to as subthreshhold eating disorders because eating and compensatory symptoms, although clinically significant, fall below the thresholds of the frequency and duration criteria for anorexia and bulimia) are, by far, the most commonly seen eating disorders among adolescent girls and young adult women (Schwitzer, Hatfield et al., 2008; Schwitzer,

Rodriguez, Thomas, & Salimi, 2001). Correspondingly, clinicians should vigilantly assess for, rather than overlook, signs of these subthreshhold eating concerns among their young women clients. Although Bulimia Nervosa might be a reasonable differential diagnostic consideration, Claire does not report any binge eating behaviors, or frequent enough purging behaviors, to meet the criteria for bulimia.

The counselor's third concern pertained to Claire's behavioral pattern of recurrently pulling out her eyelashes, eyebrows, and arm hair. In her sessions, Claire reported feeling increasing tension that was relieved once she engaged in hair pulling. The hair loss in her eyelashes and eyebrows was noticeable. Having very few lashes left and bare spots on her arms suggest clinical significance. In such cases, the diagnosis is Trichotillomania, an Obsessive-Compulsive and Related Disorder. Regarding differential diagnoses, temporary periods of hair-pulling earlier in childhood may be benign and warrant no diagnosis at all. Alternatively, Obsessive-Compulsive Disorder, which is in the same diagnostic category, might be considered because this diagnosis is defined partly by repetitive behaviors. However, Claire's behaviors occurred after childhood, in adolescence, and appear to be recurrent and clinically significant rather than temporary and benign; further, her behaviors are not in response to characteristic obsessions, as required for Obsessive-Compulsive Disorder.

In the formal diagnostic reporting, since there are multiple diagnoses, the diagnosis that is the primary reason for the referral was listed first, followed by the other diagnoses in order of clinical importance. To round out the diagnosis, Claire's family stressors are emphasized in the "Other factors" section. The information in this section is consistent with the primary mental health diagnoses.

## Case Conceptualization

When Claire Standish visited the Great Lakes Clinical Associates of Chicago, the counselor's first task was to collect detailed clinical information about the situation leading to Claire's appointment. The counselor first used this information to develop diagnostic impressions. Her concerns were described by Cannabis Use Disorder, Other Specified Feeding or Eating Disorder (Purging Disorder), and Trichotillomania. Next, the counselor developed a case conceptualization. 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 counselor understand the conditions leading up to Claire's three presenting concerns and the conditions keeping them going. In turn, case conceptualization sets the stage for treatment planning. Treatment planning then provides a road map that plots out how the counselor and client expect to move from presenting concerns to positive outcomes (Seligman, 1993, p. 157)—helping Claire better control her cannabis use, eating and weight management, and hair-pulling.

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, Claire's counselor based her conceptualization on a purist theory, Brief Contemporary Psychodynamic Psychotherapy. Various contemporary psychodynamic models are available, such as Ego Psychology, Objects-Relations Therapy, Kohut's Self-Psychology, and similar post- or neoanalytic models. Claire's counselor based her conceptualization on Kohut's Self-Psychology. She selected this approach because she found evidence that the model can be especially useful for the conceptualization of late adolescent and young adult clinical situations such as Claire's (Patton & Robbins, 1982; Robbins, 1989; Schwitzer, 1997, 2005). Brief contemporary psychodynamic therapies also are the approaches of choice at the Great Lakes practice.

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.

Claire's Inverted Pyramid Case Conceptualization Summary: Brief Contemporary Psychodynamic Psychotherapy (Kohut's Self-Psychology)

**1. IDENTIFY AND LIST CLIENT CONCERNS**

Above-average grades
Above-average PSAT scores
Student activities leader
Student government leader
Cheerleader
Gymnast
Prom queen candidate
Highly successful father and brother
Frequently absent father
Socially successful mother
Prescription dependence of mother
Alcohol abuse of mother
Emotionally absent mother
Vomits to purge as weight control
Uses mother's laxatives to purge
Self-image associated with body
Self-image associated with thinness
Skipped day of school for shopping
One-day in-school Saturday detention
Suspected and admitted recently begun problematic marijuana use
Smokes marijuana at school
Has missed homework assignments due to use
Has begun "hanging around" unfamiliar boys due to use
Sparse eyelashes and eyebrows
Admits eye-hair pulling for stress relief
Pulls hairs to feel calm and in control

**2. ORGANIZE CONCERNS INTO LOGICAL THEMATIC GROUPINGS**

1. Historically, successful, high-achieving high-SES female student
2. In recent adolescence, engaging in multiple problematic "acting out" behaviors, including marijuana use, purging for weight control, and eye-hair pulling

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

Brief Contemporary Psychodynamic Approach: Kohut's Self-Psychology

*Inferred Difficulties in Self-Function*

1. Use of marijuana and eye-hair-pulling as Defensive Maneuvers to cover over defects in self-development
2. Use of purging via vomiting and laxatives to maintain thinness as Compensatory Action to compensate for defects in self-development

**4. NARROWED INFERENCES: SUICIDALITY AND DEEPER DIFFICULTIES**

Brief Contemporary Psychodynamic Approach: Kohut's Self-Psychology

*Deeper Inferences of Difficulties in Self-Function*

Defects in Grandiose Line of Development due to Insufficient Mirroring by parents (Due to lack of psychological mirroring, unsure whether she is competent and worthy as an emerging adult; she is covering associated feelings of doubt, low mood, anxiety with marijuana use, hair pulling, drive for thinness)

*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 counselor identified all of the information pertaining to Claire's current concerns—details describing her problems with marijuana use, purging, and hair-pulling. She also identified all of the information she could gather pertaining to Claire's family dynamics, her high school adjustment, strengths and talents, and other important psychosocial information. The counselor went beyond just the main reason for referral to describe Claire's situation as fully as possible.

*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, Claire's counselor selected the Areas of Dysfunction Approach. This approach sorts together all of the Step 1 information into "areas of dysfunction according to important life situations, life themes, or life roles and skills" (Neukrug & Schwitzer, 2006, p. 205).

Interestingly, the counselor distilled all of the information collected at Step 1 into just two overarching themes at Step 2: (1) Historically, successful high-achieving, high-socioeconomic-status female student; and (2) in recent adolescence, engaging in multiple problematic "acting out" behaviors, including marijuana use, purging for weight control, and eye-hair pulling. In other words, she grouped all of Claire's strengths, family information, and background material into the first theme, and all of the details of her three current clinical

concerns into the second theme. The counselor believed this distillation allowed her to begin more clearly thinking about Claire and her needs.

*Step 3: Theoretical Inferences.* At Step 3, concepts from the counselor's selected theory, Kohut's Self-Psychology, are applied to explain the dynamics causing and maintaining Claire's problematic thoughts, feelings, behaviors, and physiological responses. 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 is believed to be the psychological etiology of Claire's current needs (Neukrug & Schwitzer, 2006; Schwitzer, 2006, 2007).

According to Kohut's Self-Psychology (Kohut, 1971, 1977, 1984), infants, children, and adolescents require specific dynamics in their relationships with their parents or primary caregivers. Specifically, parents must provide "mirroring," "idealization," and "mentorship." When provided adequately, these lead to healthy development of the self, including three different lines of development (Grandiose, Idealized Self-Image, and Twinship). When the psychodynamic parenting requirements are unmet or insufficient, the person can grow up to develop ways of covering over the inadequacies, depressed mood, anxieties, or other psychological deficiencies that form as a consequence. These ways of covering over fragile self-development are called Defensive Maneuvers and Compensatory Actions. In this way, client symptoms are reinterpreted as ways of coping.

As can be seen in the figure, when Claire's counselor applied these concepts to Claire's situation, she inferred at Step 3 that Claire's three clinical problems were methods of coping with problems in her self-development stemming from absent or emotionally absent parents (Patton & Robbins, 1982; Schwitzer, 1997, 2005). Specifically, following the theory, the counselor inferred: (a) use of marijuana and eye-hair pulling were Defensive Maneuvers to cover over defects in self-development; and (b) use of purging via vomiting and laxatives to maintain thinness were Compensatory Actions to compensate for defects in self-development.

*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). Continuing to apply Self Psychology concepts at Step 4, Claire's counselor presented a single, deepest, most-fundamental explanation of Claire's needs, namely, that she is experiencing: Defects in the Grandiose Line of Development due to Insufficient Mirroring by her parents. (In other words, due to lack of psychological mirroring, at a very deep psychological level Claire is unsure whether she is competent and worthy as an emerging adult; in turn, she is covering the feelings of doubt, low mood, and anxiety that she has about herself by using marijuana to lift her mood, pulling her hair for tension relief, and driving to be especially thin to feel good about herself).

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. The completed pyramid now is used to plan treatment, where the counselor will work with Claire in brief psychotherapy.

## Treatment Planning

At this point, Claire's clinician at the Great Lakes Clinical Associates of Chicago has collected all available information about the problems that have been of concern to her and her school. 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 Claire'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 Claire, but with all clients who present with disturbing or disruptive symptoms (Jongsma & Peterson, 2006; Jongsma, Peterson, & McInnis, 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 Anxiety Inventory-II (Beck, Steer, & Brown, 1996) 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 Claire, followed by her 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 Claire, there is one primary area of concern, "multiple problematic 'acting-out' behaviors, including marijuana use, purging for weight control, and eye-hair pulling." This array of symptoms refers to smoking marijuana at school and missing homework assignments and hanging around unfamiliar boys due to marijuana use. It also refers to pulling her eye-hair for stress control and to feel calm and in control, vomiting to

purge as weight control, using her mother's laxatives to purge, and self-image. These symptoms are consistent with a diagnosis of Cannabis Use Disorder, Other Specified Feeding and Eating Disorder (Purging Disorder), and Trichotillomania (APA, 2013; Budney, Hughes, Moore, & Vandrey, 2004; Flessner, Conolea, Woods, Franklin, & Keuthen, 2008; Keel, Heatherton, Dorer, Joiner, & Zalta, 2006; National Institute on Drug Abuse, 2008; Stein, Christiansen, & Hollander, 1999).

*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 Claire, the goals flow from her pattern of acting out behavior that includes cannabis use, purging, and trichotillomania.

With regard to her cannabis use, the goals are to maintain abstinence from marijuana use, to reduce the level of personal and family stress related to marijuana use, and to develop coping/self-regulation skills necessary to remain abstinent. With regard to the symptoms of Claire's eating disorder, the goals are to terminate the pattern of eating/purging behavior, to help her develop awareness of the relationship between stress and purging, to assist her in changing the definition of "self" that does not include weight, to restructure the distorted thoughts that maintain this behavior, and to restore her normal eating/elimination patterns. With regard to her trichotillomania, we will help Claire to recognize the relationship between stress and hair-pulling, to eliminate the hair-pulling behavior, and to replace the hair-pulling behavior with adaptive responses to stress. All of these goals are consistent with helping Claire to develop a clear and valued sense of self, in spite of the emotional neglect she has experienced in her family.

*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, Inter-personal Therapy, and Feminist Therapy); and when delivered through specific treatment modalities (individual, group, and family counseling).

In the case of Claire, we have decided to use a Brief Contemporary Approach based upon Heinz Kohut's Self-Psychology (Kohut, 1971, 1977, 1984). According to Kohut, we all have specific needs that must be met if we are going to achieve a healthy sense of self; these include the need to feel special (recognition), the need to believe that parents are strong, capable, and self-assured (idealizing parents), and the need to be like others and to belong (twinship) (Neukrug, 2011). Parents who possessed these qualities and were capable of nurturing the child's sense of importance were considered "good enough parents" whom the child would internalize as a guidance system of sorts. Children who were not valued developed poor self-esteem and a sense of worthlessness. Additionally, if parents were emotionally unavailable or punitive, the child would internalize them as negative parts of his or her own sense of self. Without the mirroring of people who regarded the child in positive ways, he or she would grow up to feel unwanted and as an outsider. Based upon this model, the role of the therapist is to be a good-enough parent substitute who values the client and provides a "corrective emotional experience" in which a positive sense of self can be developed. Kohut divided the therapeutic work into two phases: the empathic mirroring phase (understanding) and the interpretation phase (explaining) (Bachar, 1998). In the case of eating disorders, and other conditions in which the client is attempting to regulate states of inner tension along with his or her self-image (substance use and hair-pulling), the therapeutic relationship can re-

establish confidence in the "capacity of close human relationships [rather than substances and dysfunctional behaviors] to calm and mitigate dysphoric moods and build a positive self image" (Bachar, 1998, p. 152).

Specific techniques drawn from this theoretical model as applied to Claire will include using empathic attunement in order to understand and acknowledge Claire's unique perspective on her problems and to confirm her inner reality, to allow an unfolding of the various self-objects that Claire has internalized, to help her understand the relationship between early family experiences and her current ways of perceiving herself, to facilitate a valuing mirroring of Claire, analyze her defenses and resistance against the emergence of new versions of herself, and perhaps most importantly, reflect pride in Claire and her accomplishments.

*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 Claire's case, we have implemented a number of these, including pre-post measures on the Eating Disorder Inventory-III (Garner, Olmsted, & Polivy, 1983), pre-post measures on the Milwaukee Inventory for Styles of Trichotillomania—Child Version (Flessner et al., 2007), pre-post measures on the Marijuana Screening Inventory (Alexander, 2003), client self-reported awareness of and ability to regulate mood and behavior without acting out, clinician-observed improvement in self-object awareness and self-image, and client and parent report of improved relationships.

The completed treatment plan is now developed through which the counselor and Claire will begin their shared work of enhancing her self-image and eliminating the symptoms of her eating disorder, cannabis use, and trichotillomania. Claire's treatment plan appears below and a summary can be found in the table that follows.

**TREATMENT PLAN**

**Client:** Claire Standish

**Service Provider:** Great Lakes Clinical Associates of Chicago

BEHAVIORAL DEFINITION OF PROBLEMS**:**

1. Multiple problematic "acting-out" behaviors—Smoking marijuana at school, missing homework assignments, and hanging around unfamiliar boys due to marijuana use, pulling eye-hair for stress control and to feel calm and in control, vomiting to purge as weight control, using mother's laxatives to purge, and self-image problems associated with body and thinness

GOALS FOR CHANGE:

1. Multiple problematic acting-out behaviors

*With regard to cannabis use*

- Maintain abstinence from marijuana use
- Reduce level of personal and family stress related to marijuana
- Develop coping/self-regulation skills necessary to remain abstinent

*With regard to the eating disorder*

- Terminate the pattern of eating/purging behavior
- Develop awareness of the relationship between stress and purging
- Assist in changing the definition of "self" to one that does not include weight
- Restructure the distorted thoughts that maintain this behavior
- Restore normal eating/elimination patterns

*With regard to trichotillomania*

- Recognize the relationship between stress and hair-pulling
- Eliminate hair-pulling behavior and replace with adaptive responses to stress

THERAPEUTIC INTERVENTIONS:

A short-to-moderate-term course (4–6 months) of Brief Contemporary

Psychodynamic Psychotherapy supplemented with group counseling

1. Multiple problematic "acting-out" behaviors

- Using empathic attunement to understand and acknowledge unique perspective and to confirm inner reality
- Allow an unfolding of the various internalized self-objects
- Help understand the relationship between early family experiences and current ways of perceiving herself
- Facilitate a valuing mirroring
- Analyze defenses and resistance against the emergence of new versions of self
- Reflect pride in accomplishments and herself
- Supportive group counseling

OUTCOME MEASURES OF CHANGE:

An elimination of acting-out behaviors and improved overall functioning at home and at school as measured by:

- Pre-post measure on the Eating Disorder Inventory-III
- Pre-post measures on the Milwaukee Inventory for Styles of Trichotillomania—Child Version
- Pre-post measures on the Marijuana Screening Inventory
- Client self-reported awareness of and ability to regulate mood and behavior
- Clinician-observed improvement in self-object awareness and self-image
- Client and parent report of improved relationships

Claire's Treatment Plan Summary: Brief Contemporary Psychodynamic Psychotherapy (Kohut's Self-Psychology)

| *Goals for Change* | *Therapeutic Interventions* | *Outcome Measures of Change* |
|---|---|---|

| | | |
|---|---|---|
| **Multiple problematic acting-out behaviors**<br>*With regard to cannabis abuse*<br>Maintain abstinence from marijuana use<br>Reduce level of personal and family stress related to marijuana<br>Develop coping/self-regulation skills necessary to remain abstinent.<br>*With regard to the eating disorder*<br>Terminate the pattern of eating/purging behavior<br>Develop awareness of the relationship between stress and purging<br>Assist in changing the definition of "self" to one that does not include weight<br>Restructure the distorted thoughts that maintain this behavior<br>Restore normal eating/elimination patterns.<br>*With regard to trichotillomania*<br>Recognize the relationship between stress and hair-pulling<br>Eliminate hair-pulling behavior and replace with adaptive responses to stress | **Multiple problematic acting-out behaviors**<br>Using empathic attunement to understand and acknowledge unique perspective and to confirm inner reality<br>Allow an unfolding of the various internalized self-objects<br>Help understand the relationship between early family experiences and current ways of perceiving herself<br>Facilitate a valuing mirroring<br>Analyze defenses and resistance against the emergence of new versions of self<br>Reflect pride in accomplishments and herself<br>Supportive group counseling | **An elimination of acting-out behaviors and improved overall functioning at home and at school as measured by:**<br>Pre-post measure on the Eating Disorder Inventory-III<br>Pre-post measures on the Milwaukee Inventory for Styles of Trichotillomania—Child Version<br>Pre-post measures on the Marijuana Screening Inventory<br>Client self-reported awareness of and ability to regulate mood and behavior<br>Clinician-observed improvement in self-object awareness and self-image<br>Client and parent report of improved relationships |

## References


Alexander, D. (2003). A Marijuana Screening Inventory (experimental version): Description and preliminary psychometric properties. *American Journal of Drug and Alcohol Abuse, 29*(3), 619–646.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Bachar, E. (1998). The contributions of self-psychology to the treatment of anorexia and bulimia. *American Journal of Psychotherapy*, *52*(2), 147–165.

Beck, A. T., Steer, R. A., & Brown G. K. (1996). *BDI-II, Beck Depression Inventory: Manual* (2nd ed.). Boston, MA: Harcourt Brace.

Budney, A. J., Hughes, J. R., Moore, B. A., & Vandrey, R. (2004). Review of the validity and significance of cannabis withdrawal syndrome. *American Journal of Psychiatry, 161,* 1967–1977.

Flessner, C. A., Conolea, C. A., Woods, D. W., Franklin, M. E., & Keuthen, N. J. (2008). Styles of pulling in trichotillomania: Exploring differences in symptom severity, phenomenology, and functional impact. *Behavioral Research Therapy, 46,* 345–357.

Garner, D., Olmstead, M., & Polivy, J. (1983). Development and validation of a multidimensional eating disorder inventory for anorexia and bulimia. *International Journal of Eating Disorders, 2*(2), 15–34.

Hughes, J. (Producer & Director). (1985). *The breakfast club* [Motion Picture]. United States: A & M Films.

Inaba, D. S., & Cohen, W. E. (2000). *Uppers, downers, all-arounders: Physical and mental effects of psychoactive drugs* (5th ed.). Ashland, OR: CNS.

Jongsma, A., & Peterson. (2006). *The complete adult psychotherapy treatment planner.* New York, NY: Wiley.

Jongsma, A., Peterson, L. M., & McInnis, W. (2003a). *The adolescent psychotherapy treatment planner.* New York, NY: Wiley.

Jongsma, A., Peterson, L. M., & McInnis, W. (2003b). *The child psychotherapy treatment planner.* New York, NY: Wiley.

Keel, P. K., Heatherton, T. F., Dorer, D., Joiner, T. E., & Zalta, A. K. (2006). Point prevalence of bulimia nervosa in 1982, 1992, and 2002. *Psychological Medicine, 36,* 119–127.

Kohut, H. (1971). *The analysis of the self.* New York, NY: International Universities Press.

Kohut, H. (1977). *The restoration of the self.* New York, NY: International Universities Press.

Kohut, H. (1984). *How does analysis cure?* New York, NY: International Universities Press.

National Institute on Drug Abuse (NIDA). (2008). *NIDA InfoFacts: Treatment approaches for drug addiction.* Retrieved from http://www.nida.nih.gov/PDF/InfoFacts/Treatment08.pdf

Neukrug, E. (2011). *Counseling theory and practice.* Belmont, CA: Brooks/Cole.

Neukrug, E. S., & Schwitzer, A. M. (2006). *Skills and tools for today's counselors and psychotherapists: From natural helping to professional helping.* Belmont, CA: Wadsworth/Thomson Brooks/Cole.

Patton, M. J., & Robbins, S. B. (1982). Kohut's self-psychology as a model for college-student counseling. *Professional Psychology, 13,* 876–888.

Robbins, S. B. (1989). Role of contemporary psychoanalysis in counseling psychology. *Journal of Counseling Psychology, 36,* 267–278.

Seligman, L. (1993). Teaching treatment planning. *Counselor Education and Supervision,* 33, 287–297.

Seligman, L. (1998). *Selecting effective treatments: A comprehensive systematic guide to treating mental disorders*. Upper Saddle River, NJ: Merrill/Prentice Hall.

Seligman, L. (2004). *Diagnosis and treatment planning* (3rd ed.). New York, NY: Plenum Press.

Stein, D. J., Christiansen, G. A., & Hollander, E. (Eds.). (1999). *Trichotillomania.* Washington, DC: American Psychiatric Press.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Erlbaum.