Slumdog Millionaire's Jamal Malik

Introducing the Character

Jamal Malik is the main character in the internationally acclaimed Oscar-winning film *Slumdog Millionaire* (Boyle & Tandan, 2008), which first appeared as the novel *Q & A* by Indian author Vikas Swarup (2008). The story follows the orphan street hustler Jamal Malik through his unlikely success as a contestant on the Indian version of the popular American game show *Who Wants to Be a Millionaire?*

At the beginning of the film, the audience watches Jamal being tortured by local Mumbai police who are pressuring him to confess that he has been cheating on the television show *Who Wants to Be a Millionaire*? Of great interest to the police, but of even greater interest to the game show producers, is how this otherwise impoverished, uneducated, and itinerant young man knows the answers to the increasingly complex questions he is being asked before a live audience and millions of Indian TV viewers. Over the course of the narrative, it becomes clear that Jamal knows the answers to the various questions because in one way or another, and over the course of his young life, he has either directly or indirectly experienced situations that he is later able to parlay into answers to the game show questions.

Orphaned at birth, he, along with his older brother, Salim, learned to survive on the tough and gang-infested streets of the Juhu slums in Mumbai, India. There, he meets and falls in love with Latika, who in turn falls prey to the Mumbai gangs and who, over the course of her own tormented childhood and adolescence, connects deeply with Jamal. The story is an intricate tapestry, weaving together issues of politics, social class, religion, and the power of capitalism and Western greed to transform not only a single individual, but a society as well. It is also a story of hope. The following basic case summary and diagnostic impressions describe what we portray as Jamal's clinically significant negative reactions to his exposure to the traumatic experience of police capture and torture.

Basic Case Summary

Identifying Information. Jamal Malik is a homeless 17-year-old Indian youth who was orphaned at birth and who has been living in the Juhu neighborhood (characterized as a slum) of urban Mumbai with his brother, Salim. Jamal has labored in sweat shops, stolen food, engaged in robbery, and has prostituted himself. He has nevertheless been able to remain uninvolved with the local gangs that have claimed the loyalty of his brother. In appearance, he is a tall, slender, athletically built young man who could be described as having "chiseled features" and "piercing dark brown eyes." Regarding religious identity important to his context, although Jamal is of the Muslim faith, he reports that he does not believe in God and professes a deep conviction that "I watch out for myself" and that he will "work my way out of these miserable slums no matter what it takes."

Presenting Concern. Jamal Malik was referred to the Government Community Services Center of Mumbai by staff of the Center for Spiritual Enlightenment. Jamal's brother initially brought him to the center once he noticed that his brother appeared to be "in a daze" almost all day long and at night either could not sleep or called out during repeated nightmares. His brother also said he could not be induced to walk anywhere near the local police station or jail building and that he turned corners to avoid walking down the same streets as police on patrol. His brother estimated that Jamal had been "like this" since his experience appearing on *Who Wants to Be a Millionaire*? which ended about 15 days ago. When interviewed, Jamal said he "really couldn't remember too much about all of that," although it was exciting. He seemed overly sensitive to noises and distractions during the interview and said he "wasn't quite feeling like himself."

Background, Family, and Relevant History. The onset of Jamal's presenting concerns appears to be recent, extending back about 2 weeks. Background and relevant history prior to onset include his developmental experiences growing up parentless in severe poverty, briefly in government facilities, and, since about age 7 to the present, homeless on the streets with his brother and peers. Jamal was originally seen at the Center for Spiritual Enlightenment, where the staff described his symptoms as *jiryan* or *dhat syndrome*, which is a culturally-specific folk diagnosis in South Asia (APA, 2013); however, a spiritual advisor at the center who had

obtained a master's degree in counseling in Dublin recommended referring him to the Government Community Services Center for what appeared to be symptoms of what Western mental health professionals would describe as Posttraumatic Stress Disorder or Acute Stress Disorder.

Although stressful, appearing on the recent game show does not meet the criteria for a traumatic event. However, it appears that Jamal has experienced captivity and torture by the local police, during which he was threatened with death and actually physically and mentally tortured. Along with the presenting symptoms of sleep difficulties, what appears to be hypervigilance (he seems to startle easily), and a lack of emotional response about his recent major life events (his brother described him as "in a daze"), Jamal said that at times during the day he feels as though the city around him "just isn't really real . . . it's just moving along around me" or as though he is now a detached observer of his behavior as he watches "the world bump along." His various symptoms and experiences appear consistent with negative reactions to a traumatic event.

Goals for Counseling and Course of Therapy to Date. Based on Jamal's brother's description, referral data provided by the center, and Jamal's intake, it appears that he is experiencing clinically significant reactions to recent events to which he reacted with intense fear and other distressful responses. To date he has participated in two meetings at the Center for Enlightenment and one intake here at the Government Services Center. Jamal agreed to our recommendation that he remain a client at this center primarily due to the encouragement of his brother. The immediate plan includes: (a) follow-up assessment to make a final determination of diagnosis and treatment plan, (b) ongoing treatment at this center, and (b) referral to the social services wing of the Government Community Services Center for assistance with housing and basic needs.

Diagnostic Impressions

308.3 (F43.0) Acute Stress Disorder

Other factors: V62.5 (Z65.1) Recent incarceration, V62.89 (Z65.4) Victim of torture, violent interrogation by police, V60.2 (Z59.5) Extreme poverty, difficulty collecting game show winnings, V60.0 (Z59.0) Homelessness, unsafe neighborhood

Discussion of Diagnostic Impressions

Jamal Malik was referred to the Government Community Services Center because his brother and the referring counselor were concerned about him "being in a daze," not sleeping or at other times having nightmares, staying away from the local police building and jail and avoiding police on patrol, and seeming to be overly vigilant about the goings-on around him. In the interview, Jamal reported that, in fact, he could not remember much about his *Millionaire* adventure beyond its excitement. He also said that along with being in a daze, at times the city around him seems unreal. As the case discussed, he recently survived police capture and torture during an interrogation.

The predominant feature shared by all of the diagnosable conditions found in the Trauma- and Stressor-Related Disorders section of the *DSM-5* is the "exposure to a traumatic or stressful event" (APA, 2013, p. 265) that is either directly experienced or witnessed. This chapter includes Reactive Attachment Disorder, Disinhibited Social Engagement Disorder, Posttraumatic Stress Disorder, Acute Stress Disorder, and Adjustment Disorders.

This case described what we portrayed as Jamal's clinically significant negative reactions to his exposure to the traumatic experience of police capture and torture. Jamal experienced an event characterized by threat to his physical integrity (he was held against his will), was subjected to painful torture and physical injury, and the threat of serious physical damage or possibly death; he reacted with intense helplessness and fear. These characteristics meet the *DSM-5* definition of a traumatic event. Following the event, Jamal has been experiencing dissociative symptoms, including reduced awareness of his surroundings (he feels "in a daze"), derealization (his external worlds seem unreal and mechanical), and some amnesia (failure to fully recall the event). He has been re-experiencing the event during nightmares. He has also been avoiding places (i.e., the police station and jail) and people (i.e., police patrols) reminiscent of the event. He has signs of anxiety, including sleep disruption. According to the case timeline, it has been 15 days since the traumatic event. These factors indicate a diagnosis of Acute Stress Disorder. Differential diagnoses might include Posttraumatic Stress Disorder (PTSD) or Adjustment Disorder. However, PTSD requires more than 1 month of symptoms, whereas

Acute Stress Disorder fits when symptoms occur within 3 days to 1 month of a severe stressor. Acute Stress Disorder describes the concerns of individuals "who have immediate and intense stress reactions to traumatic events and need immediate clinical attention rather than waiting more than a month [for the symptoms of PTSD]" (Munson, 2001, p. 185). Should Jamal's symptoms persist, the diagnosis may later change to PTSD. Adjustment Disorders are negative reactions to any sort of life stressors, as opposed to a trauma. In this case, Jamal has indeed experienced exposure to an extreme stressor meeting the diagnostic definition of trauma, and his reactions conform to the specific constellation symptoms characteristic of Acute Stress Disorder and PTSD, which go beyond the general criteria set for Adjustment Disorder.

To wrap up the diagnosis, Jamal's trauma and other psychosocial stressors are emphasized in the "Other factors" section. The information presented in this case is appropriate for a diagnosis of Acute Stress Disorder.

Case Conceptualization

When Jamal Malik came in to the Government Community Services Center of Mumbai, his intake counselor collected as much information as possible about the symptoms and situations leading to his referral. Included among the intake materials were a thorough history, client report, the reports of his brother and referring Center for Spiritual Enlightenment staff, counselor observations, and written psychological assessments. Based on the intake, Jamal's counselor developed diagnostic impressions, describing his presenting concerns as Acute Stress Disorder (ASD). A case conceptualization next was developed.

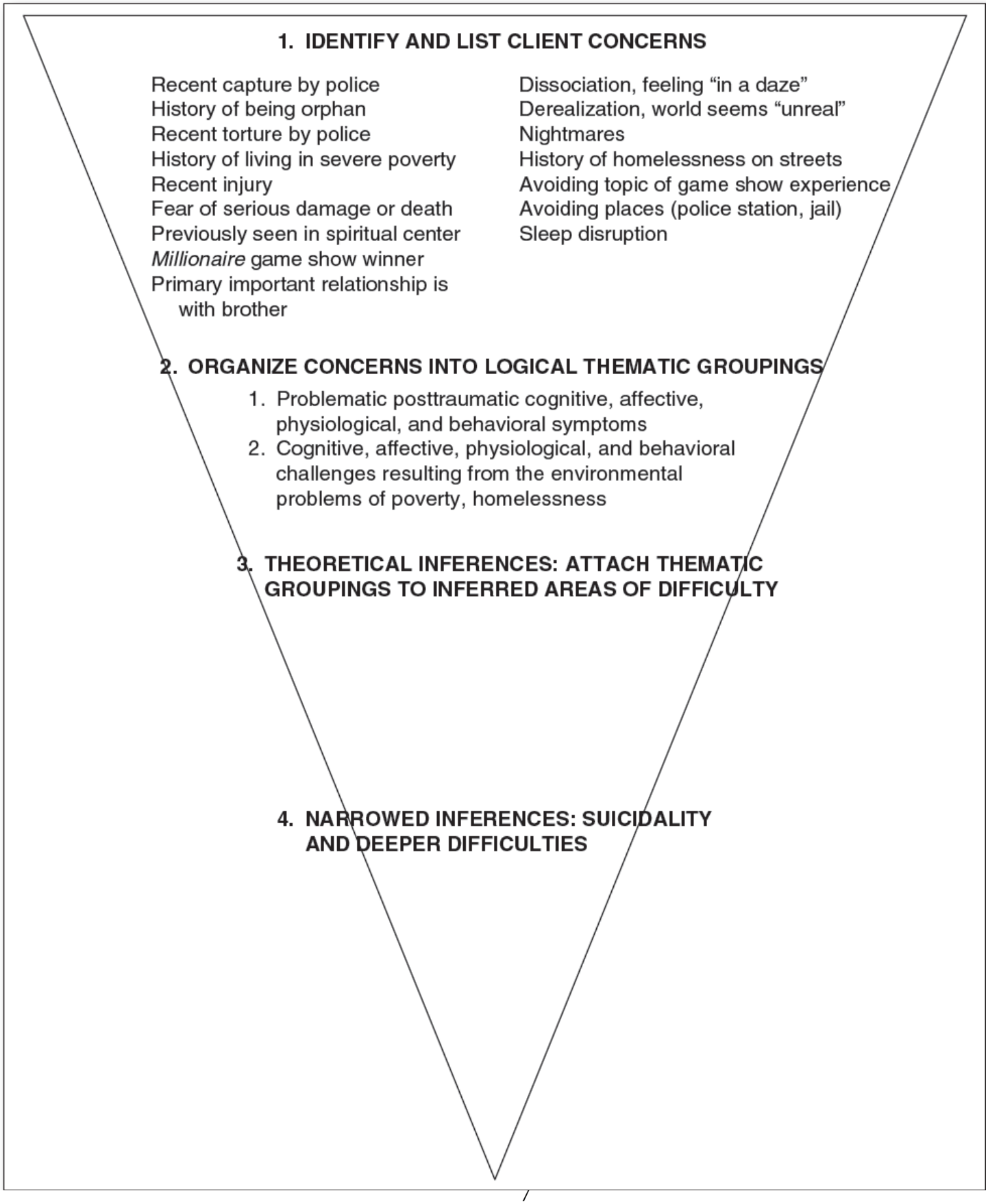
At the Government Community Services Center of Mumbai, Brief Solution-Focused Counseling is used. The center employs this particular model because it is believed to be an efficient and effective method of providing services, and outcome studies suggest the approach can be successful with a range of presenting problems (de Jong & Berg, 2002; MacDonald, 1994). Whereas the purpose of diagnostic impressions is to *describe* the client's concerns, the goal of case conceptualization as it is applied to Brief Solution-Focused Counseling is to better *understand* and clinically *organize* the person's experiences (Neukrug & Schwitzer, 2006). It helps the counselor determine the circumstances leading to Jamal's Acute Stress Disorder and the factors maintaining his presenting concerns. 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 Jamal Malik return to his previous level of functioning.

Generally speaking, when forming a theoretically based case conceptualization, the clinician applies a purist counseling theory, an integration of two or more theories, an eclectic mix of theories that focuses extensively on diagnosis, history, and etiology; by comparison, when forming a solution-focused case conceptualization, the counselor applies an eclectic combination of solution-focused, or solution-creating, tactics to his or her immediate understanding of the client and engages quickly in identifying and reaching goals (Berg, 1994; de Shazer & Dolan, 2007; Gingerich & Eisengart, 2000).

Jamal's 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). Generally speaking, when the method is used with a theory-based conceptual model, there are four steps: Problem Identification, Thematic Groupings, Theoretical Inferences, and Narrowed Inferences. However, when the Brief Solution-Focused Counseling model is applied, only the first two steps are needed: Problem Identification and Thematic Grouping. From a solution-focused perspective, it is these two steps that focus attention on what clients want and need and what concerns will be explored and resolved (Bertolino & O'Hanlon, 2002). Brief solution-focused counselors make carefully thought-out professional clinical decisions at Steps 1 and 2 of the pyramid; they are sure to have a rational framework for their decisions rather than implementing techniques and approaches at random (Lazarus, Beutler, & Norcross, 1992; Norcross & Beutler, 2008). Jamal Malik's counselor's solution-focused clinical thinking can be seen in the figure that follows.

Jamal Malik's Inverted Pyramid Case Conceptualization Summary: Brief Solution-Focused Counseling Emphasizing Cognitive Behavioral Interventions With Adolescents



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 Jamal Malik's recent traumatic events (game show and police capture), his various presenting symptoms (dissociations, avoidance, etc.), additional environmental and situational obstacles (poverty, living on the street, etc.), as well as positive relationships (with brother) and supports (spiritual center). The counselor attempted to go beyond just the presenting symptoms in order to be as descriptive as he could.

The counselor first grouped together all of Jamal's cognitive concerns connected to dissociation, derealization, nightmares; all of Jamal's behavioral concerns connected to avoiding anxiety-producing people, places, and topics reminiscent of the trauma; and all of Jamal's physiological symptoms of anxiety and post-trauma into the theme "Problematic posttraumatic cognitive, affective, physiological, and behavioral symptoms." The counselor next formed an additional category comprising all of Jamal's environmental problems connected to being an orphan and in poverty: "Cognitive, affective, physiological, and behavioral challenges resulting from the environmental problems of poverty and homelessness." The counselor selected the Clinical Targets Approach to organize Jamal's concerns from a Solution-Focused Counseling perspective on the basis that he planned to emphasize cognitive and behavioral interventions that he believed would lead to good solutions with adolescents such as Jamal (Vernon, 2009).

With this two-step conceptualization completed, the client information in Step 1 leads to logical-intuitive groupings on the basis of common denominators in Step 2, and the counselor is ready to engage the client in planning and implementing Brief Solution-Focused Counseling.

Treatment Planning

At this point, Jamal Malik's clinician at the Government Community Services Center of Mumbai has collected all available information about the problems that have been of concern to him and the referring counselor. 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 Jamal'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 Jamal Malik, but with all clients who present with disturbing and disruptive symptoms and/or posttraumatic 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-II (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 Jamal Malik, followed by his specific treatment plan.

Step 1: Behavioral Definition of Problems. The first step in solution-focused 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 Jamal, there are three primary areas of concern. The first, "problematic posttraumatic cognitive, affective, physiological, and behavioral symptoms," refers to Jamal's fear of serious damage or death; sleep disruption; dissociation or feeling "in a daze"; derealization in which the world seems "unreal"; nightmares; and avoiding people, places, and the topic of the game show experience. The second, "environmental problems," refers to his history of being an orphan, homelessness, and severe poverty. These symptoms and stresses are consistent with the diagnosis of Acute Stress Disorder (APA, 2013; Bradley, Greene, Russ, Dutra, & Westen, 2001; Brunello et al., 2001; Bryant et al., 2008; Kessler et al., 1994; Kessler et al., 1995).

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 Jamal, the goals are divided into two prominent areas. The first, "problematic posttraumatic cognitive, affective, physiological and behavioral symptoms," requires that we help Jamal to verbalize an understanding of how the symptoms of ASD develop, to reduce the negative

impact that the traumatic event had on his life, to develop and implement effective coping skills, and to recall the traumatic event without becoming overwhelmed with stressful feelings or dissociating. The second, "environmental problems," requires that we help Jamal to understand the relationship between the conditions in which he grew up and his current psychological and behavioral functioning as well as use his game show winnings to improve the quality of his life.

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 Jamal, we have decided to use Brief Solution-Focused Therapy (De Jong & Berg, 2002; de Shazer & Dolan, 2007; Gingerich & Eisengart, 2000; Gutterman, 2006), emphasizing cognitive interventions with adolescents (Corcoran & Stephenson, 2000; Hopson & Kim, 2005; Lines, 2002; Vernon, 2009). This counseling approach is "pragmatic, anti-deterministic and future oriented [and as such] offers optimism, and hope about the ability of the client to change" (Neukrug, 2011, p. 426). It de-emphasizes psychopathology and the past and instead focuses on the client's strengths, resources, and skills in order to generate solutions to the problems and concerns. Forward-looking and quickly moving, Solution-Focused Therapy's basic assumptions include that change is constant and inevitable, clients have the inherent skills and abilities to change, small steps

lead to big changes, exceptions to problems do occur and can be used for change, and the future is both created and negotiable; as well as the simple axioms "if it ain't broke, don't fix it," "if it works, do more of it" and "if it's not working, do something different" (Neukrug, 2011).

We view Brief Solution-Focused Therapy as being particularly useful in Jamal's case due to its emphasis on change, the future, and tapping into the client's resources and skills. Additionally, solution-focused treatment is fast-moving, makes use of creative techniques (art, play, and narrative) with children and adolescents, and relies on challenging, strength-based questioning that can be highly engaging with adolescents. Specific techniques for his symptoms include: education and orientation to Brief-Solution Focused Treatment; goal setting with regard to Acute Stress Disorder symptoms; initial "scaling" of his posttraumatic symptoms to provide context and perspective as well as a starting point for change; ongoing scaling to gauge improvement; use of the miracle question to help him begin to cognitively process the possibility of change; externalizing the symptoms by using solution talk and creating hypothetical solutions; identifying and complimenting Jamal on past and current use of skills to solve problems plus amplification of previously successful strategies for self-care; using preferred-goal, evaluative, coping, exception-seeking, and solution-focused questions; and psychiatric referral for possible psychopharmacotherapy; and relaxation training. Specific techniques for his environmental problems include: referral to a financial planner as well as a real estate agent.

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 Jamal's case, we have implemented a number of these, including pre-post measures on the Clinician-Administered PTSD Scale for Children and Adolescents (Newman et al., 2004) and clinician-observed and client report of reduction in

affective, cognitive, physiological, and behavioral symptoms of ASD, effective wealth management, and improved living circumstances.

The completed treatment plan is now developed through which the counselor and Jamal will work through the traumatic experience and reverse the circumstances of his poverty and homelessness. The treatment plan appears below and is summarized in the table that follows.

TREATMENT PLAN

Client: Jamal Malik

Service Provider: Government Community Services Center of Mumbai

---

BEHAVIORAL DEFINITION OF PROBLEMS:

1. Problematic posttraumatic cognitive, affective, physiological, and behavioral symptoms—Fear of serious damage or death, sleep disruption, dissociation, or feeling "in a daze," derealization in which the world seems "unreal," nightmares and avoiding people, places, and topic of the game show experience
2. Environmental problems—History of being an orphan, homelessness, severe poverty

---

GOALS FOR CHANGE:

1. Problematic posttraumatic cognitive, affective, physiological, and behavioral symptoms

---

- Verbalize an understanding of how the symptoms of ASD develop
- Reduce the negative impact that the traumatic event had on life
- Develop and implement effective coping skills
- Recall the traumatic event without becoming overwhelmed with stressful feelings or dissociating

2. Environmental problems

- Understand the relationship between growing up in poverty and his current beliefs, behaviors, and emotions
- Use his game show winnings to improve the quality of his life

THERAPEUTIC INTERVENTIONS:

A short-to-moderate-term course (3–4 months) of individual Brief Solution-Focused Counseling supplemented with psychopharmacotherapy and relaxation training

1. Problematic posttraumatic cognitive, affective, physiological, and behavioral symptoms
    - Education and orientation to brief solution-focused treatment
    - Goal setting with regard to ASD symptoms
    - "Scaling" of posttraumatic symptoms to provide context and perspective as well as a starting point for change
    - Ongoing scaling to gauge improvement
    - Use of the miracle question to help begin to cognitively process the possibility of change
    - Externalizing the symptoms by using solution talk and creating hypothetical solutions
    - Identifying and complimenting past and current use of skills to solve problems
    - Amplification of previously successful strategies for self-care
    - Using preferred-goal, evaluative, coping, exception-seeking, and solution-focused questions
    - Psychiatric referral for possible psychopharmacotherapy
    - Relaxation training involving deep breathing, progressive muscle work, and guided imagery
2. Environmental problems
    - Referral to a financial planner and a real estate agent

OUTCOME MEASURES OF CHANGE:

Alleviation of symptoms of posttraumatic stress and reversal of circumstances of his poverty and homelessness as measured by:

- Pre-post measures on the Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA)
- Clinician-observed reduction in affective, cognitive,

physiological, and behavioral symptoms of ASD

- Client reports of reduction in affective, cognitive, physiological, and behavioral symptoms of ASD
- Physician report of medication compliance
- Effective wealth management and improved living circumstances

Jamal Malik's Treatment Plan Summary: Brief Solution-Focused Counseling Emphasizing Cognitive Behavioral Interventions With Adolescents

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

Problematic posttraumatic cognitive, affective, physiological, and behavioral symptoms Verbalize an understanding of how the symptoms of ASD develop Reduce the negative impact that the traumatic event had on life Develop and implement effective coping skills Recall the traumatic event without becoming overwhelmed with stressful feelings or dissociating **Environmental problems** Use his game show winnings to improve the quality of his life	**Problematic posttraumatic cognitive, affective, physiological, and behavioral symptoms** Education and orientation to brief-solution focused treatment Goal setting with regard to posttraumatic stress disorder symptoms "Scaling" of posttraumatic symptoms to provide context and perspective as well as a starting point for change Ongoing scaling to gauge improvement Use of the miracle question to help begin to cognitively process the possibility of change Externalizing the symptoms by using solution talk and creating hypothetical solutions Identifying and complimenting past and current use of skills to solve problems Amplification of previously successful strategies for self-care Use preferred-goal, evaluative, coping, exception-seeking, and solution-focused questions Psychiatric referral for possible psychopharmacotherapy Relaxation training involving deep breathing, progressive muscle work, and guided imagery **Environmental problems** Referral to a financial planner and a real estate agent	**Alleviation of symptoms of posttraumatic stress and reversal of circumstances of his poverty and homelessness as measured by:** Pre-post measures on the Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA) Clinician-observed reduction in affective, cognitive, physiological, and behavioral symptoms of posttraumatic stress disorder Client reports of reduction in affective, cognitive, physiological, and behavioral symptoms of posttraumatic stress disorder Physician report of medication compliance Effective wealth management and improved living circumstances

References

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

Beck, A. T., & Steer, R. A. (1990). *Beck Anxiety Inventory manual*. San Antonio, TX: Psychological Corporation.

Berg, I. K. (1994). *Family based services: A solution-focused approach*. New York, NY: Norton.

Bertolino, B., & O'Hanlon, B. (2002). *Collaborative, competency-based counseling and therapy.* Boston, MA: Allen & Bacon.

Boyle, D., & Tandan, L. (Directors). (2008). *Slumdog millionaire* [Motion Picture]. United States: Caleador Films.

Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry, 162,* 214–227.

Brunello, N., Davidson, J. R., Deahl, M., Kessler, R. C., Mendlewica, J., Racagni, G., … Zohar, J. (2001). Post-traumatic stress disorder: Diagnosis, and epidemiology, comorbidity and social consequences, biology and treatment. *Neuropsychobiology, 43*(3), 150–162.

Bryant, R., Mastrodomenico, J., Felmingham, K., Hopwood, S., Kenny, L., Kandris, E., … Creamer, M. (2008). Treatment of acute stress disorder. *Archives of General Psychiatry, 65*(6), 659–667.

Corcoran, J., & Stephenson, M. (2000). The effectiveness of solution-focused therapy with child behavior problems: A preliminary report. *Families in Society, 81,* 468–474.

De Jong, P., & Berg, I. K. (2002). *Interviewing for solutions* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

de Shazer, S., Dolan, Y. M. (with Korman, H., Trepper, T., McCullom, E., & Berg, I. K). (2007). *More than miracles: The state of the art of solution-focused brief therapy.* New York, NY: Haworth Press.

Gingerich, W. J., & Eisengart, S. (2000). Solution-focused brief therapy: A review of the outcome research. *Family Process, 39*(4), 477–498.

Gutterman, J. T. (2006). *Solution-focused counseling.* Alexandria, VA: American Counseling Association.

Hopson, L., & Kim, J. (2005). A solution-focused approach to crisis intervention with adolescents. *Journal of Evidenced-Based Social Work, 1*(2–3), 93–110.

Jongsma, A., & Peterson, L. M. (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.

Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., … Kendler, K. S. (1994). Lifetime and 12-month prevalence of *DSM-III-R* psychiatric disorders in the United States. *Archives of General Psychiatry, 51*(1), 8–19.

Kessler, R. C., Sonnega, A., Brommet, E., Hughes, M., & Nelson, C. B. (1995). Post-traumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52*(12), 1048–1060.

Lazarus, A. A., Beutler, L. E., & Norcross, J. C. (1992). The future of technical eclecticism. *Psychotherapy, 29*(1), 11–20.

Lines, D. (2002). *Brief counseling in the schools*. London: Sage.

MacDonald, A. J. (1994). Brief therapy in adult psychiatry. *Journal of Family Therapy, 16,* 415–426.

Munson, C. E. (2001). *The mental health diagnostic desk reference: Visual guides and more for learning to use the* Diagnostic and Statistical Manual (DSM-IV-TR) (2nd ed.). Binghamton, NY: Haworth Press.

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.

Newman, E., Weathers, F. W., Nader, K., Kaloupek, D. G., Pynoos, R. S., & Blake, D. D. (2004). *Clinician-administered PTSD Scale for Children and Adolescents (CAPS-CA).* Los Angeles, CA: Western Psychological Services.

Norcross, J. C., & Beutler, L. E. (2008). Integrative psychotherapies. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (8th ed., pp. 481–511). Belmont, CA: Brooks/Cole.

Schwitzer, A. M. (1996). Using the inverted pyramid heuristic in counselor education and supervision. *Counselor Education and Supervision, 35,* 258–267.

Schwitzer, A. M. (1997). The inverted pyramid framework applying self psychology constructs to conceptualizing college student psychotherapy. *Journal of College Student Psychotherapy, 11*(3), 29–47.

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.

Swarup, V. (2008). *Slumdog millionaire.* Toronto, ON, Canada: Harper.

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