

Peter Pan's Tinkerbell

Introducing the Character

Tinkerbell is a pixie in J. M. Barrie's fantasy tale *Peter and Wendy* (1911), which was later made into the *Peter Pan* films by Disney (Geronimi & Jackson, 1953; Hogan, 2003). She is both companion and guardian of the story's protagonist Peter Pan, and unbeknownst to him, an unrequited lover.

The story of Peter Pan, the perennially youthful leader of the Lost Boys and nemesis of Captain Hook, begins in London, where Peter has traveled to retrieve his shadow from the bedroom of Wendy Darling. Awakening with a fright, Wendy meets Peter for the first time and is immediately attracted to his playfulness, fearlessness, and spirit of adventure. She, along with her siblings Michael and John, follow Peter back to Never Land where she meets the Lost Boys and Captain Hook and his deadly band of pirates. Wendy also meets Tinkerbell, a pixie who, unknown to Peter, falls deeply in love with him. Inventive, clever, and impish, Tinkerbell is very possessive of Peter and immediately jealous of his growing affections for Wendy. A muse who enjoys the arts, Tinkerbell is determined to thwart the budding romance. However, because of her diminutive size, Tinkerbell is capable of expressing only one emotion at a time and vacillates between giddy glee, vengeful rage, painful guilt, and moments of deep despair. In spite of her powers and abilities, Tinkerbell is ultimately no match for the life-sized and more well-rounded Wendy Darling. The story of Peter Pan is a timeless comedy, adventure, and passion play with something for audiences of all ages.

Peter Pan's pixie, Tinkerbell, experiences prominent changes in mood, delusional ideas about winning Peter's love, and notions about pixie dust and flying that might be seen as hallucinations outside of Never Land. As follows, using her experiences as our jumping-off point, in the following basic case summary and diagnostic impressions we recreate Tinkerbell in order to illustrate one example of the Schizophrenia Spectrum and Other Psychotic Disorders.

Basic Case Summary

Identifying Information. Ms. Tinker Bell is a 45-year-old owner of the Never Land Foster Home, an institution she single-handedly built and operates. Her diminutive size, owing to a congenital growth condition and deceptively youthful appearance, has given her the nickname of Momma Pixie among the generations of orphaned boys whom she has taken into her care. She is an outspoken advocate for her charges whom she has lovingly come to call “my lost boys.”

Presenting Concern. Ms. Bell was referred to the Never Land Community Mental Health Center out of concern by the chairman of the Never Land Foster Home Board of Directors, Charles Smee III. In a phone interview, Mr. Smee noted that although Ms. Bell has been an invaluable asset to the community, she seems to “be acting out of the ordinary.” He said he has been getting increasing reports of her expressing very odd statements and beliefs about magic potions, pixie dust, spells, and being able to fly. He said she seems focused on finding what she calls “love spells.” Out of respect, Ms. Bell came to the intake appointment but vociferously denied anything unusual, although she did admit that she has been feeling very depressed lately and has been looking for a cure that will make her feel better and also bring her the love of her life.

Background, Family Information, and Relevant History. Ms. Bell was born at Never Land General Hospital, where she was abandoned soon after birth by her parents who were reportedly incapable of caring for a “special needs child.” Although they received counseling and the offer of unlimited state resources, Mr. and Mrs. Bell believed that their daughter, because of her translucent skin and diminutive size, was “an aberration.”

Ms. Bell was raised in the Never Land foster-care system where she was the subject of ongoing ridicule as well as verbal and physical abuse by the other children. Ms. Bell excelled in academics and tinkering (and hence, her nickname Tinker) but showed an early interest in the occult and believed that she had the ability to cast spells with a homemade substance she called “pixie dust.” Over the course of her childhood and early adolescence, she was evaluated by several psychiatrists who could never quite agree on a diagnosis but who

suspected an underlying psychotic process. She also experienced periods of depressed mood during which she ruminated about suicide and themes of death.

With intensive support that included psychiatric medication, individual psychotherapeutic support, and group support, she was able to progress through her school years. During her senior year of high school, Ms. Bell did a psychology internship at the Never Land Outreach Clinic and believed at that time that she had found her calling. It was at the clinic that Ms. Bell met Peter Pan, a spry and waif-like boy who, like her, was abandoned at birth. She became fascinated by Peter and his seeming ability to ignore the demands of both the real and adult world in favor of a rich fantasy life that included the delusion that he could fly and was being persecuted by a one-armed pirate named Hook. To the exclusion of her work and peer relations, Ms. Bell spent most of her time at the Outreach Center Library researching material that would help her better understand Mr. Pan. Being an accomplished tinkerer, Ms. Bell devised numerous exotic contraptions that she believed had the power to read minds and connect with other people's souls. She also claimed to have built a virtual sensory device that created the illusion of flight.

Around age 20, Ms. Bell experienced what was described as a "setback" that constituted a deterioration in her ability to manage her mood and everyday functioning. In her thinking and conversation, she seemed to easily become derailed. She held closely to her romantic delusion about winning Mr. Pan's love with a potion. Following what appeared to be a several-months-long gradual decline, she was no longer able to successfully complete her work due to intruding hallucinations and bizarre ideas. She was seen on intake by a community counselor and was then admitted to the psychiatric unit of the Never Land General Hospital, where she was treated with antipsychotic medication, electroconvulsive therapy to improve her mood, and psychological counseling. By the time of her discharge 2 months later, Ms. Bell was considered to be recovered with continued reliance on medication and outpatient supportive counseling for chronic mental illness. Eventually, she even was able to procure a license as a foster facility administrator. It was through her work with the state and her compassion for children that Ms. Bell was referred to the most difficult and challenging boys in Never Land. It was her hope that she could "help my lost boys find the home that everyone deserves." However, she

continued to occasionally experience passing thoughts of developing ways to attract her love interest, Peter; other strange ideas she could not eliminate; and sometimes, periods of depression.

Problem and Counseling History. When she was seen for the current intake session, Ms. Bell's small stature and odd pinkish skin did indeed give a pixelike impression to the evaluator. She was dwarfed in size by the chair in which she sat uncomfortably and from which she angrily darted at times when the conversation turned to her "delusion" about Mr. Pan. Ms. Bell raged when describing his interest in another woman by the name of Wendy Darling and vowed that she would "do whatever it takes to rid Never Land of that beast of a girl." When asked about her relationship history, Ms. Bell receded into the chair and cried for minutes at a time. The intensity of her labile affect and implausibility of her stories suggested that, as was noted by her coworker, Ms. Bell might indeed be a danger to both herself and to Mr. Pan. Ms. Bell was reluctant to talk about her 5-year experience at the residential facility and asserted that "no one has the right to know about my past except me." Evident on Ms. Bell's forearms was a series of parallel cuts that she acknowledged inflicting upon herself and that the evaluator later found out was a component of a self-mutilation ritual that she had been engaging in for the last 5 years. Given the severity of her presenting symptomology, Ms. Bell was detained and referred to the Crisis Treatment Center at Never Land Regional Psychiatric Hospital.

Goals for Counseling and Course of Therapy to Date. At the time of this report, Ms. Bell was not able to convince the evaluation team at Never Land Regional that she was capable of caring for herself as well as not be a danger to herself or others. She was being referred for a comprehensive neuropsychiatric assessment by the multidisciplinary team at Regional, which was charged with developing a comprehensive treatment plan that would assess her multitude of needs. Ms. Bell was noted to have said, "Just because I'm an orphaned pixie doesn't mean I can't help other people or myself."

Diagnostic Impressions

295.70 (F25.1) Schizoaffective Disorder, Depressive Type; Traits of Borderline

Personality Disorder; Pixiated Growth.

Other factors: V15.49 (Z91.49) Other Personal History of Psychological Trauma—Estrangement by parent, stresses of foster care.

Discussion of Diagnostic Impressions

Ms. Tinker Bell was referred to the Never Land Community Mental Health Center by peers who were concerned that she was behaving out of the ordinary. In the interview, Ms. Bell described bizarre ideas pertaining to her ability to prepare magic potions, love spells, and a concoction she called “pixie dust,” as well as a specific romantic delusion about winning love by using her magic abilities. She described a tactile hallucination of flying. In addition to these psychotic features, Ms. Bell also described depressed mood and cried notably during the interview. A review of records showed a history of both psychotic symptoms (flying hallucinations, romantic delusions, and bizarre ideas about magic and potions) and episodes of Major Depressive Disorder (low mood disrupting everyday functioning, diminished ability to think and concentrate, and feelings of worthlessness).

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 and catatonic behavior. Included in this section are schizophrenic disorders (Schizophrenia, Schizophreniform Disorder, and Schizoaffective Disorder), Delusional Disorder (Erotomantic, Jealous, Grandiose, Persecutory, Somatic, and Mixed), Schizotypal (Personality) Disorder, and several other catatonic and psychotic disorders (Brief Psychotic Disorder, psychotic disorders that are due to substance use or a medical problem).

Ms. Bell presented a complex combination of depressive mood symptoms, together with the predominant psychotic symptoms of Schizophrenia, suggesting a diagnosis of Schizoaffective Disorder. Because she presented a history of depressive episodes but no manic or mixed episodes, the subtype is Depressive Type. The criteria for Schizoaffective Disorder, Depressive Type, have several components. First, there must be an extended period during which the client experiences the symptoms of a major depressive

episode (depressed mood or loss of interest and pleasure, together with characteristic disruptions in weight or sleep or energy, plus feelings of worthlessness or thoughts of death) at the very same time as she is experiencing the predominant psychotic symptoms of Schizophrenia (delusions, hallucinations). Second, the client must experience delusions or hallucinations for at least 2 weeks in the absence of prominent Major Depressive symptoms; however, third, the person must experience prominent mood symptoms during most of the disorder's duration.

Correspondingly, Ms. Bell's presenting concerns, interview information, and history provided evidence of an uninterrupted period of dysfunction during which she experienced the mood symptoms of a major depressive episode at the same time as her flying hallucinations and delusions about magic—including time spans (we assume of at least 2 weeks according to her history) during which her mood symptoms were mostly absent but her hallucinations and delusions were still prominent, and with the additional note, that even during time spans when her hallucinations and delusions seemed less prominent, she did still have depressive symptoms.

Schizoaffective Disorder 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 a general medical condition (e.g., Psychotic Disorder Due to Another Medical Condition or Delirium Due to Another Medical Condition) or substance use (e.g., Substance-Induced Psychotic Disorder or Substance-Induced Delirium). There must be diagnosable mood symptoms concurrently with the active phase of the schizophrenic symptoms (otherwise the more appropriate diagnosis might be Schizophrenia). Conversely, the psychotic features must not be limited only to periods during depressive episodes (which would suggest Major Depressive Disorder, Severe, With Psychotic Features). One suggested resource for new clinicians is Noll's *Encyclopedia of Schizophrenia and Other Psychotic Disorders* (2007). Based on our clinical evidence, Ms. Bell's history best matched the complex criteria for Schizoaffective Disorder.

Additionally, problematic personality features and defenses can be listed even when they do not reflect a diagnosable Personality Disorder, if these personality characteristics are important to understanding the client's

functioning and are maladaptive for the person. We provided the notation Traits of Borderline Personality Disorder to describe Ms. Bell's pattern of frantic efforts to win love, relationship intensity, and self-cutting behavior—which suggested a maladaptive pattern of instability in interpersonal relationships and self-image and impulsivity. Although the primary diagnosis described accounted for much of her behavior, we took the step of noting personality features because they seemed clinically important and we recognized they could be easily overlooked in light of Ms. Bell's more florid schizophrenic symptoms.

To round out the diagnosis, Ms. Bell's pixiated growth (*sic*) is listed alongside her primary diagnosis, and her history of family and social stressors are emphasized in the "Other factors" section. This additional information is consistent with the primary mental health diagnoses describing Ms. Bell's patterns.

Case Conceptualization

Upon Ms. Bell's referral to the Never Land Community Mental Health Center, her intake counselor conducted a thorough, detailed evaluation interview. The intake evaluation comprised a thorough history, a client report, the reports of Ms. Bell's colleagues who had made the referral, counselor observations, and written psychological assessments. Based on the intake, Ms. Bell's psychotherapist developed diagnostic impressions, describing her presenting concerns as Schizoaffective Disorder, along with traits of Borderline Personality Disorder. A case conceptualization next was developed.

At the Never Land Community Mental Health Center, Solution-Focused Counseling is used. The center employs a solution-focused 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 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 Ms. Bell's Schizoaffective Disorder and personality features and the factors maintaining her 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 Ms. Bell return to an adequate 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).

Ms. Bell'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 pulling techniques and approaches at random (Lazarus, Beutler, & Norcross, 1992; Norcross & Beutler, 2008). Ms. Bell's counselor's solution-focused clinical thinking can be seen in the figure that follows.

Ms. Bell's Inverted Pyramid Case Conceptualization Summary: Solution-Focused Counseling Emphasizing Cognitive Interventions and Dialectical Behavioral Interventions

1. IDENTIFY AND LIST CLIENT CONCERNS

Bizarre ideation about magic
potions, love spells, pixie dust
Romantic delusion of winning
Peter Pan via magic
Tactile hallucination of flying
Delusion of mind-reading
Parental abandonment at birth
History of interest in the occult
History of psychiatric attention
History of hospitalization
History of psychiatric medication
Successful operation of home for
"lost boys"
Pixiated growth

Depressed mood
Crying
Diminished ability to think
Diminished ability to concentrate
Feelings of worthlessness
Unstable self-appraisal
Suicidal ideation
Self-cutting
Frantic efforts to win love
Intense intimacy behavior in love
relationships
Impulsiveness in pursuit of relationships

2. ORGANIZE CONCERNS INTO LOGICAL THEMATIC GROUPINGS

1. Historical and current negative thoughts and feelings associated with depression resulting in distress, dysfunction, and psychiatric treatment
2. Historical and current psychotic thoughts and perceptions associated with schizophrenic disorders resulting in distress, dysfunction, and psychiatric treatment
3. Historical and current impulsive, troublesome relationship and interpersonal behaviors associated with borderline personality resulting in distress and dysfunction

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

4. NARROWED INFERENCES: SUICIDALITY AND DEEPER DIFFICULTIES

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 Ms. Bell’s current as well as past symptoms of depression (low mood, crying, poor thinking and concentration, etc.), current as well as past psychotic symptoms (bizarre ideation, delusions, tactile flying hallucinations, etc.), information about her romantic relationship behaviors (frantic efforts to win love, self-cutting, etc.), details of her treatment history, as well as a medical note about her growth disorder and a listing of her strength running her boys’ home. The counselor attempted to go beyond just the presenting symptoms in order to be descriptive as she could.

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, Ms. Bell’s counselor selected the Clinical Targets Approach. This approach sorts together all of the Step 1 information “according to the basic division of behavior, thoughts, feelings, and physiology” (Neukrug & Schwitzer, 2006, p. 205).

The counselor grouped together: (a) all of Ms. Bell’s historical and current negative thoughts and feelings associated with depression resulting in distress, dysfunction, and psychiatric treatment; (b) all of Ms. Bell’s historical and current psychotic thoughts and perceptions associated with schizophrenia spectrum disorders resulting in distress, dysfunction, and psychiatric treatment; and (c) all of Ms. Bell’s historic and current impulsive, troublesome relationship and interpersonal behaviors associated with borderline personality

resulting in distress and dysfunction. The counselor selected the Clinical Targets Approach to organize Ms. Bell's concerns from a Solution-Focused Counseling perspective on the rational basis that she planned to emphasize cognitive and dialectical behavioral interventions that she believed would lead to good solutions with individuals such as Ms. Bell (Feigenbaum, 2007; McGurk, Twamley, Spitzer, McHugo, & Mueser, 2007; Pfammatter, Junghan, & Brenner, 2006).

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 Solution-Focused Counseling.

Treatment Planning

At this point, Ms. Bell's clinician at the Never Land Community Mental Health Center has collected all available information about the problems that have been of concern to her and the psychiatric team that performed her 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 Ms. Bell'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 Ms. Bell, but with all clients who present with disturbing and disruptive symptoms and/or personality 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 Anxiety 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 Ms. Bell, followed by her 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). The identified clinical themes reflect the core areas of concern and distress for the client. In the case of Ms. Bell, there are three primary areas of concern. The first, "historical and current negative thoughts and feelings associated with depression," refers to her depressed mood, crying, feelings of worthlessness, diminished ability to think and concentrate, unstable self-appraisal, and suicidal ideation. The second, "historical and current psychotic thoughts and perceptions associated with schizoaffective disorder," refers to her bizarre ideation about magic potions, romantic delusion of winning Peter Pan via magic, her tactile hallucination of flying, and her delusion of mind-reading. The third, "historical and current impulsive and troublesome relationship and interpersonal behaviors associated with borderline personality," refers to her frantic efforts to win his love, self-cutting, intense intimacy behavior in love relationships, and impulsiveness in pursuit of relationships and suicidal ideation. These symptoms and stresses are consistent with the diagnosis of Schizoaffective Disorder

and Traits of Borderline Personality Disorder (APA, 2013; Krabbendam & Aleman, 2003; Linehan, Heard & Armstrong, 1993; Livesley, 2007; Pfammatter et al., 2006).

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 Ms. Bell, the goals are divided into three prominent areas. The first, "historical and current negative thoughts and feelings associated with depression," requires that we assist Ms. Bell understand the basis for her depression; identify its cognitive, behavioral, emotional, and physiological triggers; recognize her strengths and problem-solving skills, implement problem-solving strategies to avoid depressive outcome, learn and implement relapse prevention strategies, and develop positive, life-affirming activities and a supportive social network. The second, "historical and current psychotic thoughts and perceptions associated with schizoaffective disorder," requires that we help Ms. Bell control (or eliminate) her active psychotic symptoms through medication compliance, distinguish between hallucinations/delusions and reality, improve her social skills and problem-solving, empower her to make positive and healthy changes in her life, and increase her goal-directed behaviors. The third, "historical and current impulsive, and troublesome relationship and interpersonal behaviors associated with borderline personality," requires that we assist her enhance her ability to accurately label and express feelings, understand and eliminate dangerous and impulsive behavior, reduce the frequency of her suicidal ideation and behavior by recognizing its relationship to depressive and angry states, and decrease dependence on others to meet her own needs while building confidence and assertiveness.

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 Ms. Bell, we have decided to primarily use Brief Solution-Focused Therapy (De Jong & Berg, 2002; de Shazer & Dolan, 2007; Gingerich & Eisengart, 2000; Gutterman, 2006). We will supplement it with elements of both Cognitive Therapy (Beck, 1997) and Dialectical Behavior Therapy (Binks et al., 2009; Feigenbaum, 2007; Linehan et al., 1993). Solution-focused counseling 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 client's problems and concerns. Forward-looking and quickly moving, Solution-Focused Therapy's basic assumptions are 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. Neukrug (2011) summarized these tenants using the following simple axioms often attributed to Solution-Focused Therapy: "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 Ms. Bell's case due to its positivistic emphasis on change, the future, and tapping into the client resources and skills. Rather than delve too deeply into her personality structure, it makes more clinical sense to strengthen her overall coping skills.

This approach, which, in addition, focuses on empowerment, hope, and the strengthening of support networks, has been found to be particularly useful in case management with clients coping with persistent mental health issues (Greene et al., 2006). Specific techniques for Ms. Bell include asking a series of “miracle questions” to assess goals for change and using preferred-goal, evaluative, coping, exception-seeking, and solution-focused questions; “scaling” her depressive feelings to provide context and perspective as well as a starting point for change; identifying and complimenting her use of skills; amplifying previously successful strategies for self-care; reframing her mood problems as the result of a chronic condition; identifying triggers for depressive thoughts; challenging and then reframing them; and finally, psychiatric referral.

Once Ms. Bell has been stabilized through the use of medication, we will also implement elements of both Cognitive Therapy and Dialectical Behavior Therapy (DBT). DBT relies on a combination of methods (cognitive behavior modification, mindfulness training, transference work, and dialectics), which target the “common factors” of personality disorder treatment (therapeutic structure, relationships) (Livesley, 2007) and the deficits that are specific to borderline conditions. Specific techniques for Ms. Bell will include identification of and desensitization (imaginal and in vivo) to cognitive triggers of behavioral, emotional, and physiological stress that precipitates psychotic thoughts, identification and refutation of irrational (and delusional) thoughts about the relationship with Peter Pan, cognitive restructuring and reframing of thoughts related to valuing and devaluing of self and others, and relaxation, including deep muscle work, breathing, and imagery.

In conjunction with DBT, we will use elements of Cognitive Therapy in order to restructure the way she thinks about herself and relationships. Specific techniques drawn from this approach will include identifying cognitive triggers for feelings of abandonment and their relationship to suicidal thoughts and feelings, and cognitive challenging and restructuring and reframing thoughts that give rise to distorted perceptions in relationships.

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 Ms. Bell's case, we have implemented a number of these, including pre-post measures on the Beck Depression Inventory-II, client self-reported elimination of obsessive preoccupation with Peter Pan, clinician-observed and client-reported improvement in mood, and physician-reported compliance with psychopharmacotherapy.

The completed treatment plan is now developed through which the counselor and Ms. Bell will begin their shared work of enhancing her overall coping and adaptive skills, including her physical and mental health. Ms. Bell's treatment plan is as follows and is summarized in the table that follows.

TREATMENT PLAN

Client: Ms. Tinker Bell

Service Provider: Never Land Community Mental Health Center

BEHAVIORAL DEFINITION OF PROBLEMS:

1. Historical and current negative thoughts and feelings associated with depression resulting in distress, dysfunction, and psychiatric treatment—Depressed mood, crying, feelings of worthlessness, diminished ability to think and concentrate, unstable self-appraisal, and suicidal ideation
 2. Historical and current psychotic thoughts and perceptions associated with Schizoaffective Disorder—Bizarre ideation about magic potions, romantic delusion of winning Peter Pan via magic, tactile hallucination of flying, and delusion of mind-reading
 3. Historical and current impulsive and troublesome relationship and interpersonal behaviors associated with borderline personality—Frantic efforts to win love, self-cutting, intense intimacy behavior in love relationships, impulsiveness in pursuit of relationships, and suicidal ideation
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GOALS FOR CHANGE:

1. Historical and current negative thoughts and feelings associated with depression

- Understand the basis for her depression
- Identify its cognitive, behavioral, emotional, and physiological triggers
- Recognize her strengths and problem-solving skills
- Implement problem-solving strategies to avoid depressive outcome
- Learn and implement relapse-prevention strategies
- Develop positive, life-affirming interests, activities, and a supportive social network

2. Historical and current psychotic thoughts and perceptions associated with Schizoaffective Disorder

- Control (or eliminate) active psychotic symptoms through medication compliance
- Distinguish between hallucinations/delusions and reality
- Improve social skills and problem-solving
- Empowerment to make positive and healthy life changes in her life
- Increase goal-directed behaviors

3. Historical and current impulsive and troublesome relationship and interpersonal behaviors associated with borderline personality

- Enhance ability to accurately label and express feelings
- Understand and eliminate dangerous and impulsive behavior
- Reduce the frequency of suicidal ideation and behavior by recognizing its relationship to depressive and angry states
- Decrease dependence on others to meet own needs while building confidence and assertiveness

THERAPEUTIC INTERVENTIONS:

A moderate- to long-term course (6–9 months) of Solution-Focused Therapy supplemented with Cognitive and Dialectical Behavior Interventions; and both inpatient hospitalization and psychopharmacotherapy

1. Historical and current negative thoughts and feelings associated with depression resulting in distress, dysfunction, and psychiatric treatment

- Asking a series of “miracle questions” to assess goals for change
- Using preferred-goal, evaluative, coping, exception-seeking, and solution-focused questions centered on depression and effective coping with it
- “Scaling” depressive feelings to provide context and perspective as well as a starting point for change
- Identifying and complimenting use of self-affirming and positive problem-identification and problem-solving skills
- Amplification of previously successful strategies for mood improvement
- Reframing mood problems as the result of a chronic condition
- Identifying triggers for depressive thoughts, and challenging and then reframing them
- Referral for psychopharmacological intervention for depression

2. Historical and current psychotic thoughts and perceptions associated with Schizoaffective Disorder

- Identification of and cognitive desensitization (imaginal and in vivo) to triggers of behavioral, emotional, and physiological stress that precipitate psychotic thoughts and behaviors
- Identification and refutation of irrational (and delusional) thoughts about the relationship with Peter
- Referral for psychopharmacological intervention for psychotherapy

3. Historical and current impulsive and troublesome relationship and interpersonal behaviors associated with borderline personality

- Identifying cognitive triggers for feelings of abandonment and their relationship to suicidal thoughts and feelings
- Identify and then challenge, restructure, and reframe thoughts that give rise to distorted perceptions in relationships
- Cognitive restructuring and reframing of thoughts related to

valuing and devaluing of self and others

OUTCOME MEASURES OF CHANGE:

The reinforcement and strengthening of already-present coping skills and alleviation of depression through appropriate medical care as measured by:

- Pre-post measures on the Beck Depression Inventory-II
- Clinician-observed and client-reported improvement in mood
- Client-reported and clinician-observed elimination of psychotic thoughts
- Physician-reported compliance with psychopharmacotherapy

Ms. Bell’s Treatment Plan Summary: Solution-Focused Counseling Emphasizing Cognitive Interventions and Dialectical Behavioral Interventions

<i>Goals for Change</i>	<i>Therapeutic Interventions</i>	<i>Outcome Measures of Change</i>
<p><u>Historical and current negative thoughts and feelings associated with depression</u></p> <p>Understand the basis for her depression</p> <p>Identify its cognitive, behavioral, emotional, and physiological triggers</p> <p>Recognize her strengths and problem-solving skills</p> <p>Implement problem-solving strategies to avoid depressive outcome</p> <p>Learn and implement relapse-prevention strategies</p> <p>Develop positive, life-affirming interests, activities, and a supportive social network</p> <p><u>Historical and current psychotic thoughts and perceptions associated with</u></p>	<p><u>Historical and current negative thoughts and feelings associated with depression resulting in distress, dysfunction, and psychiatric treatment</u></p> <p>Asking a series of “miracle questions” to assess goals for change</p> <p>Using preferred-goal, evaluative, coping, exception-seeking, and solution-focused questions centered on depression and effective coping with it</p> <p>“Scaling” depressive feelings to provide context and perspective as well as a starting point for change</p> <p>Identifying and complimenting use of self-affirming and positive problem-identification and problem-solving skills</p> <p>Amplification of previously successful strategies for mood improvement</p> <p>Reframing mood problems as the result of a chronic condition</p> <p>Identifying triggers for depressive thoughts, challenging, and then reframing them</p>	<p><u>The reinforcement and strengthening of already-present coping skills and alleviation of depression through appropriate medical care as measured by:</u></p> <p>Pre-post measures on the Beck Depression Inventory-II</p> <p>Clinician-observed and client-reported improvement in mood</p> <p>Client-reported and clinician-observed elimination of psychotic thoughts</p> <p>Physician-reported compliance with psychopharmacotherapy</p>

<p><u>Schizoaffective Disorder</u></p> <p>Control (or eliminate) active psychotic symptoms through medication compliance</p> <p>Distinguish between hallucinations/delusions and reality</p> <p>Improve social skills and problem-solving</p> <p>Empowerment to make positive and healthy life changes in her life</p> <p>Increase goal-directed behaviors</p> <p><u>Historical and current impulsive and troublesome relationship and interpersonal behaviors associated with borderline personality</u></p> <p>Enhance ability to accurately label and express feelings</p> <p>Identify the triggers that lead to vacillation between idealizing and devaluing self and others</p> <p>Understand and eliminate dangerous and impulsive behavior</p> <p>Recognize and control use of sex to manipulate others</p> <p>Become comfortable with own sexuality</p> <p>Reduce the frequency of suicidal ideation and behavior by recognizing its relationship to depressive and angry states</p> <p>Decrease dependence on others to meet own needs while building confidence and assertiveness</p>	<p>Referral for psychopharmacological intervention for depression</p> <p><u>Historical and current psychotic thoughts and perceptions associated with Schizoaffective Disorder</u></p> <p>Identification of and cognitive desensitization (imaginal and in vivo) to triggers of behavioral, emotional, and physiological stress that precipitate psychotic thoughts and behaviors</p> <p>Identification and refutation of irrational (and delusional) thoughts about the relationship with Peter</p> <p>Referral for psychopharmacological intervention for psychotherapy</p> <p><u>Historical and current impulsive and troublesome relationship and interpersonal behaviors associated with borderline personality</u></p> <p>Identifying cognitive triggers for feelings of abandonment and their relationship to suicidal thoughts and feelings</p> <p>Identify and then challenge, restructure, and reframe thoughts that give rise to distorted perceptions in relationships</p> <p>Cognitive restructuring and reframing of thoughts related to valuing and devaluing of self and others</p>	
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