CHAPTER 1

Benefits of Case Formulation and a Conceptual Framework

THE CASE OF MALCOLM

Malcolm's third-grade teacher noticed that he seemed unfocused. He was frequently caught off guard when asked a question, and he rarely finished assigned tasks. The teacher suggested to Malcolm's parents that they investigate the possibility that Malcolm had attention-deficit/hyperactivity disorder (ADHD). Malcolm's mother indicated that she had not found Malcolm to be inattentive at home, and added immediately, "And I will not have my child drugged because you don't know how to teach him." She acknowledged, however, that her son sometimes had stomachaches before school and thought that his family doctor should refer Malcolm for a mental health assessment to determine if he had an anxiety disorder. Malcolm's father, on the other hand, stated, "The boy is fine. He's a little lazy sometimes, but that's because his mother is too soft with him." Nobody asked Malcolm about his difficulties.

After his mother spoke to the family doctor, Malcolm was referred to a child mental health clinic for an anxiety-focused assessment. The psychiatry resident in the clinic did a thorough diagnostic interview with Malcolm's mother, briefly evaluated Malcolm's mental status, and concluded that Malcolm met criteria for ADHD, inattentive type, and generalized anxiety disorder. Given his mother's aversion to using stimulant medication (the evidence-based treatment of choice

for ADHD), the resident referred Malcolm for anxiety-focused, group-based cognitive-behavioral therapy (CBT), a therapy focused on changing anxious thoughts and behaviors).

The group therapist noticed that Malcolm seemed unfocused, was often caught off guard when asked a question, and rarely finished assigned tasks. She asked for a meeting with Malcolm's parents in order to explain to them that he was deriving little benefit from the group, and they should consider having him treated for his primary diagnosis (ADHD). Malcolm's mother responded with a voice mail message indicating that she and her husband had recently separated, so he would not be attending the meeting. At the meeting, she reiterated her opposition to medication and declined further mental health treatment for Malcolm. She told the therapist that she was planning to enroll Malcolm in a private school "once his father starts paying child support."

Malcolm's parents became embroiled in a bitter custody battle that lasted 3 years. During this time, Malcolm's school performance continued to deteriorate.

WHAT WENT WRONG IN THIS CASE?

At first glance, it seems that Malcolm is merely the victim of unfortunate circumstances. His teacher correctly identified his difficulty focusing, resulting in an eventual diagnosis of ADHD. His family doctor referred him to a mental health clinic that was able to provide a thorough diagnostic assessment. The assessment confirmed that the observations of Malcolm's teacher and his mother were correct, and he indeed had two diagnoses: ADHD and generalized anxiety disorder. The treatments recommended (stimulant medication for ADHD and CBT for the anxiety disorder) were both evidence based and appropriate. One could perhaps argue that Malcolm would have derived more benefit from individual rather than group-based psychotherapy, but given the large number of children who need mental health services, individual therapy is not always readily available.

Malcolm's poor outcome, however, begs the question "What else could the mental health professionals involved have done in this case?" Should they have obtained more details about the relationships within Malcolm's family, rather than focusing exclusively on diagnostic criteria during the assessment? Should they have explored the possibility that Malcolm might have a learning disability, seizure disorder, or

other neurological reason for his inattention? Would they have learned more if they spent more time interviewing Malcolm? Would it have been worthwhile to explore the reasons why Malcolm's mother was so opposed to medication?

A cynic might reply, "Hindsight is 20/20. They did the best they could, given what they knew at the time." While there is some truth to this statement, it is also rather discouraging. In my practice as a child psychiatrist and child psychiatric consultant, I have run across far too many children with histories that are similar to Malcolm's story. Professionals involved in these cases are often knowledgeable and well intentioned and meet the minimum standard of practice. Regrettably, they miss key pieces of relevant information when assessing these children, often with disastrous results.

THE GOAL OF THIS BOOK

The main goal of this book is to reduce the number of "Malcolm stories" in the field of children's mental health. To achieve this goal, a case formulation approach is presented that illustrates how to systematically collect and synthesize information that is relevant to understanding presenting problems in child mental health. The case formulation approach is not specific to any one discipline but can inform the practice of all professionals who evaluate and treat children with mental health difficulties.

Information used in case formulation includes symptoms relevant to diagnosis as well as historical and contextual information that provides a more complete understanding of the child's life and his or her emotional and behavioral problems. The latter information not only provides an enhanced understanding of the child but is also very useful clinically. Synthesized effectively, such information allows clinicians to generate linked hypotheses about why a particular child presents with particular difficulties. This set of linked hypotheses constitutes the case formulation. When defining case formulation, experts in the field have emphasized three important elements: 1) the case formulation as hypotheses about factors contributing to a person's emotional and behavioral problems; 2) the case formulation as a means of organizing complex and sometimes contradictory information about a person's difficulties; 3) the case formulation as a blueprint for guiding treatment (Eells, 2006, p. 4). Case formulation hypotheses can be tested and (if needed) revised as the child develops and responds or fails to

respond to treatment. Thus, the child's response provides evidence that either supports or fails to support certain hypotheses, allowing a more and more accurate case formulation to emerge over time.

Before describing case formulation in more detail, however, it is important to dispel two common misconceptions and to provide a conceptual framework that will be used in this book. The two misconceptions are (1) that people who practice case formulation do not value mental health diagnoses, and (2) that the process of case formulation is unscientific or not evidence based. Each of these misconceptions is now discussed, followed by a description of key concepts used throughout this book.

DIAGNOSIS AND CASE FORMULATION

The title of this section, "diagnosis *and* case formulation," reflects the idea that these two approaches do not compete with but rather complement each other. Each has something different to offer, as shown in Table 1.1. Diagnosis in children's mental health, whether described in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) or the *International Classification of Diseases* (ICD-10; World Health Organization, 1994), is based on phenomenology. That is, it is based on the presence or absence of certain symptoms or behaviors in the child. For many diagnoses, the symptoms must be present for a certain length of time and/or interfere with the child's day-to-day functioning. In many jurisdictions, the privilege of assigning a diagnosis is restricted to certain child mental health professionals, typically psychiatrists and psychologists.

The child mental health diagnosis does not, however, imply any particular cause for the child's symptoms. In theory, this ensures that the diagnosis is based on objective facts, rather than being subject to the clinician's (often subjective) speculations about causality. In practice, diagnostic information about young children is often obtained from adults around the child, and is thus influenced by the objectivity (or lack thereof) of the observer. Nevertheless, diagnostic information is considered relatively objective and provides a helpful shorthand for professional communication. Saying, "This adolescent suffers from bipolar affective disorder," for example, is clearer and faster than listing all of the adolescent's symptoms that may relate to this diagnosis. Assigning a diagnosis can also be helpful when seeking access to resources for a particular child. For example, in the school system,

TABLE 1.1. Comparing Diagnostic and Case Formulation Approaches

Diagnostic approach	Case formulation approach
Based on phenomenology (symptoms)	Includes ideas about etiology as well as phenomenology
Restricted to psychiatrists and psychologists	Not restricted by discipline
Less speculative	More speculative
Easy to communicate	More difficult to communicate
Can be used to access resources	Not helpful in accessing resources
More stigmatizing	Less stigmatizing
Sometimes results in "lumping" dissimilar children	Treats each child and his or her difficulties as unique
More likely to result in missing relevant contextual or historical information	Less likely to result in missing relevant contextual or historical information
Sometimes results in erroneous assumptions about etiology	Results in testable hypotheses about etiology

children who are diagnosed as being on the autism spectrum and suffer from learning disabilities often have access to more educational supports than children with learning disabilities who do not have this diagnosis.

Disadvantages of diagnosis include stigmatization, an overly narrow understanding of the child's difficulties, and the potential for erroneous assumptions about causality and about different children who meet criteria for the same diagnosis. Stigmatization occurs when the diagnostic label is considered shameful by the child, family, or others. In some cultures, any mental health diagnosis is considered stigmatizing. In other cultures, only some mental health conditions (e.g., addictions or schizophrenia) are considered stigmatizing. Public education efforts in recent years have tried to ameliorate mental health stigma in North America, but some prejudice toward people with certain mental health problems remains. On the other hand, when children are already stigmatized by certain behaviors (e.g., a child with unusual rituals or tics who stands out in class), providing a diagnostic label (such as obsessive–compulsive disorder or Tourette syndrome) may help explain the behaviors to others and thus serve to reduce stigma.

Malcolm's story, just described, illustrates the pitfalls of an overly narrow understanding of the child's difficulties, in particular an understanding based almost exclusively on diagnostic information. Some

clinicians make treatment decisions based on the assumption that a particular diagnosis implies a particular etiology. In Malcolm's case, the psychiatry resident assumed that his diagnosis of ADHD, inattentive type, implied a need for stimulant medication without considering the possibility of an underlying learning disability, distraction related to emotional distress (given the high-conflict home environment), or other reason for his inattention. The decision to refer Malcolm to the anxiety-focused cognitive-behavioral group was based on the diagnosis of generalized anxiety disorder, and the assumption that children with this diagnosis are all similar enough to benefit from the same treatment. In Malcolm's case, this assumption was false.

Case formulation, by contrast, includes a wider range of information than diagnosis does and thus has the potential to lead to a broader, more complete understanding of the child's difficulties. Case formulation assumes that each child has unique reasons for presenting with his or her difficulties, reducing the potential for erroneously "lumping" dissimilar children into the same category. In Malcolm's case, a clinician using a case formulation approach would have gathered additional information about his home environment, his early development (both medical and psychological aspects), and his previous learning history. His relationships with each of his parents, with his teacher, and with his peer group would also have been explored from multiple points of view (Malcolm and his parents at a minimum; ideally his teacher as well). Gathering such information is described in more detail in the next chapter.

Synthesizing this information to create a case formulation is, of necessity, more speculative than assigning a diagnosis. Case formulation includes examining various contributing factors and possible causes for the child's difficulties, as well as a detailed description of symptoms. Most practitioners, however, are careful to phrase their ideas as *possibilities*, rather than certainties. In addition, because the case formulation contains testable hypotheses, it lends itself to objective evaluation over time. Essentially, the various interventions and the child's response or lack of response to them become an experiment that allows the clinician to identify the most valid aspects of the formulation and the aspects requiring refinement. Thus, case formulation has the potential to complement diagnosis in order to determine the most effective intervention(s) for a given child.

Case formulation is sometimes less stigmatizing than diagnosis, but not always. Some parents, for example, feel stigmatized when clinicians explore family interactions or past childrearing practices in

relation to the child's symptoms. Also, case formulation cannot generally be used to advocate for additional resources for children, and communicating a case formulation to another professional is usually more time-consuming than communicating a diagnosis.

In summary, diagnosis and case formulation both make unique contributions to the evaluation of mental health problems in children. Therefore, they should not be seen as competing approaches. Most children benefit from mental health assessments that include both.

EVIDENCE-BASED PRACTICE AND CASE FORMULATION

The idea that case formulation is incompatible with evidence-based practice is a myth. Usually, this myth is based on a false understanding of what constitutes evidence-based practice, a false understanding of how to use case formulation, or both.

When describing evidence-based practice, experts usually emphasize that it includes but is not limited to research findings. For example, in a well-known evidence-based practice model, Parry, Roth, and Fonagy (2005) suggest that evidence-based practice adhere to clinical practice guidelines that are based on both research findings and expert consensus. These guidelines should be applied using clinical judgment that is based on a clear formulation of the patient's difficulties (Parry et al., 2005). Thus, these authors see case formulation as an important component of evidence-based practice.

Moreover, basing one's practice exclusively on research findings could be problematic, due to the many limitations of existing research in child mental health and the unique nature of each child. Some important research limitations to bear in mind include the tendency for researchers to focus on interventions that are easy to study (Roth & Fonagy, 2005); the differences between success in academic practice (called "efficacy") and success in community practice (called "effectiveness") (Manassis, 2009a); differences in outcomes depending on who is reporting outcome (Kazdin, 1994); frequent lack of attention to child functioning and to long-term follow-up (Adler-Nevo & Manassis, 2009); and the absence of high-quality studies for some conditions (e.g., see Manassis, 2009b, regarding selective mutism). For example, CBT is easier to study than many other psychotherapies because it is time limited (allowing the researcher to finish his or her study in a short, defined granting period) and well described in specific manuals (making it relatively easy to measure therapist adherence and to

replicate studies in different sites). These research advantages may amplify the number of positive studies for CBT relative to other therapies. Differences between the concepts of efficacy and effectiveness may result in disappointment in clinical practice, as interventions that work in research settings are often not nearly as helpful in community practice. Reasons for this phenomenon include more disadvantaged populations and more complex presentations in community settings, frequent lack of training or lack of supervision of community practitioners, and practice parameters that differ from those of academic centers (e.g., lack of diagnostic interviews prior to treatment, limited number of treatment sessions permitted). Research findings also need to be interpreted carefully with respect to informant, as children and parents often provide different reports of outcome (Barbosa, Manassis, & Tannock, 2002). One must also question the clinical meaning of studies that report improvement in symptoms but do not comment on the child's overall functioning or report improvement immediately posttreatment but do not provide follow-up data. Finally, it can be difficult to find reliable data on some child mental health conditions. For example, there are very few randomized controlled trials regarding the treatment of selective mutism (a condition where children do not speak in certain social environments), and most of the literature consists of case reports (Manassis, 2009b).

A further problem with relying exclusively on research findings when planning treatment occurs when clinicians try to fit children into particular diagnostic categories that have been studied. As we discussed, diagnosis is not a problem per se, but few children in community practice fit neatly into a single diagnostic category. Comorbidity (the occurrence of more than one psychiatric condition) is very high in child mental health, and the presence of one disorder may affect the treatment of another. For example, in the case described earlier, Malcolm's ADHD affected his ability to learn anxiety management skills in CBT. Even in the absence of comorbidity, children with the same diagnosis do not all respond to a given treatment in the same way. Research studies usually describe *average* degrees of change in response to treatment for dozens, sometimes hundreds of children. Therefore, if two children have the same diagnosis and receive the same treatment, they will not necessarily show equal benefit. Some studies describe moderators of outcome (factors associated with better or worse outcomes), but it is still not possible to precisely predict treatment response for an individual child.

Therefore, to best serve individual children, astute clinicians

think about how the children they treat resemble or differ from those studied in relevant research, consult clinical practice guidelines, and apply their knowledge in the context of a clear, thoughtful case formulation (see Figure 1.1). In devising the formulation, clinicians synthesize information about biological, psychological, social, and spiritual influences on the child and their interactions. The formulation is not, however, a static, rigid set of beliefs or causal attributions. Rather, it is a dynamic set of hypotheses that provide one possible explanation for the child's difficulties (the "explanatory model"), which can be tested and revised. Treatment response or lack of response tests the hypotheses, supporting or disconfirming them. Hypotheses are then updated to create a revised formulation that is consistent with this new information. Additional information, life events or other changes in the child's environment, and developmental changes (including those resulting from the child's response to treatment) can also result in the need for an updated, revised formulation. Ongoing revision of the formulation allows for a better understanding of the child over time and improves the chances of providing ever more effective care. When an accurate

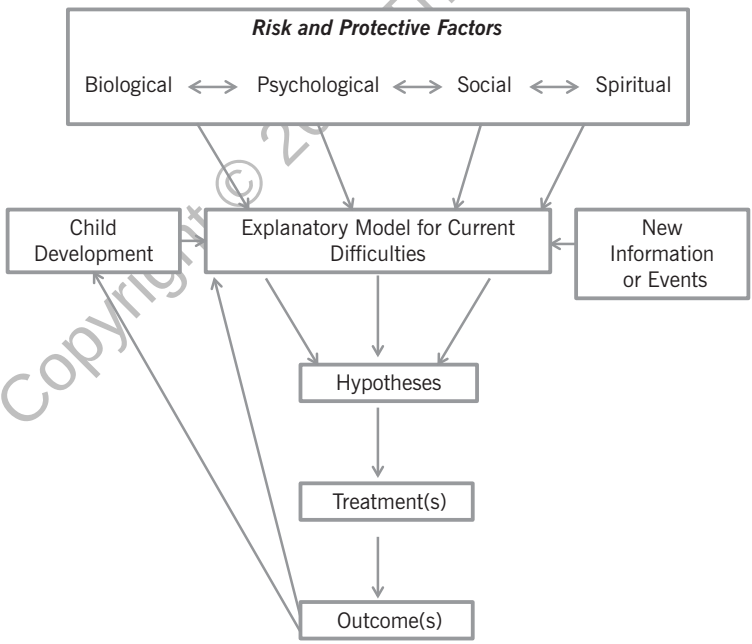

FIGURE 1.1. The dynamic case formulation.

formulation is shared with the child and family, feeling understood in turn can improve their motivation to work with the practitioner, contributing to further progress.

In summary, when used appropriately, case formulation supports and often enhances evidence-based practice by allowing clinicians to apply both research evidence and case-specific information to develop an effective plan of care for each individual child.

A CONCEPTUAL FRAMEWORK FOR CASE FORMULATION IN CHILD MENTAL HEALTH

Since first described by George Engel (1977), the biopsychosocial approach to case formulation has been widely used in medicine and mental health care. Rather than merely focusing on a particular disease process, this model advocates examining a variety of biological, psychological, and social factors that might be contributing to the patient's presentation. Interactions among these factors are also considered. Thus, the model takes a more holistic and humanistic approach to care than the disease-focused approach. In the last decade or so, many authors have advocated expanding this model to one that is biopsychosocial–spiritual (Skinner, 2009). Originally, the addition of spiritual considerations was advocated when treating addictions (in 12-step programs) or when treating the grieving or dying patient, but recently it has become a part of many general medical and mental health curricula as well. When clinicians work with people from cultural backgrounds that differ from their own, sensitivity to diverse beliefs, values, and spiritual practices is particularly relevant, so the final dimension of the model is sometimes defined broadly as "spiritual/cultural considerations."

In child mental health, the biopsychosocial–spiritual model needs to be understood in the context of children's ongoing development. The same problem may have a completely different meaning in an older child than in a younger child, and be due to different biological, psychological, social, and spiritual factors. A 4-year-old who has not previously attended day care and is anxious about leaving the house to start kindergarten, for example, may not be considered abnormal. His difficulty is probably due to a somewhat inhibited temperament (biological factor), a family environment that limited opportunities to spend time away from home (social factor), and parental values or beliefs (spiritual/cultural factor), with the result being a lack of confidence about

his own ability to cope with unfamiliar environments (psychological factor). By contrast, a 14-year-old who suddenly develops a fear of leaving the house to go to school requires a thorough mental health assessment. There could be numerous factors contributing to this presentation, and the sudden onset of symptoms suggests that a significant stress or trauma has recently occurred.

To better understand how various biological, psychological, social, and spiritual factors interact throughout development, the field of developmental psychopathology has grown increasingly salient. This field has been defined as "an integrative discipline that seeks to unify, within a developmental, lifespan framework, contributions from multiple fields of inquiry with the goal of understanding psychopathology and its relation to normative adaptation" (Cicchetti, 1990, p. 3). Because it is defined as an "integrative discipline," developmental psychopathology can include various theories and ideas, and thus serve as a framework for discussions of children's cognitive, emotional, and behavioral development. This framework is used throughout the book as various aspects of case formulation are examined.

Developmental psychopathologists have enriched our understanding of children's risk factors as well as sources of resilience for various disorders. They are interested in developmental pathways as well as outcomes. The pathway that an individual follows for a given characteristic is termed a developmental trajectory, and it is governed by the interactions among risk and protective factors. This ongoing interaction means that children who start with similar characteristics may develop diverse outcomes over time (termed "multifinality"). For example, children who suffer physical abuse can have a variety of mental health outcomes as adults, and some will abuse their own children while others will not. Conversely, sometimes children start with very different characteristics but have a common outcome (termed "equifinality"). For example, depressed adolescents may have no previous psychiatric history or family history of depression, a family history of depression only, a previous psychiatric history only (e.g., an anxiety disorder or ADHD), or a psychiatric history as well as a family history of depression. Depression in a previously high-functioning teen may have a very different course and prognosis than depression that occurs in a teen who has been suffering for years with other mental health issues. The latter may require more intensive treatment to address the teen's multiple mental health issues and their adverse effects on his or her development. Finally, the same disorder may manifest differently over time (termed "heterotypic continuity"). Thus, a child with ADHD

may appear very distractible in school, while an adult who has a profession that does not require much sustained attention (e.g., a salesperson) may not seem any different from her peers. Yet, other situations affected by inattention may result in functional problems in other areas, such as having a poor driving record or unpaid bills that hurt her credit rating. It is also important to note that children's development does not necessarily proceed at the same rate for different aspects of their growth. For example, if there are two children of similar age, one may be advanced academically but socially immature, while the other may struggle with academics but behave more maturely with peers.

Understanding these variations in development is critical when working with children and providing guidance to their parents. For example, in treating the two children previously mentioned for anxiety, the therapist might want to role-play social situations with the child who is socially immature and spend more time assisting with the cognitive aspects of treatment in the child with academic difficulty. Parents would need to be cautioned differently about the limitations of treatment in each case and given different advice on how to support the child's progress. Interestingly, academic and social difficulty could each adversely affect self-esteem in these children (an example of equifinality).

BASIC DEVELOPMENTAL CONCEPTS RELATING TO CASE FORMULATION

For some readers, the ideas described above may raise the question "Does one have to be an expert in all aspects of normal and abnormal child development in order to do a good case formulation?" Fortunately, the answer is no. Although trying to learn more about child development is a laudable goal, knowledge in the field is expanding so rapidly that even so-called experts may not be aware of some recent findings. On the other hand, a basic understanding of how children think and what they need emotionally at various developmental stages can be very helpful in case formulation. Some of these ideas relate to theories of psychological development, which are described in detail in Chapter 4.

A few relevant developmental ideas, however, are not linked to specific theories but are instead subscribed to by most authors in the field of children's mental health (Cicchetti, 1990; Weisz & Kazdin, 2010). These include the following:

- Children are highly dependent on their environment, especially when very young.
- Families constitute children's main social influence, especially when very young.
- Aspects of children's environments outside the family (e.g., school, peer group) become increasingly important to them as they mature.
- In preadolescents, parents often define the problem that is presented to the clinician, and parents need to "buy into" (i.e., agree with and accept) the formulation and treatment recommendations if these are to be followed.
- The ability of youth to define their own problems and the need for youth to "buy into" the formulation and treatment recommendations increase as they become adolescents.
- Parents often benefit from information about what is developmentally normative for their child, and children benefit from this information as soon as they are old enough to understand it.
- Developmental norms for behavior often differ by culture and should be explored to ensure an accurate formulation and improve family engagement in treatment.
- Anticipating children's future developmental challenges can be a valuable addition to the case formulation.

Each of these ideas will now be illustrated in more detail.

Young Children and Their Environment

To understand young children's dependence upon their environment, imagine yourself as an infant. You cannot walk, crawl, or even roll over yet, so you are entirely dependent on others to provide you with food, ensure you are comfortable, and keep you safe. You can't seek out your favorite activities or experiences. Instead, experiences are brought to you. Faces lean over you, enormous hands encircle your body to lift you, clothes are pulled on and off your body, and mobiles or other moving or noise-making objects may be put in front of you to stimulate your brain (or at least that's what the adults think). Your senses may be overwhelmed by everything that is presented to you, dulled by neglect, or kept alert and calm when the level of stimulation is just right. It will probably take a while for the adults to figure out that "just right" level, so life is not always pleasant. Hopefully, though, they will keep trying to find out what you need. As they become more predictably helpful,

you are calmed, and your ability to calm yourself improves too. You get better and better at regulating your internal states, and you have energy left over to observe and explore the world around you.

This idealized description begs the question "What could go wrong with this picture?" One obvious problem might be that adults fail to attend to the infant's basic needs for food, comfort, and safety. For example, a parent who is focused on his or her own psychological challenges could be unavailable to meet these basic needs for periods of time, which may result in discomfort or sometimes even life-threatening peril for the infant. In response, the infant would focus his energies on these unmet basic needs and have little left over for observing or exploring the environment. A second problem might be a parent who provides the basic necessities but misreads the infant's cues, resulting in too much or too little environmental stimulation. In this case, the infant would not be able to trust the parent to be predictably helpful and calming, and so would have difficulty learning to soothe herself. It is also possible that the infant has an unusually high or unusually low need for stimulation, or a strong preference for certain types of stimulation (e.g., light touch vs. strong touch; aversion to certain noises; preference for certain textures), making it difficult for the parent to provide what is optimal for him. A demanding sibling or other parental responsibilities can also limit the parent's ability to tailor the infant's sensory diet until it is optimal. In this case, difficulties with self-regulation could develop in the infant, which would also limit her ability to observe or explore her environment.

Family Influences in Young Children

So far, we have talked about the basic needs of infants and the sensory input provided to them. To understand the socializing influence of families, however, we must imagine how these events influence young children's thoughts about the world and themselves. Different theorists have described such thoughts as "schemas" or "internal working models" (Bretherton & Mulholland, 1999). These terms relate to the same concept: young children's experiences with their families create templates for their thoughts about all relationships, and about the world. In other words, when children are young, their family's world is the only world they know, so they assume that it reflects reality outside as well as inside the family. For example, if (as an infant or toddler) my parents ignore me whenever I cry or seek their attention, then I approach relationships with the assumption that others are not interested in helping

me and I must fend for myself. Consequently, I may not value close relationships very much and not be very interested in others' feelings. This attitude, in turn, may cause others to avoid getting close to me, confirming my assumption that others are not interested in helping me, and reinforcing my emotionally distant, self-reliant attitude in a self-perpetuating pattern. These ideas are elaborated in the section on attachment theory in Chapter 4.

Even in the presence of secure parent–child relationships, children can struggle with distorted views of themselves and others. For example, the child who is temperamentally very different from his siblings or parents may feel like he doesn't belong in the family and therefore question his place in the world. Thus, a musical prodigy may feel out of place in a very athletic family, and an exceptional athlete may feel uncomfortable in a family of musicians. Children who have been adopted or separated from their families for long periods of time sometimes share these feelings of being an outsider.

On the positive side, families can help young children modify temperamental tendencies to allow for better social adaptation. For example, children who have an inhibited temperament (aversion to new people and new situations) are predisposed to anxiety disorders, but most do not develop them. It is thought that in most cases parents patiently encourage and support their inhibited child in facing new situations, allowing the child to gradually develop the ability to deal with such situations independently. Similarly, parents who deal with tantrums or other misbehavior by calmly setting limits (e.g., using a short time out) often help the child gradually control that behavior.

Influences Outside the Family

Once children begin to attend day care or kindergarten, they are obviously exposed to social influences outside the family. As they mature, these influences grow increasingly important to children, but the confidence to deal with them successfully usually requires family encouragement and support. New environments can be a source of stress (e.g., conflict with teachers or peers, learning difficulties) or present new opportunities. For example, academic or athletic success can be a source of self-esteem for some children; exposure to a caring, encouraging teacher can help heal some of the emotional wounds left by negative family experiences.

When there is a discrepancy between family expectations and the expectations of school personnel or friends, for example, children may

feel plunged into feelings of uncertainty, confusion, or distress. Many children experience such discrepancies at adolescence as they begin to experiment with behaviors that may conflict with parental norms. Most parents of teenagers have found themselves saying at least once, "If all your friends were jumping off a cliff, would you?" or making some similar frustrated comment. Adolescents often oscillate between identifying with their peer group's expectations and the expectations of their parents, and most eventually come to a resolution that they are comfortable with.

Young children, on the other hand, are typically much more distressed by discrepant expectations. This can be particularly poignant in children of parents who have recently immigrated to North America. The child may want to fit in at school and with peers and feel embarrassed by parental customs or culturally based attitudes. The parents, on the other hand, may fear losing their cultural identity in the North American "melting pot," resulting in fervent adherence to their cultural practices. Some schools do celebrate cultural diversity by, for example, having an international food day or noting religious holidays from multiple faiths on the calendar. Too often, though, children who stand out because of their religious or cultural background are still made to feel awkward and torn between their families and the "new world."

Preadolescents and Mental Health Care

When preadolescent children are brought to a mental health practitioner, they face yet another new environment, and, understandably, they are usually wary of this environment. Therefore, it is not uncommon for parents to do most of the talking during a mental health assessment of a preadolescent child. Moreover, the parent often brings the child to the practitioner with certain unspoken expectations. These expectations may or may not coincide with the practitioner's formulation and treatment expectations.

One common expectation is that, similar to a family doctor, the mental health practitioner will diagnose a problem within the child, and the solution to the problem will be something that the mental health practitioner does to or with the child. Even though they rarely say so, these parents are thinking, "Here's my child, Doc. Go ahead and fix her." Meanwhile, the mental health practitioner is thinking, "The factors contributing to this problem relate to the child, the child's environment (including the family environment), and the relationship between them." Thus, treatment recommendations can be focused on

the child, the parent, the relationship between the child and the parent, on other family relationships, or on school or other environments outside the family. Moreover, even those recommendations that focus on the child may require considerable parental support or encouragement. Thus, one or both parents are almost always actively involved in the treatment, and the practitioner can "fix" very few problems without them.

It is important to be explicit about these issues and ensure that children and parents understand their respective roles in treatment. Sometimes, providing facts about how the treatment works is helpful. For example, CBT requires "coaching" of new skills both within the office (by the therapist) and outside the office (by the parents), and lots of practice (by the child). Similarly, most medications require regular parental reminders if they are to be taken consistently and parental observation of their children to determine medication benefits and side effects. Behavior management requires that parents refrain from becoming angry or upset because such emotional reactions provide attention to the child and thus inadvertently reinforce bad behavior.

Sometimes, treatment discussions are not limited to facts. This may occur either when parents have strong opinions about the treatment their children need or when they need treatment for their own mental health problems in order for their children to improve. For example, in the case described at the beginning of this chapter, Malcolm's mother was strongly opposed to using medication to treat his ADHD. Considerable discussion would have been needed to explore the reasons for this opinion, their validity, and any room for negotiation. Parents may be upset by the suggestion that they themselves require treatment since they expect the therapy to focus on the child. However, when gently reframed as a means of helping their child, the suggestion sometimes becomes more acceptable. However, considerable diplomacy and more than one discussion may be needed. Some parents recognize the need for personal mental health care after struggling (often with limited success) to support their child's treatment.

Adolescents and Mental Health Care

When adolescents present with mental health problems, most practitioners report that they are more difficult to engage in treatment than younger children. Perhaps it is more accurate to say, however, that they disengage from treatment more easily than younger children. Adolescents are often adults in physical, if not emotional, stature and more

autonomous than younger children, so it is usually not possible for parents to force them to attend treatment sessions, and some adolescents will deliberately avoid treatment in order to defy parental wishes or assert their autonomy. Even if distressed by symptoms, adolescents may deny their problems or be reluctant to seek treatment because of a fear of the stigma that may be associated with mental health treatment in their peer group. Some adolescents will recognize their problems and be motivated to work on them, but these are in the minority.

To engage adolescents, practitioners often need to phrase various aspects of the formulation in terms that are relevant to them. For example, a practitioner may think that there are negative, self-perpetuating circular interactions between parent and teenager but say, "I think that when your mom nags you about homework, that bugs you so you put off doing it. [Teenager nods in agreement.] Unfortunately, the more you put it off, the more worried she gets about your grades, and the more she nags. Then, you put off doing it even more. Do you see how that might get the two of you stuck?" This explanation is not only provided in teen-friendly language but also leads nicely into a discussion of how mother and adolescent might begin to get "unstuck," and how treatment might help (e.g., family therapy).

Similarly, the treatment plan should be phrased in terms of its contribution to the adolescent's goals, not just parental goals for the adolescent. For example, parents may want treatment to improve the adolescent's behavior at home and boost school performance. The adolescent, on the other hand, may place greater value on feeling better and enjoying more activities with friends. The practitioner should not, however, presume to know the adolescent's or parents' goals. For example, some adolescents value school performance more than their parents do, and some parents value the adolescent's feelings more than good behavior. Treatment goals need to be elicited separately from parents and teenagers, and hopefully some overlap can be found. When it cannot, practitioners usually do best focusing on the adolescent's goals, as it is ultimately the adolescent who determines whether or not treatment occurs.

Education about Developmental Norms

Parents or children seen in mental health practice can have unrealistic expectations about what is considered developmentally normal or average at certain ages. When the child's development is not far from the average, informing the child and parents about this fact can be

reassuring. Thus, if the child is old enough to understand, it is often helpful to say, "Many kids struggle with this at your age" or "Not everyone can do that at your age." Even when the child's development appears delayed in one area, this delay may not be disastrous depending on its importance. For example, parents sometimes assume that because their friends' children all started going to summer camp after third grade, their child should be able to do the same. If the child is unable to do so, this is inconvenient to the parents (as they must find an alternative plan for the summer) but may not be a cause for concern if there are no other symptoms of anxiety or other emotional difficulty in the child. Furthermore, there is a wide range of "normal" for some developmental changes. For example, the "normal" age for learning to ride a bicycle can range from 4 to 8 or older. The age of onset of puberty can vary even more widely.

Sometimes, there is a therapeutic value to correcting unrealistic developmental expectations. This is particularly true when parents' expectations are clearly too high or too low. For example, parents who expect their 6-year-old to do a chore every day in order to earn a treat on the weekend are harboring unrealistic expectations. These parents may become angry when the child does not comply, thus creating interpersonal problems that could easily be avoided if they understood they have set an overly high developmental expectation. Six-year-olds have a very short concept of time, so a treat that is 6 or 7 days away is meaningless to them. Furthermore, the ability to delay gratification (rather than just stealing the treat from the cupboard) is poorly developed in most 6-year-olds. Therefore, getting angry is not only unfair to the child, it is confusing and will likely make the child feel badly about himself. Saying to the child, "When you put your dishes away, then you can have dessert" is much more meaningful than promising a bigger treat in a week's time.

Occasionally, parents have unrealistically low expectations. This sometimes occurs when they are reluctant to set limits on misbehavior that the child could control with effort. Parents may make excuses like "boys will be boys" when children engage in minor vandalism or roughhouse to the point where someone is injured. They may also want to relate to the child as a friend and leave the limit setting to someone else (e.g., the other parent or the "mean" vice principal). Regardless of the reasons, parents benefit from hearing that the ability to control behavior does not develop automatically in children. Children need consistent limits that control their behavior if they are to develop the ability to control behavior themselves in the long run. Furthermore,

misbehavior is unlikely to be "outgrown" without parental intervention. Rather, small boys and girls who misbehave become big boys and girls who misbehave, and the latter are much more difficult for parents to manage.

Developmental Norms and Culture

When should children be expected to dress themselves? When should they sleep in their own beds? When should they be allowed to plan their own weekend activities and merely "check in" with parents periodically? When should they be allowed to have their own cell phones? When should they be allowed to date? The answers to these questions vary widely across and even within cultures. For example, in some cultures the answer to the last question is "never"; in others it may be "around 16, but with accompaniment." In still others there are fewer restrictions. People within the same culture may be more or less traditional, depending on the extent to which they have embraced mainstream North American culture (so-called "acculturation") and the extent to which they have retained their traditional practices and values. Also, the degree of acculturation is not necessarily related to the ability to speak English. Thus, a highly proficient English speaker may have very traditional expectations of his or her family, or not. The processes involved in becoming a responsible adult and becoming independent of one's family of origin also differ across cultures. Some cultures have rites of passage marking certain transitions (e.g., confirmation, first communion, bar or bat mitzvah); others encourage gradual exploration of adult roles. Expectations concerning mental health and mental health treatment also differ across cultures, which will be discussed more in Chapter 6.

For all of these reasons, the mental health practitioner is well advised to avoid making assumptions about developmental norms based on culture, and to openly discuss cultural values that relate to treatment with the child and parents. For example, one might ask, "In North America, children of this age would typically be doing _____. What would be expected [or allowed] in your culture?" Or, "Usually, we recommend treatment for this, but I'm not sure if you see it as a problem at this age," or "How is his or her behavior different from what you would expect or hope for at this age?" With respect to treatment, one could ask, "Usually we involve the child and the parents in this type of treatment. How would that be for you?" or "How would you hope to see your child change with treatment?" Depending upon the

responses, follow-up questions could then be used to clarify specific cultural differences.

Anticipating Developmental Change

Understanding children's difficulties in a developmental context often allows the therapist to anticipate future problems. In particular, children whose problems are only partially amenable to intervention may face challenges related to their ongoing difficulties, and to increasing awareness of these difficulties. For example, children on the autism spectrum can learn to regulate certain behaviors and anxieties with treatment. However, ongoing difficulty with transitions may pose a challenge as they enter middle school, where frequent class transitions are the norm. Ongoing social awkwardness may also greatly concern these youth—and their parents—when they reach adolescence, as they become increasingly aware of being different from their peers. This awareness of being "different" and other ongoing struggles with their symptoms can predispose to adolescent depression in this population. Preparing for the challenges associated with adolescence, particularly the transition to high school, can therefore be an important contribution to the mental health of youth on the autism spectrum. Youth with ongoing anxiety, ADHD, learning disabilities, and other chronic mental health conditions often also need additional support at times of transition.

WHAT ABOUT MALCOLM?

To conclude, let's take a look at how some of these ideas might have helped Malcolm, the boy described at the beginning of the chapter. Developmentally, Malcolm is a preadolescent. Thus, his parents define the problem that is presented to the clinician, and his parents need to agree with and accept the formulation and treatment recommendations if these are to be followed. Since Malcolm's parents cannot agree on the nature of the problem, the parents' views do not correspond with those of the school, and nobody has interviewed Malcolm, the clinician is put in the position of a referee who is expected to correctly define the problem. The clinical diagnoses of ADHD and generalized anxiety disorder are partially consistent with the views of Malcolm's school and those of his mother but do not address the father's view that Malcolm is "lazy." Not surprisingly (given the lack of attention to his view), Malcolm's

father does not become involved in his son's mental health care. The psychiatry resident therefore presents the treatment recommendations (without a formulation) to Malcolm's mother and pursues the part of the treatment she is willing to accept: the anxiety-focused group. Treatment for the primary diagnosis, ADHD, is not pursued in deference to the mother's wishes. In short, both the problem definition and the treatment provided have been tailored to the mother's needs, which may not be in Malcolm's best interest.

From Malcolm's point of view, his family is still an important social influence, but the opinions of his school and his peer group are becoming increasingly important. His lack of success at school will soon begin to affect his self-esteem and may result in some teasing by peers, leading to a further source of distress. Each of these problems places him at risk for further anxiety and possibly depression (due to low self-esteem) as he matures. These future developmental challenges can be anticipated, so improving Malcolm's school functioning should have been prioritized in treatment.

Apart from these developmental considerations, it would have been very helpful to gather additional information during Malcolm's mental health assessment in order to construct a formulation of his difficulties. For example, the fact that Malcolm's anxiety symptoms are so consistently linked to the school day suggests a need to investigate school problems in more detail. Learning disabilities are a biologically based factor that often contributes to both inattention and anxiety symptoms. Overly critical teachers and bullies are common environmental sources of distress at school. Children from certain cultural or religious groups can experience discomfort with secular ideas and attitudes in the public school system. Any of these could contribute to Malcolm's morning stomachaches.

Parental disagreements about the nature of children's problems are often a clue to other types of family conflict. Therefore, it would have been helpful to interview Malcolm alone and ask him about how people in his family get along. The practitioner also could have made an effort to reach Malcolm's father and obtain his perspective on the family. It is even possible that most of Malcolm's symptoms relate to worry about his conflicted family or (in the case of child abuse or domestic violence) traumatic memories affecting his ability to attend at school.

The strong opposition to medication voiced by Malcolm's mother also deserves further exploration to allow for the opportunity to address her concerns. Sometimes, such opposition is based on misinformation about medication garnered from friends or the media. Sometimes, it

is based on cultural or religious views that discourage or prohibit the use of psychotropic medications. Sometimes, the reasons are more personal. For example, Malcolm's mother might have had a negative experience with psychotropic medication herself. Alternatively, she might have an acrimonious relationship with Malcolm's school and feel that giving Malcolm medication for ADHD represents an acknowledgment that the school was right about her son and she was wrong. It is worth inquiring about each of these possibilities.

Finally, a good formulation would have revealed factors that might perpetuate Malcolm's problems, as well as factors that might be protective. Sadly, one of the likely perpetuating factors in this case would be the treatment itself. Malcolm's inability to succeed in the anxiety-focused group treatment mirrors his inability to succeed at school and would probably increase his anxiety and further decrease his self-esteem. Protective factors might include personal strengths or supports that are not obvious from the diagnostic interview. For example, Malcolm might have the ability to make friends, an athletic or musical ability, or a supportive relationship with an encouraging teacher or coach.

It may seem like a great deal of extra time would be needed to elicit all of this extra information, but this is not always true. As we will see in the next chapter, an astute clinician can use interviews, questionnaires, and other investigations selectively to ensure a thorough understanding of the child's difficulties in a reasonable period of time.

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