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Book Title: Case Conceptualization: Mastering this Competency with Ease and Confidence

Author: Sperry & Sperry

Begin/End Date of Enclosed Course: 1 JAN 2023 / 30 APR 2023

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PSYCHOPATHOLOGY PSY4031

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Text Read; Case Conceptualization: Mastering this Competency with Ease and Confidence, 2nd Ed. Len Sperry & Jon Sperry (2020) ISBN: 9780367256654. 237 pages in 2 parts and 10 chapters. Section I. Introduction to the Chapters in Part I. (ch 1) Case Conceptualizations An Overview (ch 2) Assessment and Diagnostic Formulation. (ch 3) Explainations and Clinical and Cultural Formulations (ch 4) Treatment Planning and Treatment Formulations (ch 5) Case Conceptualizations: Individual, Couple and Family. Section II. (ch 6) Biopsychosocial Case Conceptualizations. (Ch 7) Cognitive-Behavioral Case Conceptualizations (ch 8) Time-Limited Dynamic Psychotherapy Case Conceptualizations (ch 9) Adlerian Case Conceptualizations (ch 10) Acceptance and Commitment Therapy Case Conceptualizations.

INTRODUCTION: The text's Introduction tells its reader "If you are a trainee in a graducate mental health program, this book was likely assigned to assist you in learning this competency." The definition of a Case Conceptualization is a "method for understanding and explaining a client's concerns and for guiding the treatment process." The text further offers: "Case Conceptualizations provide clicians with a coherent treatment strategy for planning and focusing treatment interventions in order to increas the likelihood of achieving treatment goals," and "a method and clinical strategy for obtaining and organizing information about a client, understanding and explaining the client's situation and maladaptive patterns, guiding and focusing treatment, anticipating challenges and roadblocks, and preparing for successful termination." [Sperry, Core Competentcies in Counseling and Psychotherapy: Becoming a highly competent and effective therapist. (2010)][Sperry, Psychopathology and psychotherapy, pp. 36-50 (2015)]

The definition highlights five interrelated functions: 1) obtaining and organizing, 2) Explaining, 3) guiding and focusing treatment, 4) Anticipating obstacles and challenges, and 5) preparing for termination. The first function is about taking the first client contact and forming hypotheses as to the client's presentation, his expectations and dynamics. These hypotheses will be tested while searching for maladaptive patterns in the client's life - past and present - regarding factors that precipitate, predispose and per-

petuate the maladaptive pattern. The second function is to form anoexplaination for these patterns using diagnostic, clinical, and cultural data. The explaination provides the reasons for treatment tailored to the clients needs, expectations, culture and personality. The third functionsis based in the explaination; a treatment plan, specifying targets (goal-setting) and strategies to implement treatment. The fourth function is to predict likely obstacles and challenges, especially whether the client will actually engage in therapy, commit to the therapy process, keep to the therapy, resistance, ambivalence, alliance ruptures, transference enactments, relapse and termination of treatment. The Fifth function is to deal with the ultimate need to terminate treatment. Treatment must come to an end unless the patient intends to remain in treatment for life, which would call into question the efficacy of the treatment and termination can be very stressful for clients. Termination particularly will affect those with dependency issues, rejection sensitivity and histories of abandonment. [Cucciare & O'Donohue, Terminating psychotherapy: A clinicians guide, pp. 121-46 (2008)]

A case conceptualization consists of four components; a diagnostic formulation, a clinical formulation, a cultural formulation, and a treatment formulation. [Sperry, supra] The Diagnostic formulation provides a description of the client's presentaion and answers the "What Happened?" question. Usually includes a DSM-5 diagnosis and contains discussion of client's personality pattern, triggers, and perpetuants. The clinical formulation provides an explaination of the client's patteen and answers the "Why did it happen?" question. The Why? is the central component in a case conseptualization linking the diagnostic and treatment formulations. The cultural formulation answers the "What role does culture play?' question; specifically the client's cultural identity, and his level of acculturation (adaptation to the dominant culture of his community where he lives.) The treatment formultion is the roadmap answering the "How can it be changed?" question. This is the planning part that sets forth the treatment goals, focus, strategy and specific interventions to be undertaken.

A case conceptualization is not merely a case summary. A case summary has no explanatory power or predictive power; nor does a case summary contain a treatment plan. Research is showing that case conceptualizations do have a positive correlation to superior treatment outcomes. [Kuyken, et al., Collab-

orative case conceptualization: Working effectively with clients in Cognitive-Behavioral therapy. (2009)] Case formulation (as case conceptualization was called before it matured into its present competency) "is a cornerstone of evidence based CBT practice." [Kuyken, et al., Behaviour Research and Therapy, 43(9):1187-1201 (2005)] Case conceptualizations are not so difficult or time-consuming as to hinder their use. Research supports that the value of doing case conceptualizations outweighs the costs in time and training. [Binensztok, The influence of reflective practice onthe case conceptualization competence of counselor trainees. (2019)] Case conceptualizations are highly customizable, and are as individual as the clients they are written for and the practitioners who write them.

The use of Case Conceptualizations is ratified by professional accrediting organizations in this field to include the American Psychological Association (APA) and the Counsel for Accreditation of Counseling and Related Educational Programs (CACREP) see ("APA Task Force" 2006, pp. 271-85) and (Sec. 2:F.1.b., CACREP standards, 2016, p. 12)

COMPONENTS OF THE CASE CONCEPTUALIZATION

(1) The Diagnostic Component of the case conceptualization is intended to answer the "What Happened?" question and give a diagnosis from the DSM-5. Additionally to naming a disorder from the DSM-5 (eg. an anxiety disorder, a personality disorder, a substance abuse disorder, etc.) this component may include a Level of Psychological Functioning Scale (LPFS) analysis. The LPFS is a quick and accurate means to find the presence of a personality disorder, assessing: identity, self-direction, empathy and intimacy. The LPFS is scored on a continuum 0 to 4 where 0 is little or no impairment and 4 is extreme impairment (DSM-5, APA pp. 775-8, 2003)

The key elements here are presentation, precipitant and pattern. Related to one another in this way:

precipitant ----------> [pattern] ----------> presentation

The precipitants refers to the triggers or stressors that activate the pattern. Where did it occur, what time, who was there, what was said/done, what happened next? These precipitatnts are likely outside of the client.

The pattern is within the client. The pattern is a sudcinct description of the client's way of perceiving, thinking, and responding. If the mal-adaptive pattern is sufficiently distressing or impairing, it can be diagnosted

as a personality disorder.

The presentation is the (outwardly observable) problem. This is the symptoms, the impairment in personal and interpersonal functioning.

(2) The Clinical Component of case conceptualization answers the "Why?" question. Some of this answer may be composed of predisposition (called etiological) factors. The predisposition may be biological, social, or developmental (or any combination therof.) Biological vulnerabilities may be medical history, family history, physical health, drugs and substance abuse. A social predisposition may be from one's relationships, workplace or other environmental factors. Some examples given that would need to be identified are drinking-friends, living in poverty or a hostile marraige. Protective factors are the opposite of risk factors, mirroring these given would be sober friends, higher socioeconomic status and a healthy happy marraige. Perpetuants maintain the client's circumstances, serve to "protect" or "insulate" the client from symptoms, conflict or demands of others. An example offered is where a shy person may choose to live alone in order to avoid others.

(3) In the Cultural Component a practitioner is going to be interested in the cultural beliefs, values, attitudes and practices of his client. The text offers 2 acronyms mnemonics to use for modelling cultural considerations. These are:

RESPECTFUL	ADDRESSING
Religious Values	Age/generational
Economic/Class issues	Disability (developmental)
Sexual identity issues	Disability (acquired)
Psychological developmental issues	Religion
Ethnic/racial identity issues	Ethnicity/race
Chronological	Social status
Trauma and threats to well-being	Sexual orientation
Family issues	Indigenous heritage
Unique physical issues	National origin
Language and location of residence issues	Gender

Acculturative stress is the adaptation to another culture. Acculturation-specific issues are those such as ethnic identity, discrimination, cultural values, cultrual competence, and second language competence. [Wu & Nak, The Counseling Psychologist, pp. 40(1):66-92 (2012)] One tool used to measure

acculturation is the Brief Acculturation Scale, 3 items on a 5 point scale; client's language (foreign v. local), generation (1st - 5th) and social activities (friend preference - like oneself ethnically or mainline)

The Treatment Component of the case conceptualization is intended to answer the "How can this be changed?" question. Treatment goals are specific outcomes clients expect to achieve in their treatment, also called treatment targets and therapeutic objectives. Typical short term goals are symptom reduction, increased relatioonal functioning, return to baseline functioning, and return to work.

Treatment focus refers to the central therapeutic emphasis that provides directionality to treatment and aims at replacing a maladaptive pattern with a more adaptive pattern. Our text says a common seenario for trainees is to get lost or sidetracked in an unproductive discussioon with clients. Reaching back to Kuyken, who found that case conceptualizations was correlated to better outcomes, this directionality and focus may be a strong supporting fact for the result. A treatment session could very easily go into an unplanned direction. The treatment focus element of this treatment component of the case conceptualization would help to avoid wasted sessions in a limited resource situation. Revieing the case conceptualization by the therapist will help to keep the conversation moving in the right direction.

The treatment strategy element is the action plan for implementing specific interventions to replace maladaptive patterns with more adaptive ones. Treatment interventionsmay be Cognitive restructuring (often considered the first step when using CBT [Wright, et al., Learning cognitive-behavior therapy: An illustrated guide. (2006)]), or exposure (as we discussed with the simple phobias), or social skills training or pharaceutical interventions (psychotropic drugs: anti-depressants, anxiolytics, anti-psychotics, anti-manics, etc.)

This Component of the case conceptualization will also outline the obstacles and challenges to therapy. The text admits that full discussion of these issues is beyond the scope of our text but offers examples of a patient who is a procrastinator, and the possibility for transference enactments (such as a client with a trauma history-- implied that the client might relate that trauma to his therapist).

The treatment prognosis is a prediction of the likely course, duration,

severity and outcome of a condition or disorder with orwithout treatment.

Another consideration under this component of the case conceptualization is the readiness to change stage where the client finds himself. The five stages are precontemplation, contemplation, preparation, action and maintenance. Because the patient may move between these stages throughout treatment, and because relaps is common among various psychological conditions, the practitioner will want to include the patient's readiness to change in the case conceptualization. [Prochaska, et al., Am.Psychologist 47:1102-1114 (1992)]

INDIVIDUAL, FAMILY; AND COUPLE CASE CONCEPTUALIZATIONS

The text offers one more formulation of case conceptualizations; differentiating among Individual, Couple and Family case conceptualizations. These types are mostly self-explanatory, the differences being that some new dynamics and considerations be accounted for. The couples case conceptualization will be heavily concerned with the relational interaction pattern. "Specifically, therapists focus on identifying the problem interaction cycle around the presenting problem. Typically, couples... have one or two basic patterns of interaction that characterize the presenting problem. [Gehart, The SAGE encyclopedia of marraige, family and couples counseling. p. 256 (2017)] The text offers several of these patterns in couples/couples therapy; demand/withdraw, demand/submit, withdraw/withdraw, attack/attack, reactive demand/withdraw, and constructive engagement.

In family case conceptualizations the family and/or systemic dynamics are incorporated. A family case concptualization will "focus on the unique contexts, needs and resources of the individual family members and the system as a whole." [Ritter, p. 374 (2009)] This will include a detailed assessment of family system dynamics; couple, parental and sibling subsystem dynamics.

The Beavers System Model of Family Functioning divides families into categories; optimal families, adequate families, midrange centripetal families, midrange centrifuagal families, midrange mixed families, borderline centripetal families, borderline centrifugal families, severly dysfunctional centrifugal families and severely dysfunctional centripetal families. Here the style dimensions of centripetal and centrifugal refer to being "internalizing and clinging" and "demanding, attacking and externalizing." The competence dimensions are a continuum and self-explanatory. [Beavers, J.Marital and Family Therapy 7(4):299-307 (1981)]

SECTION II

Part 2 of the text changed from explaining and defining the components of a case conceptualization to introducing five methods of case conceptualization. These are Biopsychosocial, Cognitive Behavioral, Time-Limited Dynamic, Adlerian, and Acceptance and Commitment Therapy (ACT) case conceptualization.

Biopsychosocial perspective

The Biopsychosocial perspective was proposed by George Engel in 1977. [Engel, Science 196(4286);129-136 (1977)] Owing to the biological basis, this method appeals to psychologists, psychiatrists and nurses with prescription priviliges. This perspective will emphasize family health history, medication and medical treatment, exposure to environmental toxins and substance use: illicit drugs, alcohol, nicotine, and caffeine.

Cognitive-Behavioral perspective

Cognitive-Behavioral Therapy represents a merger of the Cognitive and Behavioral therapy perspectives. [Wrights, Learning Cognitive-Behavior therapy; An illustrated guide (2006)]

CBT is the most commonly utilized therapeutic approach as of the time of the authorship of the text (2020). CBT has been adapted to nearly all diagnostic conditions. CBT focuses on changing maladaptive automatic thoughts and rigid modes of thinking, mood and behavior. CBT operates on the premise that because behavior is learned, new effective bheaviors can be learned and negative behaviors unlearned. [Sperry & Sperry, Cognitive Behavior therapy in counseling practice, (2018)] There are undertones of classical conditioning in CBT, à la Ivan Pavlov.

Time-Limited Dynamic perspective

The time-limited dynamic perspective is based on the observation that early in life clients develop a cyclic maladaptive pattern of relating to others and this pattern influences all aspects of their life functioning in the present. [Levenson, Time-limited dynamic sychotherapy (1995)] "The practitioner's job is to use the clinical relationship to facilitate for the client a new experience of relating, allowing the client to break the old pattern and thereby resolve the presenting issues." [Levenson & Strupp, Handbook of psychotherapy case formulation, p. 76 (2007)] Time-limited Dynamic Psychotherapy (TLDP), based on this perspective, is among the psychodynamic/interpersonal dynamics psychotherapies that are currently in vogue.]Levenson, Brief dynamic therapy 2nd ed. (2017)]

Adlerian perspective

The Adlerian perspective case conceptualization will center on the constructs of lifestyle, belonging, birth order, family constellation, private logic, social interest, lifestyle convictions and basic mistakes. A therapist who subscribes to Adlerian psychotherapy will be especially interested in his patients' family constellations, meaning: were they an only child, an eldest child, a youngest child, or a middle child? Were thay a favorite among siblings? What were they expected to be "When they grew up?" A common entré into this line of conversation would run, "Think back to your early life -- the age of nine -- and tell me your first memory." The premise that undergirds this perspective is that the family constellation and the lifestyle convictions (rooted in upbringing) lead to predispositions in the patient that may explain diagnoses and further provide the client and therapist a target for treatment. An interesting treatment intervention that may be suggested in a Adlerian case conceptualization is to act "as if" in engaging with others. For example, a client with an MDD diagnosis would be encouraged to act "as if" she were not feeling depressed and go out on the weekends. [Sperry, Learning and practicing Adlerian therapy (2019)]

Acceptance and Commitment Therapy perspective

The Acceptance and Commitment Therapy (ACT) perspective challenges the "disease" and "illness" assumptions about human psychological distress. The medical model belongs to the "second-wave" behavior therapies, where ACT belongs to the "third-wave" behavior therapies. Some deem it a "Radical Behaviorism" approach. This is rooted in ACT's beginnings as "Comprehensive Distancing" -- the process of creating "distance" between the individual and their uncomfortable and unwanted private experiences. [Hayes, Behavior Therapy 35:639-65 (2004)] The ACT therapist is going to be very focused on Cognitive Fusion, defined as: "a process by which verbal events exert strong stimulus control over responding, to the exclusion of other contextual variables." [Hayes, et al., Acceptance and commitment therapy: The process and practice of mindful change (2012)]

The ACT treatment interventions proffered in the text had very interesting names, and will need to be investigated outside the text because the author did not describe them. (eg. "Milk Milk Milk," "tug-of-war with a monster," "uninvited party guest," "Leaves on a stream," "body scan," "Chessboard

metaphor," "Cycling jersey," 'values card-sort," "two trains," "walking the path," 'Thanking your mind," "pop-up blocker," & "deictic framing."

EXAMPLE CASE CONCEPTUALIZATIONS

The text used five example clinical cases, and case conceptualizations for these five cases throughout the book. These five cases were re-conceptualized using the different perspectives, and demonstrated how different elements and components were used based upon the different perspectives. The purpose of this was to contrast the perspectives using the same cases which the reader grew familiar with while reading. Here, we'll copy one of the cases that was most memorable because the featured pationet was Antwone Fisher, as famous from the eponymous movie and his autobiography.

Antwone is an African American Navy seaman in his mid 20s. An otherwise talented seaman, he has a short temper and recently lashed out at crew members at the slightest provocation. After his most recent fight, which Antwone claimed was racially motivated, his commander fined and demoted him and then ordered him to undergo counseling from the base psychiatrist. Antowne initially resisted working with the psychiatrist, but after a period of testing him, Antwone agreed to cooperated. He recounted a painful early childhood in which his father was killed by an irate girlfriend, and his mother -- another of his father's girlfriends -- gave birth to him in prison. She was convicted of drug dealing. Afterward, he was placed in foster care with an African American family where he was alternately neglected and then abused (emotionally, verbally, and physically) by his foster mother and sexually abused by her adult daughter. Antwon was one of three foster boys in the home. Their foster mother condescendingly called the three "niggers" and demanded that they meet her every demand. At one point, the foster mother beat him unconscious. Thereafter, he assumed a flight mode and would cower in fear whenever she was around. Seh despised his best friend Jesse, in part because after episodes of sexual abuse, Antowne would run to Jesse who would emotionally calm and support him. When he was 15, however, as the foster mother began to berate him, he could no longer endure her tyranny and he grabbed the shoe with which she was beating him and threatened her. She responded by throwing him out to live on the streets. Subsequently, he lashed out at perceived injustices. By base policy, treatment at the mental health clinic was short, with a maximum of three sessions. During their third session, the psychiatrist indicated that treatment would be

ending and encouraged Antwone to find his real family. He emphasized that this was an important step for Antwon to get closure on his issues. An infuriated Antwone lashed out, yelling that everyone in his life abandoned him, including Jesseand now the psychiatrist. Antwone recounted that he was an innocent bystander when Jesse was shot while robbing a convenience store. For the first time, Antowne was able to admit his anger at being abandoned by Jesse as well as the psychiatrist. He realized that finding his family was necessary. With much effort and persistence, he finds and meets both his father's family and his mother as well as confronting his foster mother and her daughter.

This case conceptualiziation is further developed throughout the book, and variations upon it are given to demonstrate the difference between the different styles and perspectives available.

Provided here are examples of case conceptualizations produced by this student, using the skills learned in the text and based upon semi-fictionalized observations of potential patents here inside Buena Vista Correctional Facility.

SAMPLE CASE CONCEPTUALIZATION #1: "Billy"

Billy is a 26 year old Caucasian male who presents with paranoid schizophrenia, Bipolar I Disorder, ADHD, and substance abuse disorder. He is currently incarcerated, convicted of an attempted murder based on a dubious set of facts provided to law enforcement by the putative "victim." Billy's current imprisonment began as a result of a suicide attempt, which itself was a result of an overdose condition and reaction to an anti-depressant (bupropion) prescribed to him at his last inpatient treatment center.

Billy has a history of run-ins with law enforcement that began in his late teens and corresponds to typical onset of schizophrenia in males. The legal troubles additionally correspond to typical impulsivity seen in male ADHD patients in their teens. Further, Billy's legal issues are highly co-related to his substance abuse. Billy's drug of chice is methamphetamine, which he uses exclusively by smoking. Bill denies intravenous drug use. Billy further denies alcohol use or other illicit drugs. Billy is a cigarrette smoker when he is not imprisoned. The substance abuse mirrors typical self-medication behavior commonplace in both schizophrenia and mania/ADHD patients. Billy denies use of any substances since he has been imprisoned, but relapse is probable without addressing symptom care. Pharmacological intervention is indicated, yet care must be exercised as any drug with a potential for abuse may result in abuse, and the history of overdose with anti-depressant use

indicates a need for careful supervision. The risk of suicidality is common with anti-depressants and Billy has already experienced one event that nearly cost him his life.

Billy has strong family support. his Mother, Father and older sister are all actively participating in his daily life and support his treatment efforts. There is a family history of mental disorder. His mother reports a history of Bipolar II Disorder.

One of Billy's greatest barriers to treatment is his lack of trust in clinicians. Owing to the interplay between Billy's law enforcement run-ins, the criminal justice system and his mental illness; Billy has come to associate mental healthe professionals to the prison-industrial complex. Indeed, during his most recent and most dangerous episode his defense counsel sought a not-guilty by reason of insanity plea agreement with the goverment which would have resulted in Billy's commitment to the State's mental health hospital. For reasons incmprehensible to this clinician the state's evaluation found Billy both competent to stand trial and sane during the commission of the incident, resulting in a 34-year prison sentence. For this reason, and owing to his experiences with many prior clinicians, Billy's lack of faith in the health care professionals will require many sessions to build trust with Billy. Further, it will require diligence to maintain Billy's faith. Another barrier to Billy's treatment will beto overcome his difficulties in concentration that result from the mania and ADHD. Avoiding sidetracks and distracting pitfalls in treatment will be critical to Billy's progress.

Predisposition: Billy deals with hyperactivity and impulsivity. In the prison environment, Billy has been fairly successful owing to the lack of maladaptive outlets for his great energy; Billy is intelligent and athletic, and has diverted his energy into reading and exercise. Billy's tendency toward mistrust of authority figures has been rewarded in prison, and will demand correction before he will be able to have success outside of prison.

Treatment Goal: Treatment goals for Billy include avoidance of substance abuse as a means to self-medicate. Billy cannot be permitted to relapse to methamphetamine use. Other goals for Billy will include improving communication skills, self-regulation of his hyperactive/manic energy level, and reducing the maladaptive thought patterns concerning his paranoia that surrounds authority figures.

Treatment interventions: Pharmacological intervention is indicated for Billy. Amphetamine use in Billy is contra-indicated due to the potential for abuse; so ADHD medications as Ritalin and Adderall are to be avoided. A non-amphetamine treatment such as Strattera-SR (atomoxetine) should be considered, and tried with supervision. Billy reports that Haldol for his schizophrenia has been poorly tolerated due to side-effects. For this reason Zyprexa (olanzapine) will be attempted in Billy. Zyprexa is an anti-psychotic medication that will benefit his paradoid symptoms along with stabilizing his mood giving relief to his manic symptoms. An investigation of the literature to confirm there is no negative drug interaction concern between the Strattera and Zyprexa will be needed (a cursory review of a desk manual suggests no adverse reaction) as will some trial beriod to properly set the dosages. Billy will require a minimum weekly checkin until we can be sure the dosages are well tolerated.

In addition to pharmacological intervention, Billy will need to participate in Cognitive-Behavioral Therapy. Billy will have twice weekly sessions to begin. Because of Billy's excellent family support serving as a protective factor, the sessioons should be one family session and one individual session for the first 6 weeks. This will reduce to one weekly individual session and on monthly family session for the next 3 months, and then reducing to bi-monthly individual sessions. until Billy can be properly discharged. Once every 6-month maintenace sessions thereafter will serve as a back-stop to concerns of illicit drug relapse, problems with prescription medication or other treatment concerns.

The CBT sessions will focus on Billy's ability to self-regulate his energy level, especially in the social setting. Billy's manic energy and lack of concentration has been maladaptive in professional settings in the past, and has led to difficulty in communication with authority figuers. The sessions will also serve to correct faulty thinking patterns, especially paranoid beliefs that people are "out to get him." Lastly, the CBT sessions will concentrate on impulse control

SAMPLE CASE CONCEPTUALIZATION #2: Tomás

Tomás is a 38 year old Chicano who presents with Narcissistic Personality Disorder. Tomás is highly acculturated, 3rd generation Hispanic-American who speaks English and has only limited use of his Grandparents' Spanish language. Tomás identifies as Chicano and acknowleges his Mexican nationality, but typically identifies as Caucasian professionally and goes by the more mainstream

"Tom" with his European-American, African-American and mixed ethnicity friends and collegues.

Tomás is currently incarcerated serving a 10-years-to-life sentence for sexual assault. Tomás reports that his incarceration is based on a false allegation he calls a "regret rape," and says that the alleged victim "wanted to have sex while we were doing it." Tomás admits that he and she had been drinking and using cocaine at the time of theincident but says that "things didn't ever get out of control." Due to the stigma of sex offeenders in the prison environment, Tomás is careful to keep the details of his incarceration to himself and is cautious about sharing even when talking with his mental health professionals.

Tomás is of above average intelligence, and he flaunts it in the prison environment. Tomás is studying to earn his associate's degree while imprisoned and enjoys demonstrating his "superior knowledge" to thos from less advantaged socio-economic or educational backgrounds which are prevalent in the prison. Tomás hold an over-sized opinion of his abilities and accomplishments. He feeds on attention from others (be it positive or negative attention), and he enjoys belittling people around him. Tomás was referred to treatment following a physical alteration with another inmate which he attributed to that "other guy's jealousy." Tomás takes no responsibility for the confrontation.

Barriers to treatment with Tomás will come from his attitude of superiority over everyone with whom he interacts. The clinical practitioner will fail to succeed in the treatment process if he attempts to confront him head-on. Any perceived besting of the clintioan at the hands of Tomás will reduce the clinician's esteem and eliminate any opportunity for effective treatment. The clinician will need to allow Tomás to believe hisis treating himself and arriving at his own conclusions throughtout therapy.

Precipitationg and perpetuating factors for Tomás are related to his educational and professional success prior to prison, and continued presence in prison currently. Tomás had been a financially successful salesperson in a marketing firm. His success likely grew from his out-sized confidence, and the two (success and confidence) have created a feedback loop which spiralled and ultimately resulted in the maladaptive patterns that exist in Tomás today.

Predisposition: Tomás was a precocious child. He reports a close relationship to his mother and two sisters, and makes no mentions of a father or father-like personality in his upbringing. his maladaptive patterns in relationships with women may be rooted in this childhood household. Tomás doesn't demonstrate overt misogyny, his condesension and lack of concern for the feelings of others is directed universally toward all. That said, having been surrounded by females early in life, these were his first victims. If there was a father present, he may have been weak or otherwise absent or incapable in averting Tomás' Narcissistic tendencies. Tomás often mentions "being a man" and demonstrating "machismo" behaviors. The close relationship he cites with his mother may have been a one-way doting mother that only reinforced the behavior, a subject to be explored throughout counselling.

Treatment Goals: Tomás has abstained from alcohol and cocaine use while imprisoned. While relapse upon release is possible, it seems unlikely. Tomás' substance abuse appears to be an artifact of youth-culture and early financial success, both of which he has aged-out from while imprisoned. Because Tomás' substance abuse is not comorbid with MDD or an anxiety disorder, it will need only to be monitored but not a primary focus. Our main goal will be to adjust Tomás' perspective to account for the feelings of those around him. Tomás' Narcissistic Personality Disorder is overwhelmingly marked by a lack of empathy which is the most detrimental factor and which objectively has been cause to his failings.

Treatment Interventions: Cognitive-Behavioral Therapy (CBT) is indicated in Tomás' treatment. No pharmacological intervention is indicated with Narcissistic Personality Disorder.

CBT will focus on realigning Tomás' cognitions and behaviors with mainstream norms. The therapist will need to give Tomás the chance to "treat himself," not directly challenging Tomás while simultaneously not being so passive as to invite Tomás' belittling pattern. Some educational materials will be provided to Tomás to read on his own, as he is an auto-didactic type. These materials will focus on helping Tomás learn how his insults and lack of empathy effect those around him. He will be encouraged to act "as if" he did care about others' feelings. He will be taught skills in therapy, as to how to deliberately uplift those around him without appearing to be condescending. Then, in a classical conditioning behavior modification Tomás will be asked to "as a game" keep a "score" and an empathy journal, taking account of specific examples

where he has properly applied the new skills. Tomás will be asked to reward himself by purchasing a special gift that he normally would deny himself. (eg. a luxurious dinner, sports tickets, etc.) Ultimately the goal will be that Tomás will find a reward in others around him not being made miserable by Tomás' insults and belittling -- a self-reinforcing social reward created by the behavioral change.

CONCLUSION

After having read the Sperrys' textbook, Case Conceptualization, this student was able to use the competency that was learned to prepare the two above mock Case Conceptualizations. While these were based loosely on actual cases hereein Buena Vista Correctional Facility, this student is not a qualified mental health practitioner. One must hope that the would-be patients find competent treatment. This is indeed an epidemic seen here, the mental health conditions throughout the prison system, and the complete lack of treatment available to these cases.

It is anticipated that future writings will include more observations of counseling needs that exist in this student's immediate surroundings.