CHAPTER 2

Cognitive Therapy Case Conceptualization

PSYCHOLOGICALLY SPEAKING, WHY DO STUDENTS DO WHAT THEY DO?

So far, we have suggested that the environment or situation itself does not cause students to feel as they do. Instead, it is the way that students see or think about their situation that leads to particular emotions and behavior. To illustrate this point, let's look at some of the automatic thoughts that students might have as they enter your office. The following are the thoughts of three different students, of which the student may or may not be conscious.

Student 1: "Counseling may be helpful, but it may be a waste of time. I'll give it a couple of sessions before I make a decision."

Student 2: "Meeting with a counselor is a waste of time. She won't get what I'm going through and I'm missing art class."

Student 3: "I really need some help. The counselor really helped Amy, so maybe she can help me."

Given what you have read so far, you probably can guess that these students would each be feeling differently. What would you guess that each is feeling?

Student 1: _____

Student 2: _____

Student 3: _____

You may have guessed that Student 1 was feeling cautious, Student 2 was feeling annoyed, and Student 3 was feeling interested and excited—based on what they were thinking. As we described in the last chapter, the way people think is directly related to the way they feel. And . . . the way we automatically think about something is directly related to our intermediate and core beliefs. Our intermediate and core beliefs therefore guide much of how we feel, and these underlying beliefs and subsequent automatic thoughts and compensatory behaviors can be diagrammed and understood through what a cognitive clinician calls a **cognitive conceptualization** (Beck, 1995). The cognitive conceptualization usually changes over time as clinicians learn more about their students, as the students learn more about themselves, and as students make changes during counseling. The conceptualization represents a clinician's best current understanding of:

- The student's experiences that results in or are related to the formation of the student's beliefs.
- What a student believes about him- or herself, others, and the world.
- The rules students have to live by, given their core beliefs.
- The thinking patterns, based on deeper beliefs that the student may have at a conscious level or just below a conscious level.

Clinicians use a cognitive case conceptualization to diagram a student's background information, underlying beliefs, automatic thoughts, and compensatory strategies.

In thinking about the cognitive conceptualization, do you find yourself feeling anxious or guarded, wondering "That sounds like a lot of work! Why do I need it?" If you are aware of thoughts like this, we hope that you approach this self talk with an open mind and a thought like, "Hmmm . . . Apparently, the cognitive conceptualization—whatever it is—is part of this approach that has been proven effective, so I'll give it a shot." You may find that a thought like this shifts any feelings of frustration to feelings of curiosity or optimism. If you are not having success with shifting your thinking just yet, hang in there. The following chapters will strengthen your skills for doing so, for students and for yourself!

Before you read on, take a moment to first consider how you currently make sense of the students you work with. Do you try to gain a sense of who they are, why they think and act as they do, and what contributed to their being that way? If you do, you are already conceptualizing in a fashion similar to that of a CT clinician—*great*! Much of what is presented in this chapter may be similar to what you are already doing. If this way of thinking about your students is really different from how you usually approach counseling, we invite you to think about what may be different about this kind of conceptualization and how you could integrate CT or the cognitive conceptualization itself into your work with students.

With the student's cognitive conceptualization in mind, the cognitive clinician will be able to target the behaviors, thinking patterns, or underlying beliefs that are interfering with the student reaching his or her goals. In doing so, cognitive counseling goes beyond what traditional supportive therapy accomplishes, as clinicians anchor their work with students to specific thinking patterns or beliefs that are causing problems in the students' lives.

We use the term **anchor** to convey the fact that counseling overall, as well as each session you have with a student, will be tied to the theme or aspect of the student that you and the student are attempting to change.

For some students, you will anchor the treatment to helping students understand and eventually change the role that *unhelpful thoughts and behaviors* play in their functioning. However, when students are interested in and capable of addressing underlying beliefs, there can be even longer lasting changes when you help them change not only the unhelpful thoughts and behaviors, but also the underlying beliefs that are their foundation. When this occurs, you are anchoring each session to the *underlying beliefs* that are related to their current problems and keeping the students from reaching their goals. The cognitive conceptualization of the student will guide you in choosing how to anchor treatment and which interventions to use. Cognitive counseling that is anchored to behaviors, thoughts, and/or underlying beliefs creates continuity between sessions, and the clinician and student alike will have a clearer view of the targets they are working to change. The cognitive conceptualization that informs this process is described in this chapter, and treatment planning that is anchored to behaviors, thinking patterns, and/or underlying beliefs is described in greater detail in Chapters 3 and 5. A depiction of CT sessions as anchored to behaviors, thinking patterns, and/or underlying beliefs is shown in Figure 2.1.

COGNITIVE CONCEPTUALIZATION

Whether you anchor your sessions to the student's thoughts and behaviors or to the students' deeper underlying beliefs, you will always want to have a preliminary cognitive conceptualization of the student formed by about the third session. Contrary to counseling in a traditional outpatient setting, we have found that cognitive school clinicians may not have enough time to work on underlying beliefs with the majority of students. Even if you are not anchoring your sessions to underlying beliefs, it will still be important to understand how

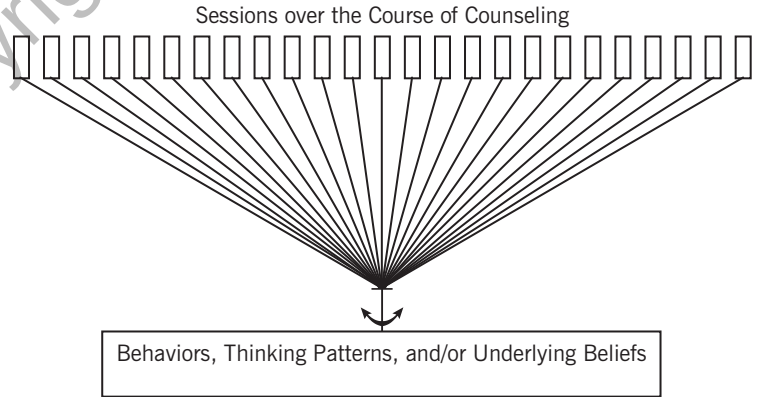

FIGURE 2.1. CT sessions across time.

students' thinking or behavior patterns influence and are influenced by their beliefs. This will help you choose interventions, understand when interventions are not working, and understand why students behave as they do.

Cognitive conceptualizations of the students described in our introductory vignettes are presented throughout this chapter. In fact, you already started working with cognitive conceptualizations and beliefs with David in Chapter 1. Three levels of beliefs are described in detail in the following pages: core beliefs, intermediate beliefs, and automatic thoughts. Core beliefs and intermediate beliefs are students' underlying beliefs about the world and themselves as well as their beliefs about what they need to do to get by in the world. In the following pages, we will first describe core and intermediate beliefs separately, then show how they can be considered together as simply underlying beliefs. Next, we describe how automatic thoughts flow out of these underlying beliefs.

CORE BELIEFS

Core beliefs are the foundational beliefs that a child develops early in life. These beliefs set the stage for later beliefs and thoughts. Core beliefs can be hard to change and are directly related to each student's early childhood experiences. These beliefs about one's self can generally be funneled into one of two categories—beliefs about helplessness or unlovability (Beck, Wright, Newman, & Liese, 1993). For instance, a child who is repeatedly exposed to developmentally inappropriate tasks that are too difficult for her to deal with may develop the belief that she is helpless or incompetent. A child who is repeatedly pushed away in response to efforts for attention may develop the belief that he is unlovable. Alternatively, a child who has experiences of being successful and competent at many of the things she tries may develop a belief that she is capable of navigating the demands of her environment. A child who is accepted and loved is likely to develop the belief that he is lovable.

Many core beliefs may be shaped directly or indirectly by students' families, with effects that span across many generations. For example, consider a little girl who was raised in an abusive home. The violence that followed from anger in that home may have led that little girl to believe that anger is dangerous. She then exhibits a behavioral coping pattern of withdrawing from people expressing anger as a result of automatic thoughts like, "I am in danger!" when she sees her father's anger. Over time, as a way of protecting herself, she withdraws from anyone or any situation in which anger appears. When that child grows up and becomes a mother, she withdraws from her son when he becomes angry, even when that anger is appropriate and not dangerous. Her son observes his mother withdrawing from him whenever he shows anger, and develops the intermediate belief "If I show anger, then people won't love me." In this way, beliefs can be unintentionally passed across generations, taking different forms as they are passed along. When the beliefs of other family members are also added to this mix (a father who believes that anger should be shown as part of discipline, an aunt who reacts to anger with greater anger, etc.), belief systems can become very complicated and very deeply embedded in our personalities.

Other beliefs that originate in childhood are not necessarily passed from one generation to another and are the result of experiences in the child's early life. Let's take a look at Michele for example, who had thoughts like, "No boy will ever truly care about me." As we try to build a cognitive conceptualization of Michele based on her history and the information we learned from her in early sessions, we may hypothesize that those thoughts come from a core belief that she is unlovable and relate to an intermediate belief that sex is the only thing she has to offer others. These beliefs were the result of sexual abuse experiences that were perpetrated by a nonfamily member in childhood, rather than necessarily being a belief system that was passed on from previous generations. Of course, her family may also have beliefs related to sexuality and abuse, but her experience of being abused may have been the biggest factor in Michele developing these beliefs.

Just like automatic thoughts and intermediate beliefs, core beliefs can be (1) true and helpful, (2) true but not very helpful, or (3) untrue. A long-term goal in therapy is to build up and strengthen helpful core beliefs, and to reduce or modify unhelpful ones. Because core beliefs are so deeply ingrained in students (as they are in any other person), and because they are so rigidly and absolutely believed, modifying core beliefs can be a long process. We explore ways to work on changing core beliefs in Chapters 3 and 4 on interventions. Through this discussion, are you beginning to see how early experiences relate to core beliefs which, in turn, affect the way students think about and interact with the world around them?

INTERMEDIATE BELIEFS

Intermediate beliefs are the (usually unexpressed) rules, as a student perceives them, for how the world functions (Beck et al., 1979). As a clinician, you may find it helpful to think of core beliefs as students' "truths" about the world and themselves and intermediate beliefs as the "rules" that they believe exist as a way to deal with their "truths." Those rules then guide the students as they try to navigate the events around them.

Intermediate beliefs are midlevel beliefs that lie just underneath automatic thoughts. When you attempt to help a student become aware of his or her automatic thoughts, the pattern or common thread that emerges among those automatic thoughts will point to the student's intermediate beliefs. Intermediate beliefs can be thought of as the student's internalized "rules" for how the world works. These rules are often framed as if–then statements, where the student believes that *if* one thing happens, *then* it will lead to a specific result (which may be positive or negative).

In the introduction to these concepts in Chapter 1, we looked at Michele's automatic thoughts and actions and started to make an educated guess about her intermediate beliefs. She thinks things like, "*If* I have sex with that boy, *then* it will mean that he likes me," and "*If* boys do not like me, *then* I am worthless." Based on those thoughts, we could take a good guess that she may believe that (1) her value as a young woman is based on approval from males, (2) having sex with males is a good way to get approval, and (3) having sex is a sign that she is not physically unattractive.

COMPENSATORY STRATEGIES

Based on the underlying beliefs that students have about others, the world, and themselves, they develop a set of compensatory strategies, or behaviors, that they use to deal with their underlying beliefs and then live according to the "rules" of their world. These compensatory strategies (Beck, 1995) are behaviors that are sometimes baffling to observe and may be very frustrating to deal with because they seem to work against logic. A key point to remember is that just because these behaviors may go against *your* logic (based on your own set of beliefs) does not mean that there is not logic behind the behavior. Often, when we are able to stop and understand how the world looks when seen through the student's eyes, the behaviors will make sense according to the student's underlying beliefs.

As we mentioned in Chapter 1, compensatory strategies usually fall into one of three categories: (1) maintaining strategies (support a core belief), (2) opposing strategies (ways of trying to prove that a core belief is wrong), and (3) avoiding strategies (ways in which the student tries to keep from triggering the core belief). Students may use more than one compensatory strategy to manage their core beliefs. For example, we looked at one of Michele's compensatory strategies in Chapter 1, as summarized in Figure 2.2.

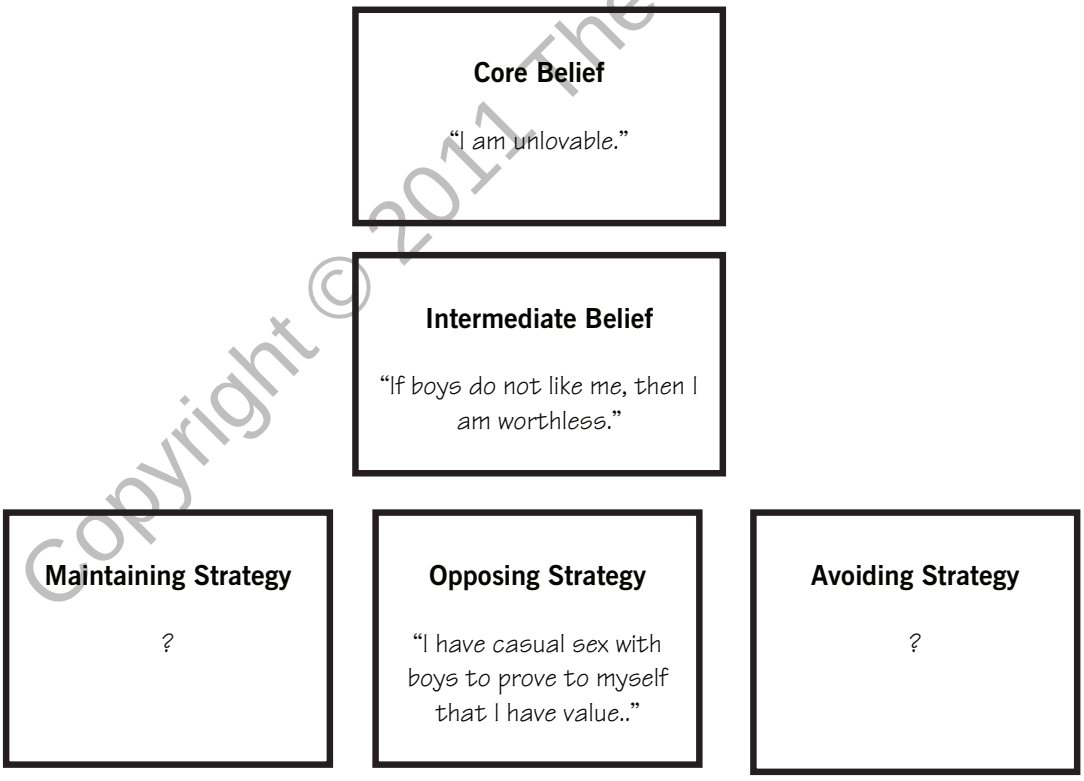

FIGURE 2.2. Michele's compensatory strategies.

Michele's opposing strategy had a significant flaw in it. When boys dismissed her after casual sex, she saw the rejection as a evidence that she is worthless, unlovable, and unattractive. Ultimately, her underlying beliefs about herself were being strengthened. What kind of maintaining and avoiding strategies might you see in Michele? How would these strategies, or behaviors, be likely to affect her beliefs?

Maintaining strategy: _____

_____

_____

How the maintaining strategy affects beliefs: _____

_____

_____

_____

Avoiding strategy: _____

_____

_____

How the avoiding strategy affects beliefs: _____

_____

_____

_____

As her clinician, you would help her watch for these and other behaviors that might seem to be at odds with what Michele really wants. Understanding how and why she uses these strategies, based on her underlying beliefs, can help to build a clearer sense of how Michele understands the world and why she acts as she does. Over time, cognitive counseling can focus on new strategies and interventions to deal with beliefs in a way that does not cause problems for the student or reinforce unhelpful beliefs.

A case conceptualization is an evolving picture of the student, representing your understanding of the student at a given point in counseling.

Take a moment now to look at Figure 2.3. This case conceptualization worksheet (based on Beck, 1995) lists the questions you will want to consider when identifying core and intermediate beliefs, so that you can start to understand your students. We strongly encourage you to use a case conceptualization diagram like this one (included in a reproducible Appendix 2.1 at the end of the book) for each student on your caseload. Case conceptu-

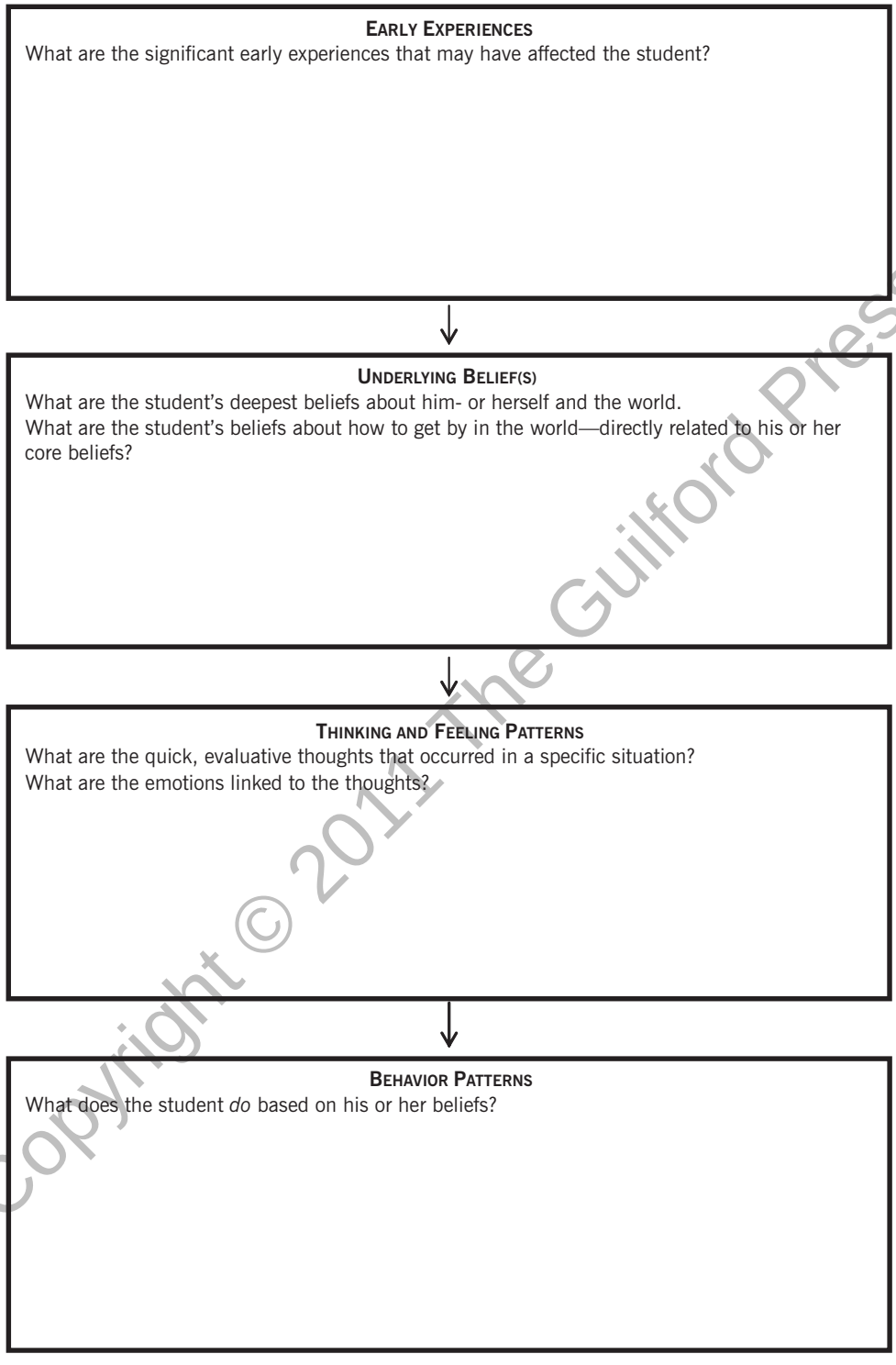

FIGURE 2.3. Michele's blank cognitive conceptualization (based on Beck, 1995).

alizations are expected to change over time, as you and the student learn more about the student's thoughts and beliefs and as those thoughts and beliefs change in counseling. After reviewing Michele's story in Chapter 1, think about how you would answer the questions in the blank cognitive conceptualization form (Figure 2.3). After you have filled in your preliminary cognitive conceptualization of Michele, look at our completed cognitive conceptualization (Figure 2.4) to check whether you are thinking along the same lines as we did about Michele.

SIMPLIFYING THE COGNITIVE CONCEPTUALIZATION

Our experience in high schools suggests that most clinicians will not have time to help all students understand the effect of their underlying beliefs. However, when treatment is anchored to changing underlying beliefs, attempting to explain the difference between

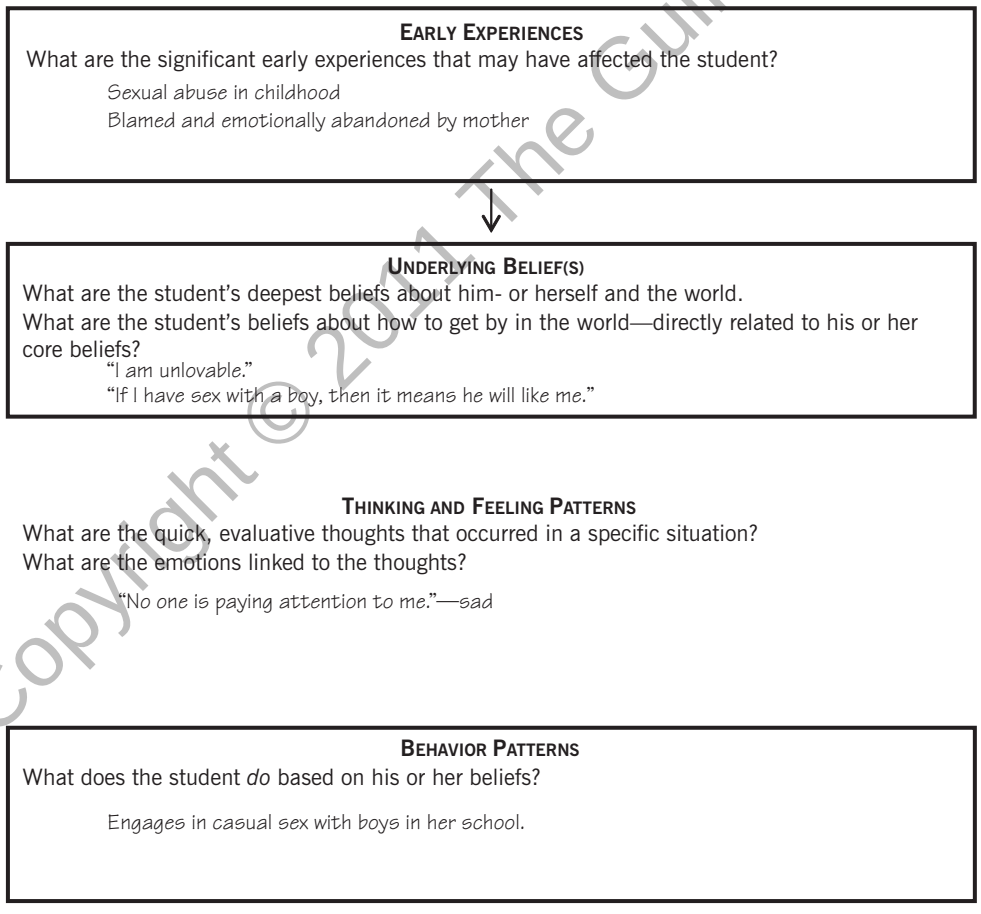

FIGURE 2.4. Michele's completed cognitive conceptualization.

FIGURE 2.5. Cognitive conceptualization presented to Michele.

Sharing the case conceptualization with the student is an important way to check in about the student's understanding of his or her own thoughts and beliefs.

students' intermediate and core beliefs to them is not always beneficial or necessary. As an effective cognitive clinician, it will be important for you to understand the difference between these concepts, even if you do not choose to explain the difference to students. As such, we explained core and intermediate beliefs separately so that you can understand their unique explanatory power. However, we encourage you to combine and describe them as underlying beliefs as you talk with students who are attempting to change these beliefs and to anchor their treatment to such change. The diagram in Figure 2.5 is a condensed cognitive conceptualization that we would share with Michele. Although having a more detailed cognitive conceptualization would still be important for treatment planning, the simplified diagram would be used to communicate the early experiences and underlying beliefs that are interfering with Michele meeting her goals in an easy-to-understand way.

In diagramming beliefs, we recommend that you have a full conceptualization written out prior to the session to mentally guide you as you fill in the underlying belief conceptualization with the student. The full cognitive conceptualization will be held in the back of your mind for guiding sessions and interventions, but will not necessarily be shown to the student. After you complete the diagram with the student, it will be important to compare what you have in your notes to what you and the student agree on. This will help you see

where you may need to make changes to your initial cognitive conceptualization hypothesis, and in some cases, also perceive what the students are struggling to see in themselves.

USING YOUR COGNITIVE CONCEPTUALIZATION

Your initial cognitive conceptualization of a student should be developed during the first three sessions with the student, and it should be viewed as a working hypothesis. This hypothesis or educated guess is continually questioned by the clinician in light of what the student brings to each session, and it is changed as the clinician and student learn more about how the student views the world and him- or herself. Over the course of therapy the cognitive conceptualization is also continually refined in light of changes that the student makes in his or her thinking patterns and underlying beliefs (Beck, 1995).

It is unlikely that changes will be made in a student's underlying beliefs in early sessions, before changes in behaviors and thinking patterns are continually demonstrated by the student. As such, most beginning sessions and counseling with high school students in general will focus on changing the thoughts and behaviors of the student. However, this does not mean that focusing on and changing thoughts and behaviors does not affect underlying beliefs. In fact, when your sessions are anchored to underlying belief change, this change will frequently occur as a result of the challenge to the thoughts and behaviors that are interwoven with underlying beliefs. The difference between counseling that is anchored to underlying beliefs rather than to behaviors and thinking patterns is that the student and clinician explicitly review the cognitive conceptualization and how changes in underlying beliefs affect the student. Regardless of what counseling is anchored to, as you and the student work together to find more accurate and helpful thoughts and behaviors, and as the student learns the skill of continuing to use these helpful thoughts and behaviors for themselves, an overall shift in core beliefs will occur.

Let's apply what we know so far to David, another student introduced in our vignettes. David grew up in a Southern Baptist household where gender-typical behaviors were valued and success in school and sports was used as a measuring stick for him and his brothers. David has had academic difficulties for as long as he can remember and was recently diagnosed with a learning disability. Contrary to his family norms, David refrained from participating in sports. David is also gay, which conflicts with his family's values. Now in high school, David has been attending classes less and less frequently. From other students you hear that David thinks that "everyone hates him," and that he believes that he does not fit in with his peers.

Before you read on, take a moment to reread the vignette of David and think about how you would initially make sense of him and how you would approach counseling. In doing this, try and incorporate as much of what you learned from the pages you already read. When you are finished describing how you would make sense of him and how you would approach counseling, take a shot at completing a preliminary cognitive conceptualization (see Figure 2.6).

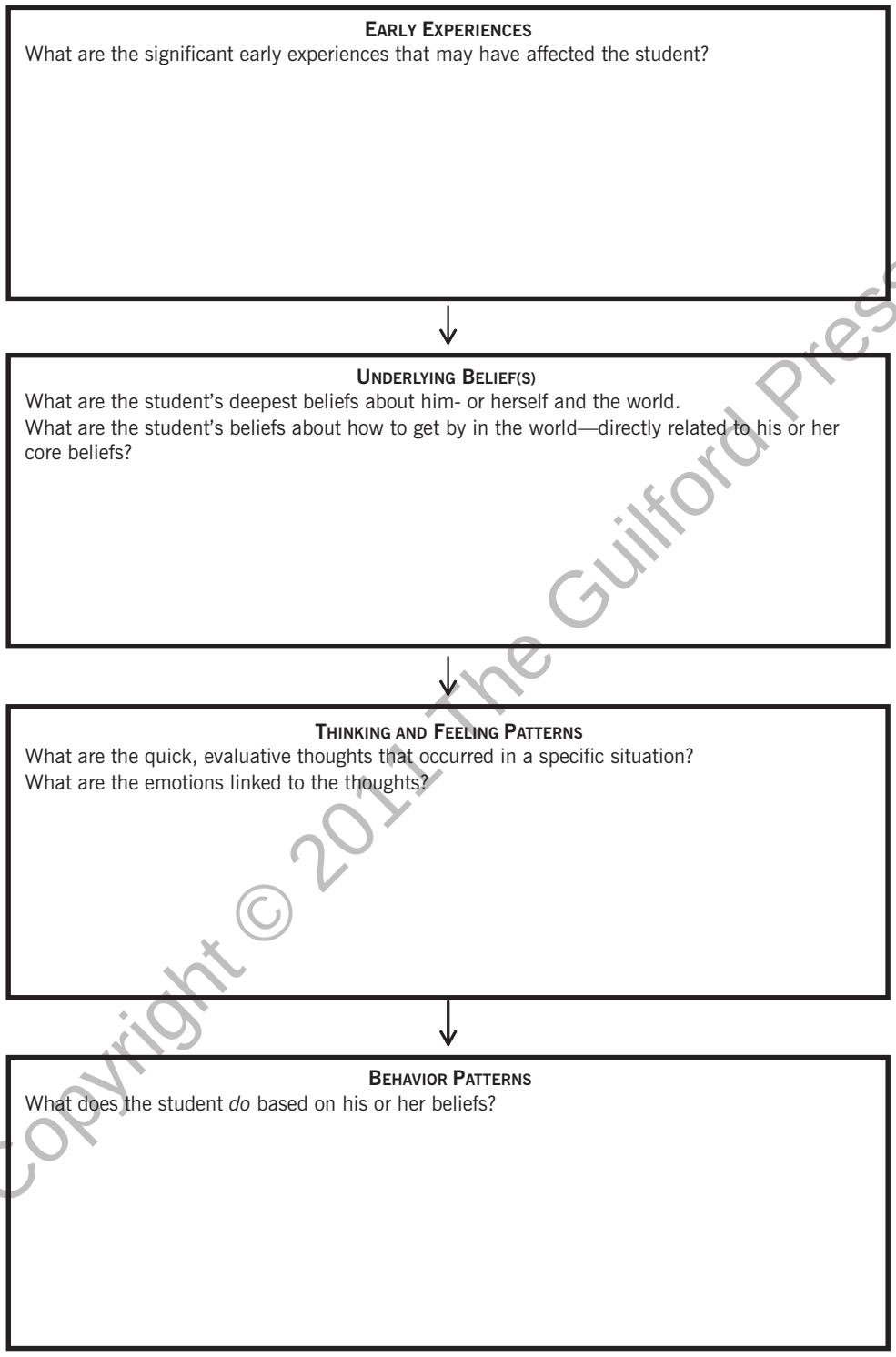

FIGURE 2.6. David's blank cognitive conceptualization (based on Beck, 1995).

How would you initially make sense of David and why he is having difficulties?

What information would you take into account when trying to understand David?

How would you help David address his psychological issues?

What do you think might or might not work for David in counseling?

After reading the following pages, take a look at your approach and preliminary cognitive conceptualization and consider the differences between your approach and conceptualization and ours. After meeting with David a couple of times, reading his file, and collecting background information from other school staff, we had a strong hypothesis about the underlying beliefs that David has about himself and how these beliefs are influencing him. David is probably not aware of his underlying beliefs, but his automatic thoughts will be fairly accessible upon talking to him in counseling. Some of the evidence for our hypotheses came when we saw a well-meaning fellow student provide David with constructive feedback in class. In this and other situations, we noticed that David interpreted constructive feedback as a negative, attack on himself.

Let's look at Figure 2.7, which considers core and intermediate beliefs separately. (A blank cognitive conceptualization form [based on J. S. Beck, 1995] is included in Appendix 2.1 at the end on the book for you to copy and use for formulating your conceptualization of students. Figure 2.7 presents the case conceptualization that we developed after Session 7. An earlier version of this diagram was presented in Chapter 1 (Figure 1.8), but as you will see, we have refined the case conceptualization as we have learned more about David. We conceptualized David as having core beliefs, such as "I am an idiot," which result from not being able to excel in the areas that his father associated with competency. Did you conceptualize something similar? Finally, we included the intermediate belief that "If I'm attracted to boys, then I'm messed up," which David acquired as a result of growing up in an environment with a father who stated that men who are attracted to men are "messed up." We are hoping that you included similar information in the early experiences and intermediate belief sections of your cognitive conceptualization.

The case conceptualization in Figure 2.7 was based on the information gathered by the clinician from conversations with David, information gleaned from other staff members in the school, and case notes acquired from his previous clinician. Some of the information in the case conceptualization may accurately describe David's true thoughts and beliefs, but it is likely that the clinician completing the form also made some mistakes. After all, clinicians are not mind readers, so clinical judgment was used to make the informed guesses (working hypotheses) that led to his developing cognitive conceptualization.

As David and his clinician work together over time, the clinician may discover new factors that should be included in the conceptualization or fine-tune components that are already there. These changes are an expected part of working with a student and, over time, the conceptualization should evolve as a better and better representation of the clinician's

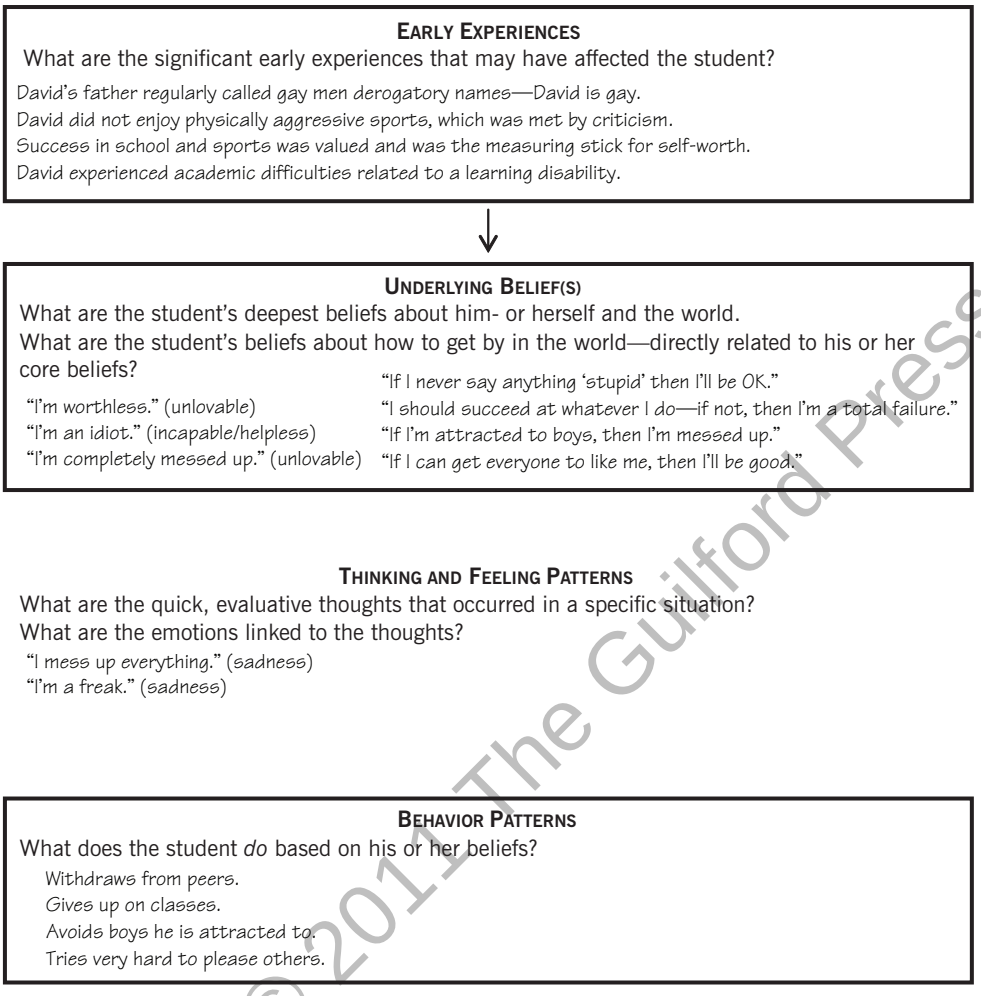

FIGURE 2.7. David's completed cognitive conceptualization.

understanding of the student. If sessions are anchored to underlying beliefs, David and his clinician could refer back to their modified cognitive conceptualization as a framework for understanding David's reactions to new and ongoing situations.

AUTOMATIC THOUGHTS: SHEDDING LIGHT ON UNDERLYING BELIEFS

As noted in Chapter 1, automatic thoughts are thoughts that lie in the stream of conscious processing. Although most of this chapter described the underlying beliefs from which the automatic thoughts flow, challenging and modifying automatic thoughts will be the primary focus of your work with most high school students. To understand how automatic thoughts relate to core and intermediate beliefs, see Figure 2.8.

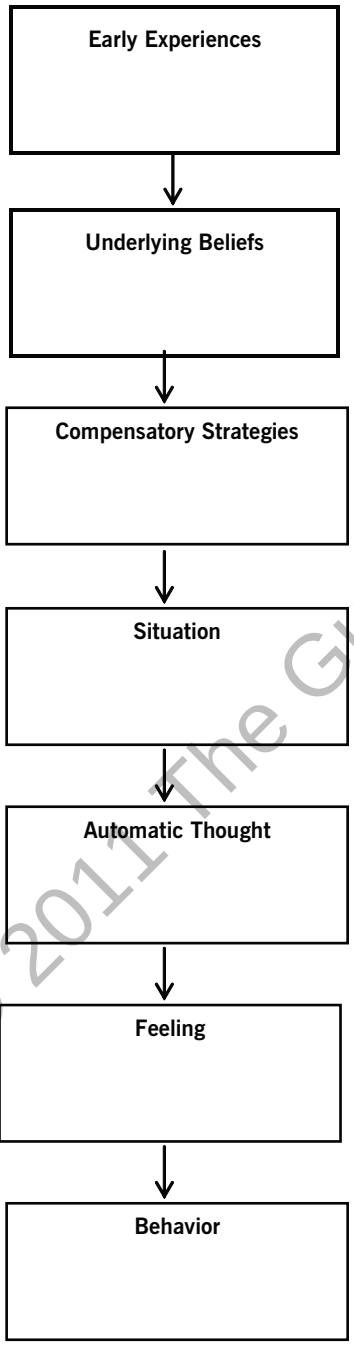

FIGURE 2.8. Cognitive conceptualization affecting automatic thoughts.

Figure 2.8 shows how underlying beliefs influence the way that students think about their situations. With students whose sessions are anchored to changing underling beliefs, the diagram can be helpful in showing them how their thoughts relate to their underlying beliefs, guiding them through examples from their lives. The following narrative presents a clinician attempting to explain to David how his underlying beliefs may relate to his problems, and it takes place in the 10th counseling session. Please note that in a real counseling session, it is unlikely that the conversation would move this quickly or that the student would give such "ideal" answers. However, in the interest of showing how a clinician and student can work together to understand how beliefs play out in a student's life, we present the following simplified narrative. In a real session, your goal would be for the student to reach the same kinds of conclusions, but the process may be slower.

CLINICIAN: David, we have been meeting for a few weeks now, and I'm noticing some patterns. Yesterday, when your friend Jimmy said that you seemed "off" during play practice, you felt pretty bad and left practice early.

DAVID: Yeah, I felt horrible. I said to myself, "I completely mess up everything I do."

CLINICIAN: I get the sense you were really hurt, and I like that you were able to identify the thought that went with that feeling—"I mess up everything I do." I'm noticing a pattern where you get down on yourself pretty quickly. You have even left school a couple times after doing poorly on schoolwork. After we talked about those times you've remembered having thoughts like "I'm an idiot," or "It's no use trying," go through your head.

DAVID: I know . . . this happens to me all the time.

CLINICIAN: Yeah, you get down on yourself and focus in on one comment or grade and forget the fact that you are doing well in many of your classes and have a lead role in the upcoming play. It must be really hard to have those negative thoughts so often.

DAVID: I don't know why I do that—but sometimes it feels like those other good things don't matter.

CLINICIAN: Let's look at your patterns together and see if we can come up with something. Let me explain how I am beginning to understand you, and then you tell me if you think I am getting it or I'm missing it, OK?

DAVID: OK.

CLINICIAN: I would appreciate that. Growing up, your family, especially your dad, seemed to approve of you only when you were doing well in school or being a "guy's guy."

DAVID: Yeah, but I didn't always do well in school and I'm not a guy's guy . . . it seems like I'm always trying for that and falling short.

CLINICIAN: I'm sure that has been really hard to have your skills and abilities not line up with what your dad valued.

DAVID: Yeah.

CLINICIAN: It seems like you were led to believe that the only way to be worthwhile or effective was to be a great athlete or student.

DAVID: Yeah, but I was an actor and a so-so student, and I always felt like I was messed up or an idiot.

CLINICIAN: I think those statements may be some of those underlying beliefs that get triggered when you are at your lower points.

DAVID: Yeah.

CLINICIAN: I have also noticed that you have some beliefs like "Everyone should like me," and "I should be good at everything I do."

DAVID: Yep, my friends keep telling me that it's OK that everyone won't like me—no one is liked by everybody—and Mr. Kuse keeps telling me that every practice can't be a perfect practice. I think they just feel bad for me, though.

CLINICIAN: So, let's take a look at this diagram. It has boxes for us to list the experiences and underlying beliefs that relate to one another and the resulting thoughts you have when you feel bad. (*Shows Figure 2.9 to David.*)

The clinician would then collaboratively diagram out early experiences and underlying beliefs and show how they result in automatic thoughts as indicated in the previous conceptualization. This cognitive conceptualization was created collaboratively, with the clinician drawing as much information from David as possible, while helping David to figure out its placement in the different sections of the diagram. While doing so, the clinician would

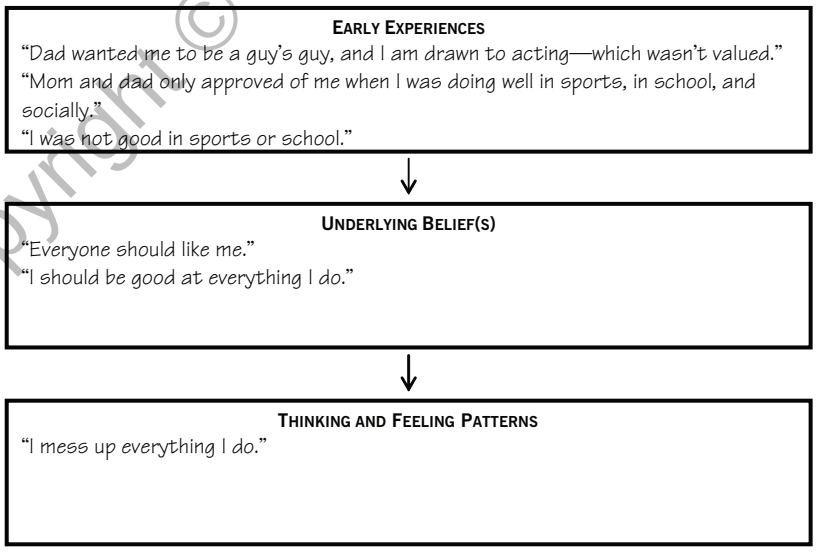

FIGURE 2.9. Counseling with David.

continually check with David to see if what they are writing makes sense to him, and if any of it may be wrong.

CLINICIAN: Now that we have this drawn out, is there anything that we should add to or take out of the diagram? I want to make sure that I am not getting anything wrong or putting words into your mouth.

DAVID: No, this actually makes sense.

CLINICIAN: So can you see how, when someone says you had a bad practice or expresses something negative, that you make meaning out of it in a way that brings you back to negative beliefs about yourself?

DAVID: Yeah, it's not always me, sometimes it's just the way I am making sense of it . . . making sense of it in a negative way.

Once again, anything David does not agree with should be explored, so that the evolving conceptualization feels like a fit for him. This helps to ensure that the diagram is correct and that it is understood by the student. When working with students like David who have their treatment anchored to underlying beliefs in addition to thoughts and behaviors, this diagram should be referenced and updated when problems arise in future sessions so that the diagram becomes more accurate and nuanced and students become more aware of why they react as they do.

When working with students who do not have their treatment plan anchored to their underlying beliefs, you will still fill out a full cognitive conceptualization, but this cognitive conceptualization will not necessarily be presented to these students. Instead, it will be used to help you think about why students are or are not making progress toward their goals and what interventions and approach you should use in counseling. If you were doing this with David, you would still create a cognitive conceptualization of him, and this would help you understand why he is engaging in some of the thinking traps introduced in Chapter 1 as well as why he finds it difficult to change particular thinking patterns. The direction of treatment and the interventions you choose will be guided by your conceptualization, so that you can change the patterns that are getting in the way of his meeting his goals.

COGNITIVE CONCEPTUALIZATION, TREATMENT ANCHORS, AND THE PRESESSION QUICK SHEET

You may not have the time to focus on changing underlying beliefs with many of your students. Counseling sessions in a high school are usually shorter than the traditional weekly 50 minute hour in outpatient settings, and high school students frequently come to the clinician's office immediately after they experience a problem that they are hoping the clinician can address. This context sets the stage for counseling that is anchored to patterns and/or underlying beliefs while simultaneously allowing the clinician to address the immediate concerns of the student.

In our experience, students often come to the clinician's office because of an immediate problem they are having, like fighting with their parents, academic difficulties, conflict with peers, and so on. These problems are frequently seen by the student to have end-of-the-world consequences. Students seek help to make these problems go away, and while this may be one of your immediate goals, you can facilitate longer lasting positive change by helping students see how their current problems relate to their behavior patterns, thinking patterns, and in some cases, underlying beliefs. For instance, when a student routinely shows up at your door with academic difficulties caused by a tendency to avoid stressful or challenging situations, you may focus on thoughts or avoidance behaviors, while simultaneously addressing the immediate concern. This method addresses the immediate issue while also helping the student understand the "what and why" that underlies the pattern of problems.

With some students who are less invested in therapy, younger, or lower functioning, you may want to focus only on their thinking and behavior patterns, but with higher functioning students you may be able to address their behavior, thinking patterns, and underlying beliefs. This approach will help you move from "putting out fires" to modeling how students can understand and address difficulties so that they are equipped to "put out their own fires" in the future. While this method may slow down the problem-solving process initially for the clinician and student, it decreases the demand on counseling in the long term. This understanding, coupled with being taught cognitive strategies, will eventually help students internalize the understanding that they have the tools to address their difficulties with limited or no need for clinician support. Strategies for identifying and changing thinking patterns and underlying beliefs are described in Chapter 3 and strategies for changing behavior patterns are presented in Chapter 4.

To help students understand the thinking and behavior patterns that are related to their problems and serve as the "anchor" for their treatment plan, we recommend asking students to fill out a Presession Quick Sheet (see Figure 2.10). The Quick Sheet, which will be discussed further in Chapter 5, can be completed quickly in the moments after a student arrives to see you. This worksheet requires the student to stop and reflect on the behaviors, feelings, and thinking patterns that relate to the current situation as well as to apply techniques learned in previous sessions. Having students think through the Quick Sheet questions before the sessions reinforces both their ability to apply already learned CT concepts and the active role they can play in addressing their problems. In an effort to begin understanding the Quick Sheet and how it can help students take an active role in addressing the problems (treatment anchors) that are interfering with their meeting their goals, take a moment to reference the one that Alfred created and its relationship to the work that he and his clinician are doing together. (See Figure 2.10.) This Quick Sheet was created by Alfred prior to Session 9, when Alfred presents with a recurring problem of fighting with peers. A reproducible Presession Quick Sheet can be found in Appendix 2.2 at the end of the book.

The Presession Quick Sheet helps students to reflect on thought, feeling, and behavior patterns and on acquired skills.

In working with Alfred for a few months, the clinician noted that Alfred continually writes on his Quick Sheet automatic thoughts like "I've gotta take this guy out." After

Today I want to talk about:
Keith tried to come at me in the hallway today.

I am feeling:
Happy
Angry
Sad
Worried
Excited
Embarrassed
Guilty
Relaxed
Other

Intensity of feeling:
Highest
10
9
8
7
6
5
4
3
2
1
Lowest

What I'm thinking about it is:
I gotta take Keith out if he thinks he can do this to me.

My best way to deal with it is:
Not sure. I want to take him out, but I know you're gonna say that I should just ignore it or something.

Things I'm thinking about from our last meeting are:
Automatic thoughts—I don't think I have those.

I did _X_ did not _____ do my practice task.

FIGURE 2.10. Alfred's Presession Quick Sheet.

exploring this thought with Alfred, the clinician believes that this is actually related to an intermediate belief that can act as a treatment anchor. The clinician has a strong hunch/hypothesis that Alfred has both an underlying belief that the world is dangerous and an intermediate belief that the only way for him to stay safe is to attack before he is attacked. Alfred's beliefs were true in many situations and helpful when he was younger and growing up in a dangerous neighborhood. Alfred's beliefs resulted in an aggressive behavior pattern that was reinforced by successes in street fights, in wrestling, and when protecting his brothers and sisters. However, his blanket view of the world as dangerous and aggressive response pattern is no longer working for him, nor is it particularly true when he is in school and around people who want to help him. Please keep in mind the Presession Quick Sheet in Figure 2.10 and how this plays an important role in the counseling presented in the following narrative.

CLINICIAN: Great work on your Quick Sheet, Alfred.

ALFRED: Thanks.

CLINICIAN: I noticed that you had another problem this week where you thought that people were trying to attack you before you really found out what was going on. It seems like that's happening a lot?

ALFRED: I guess. I don't exactly want to wait around to find out if someone's trying to fight me. It's better to just show them I can't be pushed around.

CLINICIAN: Yeah, I understand that thinking when I consider what has happened to you. In fact, I think that it relates to an underlying belief that relates to a lot of your difficulties.

ALFRED: Yeah, it gets me into a lot of trouble, but it's true.

CLINICIAN: Thank you for your honesty, and let's take a look at that statement. Have I ever tried to fight you?

ALFRED: No. I usually don't fight with teachers. It's the kids here that give me a hard time.

CLINICIAN: OK. How many kids at this school have you had a fight with?

ALFRED: Maybe 12.

CLINICIAN: Well, there are about 1,400 kids in this school. Twelve is a lot, but out of the whole school, that's less than 1% of the kids.

ALFRED: Fine. I guess it isn't everybody—just some people.

CLINICIAN: Exactly, but it seems like because of the experiences you had with people growing up, you assume that most people who you don't know will try to come after you and fight you. Does that make sense?

ALFRED: Yeah, but how do I tell which ones want to come at me? How do I know which ones aren't coming after me because they know I'm gonna fight back, and which ones I can ignore?

CLINICIAN: Great questions, and we can figure that out, but first I want to make sure that you understand why you do it. In doing so, we will be anchoring our sessions to understanding why you do it, which will lead to you being better at knowing who is coming at you and who you can trust. What results is your becoming your own clinician.

ALFRED: That would be cool—I like the sound of Dr. Alfred, and I hope Dr. Alfred will get back on the wrestling team and out of detention.

CLINICIAN: Sounds like great goals, Doc!

In the next session, the clinician and Alfred would write out on a cognitive conceptualization diagram the early experiences in Alfred's life that contributed to his seeing people the way he does. In doing so, the clinician should describe how it is natural for Alfred to

be hypervigilant and aggressive and how this behavior was protective for him because of where and how he grew up. The clinician should be careful to not discredit or challenge the fact that this behavior may still be protective in dangerous situations outside of school. After Alfred demonstrates that he understands how his underlying beliefs were influenced by his childhood, the clinician can help Alfred see how those beliefs are sometimes problematic with techniques like guided discovery (see Chapter 3).

As in any work with adolescents, it is particularly important to use examples that students can understand and/or identify with, and that give them an image to reference as they attempt to change their behaviors, thoughts, and underlying beliefs. Given Alfred's involvement in sports, the clinician may want to use sports figures who are very aggressive when playing or coaching sports, yet calm and collected when at meetings or talking to the press. The clinician will then explicitly review with Alfred how sessions will be anchored to underlying beliefs in addition to the thoughts and behaviors that they were previously targeting. After developing a cognitive conceptualization of Alfred with him, the clinician will also encourage Alfred to think about the role that his underlying beliefs play in daily problems on future Presession Quick Sheets prior to each session.

SUPPORTING EVIDENCE

Case conceptualization is, in essence, the way in which a CT clinician thinks about a student and chooses specific interventions for specific recurring concerns. The use and development of the case conceptualization is based on CT, and research to test the utility of this way of thinking would be very difficult to do. To determine whether case conceptualization is, itself, an empirically supported technique, researchers would compare cognitive therapy, done with or without a case conceptualization, to measure whether the presence of the case conceptualization made a difference in the outcomes of therapy. However, CT without a case conceptualization would not be CT! Instead, the overall therapy is empirically supported (as we described in Chapter 1).

If you would like to read more about the details of case conceptualization and the ways in which is guides a CT clinician's therapeutic choices, we recommend:

- Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford Press. This text, written by the director of the Beck Institute for Cognitive Therapy and Research, is an excellent resource for a strong foundational understanding of case conceptualization and is written in a way that readers generally find easy to apply to their cases.

SUMMARY AND FURTHER THOUGHTS

This chapter presented a lot of information about how clinicians can make sense of the students with whom they are working. It began with a brief introduction to the cognitive

model that places an emphasis on the thoughts that relate to what students do and how they feel. These thoughts are influenced by the underlying beliefs of the student, which are diagrammed with a cognitive conceptualization. Having a cognitive conceptualization of the students underlying beliefs allows the clinician to understand why students do what they do. When a student's treatment is anchored to underlying beliefs, the student, too, will see the role underlying beliefs play in the way they think, behave, and feel.

The cognitive conceptualization was divided into core beliefs, intermediate beliefs, and automatic thoughts, which will help you map out and understand your students. However, because of the complexity of this method, we suggest that you condense intermediate and core beliefs into underlying beliefs when discussing cognitive conceptualizations with students. With lower functioning students, younger students, or students who are reluctant to delve into themselves, or when faced with time constraints, you may want to anchor your sessions to the thinking and behavior patterns that are explained by your cognitive conceptualization. Counseling that is initially anchored to addressing thoughts and behaviors can be anchored to underlying beliefs in later sessions if it is clinically indicated, and the student and clinician will establish a cognitive conceptualization at that time. Regardless of whether you are anchoring counseling to underlying beliefs, the cognitive conceptualization will serve as an important framework for understanding and empathizing with each student, choosing the most effective techniques, and understanding why students are or are not making progress in counseling.

READER ACTIVITY: COGNITIVE CONCEPTUALIZATION

In thinking about the concepts in the first two chapters of this book, consider which aspects of the cognitive model are consistent or inconsistent with how you made sense of your students prior to reading this book. We also invite you to conceptualize yourself with a cognitive conceptualization. You can use Figure 2.11, Appendix 2.1, or your own sheet of paper. After you complete a cognitive conceptualization of yourself, we ask that you complete the following questions. Try not to read the questions until after you have completed your cognitive conceptualization.

What automatic thoughts and emotions occurred within you as you completed your cognitive conceptualization?

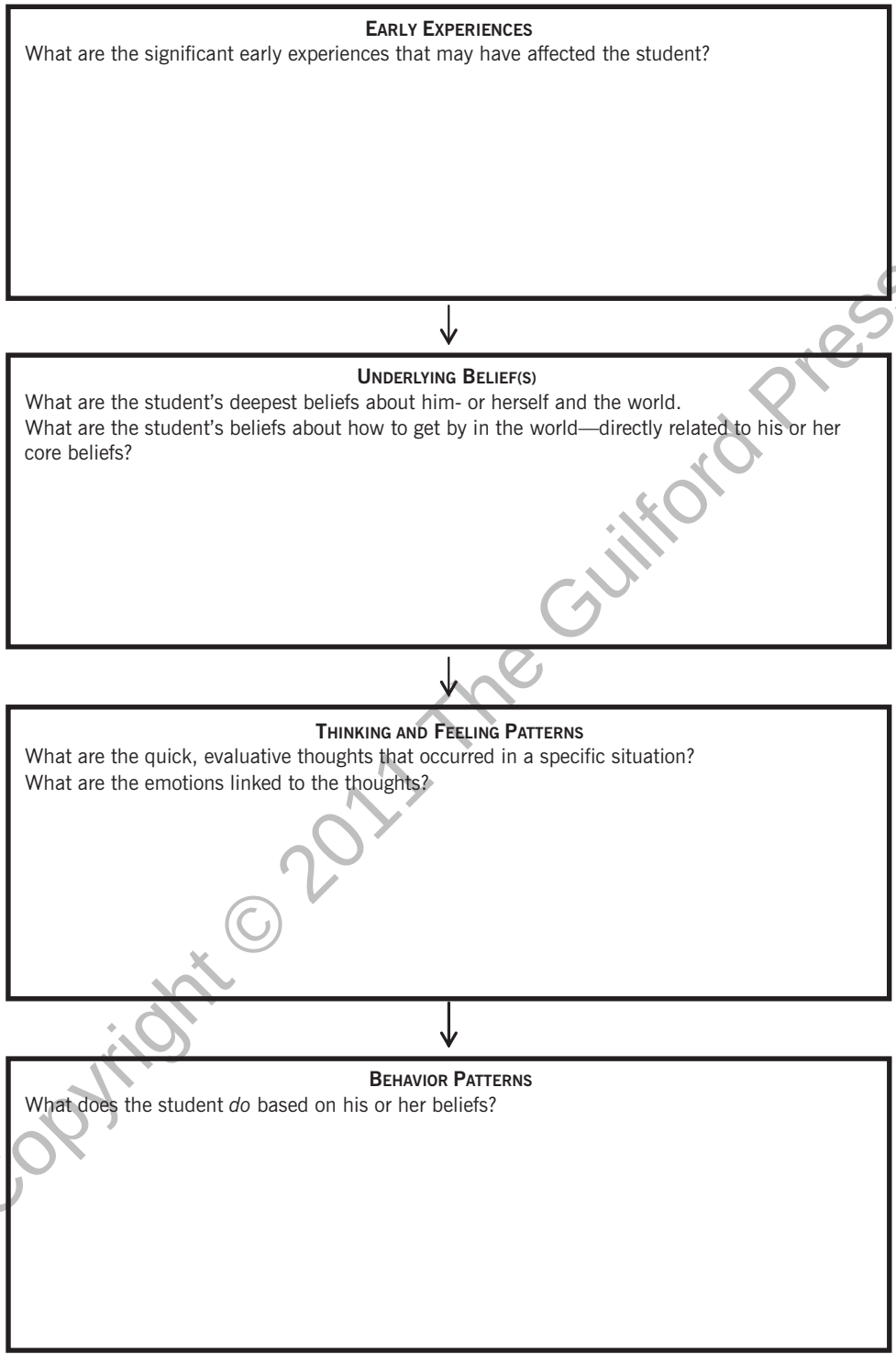

FIGURE 2.11. Clinician's cognitive conceptualization.

We frequently find that this can be a difficult task for clinicians and students alike and hope that completing your cognitive conceptualization will help you empathize with the process that you will be taking your students through and the shame, anger, sadness, and other feelings, that can coincide with this self-reflective act.

What surprised you about yourself when you completed your cognitive conceptualization?

How may your understanding of yourself and your early experiences impact your counseling?

We have found that clinicians' experiences influence the way they conceptualize their students. For example, beginning CT clinicians may have an unconscious tendency to conceptualize their students in a way that parallels their own experiences and conceptualization. If you find that this is the case or if many of your students have similar conceptualizations, review them again and make sure that you are not making hypotheses that are based on your own experiences or automatic thoughts. Instead, you will want to make sure that your student conceptualizations are a reflection of what each unique student brings to sessions—the data that spurs your hypotheses.

If you were to enter your own counseling, how would having this cognitive conceptualization influence counseling, and would it be useful?