Capstone Project: Theoretical Framework for Ethical and Effective Counseling

Hope V. Charles

Department of Counselor Education and Family Studies, Liberty University

Author Note

Correspondence concerning this paper should be addressed to Hope V. Charles, Department of Counselor Education and Family Studies, Liberty University, 1971 University Boulevard Lynchburg, VA 24515. Email: hvcharles@liberty.edu

Abstract

It is essential that individuals whose chosen career is in the Mental Health space have a firm foundation and understanding of the field. This paper will present my theoretical framework for guiding an adult client through their personal counseling journey. This will provide the reader with my personal theories of choice that I choose to apply in counseling, to include Person Centered Therapy and Gestalt Therapy. I will also take a deep dive into the comprehensive methodology used in applying the biopsychosocial, multicultural, and spiritual assessments. These assessments will give further insight into understanding the nature of the client. I will explain my case conceptualization process in which I use the Inverted Pyramid Method, to identify client concerns, identify the reoccurring themes, and develop a treatment plan. Lastly, I will establish a method for enforcing an effective aftercare process once sessions have concluded.

Keywords: Person Centered Therapy, Gestalt Therapy, Inverted Pyramid Method, Diagnosis, and Treatment planning

Feedback Provided by Faculty Member on First Paper (Student must list every element of feedback given)		**How I Applied the Feedback in Paper Two (Student must have corrected every element of feedback given)**
1.	Per APA, the running head is unbolded.	Corrected running head to reflect APA-7 format.
2.	Please correct the spacing so that the after spacing is set at 0 and not 8 pt. The paragraph option is under the Format tab.	Corrected the after spacing to 0 and not 8 pt.
3.	Please revise passive voice. For example, here where you wrote “I will pull information” using active voice is: “I pull.”	Corrected all passive voice throughout the entire paper.
4.	Please go through the entire paper and wherever you can, revise passive voice to active voice.	Corrected all passive voice throughout the entire paper.
5.	For your final paper, please correct so you cite this in APA-7 format.	Added “et al.,” to citable units with three or more authors.
6.	Please correct multiple author citations to APA-7 for the final paper.	Added “et al.,” to citable units with three or more authors.

Capstone Project: Theoretical Framework for Ethical and Effective Counseling

The goal of counseling is to help our clients to overcome the complications that they will face in the world they live in (Murdock, 2017). The method in which clinicians use to help their clients will vary from clinician to clinician. Ultimately, the hope is that the clinician is well trained and well versed in the various theories and interventions available to them, to further aid their clients into a successful, thriving future. The theories that a clinician uses will vary and may be altered depending on the needs of the client. The theoretic approach used, will typically guide the clinician, and speak volumes, as it pertains to their personal worldviews, and lens from which they see their ability to aid in sessions. I have found that I gravitate to the Person-Centered Therapy, as well as the Gestalt Therapeutic approaches.

Person-Centered Therapy (PCT)

Person-Centered Therapy was founded by Carl Rogers, who is revered as being the Father of Psychotherapy (Jones & Butman, 2011). Rogers adopted the belief that the client was the expert and had all they needed to disregard the hindrances that stood in their way. Since the client is believed to be the expert, the clinician tends to adopt the worldview of the client, not in life, just in session with the client (Quinn, 2013). Having the ability to use bracketing and take on the worldview of another person (Remley & Herlihy, 2020), especially should it conflict with your own can cause internal struggle. It is for this reason that I refer to the goal of counseling; to help our clients to overcome the complications that *they* will face in the world they live in.

Gestalt Therapy (GT)

In Gestalt Therapy there is an underlining focus on understanding how the parts of a being is in correlation with the whole being (Bourgault du Coudray, 2020). It is furthermore believed that persons are communal and impact other people and their environment (Böhm,

2021). Gestalt Therapy is ideal for helping clients tackling the turmoil and internal conflict centered around unmet needs and unfinished business (Neukrug, 2021). By flushing out these unmet, unfulfilled dreams, I assist the client in identifying the attributes that are missing in the present, to create a space where they can thrive and finally feel fulfilled.

Comprehensive Method of Bio-psycho-social/cultural/spiritual Assessment

When I first meet with a client there is a large array of data that is being provided by the client, and I, as the clinician need to assess and sift through the details being provided to gather pertinent information. But why am I gathering this information? During the initial intake interview my goal is threefold: 1) To walk away with a firm understanding of the presenting problem that brings the client to therapy. 2) Gain pertinent history about the client that speaks to the onset of the problem. 3) And lastly, their ability to navigate life with their presenting problem (Sommers-Flanagan & Sommers-Flanagan, 2017).

I find that the best way to gather the required information is through a semi-structured interview. Upon completing their initial intake form, a battery of questions is reviewed with the client, to evaluate their Biopsychosocial/ Cultural/ Spiritual well-being. The following are items I assess for during this stage of the therapeutic relationship.

Biological Assessment

When I assess a client and their biological features, one of the first vital pieces of information I need to know is whether they are up to date on their yearly Physical Examinations. Whether they have a primary care physician will let me know if they are keeping people aware of their physical well-being. Their exercise routine and whether they have one, gives insight into matters of health, strength, and discipline. Questions centered around surgeries, hospitalizations, medications, and substance use are also asked during this time. It is crucial I am aware of

substances, legal and otherwise used that could impact their mental well-being. Finally, their nutrition, sleep patterns, and appetite are also discussed to ensure they align within reasonable standards. Since many of these items are typically covered during the intake interview, I review the client's intake paperwork and dialog with them further on the details behind specific questions (Sommers-Flanagan & Sommers-Flanagan, 2017).

Psychological Assessment

To continue to gauge the clients current state, I move into examining their psychological well-being. This is crucial since their psychological state can have both a direct and indirect effect on them. It could also exacerbate the presenting problem that brought them into counseling. I continue to review their intake paperwork, which provides a thorough account of their mental health, but depending on their responses, I offer a Risk assessment, should they report any suicidal ideations, or previous suicide attempts.

Another wonderful tool available to clinicians are the DSM-5-TR Self-Rated Level 1 Cross Cutting Symptoms Assessment. This tool allows the client to self-assess themselves, through a series of questions, where they rate the severity (American Psychiatric Association, 2022). This is helpful since it provides insight over various realms to include intrusive thoughts, anxiety, depression, and anger. Depending on their responses, additional assessments may be necessary, to include, but not limited to: VAMC SLUMS Exam (SLUMS), to assess their cognitive ability, Millon Clinical Multiaxial Inventory-IV (MCMI-IV), to assess for symptoms of personality disorders, or the Buss Perry Aggression Questionnaire, to test for aggression.

Social Assessment

For the social assessment, I pull information from various facets of the client's life. First, I ask questions pertaining to their family history. Learning the family dynamic gives a glimpse

into both the history, and at times, the onset of some of the client's deepest-rooted traumas. Depending on the family, I ask to do a Genogram with the client, to further assess the patterns and internal family issues (McGoldrick, et al., 2020). I ask about the social circle of the client and how large or small the circle is. Obtaining a realistic view of the support systems helps me assess if the client has additional support should things progress in the therapeutic process. Recently, I started having the client create a life map to point out significant times and occurrences within their lives. This is a great way of drilling down to find the onset of some of the concerns that they've now tackling.

Multicultural / Spiritual Assessment

Our ethnic background, religious beliefs, and even social class speaks to the cultural identity (McGoldrick, et al., 2005). Being cognizant of the therapeutic approach that works best for a client, culturally, is being abreast of their needs at a deeper level (Glauser & Bozarth, 2001). To truly embrace the Person-Centered therapeutic approach and adopt the worldview of the client for a greater sense of empathy, it starts with understanding their culture and how it shapes and forms them as a person.

While some clients do not have a spiritual belief system that they subscribe to, others do. They may or may not want to incorporate these systems into counseling. It is paramount that I practice bracketing and ensure I adhere to the ACA Code of Ethics whether they assert to use religious practices or not (American Counseling Association, 2014). I keep my personal beliefs out of the session and allow them to explore their own is essential. Though my beliefs are a part of my makeup, and show up with me in session, I reframe from sharing them and allow the client the space they need to use their own spirituality, as they desire.

Case Conceptualization

After I fully assess the clients Biopsychosocial/ Cultural/ Spiritual well-being, I take the data that I have gathered and strategize a means of treating the client. This is done through case conceptualization. This is the means used to help the clinician fully grasp the concerns of the client. By identifying the themes, and the symptoms they create a treatment plan is created to tackle underlying distortion (Schwitzer,1997).

Inverted Pyramid Method

I use of Inverted Pyramid Method (IPM) when I create a case conceptualization for clients. The IPM provides a top-down visualization of the presenting problem. I drill down to the inner most, underlying thoughts that are creating the behaviors in question. The IPM accomplishes case conceptualization in four main steps: 1) Establish the client's presenting criteria. 2) Break down the presenting criteria into organized themes. 3) Organize themes diagnostically from a therapeutic approach. 4) Drill theme down to the fundamental area of distortion.

DSM-5-TR Diagnosis Process

After I look at the presenting problems, repeating themes, and core distortion, I assess the connections in the data provided by the client (Hebert, 2005). The presenting criteria lends itself to the diagnostic disorder that is associated with the symptoms the client is experiencing (American Psychiatric Association, 2022). Using the DSM-5-TR to drill down these symptoms, I find the disorder, though it takes time and thorough care to ensure the proper disorder is diagnosed. Ruling out any differential diagnosis is critical during this stage of the process. Additional consultation from Supervisors is crucial during this phase. Finally, ensuring the client knows that they are not their diagnosis, is the start of their treatment plan.

Treatment Planning Process

Using the Case Conceptualization to see the behaviors, thinking patterns, and distortions needing to be tackled is where the treatment plan takes shape. Resources like Jongsma, Peterson, and Bruce, The Complete Adult Psychotherapy Treatment Planner (Jongsma, et al., 2014) provides a framework to the various SMART goals we establish for the client. It is a collaborative effort between the client and myself to ensure I have their buy in for the goals set forth for their treatment. Their buy in is also essential to ensure there is not reliance on the counselor, but on self, once goals are accomplished (Beutler, et al., 2003).

Method of Outcomes Assessment During the Treatment Phase

The risk of premature termination of a client is a daunting concern for many novice and seasoned clinicians. To ensure I reframe from making this mistake, I adopt a practice of offering short term treatment goals and homework during the first session, at the intake interview (Hatchett, et al., 2002). Depending on the severity of the diagnosis, earlier goals are recognized to ensure the client has a reasonable length of time to practice the goals established. Follow up assessments and retest on various Psychological Assessments also serve as a good rule of thumb to ensure the client is accomplishing the treatment goals set forth (Allen, et al., 2009).

Aftercare/Maintenance Planning Process

Providing the client with a well thought out, thorough course of attention for their aftercare needs is crucial for their sustainable success. Providing a written-out plan, key take-a-ways, and resources ensures the client will not have to rely on their memory for lessons learned during sessions (Kisely, et al., 2017). Also, just because individual therapy has concluded, does not mean further therapy isn't still an option. Providing additional resources like, family

therapist, group therapy, and local vocational resources prove to be an additional benefit for the client's long term maintenance care (Lurie & Ron,1972).

Case Study

The following case study will describe a fictitious adult client, by the name of Stephanie. The material surrounding Stephanie's history is to meet the needs of this assignment. The data described will give insight into my counseling methods from the onset of our therapeutic relationship until her termination.

Background Information

Stephanie is a 26-year-old black female, who identifies as heterosexual. She is unmarried but has been in a committed relationship for a year. Stephanie was born in Alabama, where her family still lives, but moved away after college. Stephanie lives in the Central Florida area. Stephanie works in the medical field and has gone back to school to obtain her nursing degree. She has another year of her program before she graduates. Stephanie admittedly puts a great deal of pressure on herself to do well in school to give her little sister something to strive for. Stephanie has stated that this is her role as the big sister.

Stephanie was in counseling in the past, for a year. At that time, she was diagnosed with Generalized Anxiety Disorder. She reports the counseling was helpful, but when she was terminated, she never returned for further checkup appointments after her termination.

Presenting Problem

Stephanie requested to go to counseling and was referred to me after finding our practice on PsychologyToday.com. She reportedly wanted a counselor with her ethnic background, which is Black American, so the office assigned her to me. Upon arriving at the office, Stephanie was given an Intake packet to fill out. This paperwork included details surrounding her

Biopsychosocial and Spiritual History. It also inquired about her family history and concluded with a self-rated assessment that rated various emotions on a 5-Point Likert Scale with a range of: Never, Less than Monthly, Monthly, Weekly, and Daily.

Stephanie reported having concerns surrounding her excessive anxiety, her relationship, and anger management. Stephanie stated that she had been fighting with her partner and her friends due to her reportedly controlling behavior. She reported they stated she was closed off to them and they only knew what she wanted them to know about her. She stated she always had to fix their problems and needed help in being able to share with them who she truly was.

Stephanie's Counseling Narrative

Stephanie's Intake Interview session presented Stephanie as very open and willing to share. She reportedly experienced racing thoughts, wondering about my feelings concerning the answers she was providing during her intake. She reported having no suicidal or homicidal thoughts, in the past or present. She also reported having no hallucinations or reports of hearing voices that were not there. She reported that birth control was the only medication that she was taking and that she only drank socially with friends on the weekends. She reported no drug and narcotic usage.

Observational Data

During our intake interview Stephanie was oriented on the current place, time, and situation. Stephanie was very well groomed. I noted that she commented how she was always raised to come out the house looking presentable. Her smile widened when she stated this. She was well dressed and pleasantly groomed. Her motor skills, speech pattern, and affect were all within normal range. Her memory, both long and short term, were intact. Stephanie's processing skills showed as normal. I did note, however, that she spoke very quickly, and her thoughts

seemed to race. I also noted that she spoke faster when she was excited about what she was speaking about.

Biopsychosocial History

Stephanie reported being born and raised in Florida and was the oldest born between her and her younger sister. While she was close with her mother, she reported having no relationship with her father. Stephanie reported being raised by her mother and fraternal grandmother. Stephanie reported her father was diagnosed with Schizophrenia and was kept away from her throughout her entire life. She reported feeling abandoned and began to cry as she spoke of him. She quickly dried her tears and presented anger, stating his diagnosis was an excuse asserting he could have been there for her if he wanted to.

While I would typically ask the client to draw out a Genogram of their family, Stephanie had somewhat of a limited insight into her family history. Given her mother and grandmother shielded her from certain aspects surrounding her dad, I found the more I probed, the less she knew concerning certain aspects of her family history. This told me that I could only rely on her limited insight into her family genealogy.

Stephanie went on to share that she expects a lot from her boyfriend, since she gives a lot in the relationship. She reported several painful relationships in the past but smiled when she spoke of her current partner. She reported fearing she would do something to mess the relationship up and reported testing him to make sure he was the right one for her. She also reported testing her friends in the same manner and having high expectations of them. She reported worrying that her relationship would end like the other did in the past. She reported anxiety and worry to the point that it keeps her up at night. Stephanie also reported being tired of

always being the example for her family and friends. She presented irritation when this topic came up in conversation.

Challenges and Risk Factors

Stephanie shared she feels that she is under a great deal of pressure to show her friends and loved ones, her very best. She puts herself under a strict microscope to ensure that she lives up to a standard of excellence. When probed further, she explained that there are societal standards such as being married by the age of 30 and having a child by the age of 31, that she feels a need to meet. Stephanie goes on to share that this time crunch has put strains on relationships in her past.

Stephanie's unhealthy approach to meeting societal standards is a potential challenge for her. Setting unnecessary pressure on herself forces her to see her role in relationships, as an example, rather than a friend. Also, this pressure puts a wedge in between her romantic relationship, forcing them to move further and faster than they would or should. She could potentially miss warning signs of an unhealthy relationship, due to her focus on being married by a certain age. This could also create a wedge in the friendships she has, causing resentment down the line.

Stephanie's family showed a history of Schizophrenia. Stephanie was unable to give many of the symptoms that her dad displayed since she was kept away from him during her childhood. She was, however, able to share that the medication for his Schizophrenia that he had been prescribed he allegedly did not take, and reportedly took illegal drugs instead. Stephanie reported that this was one of the things she felt he put before his relationship with her.

Since Schizophrenia has a peak onset age of the late twenties in women (American Psychiatric Association, 2022) I administered the Millon Clinical Multiaxial Inventory-IV

(MCMI-IV) for Stephanie. This was to assess her for symptoms of personality disorders. The assessment included a battery of 195 True or False questions. The assessment reported favorable for Generalized Anxiety Disorder. The report coincided with her prior diagnosis when she was in counseling previously. Since Stephanie had been treated previously for Generalized Anxiety Disorder, I was confident with this new knowledge, since I was never given authorization to pull any of her prior records and to do a consultation with her prior therapist. Furthermore, this assessment allowed me to rule out a diagnosis and risk factor of Schizophrenia and confirm her diagnosis of Generalized Anxiety Disorder.

Treatment Goals and Interventions

At the completion of our intake interview I summarized what I heard Stephanie report, to assess if what I deduced was what she reported. She confirmed my summation of the session. I gave Stephanie an explanation of the repeated themes that I surmised from her and the root distortion that she exhibited, a lack of trust. Stephanie and I then collaborated over her Treatment Plan. We concluded the following were both feasible and attainable goals: 1) To learn the triggers that create her worrying. 2) To establish self-soothing skills to reduce anxiety. 3) Reduce the frequency and duration of anxiety. 4) Set boundaries for herself and others. 5) Set realistic expectations on herself and others (Jongsma, et al., 2014).

I then explained to Stephanie how sessions would look moving forward. I gave her a simplified explanation of Person-Centered Therapy and Gestalt Therapy. We discussed some interventions that we could use in the future, with her buy-in and I explained why I thought these therapeutic approaches would be good fit for her criteria and family background. I also explained that based off her needs, I could end up using additional variations of other therapeutic

approaches and interventions, should her treatment plan call for them. She was accepting of this approach.

I started dealing with the anxiety first by having Stephanie journal to track her feelings. This enabled her to establish a timeline on her emotions and assess what triggered the feelings of anxiety and worry. This was helpful in gauging conversations and feelings that acted as warning signs for the anxiety. Next, I provided Stephanie with relaxation techniques to combat the feelings of anxiety. Deep breathing exercises, along with self- soothing the five senses both worked well for Stephanie.

Two Cognitive Behavior Therapy interventions were used in conjunction with the Person-Centered approach, Thought-Stopping and Worry Time. I found that for Stephanie's case, I needed to use a more eclectic approach to her treatment plan. The CBT approach to change her thought process was helpful in dealing with the anxiety. Stephanie responded well to the intervention and was able to apply the methods right away.

During the mid-way point into our therapy sessions, Stephanie and I did Psychoanalysis work to deal with some inner-child work. This was in relation to her issues surrounding her dad not being there for her emotionally. Stephanie was able to have a breakthrough in tapping into the pain from her childhood. This session proved to be a turning point for her unspoken fear of abandonment.

By the end of Stephanie's treatment, we focused more on her the boundaries that were set for herself and her loved ones. Stephanie previously had a distorted view of her role in her relationships and believed she had to exemplify perfection. She not only held herself to a high standard, but she held others to this high standard. She was now able to identify the unrealistic demands she was placing and was able to set more attainable goals for herself.

Stephanie was also able to identify the triggers within her relationship that caused her anxiety. She had a fear of abandonment that caused her to lash out when she felt someone could leave her. By dealing with the root cause of the abandonment, stemming from her father, we were able to deal with the current fears in the relationship with her partner. Stephanie was able to identify words and actions that triggered her and was able to articulate them to her partner. This created trust and a greater bond within the relationship, thereby, reducing the anxiety that brought her into counseling.

Termination/ Aftercare/Maintenance

As a clinician, I must ensure that my client has accomplished all the goals set forth before termination can be a consideration. I never want to prematurely terminate a client before they are ready because this could have an adverse effect on their treatment and on their confidence in themselves. For this reason, I made sure that the goals set for Stephanie were well spelled out and attainable to her initial mission surrounding her entering counseling. I wanted to ensure that I was setting her up for success.

For Stephanie's termination process, we had conversations for the month prior to her termination goal date. I wanted to ensure that her termination process was well thought out and a collaborative effort, much like her treatment plan. Ensuring that I had her buy-in for termination was paramount, for a successful transition. A client transitioning from speaking with me on a weekly or bi-weekly basis, to now relying on themselves for the tools needed to walk through life, is tall order. I wanted to make sure Stephanie was clear on these expectations and what this would look like.

Stephanie and I discussed what she felt was needed from herself to ensure she had the tools necessary to be successful on her own. From that point, I made sure she had those exact

tools so that she was confident in herself and her ability to maintain a strong mental space moving forward. I conducted check-ins with her during each session, for the month prior termination to make sure she was still comfortable with terminating.

Stephanie was provided a written-out plan of care that summarized her goals and key wins accomplished while in counseling. This served as a reminder of her growth over the course of her sessions. Stephanie was also given key take-a-ways, and additional local resources, to include various group therapy and couples therapy options in her local surrounding area. By her final session, Stephanie was fully equipped and prepared to terminate with confidence in herself and in her ability to move forward without our bi-weekly therapy sessions.

Prognosis

Currently, Stephanie continues to present a very positive prognosis. She is out of counseling but continues to do yearly check-ins with my office, by way of phone calls to let me know how she is doing since counseling. She and her partner have attended counseling for premarital counseling purposes. They have both benefited from her learning how to set healthy boundaries. Stephanie continues to practice these healthy habits.

Her personal relationships with her friends have also improved. Stephanie reports that when she stopped trying to be an example for her friends, she learned how to be a friend. She reports that she has been able to forge healthy relationships with boundaries that she has been able to maintain. Stephanie reports that the counseling process showed her that some relationships she was investing in were toxic relationships. Stephanie reportedly gained the tools needed to end those unhealthy bonds so that she could focus on her genuine friendships.

Stephanie has been able to reframe from falling back into the snares of anxiety and worry. When asked how she was able to stay diligent in her resolve, she explained that it was not

just through the therapeutic process. Stephanie is a woman of faith and she reported that she has been able to couple her counseling with Godly principles taken from the Bible. Stephanie reported that by using the CBT Thought-Stopping intervention she learned in counseling and pairing it with thoughts about God and who He says she is, has been a reported game changer for her. She exclaims that focusing on God, as opposed to the problem has helped her tremendously. Stephanie has also reported that this has strengthened her walk with God and has inspired her fiancé to do the same.

I am truly excited for Stephanie's future and all that is instore for her and her fiancé moving forward. I am also thankful for the time and the opportunity in being able to share this experience with her. As her clinician I am thankful for having the opportunity to walk along her on her journey of life.

Conclusion

In this theoretical framework, I have provided my preferential theories of choice for counseling. I have also provided a brief history and rationale for my use of the therapeutic approaches. I provided a glimpse into the various assessments that I use to help my full understanding of my client (biopsychosocial, multicultural, and spiritual assessments). I also provided an explanation of how I gain insight from these each of the assessments. Next, I explained my approach for case conceptualization through the use of the Inverted Pyramid Method. I showed how I facilitate the clients concerns in the development of their diagnosis and how I use a collaborative treatment plan. I discussed my methods and aftercare plans for the client, with their continued success in mind. Lastly, I shared a Case Study of a fictitious adult client and showed the entire process in action.

References

Allen, J. G., PhD., Frueh, B. C., Ellis, T. E., PhD., Latini, D. M., PhD., Mahoney, Jane S,PhD., R.N., Oldham, J. M., M.D., Sharp, C., PhD., & Wallin, L. (2009). Integrating outcomes assessment and research into clinical care in inpatient adult psychiatric treatment. *Bulletin of the Menninger Clinic, 73*(4), 259-95. DOI: 10.1521/bumc.2009.73.4.259

American Counseling Association. (2014). 2014 ACA code of ethics. https://www.counseling.org/docs/default-source/default-document-library/2014-code-of-ethics-finaladdress.pdf

American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Beutler, L. E., Moos, R. H., & Lane, G. (2003). Coping, treatment planning, and treatment outcome: Discussion. *Journal of Clinical Psychology.*, *59*(10), 1151–1167. https://doi.org/10.1002/jclp.10216

Böhm, A. (2021). Basic Principles for Therapeutic Relationship and Practice in Gestalt Theoretical Psychotherapy. *Gestalt Theory: An International Multidisciplinary Journal*, *43*(1), 69–86. https://doi.org/10.2478/gth-2021-0001

Bourgault du Coudray, C. (2020). Theory and Praxis in Experiential Education: Some Insights from Gestalt Therapy. *The Journal of Experiential Education.*, *43*(2), 156–170. https://doi.org/10.1177/1053825920904387

Glauser, A. S., & Bozarth, J. D. (2001). Person-centered counseling: The culture within. *Journal of Counseling and Development: JCD, 79*(2), 142-147. https://doi.org/10.1002/j.1556-6676.2001.tb01953.x

Hatchett, G. T., Han, K., & Cooker, P. G. (2002). Predicting Premature Termination from Counseling Using the Butcher Treatment Planning Inventory. *Assessment.*, *9*(2), 156–163. https://doi.org/10.1177/10791102009002006

Hebert, D. J. (2005). Case Conceptualization and Treatment Planning: Investigation of Problem-Solving and Clinical Judgment. *Journal of Mental Health Counseling.*, *27*(4), 348–372. https://doi.org/10.17744/mehc.27.4.cw8uyjum3w4dnfmn

Jones, S. L., & Butman, R. E., (2011). *Modern Psychotherapies: A Comprehensive Christian Appraisal*. (2nd ed.). InterVarsity Press.

Jongsma, A. E., Jr, Peterson, L. M., & Bruce, T. J. (2014). *The Complete Adult Psychotherapy Treatment Planner* (5th ed.). Wiley.

Kisely, S., Wyder, M., Dietrich, J., Robinson, G., Siskind, D., & Crompton, D. (2017). Motivational aftercare planning to better care: Applying the principles of advanced directives and motivational interviewing to discharge planning for people with mental illness. *International Journal of Mental Health Nursing.*, *26*(1), 41–48. https://doi.org/10.1111/inm.12261

Lurie, A., & Ron, H. (1972). Socialization Program as Part of Aftercare Planning. *Canadian Psychiatric Association Journal. Revue de l'Association Des Psychiatres Du Canada.*, *17*(6_suppl2), 157–162. https://doi.org/10.1177/07067437720176S226

McGoldrick, M., Gerson, R., & Petry, S. (2020). *Genograms: Assessment and treatment*. (4th ed.). WW Norton & Company.

McGoldrick, M., Giordano, J., & Garcia-Preto, N. (2005). *Ethnicity & family therapy* (3rd ed.). The Guilford Press.

Murdock, N. L. (2017). *Theories of counseling and psychotherapy: A case approach*. (4th ed.). Pearson.

Neukrug, E. (2021). *Contemporary theories in counseling and psychotherapy*. Cognella.

Quinn, A. (2013). A Person-Centered Approach to Multicultural Counseling Competence. *The Journal of Humanistic Psychology.*, *53*(2), 202–251. https://doi.org/10.1177/0022167812458452

Remley, T. P., & Herlihy, B., (2020). *Ethical, legal, and professional issues in counseling*. (6th ed.). Pearson.

Schwitzer, A. M. (1997). The Inverted Pyramid Framework Applying Self Psychology Constructs to Conceptualizing College Student Psychotherapy. *Journal of College Student Psychotherapy.*, *11*(3), 29–47. https://doi.org/10.1300/J035v11n03_05

Sommers-Flanagan, J., & Sommers-Flanagan, R., (2017). *Clinical Interviewing*. (6th ed.). Wiley.

Appendix A

Stephanie's Case Conceptualization

Diagnostic Formulation

F41.1: Generalized Anxiety Disorder: Stephanie has reported symptoms such as worrying, excessive anxiety, irritability, and sleep disturbances.

Z62.898: Child Affected by Parental Relationship Distress: Stephanie has reported feelings of abandonment stemming from the parental relationship, which are negatively impacted her current relationships.

Clinical Formulation

Stephanie had a previous diagnosis of Generalized Anxiety Disorder. The MCMI-IV was given to confirm the diagnosis, which was confirmed. Further evidence includes her excessive anxiety. Stephanie reports feelings of irritability. Lastly, Stephanie reports having feelings of worry. Stephanie diagnosis of Child Affected by Parental Relationship Distress is exemplified in her habitual need to test friends and her partner, displaying a deficiency of confidence in their genuine affection towards her.

Stephanie's Treatment Formulation

Stephanie's treatment will be centered around the Person-Centered approach. In this approach the client is believed to be the expert, so Stephanie will play a vital role in the treatment goals going forward (Quinn, 2013). Using the Person-Centered approach offers Stephanie the empathy, positive regard, and genuineness necessary to equip her with the tools needed for effective treatment (Neukrug, 2021).

The first phase of Stephanie's treatment will focus on learning the triggers that create her worrying. In helping Stephanie to identify the things that initiate the worrying, we will drill

down to the rationale or root cause. Understanding the why's create further clarity for Stephanie in understanding the things that drive her.

Next, we will establish self-soothing skills to reduce her anxiety. When she is flooded during a conversation with her partner or her friends, Stephanie becomes defensive and goes into fight or flight mode. By helping Stephanie to establish self-soothing techniques, she will be better equipped to stay engaged in the conversation and not run away from conflict. This will also assist her in emotional regulation and assist her with her anger management.

The third goal that we will tackle will be to reduce the frequency and duration of anxiety. This naturally will happen once we master the two prior goals. When we identify her triggers, and teach her to self-soothe, the cause and effect is a reduction in her anxiety and the frequency of its occurrences.

The fourth goal entails helping Stephanie to set boundaries for herself and others. Stephanie has spent much time acting as the example for her friends or testing them to see whether they will live up to her expectations. There have been unhealthy habits, formed regarding the dynamics between Stephanie and those closest to her. Establishing healthy restrictions will aid in the longevity of her relationships.

The fifth and final phase of Stephanie's treatment plan is setting realistic expectations on herself and others. Stephanie has mentioned unrealistic timelines and unnecessary pressures she's place on herself and others due to societal expectations. Identifying realistic attainable goals that are better suited for her will relieve the pressure that she has placed on herself and on those closest to her.

Appendix B

Treatment Plan

Problem or Concern	**Measurable Treatment Goal**	**Treatment Interventions**	**Expected Number of Sessions Devoted to Reaching This Goal**	**Measurable Means of Evaluating and Monitoring Progress Toward Treatment Goal**	**Aftercare Plan/ Follow-Up (Means of maintaining treatment gains)**
Excessive anxiety	To learn the triggers that create her worrying. To establish self-soothing skills to reduce anxiety. Reduce the frequency and duration of anxiety.	Stephanie will journal when worried, to track her triggers. Stephanie will apply techniques like relaxation or mindful breathing. Stephanie will apply Thought-Stopping Technique" and "Worry Time"	These three interventions will take 10 sessions.	Stephanie will track her progress by journaling and reporting her findings in session. I will practice the self-soothing techniques in session. I will also practice the Thought-Stopping techniques in session.	Stephanie will continue to journal to track feelings and emotions. Stephanie will continue to apply self-soothing techniques when feeling flooded. Stephanie will continue to apply Thought-Stopping to reduce the duration of anxiety.
Controlling behavior	Set boundaries for herself and others. Set realistic expectations on herself and others	Stephanie will have bibliotherapy *Boundaries: Where You End, and I Begin* Stephanie will establish realist expectations with self and others	These two interventions will take 5 sessions.	Stephanie will read the text and take notes on material. Stephanie will list new expectations. I will follow up on both.	Stephanie will continue do check-ins loved ones to ensure boundaries are still in place. Stephanie will do check-ins on expectations of self.