Benchmark Capstone Project: Theoretical Model, Case Study, and Appendices Paper

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Abstract

Effective counseling involves the development of a sound theoretical model that guides the overall therapeutic process. It is imperative that those engaged in mental health care are able to conduct sound practices such as assessment, appropriate diagnosis, case conceptualization, treatment planning, outcome-based approaches, and after care planning in order to provide the most effective and beneficial care possible. A counselor must also be able to demonstrate those skills in a clear and meaningful way that helps to resolve the client's symptoms and problematic issues. As the counseling field continues to emerge, it is also necessary that counselors stay current in the latest research, scholarship, and practices and integrate those findings in their mental health care and counsel. This paper includes a personal reflection of my professional identity and understanding of the counseling process. Areas examined include my counseling theories of choice which involve Cognitive-Behavioral Theory and Attachment Theory, biopsychosociospiritual assessment techniques, determination of proper diagnoses, case conceptualization, development of evidence-based treatment plans, evaluation of outcome-based methods, and aftercare planning. Further, a counseling narrative on a fictitious client is included to demonstrate my understanding and implementation within the counseling process. Additionally, a case conceptualization and treatment plan for this fictional client can be found in the appendices portion of this paper.

Keywords: counseling, theoretical framework, therapeutic process, case conceptualization, treatment plan, counseling narrative

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Mental health care is becoming more and more recognized as a critical service to meet the needs of today's generations (Khan et al., 2020; Mukhtar, 2020; Pakpour & Griffiths, 2020). Mental health providers are called to develop a strong understanding and foundation of knowledge and skill as a basis for effectively speaking into the lives of those seeking help, hope, and encouragement (Jongsma, Jr. et al., 2014). The following paper is an exercise in processing my professional identity as evidenced in the therapeutic process including my theories of choice, assessment techniques, diagnostic process, case conceptualization, structure of evidence-based treatment planning, evaluation of counseling effectiveness, after care planning, and more. Additionally, I will present my theoretical model of counseling in a fictitious case study as an example of my engagement in the therapeutic process.

Theoretically Grounded Model of Clinical Counseling

According to Piccardo and North (2019), nothing is more practical and useful within the helping process than a sound theoretical framework. It is imperative that every counselor develop a model of understanding and intervention to help guide the therapeutic process (Dailey et al., 2014). As a part of personal growth and development within an emerging profession, mental health providers should constantly ask Lazarus's (1984) metatheoretical question which prompts the evaluation of what works best, with what persons, under which conditions. As a Christian, I think we need to continually expand our understanding of a biblical worldview (Thomas, 2018).

Counseling Theories

In my current practice, as I have worked to develop a personal framework, I have anchored it primarily in the cognitive behavioral and attachment evidence-based practices.

Although I utilize both often, depending on the individual's needs and given case, I plan on furthering my understanding of them to offer the most beneficial care possible.

Cognitive-Behavioral Therapy (CBT)

CBT is a counseling theory that was originally founded by Aaron Beck in the 1960s which can be seen as an integration of two separate strains of psychotherapy including cognitive therapy (CT) and behavior therapy (BT; Beck, 1976; Thoma et al., 2015). According to Clark and Beck (2010), the cognitive model is known to be the foundation on which CBT is built proposing that an individual's thoughts and perceptions of certain experiences or situations significantly impact and influence his/her emotions and behaviors (Hofmann et al., 2013). Beck believed that an individual's interpretations of the world were fed by three distinct aspects of cognition which include automatic thoughts, cognitive distortions, and underlying beliefs or schemas (Beck, 1976; Chand et al., 2021).

According to DeRubeis et al. (2010), schemas are the most basic unit of psychological functioning, identified as cognitive structures that help organize the large amount of information with which an individual is constantly confronted. Beliefs are then broken down into two unique components of schemas including core beliefs and intermediate beliefs (Clark & Beck, 1999; Beck, 2011). Core beliefs are known to be the hardest to modify as they are the most basic level of beliefs that an individual holds tending to be overgeneralized, absolute, and self-referent (Clark & Beck, 1999). On the other hand, intermediate beliefs, also known as assumptions, rules, and attitudes, are situated between core beliefs and automatic thoughts (Beck, 2011). These intermediate beliefs include "should" and "must" statements as well as conditional beliefs that help an individual create meaning from experience (Murdock, 2017). Further, intermediate beliefs also include coping strategies used by an individual in reaction to his/her other beliefs

(Beck, 2015). Finally, as a result of one's core and intermediate beliefs arise automatic thoughts (Murdock, 2017). Automatic thoughts were given their name as they often just pop out of nowhere and have been recognized as swift, evaluative statements or images existing alongside one's more conscious thoughts (Beck, 1976). Ultimately, if an individual's schemas, beliefs, and automatic thoughts are scene as maladaptive, CBT believes that they should be identified, arrested/challenged, and replaced with more effective and adaptive cognitions (Beck, 1976; Sokol & Fox, 2019).

CBT has been identified as a successful empirically based intervention that seeks to influence negative thought patterns in order to reduce an individual's psychological suffering (Hofmann et al., 2013; Carpenter et al., 2018). During my personal counseling and supervision experience, one of the main mental health challenges that the clients I typically interact with face is anxiety. Ongoing research has shown CBT to be highly credible and effective in treating anxiety as it is known to identify negative and intrusive, exaggerated judgments of perceived or actual threats which are often a core element underlying an individual's pathological anxiety (Beck & Haigh, 2014; Clark & Beck, 2010). In turn, the Mayo Clinic (2020) describes CBT as helpful for individuals to grow an awareness of inaccurate or negative thoughts or thought patterns and to view challenging or stressful situations through a different perspective that allows for a more appropriate and effective response.

As a Christian counselor, two of my favorite verses/passages in Scripture that I believe relate to CBT include II Corinthians 10:5 which states we are called to "take every thought captive" (New International Version) and Philippians 4:8 which says, "Finally, brothers and sisters, whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable – if anything is excellent or praiseworthy – think about such

things." Both of these verses clearly highlight to me the importance of our thoughts and placing an emphasis on filling our minds with the truths anchored in God's Word. However, although many have constructed research to show the efficacy of CBT, Baijesh (2015) notes that some individuals continue to show residual signs and symptoms of impairment or negative responses to treatment, leading one to be open to consider a secondary treatment style.

Attachment Theory

A second theory that has guided much of my clinical practice and interactions is Attachment Theory. John Bowlby has been credited as being the founder of Attachment Theory as he firmly believed in the importance and significance of parent and child interaction (Diamond et al., 2020). Interestingly, Diamond et al. (2020) described that Bowlby, with the help of his colleague, Mary Ainsworth, established a practice of programmatic research which highlighted the importance of a child's early attachment as the means and groundwork for healthy development (Diamond et al., 2020). In contrast to the belief that the developmental process is driven by intrapsychic needs, Attachment Theory states that the developmental process is driven by the influence and impact of real relationships since the time of childhood (Diamond et al., 2020). Ultimately, this theory suggests that early interactions between a baby and their caregiver has the power to influence his/her internal working model which will then affect one's behavior, sense of self, emotion regulation skills, and perception of others (Armstrong, 2019).

According to Diamond et al. (2020), at the heart of Attachment Theory is the proposition that a child has an innate desire and instinct to seek out one's caregiver for both protection and comfort. When experiencing moments of distress or fear, children often turn to their caregivers for comfort and reassurance (Diamond et al., 2020). Further, when a caregiver is attentive to the

needs of the child, the child is more likely to become more confident in his/her attachment figure's availability thus developing an expectation of an optimistic response from the attachment figure during the child's signals of distress. Bowlby (1969) and Van IJzendoorn (1995) described this as a secure attachment style as attachment figures who respond with this attentiveness and sensitivity allow their children to view them as trustworthy, reliable, and available along with instilling within themselves a view that they are worthy of love and protection. Moreover, Thompson and Gullone (2008) discovered that attachment security is positively associated with several adaptive outcomes including increased self-esteem, positive affect, and even better physical health.

However, on the contrary, children who do not have sensitive and available attachment figures are left more vulnerable to experiencing the development of an insecure attachment style (Diamond et al., 2020). Clinton and Sibcy (2002) note that children with an insecure attachment style are more inclined to feeling like they are unworthy of being protected and loved as they are less confident that their caregiver will respond to their needs. Unfortunately, the development of attachment strategies that protect children against, or help them cope with the inadequate caregiving are then formed into one of three attachment styles including ambivalent/anxious, avoidant, or disorganized (Groh et al., 2012; Kobak et al., 2006; Clinton & Sibcy, 2002). To begin describing these, an ambivalent attachment style may arise due to an attachment figure who is intermittently available leaving the child to constantly seek the engagement of the disengaged caregiver to maximize opportunities for closeness (Diamond et al., 2020). Clinton and Sibcy (2002) go on to describe the ambivalent attachment style as the internal belief that while others are capable of meeting their needs and are seen as trustworthy and reliable, inwardly they believe they are not worthy of love and are incapable of receiving the love that they need

apart from growing angry and/or clingy. In contrast, the avoidant attachment style which evolves when attachment figures are consistently unavailable emotionally may leave a child believing that while he/she is worthy of love and capable of getting the love and support they need, others are unwilling or incapable of loving them (Diamond et al., 2020; Clinton & Sibcy, 2002). Finally, the disorganized attachment style arises when attachment figures are not only unavailable and insensitive, but they have also been a threat or frightening to the child (e.g., abuse, neglect, abandonment) (Diamond et al., 2020). In other words, the individuals that a child looks to for his/her greatest source of love and support have instead become the child's greatest source of pain (Clinton & Sibcy, 2002). Clinton and Sibcy (2002) go on to note that a disorganized attachment style leaves children believing that not only are they unworthy and incapable of receiving the love that they need, but others are also unable to meet their needs as they are untrustworthy and unreliable.

Interestingly, Clinton and Sibcy (2012) describe one's understanding and capacity to love and be loved that is shaped during these early years of life as having a unique and profound influence on one's mind, brain, and body connection. Additionally, Johnson (2015) describes that helping one take steps toward healing and developing healthy, safe, and secure attachment can have life changing results. Research has even shown that individuals who understand and develop secure attachment have reported higher levels of resilience in the face of stress or duress, optimism, positive self-esteem, confidence, curiosity, sense of belonging, emotion regulation, adaptive perspectives, and more (Jurist & Meehan, 2009). What I believe that statement tells us in Layman's terms is that healthy relationships are essential to living a healthy life. God's Word clearly discusses the significance of relationships, even stating that we were made for them (Genesis 2:17). Further, the foundation of our faith is built on the development of a personal and

intimate relationship with Christ (Colossians 3:1-3; John 15:4-5). However, I've unfortunately heard it said that many people do not truly know God, they just know a distorted version of Him based on the experiences and relationships they have developed throughout their journey. My prayer is that through fostering a safe, secure, and consistent therapeutic relationship with each of my clients, I could be an extension and reflection of Christ through the love, grace, and compassion I carry myself with.

Assessment

According to Brown and Clark (2015), assessment is the "feeder" for clinical case formulation. Assessment begins with the understanding that numerous factors influence human behavior so one must collect as much pertinent information as possible while determining the meaning of a client's presentation (Dobson & Dobson, 2017; Drummond et al., 2016). Drummond et al. (2016) have also noted that effective assessment does not only reveal the amount and degree of a client's problems, but it also assesses one's readiness for change, prognosis, therapeutic goals, interventions, and more. Further, research from the University of Reno, Nevada (2020) highlighted that individuals are mainly impacted in four distinct ways: biologically, psychologically, socially, and spiritually. Therefore, Thomas and Sosin (2011) emphasize the importance of utilizing a biopsychosociospiritual assessment approach in and throughout the therapeutic process to deliver the most comprehensive, effective, and beneficial help and care possible (Brown & Clark, 2015).

Biological Assessment

The manner in which I assess my clients biologically is typically through verbal communication such as asking them about their most recent physical and/or doctors' appointments and visits. Other questions I may ask initially include whether my clients have ever

been diagnosed with any physical diseases, experienced any significant injuries, and or had any surgeries throughout their life to get a better understanding of where they are at physically. If my clients are not being examined by a physician annually, I typically recommend that he/she see their primary care physician for a checkup to rule out any medical conditions that could be related to the identifying problem. Dailey et al. (2014) describe biological assessment as paramount within the counseling process as some mental health conditions are caused by medical problems, medication, or substances, and without acknowledging these facets, counseling will prove ineffective. Additionally, before my clients ever step foot in my door for the initial intake session, our counseling practice sends them intake forms that request information on sleeping patterns, medication, substance use, physical exercise, eating habits, family medical/illness history, and more.

Psychological Assessment

As previously mentioned, all of my clients fill out intake assessment forms and questionnaires prior to the initial assessment which affords a brief picture and idea of what the presenting problem may be in his/her life. However, I like to utilize the first couple of sessions, usually two, to capture and collect as much pertinent information as possible pertaining to my client's schemas, automatic thought patterns, and internal beliefs about self. One way I have found beneficial in gathering this information is through an informal interview style that welcomes safety and security to establish a warm therapeutic alliance (Sommers-Flanagan & Sommers-Flanagan, 2016). According to Sperry (2005), these informal conversations and time together can allow therapists to begin recognizing and understanding a client's presentation, precipitating factors, predispositions, and perpetuants which is further discussed within the case conceptualization section of this paper.

Additionally, throughout the assessment process, it is imperative to recognize a client's mental status evaluation (MSE; Dailey et al., 2014). Dailey et al. (2014) note that the MSE identifies factors such as one's appearance, orientation, behavior, speech, affect, mood, thought processing, thought content, perception, judgment, insight, and more. Thankfully, the EHR platform that we use at Light Counseling called Theranest has the mental status evaluation embedded into each progress note which helps us as therapists keep up with the continual assessment of our clients. Moreover, depending on the client's presenting problem(s), I like to incorporate additional inventories into my assessment that tailor to his/her needs such as the Beck Anxiety Inventory and the Beck Depression Inventory (Piotrowski, 2018).

Social/Multi-Systemic Assessment

When conducting social and systemic assessments, I typically gather this information through questions related to one's familial relationships and history, friends and social networks, memberships in clubs/gyms, church attendance, hobbies, sports, etc. I really find it interesting to discuss one's upbringing during this time to begin seeing what type of relationship style they may have developed depending on their perception of relationship during childhood. By doing this, I believe it takes the emphasis away from the problem and instead places it on the individual and his/her early memories, family history, unique experiences, romantic relationships, and more. Additionally, to further assess familial relationships within an individual's life, I often revert back to the use of a genogram which has been identified as one of the most widely used psychotherapeutic tools within family therapy (DeMaria et al., 2013). Finally, it is also important to assess the client's multicultural and spiritual beliefs as well.

Multicultural/Spiritual Assessment

McGoldrich et al. (2015) indicate that cultural identity and resources can drastically impact and influence one's mental and physical health. Therefore, Ratts et al. (2015) encourage counselors to be attentive to their awareness, knowledge, skills, and counseling and advocacy interventions in order to counsel in a sensitive and multiculturally competent manner. Hays and McLeod (2018), described multicultural counseling as the ability to integrate cultural identities and take into account the influence they may have on the counseling relationship, process, and outcome. As I have had the privilege and opportunity of serving many individuals from many different cultural backgrounds, I have found that empathy, inquiry, warm communication, and a desire to educate myself on the culture and ethnicity of client's I am unfamiliar with has helped create safety, trust, and alliance within the therapeutic relationship.

When assessing my clients' spirituality, I typically will ask, "Do you have any spiritual or religious beliefs that help and serve as a resource for you?" If they do, I will ask further questions in order to get a better understanding and grasp to see how their spirituality may influence their internal values, experiences, and practices throughout their daily life. Being a Christian counselor myself and serving at a Christian counseling practice, I typically see and treat individuals that share my same religious beliefs and who are very open to the idea of incorporating God into our conversations and time together. However, I always ask initially if the client wants spirituality to be a part of treatment in order to maintain the ethical guidelines from the American Counseling Association's (2014) Code of Ethics which states that one may expose his/her beliefs but may not impose them onto their client. Ultimately, my desire is to make each individual feel heard, seen, and valuable regardless of the differences in our upbringings, cultural heritage, ethnic backgrounds, or spiritual views.

Case Conceptualization

One of the most significant steps in the therapeutic process, also described as the “lynch pin” which holds theory and practice together includes the formulation of an accurate case conceptualization (Butler, 1998). According to Sperry and Sperry (2020), apart from the development of a good therapeutic alliance and rapport with one’s client, case conceptualization is the most important counseling competency to learn and understand. Further, this crucial step has been identified as the cognitive map that counselors may draw from to guide the direction of therapy as one continually progresses in his/her understanding of a client’s presenting problem(s). This formulation is developed collaboratively between the therapist and client beginning at the initial assessment phase of therapy yet remaining fluid throughout the therapeutic process (Cronin et al., 2015). The reason for continuous formulation and revision of pertinent information throughout one’s course of treatment is to help counselors and clients alike understand the origin, current status, and maintenance of a problem (Meichenbaum, 2014).

A format that I have found very helpful when formulating case conceptualizations within my own counseling experience includes Sperry and Sperry’s eight Ps model (Sperry & Sperry, 2020). This model has helped me understand the uniqueness of each individual and truly tailor my services to the exact needs of the client at hand. These eight elements that Sperry and Sperry (2020) present, which have been viewed as effective in understanding and expressing the nature and origins of a client’s presentation and succeeding treatment strategy include one’s presentation, predisposition, precipitants, protective factors/strengths, pattern, perpetuants, plan, and prognosis.

To break down this model and define these unique points, Sperry and Sperry (2020) begin by defining a client’s presentation which refers to one’s description of his/her symptoms,

personal concerns, and interpersonal conflicts that ultimately led them to seeking help. An understanding of the predisposition and/or onset of the symptoms may then be found through the careful gathering of as much pertinent information as possible which may include the biological, psychological, social, and cultural factors. This gathering of information helps to more clearly define the precipitants including the physical, psychological, and social stressors that may coincide with the individual's symptom onset or relational struggles. Next, one must also collect information regarding the client's protective factors, also known as strengths, which may include elements such as coping skills, healthy support systems, or a secure attachment style that may help reduce the likelihood of the clinical condition. Another important factor to consider is an individual's pattern(s) which may include his/her consistent style of thinking, feeling, acting, coping, and defending themselves in all circumstances. After grasping the client's patterns, one must then take it a step further and begin identifying the perpetuants which are the processes by which an individual's patterns are confirmed by not only the individual but by his/her environment as well. Following the gathering of all this pertinent information, one should now have enough material to begin developing a plan of action including careful consideration of the unique treatment goals, objectives, and interventions necessary to provide the most effective and beneficial care as possible. Finally, the last element described in this model is one's level of prognosis which estimates a client's expected treatment response based on their assembly of risk and protective factors, strengths, and readiness or desire to change (Sperry & Sperry, 2020).

DSM-5 Diagnostic Process

Diagnosis has also been described as one of the most critical components within the counseling process, yet several professional counselors may feel unprepared or uncomfortable when diagnosing a client as they fear their diagnosis may be offensive or come across as

judgmental (Dailey et al., 2014; Mannarino et al., 2007) Due to the severity of this step, I typically take some time to reflect back on all of the pertinent information of the case and surrender it all over to the Lord praying that He would guide and direct my steps to provide the most effective and accurate diagnosis for a journey toward healing to begin. Following this meaningful time, I use the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) to help clarify and discern through specific disorders that I may believe my client is struggling with. According to the American Psychiatric Association (2013), the DSM-5 has specific diagnostic criterion that helps counselors decipher between specific disorders that are often difficult to find the differences in (Dailey et al., 2014). However, sometimes a diagnosis may still remain unclear, which typically pushes me to seek guidance from my supervisor/colleagues, consultation, and further examination and detailed research regarding diagnostic features and differences. Furthermore, I may utilize additional symptom measures, specific severity measures, inventories, or interview styles to help clearly distinguish the best diagnosis and begin developing the most effective treatment plan as possible.

Treatment Planning Process

The next step in the therapeutic process involves the development of an effective treatment plan which is the result of an accurate case conceptualization (Thomas & Sosin, 2011). Berman (2019) identified a treatment plan as a beneficial tool that is often perceived as a theory-driven action plan for helping an individual spark constructive change within his/her life. After I finish the initial assessment, case conceptualization, and select a proper diagnosis, I typically collaborate with my clients in developing this treatment plan based on current research, literature, and evidence-based treatment approaches (Jongsma, Jr. et al., 2014). During a treatment plan's development, Jongsma, Jr. et al. (2014) noted the therapeutic alliance and

relationship as playing a pivotal role as contributing factors in the success and effectiveness of the treatment. Therefore, I consult with my clients because I believe each treatment plan should be unique and tailored to the individual and his/her presenting problem and specific needs (Jongsma, Jr. et al., 2014). Other than creating and sustaining a good rapport with my client, other clinical resources that I have found valuable in developing effective, evidence-based treatment plans include the Practice Planner books produced by Wiley along with the Wiley Treatment Planning feature through Theranest which the counseling practice I currently serve at uses.

Following one's identification and definition of the primary and secondary problems that should have already been discussed within one's initial assessment, formulated in the case conceptualization, and affirmed within the diagnostic criterion, one's next step involves working with the client to develop broad goals for the resolution of the presenting problem (Dailey et al., 2014; Jongsma, Jr. et al., 2014). Although these broad goals need to be constructed in measurable terms, they can be long-term, future oriented goals that exemplify a client's desire for a positive outcome following the treatment process. After classifying goals, the next step is to construct short-term objectives for the client that will push them toward his/her long-term goals (Jongsma, Jr. et al., 2014). Jongsma, Jr. et al. (2014) state that these objectives should be described in an attainable/measurable language so that the client, therapist, agencies, and third-party organizations can clearly see if and how progress is being achieved. Finally, the last step is to implement evidence-based interventions which are the clinician's actions that are fostered toward helping the client reach his/her established objectives and pushing them toward their desired goals (Jongsma, Jr. et al., 2014). With clear goals, objectives, and interventions in place,

one can then construct outcome-based assessments to see the progression, stagnancy, or regression within the therapeutic process (Dailey et al., 2014).

Outcome Assessment During Treatment

Walton (2012) noted that once an effective, evidence-based treatment plan has been established, the tracking of one's progress and outcomes throughout the treatment process is beneficial for both counselor and client to regulate if the conducted objectives and interventions are actually helping. One of the easiest ways to do so that I often do in therapy is through self-reports and open communication and discussion with my clients to determine if the measurable objectives are being met and to see if the client is actually working toward the established therapeutic goals (Walton, 2012). This can easily be done through a Solution-Focused intervention which involves scaling questions (Tyrell, 2015). For example, if I am helping a client who is battling persistent anxiety, I may ask him/her "If were to use a scale that had one side of the spectrum being a 10 which represents the most unbearable worry, fear, and anxiety you have ever felt in your entire life with the other side being a 1 meaning the most peaceful and confident you have ever been, where would you put yourself on that scale today?" Other helpful tips and tactics may include utilizing pre-test/post-test work which may include administering the Beck Anxiety/Depression Inventory not only before treatment as previously mentioned buy also retesting a client's levels and score during treatment to see if there has been any progress pertaining to the presenting problem at hand (Scheeringa, 2019). Finally, if a client is not seeing progress or even regressing during the course of treatment, a counselor can easily reconvene with him/her to make adequate and necessary adjustments to collaborate an alternative route moving forward (Walton, 2012).

Aftercare/Maintenance Planning

When approaching termination, one must first confirm that the client has returned to his/her normal level of functioning (Thomas & Sosin, 2011). If a client has not yet returned to that normal level of functioning, then a referral to a provider who offers the needed level of care may be necessary (Granello & Young, 2018). Typically, what I have found helpful is when a client seems to be approaching his/her goal(s) we begin spacing out our sessions together (e.g., weekly to biweekly/monthly) hoping to promote confidence and independence. However, I never want the client to feel as if I am abandoning him/her or pushing them away, so I always assure them in understanding that if my schedule permits, a tune up session(s) will always be available if needed.

Another important aspect of aftercare/maintenance planning involves communication and psychoeducation on relapse prevention (Jongsma et al., 2014; Norcross, 2012). In Norcross's (2012) change cycle, the most important aspect that he highlights is the final stage which involves maintenance. He describes maintenance as the understanding that one not only needs to attain his/her goal, but then one must take it a step further to sustain that work. I often reflect on and discuss with my clients the two words Norcross uses to break this maintenance stage down which are perseverance and persistence. According to Norcross (2012), perseverance is defined as the continual journey toward one's desired goal(s) regardless of the challenge or adversity that may arise. In other words, difficulties will come, leaving us susceptible to experiencing slips-ups/lapses in our journey, urges to give up, and cravings to regress, yet we must to do everything in our power to continually get back up and on track with our goal (Norcross, 2012). Persistence on the other hand involves the intentional and active pursuit an individual must have to continually create change, move forward, and progress throughout one's journey. Jones (2008)

describes the enemies of persistence as complacency and stagnancy and encourages individuals to continually set new goals in order to "reinvent" themselves. Finally, a third word that I have personally added into this aftercare/maintenance stage of counseling before termination involves the topic of purpose. I always try to remind my clients that often times we place ourselves in vulnerable positions when we are willing to trade what we want most for what we want now.

My hope and prayer is that throughout the counseling process I can help my clients develop their own personal "WHY" statements that will help forge them through any difficulties and challenges they may face as well as remind them that their significance, worth, and identity are not defined by their circumstances. Additionally, my ultimate desire as a Christian counselor through word or deed is to help each individual that steps foot in my office to know that they matter and are loved, wanted, and pursued by a God who gave it all for them. As these therapeutic relationships come and go, I trust the Lord's leading and guidance for each client and my personal journey moving forward. Subsequently, I will include a case study pertaining to a fictitious client to demonstrate how I would integrate the abovementioned information.

Case Study

As per the assignment instructions, the following section includes my typical counseling process in a narrative, story-like manner. However, before beginning, I want to emphasize that the following client is not a real client and only comes from my imagination, therefore confidentiality is not at risk. Now, I will describe several important aspects of the client's life and presenting issues before diving into his counseling narrative.

Demographic Information

Bobby is a 30-year-old single, Caucasian, male that is currently unemployed. Bobby is a former professional baseball player who was recently released from his professional ball club a

few months ago and was not picked up as a free agent following his release. Therefore, he moved back to the local area to find an apartment where he currently resides with one roommate as he finishes up his undergraduate degree at a local university. Bobby's immediate family includes his father, mother, and one younger brother. He described his relationships with his younger brother and mother as "very good," but described his relationship with his father as "strained." Bobby claims that during his baseball career his father was always very hard on him when he didn't perform well saying things like "You're an embarrassment," "Just figure it out for once," and "I didn't think I raised such a loser." This has caused their relationship to dwindle over time with very few exchanges taking place anymore. Bobby has seen a primary care provider within the last month and plans to see them annually moving forward. He reports being healthy with no prior health concerns other than a few broken bones growing up due to sports. His religious affiliation is Christian.

Presenting Problem

Bobby came to counseling because he claims that he is frustrated with life and is tired of "constantly worrying" and "fearing failure." He also described a desire to improve his self-esteem and confidence as he often experiences feelings of inadequacy. For more details pertaining to Bobby's case, please see Appendix A, where his case conceptualization will be described in detail. Further, Bobby expressed no substance use.

Observational Data

Bobby was well dressed in casual clothing, arrived on time, and appeared his stated age. Bobby has an athletic physique as he is fresh out of his professional baseball career and continues to train in case of an opportunity arising for a comeback in the future. He made appropriate eye contact, had positive engagement, was appropriately interactive, and seemed

motivated to get help for the presenting problem. Bobby's mood at times seemed anxious as I could tell it was a little difficult for him to open up about certain things. His speech was clear, and his tone was normal. His insight, judgment, and affect were all within normal limits. His thought process was logical and coherent with no report of delusions, hallucinations, or harm/risk to self or others. Finally, his orientation was 4X, and his behavior was appropriate.

Bobby's Counseling Narrative

Bobby and I initially communicated after he had heard about my passion and specialization in helping athletes and former athletes overcome mental health challenges. Our phone call was brief, yet I devoted my full attention to the uniqueness of his situation and began implementing empathy, validation, and understanding to start developing good rapport. Once we locked in a date for an initial intake assessment and confirmed it within the counseling practice's schedule, they sent Bobby intake forms and HIPPA documents. Upon Bobby's arrival to our intake session, I briefly introduced myself, explained the meaning of confidentiality and its limits, covered the informed consent information, and then had him sign off once I felt he had a good grasp and understanding of the information. Afterward, I began assessing Bobby utilizing the biopsychosociospiritual model and Sperry's case conceptualization model previously mentioned to further understand Bobby's presenting problem(s) at a deeper level.

Client's History and Assessment

As noted in the preceding sections of this paper, Bobby's presenting problems seem to be consistent with an anxiety disorder. However, I began the assessment by ruling out any other potential medical conditions or substance/medication use to eliminate the possibility of an additional contributing factor to his presenting problems. Next, I transitioned into asking him questions related to any previous counseling experiences and if he knew of any family members

with psychological issues, to which he responded “no” to both. Further, Bobby expressed himself as someone who has “always worried” and “feared failure” his entire life. However, he has seen his worry intensify here recently as he was released from his professional baseball team making him uncertain of what is next and fueling his insecurities of “not being good enough” or not measuring up to other’s expectations. Therefore, I not only used a verbal scaling technique to assess the severity of Bobby’s anxiety, but I also administered him the Beck Anxiety Inventory (BAI) in which he reported a raw score of 25 which represents a moderate and almost severe level of anxiety. Additionally, along with his worry, the client also presented with sleep disturbance, fatigue, irritability, muscle tension, and constantly feeling on edge.

Interestingly, Bobby described his “overwhelming” sense of intrusive worry and negative thoughts as being present for as long as he could remember. I then asked him about his childhood experiences in which he remembered being raised in a home where “success was demanded” and “failure was degraded.” He also noted that due to his parents, specifically his father, placing unrealistic demands and expectations on him as well as a little brother who was always looking up to him, Bobby has always felt as if his value, worth, and identity are “tied to his performance.” Upon further discussion, he presented with an avoidant attachment style including a persistent struggle in maintaining a wide social network, which seems to be connected with a lot of father related issues. This belief system and attachment style has only fueled his battle with anxiety especially in performance-based situations. As a source of strength, Bobby identified hobbies such as working out and hiking as well as described his spiritual walk with the Lord as his help and hope to press through some of these issues and challenges.

Following the initial biopsychosociospiritual assessment, I checked the DSM-5 to confirm that Bobby met the diagnostic criteria for Generalized Anxiety Disorders (300.02

[F41.1]) (GAD; American Psychiatric Association (APA), 2013). His consistent, intrusive worry has been uncontrollable for well over 6 months; he is easily fatigued, has sleep disturbance, muscle tension, and irritability. I also considered the possibility of an adjustment disorder during the first 2-3 sessions due to the major life change after being released from his professional baseball career, but over time Bobby's symptoms confirmed the initial diagnosis of GAD. However, I also gave Bobby the V61.20 code (Parent-Child Relational Problem) due to the discord Bobby has experienced with his father (APA, 2013).

During the first session following the initial assessment, I collaborated with Bobby to identify his therapeutic goals to begin the treating planning process. These goals included the managing and lessening of his anxiety levels, development of a more positive self-concept, and to more fully understand the nature of relationships and how he does or does not do intimacy with others. To achieve these goals, I then utilized the Wiley treatment planning tool through Theranest to identify evidence-based objectives and interventions that related to my cognitive-behavioral and attachment-based theoretical roots. Over time, as sessions developed, I provided psychoeducation about anxiety, explained how the limbic system within the brain works, helped Bobby identify, arrest, and replace his maladaptive thoughts to improve his internal working model, helped him develop an awareness for elements that trigger anxiety in his life, and reinforced successful patterns, thoughts, and behaviors that helped him improve his development of secure attachment (Jongsma, Jr. et al., 2014).

Outcome measures were conducted throughout the therapeutic process not only through verbal communication, but also through the retest of the BAI which had dropped by week 12 to a raw score of 6 which is considered minimal range (Piotrowski, 2018). Following these promising results that showed therapeutic effectiveness, we decided to space our sessions out to every 3

weeks which helped instill within Bobby independence and confidence moving forward. Prior to termination, Bobby and I discussed the importance of continued growth and reiterated all of the skills and gains that he had made during our time together. After a few sessions of this, I recognized no need to refer Bobby out for additional psychological services and we collaboratively decided that we were ready to terminate. In my termination letter, I expressed my appreciation for his efforts and encouraged him to persevere in times of adversity and challenge as well as remain persistent in his constant development to improve each day. My prayer for Bobby, as it is for all of my clients, is that he would find his worth, value, and identity in the Lord and that he would continually allow God to lead and guide his steps moving forward.

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Appendix A

Bobby's Case Conceptualization

Sperry (2020) notes that one's diagnostic formulation evolves from the clients presentation and related precipitants. Bobby's presenting problems included being "worried for as long as he could remember" and experiencing an elevated "fear of failure." The trigger that ultimately drove Bobby to counseling (precipitant) was due to the uncertainty of his future following the release from his professional baseball team. This only served to fuel and heighten his underlying struggles with anxiety. The increase in the severity of his worries (presentation) caused significant sleep disturbances, cognitive distortions, and irritability over time. Additionally, the unique pressures and unrealistic expectations placed on him as a young boy negatively influenced his internal working model including his schemas, internal beliefs, and automatic thoughts (Beck, 1976). These unique factors have significantly impacted Bobby in his most meaningful relationships. He fears not being enough or being incapable of measuring up to others' expectations. Therefore, he struggles with being lonely and has a real lack of social support in life.

When considering the predisposition and perpetuants of Bobby's anxiety related symptoms, much of it is rooted in childhood as he grew up in a home where his parents, specifically his father, lacked emotional connection and attentiveness. Growing up as a young boy, sports performance held significant value within his family. His father's reactions in response to his success as compared to his failure led him to believe that his love was very result driven and contingent on his performance. Unfortunately, this belief system placed Bobby in a vulnerable position to develop an avoidant attachment style believing that although he is capable and worthy of love and affirmation from others, they are unwilling or incapable of extending the

love that he/she ultimately wants and desires (Clinton & Sibcy, 2002). Further, this avoidance mechanism has only distanced him from relationships throughout his life as he lacks trust and fears rejection. This isolation has also unfortunately caused an increase in self-esteem, self-worth, and self-talk challenges and issues. Moreover, due to Bobby's isolating tendencies as well as his difficult upbringing he struggles with self-soothing, emotion regulation, and interpersonal skills.

To help Bobby manage and overcome some of his negative and intrusive thoughts along with his natural tendency to disengage from relationships, we collaboratively identified long and short-term goals, developed a specific treatment plan, and distinguished some cognitive-behavioral and attachment based interventions that have proven to be beneficial in overcoming stress and anxiety (see Appendix B). Some of Bobby's treatment goals include developing more peace with his present life situation, having more positive thoughts about self and others, pressing into and constructing healthy relationships, and growing in his relationship with God by developing a better understanding of who God is and His steadfast love for us. Treatment will take approximately 8 to 12 sessions to complete. Bobby is a very motivated and invested individual who seems like he is very committed to taking action steps toward positive growth and change. Obstacles that may arise throughout treatment include his perfectionistic and avoidant like tendencies. However, I believe that Bobby's prognosis is encouraging and strong and I will continually monitor his intentionality as we move forward including his timeliness and attendance of sessions, participation and engagement during sessions, completion of his homework assignments after each session, and his ability to further develop self-soothing, emotion regulation, and interpersonal skills.

In conclusion, my case conceptualization has been formulated around Bobby's unique experiences and values. I believe like Sperry and Sperry (2005) that each case conceptualization should be tailored to the uniqueness of the client and his/her presenting problem(s) at hand. I will devote myself to continually being open and engaged throughout this therapeutic process to better understand Bobby's life experiences as well as successes and failures along the journey. I will also be sensitive to not project any of my own personal beliefs and experiences onto the client to develop as safe and secure of a therapeutic alliance as possible (ACA, 2014). In addition, I will be sensitive to the leading of the Holy Spirit throughout the process, asking the Lord to direct our efforts together. I believe God calls us to be both salt and light in the helping process as we deliver responsible, effective care and counsel.

Appendix B
Bobby's Treatment Plan

Problem or Concern	Measurable Treatment Goal	Treatment Interventions (Be Specific)	Expected Number of Sessions	Measurable Means of Evaluating and Monitoring Progress Toward Treatment Goal	Aftercare Plan/Follow-Up (Means of maintaining treatment gains) (Include titration of treatment dosage)
Experiencing thoughts and feelings of stress/anxiety within everyday life.	Implement self-regulation and coping skills to manage/lessen anxiety	Bobby will learn basic mindfulness techniques including relaxation techniques such as deep belly breathing during session. During each deep breath in and out the client will focus on releasing his anxious thoughts and instead reflecting on God's spiritual truths (Jongsma, Jr. et al., 2014). Bobby will also learn muscle relaxation techniques such as progressive muscle relaxation where he will focus on slowly tensing and then relaxing each muscle group to relieve himself of stress and anxiety.	Bobby will develop these skills and techniques through psychoeducation and practice within our sessions together but will also be asked to utilize these skills in his daily life outside of session as well. I believe he will be able to rely on this new acquired skill within 3-4 sessions.	I will evaluate and monitor Bobby's progress through self-report. I will also have him monitor the amount of times he practiced these skills during his week by simply writing a note in his phone. We will then discuss in session if these techniques seem to be working.	I will ensure that Bobby was effectively able to implement these skills within his daily life, especially in between sessions and as we schedule sessions further apart closer to termination.

	Grow an awareness of and begin to control his thought life	Bobby will first learn a CBT approach that helps him identify his negative, intrusive thoughts. This will done through simple not taking and/or journaling techniques. He will then learn thought stoppage by arresting his negative thoughts in the moment. Finally, he will learn to replace those maladaptive thoughts with more healthy, positive truths built on God's Word (Jongsma, Jr. et al., 2014).	Bobby will continually practice this thought identification, stoppage, and replacement technique in and throughout our time together as well as during his free and personal time. I expect this to take around 3-5 sessions to help fully impact and change his cognitive patterns.	I will continue to assess his progress through self-report. I will also retest the BAI throughout treatment to see if progress has been made in lessening his anxiety levels (Beck, 1976).	Before termination, we will discuss the significance of controlling one's thoughts and reiterate the importance of thought identification, stoppage, and replacement moving forward.
Lack of social support	The client will identify significant familial relationships in his life and the relationship patterns within his family.	Bobby and I will draw out a genogram together to identify all of the meaningful familiar relationships within his life. In this genogram we will also identify emotions within the relationships (e.g., love, close,	This genogram drawing should only take 1 session to construct. However, we will review the family dynamic and relational patterns for 1-2 additional sessions as well.	Bobby will draw this genogram out in session and take it with him so he can reflect back on his familial relationship history to continually invest in certain relationships moving forward. This will be assessed through	Bobby learned the significance of connection and recognized how his familial relationship patterns have spilt over onto him and his life as well. This has caused him to begin pursuing relationships and connecting with friends and even

		discord, hostile, etc.) to identify and decipher any patterns within the family dynamic (DeMaria et al., 2013).		self-report and honest and open conversations regarding his father.	extending forgiveness and compassion to those who have hurt him in the past. His expressed happiness and joy following these changes leaves me assuming that this will be a lifestyle change.
	Identify some people that he would like to get to know better.	Bobby will learn assertiveness and social skills such as eye contact, display interest, and curiosity through role-playing with myself in session. This will prepare him for interactions that he may experience at the gym working out, at church, and at school with his peers and classmates (Jongsma, Jr. et al., 2014).	These skills will be taught through psychoeducation during session, but the client will be expected to begin implementing them outside of session as well. I would expect this goal to take the majority of our treatment as it revolves around the development of his self-worth and confidence which comes from the lessening of anxiety, forgiveness of past relational wounds, and more.	His progress in relationship building will once again be measured through self-report as we will discuss fun activities he is doing and how his interactions are going with others as time develops.	
Problems with sleep disturbance	Learn sleep hygiene and improve his sleeping patterns	The client will learn of the importance of healthy sleeping patterns through the use of psychoeducation.	The psychoeducation and development of a sleep schedule should only take about 1-2 sessions.	Progress will be measured through self-report as well as the logging of his sleeping hours within our sleep	Bobby will continue to reflect on all of the goals he has made throughout therapy and hopefully utilize

		We will collaboratively build a daily schedule/routine for Bobby so he can begin to implement a consistent sleep/wake time. Further, we will explore any other prohibiting factors and/or habits such as caffeine intake, light, noise, electronics, exercise, etc. that may be detrimental to his sleeping pattern.		schedule that will be collaboratively built.	the benefits he has seen from a healthier sleeping schedule and patterns throughout his everyday life.
Poor view of self, based on performance, worth, and value to others.	Strengthening the client's inner sense of wellbeing including self-esteem, worth, and identity.	Bobby will begin implementing positive self-talk by growing an awareness of his maladaptive self-disparaging patterns. He will begin identifying positive characteristics and writing out 5-20 positive statements about himself on a weekly basis to share within our next sessions together.	I believe that this identification and implementation of positive self-talk will take around 3-5 weeks as we begin to change his internal working model.	I will continue to assess the client's thought processes and way of speaking about himself throughout our time together through self-report.	We will continue to collaboratively work toward the understanding that it is not the negative thought that matters, but the thought that we attach to. Therefore, we do not have to believe everything that we think.