Theoretical Model, Case Study, and Appendices Paper

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Abstract

This theoretical model, case study, and appendices paper has been thoroughly reviewed and has been a significant endeavor. It covers everything from personal theories used, like cognitive behavior therapy (CBT), mindful-based cognitive therapy (MBCT), and solution-focused brief therapy (SFBT) to a few approaches that would be a great addition to my counselor toolbox. The methods that I would like to learn are dialectic behavioral therapy (DBT), eye movement desensitization and reprocessing (EMDR), and acceptance and commitment therapy (ACT). The bio-psycho-social/multi-systemic-cultural/spiritual assessment is explained and utilized later in the paper. Sperry & Sperry presented a model for case conceptualization that I chose and I describe how it works. Next, a fictitious case with everything incorporated to show how everything meshes together in multiple sessions, from the first to the last. The fictional case conceptualization and treatment plan I created are in the appendices section.

Keywords: Bio-psycho-social/multi-systemic-cultural/spiritual assessment, CBT, MBCT, SFBT, Case conceptualization, treatment plan

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Comprehensive Theoretically Grounded Model of Clinical Counseling

To truly understand what I believe a theoretically grounded model of clinical counseling is, I will have to walk you through many layers of teaching, basic knowledge, methods used, and techniques to be explored. Further, I look to bring you through the assessment process used at the clinic I work at. I will then give examples of the assessments that I use to develop a strong case conceptualization that is needed to provide a proper diagnosis. Many working parts go into a comprehensive, theoretically sound functioning treatment plan, and it revolves around the intake, the diagnosis, and developing a solid rapport with the client. Once the client has a diagnosis, the treatment plan can be created along with the clients' help, using the symptoms and her case conceptualization. Trust is vital if there is to be a success.

Theories I apply in counseling

Theoretical foundations that are empirically supported are essential for a therapist to ensure the ethical treatment of any client. Murdock (2017) expresses that controlled case studies of the theories will guarantee they are safe for the treatment of clients for specific diagnoses. The strategies, interventions, and techniques (SIT) are essential parts of the theories and the types of diagnoses they are designed for (Thomas, 2018). I have three theories I am currently using in therapy but have three I would like to learn and add to my counselor toolbox because they are beneficial for trauma treatment. The following theories I use are cognitive behavioral therapy, mindfulness-based cognitive therapy, and solution-focused therapy. I prefer to integrate most of these theories into my treatment plans as each one has a specific function and works specifically with certain symptoms. The theories that I would like to add to my toolbox are dialectic

behavioral therapy, eye movement desensitization and reprocessing, and acceptance therapy. I will discuss the reason for needing these methods added to my toolbox.

Cognitive Behavioral Therapy (CBT)

Cognitive therapy was created by Aaron Beck, while behavioral therapy by B.F Skinner (Murdock, 2017). Cognitive-behavior therapy (CBT) is seen more as a byproduct of behavior therapy, where cognitions are incorporated and must be explored and changed (Murdock, 2017). CBT looks at the clients' misconceptions or irrational beliefs and finds ways to redirect these maladaptive cognitions (Thomas, 2018). Relaxation techniques will systematically desensitize the clients' cognitions and behaviors through relaxation (Murdock, 2017). According to Reichenberg& Seligman (2016), trauma-focused CBT (TF-CBT) has been the most effective evidence-based treatment for PTSD. TF-CBT is a mixed-method comprised of prolonged exposure therapy and cognitive processing therapy (Watkins et al., 2018). Based on the clinical experience of treatment methods, the APA and several studies suggest the TF-CBT be one of the first methods used to treat clients with PTSD, based on the clients' preferences (Watkins et al., 2018). I use CBT as my primary treatment method for most clients due to its versatility and the vast variations.

Mindfulness-Based Cognitive Therapy (MBCT)

Mindfulness-based cognitive therapy (MBCT), mindfulness therapy is associated with Marsh Linehan, while Segal, Williams, and Teasdale created MBCT (Murdock, 2014). MBCT focuses on teaching the client to stray away from old patterns of thinking and behaviors by being mindful of staying in the present and letting go of the past (Murdock, 2014). One crucial factor to consider when using MBCT is that it was designed for clients with depression, giving them a way of preventing relapse through the use of these techniques learned in therapy (Kuyken et al.,

2016). Mindfulness-based stress reduction techniques are used for those with PTSD to help reduce and regulate a clients' stress level triggered by flashbacks or nightmares of the trauma through yoga, deep breathing, and deep muscle relaxation to relieve the pressure (Boyd et al., 2018).

Boyd et al. (2018) realized that you could effectively reduce the dissociative symptoms of PTSD through mindfulness-based approaches used in therapy sessions. Mindfulness has a 95% completion rate among veterans with PTSD (Boyd et al., 2018); this is a very high success rate. Mindfulness is a method created out of the CBT model. It has been very effective in working with PTSD, so integrating it with additional CBT techniques will make success more attainable than working with it alone (Boyd et al., 2018). The key to success with any treatment method for PTSD or other trauma-related disorders is keeping the client involved with counseling. Hopefully, the client will not leave before the last sessions of treatment.

Solution Focused Brief Therapy (SFBT)

Solution-focused brief therapy (SFBT) has two essential foundations. Steven de Shazer and Insoo Kim Berg developed the first version, and the second version came from Bill O'Hanlon (Murdock, 2014). As the technique developed, the name associated with this technique was SFT (Murdock, 2014). If I were a betting man, I would place all my chips on the probability that the most utilized SFBT technique is the miracle question, as I would bet that every counselor has used the miracle question with at least one client (Murdock, 2014). I like the notion associated with SFBT that there is a belief that if something is not broken, do not try to fix it (de Shazer & Dolan, 2007). In other words, don't look into areas of the person that are okay. Focus on the areas that they need to work on only. A few more tenets of SFBT that I can relate to are remembering that if my client takes small steps, she will have a better chance of success than

taking significant steps and falling short of her goal. Sometimes the solution we are looking for is not directly related to the problem (de Shazer & Dolan, 2007).

De Shazer & Dolan (2007) also mentioned another tenet which suggests that if it works, keep using it, but if it does not work, change it out until you find something that will work for the client. SFBT would seem like a logical therapy method because I am always looking for a solution to help the client with her symptoms and accomplish this task. Sometimes the answer is much easier to find than the problem leads the client to believe.

Dialectical Behavioral Therapy (DBT)

Although I have never practiced dialectical behavioral therapy (DBT), my counselor taught this method for many years and used it with her clients. I like it because it seems like a more Biblical-based method than many other methods. Marsha Linehan developed this method for working with suicidal clients (Murdock, 2014). Linehan & Wilks (2015) expressed how DBT's focus was to help suicidal clients build a life worth living through the teaching of effective problem-solving strategies. My desire to develop my skills in DBT is that it uses many of the skills I already use in therapy sessions. DBTcombines them in an evidence-based way that is highly effective with suicide patients and can work with PTSD and other trauma patients. There are several stages to this method; stage one involves the training of skills for the client, such as mindfulness, interpersonal effectiveness, emotional regulation, and distress tolerance (Linehan & Wilks, 2015). Linehan & Wilks (2015) claim that stage two is where the therapist will treat PTSD. Linehan & Wilks (2015) developed stage three of DBT to reduce fundamental living problems, and then stage four gives the clients a sense of fulfillment as they may find joy or reach a sense of wholeness.

Eye Movement Desensitization and Reprocessing (EMDR)

Eye movement desensitization and reprocessing (EMDR) by Francine Shapiro helps clients with PTSD (Shapiro, 2001). Some may see EMDR as a form of exposure therapy as it will expose the client to the trauma in the beginning but not stay focused on the traumatic event (Shapiro, 2001). Although EMDR uses different therapeutic techniques, challenging maladaptive cognitions, exposure, homework, and challenging the clients' beliefs are not used for extended periods (Shapiro, 2014). The whole eight-step process aims to speed up the clients' information processing rate, targeting or accessing the clients' maladaptive thinking (Shapiro, 2001). There are quite a few trauma patients in our clinic and several EMDR certified counselors. After speaking with them about how effective EMDR is on these patients, I am inclined to become an accredited practitioner myself. If I feel the need for EMDR on the client, I will refer to one of our currently certified counselors.

Acceptance and Commitment Therapy (ACT)

Steven Hayes was the developer of acceptance and commitment therapy (ACT). After becoming overtaken by anxiety, he started working on this idea, and his cognitive thinking training did not help him (Murdock, 2014). Hayes et al. (2006) believe that ACT, a third wave CBT intervention, is grounded in empirically principle-focused therapy approaches. Hays developed ACT through an extensive empirical supported research treatment process called the rational frame theory (RFT) (Hayes et al., 2006). The unique feature of ACT is that not all negative cognitions are forced to be eliminated but accepted with reduced inference (Hayes et al., 2006). In the ACT model, there are six core targets of psychological flexibility: acceptance, values, defusion, committed acceptance, contact with the present moment, and self as context (Hayes et al., 2006). These six targets the broken into mindfulness and acceptance processes and

commitment and behavior change processes (Hayes et al., 2006). ACT seems to be a theory that I would be willing to gain more knowledge on to help my clients.

Bio-psycho-social/multi-systemic-cultural/spiritual assessment

When conducting the comprehensive assessment created for my company by NextGen, the electronic health recording system (EHR), every assessment step is divided into sections associated with the bio-psycho-social/multi-systemic-cultural/spiritual aspect. As each area of the assessment completes, another portion opens. The assessor can develop an official diagnosis and treatment plan. At my workplace, we call the treatment plan the behavioral service plan (BHSP), which is reviewed every ninety days with the client to ensure there is no need for change to the treatment plan and explore the client's progress making. The clinical interview is the building block for the rest of the counseling process (Thomas & Sosin, 2011).

Biological Assessment

Assessing a clients' biological aspects can be done through a structured clinical interview (Anthony & Barlow, 2020). During their first session, the client fills out a Dr. survey, which lists their medical history and any medications that they are taking—knowing what drugs and the medical history will help diagnose the client. In this assessment section, any physical ailments addressed can be ruled out as medically induced symptoms (Schwitzer & Rubin, 2015). Simple everyday practices observed are if the client exercises regularly, eats at home, does daily household chores, and owns or rents their home. During the comprehensive assessment, I gained most of my biological information while building rapport with the client.

Psychological Assessment

The use of valid and reliable questionnaires supports an accurate diagnosis and the development of the client's treatment plan (Anthony & Barlow, 2020). The assessments look at

the client's psychological background and other psychological symptoms for the diagnosis and treatment plan. The clinician-administered PTSD scale for DSM-5 (CAPS-5) will help the therapist better understand where the client is as far as the intensity, functioning, frequency, and severity of the client's PTSD symptoms are (Anthony & Barlow, 2020). Then there is the severity of posttraumatic stress symptoms entitled the national stressful events survey PTSD short scale (NSESSS). It is a nine-item measure used to determine the severity of PTSD in people eighteen years and older (American Psychiatric Association, 2013). This assessment concludes the comprehensive evaluation. The patient healthcare questionnaire 9 (PHQ-9) is incorporated into my comprehensive assessment through NextGen and is designed to quickly reference the client's potential depressive symptoms if they are present (Williams, 2014). The Beck depression inventory (BDI) looks at twenty-one symptoms and attitudes displayed by depressive patients (Beck et al., 1988). The BDI is not part of the comprehensive intake assessment but helps diagnose depression.

Social/Multi-Systemic Assessment

The mental status exam (MSE) helps the counselor understand multiple systemic conditions and explore the client's social aspects to understand better the developmental aspects of the symptoms presented for diagnosis and treatment planning (Norris et al., 2016). The MSE is part of my initial comprehensive assessment. The therapist gathers client information such as physical impressions of the client observed and actions presented during the first session. The World health organization disability assessment schedule 2.0 (WHODAS 2.0), a self-report assessment tool comprised of six domains, explores the client's ability to perform certain activities in the past thirty days (Gold, 2014).

Multicultural/Spiritual Assessment

The multi-cultural and spiritual assessments are combined because they are integrated for most clients as their spirituality is a part of their culture. Getting vital information on a client's culture, such as race, ethnicity, and socioeconomic status is crucial during the initial assessment session. It will determine if the client will trust the therapist and continue with treatments (Hays & Erford, 2018). Because spirituality plays a vital role in many clients' lives, understanding their beliefs will also play an essential role in developing a healthy treatment plan (Hays & Erford, 2018). There are a few ways of gaining this information during the initial assessment. To explore the clients' culture, a series of questions produced by the American Psychiatric Association (APA) as part of the DSM-5 is the cultural information interview (American Psychiatric Association, 2013).

The following questions concerning religion/spiritual orientation are part of the EHR: do you have a religious or spiritual affiliation? What is your affiliation? Are you currently involved with any religious/spiritual activities? They will describe these activities. DO you have a higher power or spiritual beliefs? They explain their beliefs. Although there are limited questions, they are specific enough that I can determine where they stand on incorporating spirituality into the treatment plan.

DSM-5 Diagnostic Process

Providing a proper diagnosis is probably the most crucial part of the intake because the treatment plan developed to treat the diagnosis. The Diagnostic process will review all data collected from the intake assessments and the data obtained from the comprehensive assessment done during the first session—a list of symptoms that best describes the diagnosis incorporated into my EHR. Through my clinical interview or comprehensive assessment, I can review the clients' list of questions for each disorder as the client expresses the problem to me. Using a

DSM-5 assessment that measures the severity of posttraumatic stress symptoms for adults, the stressful national events survey PTSD short scale (NSESSS) (Kilpatrick et al., 2013). Another assessment that I may use is the CAPS-5 assessment because it looks at the twenty DMS-5 symptoms of PTSD (Anthony & Barlow, 2020). The alcohol use disorders identification test (AUDIT) measures any excessive use of alcohol in the individual (Anthony & Barlow, 2020).

Case Conceptualization Process

Upon completing an accurate diagnosis, the counselor must assess all the data collected in the bio-psycho-social/multi-cultural/spiritual assessments to look at the clients' presenting problems, otherwise known as the case conceptualization (Thomas & Sosin, 2011). The clients' health is of utmost importance, relying on a solid case conceptualization. According to Schwitzer & Rubin (2015), efficient case conceptualization skills are prudent for an ethically sound treatment plan.

The model that I will use is Sperry & Sperry (2020), the eight P's. They create a well-drawn-out and efficient case conceptualization that is easy to follow. The first p is presentation; the counselor writes down any symptoms presented by the client and looks at any personal concerns and interpersonal issues that the client presents (Sperry & Sperry, 2020). Predisposition is the next p; it takes a holistic look at the clients' bio-psycho-social/multi-systemic/multi-cultural/spiritual aspects, giving the counselor a better understanding of the client as a person (Sperry & Sperry, 2020). Sperry & Sperry (2020) explain precipitants are stressors associated with the client spiritually, socially, psychologically, and physically and they are triggers that bring about the problem.

When creating the case conceptualization, I will consider patterns. These can be maladaptive patterns that present the problem (Sperry & Sperry, 2020). These include how a

client acts, feels, thinks, can cope, and defends herself during stressful and non-stressful situations. Perpetuants represent how the client processes, reinforces, and accepts the client's patterns and her environment (Sperry & Sperry, 2020). Through the exploration of a clients' protective factors and strengths, the clinician can use these to develop positive aspects of the treatment plan as a form of reassurance that the goal is achievable for the client (Sperry & Sperry, 2020). Sperry & Sperry (2020) continue with the plan as the next p; the need for an effective treatment plan will include interventions, goals, objectives, and ways to ensure the client is being treated ethically with evidence-based methods.

Prognosis is the last p; the client and therapist look at the expected outcome and response to the treatment by the client, using positive individuals, willing to partake in the treatment with the client, the strength and desire to change by the client as part of the purpose (Sperry & Sperry, 2020). All eight of these p's are essential in developing an ethically sound case conceptualization. When I build my case conceptualization from the comprehensive assessment incorporated into my EHR, these are considered and are part of the overall impression.

Treatment Planning Process

The development of the treatment plan is subsequent and will be the guide to all future sessions. It is a work in progress as the therapist will consider changes to accommodate what is working and what is not (Thomas & Sosin, 2011). Every individual treatment plan should integrate the following bio-psycho-social/multi-systemic-cultural/spiritual assessment during the initial assessment to create a highly effective treatment plan. Jongsma and associates have created a series of highly efficient practice planners that aid in developing treatment plans. Each planner focuses on specific diagnoses and specific categories. They consider factors such as symptom severity, safety, and acceptability of the treatment plan for the individual (Boyd, 2018).

Jongsma et al. (2014) give the therapist well-developed treatment plans with definitions, goals, objectives, and both evidenced-based and non-evidenced-based interventions for several DSM-5 disorders.

I use Jongsma when developing my treatment plans because of the vast options he and his associates have presented in the planners. After establishing a diagnosis and reviewing the assessment data, I create the treatment plan during a separate session with the client. This way, I have a chance to review the data and ensure the diagnosis is correct. The client remains actively involved throughout the entire treatment planning process; this ensures the client gives consent for treatment (Thomas & Sosin, 2011). I will first review the clients' goals and reasons for seeking therapy (Schwitzer & Rubin, 2015). Then I will work to develop appropriate objectives associated with the client's goals. Once the client agrees to the objectives, we choose which interventions the client feels most comfortable using. I educate the client on the different interventions and the purpose of each intervention chosen (Schwitzer & Rubin, 2015). Clients are more willing to stay in counseling if they feel a part of their treatment and feel more obligated to finish it.

Method of Outcomes Assessment During the Treatment Phase

Throughout the assessment and treatment process, using several types will ensure that the client is getting the most efficient treatment methods and that they are working. We hand out a self-assessment called the Ohio Scales at the clinic. These measures were designed for children but are also used for adults to measure the effectiveness of the therapeutic interventions used in counseling (Ogles et al., 2001). There are three parts to the assessment; if a child is under twelve, the parent fills out the parent assessment form. There is a particular form; if the client is over the age of eighteen, they will fill out the adult version. The counselor also fills out a form to compare

the outcomes with the clients'. The client fills out the Ohio scales during the initial intake session. They fill one out every ninety days when their treatment plans are reviewed and updated with the therapist and parents. We use the Ohio scales to check whether treatment is effective or if there is a need to change the plan. Other assessments can be given as needed, such as the PHQ-9, BDI, AUDIT, and the CAPS-5, to measure any differences in outcomes from the tests compared to intake outcomes. Hopefully, there is some resemblance of positive changes in these outcomes, giving the counselor and client hope and assurance that the treatment plan is working.

Aftercare/Maintenance Planning Process

Every technique involves skill teaching and developing coping mechanisms for the client to efficiently handle any relapses upon completion of therapeutic services. There will be a two-to-three-week preparation period in the sessions that will help prepare the client for the termination in a perfect world; unfortunately, this is not always the case when the client quits coming to sessions. Appropriate termination will look like this, all the goals and objectives are achieved, the client feels comfortable with termination, and the client believes that she is self-sufficient with the skills and tools she has gained during the sessions (Thomas & Sosin, 2011). At the clinic I work at, the most crucial measure to ensure the clients' safety is to ensure she has reached her goal to leave therapy for 90 days. The client will have emergency contact information and the knowledge that she may return to treatment should the need arise.

Case Study

The following is a fictional narrative that describes the intake assessment, the diagnosis, the case conceptualization, the treatment plan, and the termination of this fictional client. I will now give a brief background of the client and then a complete narrative of my treatment process and the clients' termination.

Demographic Information

Michael is a 37-year-old white/African American male with a history of PTSD. When Michael was 8, his father shot and killed his mother and then shot and killed himself in front of him. He has been free of any symptoms of PTSD for over fourteen years. Michael was diagnosed with Alcoholism at the age of 15 but has been clean from alcohol after going to a juvenile detention center. He attended Teen Challenge, a youth-based drug, and alcohol rehabilitation organization. Since he was nineteen, he has worked as a foreman in the local mill. Michael met his wife Meinlan in high school and got married at eighteen. She passed away eight months ago from Covid-19. Both of his parents are deceased. He has three children, Michael Jr., age 15; Mya, age twelve; and Sela, age 8. He has contact with his in-laws but has become estranged since the death of his wife. Her parents came to America from China and never approved of their marriage. Michael is protestant but has not attended church since his wife got sick and passed away. He was physically active, played basketball in an adult league, ran, and enjoyed fishing. He has two dogs, Milo and Ren. The family home is in a nice middle-class neighborhood with many friendly and caring neighbors. Michael's best friend and neighbor, John, lives two houses down from him.

Presenting Problem

Michael has come to counseling today because his boss has given him an ultimatum, either get some help or lose his job. Michael, presented with the following symptoms of anxiety, having difficulty controlling stress and worry about getting Covid-19, irritability due to sleeplessness (American Psychiatric Association, 2014). Michael presented with the following symptoms of panic; sweating and fear of dying from Covid-19. At the same time, the following are symptoms of depression presented, diminished interest or pleasure in things that previously

pleased him, depressed mood most days, insomnia, no motivation to do anything, and excessive guilt over the death of his wife (American Psychiatric Association, 2014). Michael presented with the following symptoms of posttraumatic stress disorder; the client experienced the traumatic death of his wife and blamed himself for allowing the doctors to pull the plug and let her die; he is experiencing distressing dreams of pulling the plug on his wife's respirator; he constantly feels as if the day they pulled the plug, keeps playing over and over every day; cannot fall asleep in fear of dreaming about that day; Michael has become detached and estranged from his children and work; because of lack of sleep, he no longer has any desire to be involved in any of the activities he once enjoyed. The activities include spending time with kids and going to work (American Psychiatric Association, 2014). The client started self-medicating by using alcohol to numb himself shortly after his wife passed away.

Observational Data

Michael is approximately 5'9", 235-pound has dark hair and blue eyes. He presented well dressed, neat appearance, clean, trimmed beard and mustache, hair groomed, and well versed. Michael hides his drunkenness well, and I would never have known of his intoxication if I had not smelled it on his breath during his session. He said, "I feel comfortable," but I am unsure if he was comfortable with me or because he was intoxicated. The client did appear to be a little anxious about being in the same room as me; even though we wore masked, Michael a little a seemed on edge. He looked at his watch several times during the session but never asked if the session was about over. Although the client had a request to attend sessions, he feels "my previous experience with therapy was a successful one, so I look forward to getting my life back."

Michael's Case Narrative

There are many therapists in the organization, and each works with specific groups, so it is crucial to connect with the right counselor. Michael spoke with one of our trained customer service representatives, who did his initial intake, getting just some brief information from Michael to set him up with the appropriate therapist. They proceeded to get his mailing address and email address, whichever he preferred, so that he could complete the intake package. The intake package has plenty of information for the client concerning patient rights, telehealth form, the release of information forms, confidentiality, the ethical practices of the clinic, the Ohio Scales assessment, the ACES assessment, a Dr. medication form with a disclaimer to discuss medication with the Dr., and the clinics' mission statement. Michael needed to complete the paperwork and return it before his scheduled appointment. Upon getting his address, the customer service representative sets him up with an appointment to conduct a comprehensive assessment.

I was assigned Michael; therefore, I received all his paperwork to review before completing his comprehensive assessment. The comprehensive assessment will generally take between 1 ½ to 2 hours to go through and complete. It will depend on how well the rapport building goes, how comfortable the client feels and how well I can keep the client on track for the assessment. I have to remember that the female runs the house in African American families. However, his wife was Chinese, so I have to be aware of the possible mindset of Michael that he may have anxiety trying to run the household alone (Hays & Erford, 2018). The client often wants to start therapy as soon as they get there, but I have to explain we have to complete this section and the treatment plan and a diagnosis before any actual treatment can begin. The client receives a few more assessments and papers to sign, the Ohio scales, a signature supplement for the treatments he agreed to, and the signature addendum for the crisis plan created for the client

and clinic. I introduce myself, give a quick bio of myself, roughly 5 minutes, and ask if they have any questions.

Next, I explain what informed consent is, and then we discuss how I am a mandated reporter with the state of Ohio. I am obligated to report any child abuse, elder abuse, or the desire to harm another or himself. Then we discussed other than a court mandate, and there would be no other instances where I would be required to break confidentiality. Everything else would be just between him and myself. I will then ask the client when his last physical appointment with his primary care doctor is and if there are any other doctors, he visits for any other medical diagnosis.

In our second session, I had a chance to review the data from the assessments and provide a diagnosis based on his presenting symptoms and data. Michael presented with the following diagnoses, 309.81 (F43.10) posttraumatic stress disorder, unspecified; 305.00 (F10.10) Alcohol use disorder, mild The treatment plan created with Michael will focus on his anxiety, the symptoms associated with his PTSD, and eliminating his drinking of alcohol. The client is involved in the whole developmental process of the treatment plan; this is important in making them feel involved in the beginning stages of therapy. In our first few sessions, we will work on building a rapport to gain Michael's trust and allow him to feel more comfortable and willing to begin working on therapeutic procedures. Upon his consultation with a local psychiatrist, the doctor said he did not need any medications for his PTSD. . It is a mild case, and no other disorders were found. The Psychiatrist has given him the okay to continue with therapy.

With a reassessment of the BDI for his anxiety, his initial score was 28, but after three weeks of treatment, it was down to 19, showing some progress (Beck et al., 1988). Over the next four weeks, we will work on his anxiety symptoms by teaching him the mindfulness technique of

ocean breathing and a safe place. He states, “I feel too relaxed; this is amazing.” I explained why he needed to practice these techniques, so he would have them in his toolbox when needed. He agrees, “that makes sense, and I will practice them. We also discussed the value and importance of joining a support group such as Alcohol Anonymous (AA) to maintain his sobriety through support and accepting that he cannot drink because he has no control. He has attended three AA groups a week for a month and is excited to be sober.

We focus on the trauma-related symptoms as his anxiety levels drop over the next four weeks. I used trauma-focused cognitive behavioral therapy and solution-focused therapy to identify the maladaptive thinking patterns and what triggers them, leading to anxiety and worry. I asked the miracle question, and his response was about what I expected, “There is no more Covid-19, and my wife was still alive and helping me raise my three children”. Michael will next look at what triggers his anxiety. He first points out, “I fear Covid-19 will take my life and leave my children alone”. This fear is real, but I ask him if he trusts God? Michael looked at me and said, “yes, I do, but I am angry with him right now.” He then expressed how he felt, “God could have answered my prayers to heal her.” I then asked him, “Isn’t that what God did?” He began crying, looked at me and said, “I never really looked at it that way.” We worked on some more maladaptive thinking he was experiencing. I taught him how to use his strengths to help him when he feels like he cannot do it. Then we looked at cognitive restructuring and what thoughts were his opinions, and what were facts. Michael began to see that most of his worries were opinions. We explored the BDI assessment, and he scored a 16. He felt please with this score. Michael improved significantly on the Ohio Scales, and his scores were 35 and 15. You should see this type of progress happening.

The final four weeks were intense as we added some mindfulness techniques to his toolbox. Some of these consisted of belly breathing, ocean breathing, and for drinking, we incorporated urge surfing and a happy place. I usually have a client learn a few techniques because sometimes one may not help, so they have a second one to fall back on, they are all similar, but it has something to do with their subconscious mind that allows one to work. We look at his goals, see where he is, and begin working on termination. We find that Michael has reached all his goals; he is attending AA regularly and wants to lead the next meeting. He even asked me to attend this meeting, and I am looking forward to that. Michael has scored eight on his last BDI, and the Ohio Scales continued to go down in the first section and up in the second section. He has many great tools to work with and is glad that his boss pushed him here. Michael is finally starting to feel like the father he once was with his children. Michael has said that he has even begun to mend ties with his in-laws. Michael also has a strong support team through his pastor and the men's group at church, AA, and his best friend, Joe.

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Appendix A

Michael's Case Conceptualization

According to Sperry & Sperry (2020), for a case conceptualization to be considered adequate, it will need to meet the eight p's, starting with the presentation. Michael's current presenting problems stem from the death of his wife from Covid-19, as he had to decide to take her off life support. He now blames himself for her death and is fearful of contracting and dying from Covid-19 himself, leaving his three children without both parents. The predisposition portion consists of the bio-psycho-social-cultural/spiritual aspects of the client assessment (Sperry & Sperry, 2020). Michael's father struggled with schizophrenia, using alcohol and marijuana as a form of self-treatment. His mother was diagnosed with depression, but she was not permitted to get treatment by his father. At age eight, his father shot and killed his mother, then took his own life right in front of Michael and his younger siblings (Biological).

Michael was placed into foster care and received therapy for PTSD and adjustment disorder. At 15 was arrested for drug and alcohol use (Psychological), put into the juvenile justice system for a few months, and released to attend Teen Challenge. He spent a year there and graduated from the program, then placed back into the foster care system until he was eighteen (Social). While living with a Puerto Rican pastor and his family from the teen challenge program, Michael attended church regularly and "grew close to the Lord, I was saved and loving God with all my heart" (Cultural/Spiritual). Michael's life was no easy journey, but he had a

loving wife and three beautiful children he adored until eight months ago when he lost his wife of 19 years. What pushed him over the edge was that he had to permit the doctors to take her off life support; because of the trauma from her death, he blamed himself, relapsing his PTSD (Precipitants).

Although Michael has always looked at himself as a survivor, he lost his sense of security when his wife died. He still feels he has a strong faith in God, but he always had great self-control and was very reliable, especially when taking care of his family and work ethic (Protective factors and Strengths). Michael now questions many things. He lives with the fear of contracting covid-19 and dying. Michael slips deeper into a depressed state, filled with fear and anxiety due to Covid. His levels of PTSD are becoming overbearing and have led to increased alcohol use to numb these feelings. Michael's drinking has made him miss work and children services to pay him a visit about his children's welfare (Perpetuants). Michael now wonders if God can protect him since He did not protect his wife and questions if he can take care of his family and maintain his strong work ethic, as he feels numb and empty at times (Pattern).

Michael has come to counseling seeking help because his boss made him. He has high expectations because he has been through counseling in the past, which has changed his life for the better. He has taken the first step of creating a well-thought-out and evidence-based treatment plan. Michael will first seek the consultation of a psychiatrist to see if he has any other underlying disorders and needs medications. I will utilize trauma-focused cognitive behavioral therapy techniques to reduce the negative impacts on his everyday functioning and coping skills to change maladaptive thinking patterns, mindfulness-based cognitive therapy, solution-focused therapy, and Alcoholics Anonymous (Plan). Michael has many great strengths that he can fall back on, he has already overcome the alcohol addiction and PTSD once before, and he believes

that God will bring him through it again. He has contacted Pastor Ramirez, his old foster parent, and asked him for prayers. He knows that counseling works and is looking forward to starting. Michael is thankful for his boss caring enough to give him this ultimatum to get help and God (Prognosis).

Appendix B

Michael's Evidence-Based Treatment Plan

Problem or Concern	Measurable Treatment Goal	Treatment Interventions (Be Specific)	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) (Include titration of treatment dosage)
Excessive, uncontrollable anxiety and worry	G.1. Client will learn to implement calming skills and or medication if needed to reduce overall anxiety and manage anxiety symptoms	O.1. Teach client calming and relaxation skills such as ocean breathing with safe place meditation	Up to 2 sessions per week up to 8 times a month, for 16 weeks.	The client presented with anxiety levels of 9/10 intensity each day, which will reduce client anxiety to 3/10. His progress will be measured by verbal communication, Beck Anxiety Scale assessment, and the review of the clients' progress every four weeks of treatment.	The client will continue to use ocean breathing and safe place meditation once daily to maintain his ability to utilize calming techniques when needed. The client may return to counseling as needed.

Excessive, uncontrollable anxiety and worry	G.1. Client will learn to implement calming skills and or medication if needed to reduce overall anxiety and manage anxiety symptoms	O.2. The client will cooperate with a psychiatric evaluation to assess the need for psychotropic medications and rule out any other disorders.	Treatment will take as many sessions as needed by the Psychiatrist to evaluate and determine the need for medication d to rule out any other disorder.	The Psychiatrist will present any findings, prescribe any medications if needed, to work alongside therapeutic interventions	The client will continue to maintain any medications if the Psychiatrist feels he needs them upon completion of therapy.
The client is having trouble functioning in social situations, at work, and with his family	G.2. Client will learn to eliminate or reduce the negative impact the trauma-related symptoms are having on the clients' social, occupational, and family functioning	O.1. The client will participate in solution-focused brief therapy to reduce the trauma's impact on the client and those around him.	Up to 2 sessions per week up to 8 times a month, for 16 weeks.	The client presented with impact levels of 9/10 and will work to reduce the traumas impact levels to 2/10. These will be reveiwed every four weeks with the Ohio Scales and BDI	The client will continue to utilize the coping skills taught in sessions to maintain a level of 9/10.
The client is having trouble functioning in social situations, at work, and with his family	G.2. Client will learn to eliminate or reduce the negative impact the trauma-related symptoms are having on the clients' social, occupational, and family functioning	O.2. The client will participate in trauma-focused cognitive behavior therapy to process the trauma to reduce its impact on the client and those around him.	Up to 2 sessions per week up to 8 times a month, for 16 weeks.	The client presented with a functional level of 2/10, and we will work to restore the clients' functioning levels to a 9/10. These will be reviewed every four weeks with the Ohio Scales and BDI	The client will continue to utilize the coping skills taught in sessions to maintain a level of 9/10.
The client struggles with the ability to overcome the maladaptive thoughts that the	G.3. Client will return to a psychological level of functioning before the	O.1. The client will participate in trauma-focused cognitive behavioral	Up to 2 sessions per week up to 8 times a month, for 16 weeks	The client will be able to manage and successfully overcome any situation	The client will continue t utilize the coping skills explored and learned during therapy. The

traumatic situations produce in his life.	exposure to the traumatic event	therapy to develop coping skills that challenge the negative thoughts that these situations have on him		associated with the trauma from 2/10 times to 9/10 times. These can be assessed every four weeks with the CAPS-5	client will continue to work to maintain a level of 9/10 times
The client struggles with the ability to maintain sobriety	G.3 Client will return to a psychological level of functioning before the exposure to the traumatic event	O.2. The client will develop and commit to an action plan directed toward termination of substance use	Up to 2 sessions per week up to 8 times a month, for 16 weeks	The client will get involved with Alcoholics Anonymous two to three times a week to maintain the sobriety he once enjoyed	The client will attend meetings at least twice a week until comfortable enough to attend once a week to every other week as needed.