BENCHMARK CAPSTONE PROJECT

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Abstract

The first premise of counseling is non-maleficence. It is not enough to enter a counseling relationship with a client without the intention of causing harm. It is just as harmful to enter that relationship without using efficacious practices. Understanding theoretical models as a counselor is a must. Knowing which model to employ in each counseling relationship based on the client's needs is essential. The same is true for performing comprehensive assessments that examine the client as a whole: spiritually, physically, mentally, and socially. This paper will delve into the theoretical counseling models and discuss what each contributes to the counseling profession. It will also discuss interventions that can be used within each model. This paper covers the definition and importance of comprehensive clinical assessments, case conceptualizations, as well as the development of treatment plans. Finally, this paper will provide an example of my case narrative and treatment plan.

Keywords: theoretical models, comprehensive clinical assessments, case conceptualization, treatment plan

Benchmark Capstone Project

Counselors working with clients generally have a preferred theoretical model or models. They use these models to work with clients to lead them through self-exploration and mental wellness. The choice of use is based on the clinician's preference and the client's need based on the case conceptualization information. Below is a detailed description of the primary counseling theories.

Comprehensive Theoretically Grounded Model of Clinical Counseling

There are several counseling theories; however, the theories I will address in this paper are Cognitive, Behavioral, Humanistic, Psychoanalytic, and Systemic. Cognitive theory addresses the human mind and its thought processing. It supports that the mind records past events and determines the emotions an individual will accept once stimulated by a similar current event, regardless of whether that historical event was positive or negative. This memory recall will dictate which emotional responses the individual will allow/support for the current stimuli (Beck, 1960). An example is if a teen gets bullied at school, the teen could decide to respond with anger and aggression. The personal thoughts surrounding the previous event by the teen, whether witnessed or experienced, determine which emotion and behavior the teen employed for the current stimuli. Thus, it is as if the mind is a computer storing memories, thoughts, and behaviors and is programmed to repeat if the same or similar events occur in the future. Moreover, this theory supports that if the individual's cognitive processing is maladaptive and does not correlate with the practicality of what is happening, their behaviors will also be maladaptive (McAdams, 2022).

The cognitive theory also supports that there is a correct and incorrect way of thinking. To assist the client in realigning with reality and modifying thoughts and behaviors, the therapist

may employ psychoeducation, teaching the client about cognition. The therapist will also facilitate cognitive restructuring exercises with the client to change their thought processes, perspectives, and behaviors. Cognitive behavioral therapy (CBT), motivational interviewing, and reality therapy are the modalities that are widely used within cognitive theory (McAdams, 2022).

The premise of the behavioral theory is that an individual's cognitive processing and congruent behavior are rooted in and precipitated by their socioeconomic background and environment (McAdams, 2022). Because of repetitive, consistent behaviors of others in their environment and conditions of their environment, the individual views their behaviors as a social norm instead of a maladaptive behavior. Not only are the maladaptive behaviors viewed as standard, but behavioral theory supports that those same behaviors will exasperate unless the individual's environment changes or an intervention such as counseling is employed by the individual (McAdams, 2022). The most common modality used with clients within the behavioral theory is CBT.

The humanistic theory supports the belief that everything that an individual needs to survive, make positive changes, achieve goals, and function effectively is already internal to their being (Rogers, 1942). The catalyst for positive change in this theory is initially the clinician's responsibility. The clinician is responsible for setting the tone for the therapy and establishing a safe, non-threatening, or judgmental environment for the individual to attempt to make the desired changes (Center for Substance Abuse and Treatment, 1999). Next, the process of self-actualization and realization begins through counselor facilitation (Center for Substance Abuse and Treatment, 1999). The modalities mainly employed by a therapist within this theory are person-centered, positive psychology, and existential therapy (Rogers C. R., 1963).

Psychoanalytic theory is founded on the belief that an individual is driven by unconscious thoughts, memories, and behaviors (Freud, 1920). Many of these unconscious memories originated during the individual's childhood (Loewald, 2017). Within the psychoanalytic theory, talk therapy is employed to work with clients. In talk therapy, the counselor assists the client in uprooting and analyzing past events or emotions from their subconscious. The goal is to determine if the unearthed memory is the cause of current behaviors or thought patterns (Loewald, 2017). I have employed this therapy as a starting point when working with adult clients who have experienced childhood traumas such as neglect and sexual or physical abuse.

Lastly, the systemic theory is precisely as it sounds. It is focused on understanding how the entire system and components of that system function and why. For example, in the case study below, Tisha is considered the family's matriarch even though she is the middle child. The mother is a substance abuser, and her stepfather is a physical and sexual abuser. At the young age of 4, Tisha took on the responsibility of protecting herself and her younger sister. This exemplifies a needed systemic change in Tisha's family system. Tisha also has acquired some negative perceptions, behaviors, and thoughts, as a result, that need to be cognitively restructured through therapy facilitated by a clinician (McAdams, 2022).

Theories I Apply in Counseling

I have used many parts of the five theories referenced above when counseling. There are two main theories I apply when counseling clients. The first is the humanistic theory using the person-centered intervention. Focusing on the client and establishing an environment of safety and trust is a powerful tool when forming the client/clinician relationship (Murphy, 2016). This is the first step in establishing an effective client/clinician relationship. This methodology is also integral in gaining consensus with the client on the treatment plan and goals.

The second theory I use is the Cognitive theory coupled with behavioral in the intervention CBT. Once the diagnosis and a treatment plan are established, I work with the client using psychoeducation. I am an avid supporter of educating clients on how the mind works and how it affects them behaviorally and physiologically. Psychoeducation can even be used with children. It is incredible to process their behaviors with them and teach them how to identify triggers that lead to their conduct issues. They are very descriptive in explaining their emotions and what caused the change in their emotions. Unlike adolescents and adults, children tend not to shy away from the triggers and events and how something makes them feel once they are in a trusted environment. Cognitive restructuring is another tool I use within CBT, teaching clients how to challenge their thoughts and replace maladaptive thoughts with adaptable ones.

Comprehensive Clinical Assessment

The comprehensive clinical assessment is a written assessment of the client's physical, mental, spiritual, cultural, and socioeconomic makeup and experiences. It is an assessment of the client's worldview and a look into the formation of those worldviews. This assessment is also vital to the counseling purpose and client relationship. It gathers information that will aid in charting the psychotherapeutic journey from start to finish. The comprehensive assessment aids in identifying diagnoses and developing a treatment plan (Butts, 2018). It will also provide insight into whether the clinician should guide the client to advocacy programs and referrals such as physicians or other care programs.

My method of compiling a comprehensive clinical assessment starts with the client intake and is developed through the biopsychosocial assessment form. This document is an interview tool for me to query the client regarding psychological, biological, cultural, and spiritual aspects of their lives, past and present. After the client is made aware of the policies and procedures of

the office and his/her privacy rights, I begin the face-to-face interview. The first part of the biopsychosocial assessment form queries the client regarding his or her presenting problems and what prompted the client to seek counseling services.

Biological Assessment

The biological portion of the clinical assessment involves what factors the client may be experiencing that affect his/her presenting issues. For example, shaking, sleeplessness, weight gain or loss, and increased or loss of appetite could be attributed to thyroid or many other physical problems. Not only is the biological assessment for identifying possible other causes of the presenting symptoms the client is experiencing, but it also can be an indicator of biological predisposition to issues such as substance or alcohol addictions (Cox, 2004). The biological section of my biopsychosocial form involves interviewing the client about birth to developmental maturation issues. It also polls the client regarding past or current medical diagnoses and medications. I also refer all my clients for a medical examination to rule out physiological basis for presenting issues. In addition, this portion of the interview also asks the client to provide that same information, if known, about their family.

Psychological Assessment

As I mentioned above, the first part of my interview is understanding the client's presenting problems. Understanding the client's presenting problems is one of the three primary purposes of psychological assessment. The psychological assessment also allows the clinician to observe the client's behaviors (mental status exam - MSE), form a diagnosis, and help monitor treatment progress (American Psychological Association, 2013). Much like biological assessment, psychological assessment gathers information about the client's current and past psychological experiences and their family member's psychological history and current

diagnosis. In addition to the MSE, individual, and client history, the psychological assessment polls the client for traumatic events such as sexual, verbal, and physical abuse and neglect. That means the APA Cross Cutting Surveys will be used starting at level 1 and moving to level 2 as needed (American Psychiatric Association, 2013). The WHODAS 2.0 will also be utilized to evaluate disability and functioning across six domains of life and is recommended for use in conjunction with DSM-5 diagnoses (World Health Organization, 2010)

Social Assessment

The social assessment gathers information about the client's social support system, whether friends or family. It also gives the clinician insight into estranged relationships in the client's life, such as marriages, partners, and family. The social assessment also examines whether the client has any community involvement or support systems, hobbies, or interest and the frequency of such activities. This type of assessment provides information regarding any legal issues the client may be dealing with and any open cases with the Department of Children and Families (DCF).

Multicultural Assessment

There is no separate section on the biopsychosocial questionnaire I use to conduct a multicultural assessment. However, the information is captured within the questionnaire's lifestyle and social activities section. The value of a multicultural assessment within a comprehensive clinical assessment is multifaceted. This type of assessment shines a light on how a client thinks, behaves, and feels based on cultural beliefs, rituals, practices, family identity, and gender roles. One assessment that can be used is the Cultural Formulation Interview (CFI) (APA, 2013). The CFI is a standardized assessment developed by the American Psychiatric Association. This assessment is a semi-structured interview that is designed to assist clinicians systematically

access how a client's cultural background influences their understanding of their problems, coping strategies, help-seeking behaviors, and relationship with others, including the clinician (APA, 2013). Multicultural assessments allow the clinician insight into which assessment tools to use with clients for diagnosis. Some assessment tools have been normalized and efficacy proven using Caucasian populations and thus may render ineffective for other cultures (Sedlacek, 1995).

Spiritual Assessment

Spiritual assessment is the assessment of the client's beliefs and definition of spirituality. Many studies have shown the value of understanding and incorporating the client's spirituality into the counseling environment. These studies have proven that incorporating spirituality into counseling yields positive clinical results (McGee, 2006). While incorporating spirituality into the client's care and treatment plan can be beneficial to the client and the client/clinical relationship, it is also essential to note whether this incorporation will aid in reaching goals or create a chasm of negative results such as triggering anxiety or other traumatic responses based on the client's past and current relationship with spirituality. All these factors are essential for the clinician to know in creating an effective treatment plan and maintaining the therapeutic relationship.

When considering my own practices as a clinician, I always ask the client what their spirituality looks like during the biopsychosocial. I allow the client to tell me where they are and what they consider spiritual. Sometimes the client says they don't have spirituality, some give what they consider spiritual while others share their religion. Regardless of what they share, I integrate my faith of Christianity. This comes in the form of patience, grace, non-judgment, willingness to listen, and most of all prayer for my client before they even come into my office. I

don’t share my faith with the client as it is their session and they have needs that I need to be present for and help them address .

Case Conceptualization Process

The case conceptualization process is essential in establishing a cohesive client/clinician relationship, formulating an accurate diagnosis and treatment plan, achieving therapeutic goals, and follow-up after treatment. The model I employ is the Sperry Model. The case conceptualization process has eight phases within the Sperry model: diagnostic, clinical, and treatment formulation (Sperry, 2005). The eight formulations are the case conceptualization process's presentation, predisposition, psychological, precipitants, pattern, perpetuants, protective factors, plan, and prognosis (Sperry, 2005).

The diagnostic formulation is a statement that documents the client’s mental status, its severity, origin, and what level of urgency needs to be taken to address the psychological state and aligns with symptoms in the DSM-5-TR for specific diagnosis (Sperry, 2005).

The clinical formulation is the why of the formulation equation. It is the investigation into why clinical components exist. It examines the thought processes, behaviors, and life experiences that created the current diagnostic situation (Sperry, 2005). This formulation is based on empirical psychological theories referenced above. It also paves the way for an accurate and effective treatment plan specific to the client’s diagnosis and need.

Lastly, the treatment formulation is created from the foundations created by the findings of the clinical and diagnostic formulations (Sperry, 2005). It is the how of the three formulations. The how specifies what change can be accomplished by employing acceptable treatment goals, interventions, length of the treatment, and expected treatment outcomes. All three of these formulations are documented.

DSM-5-TR Diagnostic Process

The diagnostic formulation of case conceptualization involves using a professional standard classification system for mental disorders to align the client's symptoms and behaviors. This classification system is the Diagnostic Statistical Manual (DSM-V-TR). The DSM-V-TR consists of 20 categories and sub-categories of mental disorders. Each disorder provides detailed symptoms, the length of time symptoms are experienced, and identifies what symptoms are acute or standard (American Psychiatric Association, 2013). The biopsychosocial form I employ encompasses the case conceptualization process, including forming a diagnosis using the DSM-V-TR.

Treatment-Planning Process

The treatment planning process comprises two activities planning and administration (Hohenshil, 1996). In the planning stage, the clinician verifies that the correct diagnosis has been given. I do this by using the DSM-V-TR to compare the client's symptoms, the length of time experiencing those symptoms, identifying the severity of the diagnosis, and the differential diagnosis with the mental disorder that fits. Next, I create the treatment plan, including the client's presenting problems, strengths, and weaknesses, documented diagnosis and other focus of treatment, the goals and objectives, and the frequency of prescribed services. Adding the client's strengths and weaknesses is essential to document what will aid or detract from successfully achieving the treatment goals. After documenting the treatment plan, I review it with the client to make sure he or she agrees with what has been documented. If so, the client signs off on the treatment plan, and I sign off as the clinician. If not, I communicate with the client to understand the disagreements and update the treatment plan.

Method of Outcomes Assessment

The method of outcome assessment phase is when the clinician assesses the client's progress against the treatment methods chosen according to the diagnosis. For example, when assessing the client for anxiety levels, the same assessment used to contribute to the diagnosis can be used to evaluate the treatment plan's effectiveness, such as those found in the DSM-V-TR. Assessments can be performed multiple times within the treatment process to ensure the modalities and techniques chosen are effective. If not, it allows you to shift to other modalities or techniques.

Aftercare and Maintenance

Termination of the counseling relationship is predicated on determining whether the client was able to achieve the goals identified in the treatment plan. Another thing to consider is whether the client can maintain improved functionality achieved during therapy (Abramson, 2022). If the client has not improved or cannot maintain improved functionality, then the clinician must refer the client to receive more experienced help. Whereas the client can discontinue therapy at any time, it is unethical for a clinician to terminate a client without providing the client a referral for care (Natwick, 2017).

Case Study Narrative

Working in a community office setting, my colleagues and I received referrals from primary care doctors' offices and walk-ins. The office staff takes note of each of the therapist's preferences for clients. The office accepts all the major insurances as well as Medicaid. I received a referral through the office staff for Sally, whom her primary care physician referred. Sally is a 52-year-old African American female who is seeking therapy. After receipt of the referral, I called Sally and left a message providing her with two choices of dates for a session.

Sally returned my call, and we confirmed Wednesday at noon. Upon meeting, I reviewed the intake documents with Sally, including the company counseling guidelines, informed consent forms, and HIPPA privacy forms. Sally shows understanding and agreement and signs the forms with no questions. Next, I conducted the intake assessment using the biopsychosocial assessment form, which gathers the client's physical, mental, social, and spiritual information, family history, and any legal problems Sally may be experiencing. After gathering all the client's information and assessing all the factors contributing to Sally's presenting problems, I examined her symptoms using the DMS-5-TR. Once the diagnosis has been confirmed, I began developing the treatment plan as detailed above. I then reviewed the treatment plan with Sally to get a consensus. Once consensus was gained, the client and I signed the treatment plan. I suggest the therapy frequency to be weekly, the client agreed, and I scheduled the next session.

References

American Counseling Association. (2014). *ACA Code of Ethics.* Retrieved from American Counseling Association: https://www.counseling.org/resources/aca-code-of-ethics.pdf

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders fifth edition.* Arlington, VA: American Psychological Association.

American Psychological Association. (2013, November 10). *Understanding psychological testing and assessment*. Retrieved from Testing Assessment and Measurement: https://www.apa.org/topics/testing-assessment-measurement/understanding#:~:text=Psychological%20testing%20may%20sound%20intimidating,a%20diagnosis%20and%20guide%20treatment.

Beck, A. (1960).

Butts, C. M. (2018, October 11). Expanding intake assessment to incorporate spirituality using five functional tasks. *Counseling & Values, 63*(2), 147-163. doi 10.1002/cvj.12085

Center for Substance Abuse and Treatment. (1999). *Brief interventions and brief therapies for substance abuse.* Rockville, MD, US: SAMSA. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK64939/

Cox, W. M. (2004). *Handbook of motivational counseling concepts, approaches, and assessment.* West Sussex: John Wiley & Sons, Ltd. Retrieved from https://books.google.com/books?hl=en&lr=&id=IkD9iHRiFRgC&oi=fnd&pg=PR5&dq=assessing+biological+factors+in+counseling&ots=oLhCEZuI0C&sig=yfnPBBZ5cGpsgLyZfdOveB14aQo#v=onepage&q=assessing%20biological%20factors%20in%20counseling&f

Freud, S. (1920).

Hohenshil, T. H. (1996). Editorial: Role of assessment and diagnosis in counseling. *Journal of Counseling and Development, 75*(1), 64-67. doi:https://doi.org/10.1002/j.1556-6676.1996.tb02316.x

Loewald, H. W. (2017). Pschyoanalytic theory and the psychoanalytic process. *The psychoanalytic study of the child, 25*(1), 45-68. doi:10.1080/00797308.1970.11823275

McAdams, C. (2022, July 29). *Counseling theories and approaches.* Retrieved from William & Mary School of Education: https://counseling.education.wm.edu/blog/counseling-theories-and-approaches

McGee, M. D. (2006). Integrating spiritual assessment into a psychiatric inpatient Unit. *Psychiatry (Edgmont), 3*(12), 60-64. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2945898/

Murphy, D. &. (2016). Person-centered therapy: past, present, and future orientations. In d. j. Cain, *Humanistic psychotherapies: handbook of research practice* (pp. 185-218). doi:http://dx.doi.org/10.1037/14775-007

Rogers, C. (1942).

Rogers, C. R. (1963). Toward a science of a person. *The Journal of humanistic psychology, 3*(2), 72-92. doi:10.1177/002216786300300208

Sedlacek, ,. W. (1995). *Multicultural assessment.* Retrieved from Eric Digest, American Counseling Association: https://www.counseling.org/resources/library/eric%20digests/95-24.pdf

Sperry, L. (2005). Case conceptualization: a strategy for incorporating individual, couple and family dynamics in the treatment process. *The American Journal of Family Therapy, 33*(5), 353.364. doi:https://doi.org/10.1080/01926180500341598

Appendix A

Sally's Case Conceptualization

Sally's case conceptualization starts by documenting what, why and how (diagnostic, clinical and treatment formulation) (Sperry, 2005). Sally's presenting problems are depression and anxiety, as evidenced by severe sadness, hopelessness, crying spells, decreased sleep, loss of appetite, decreased self-esteem, and loneliness. Many factors precipitated Sally's presenting problems, her health deterioration before her kidney transplant, her diagnosis of HIV two years ago, and the trauma she experienced in childhood. During the intake, Sally communicated several estranged familial relationships, including with her siblings. Due to this, she feels alone and helpless. Sally also communicated that she feels ill the majority of the time but attributes that to the many medications she is now taking because of her physical diagnosis.

Next is the development of Sally's clinical formulation. Sally's current presenting problems precipitate from the recent physical diagnosis and her family history of neglect and physical and verbal abuse. Also, Sally was forced to care for her younger sister at an early age. At age four, she learned she had to fight to protect herself and her younger sister physically. At 15, she had to run away and falsify her age to get a job to support herself and her sister. Before she was 18, she also became the caregiver for her mother, who moved in with her with cancer. These memories plague Sally as she feels she is there for everyone, and now no one is there for her. It is also worth noting that Sally has only disclosed her HIV diagnosis to two of her nieces and her youngest sister. Sally has seven siblings. From the information listed above, Sally has not had the benefit of secure attachment due to not having parental models for primary caregiving or emotions. Also, her emotions, thoughts, and behavioral responses to life directly result from historical events her subconscious mind has recorded and programmed for specific

reactions (Beck, 1960). Thus, Sally does not easily trust others and, as a result, has no support network.

Sally's treatment formulation includes goals and objectives for each goal to address her diagnosis of Unspecified Depressive Disorder (F32.9) and Unspecified Anxiety Disorder (F41.9). Sally has reviewed and agreed to each set of goals and their objectives. The treatment plan has a time plan of six months for completion. Sally's treatment plan can be viewed in Appendix B of this document.

Appendix B

Sally's Treatment Plan

PSI Behavioral Health, LLC
Mental Health Services

Master Treatment Plan/ Treatment Plan Review

Name: Sally Feist
DOB: 08/14/1970
Medicaid Number: **12345678**
SS#: XXX-XX-XXXX
Date of Admission: 04/16/2023
Date of Treatment Plan: 04/16/2023

Presenting Problem: The client is a 52-year-old African American female who presents with depression and anxiety as evidenced by severe sadness, hopelessness, crying spells, decreased sleep, appetite loss, decreased self-esteem, intrusive negative thinking, feeling overwhelmed, and increased isolation from family. The client has experienced these symptoms for approximately two years, with the past six months being more intense. The client previously received mental health treatment in 2019 at MHRC. At this time, the client would like to receive treatment through therapy and medication management to improve positive daily functioning. The therapist assessed the client for SI/HI, and the client reported some SI. The therapist assessed the level of risk and discussed the safety plan with the client. No HI has been reported at this time.

Client Strengths: *The client has proven resilient, survived past traumas, and is protective of those she loves.*

Client Weaknesses (Barrier to Treatment): The client does not perceive self positively.

Diagnosis- DSM-V:
F32.9 Unspecified Depressive Disorder
F41.9 Unspecified Anxiety Disorder
Medical: Kidney transplant recipient, HIV, high pretention and diverticulitis
Other focus of Treatment: Medication Management

Goal # 1: The client is to meet with psychiatrist for psychiatric evaluation and medication management for Anxiety and Depression.

Objectives:

1. Client will fully comply with psychiatric and clinical evaluations and recommendations for medication/medication compliance.
2. Client will attend all scheduled appointments with the psychiatrist and Therapist.
3. Client will call 48 hours in advance if they are going to miss their appointment.

Expected Achievement Date: 10/16/2023

Goal # 2: The client will decrease the intensity, duration, and frequency of Anxiety and Depression, so daily functioning is not impaired.

Objectives:

1. Client will develop two coping strategies to decrease anxiety and negative thoughts to a manageable level. (strategies such as mindfulness exercises or challenging negative thoughts)
2. Client will be able to identify and work through triggers/situations that increase anxiety.

Expected Achievement Date: 10/16/2023

Prescribed Services:

Services	Frequency	Duration	Time Frame
Bio-psychosocial:	Once	60 minutes	Yearly
Individual Therapy:	Bi-Weekly	60 minutes	6 months
Psychiatric Eval.:	Yearly	60 minutes	Yearly
Med. Management:	Monthly	15 minutes	6 months
Case Management:	N/A		

Transition/Discharge Criteria: Sally is recommended and interested in psychiatric support as scheduled to improve mental health symptoms. At the time of the session, there were no indications that the client wants to harm others. If these thoughts occur, they will go to the nearest emergency room or call 911. The client will remain in contact with PSI until maximum benefits have been reached, or if there is a decision to leave PSI at that time, the client will be referred back to PCP for continuity of care.