Theoretical Framework for Ethical and Effective Counseling Journeys

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Abstract

The essential responsibility of counselors, according to the ACA Code of Ethics (American Psychiatric Association, 2022), is to care for our clients, protecting their dignity and promoting their welfare. Though there are a multitude of theoretical lenses to look through, the focus must always be on the client welfare, and helping them reach their goals in a way that aligns with their values and comfort level. This capstone project is an illustration of how I help guide my clients through their counseling journey. The paper identifies two theoretical frameworks that I apply as a starting point with my clients, primarily Person-Centered Therapy, and Gestalt Therapy. From there, the paper unfolds the application of the biopsychosocial assessments that I utilize with my clients, including the intake interview and various pertinent assessments tailored to the patient's individual needs. The paper then describes my case conceptualization process, using the Sperry and Sperry model, which is essentially a map that clarifies the patient's behavior pattern and helps organize a plan of care using a diagnostic formulation, a clinical formulation, and a treatment formulation. The paper concludes with an aftercare/maintenance planning process that describes the care and plan for the client after their treatment with me concludes.

Keywords: Person-Centered Counseling, Case Conceptualization, Assessment

Capstone Project

Comprehensive Theoretically Grounded Model of Clinical Counseling

Clinical Counseling is grounded and governed by an ethical framework that protects both the counselor and the client. The primary responsibility of the counselor is to care for the client in a manner that both protects their dignity and promotes their welfare (ACA, 2014). As a counselor, I use a variety of theories to guide my work with clients, and I choose theories that dovetail my values and skills, while meeting the needs of the client. The theory that I choose is a guide that is used to hypothesize possible solutions to a problem that the client is presenting (Gladding, 2008). I correlate the counseling journey with a tour guide and a tourist. As an eclectic, person-centered counselor, I see myself as a tour guide, discovering the needs and wants of the client and then helping them design a route to arrive at their destination, whatever that looks like for them at the time; allowing for pit stops, detours, and re-routing, while offering tools for them to use along their journey. My personal counseling style utilizes a combination Person-Centered Therapy and Gestalt Therapy.

Person-Centered Therapy (PCT)

Person-Centered Therapy is rooted in existential-humanistic therapies driven by Carl Roger's theory of person-centered counseling. Roger's core conditions for counseling are empathy, unconditional positive regard, and genuineness (Rogers, 1967). Empathy is a powerful tool used to build connection with a client; it allows me as the counselor to connect to an emotion that another person is experiencing and feel it with them (Brown, 2023). Unconditional positive regard is a skill that I use that encourages the client to freely express themselves without fear of judgement. This skill encourages me to practice self-reflection and self-awareness in order to accept people in their differences, to be open to other viewpoints, and to hone my

listening skills, which all help lead to positive client outcomes (Neukrug, 2021). Genuineness may seem self-explanatory but is a skill that is rooted in self-awareness. As a clinician, I must continually practice self-awareness to deepen my own understanding. By providing empathetic care and unconditional positive regard for my clients, I can be my most genuine self with them. The client and their needs are the focus of the sessions, and as a person-centered counselor, I avoid giving advice or direction; rather, I join the client in the counseling journey, empowering them to make choices that align with their talents and ways of being (Neukrug, 2021).

Gestalt Therapy

Gestalt Therapy, also rooted in existential approaches, was developed by Fritz Perls and others, and is focused primarily on the here and now of existence, using now language that focuses on the present, issue in the present, and how they can be addressed (Perls,1973). Getstalt Therapy is a humanistic, holistic approach that views the client as a whole, not the sum of their parts. In addition to the here and now concept of focusing on the present, the Gestalt therapist also introduces the concept of unfinished business and the empty chair to help the client process their emotions in therapy. The concept of unfinished business illustrates that a client who has unmet needs also has unfinished business, and unfinished business can lead to a non-genuine or inauthentic existence for the client. Addressing the unfinished business while focusing on its relationship to the issue at hand helps the client work toward resolving the unfinished business, while striving towards an identity rooted in genuineness (Neukrug, 2021). When a client is struggling with an unresolved issue with someone, the I can employ the technique of the empty chair; this allows the client to sit across from an empty chair and speak to it as if the person is sitting with them. By verbalizing their feelings to the empty chair, I help the client process their

feelings about the issue and about the person, hopefully working toward resolution or closure for them (Wagner-Moore, 2004).

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

Assessments in therapy refer to how a counselor evaluates and understands the needs of the client (Hays, 2017). I strive to make the assessment a personal and comfortable experience for the client, sharing with them that the assessment helps me have a better understanding of their needs and how I can help them identify treatment needs and goals of therapy. There are several types of assessments available to use, including career assessments, personality assessments, culture-fair tests, and the Mini-Mental State Examination (Hays, 2017).

My assessment process depends on the needs of the client and the reasons they are seeking therapy. The focus of the assessment is to allow the client space to communicate their perception of the presenting problem, or the reason they are seeking therapy (Woods, 2015). Once I understand why they are coming to therapy, I can determine an appropriate assessment to use that will best fit the client's needs. Overall, I use the bio-psycho-social/multicultural/spiritual framework that leans on a holistic lens of treatment. This type of framework allows me to capture a full picture of the client, not just a list of their symptoms.

Biological Assessment

Regarding the biological assessment, I again look at the whole picture of the client. I strive to look through a non-judgmental lens, offering unconditional positive regard for the clients throughout the therapeutic process. I ask about the client's medical history, and if they have a primary care provider. To identify any existing medical conditions that might be pertinent to their clinical care with me, I would ask when their last physical was, any medications they are prescribed, and if they are following the prescription protocol. Lastly, I would check when their

last follow-up was with the doctor, including a prescription review to ensure all medications are current. If I discover that the patient has not seen a primary care physician within the last six months, I refer them to get a full physical exam, including blood work, to rule out any medical conditions that may be related to their presenting concerns. I also ask about their perception of their health, including diet and exercise, food allergies, and any hereditary medical conditions that might be pertinent to their care. When appropriate, I complete a substance use screening using the Audit-C for adults and the CRAFFT for adolescent clients. These audits allow me to assess for any substance use disorder that may need to be addressed in counseling, as well as the discussion of coping mechanisms.

Psychological Assessment

For this portion of the assessment, I strive to gain more clarity from the client on their presenting needs that brought them to counseling. I primarily use an informal intake interview to gain a better understanding of the client's history, assess the nature and severity of the client's presenting problems, as well as history with other mental health professionals (Hays, 2017). Depending on the age of the client, I will also use the Mental Status Exam (MSE) or the Mini-Mental Status Exam that assesses for cognitive impairment (Neukrug, 2021). To ensure that I cover all possible diagnoses, I would incorporate the WHO Disability Assessment Schedule (WHODAS 2.0) (Üstün, 2010), combined with the DSM-5-TR (American Psychiatric Association, 2022). The WHODAS is a questionnaire designed to measure general health and disability levels, including mental and neurological disorders (Üstün, 2010) and the DSM-5-TR uses criteria to help diagnose mental health disorders (American Psyciatric Association, 2022).

Social Assessment

The social assessment allows me to learn more about the client as a person; I ask about their social lives, what they enjoy doing for fun, their work and school background, family relationships, friend groups, and personal interests. I also hope to learn their personality style; for instance, are they introverted, extroverted, or a combination? Are they outgoing and talkative, or more reserved and thoughtful? What is their body language when the discuss their family and friends? Gathering this information helps me learn how to best relate in a genuine fashion with my client while helping them feel comfortable in our counseling sessions.

Multicultural/Spiritual Assessment

As a counselor, I am ethically required to be culturally sensitive in my practice (ACA, 2014); consulting with supervisors and colleagues can be helpful, as well as practicing self-awareness and examining assumptions, values, and biases (Singh, et al., 2020). It is important for me to be self-aware so that I can explore my worldview and beliefs and attitudes around it so that I can remain unbiased in my client's care (Singh, et al., 2020). The cultural assessment would include gathering information including the client's cultural identity, age, ethnicity, race, gender and sexual orientation, religion, country of origin, socioeconomic status, language, and education (Sperry, 2023).

Regarding the spiritual assessment, I recognize that this is a highly personal topic, and I treat it with respect and dignity. Though a client may have no religious or spiritual affiliation, or one that is different from my own, I am ethically bound to provide unconditional positive regard for them, and will strive to do so through self-examination, consultation, and reflection (ACA, 2014). Spiritual assessments can be particularly helpful in determining the importance of spirituality to a client's overall health (Kuckel, et. al, 2022). Studies suggest that there is a

strong relationship between spirituality and medicine, and many patients would like this to be considered in their medical care (Anandarajah, et. al, 2001). One helpful spiritual assessment that I would use is the HOPE questionnaire (Ananadarajah, et. al, 2001). The HOPE concepts are as follows: H-source of hope, strength, comfort, meaning, peace, love, and connection; O- the role of organized religion for the patient; P-personal spirituality and practices; E-effects on medical care and end-of-life decisions (Anandarajah, et.al, 2001). If a client does not wish to discuss their spiritual beliefs with me, I would respect that decision and make note of it in the client's notes.

Case Conceptualization Process

The case conceptualization process is a method for gathering and organizing information about the client to help set goals, form a treatment plan, anticipate potential problems, and prepare for successful termination of therapy (Sperry, 2020). As a client-centered clinician, I look through the lens of the client-focused conceptualization that gleans from the client's experience, needs, and expectations (Sperry, 2005). In this process, I also consider the client's age for assent/consent to treatment purposes, and I also share the limits of confidentiality as with the client.

Sperry's Case Conceptualization Model

My clinical model utilizes Sperry & Sperry's (2020) case conceptualization, which emphasizes the establishment of an effective therapeutic relationship, or alliance (Sperry, 2023). A case conceptualization is cognitive map for explaining the client's presenting issues and collaboratively making a plan of treatment (Sperry and Sperry, 2020). By gathering and organizing information from my client, I will have a better understanding of their concerns, and can address any maladaptive patterns, treatment focus, possible barriers, and help prepare the client for a successful termination of treatment. The method for practicing this case

conceptualization utilizes the following eight "P" elements: Presentation is the nature and severity of the client's clinical presentation. Predisposition includes four factors that holistically effect a client, including biological, psychological, social, and cultural. Precipitants are physical, psychological, and social stressors that may be causative in nature. These can be physical stressors such as trauma or withdrawal from addictive substances, or psychological stressors like loss, rejection, or disappointment. Social stressors can include illness, death, job loss, or significant change that causes stress. Protective factors are coping skills, positive support, and secure attachment style. These factors help decrease the likelihood of the client acquiring a mental health condition. The next element is Pattern, and this refers to the congruous manner in which the client thinks, feels, and copes with positive and negative experiences. Perpetuants refer to how the client reinforces and confirms their process. This can be physical, psychological, or social in nature. Plan illustrates the treatment intervention including goals, methods, and strategies. The last element is Prognosis, and this refers to the client's expected response to the planned treatment (Sperry and Sperry, 2020). Once I have determined these eight elements, my client and I can collaboratively make a plan for treatment.

DSM-5 TR Diagnostic Process

As a counselor, I recognize the stigmatism that may be associated with a mental health diagnosis, and as such, proceed with great care when gathering information for a diagnostic assessment. The purpose of this assessment is to understand the symptoms that a client is experiencing, and accurately and collaboratively arrive at a diagnosis with the client. I practice self-reflection and consult with my supervisor regularly in the diagnosis process, refraining from judgement or bias in the process (ACA, 2014). Since I believe the client is the expert in their story, I remain curious, asking open-ended and clarifying questions, as well as offering

reflections to help me accurately arrive at a diagnosis for the client. I use the DSM-5-TR that includes 22 diagnostic categories accounting for more than 300 mental disorders to help clarify criteria for the client's diagnosis, and initially look for the broadest form of the diagnosis, knowing that I can specify it further as our sessions progress (Sperry, 2023).

Treatment Planning Process

My counseling treatment planning process is based on Sperry and Sperry's Model and includes developing appropriate treatment goals, identifying treatment focus, anticipating likely obstacles, and challenges to achieving the treatment goals. Though it is important to create framework for the treatment plan, I also recognize that it is fluid in nature, and can change as the client's need may change or shift. The treatment focus serves as a guide or action plan for me to use to help my client achieve their goals and is derived from theoretical framework that informs my treatment style. Treatment goals are specific benchmarks set by the client and the therapist to encourage movement toward something. Anticipating obstacles is immensely helpful in the process of achieving goals as obstacles help identify potential resistance, ambivalence, and transference issues in treatment, as well as test the viability of the goals and their need for adjustment (Sperry, 2023). Treatment planning is collaborative in nature and elicits acceptance and unconditional positive regard throughout the process.

Method of Outcomes Assessment During the Treatment Phase

As a therapist, I strive to both provide effective treatment and demonstrate its effectiveness, while always looking through the lens of person-centered care. The best way for me to measure the effectiveness of care is to elicit feedback from my clients (Sperry, 2023). By involving the client in the treatment planning process, they may be more likely to share their feelings about the effectiveness of the goals set and methods used in treatment. Studies have

consistently shown that when therapists receive feedback on their work with clients, their therapeutic relationship and treatment effectiveness increase significantly (Sperry, 2023). Another component that I employ is consultation; I consult with my supervisor and colleagues regularly to elicit feedback, ensure I am within my scope of practice, and practicing within the ethical framework provided to me as a counselor (ACA, 2014). While I don't use standardized measures at this point in my counseling career, there are several available including the Polaris MH, COMPASS-OP, OQ-45, and the Sessions Rating Scale (SRS) (Sperry, 2023).

Aftercare/Maintenance Planning Process

To assess the attainment of goals and client satisfaction with therapy, I reflect, ask clarifying questions, and ask for feedback from the client. I also begin discussing counseling termination a few sessions before we conclude to help prepare the client for termination. Using the treatment plan as a blueprint, we will re-clarify goals, practice coping skills and interventions used throughout our sessions, and discuss any adjustments that need to be made before termination to ensure the client's comfort. If, at any time I feel that I am practicing out of my scope of practice or may need further support, I will consult with a supervisor and then refer to another counselor when appropriate (ACA, 2014).

Case Study

Regarding this case study, I will illustrate a counseling narrative with a hypothetical pediatric client. This case study will outline the counseling process from the intake session through the termination stage of therapy.

Demographic Information

William is a 12-year-old Caucasian male who lives at home with his mother, father, and two sisters. He lives in a stable home environment and enjoys spending time with his family. He is the only son in his immediate family and has a 14-year-old sister and a 10-year-old sister. William enjoys playing sports and is a member of the soccer and swim team. Though he is a bit introverted and does not enjoy being in large crowds of people, he does like meeting new friends and talking to them individually. He is doing well in school, enjoys math and science, and struggles a bit with literature. Overall, he is well-adjusted and happy.

William's parents invited the family to help plan a family vacation together. William and his sisters were thrilled to be part of the planning process and they unanimously decided to go on a beach vacation together for a week. They painstakingly planned each day of the trip and included things that each family member enjoyed doing together. During the first day of the trip, William's family was inside the condominium cleaning up for the day, and William realized he had left his favorite towel on his chair. He asked if he could run and grab it, and dashed out the door of the condo, hoping someone had not taken his towel. In his haste, he did not look both ways for oncoming traffic as he was crossing the street and was struck by a truck. The driver immediately stopped, and William was unresponsive on the side of the road. Since he did not have identification on him, the driver was unclear who to contact, and dialed 911 for emergency personnel. Meanwhile, William's father became concerned that he had not returned yet and

started walking to the pool to check on William. He immediately recognized William on the side of the road and ran to his aide. The ambulance arrived as the driver explained that William appeared out of nowhere as he was driving down the 45 mile per hour road. William's father was distraught and immediately called his wife to explain what happened and asked her to please stay at the condo with the girls and he would ride to the nearest hospital with William. Because they were on vacation, William's father was not familiar with the hospitals in the area and became overwhelmed with their current predicament.

Upon arrival at the hospital, William was intubated and sedated, with an unclear prognosis for recovery. He was intubated and sedated for three days, and then his condition began improving. He was able to breathe on his own, and he continued progressing until he was released from the hospital with a broken leg and broken arm. While he did not suffer from a concussion or a traumatic brain injury, he did experience a marked change in his overall affect. After a week of being home, he was having trouble sleeping and having recurrent nightmares about his accident. His nightmares began interfering with his ability to get rest and participate in his physical therapy sessions for his recovery.

Presenting Problem

William was referred to me for counseling by his parents three weeks after his accident. They knew that I was trained in trauma-informed care, and they wanted help for William regarding his nightmares and change in affect. They said that he was reluctant to discuss the accident and would change the subject if any of his family members discussed it or the details of the accident. Prior to our initial meeting, William had not seen any therapists for any mental health concerns.

When I asked William what brought him to the office and what he would like to talk about with me, he shrugged ambivalently, and played with his fidget spinner. He seemed nervous and unsure of why he was at a counseling session. His mother tried to encourage him to talk, and I assured her that it was okay that he was not very talkative. I chose to allow some silence and then told William that I liked his fidget spinner. We talked about his favorite color, what he liked to do for fun, and I assured him that we did not have to discuss anything that he did not want to talk about. That reassurance seemed to comfort him, and he began to engage a bit more in conversation with me.

William's Counseling Narrative

In his initial evaluation, I met with William and his mother, and he seemed disengaged from the conversation and was intent on playing with his fidget spinner, nodding his head, or shaking his head to answer his mom's questions. He would also shrug his shoulders in response to her as well. I recalled from his chart that William was a bit introverted and that he had experienced a shift in his overall affect after the accident, so I was looking for a baseline of behavior before engaging in the intake questions.

After we looked at his fidget toy and built some blocks together, William began to share a bit about his accident. He did not like talking about it and he shared that he does not like having a bunch of people over to talk about his accident when they visit. He likes to play video games now that he must stay inside while he recovers, and he seems to enjoy the distraction that the games provide. He wishes that his mom would stop asking him about the accident and wants life to go back to normal. He did share that he has had trouble sleeping, and he has been having lots of nightmares about the accident. He also said that he feels grumpy a lot and has a hard time paying attention. He feels very fearful when he has to ride in a car, and he gets a nervous feeling

in his stomach. He also has thoughts that he is going to get hit by a truck when he is walking to the car.

Observational Data

William was oriented to time, place, person, and situation in our initial intake assessment. He was neatly dressed and had a pleasant, but somewhat flat, affect. William displayed normal speech patterns and there were no psychomotor issues that I observed, and I also confirmed this with his mother. William maintained age-appropriate insight and thought content. He appeared to have mild challenges in his attention, as noted in his presenting problem, but he did not display any delusional behavior.

Social, Relationship, Work, and Medical History

William was born in Winston Salem, NC and lives with his mother, father, and two sisters. His parents have been married for 20 years, and he has an older sister who is 14 years old, and a younger sister who is 10 years old. They all live together in Winston Salem, NC. They are a very close nuclear family, and do not have other families that live in NC, but they do visit their grandparents every summer. William's father is a residential builder, and his mother is a stay-at-home mom who volunteers at his school. The family provides a stable environment and live in the same family home they have been in for 20 years. They are actively involved in their church and community.

William has a few close friends but is a bit introverted. The accident seems to have made him retreat a bit more inwardly and his affect has shifted a bit as well, which has concerned his parents. William does not have any behavior issues at school, but his mother maintains that he has been experiencing issues with paying attention and staying on task since he has been home from the hospital.

William's mother denies any pre-existing medical conditions or long-term medical concerns, and William is not taking any prescription medication. He does take seasonal allergy medications, as well as a daily whole-food multivitamin. He has current, yearly physicals with his primary care provider and has no reported health concerns.

Challenges and Risk Factors

William is hesitant to share what he has been experiencing, both physically and emotionally since his accident. His mother seems supportive, but also tends to answer for him or talk over him during our initial session together. I tried to assure her that there were no "right" answers in therapy, and that William would help me chart a path for his care. I did not want her to feel as though she was not included in the process of her son's therapy, but I also wanted to help encourage autonomy for William, since he was my patient. In order to properly assess William for acute stress, I administered the Child Trauma Screening Questionnaire (Kenardy, et. al, 2006). The CTSQ is a 10-item self-report screening tool that is used to assess a child's risk of developing PTSD. The questions in the CTSQ are created to identify a child's traumatic stress reaction to a potentially traumatic event (Kenardy, et. al, 2006). If a child answers "yes" to 5 or more of the questions, they are considered positive for acute stress. According to the DSM, acute stress disorder features the development of characteristic symptoms lasting from 3 days to one month following the exposure to one or more traumatic events (APA, 2022). William scored an 8 out of 10 on the CTSQ, which would be a positive diagnosis for Acute Stress Disorder. William endorsed having memories of the accident that he did not want to have, having bad dreams, feeling as though the accident is about to happen again, feeling churning in his stomach and a nervous feeling when he is reminded of the accident. He has trouble staying asleep, feels

grumpier than usual, has a hard time paying attention, and is on the "look out" for possible dangerous things that might happen to himself (APA, 2022).

William also has helpful protective factors including a supportive and stable home, and family that supports him in his physical and emotional recovery.

Treatment Goals and Interventions

During our first therapy session, William and I discussed what he hoped to gain from our time together. I assured him that this was a safe space for him, and he could talk about anything that made him feel better. I shared the limits of my confidentiality with him and his mother in our initial intake session. William did not have any suicidal ideation, so I did not feel a need to create a safety plan with him. He shared that he thought he was weird, and the accident only made him feel weirder. I asked him to share what "being weird" meant to him, and he said that he did not like all the things that the other kids liked, and that made him feel like he didn't fit in appropriately. He was quiet and shy, and liked to be around a smaller group of friends, rather than a big classroom of students. He also shared that he wanted life to go back to normal and then shared with me what that looked like for him. He did not want to feel scared when he was in a car, and he wanted to sleep better and stop having nightmares. As we discussed what felt like life returning to normal for him, we created some manageable, actionable goals for William and his family. 1). William wants to learn coping skills to help him with his acute stress symptoms including nightmares, grumpiness, and fear of driving in a car. 2.) William wants to identify what makes him feel awkward with his friends and learn positive communication skills. 3.) William wants to develop a more positive view of himself. William and I worked together to determine these goals, and he seemed excited to be part of the therapeutic process.

Once we collaboratively determined William's goals for counseling, I helped explain how he and I would work together to achieve his goals (Ribeiro et. al, 2014). I told William to think of me as a tour guide, and he was going to share where he wanted to go, and I was going to help use the tools to reach his goals. I explained what person-centered therapy was, and simply said that it meant he was going to decide what we talked about, and I was going to help him. In order to provide relational depth, my goal was to help William regulate his anxious feelings and process troubling memories from the accident in a way that was relatable and comfortable for him (Murphy & Joseph, 2016). Person-centered therapy includes developing positive unconditional regard and congruence of the therapist (Murphy & Joseph, 2016). It also offers a flexible, effective, and evidence-based therapy that is based in both theoretical development and practice (Murphy & Joseph, 2016). By allowing William to navigate and process his feelings in a safe environment, my goal is to help him achieve his goals in a way that is collaborative and comfortable for him. I want him to understand the flow and scope of person-centered therapy during the beginning phase our counseling sessions.

In the middle phase of treatment, William and I explored coping skills for him to learn when faced with anxious and fearful emotions resulting from his traumatic accident. We focused on learning what self-awareness is, and how William can practice being more aware of his feelings by using statements that start with, "I feel". By identifying how he feels, William can help verbalize when he is struggling. We discussed some simple interventions to help regulate his nervous system and help him relax. The first coping skill that we practiced was box breathing. Box breathing entails visualizing a box while inhaling for a count of four, holding the breath for a count of four, and exhaling for a count of four, then relaxing and resetting for a count of four (Balban, et. al, 2023). This breathwork exercise helps regulate the nervous system,

shows an improvement in mood (Balban, et.al, 2023), and is a simple, yet effective coping skill to implement with a pediatric patient. We also implemented some mindfulness exercises combined with box breathing to help increase William's self-awareness (Balban, et. al, 2023). This combination of interventions could also help reduce his anxiety and improve his daily mood (Balban, et. al, 2023).

In the final phase our sessions, we focused primarily on role-playing, and continuing to increase William's self-awareness. One of his goals was to learn positive communication skills and overcome his awkwardness around new peers. I introduced the concept of person-centered role-playing to William. The role-playing activity allowed him to gain mastery over the traumatic accident and its related disturbing thoughts and effects (Levenson and Herman, 1991). Role-playing also allowed William to construct his worldview and promote insight as to how he views his relationships with his peers (Levenson and Herman, 1991). By allowing him to explore his worldview and process his feeling around the accident, we increased William's self-awareness and his ability to communicate comfortably with his peers. Because William is 12 years old, we did not complete a genogram or a life map for him. However, we did complete an age-appropriate values card sort for pediatric patients, and helped William identify what he valued most at this stage of his life.

Prognosis

William experienced great success implementing the box breathing exercise. He started several of our sessions with box breathing to show me that he had been practicing and that his technique had improved. He shared that the breathing helped him not feel so grumpy anymore, and he was also sleeping better at night. When he feels anxious about driving in the car, he asks his mom or dad to do some square breathing with him and give him the space to prepare to ride

in the car. He continued to practice his mindfulness exercises and his "I feel" statements with his family and friends. As he continued to practice these interventions, his confidence increased. He has been able to utilize his role-playing skills in his online video games and has enjoyed playing the games with his friends and family. He shared that he feels comfortable expressing himself in that setting and he also enjoys playing the games.

Conclusion

This paper is an illustration of the theoretical model that I use in counseling sessions with my clients. While my approach is through the lens of person-centered counseling, I strive to use tools that will best help the client, while always counseling within my scope of practice. Per APA guidelines, I always put the patient's welfare first, and consult with my supervisor and peers regularly about my counseling practices (APA, 2022). This case study represents a model of client treatment from intake to termination.

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Appendix I

William's Sample Diagnosis and Case Conceptualization

I. Presentation Formulation:

William is a 12-year-old Caucasian male who was involved in a traumatic accident. He is from Winston Salem, NC and was on vacation with his family when the accident occurred. William presents with a flat affect and seems ambivalent about attending counseling sessions. William's parents are concerned about the change in his affect and share that he has been experiencing nightmares since the accident. He is additionally uncomfortable discussing the accident and experiences bodily reactions when he is asked to discuss it.

II. Diagnostic Formulation

308.3 (F43.0) Acute Stress Disorder

William's emotional and behavioral symptoms are consistent with an acute stress disorder diagnosis, and all symptoms have occurred within 30 days of experiencing the traumatic incident. William has no prior history of mental health concerns or ongoing health concerns.

III. Clinical Formulation

William experienced a traumatic accident while on vacation with his family. The ensuing symptoms are the perpetuants and primary cause for the acute stress symptoms that he is experiencing. William has no prior clinical history or mental health diagnosis. He began experiencing the change in his affect and the nightmares when he returned home in addition to

other noted acute stress symptoms. The nightmares and change in affect were the main concerns for his parents seeking treatment for William.

IV. Cultural Formulation

William was born in Winston Salem, NC where her currently lives with his biological parents and two sisters. He is 12 years old and has been involved in sports, enjoys being outside, and prefers having a small group of friends. He is a bit introverted and feels uncomfortable around a large group of people. William feels that he is "weird", and the accident has made him feel "weirder," so he struggles to fit in with new peers.

V. Spiritual Formulation

William is a Christian, and he and his family attend church regularly and are actively involved in their church and local outreach. William attends youth group weekly and has a few friends in the youth group. William does not share much about his involvement in youth group, and answers with a shoulder shrug when I ask about it. As we continue exploring together, I will look for ways to incorporate age-appropriate techniques that incorporate William's faith into his therapy. I will also use the HOPE questionnaire mentioned above to determine the depth of the role of spirituality in William's life (Anandarajah, et.al, 2001).

VI. Strengths Formulation

William appears to be sensitive and kind, while shy and a bit reserved. However, as he continues to be more comfortable talking with me, he is genuine and funny. Willam seems intent on feeling normal again and wants his family, especially his mom, to treat him accordingly. Though he is frustrated at wearing the casts on his arm and leg, William has found a new excitement in playing video games. Playing video games has also given him a new way to connect with his friends and he is enjoying playing with them virtually. He has a close relationship with his

family and is eager to please them. He wants to feel better physically and emotionally and explores that throughout our sessions together.

VII. Pattern Analysis

Presentation:

William is a 12-year-old Caucasian male who recently experienced a traumatic accident while on vacation with his family. He is from Winston Salem, NC, and lives with his biological parents and two sisters. Upon his return home from the hospital, William has experienced a noticed change in his affect and has been having nightmares about the accident, among other acute stress symptoms. His parents are concerned that these have not subsided since he has been home and are concerned for the impact they are having on his physical and mental health.

Precipitant:

William was involved in a traumatic accident while he was walking across the street. He was struck by a truck and was unresponsive immediately following the accident.

Predisposition:

There are no pre-existing conditions that were present prior to the accident. William has no history of mental or physical pre-existing conditions.

Perpetuants:

Since his return home from the hospital, William has been having nightmares and has a noticeable change in his affect that is concerning to his parents. He is initially ambivalent about participating in counseling but shares that he wants to feel normal again.

Pattern Explanation:

William is close to his parents and his sisters. He is introverted and shared that he feels “weird”, and the accident has only made him feel “weirder”. William’s parents have noticed a marked

change in his affect, and they are concerned for his health and happiness. Since returning home from the hospital, William has been having nightmares and other noted symptoms of acute stress. These symptoms, combined with the stress from his physical injuries led to William's parents bringing him to counseling.

VIII. Treatment Formulations

When he returned home from the hospital, William faced physical and emotional challenges. He experienced a traumatic accident and was alone when it occurred. He remembers the accident and has been experiencing nightmares and a change in affect since he has been home. Since the symptoms have occurred within 30 days of the accident, my hope is to apply helpful interventions that will alleviate the symptoms and prevent him from experiencing Post Traumatic Stress Disorder. William will receive four, one-hour sessions with me. We identified two main treatment goals:

Goal 1: Learn coping skills to help alleviate acute stress symptoms. (See treatment interventions below).

Goal 2: Determine the root cause for the change in affect and implement appropriate interventions to encourage confidence and autonomy.

The target of our treatment will be to eliminate symptoms associate with acute stress. Additionally, we will work to establish new coping mechanisms that help encourage autonomy and confidence while addressing the patient's concerns. I will be practicing from the lens of person-centered therapy, incorporating mindfulness exercises and Gestalt Therapy as well. Our counseling sessions will be limited to four weekly sessions, and each session will be one hour in duration. We will re-assess Willam's needs at the conclusion of these sessions. The treatment predictions will be that William's acute stress symptoms will subside, and he will learn valuable

skills to help him cope with them should they arise in the future. We will also work to increase his self-worth and sense of autonomy as his affect improves. At the end of treatment, William will have employed a new set of coping skills that will help manage and alleviate his acute stress symptoms. He will also gain an improved sense of self as he increases self-awareness and autonomy. We will do a 30-day follow-up to ensure he is comfortable and confident in his new skill set. With his parent's and his consent, I will also enroll him in a Trauma Survivors Network monthly support group for pediatric trauma patients.

Appendix II: 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)
Patient is having night-mares due to being involved in a traumatic accident	Decrease and alleviate acute stress symptoms associated with the traumatic accident. Learn coping skills to address acute stress symptoms.	Psychoeducation involving Person-Centered Therapy. Provide Gestalt Therapy that focuses on the here and now of existence and how issues can be addressed in the present. Introduction to mindfulness exercise and teaching box breathing skills	2	Increase in rest and overall health as nightmares subside, improving mental and physical health. Utilization of the Child Trauma Screening Questionnaire (CTSQ) to determine decrease in acute stress symptoms.	30 day follow up to ensure maintenance of goals and continued decrease or departure of acute stress symptoms. Review of coping exercises and checking on their continued effectiveness. Enroll in monthly Trauma Survivors Network Support Group for pediatric patients.
Change in affect resulting from traumatic car accident, with	Expand and increase patient's affect as patient's acute stress symptoms subside and self-worth increases. Learn positive self-talk	Utilize talk therapy to explore the cause for the change in affect. Learn and incorporate "I feel" messages to help identify and express feelings to increase self-worth.	2	Change in affect as acute stress symptoms subside or decrease. Allow for self-exploration that results in positive self-talk and increased self-	30 day follow up, reinforce coping skills, participation in Trauma Survivors Network monthly

previous under-lying issues of self-worth.	skills that improve self-worth and sense of autonomy	Determine values and how to express them effectively.		worth. Benchmark is "I feel weird", so we will work to establish what that means to the patient and how to change the narrative in his mind to increase self-worth and autonomy.	support group. Role play to reinforce "I feel" messages and self-expression.