Capstone Project Paper

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I have no known conflict of interest to disclose.

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Abstract

Being able to identify and articulate one's comprehensive and theoretically grounded model of clinical counseling shows progression of growth as a mental health counselor and as a student of higher learning. This capstone project paper will explore my expansive and theoretically grounded model of clinical counseling, including the theories used in counseling, biopsychosocial/cultural/spiritual assessments, and the processes used in the clinical counseling setting. A case study also will be thoroughly discussed, ranging from the given DSM-5 diagnosis to all phases of treatment. Appendices, showing a case conceptualization and an evidenced-based treatment plan, will also be included in this paper. Therefore, the fundamental purpose of this paper is to effectively identify and convey the best practices used in my overall model of clinical counseling, including the use of the DSM-5 to effectively diagnose, treat, and meet the needs of the counselee.

Keywords: Cognitive Behavioral Therapy, assessments, DSM-5, case study, case conceptualization, treatment plan

Applied Theories

Having a comprehensive and theoretically grounded model of clinical counseling is something that is of utmost importance. It is ethical and demonstrative of best practices. The goal in this paper is to discuss my eclectic synthesis of counseling modalities and the assessments used in the counseling experience. The case study used in this paper is enlightening. Case conceptualization is so important in having a broader and more accurate picture of the client, as well as the client's worldview. An effective treatment plan is crucial in helping to track the client's progress in therapy. I am excited to share my capstone project.

Evidenced-based methodologies are used in my mental health practice. Cognitive Behavioral Therapy, also known as CBT, is the integral counseling methodology used in my practice. It is combined with Solution-Focused Brief Therapy, also known as SFBT, Motivational Interviewing, also known as MI, and Person-Centered Therapy, also known as PCT. Cognitive Behavioral Therapy is essential because it focuses on the concept that if a person's thought process is changed it will effect a change in the person's feelings, which would create a different outcome in that person's behavior.

Cognitive Behavioral Therapy

The father of CBT (Aaron T. Beck) proposed the concept that illogical presuppositions help form an unrealistic reality, which creates issues for an individual (Ritter, 1985). The key idea is to help them observe, address, and adjust the illogical assumption, so they will experience changed thoughts, feelings, and behavior. From this experience, they learns how to create different ways to deal with and work through the issue (Beck, 1976, p. 230).

Solution-Focused Brief Therapy

In SFT (de Shazer & Berg, 1978). another model in my theoretical framework, the clinician and the client work and collaborate. One of this theory's strengths is that its focus is not on the problem but, rather, on the solution (Lewis & Osborne, 2004). Another strength is this theory's "miracle question" concept. The client uses his/her imagination to depict and to describe a moment where the problem no longer exists. It is my belief that this gives the client hope, aspiration, and inspiration to create goals that are therapeutic and to move from one place of thinking to another (De Shazer & Dolan, 2007, p. 40). A third strength is that this theory encourages client autonomy.

Motivational Interviewing

MI (Rollick & Miller, 1991) is another important element in my therapeutic practice. While it is not a theory, it is a collective counseling methodology that was implemented in the field of addictions. MI encourages change and emphasizes the client's strengths, responsibility, motivation, and dedication (Miller & Rollnick, 2013, p. 12). I implement this approach also because of its ability to be used alongside the Stages of Change model that is also used in the field of addictions (Lewis & Osborne, 2004). I have worked in the field of addictions for years and continue to work with people, who struggle with addictions.

Person-Centered Therapy

The final integrated methodology used in my practice is PCT (Rogers, 1951), which is also known as Client-Centered Therapy. This also promotes a working, collaborative relationship between the counselor and the client and promotes the autonomy of the client. An even important aspect of this theory is that the client is viewed as the leader, while the counselor takes on the role as the supporter. The ownership of the counseling experience is placed on the client. Empathy, unlimited acceptance and assistance, and genuineness are focal points of this theory

(Rogers, 2020, p. 230). I view this as important in my practice and remind the client that therapy is designed for me to aid when needed and that he/she must be committed to the process and to the work that must take place.

This integrative synthesis of counseling methodologies is grounded is evidenced-based practice and structured to function complimentarily in facilitating therapeutic change. Cognitive Behavioral Therapy is the primary source of my counseling methodology because I believe that it is essential to recognize that an issue exists, to discover the root of the issue, to look at the issue differently, and to work through that issue in a healthy and effective manner. PCT, MI, and SFT also encourage a collaborative partnership between the counselor and the client that is focused on change and on the motivation to change via solution and client autonomy.

Biopsychosocial/Cultural/Spiritual Assessment

Assessments are so important in the counseling experience. These assessments provide data that is pertinent in the treatment of the client, as well as the outcomes of that treatment (Sperry & Sperry, 2020, p. 26). In my practice, I use a behavioral EHR known as Therapy Notes. Within Therapy Notes, current problems, the mental health status, assessments, plan, and diagnosis fields are presented and discussed at the initial Intake.

In my practice, I use Zoom to virtually meet with the clients for the Intake. Before the Intake occurs, each individual downloads and uploads the HIPPA Compliance Patient Consent Form, the Introduction Form, and the Client Information, History, Contacts, and Insurance Forms into the Portal section of Therapy Notes. Once completed and uploaded back into Therapy Notes, I have data that I can review before I meet with the client. The Client History Form contains data from the biopsychosocial that can be generated into Therapy Notes at the initial, virtual Intake session with the client.

COVID-19 has affected the way I initially meet with the client. Whether in person or virtually, I aim to present the client with a safe environment that is full of empathy and respect and where the client feels safe. Working to create an effective and collaborative alliance with the client is essential in attaining important details. If not created properly, the diagnostic assessment could be altered (Nakash et al., 2015). Even though this meeting is done virtually, the client's engagement is important, and I do my best to consider the social and cultural, as well as spiritual, elements of the client.

I use MI throughout this process. The emphasis is to focus on creating a positive, effective, and collaborative working association with the individual. MI is complementary to CBT that it encourages change and encourages the individual to become motivated for that change and to acknowledge and embrace personal strengths (Miller & Rollnick, p. 12). The tools associated with Motivational Interviewing are also used alongside CBT-based questions throughout this process. Those MI tools are affirmations, reflections, open questions, and summarizing. The CBT questions assist in understanding the thoughts and feelings, as well as the behavior, of the client.

The biological, psychological, social, multicultural, and spiritual assessments are all integrated and interwoven within Therapy Notes for the Intake session. Parts of these assessments are also found in the paperwork given to the client prior to the Intake. When the Intake begins, I can add the client's completed paperwork into the proper areas and am able to add the new information that I will discuss with the client in the proper, designated areas as well.

Biological Assessment

In the biopsychosocial assessment, the biological aspects that are assessed pertain to information about the client's health history and current status, as well as substance use (Sperry

& Sperry, p. 28). The biological assessment is extremely important. It provides more information that could possibly either explain the reason for the client's mental health issue and/or could eliminate other possible mental health diagnoses (Antony & Barlow, 2020). During my virtual session, I explore with the client about his/her medical conditions/history, current medications, and current/past substance use. One of the things about this part of the session is that I am not trying to make any medical diagnosis since that is not my expertise. If I observe anything that is alarming, I refer all clients for a full medical evaluation to rule out any physiological causes for presenting problems.

Psychological Assessment

During the psychological assessment, I include a comprehensive DSM interview to rule out any conditions that the client may not report, which includes the DSM Cross Cutting Surveys Level 1 and 2 and WHODAS. I observe and assess the client's presentation and conversation, along with the information provided in the Therapy Notes' Portal. I discuss with the client about some of the following: any presenting concerns/issues, the history of those concerns, current mental health status, identification, psychiatric history, trauma history, and developmental history. I also assess for any maladaptive beliefs, emotional inconsistencies, behavioral deficits, and levels of functioning (Sperry & Sperry, p.28). The risk assessment is also given to make sure that the client is not homicidal, suicidal, unable to care for himself/herself and others, and aggressive to others and property. It also makes sure that the client does not have the risks of self-harm and/or substance misuse.

I let the client know that I take notes throughout the interview so that I will not forget any key information that is shared. Probing and open-ended questions are used with the goal of

getting more information from the client, which helps me to have a more effective case conceptualization.

Therapy Notes now provides the Generalized Anxiety Disorder-7 (GAD-7) and the Patient-Health Questionnaire-9 (PHQ-9) in the Portal. The clients now complete these forms and upload them into the system. During this part of the Intake, I talk with the client about his/her scores on both assessments and review if their scores are still the same at that moment. The GAD-7 is a self-reporting, assessment scale, consisting of seven items. It measures the severity level of the individual's anxiety symptoms and is viewed as valid, as well as reliable (Antony & Barlow, 2020).

The PHQ-9 is another self-reporting assessment scale, which measures the severity of the individual's depression symptoms. It is endorsed by the APA, is considered well-developed, and can be found online (Dailey et al., 2014). It is used in primary care settings to screen for depression and has been validated in the medical field (Beard et al., 2015).

Social Assessment

The social assessment part of the biopsychosocial assessment provides a lot of information about the client's family dynamics, as well as the client's social, vocational, and legal histories (Sperry & Sperry, p.28). I observe how the client speaks about his/her interactions with family members and with friends, along with information about work and legal issues. I monitor myself as a clinician so that I can continue to provide the client with a nonjudgmental and warm atmosphere. I can imagine that a client might feel vulnerable and would want an attentive and supportive therapist (Treiman et al., 2021). As a clinician, I do my best to create and provide this for the client.

Cultural Assessment

The multicultural part in this process is important. I do my best to be sensitive to the multicultural aspect of the client. I must keep in mind that the client's culture directly affects every area of the client's life. In fact, the client's worldview is shaped by the client's culture. This is helpful to understand when interacting with the client and assessing how the client presents and what the client says in the session. Multicultural counseling competence, which means to have an overall skill to effectively interact with clients of different cultures, is necessary and can increase positivity and client interaction (Dillon et al., 2016). If I do not understand something that the client says, I ask the client for further clarification in a nice and polite way.

Spiritual Assessment

The spiritual assessment is important in the process as well and can correlate with the client's culture. It provides another way to gauge how the client functions in life and in intense and traumatic situations. It also provides another avenue for the therapist to help meet the need of the client. In fact, spirituality is considered by some to be an essential domain of functioning (Butts & Gutierrez, 2018).

During the Intake, I ask the client about his/her spiritual/cultural factors. The client usually either gives his/her faith/belief, expresses that he/she is spiritual, or says that he/she does not believe in God. I just make sure that I respect the client's spiritual beliefs, or lack thereof, and remind myself that I am there to provide a service. The client's rights are not violated. I remain ethical and objective in the treatment of my client, make sure that the client continues to feel safe and accepted about his/her cultural faith and beliefs, and make sure that I do not infringe upon the client's rights (American Counseling Association, 2014). I am objective about

the information that the client shares. The client's information that is gathered and organized is a part of the methodology known as case conceptualization.

Case Conceptualization

Case conceptualization also helps to establish a more accurate understanding of the client and helps to create a goal-oriented treatment plan. While it is expected that some resistance might take place in the process, case conceptualization also prepares the client for a successful termination (Sperry & Sperry, p. 4). I use Sperry's model (2020), which is an inclusive and comprehensive approach. According to Sperry (2020), a case conceptualization includes diagnostic formulation, a clinical formulation, a cultural formulation, and a treatment formulation.

The Diagnostic Formulation concentrates on the client's presentation, triggers, and behavior. It aids in establishing a foundation that is ethical, accurate, and strong. The Clinical Formulation bridges the diagnostic and treatment formulation and highlights the predisposition and protective factors, as well as perpetuants. This formulation is essential because of its exploration and explanation of the situation and because of its examination of the factors pertaining to the problem.

Another important component in case conceptualization is the Cultural Formation. This formulation consists of the following elements: culture versus personality, acculturation and stress, cultural identity, and cultural explanation model. The cultural and social aspects of the client are the main points of focus. I believe that it is important that I, as the therapist, comprehend the cultural aspects of the client (the historical, psychosocial area, and functioning level). It is also important to understand that all areas of the case conceptualization are affected

by the client's cultural aspects (Ecklund & Johnson, 2007). Furthermore, the client must be seen through the proper lens of the cultural effects and influences of his/her culture.

The Treatment Formulation is the final aspect of Sperry's model. It leads the planning phase and is comprised of the following: treatment goals, treatment focus, treatment strategy, treatment interventions, treatment obstacles and challenges, treatment-cultural, and treatment prognosis (Sperry & Sperry, p. 8). What makes this formulation crucial is that all the information given in the other three formulations are combined with the focus to assist the client in changing.

Effective case conceptualization involves the systematic integration of diagnostic, clinical, cultural, and treatment formulations. If done precisely, ethically, and truthfully, the case conceptualization will present the outlook of the client that is accurate and holistic. All the information given, provided, and shared help in the formulation of the DSM-5 diagnosis, which happens to be one of the essential elements of the Intake process (Nakash et al., 2015).

DSM-5 Diagnosis

The DSM-5 diagnostic process is important in helping to create an accurate and ethical diagnosis. Contrasting criteria are explored, and unapplicable diagnoses are eliminated from the diagnostic process (Nakash et al.). An important aspect is to understand the client based upon the shared information and based upon the client's cultural, sociocultural, and spiritual elements. The criteria is explored, as well as its features, and consider the frequency, duration, and intensity of the issue(s).

Something that I keep in mind is that mental health is multidimensional and includes severity levels, which range from lesser to greater (Clark et al., 2017). Also, each client is unique and cannot be placed into a fixed categorization. With this in perspective, it is essential that I, as the clinician, properly, effectively, and accurately give a DSM-5 diagnosis. I have come to learn

that a crucial part of my identity as a professional counselor is my ability to exhaustively comprehend and navigate the DSM-5, which is an essential part of interdisciplinary communication (Dailey et al., 2014).

Treatment Planning

Once I have the DSM-5 diagnosis, my client and I are ready to collaborate on treatment planning. I do my best to continue to present myself as genuine, sensitive, and attentive, while taking into consideration the client's concerns, preferences, and ideas (Davidson et al., 2018). The treatment plan is a tool that is both essential and effective in evaluating the progress of the client. First, I explain to the client about the tenets of the treatment planning process. I share that the treatment plan helps to guide the therapy process, addresses the presenting issues, is goal-oriented, helps to gauge the client's progress, and is collaborative. I discuss with the client that this treatment plan belongs to him/her, and that this treatment plan is based upon the client's wants and goals.

Whether I am working with adolescents or adults, I work with the client to create SMART goals. This acronym stands for goals, which are specific, measurable, achievable, realistic and time bound. SMART goals assist in helping to create outcomes that can be successful for the client (Bowman et al., 2015). I believe that the therapist's goal should be that the client experiences success and is able to experience healthy change.

Outcome Assessment

It is necessary to gauge the client's success in therapy. Determining therapy's effectiveness is something that must take place in every aspect of the treatment process. Assessments and observations are the methods I use in my practice to evaluate efficacy. I support and encourage a strong alliance with the client because it encourages the client's involvement,

affects the client mentally, and makes the client's therapeutic experience enjoyable (Nakash et al, 2015).

Assessments are employed to determine the progress of the client and the efficacy of the counseling experience. Assessment instruments that are considered valid and can be implemented to estimate the client's severity level of either anxiety or depression are the PHQ-9 for depression, the GAD-7 for anxiety, and the BDI-II for depression (Perez et al., 2022).

Another important assessment instrument happens to be homework. Homework gauges the client's comprehension about what was discussed in the counseling session. I also view the self-report of the client as a tool that can be beneficial in evaluating the client's progress or growth and view the conversations with the client as beneficial also.

Observation is another important method to measure counseling efficacy. Throughout my interactions with the client, I observe the client and how he/she engages, moves, and presents himself/herself during each encounter. I am very aware of my interaction with the client and am intentional in everything that I do with the client. I am also sensitive to the client's resistance and to any change in mood and/or behavior. I always observe for changes, growth, and the client's ability to use coping skills to have successful outcomes.

Observation can prove to be beneficial, and it is important to remember the role culture plays in how the client might react to situations and to things done in the counseling session. Cultural sensitivity is paramount.

An extremely important aspect of counseling is demonstrating evidence based/best practices in clinical counseling. These best practices have been tested, and the strategies associated with these best practices have been proven to be valid and reliable, as well as usable

(Cullen et al., 2021). A therapist's use of these skills provides the therapist with the opportunity of an increased level of success.

As a clinician, I hold certain expectations during each phase of treatment. Each encounter or session with the client is designed to the client's needs. No one person is the same, and each person has different needs. In the first phase, I engage with the client about the effects of his maladaptive beliefs on his feelings and behavior and help the client to acknowledge his/her problems. In the second phase, I explore with the individual different ways to deal with his/her issues and assist him/her in recognizing, creating, and applying learned coping skills, in order change maladaptive behavior.

In the third phase, the client shows growth and experiences a level of success, whereby he/she implements his/her learned and applied skillset and can acknowledge negative thoughts, address those thoughts, realize the effects of the changed behavior, and embrace a level of success. During this phase, I will discuss about his/her feelings about decreasing the frequency of sessions. In the final phase, I will recommend that the client is discharged, will encourage the client to continue to use the skillset learned, and will let the client know that he/she is always able to contact me when the need arises. Aftercare is also discussed.

Aftercare is an important element in the process. The aftercare/maintenance planning process is something that must be dealt with and discussed intentionally and honestly. As a clinician, it is my duty to make sure that the client is ready to be fully discharged and that the client can deal with the issues that brought him/her to the counseling experience initially.

I believe that supporting the client is crucial in this phase because the client needs to know that I, as his/her therapist, believe that he/she can continue to effectively address his/her issue without coming to the therapist consistently. An empirical study suggested that those, who

provide mental health services, can increase their client's success long-term if they provide the clients with great esteem and support throughout therapy (Hart & Mc Garragle, 2010). Regardless of the client's issue, I believe that this type of uplifting engagement with the client is something that can embolden the client to continue to use the learned skillset in the community.

Something that must be discussed is the possibility of relapse in therapy. I believe that it is important to discuss with the client about his/her support system and to collaboratively work with the client to create a relapse prevention plan and to have that plan in place just in case something happens. This intervention is needed because relapse can be a great risk for some clients, and this intervention is essential to deal with the possible issue of relapse and to help minimize the change for relapse (Moriarty et al., 2020). Again, I stress to the client that I am always available, and that if he/she needs to talk and/or schedule a session, that is possible.

Termination can be hard for both the client, as well as the clinician. I do my best to make sure that I remain ethical and objective and preserve the efficacy of the treatment process. I realize that I am human and have feelings. I just keep in mind that the focus is about meeting the needs of the client. I encourage the client to do his/her best and remind that client that this therapist is always a reachable and collaborative team player.

I believe in the theories I use in my practice. They are evidenced-based, encourage change, and encourage the individual to embrace his/her strengths. They also encourage the client to grow and provide tools to help the client change and have a level of success. In addition to this, I believe that my comprehensive methodology of biopsychosocial/cultural/spiritual assessment is ethical, promotes best practices, and is effective in meeting the needs of the client throughout the phases of treatment and throughout every aspect of the counseling experience.

Case Study

In this section, I narratively describe the counseling process with an adult client with the diagnosis of depression. The purpose of this case study is to discuss a fictitious client's clinical experience in my practice, ranging from the first session to the termination and aftercare planning.

Dwayne is a 22- year-old, heterosexual, single, African American male; a sophomore at the University of Maryland. He does not have any children and is a music major (piano). Dwayne stays on campus, is a musician, and has a part-time job off campus. He regularly sees his primary care physician, does not have any prior health concerns, and does not take any medication. He denies illicit substance use, is a Christian, and regularly attends church. His presenting problem is depression due to conflict with a co-worker. Further details concerning his presenting problem are in the case conceptualization (Appendix I).

Due to COVID-19, the intake process occurred on a HIPPA compliant platform. The client was seen on time in the Zoom waiting area for his appointment. I observed that he was neatly and casually dressed. He appeared of average weight and healthy. He was fully engaged with proper eye contact. He presented as alert and oriented x4 (person, place, time, and situation) and did not present as cognitively impaired. He was cooperative, with normal speech and cadence. Dwayne denied suicidal/homicidal ideation.

Dwayne initially contacted me through Psychology Today. I responded to his inquiry with a call and introduced myself to him. He briefly told me what he was experiencing and stated that he would like to have a session. I encouraged him for reaching out to me for assistance.

An Intake session was created. I input his information into Therapy Notes, sent him a welcome email, and emailed him the Intake packet, which also includes the HIPPA Compliance Patient Consent form, the PHQ-9 assessment for depression, and the GAD-7 assessment for

anxiety. I assess across the entire DSM spectrum of conditions, which also includes the DSM Cross Cutting Surveys Level 1 and 2 and the WHODAS. He was instructed to complete and upload back into the Therapy Notes' Portal before the Intake session. I explained to him the process, and he said that he understood.

At the time of his Intake, his completed Intake packet was added into the system, and his responses were generated into the proper fields of the Psychotherapy Intake Note in Therapy Notes. Confidentiality was discussed, and he stated that he was in a private and secure area when asked. He was given an opportunity to present any questions.

I strive to present an atmosphere that is welcoming, empathetic, and safe for the client, especially as the client and I proceed into the conversation about his presenting issue(s) and as the assessment progresses. In discussing his presenting problem, Dwayne stated that he had been experiencing some depression because of a co-worker, who was transferred to his job about 1 ½ months previously. He stated that she has been with the company longer and has been creating conflicts with his work schedule for the past month. He reported that he does not feel like doing much when he goes to work or thinks about work, that he feels hopeless at times, and that he loses his appetite when he goes to work. He also said that those feelings do not last long but come and go, and he said that he is still able to function and do his work. He denied experiencing anxiety and said that he does not have a problem in that area. The GAD-7 and the PHQ-9 results were discussed. His GAD-7 score was a 0 (Minimal Anxiety), and his PHQ-9 score was a 5 (Mild Depression). I asked him if anything had changed since he initially took those two assessments, and he responded that nothing had changed. He also denied all areas of risk.

Dwayne denied having psychiatric issues, as well as experiencing any trauma. He stated that this was his first time in therapy. He denied having a family psychiatric history and denied

medical conditions and the use of medications. He denied using illicit substances and said that he does not smoke or drink. He stated that his parents are happily married and that he has an older brother and an older sister. He said that he has good relationship with his family. It was observed that he lit up when talking about his family as evidenced by his smile and change in presentation.

Socially, he attends the University of Maryland, lives on campus, and works part-time. He said that he loves his part-time job but said that since an older woman was transferred to his department he does not enjoy going to work if she is there. I observed his body language shift as he briefly spoke about this female co-worker. When asked about the things he enjoy, he said that he loves to laugh, have fun, and play the piano, which he said gives him peace. He stated that he is a Christian and plays at his family church. He said that he has never been arrested.

I asked him about his strengths, needs, abilities, and preferences (SNAP). He said that he is a good communicator and likes to encourage people. He said that he needs to work on not allowing his co-worker to get the best of him. He said that he can multitask. He said that he wants to talk with a therapist, who cares, listens, and does not judge. I responded that I am here to work collaboratively with him.

With these things in perspective, I asked Dwayne for two things that he wanted to work on in therapy. He responded that he wanted to work on his coping skills so that he can deal better with his co-worker. He said that this was the only thing that he wanted to focus on at the time. I respected his autonomy and told him that we can adjust and change his goal as needed. After this, I discussed with him my thoughts about his probable diagnosis. I told him that this diagnosis does not define who he is but rather gives some insight concerning what he is experiencing.

I shared with him that I believe that his diagnosis is Unspecified Depressive Disorder and shared with him my probable reasons for this diagnosis. I gave him the opportunity to ask

questions, and we scheduled his next appointment and discussed about the suggested frequency and duration of his counseling experience. He thanked me for seeing him and said that he felt comfortable talking with me.

Based on everything presented and observed, I believe that Dwayne met the requirements for an Adjustment Disorder with depressed mood (F43.20). What he described did not meet the full requirements for major depression. The DSM-5 was used to make this diagnosis. I kept in mind that comorbidity exists with depression and explored differential diagnosis to rule out any other possible diagnosis (Dailey et al., 2014). His depression was not medication-induced and/or due to a medical condition. His level of functioning was not greatly impaired by depression, as evidenced by his PHQ-9 score of 4 (Minimal Depression). In addition to this, he had only been experiencing the symptoms for almost a month. CBT is an empirically supported intervention for this diagnosis, demonstrating effectiveness in reducing symptom-related distress and decreasing the likelihood of relapse following treatment (Hollon et al., 2002).

In the next virtual session, we reviewed and worked on his Psychotherapy Treatment Plan. Dwayne reported that on a scale of 1 (low)- 10 (high), his depression level was a 6. I gave the BDI-II and discussed the results. He said that he felt a little hopeless and had some thoughts in his head about the co-worker. We explored his feelings and thoughts, and I spoke with him about CBT and discussed about the importance of monitoring, acknowledging, challenging, and replacing illogical thoughts with positive thoughts (positive self-talk) (Ritter, 1985). I also told him that he can make changes that are positive (Lewis & Osborn, 2004). I spoke with him about his strengths and about what he likes to do. He said that he had not been playing the piano much in the past few weeks and was encouraged to play the piano a little bit each day. I encouraged him to write his thoughts in a journal.

On Dwayne's next appointment, I gave him the PHQ-9, and his score was a 1. He stated that his co-worker was moved to another location, that the depressive thoughts were subsiding, and that he felt like he was becoming himself again. He reported that the positive-self talk helped a lot and that he was playing the piano more. He reported journaling and said that felt much better. He requested to meet once every other week. By the third phase of treatment, his PHQ-9 score was a 0, and I discussed with him about discharging. A few more sessions were added with the goal of developing resiliency and an aftercare plan. By the final phase, I prepared him for termination. He was reminded that he could reach out to me if needed. We worked on a relapse prevention plan, and he created a positive network with members of a depression group he had joined in the community. He met his goals and learned to use his tools. This case study was effective because it included the following: an expansive and theoretically grounded model of clinical counseling; an effective case conceptualization and evidenced-based treatment plan; the DSM-5 to effectively diagnose, treat, and meet the needs of the counselee; and overall best practices throughout the counseling process that included evidenced-based theories, assessments, and processes used in the clinical counseling setting.

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Appendices

Appendix I: Case Conceptualization

This case conceptualization of my client Dwayne was built upon Sperry's Cognitive Behavioral Case Conceptualization. Concerning Dwayne's diagnostic formulation, his reported change of behavior and minor depressive symptoms (presentation) appeared to be his reaction to conflict at work, which he stated was caused by his co-worker (precipitant) and by the thoughts he reported having about the uncertainty of how she might treat him and make him feel (continuing precipitant). Throughout his life, he stated that he generally got along well with others and had never had to deal with conflicts with people. Therefore, he had not developed coping skills or strategies to deal with conflict (pattern-maladaptive). He reported that his level of functioning was high until he came across his co-worker. At the time of his Intake, he presented with a full affect and was cooperative; however, he began to look sad whenever he spoke about his co-worker.

Dwayne's clinical formulation described his predisposition, perpetuants, and protective factors & strengths. His worldview was that if he gave respect then he received respect, and if he received respect, then he must be liked. This was what he perceived from his interactions with his parents (predisposition). As a result, it appeared that Dwayne worked hard to try to please people so that he could feel liked and accepted (perpetuants). He also had many protective factors & strengths. He had family and religious values, which could prove to be a source of strength. He was a college student, a musician, and a hard worker. He also got along well with most people (protective factors & strengths).

Dwayne's cultural factors were so important, especially his historical, psychosocial surroundings, present degree of functioning (Ecklund & Johnson, 2007). He identified as an

African American male and maintained his ethnicity (cultural identity). He appeared to be highly acculturated and did not appear to experience a level of stress due to his ethnicity (cultural stress & acculturation). He believed in the family unit and in his Christian faith (cultural explanation). Both his culture and his personality were effective (culture and/or personality).

The challenge for Dwayne was to not allow things that he could not control to dictate how he felt (treatment pattern). We collaborated on his treatment goal, which was to learn and apply coping skills to reduce the symptoms of depression (treatment goals). The treatment focus was on conflicting situations triggered by maladaptive behavior and thoughts (treatment focus). The treatment strategies used were as follows: Motivational Interviewing, CBT tools, SFBT questions, assessments, observations, psychoeducation, PHQ-9, GAD-7, exploration of relationships, coping strategies, mindfulness, cognitive restructuring, and cognitive refocusing (treatment strategy).

The treatment interventions used were as follows: affirmations, role play, and interactive feedback (treatment interventions). Dwayne might struggle with trying to please the therapist (treatment obstacles). I believe that it was beneficial to explore and address his parents' cultural expectations (treatment-cultural). Since Dwayne initiated seeking assistance concerning depressive issues due to conflict, I gave him a good to very good treatment prognosis (treatment prognosis).

I believe that this case conceptualization provided a more, in-depth view of my client Dwayne. Everyone is different. Every situation is unique. With all the information assimilated, I will do my best to meet him where he is and will continuously provide a haven, where my client feels safe, validated, heard, and able to work through his present situation.

Appendix II: 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)
Conflict issues	The client will learn and apply coping skills in order to reduce the symptoms of depression.	-Journaling -Positive self-talk -Cognitive Restructuring -Thought stopping -Coping strategies -Relationship exploration -Psychoeducation -Role play -Affirmations -Mindfulness -Art therapy -SFBT tools -CBT tools	8 or as needed	- PHQ-9 - BDI-II -Self-report -Observation - Verbal Scale of 1 (low)- 10 (high) for depression at the beginning of each session -Journal	- Follow-up with the client once a month -Attend a depression group in his community once a month *No medication needed