Reflective Paper

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I have no known conflict of interest to disclose.

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Abstract

Reflecting and understanding one's viewpoint on best therapeutic practices can prove to be a rewarding, informative, and enlightening experience. This reflective paper will examine the following things: integrative modalities of treatment, the procedures used during the treatment process, the importance of accurate case conceptualization, the implementation of using evidenced based/best practices, the methodology of evaluating effective counseling, and present and personal key thoughts about the ACA Ethics Codes and the ACA Counselor Competencies. In my therapeutic practice, Cognitive Behavioral Therapy, Solution-Focused Therapy, Motivational Interviewing, and Person-Centered Therapy are cohesively integrated with Cognitive Behavioral Therapy as the foundational therapeutic modality of treatment. They are evidence-based and focus on change, as well as the client's strengths. With all these things taken into consideration, the main purpose of this paper is to reflect upon, examine, and explain my outlook on the overall counseling experience, ranging from integrative theories to methodologies used during this counseling experience.

Keywords: Cognitive Behavioral Therapy, Solution-Focused Therapy, Motivational Interviewing, Person-Centered Therapy, case conceptualization, treatment process

Counseling Theories

In my therapeutic practice, I draw from an integration of the following evidence-based theories: Cognitive Behavioral Therapy (CBT), Solution-Focused Brief Therapy (SFBT), Motivational Interviewing (MI), and Person-Centered Therapy (PCT). Cognitive Behavioral Therapy forms as the foundational therapeutic methodology used, while being integrated with the other three methodologies. This methodology is important because it focuses on the precepts that if an individual changes his/her thought process then that would bring about a change in the person's feelings, which would eventually result in the person's desired change in behavior. Mr. Aaron T. Beck, who is known as the father of Cognitive Behavioral Therapy, supported the idea that a person's issues are mostly created from a distorted reality that is based on an irrational assumption(s) (Ritter, 1985). The goal is to move the person from maladaptive behavior by identifying, addressing, and changing the illicit thought, which will affect the feelings and bring about a changed behavior. Ultimately, what becomes paramount about this theory is that the client eventually develops new strategies to learn from his/her experiences, as well as to solve problems (Beck, 1976, p. 230).

Solution-Focused Brief Therapy is complimentary to Cognitive Behavioral Therapy. Founded by Steve de Shazer and Insoo Kim Berg, this theory supports the notion of the clinician and the client having a relationship that is working and collaborative. This theory also focuses mainly on solutions and not on problems (Lewis & Osborne, 2004). It is my belief that we sometimes focus too much on the problem rather than focus on creating a positive change and solution. I also implement this theory because of its use of the "miracle question," when the client is asked to imagine a time when his/her problem does not exist and to describe the details of that day. I believe that this question instills hope in the client, could give the client something

to work towards, and could be used as a way to establish therapeutic goals (De Shazer & Dolan, 2007, p. 40). I further implement this theory because it encourages the client to use resources and to understand that he/she is able to do what is in his/her best interest.

Motivational Interviewing was founded by William R. Miller and Stephen Rollnick. Even though it is not a theory, it is a collaborative counseling approach, which was originally used in the addictions field. It also emphasizes change and seeks to encourage the client to become motivated by his/her strengths, in order that the client will commit to the change process (Miller & Rollnick, 2013, p. 12). Its five fundamental principles are as follows: develop discrepancy, avoid argumentation, roll with resistance, express empathy, and support self-efficacy. It is also so important and useful because it closely supports the Stages of Change model, which supports the following identifiable stages in the counseling process: precontemplation, contemplation, determination, action, maintenance, and relapse (Lewis & Osborne, 2004). This is very useful, especially with clients who either struggle or have struggled with addictions. I have worked and continue to work with a lot with clients with addiction issues.

Person-Centered Therapy, or Client-Centered Therapy, was developed by Carl Rogers. This theory is used in my counseling because of its precepts about the client's autonomy and ability to make his/her own choice in the collaborative, counseling relationship. This theory places the client as the lead and the therapist/counselor as the supporter. It also focuses on genuineness, unconditional positive regard (unconditional acceptance and support), and empathy (Rogers, 2021, p. 230). It is my belief that the client needs to understand that this relationship is collaborative, that he/she has to do the work, and that he/she has to take ownership for his/her life, as well as choices made.

I believe that all the counseling theories I have mentioned above complement each other, are evidenced-based, and help the client to change. CBT is foundational in my counseling because I believe that change starts by recognizing that there is a problem, identifying the problem, changing the perception about the problem, and working through the problem. Solution-Focused Therapy, Motivational Interviewing, and Person-Centered Therapy are all collaborative and focus on change via solution and motivation due to the client's strength and ability to know what is best for his/her life.

Procedures for Phases of Counseling

As a clinician, I use Therapy Notes, which is a behavioral health EHR. Within the Intake process in Therapy Notes, the following sections/areas are discussed and presented at the time of the Intake: Presenting Problems, Current Mental Status, Risk Assessment, Biopsychosocial Assessment, Plan, and Diagnosis. This diagnostic assessment is important because it is focused on gathering data about the client that is crucial in the client's treatment and outcomes (Sperry & Sperry, 2020, p. 27).

Due to COVID-19, my clients are seen virtually for all Intakes via the HIPPA-compliant version of Zoom. Prior to the Intake with the client, each client completes six documents/surveys, which they download and upload into the Therapy Notes' Portal once they have been completed. The documents/surveys are as follows: an Introduction, the HIPPA Compliance Patient Consent Form, the Client Information Form, the Client Contacts Form, the Client History Form, and the Client Insurance Form. These completed forms provide the opportunity to gather information that will give more insight about the client and about his/her issue(s) before the actual Intake session. The Client History Form includes information from the

Biopsychosocial Assessment of the Intake process and can be populated into the specific fields at the time of the Intake with the client.

While initially meeting with the client virtually can be quite different from meeting with the client in person, I strive to provide the client with an empathetic and nonjudgmental atmosphere where he/she feels safe, valued, and respected. Creating a healthy alliance and rapport with the client is important in gathering information from the client, which could affect the diagnostic assessment (Nakash et al., 2015). Within the realm of the established atmosphere via Zoom, I do my best to fully engage with the client, while respectfully taking into consideration the client's social, cultural, and spiritual contexts.

Motivational Interviewing is used during my clinical interview process. The goal is to create a positive, healthy, and collaborative therapeutic relationship with the client. Cognitive Behavioral Therapy focuses on changing one's thoughts, feelings, and behavior, and I believe that Motivational Interviewing compliments this theory in that it encourages the client to reflect upon his/her own strengths, which would serve as motivation for the client to embrace change (Miller & Rollnick, 2013, p. 12). So, during this interviewing process, I ask CBT-based questions, as well as Motivational Interviewing tools, such as reflections, affirmations, summarizing, and open questions. The CBT-based questions help to see the correlation between the client's thoughts, feelings, and behavior.

At the time of the Intake, I click the History button, and the client's information is populated into specific fields, based upon the information they uploaded into Therapy Notes. As I ask probing questions and work to build a good rapport with the client, I also add more information to each section of the Biopsychosocial Assessment. With the gathered information, I

begin to formulate the mental health diagnosis, which is one of the important components of the Intake (Nakash et al., 2015).

In determining an accurate DSM-5 diagnosis, I use the "symptom" approach, explore the different criteria, and eliminate diagnoses that no longer pertain to the client (Nakash et. al.). Along with this this, I believe that it is important to understand the client based upon the information he/she has provided, as well as the sociocultural, cultural, and spiritual contexts. I also examine the features associated with the criteria, while taking into consideration how long the client has been dealing with the issue(s) and how often his/her issue has occurred. One thing that must be understood is that mental health is not one dimensional but is multidimensional, ranging from lesser to greater degrees of severity (Clark et al., 2017). This is why it is important that the clinician is able to effectively provide an accurate mental health diagnosis.

Each session is constructed for each individual client. This is important because each client is unique and is not the same. After initially meeting with the client for the Intake session, the structure of each session is detailed to the individual and is built upon the rapport created with the client during the Intake. I discuss again about CBT and its concepts. I check the client's mood, ask for any updates, discuss and explore any issues that the client might have, set goals, and give homework. Each session is collaborative and structured as to build upon the strengths of each individual client.

During the first phase of treatment, I work with the client to understand how his/her maladaptive thoughts affect his/her feelings and his/her behavior. This phase helps the client to identify his/her issues. During the second phase of treatment, I focus on exploring with the client several ways to address his/her maladaptive behavior and help the client to identify, develop, and implement coping strategies/skills to assist in preventing illicit behavior. During the third phase

of treatment, the client is able to use his/her skills or tools to recognize maladaptive behavior ("stinking thinking"), change his/her thoughts, and look at the situation from a different perspective. There is some level of success during this phase, and I will talk with the client about possibly decreasing the number of sessions. During the final phase, the client will be discharged, and I will inform the client that he/she is able to reach out whenever he/she need to talk.

Case Conceptualization

Case conceptualization is a methodology that is used for gathering and organizing information about the client, getting a better picture of the client's situation, creating a treatment plan that is goal-focused, expecting resistance during the treatment, and getting the client ready for termination that is successful (Sperry & Sperry, p. 4). In my opinion, the following formulations are important to include in a case conceptualization: diagnostic, clinical, cultural, and treatment. These four components are important because they can provide a comprehensive understanding about the client, about his/her situation, about how the client's culture plays a role in the client's life/issue, and about how the treatment plan can assist the client in change. The information given in each step provides and fuels the focus in the following step.

A case conceptualization must have a diagnostic formulation. This is important because this element focuses on the client's presentation, triggering factors, and personality patten; all of which are important in creating an accurate mental health diagnosis (*DSM-5* diagnosis). The information given and what is observed from the client must be accurate and ethically true. This step considers how the client presents during the initial encounter, examines the client's triggering factors, and maladaptive behavior. Diagnostic formulation is also important because it helps to create a solid, ethical, and strong foundation, which could provide an accurate understanding and picture about the client and what the client has experienced.

Clinical formulation plays an important part in case conceptualization. The information obtained in this formulation connects the diagnostic formulation with the treatment formulation. Its elements consist of predisposition, protective factors, and perpetuants. This is important because it explores and explains "why" something happened, as well as examines the risk and protective factors associated with issue at hand.

Cultural formulation is also an important element in a case conceptualization. Cultural identity, acculturation and stress, cultural explanation model, and culture v. personality are important elements in this formulation. This formulation focuses on the examination of the client's cultural and social implications, which must be done effectively and sensitively, in order to create a healthy, positive, and collaborative relationship with the client. Understanding the client's cultural factors, as it relates to "history, psychosocial environment, and current level of functioning," is important and should be integrated throughout the case conceptualization (Ecklund & Johnson, 2007). This formulation is also important because the client should be addressed within a proper understanding of the effects of his/her cultural influence. Another important element is to

It is important that a case conceptualization includes a treatment formulation, which guides the planning process. This formulation consists of treatment pattern, goals, focus, strategy, interventions, obstacles, prognosis, as well as cultural implications (Sperry & Sperry, p. 8). This formulation is important because it is comprised and driven by the information provided in the diagnostic, clinical, and cultural formulations. The focus is on how the client can experience change.

Diagnostic formulation, clinical formulation, cultural formulation, and treatment formulation are essential elements, which must be included in a case conceptualization. If

completed accurately, honestly, and ethically, the case conceptualization will present an accurate, powerful, and detailed holistic view of the client (Sperry & Sperry, 2020).

Evidence Based/Best Practices in Counseling

Possessing the knowledge, as well as the ability to effectively apply evidence-based/best practices in counseling, is important because it means that the strategy to be used in the counseling experience has been tested and proven, is reliable in moving the client from one point to another, and can have the possibility of reproducing another positive outcome for someone else. In other words, evidence-based/best practices in counseling allude to the strategy's "validity, reliability, and usability" (Cullen et al., 2021). Knowing how to effectively apply evidence-based/best practices increases the counselor's chances of having a greater success rate in the counseling setting.

The following evidence-based practices would be used in counseling a 9-year-old dealing with Obsessive Compulsive Disorder (OCD): Cognitive Behavioral Therapy and Solution-Focused Brief Therapy. I would work to create an empathetic environment where the client could feel safe to share, and I, as the counselor, would work to create a healthy and strong therapeutic alliance, which is a core element in therapy (Nakash et al., 2015). Psychoeducation would be used to teach and explain to the client about OCD. Knowledge is power, and I would explain this in a way that the client could fully understand even by use of a game that he could understand.

Cognitive tools/strategies (thought recording, creating solutions, questioning) would be introduced and taught to the young client so that he/she could learn how to effectively deal with OCD. For example, I would teach the client how to identify the issue/problem, change the way the issue is viewed, and replace the negative thought with a positive one, in order to bring about

the desired change. I would also teach the client about using positive affirmations throughout the counseling experience. Even though the client is 9, I believe that the child could be taught on his/her cognitive level to monitor his/her thoughts and to recognize and challenge, and replace irrational beliefs (Ritter, 1985). In addition to this, I believe that it would be beneficial for the parents to receive psychoeducation also, as well as exposure and response training. The child needs the necessary tools to endure the terror when he does not give in to the compulsion.

Solution-Focused Brief Therapy would also be used, along with some tools associated with this methodology (miracle and presuppositional questions). I and the client would work collaboratively, building upon the client's strengths and available resources, and the client would be taught and encouraged that he/she has the ability to create positive changes in his/her life, even though he/she is 9 years old (Lewis & Osborn, 2004). The treatment plan would be collaboratively worked upon as well. The overarching goal would be for the client to feel empowered to overcome OCD through use of cognitive tools, strength-based tools, and even medication if it is needed to assist the client in becoming stronger mentally.

The following evidence-based practices would be used in counseling an adult with moderate levels of depression: Cognitive Behavioral Therapy, Solution-Focused Brief Therapy, and Person-Centered Therapy. Cognitive Behavioral Therapy must be used because it has been proven to be successful in the treatment of depression due to its results of relieving acute distress, reducing symptomatic returns if continued, and reducing potential relapse post treatment (Hollon et al., 2002).

Since CBT focuses on changing or eradicating irrational thoughts and replacing them with rational thoughts in hopes of producing a desired behavior, I would model and teach the client how to identify and replace irrational thoughts with rational thoughts. I would also teach

the client about triggers and how to recognize triggers, which might bring about depression. A validated psychometric test (the Beck Depression Inventory-II; Patient Health Questionnaire-9), which is a standard way to assess depression severity, would be used often during the counseling experience in order to assess the client's level of depression (Perez et al., 2022). Homework would be given regularly in order to assess the client's growth in the counseling experience.

Solution-Focused Brief Therapy and Person-Centered Therapy would also be used to counsel this adult dealing with depression because they are also evidenced-based, as well as strength-based, and are collaborative. Miracle and presupposition questions would be used. This adult would be taught to focus on the solutions rather than on the problem and would be taught to look for the exception to the problem. The adult's autonomy in the counseling process would be respected, and the adult would be encouraged to rely on his/her own strength and to understand that he/she knows what is in his/her best interest.

While how to best address the needs of both clients can be subjective, Cognitive Behavioral Therapy, Solution-Focused Brief Therapy, and Person-Centered are all evidence-based and have been proven to be reliable, valid, and useable with the ultimate goal that the client will experience a change and a level of success.

Methods Used for Evaluating Counseling Effectiveness

The following methods are used for assessing counseling effectiveness throughout the treatment process: assessments and observations. I believe that counseling can only be effective if the therapeutic alliance is strong because this alliance affects the client's improvement, mental health, and feelings about the counseling experience (Nakash et al., 2015). If this alliance is strong, the client will engage and talk on all different levels. Assessments are used to evaluate the client's progress, as well as counseling effectiveness, during the treatment process. These are

also tools, like the treatment plan. The treatment plan is an important and effective tool that clinicians continuously use during the treatment process to evaluate the client's progress. The GAD-7 (anxiety), the PHQ-9 (depression), and the BDI-II (depression) are validated assessment tools (psychometric tests) that can be used during this process to measure the client's degree of anxiety and/or depression (Perez et al., 2022). Homework is also an important assessment tool used to engage the client's understanding about the concepts discussed in the counseling sessions. The client's self-report can also be used to discover the client's progress throughout the counseling experience, as well as intentional conversations with the client on an ethical and continuous basis.

I also use observation as a method to assess counseling effectiveness. During the treatment process, I am observing the client's engagement, body language, behavior, and presentation in each session. I am looking to see if the client is fully engaged in the conversation with this writer. I am also observing to see if the client is triggered by something stated during the session, if the client is able to articulate any negative thoughts that might arise and if the client shows any resistance at any time during the treatment process. I am also observing for any changes in growth, especially as it relates to the treatment plan and the client's ability to use coping skills and other cognitive tools more effectively.

The formulation of the treatment plan is something that should be completed collaboratively between the counselor and the client. Therefore, I, as the counselor, do not to develop the treatment plan by myself. If at any time it is realized that the treatment plan is no longer addressing the client's presenting problems, the client and I will come together and talk about the goals I assisted him/her in creating, and I will ask the client to share his/her thoughts about why the treatment goals were not met. I would then assist the client in updating and

creating new goals. If something is not working, it is not working. It is not my job to make the client complete the treatment plan goals; however, I do my best to meet the client where he/she is, assess if there is any resistance to treatment, and assist the client in recommitting to the goals or creating goals that are attainable for the client and can bring level of success.

I prepare the client to maintain progress made in counseling post-termination by reviewing the tools taught and learned, as it pertains to the client's treatment plan goals, and by discussing and exploring with the client about how he/she would currently deal with their presenting problem as opposed to when he/she first came to counseling. I present the client with real-life conflicts and ask the client how he/she would deal with the issue, while assessing his/her use of coping skills and ability to identify maladaptive behavior and replace that irrational thought with a rational thought. I empower and encourage the client to use the tools learned and encourage the client that he/she will still be able to experience success post-termination. In addition to this, I address any issue or concern that the client might have and tell the client that he/she can always reach out if a situation arises.

ACA Ethics Codes and the ACA Counselor Competencies Important Points

Some important points caught my attention as I read the American Counseling Association Ethic Codes and the American Counselor Competencies. Some of those important points relate to the client's welfare, informed consent, imposing values, avoiding inappropriate relationships with the client, understanding competence boundaries, monitoring effectiveness, providing accurate representation, and not discriminating against the client (American Counseling Association, 2014).

The section about the client's welfare really caught my attention. It discussed about the counselor's primary responsibility of protecting the client's welfare and dignity (American

Counseling Association, 2014). It is the counselor's job to make sure that the client's welfare and dignity are protected and honored throughout the entire counseling experience. It is all about the client and everything that relates to the client, and everything done on behalf of the client should be done in the best interest of the client. Another point that stood out to me was about counseling plans. The creating, implementing, and revising of treatment plans is a collaborative work between the counselor and the client that should be created to produce a level of success with the client understanding that he/she has the freedom to choose the tenets of his/her treatment plan.

Concerning informed consent, what stood out to me was the part about the counselor understanding the client's cultural background and relating information to the client in a way that the client can fully comprehend what is being presented. The counselor must be culturally sensitive, and it is the counselor's job to ensure that the client understands the information being provided about informed consent. The counselor's avoidance of imposing values upon the client really stood out to me as well. As counselors, we must remember that it is not about our values and norms but about the client's. We have to remember not to project our worldview onto the client during the counseling experience.

One of the most important points that stood out to me pertains to avoiding inappropriate relationships with the client, whether in person or virtually. As a counselor, I must always monitor my interactions with the client, in order to avoid dual relationships with current or former clients and to avoid becoming romantically or inappropriately involved with the client.

Understanding competence boundaries is very important. Reading this reminded me that I can only work within the scope of my competence as it relates to my educational process, earned credentials, and professional experience (ACA, 2014). Working outside of anything other than

my educational and professional competence is unethical, is misleading, and does not present an accurate representation of my practice and work as a counselor.

Another very important point that stood out to me pertains to monitoring my effectiveness as a counselor. Professional growth is important, ongoing, and necessary. This requires being honest about my effectiveness as a counselor and being willing to improve on my effectiveness through peer supervision.

There are some aspects I found challenging as a result of reading the ACA Ethics Code and the ACA Counselor Competencies. They are as follows: personal values, maintaining boundaries and professional relationships, and understanding responsibility to parents and/or legal guardians. As it relates to personal values, I would not say that this is challenging; however, I feel as if I am always having to make sure that I am not projecting my values onto the client. I strive to be respectful and ethical in how I perceive and observe the client's rights, feelings, and viewpoints and, at times, I have to stop and remind myself often that this experience is about the client. When the opportunity avails itself, I might ask if I can suggest an opinion but only if the client feel comfortable with that.

Something that I also strive to do is to be ethical and culturally sensitive as it relates to maintaining boundaries and professional relationships. The challenging part is that a client, based upon his/her worldview and culture, can be more interactive and livelier in the counseling experience. Therefore, it can be challenging to maintain ethical and professional boundaries with a client, who might feel offended with such boundaries and enjoy being free in his/her interaction/communication style. It can also be challenging, especially if I enjoy the client's culture and personality. There must be a constant reminder that this counselor/client relationship has to remain professional and ethical, staying clear of any misrepresentations or inappropriate

behavior. Remaining culturally sensitive and maintaining ethical boundaries has to be handled intentionally and professionally.

One of the most challenging aspects I have experienced is dealing with responsibility to parents and/or legal guardians. While I have generally had healthy, positive, and collaborative relationships with most parents and/or legal guardians, I currently have a parent/legal guardian, who contacts me constantly to tell me things about her son ("grandson") and about what she wants me to talk with him about. While appreciative, I must constantly set boundaries and must remind her that I am first here for her son/grandson, who is my client. Just recently, I had to respectfully remind her that I cannot use what she tells about her son/grandson in the counseling session. I do make sure that each parent/guardian is informed about pertinent information relating to their child, while at the same time maintain that client's confidentiality. This collaborative relationship with the parent/guardian is possible but can be challenging.

Completing this reflective paper has been a rewarding but thought-provoking experience. It has challenged me to examine my theories a little more closely, as well as the procedures I use in the different phases of treatment. I learned more about the importance and necessity of case conceptualization and gained a better understanding about the use of evidence-based practices in the counseling experience. I explored the methodology I use for evaluating counseling effectiveness throughout the treatment process, making the necessary changes, and preparing the client in maintaining desired goals during post-termination. I expressed my feelings about the important points from the ACA Ethics Codes and the ACA Counselor Competencies and expressed what I found challenging. This reflective paper has encouraged me to view the counseling experience from a stronger, holistic, and evidence-based perspective.

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