

Benchmark Capstone Project

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I have no known conflict of interest to disclose.

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Abstract

This paper includes a summation and description of my theoretical framework for ethical and effective counseling. In the first section, the theories I apply in counseling are examined, both individually, as well as collectively. The second section of the paper discusses my comprehensive method of bio-psycho-social, as well as cultural and spiritual assessments methodology.

Keywords: theoretical framework, counseling, ethical, motivational interviewing, cognitive behavioral therapy, acceptance and commitment therapy

Feedback Provided by Faculty Member on First Paper (Student must list every element of feedback given)		How I Applied the Feedback in Paper Two (Student must have corrected every element of feedback given)
1.	Use italics instead of quotation marks for emphasis of the word <i>hexaflex</i> .	Changed quotation marks to italics for <i>hexaflex</i> .
2.	Use italics instead of quotation marks for emphasis of the word <i>workability</i> and <i>workable</i> .	Changed quotation marks to italics for <i>workability</i> and <i>workable</i> .
3.	Brackets should not be used to enclose an abbreviation within a parenthetical citation for C-SSRS, GAD-7, and PHQ-9. Use the abbreviation followed by a semicolon to separate the abbreviation from the citation.	Removed brackets and replaced with semicolon within parenthetical citations for C-SSRS, GAD-7, and PHQ-9.
4.	Titles need to be italicized, and the edition and text revision should be included within the parenthetical citation.	Italicized <i>Diagnostic and Statistical Manual of Mental Disorder</i> and included the edition and text revision within the parenthetical citation (5th ed., text rev.; American Psychiatric Association, 2022).
5.	<i>That</i> should be used instead of <i>the</i> .	Changed <i>that</i> to <i>the</i> .
6.	Online article titles must be italicized in references.	Italicized the online title for the reference entry: Armstrong, T. (2020, June 12). <i>The stages of faith according to James W. Fowler</i> .
7.	Scale titles must be italicized in references.	Italicized the scale titles for <i>Columbia-suicide severity rating scale (C-SSRS)</i> and <i>Generalized anxiety disorder 7 (GAD-7)</i> .

Theoretical Framework for Ethical and Effective Counseling Journeys

In the following sections, the theories that I apply in counseling will be discussed along with my comprehensive method of bio-psycho-social/cultural/spiritual assessment. All aspects of my theoretical framework adhere to the *2014 ACA Code of Ethics* (American Counseling Association [ACA], 2014). It is important to note that my experience in counseling is limited to the paradigm of a certified community behavioral health clinic (CCBHC).

Section 1: Theories I Apply in Counseling

Though a multitude of counseling theories are available, time does not permit me to become adept at using all of them in my counseling practice. During my master's degree studies in clinical mental health counseling at Liberty University, I was fortunate to have professors who used a variety of counseling theories. I was also influenced by my practicum and internship site, which was a CCBHC. However, I had to decide for myself which theories were most applicable to my values and beliefs. Currently, I focus primarily on motivational interviewing (MI), cognitive behavioral therapy (CBT), and acceptance and commitment therapy (ACT). I have found that the three theories provide a synergy to my counseling that would not exist otherwise. Since I continued my professional counseling career at the same CCBHC at which I completed my practicum and internships, I wanted to ensure that I use evidence-based theories that are appropriate for the clients with whom I work.

Motivational Interviewing

Miller and Rollnick (2013) assert that motivational interviewing (MI) is essentially concerned with conversations about change. However, the authors caution that challenges can rise to the surface during such conversations. The conversations can become dysfunctional when they happen between a person seeking help and a helping professional. MI was designed to

mitigate the potential for dysfunctional conversations in a helping context so that the person seeking help can talk themselves into the changing behavior, all while being supported by their own values and interests. MI is essentially a conversation involving collaboration in which a person's motivation and commitment for change are enhanced by the helper.

Miller and Rollnick (2013) emphasize the spirit of MI, which incorporates four key elements: partnership, acceptance, compassion, and evocation. Miller and Rollnick (2013) posit that MI is not a technique in which the helper does something for the person seeking change. Rather, MI is a collaboration in which something is done with and for the person in a partnership paradigm. In acceptance, the helper honors the absolute worth of the other, upholds and defends the autonomy of the client, uses accurate empathy to view things through the lens of the other's perspective, and affirms what the client has done and their strengths. In MI, compassion denotes the active promotion of the client's welfare and prioritization of their needs. Evocation is based on the theory that people who seek change already possess inside themselves what is needed for that change, such as their strengths and resources. All they need is for the helper to evoke those strengths and resources to facilitate change within the client. Finally, Miller and Rollnick (2013) contend that MI is a person-centered method of counseling that is ideal for addressing ambivalence about change and uses a guiding style of communication. Liese and Beck (2022) contend that all CBT practitioners should be proficient in the MI skillset.

I was first introduced to MI during my practicum at a certified community behavioral health clinic (CCBHC), in which MI is a heavily emphasized treatment theory. Most of the clients seeking service at the CCBHC struggle with substance use and MI has been an excellent foundational theory to employ, especially during the initial assessment phase of treatment. The concept of meeting the clients where they are in their journey, without judgement, is one of the

most effective rapport-building methods I have employed in my career as a mental health counselor.

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) was developed in the 1960s and 1970s by Dr. Aaron Beck and is based on the cognitive model, whose premise is that a person's thoughts and feelings can influence their behavior (Beck, 2021). Dysfunctional thinking is the root of all psychological disturbances according to the tenets of CBT. Cognitions can occur at three distinct levels: automatic thoughts, intermediate beliefs, and core beliefs. For example, a client might have an automatic thought or mental image: "I'm terrible at parties." Such an automatic thought can lead to an emotion (sadness) and a behavior (self-isolation by staying home and not going to the party), which in turn can reinforce unhealthy core beliefs ("I'm unlovable"). CBT practitioners help their clients identify, evaluate, and change dysfunctional or unhelpful thinking (maladaptive thoughts) to promote lasting changes in both mood and behavior.

Beck (2021) posits that the foundation of CBT treatment plans are cognitive conceptualizations that evolve throughout the therapeutic relationship. The therapeutic relationship within the confines of CBT must be stable and emphasize the positive, all while stressing collaboration and active participation. CBT treatment is time-sensitive and incorporates structured sessions which usually conclude with the client being assigned homework.

CBT was the first theory that I investigated in my mental health counseling journey. CBT was intuitive and logical. Further investigation into CBT resources, specifically in the realm of substance use treatment, led me to Liese and Beck's (2022) *Cognitive Behavior Therapy of Addictive Disorders*, in which the authors emphasize the CBT model in action. Known as the ABC (Antecedent, Beliefs and thoughts, Consequences) model. In the ABC model, antecedents,

such as internal or external triggers, lead to beliefs and thoughts, which affect emotions, and behavior.

Acceptance and Commitment Therapy

In addition to MI and CBT, I have begun to incorporate acceptance and commitment therapy (ACT) into my mental health counseling practice. During my second internship at Liberty University, Dr. Brandon Waggoner introduced the class to ACT and the concept of psychological flexibility resonated with me. Though Dr. Waggoner recommended a few resources, I first read *Acceptance and Commitment Therapy: The Process and Practice of Mindful Change, Second Edition* (Hayes et al., 2012), in which the authors delve deeply into the foundation of ACT, relational frame theory (RFT), as well as the functional contextual approach and psychological flexibility as a unified model of human functioning. Human language and cognition are cornerstones of ACT. Psychological flexibility is based on commitment and behavioral action processes, as well as mindfulness and acceptance processes, which include flexible attention to the present moment, values, committed action, self-as-context, defusion, and acceptance. The model depicting psychological flexibility is known as the *hexaflex* model (Hayes et al., 2012).

While the text by Hayes et al. (2012) is a seminal work on ACT, I found Harris's (2019) book on ACT easier to read and put into practice. His discussion on functional contextualism, or the premise that behavior happens within a specific context, resonated with me, as did his discussion on cognitive fusion in which cognitions dominate behavior that is counterproductive and troublesome. Harris (2019) also introduced the concept of *workability*, which asks if what the client is doing is providing them with the life they want, in which case it is *workable* and

requires no change. If what the client is doing is not *workable*, then alternatives can be considered with the client.

Section 2: My Comprehensive Method of Bio-psycho-social/Cultural/Spiritual Assessment

While mental health counseling within a CCBHC environment can be challenging, the concept of comprehensive client assessments is well-established and automated within the electronic health record system of the CCBHC. During a client's first assessment appointment, the client receives biological, psychological, social, multicultural, and spiritual assessments to provide the treatment team of the CCBHC a broad and comprehensive overview of the client.

Observational Data/Mental Status Exam

My assessment begins as soon as I can begin observation of a client. I will note such factors as whether the client is dressed appropriately for the weather and the occasion (within reason), as well as the client's apparent health and demeanor. Normal or abnormal motor activity will be documented along with the client's insight and judgement. Other factors will also be noted, such as affect, mood, orientation (time, place, and person), whether the client is a reliable historian, concentration and focus during the session, behavior, speech pattern, and mood changes.

Psychometric Assessment

Clients are given the Columbia-suicide severity rating scale (C-SSRS; Posner et al., 2009) to assess suicidality, the generalized anxiety disorder 7 (GAD-7; Spitzer et al., 2006) to assess anxiety, and the patient health questionnaire 9 (PHQ-9; Kroenke & Spitzer, 2002) to assess depression. The assessments are then administered monthly to comply with the requirement set by the CCBHC. Shortened versions are administered during each session as well.

Biological Assessment

Each client receives a biological assessment that begins with general demographic questions about the client's age, race, marital status, and living arrangements. The questions become more granular. Biological factors such as sleep, diet, exercise, medication, medical history, and history of developmental milestones are considered. If the client reports difficulty sleeping, issues such as sleep apnea will be addressed, and the client could be referred to the psychiatric nurse practitioner at the CCBHC for evaluation. If the client is experiencing challenges with their diet, they would be referred to one of the psychiatric rehabilitation specialists at the CCBHC for assistance. Exercise will also be discussed with the client and appropriate referrals would be made if the client wants to pursue exercise options. The client's current medications will be documented as would the client's medical history. Finally, developmental milestones will be discussed with the client.

Psychological Assessment

In the psychological assessment, clients provide information to screen for substance addiction, risk assessments, family psychiatric history, and Piaget's theory of cognitive development. During screening for addiction, clients receive a diagnosis for substance abuse disorders, if applicable, and provided with a treatment intervention that adheres to New York State's *Level of Care Determination (LOCADTR)* web-based tool (n.d.). An assessment to determine whether the client is a danger to themselves, or others, is also conducted and safety planning will be completed if necessary. A client's family psychiatric history is documented as well. Finally, the client's stage within Piaget's theory of cognitive development is documented.

Social Assessment

A client's social assessment includes cultural factors, family of origin, current living arrangements, academic history, occupational history, academic history, occupational history, current social support, as well as the applicable stage of development within Erikson's psychosocial stages (Wong et al., 2021). Cultural factors such as where the client was raised and the groups with whom the client identifies (e.g., drug use, organized crime, socioeconomic, ethnic) are important in that they provide a broader perspective of the client. Current living arrangements and social support could become vital aspects of the client's recovery and should be documented.

Multicultural Assessment

My approach to multicultural assessment adheres to the Association for Assessment and research in Counseling's (AARC) Standards for Multicultural Research (O'Hara et al., 2016). The standards were developed to address the need for multiculturally competent counseling and research. This approach lends itself well to treatment-cultural element of the case conceptualization model offered by Sperry and Sperry (2020).

Spiritual Assessment

While the assessments administered by the CCBHC staff do not include a formal spiritual assessment, clients are welcome to discuss their spiritual and religious views and beliefs. A more formal spiritual assessment would include spiritual/religious history, current spiritual/religious beliefs, Fowler's stages of faith development (Armstrong, 2020), and an integration assessment would be discussed.

Case Conceptualization

My methodology of case conceptualization is based on the eight P's of Sperry and Sperry (2020) which include the following elements: presentation, predisposition, precipitants, protective factors and strengths, patterns (maladaptive), perpetuants, plan (treatment), and prognosis. Sperry and Sperry (2020) posit that case conceptualization consists of four components: 1) diagnostic formulation, 2) clinical formulation, 3) cultural formulation, and 4) treatment formulation. While the model can be adapted to many counseling theories, Sperry and Sperry (2020) note signature elements for both cognitive-behavioral method of case conceptualization, as well as that of acceptance and commitment therapy, which align perfectly with my theoretical foundation. The signature elements of cognitive-behavioral method of case conceptualization include predisposition, treatment goals, treatment focus, treatment strategies, and treatment interventions (Sperry & Sperry, 2020). Case conceptualization within the acceptance and commitment therapy paradigm includes five signature elements, which include: predisposition, treatment goals, treatment focus, treatment strategies, and treatment interventions (Sperry & Sperry, 2020).

DSM-5-TR Diagnosis Process

The diagnosis process using the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; *DSM-5-TR*; American Psychiatric Association [APA], 2022) that I employ falls within Sperry and Sperry's (2020) presentation element of case conceptualization. Presentation refers to how the client has responded to precipitants, including symptoms (severity and type), functional impairment, as well as the case history. The diagnostic process using the *DSM-5-TR* (APA, 2022) includes initial assessment, identification and classification of symptoms, differential diagnosis (rule out other diagnoses), and criteria matching.

Treatment Planning Process

My treatment planning process adheres to the case conceptualization model offered by Sperry and Sperry (2020) and includes the identification of treatment patterns (challenges), treatment goals, treatment focus, treatment strategy, treatment interventions, treatment obstacles, and cultural aspects of treatment. The treatment planning process is applicable to both cognitive behavioral therapy and acceptance and commitment therapy (Sperry & Sperry, 2020). I have found treatment planners useful, such as those offered by Kolski et al. (2014) and Switzer and Rubin (2015).

Method of Outcomes Assessment During the Treatment Phase

My method of outcomes assessment during the treatment phase includes clinical outcome measures, behavioral assessments, functional assessments, patient self-reports and journals, feedback from other members of the treatment team and those close to the client (if applicable), review of goals, and patient feedback. Clinical outcome measures used during the treatment phase at the CCBHC include C-SSRS (Posner et al., 2009) to assess suicidality, the GAD-7 (Spitzer et al., 2006) to assess anxiety, and the PHQ-9 (Kroenke & Spitzer, 2002) to assess depression.

Aftercare/Maintenance Planning Process

My aftercare/maintenance planning process begins at the beginning of the treatment journey with a client. I do my best to provide each client with a general roadmap of the treatment process, including how it begins and ends (or maintains long-term). Abramson (2022) contends that the process should be part of the informed consent process, and I subscribe to that theory in my practice. There are a variety of treatment levels within the CCBHC, some of which include residential treatment (30-90 days), intensive outpatient program (IOP), and maintenance. Each

level of treatment will have its own aftercare/maintenance planning process. For example, clients within the residential program usually transition into IOP, followed by maintenance in which the client continues with medically assisted treatment (MAT) and periodic individual sessions with a counselor. Each client is assured that they can always return for help.

Case Study

Kevin is a 35-year-old Caucasian male who self-referred to the CCBHC for mental health counseling services. Kevin reported that he suffers from symptoms associated with depression and anxiety, including panic attacks, which have begun to negatively impact his day-to-day life and functioning. Kevin described the symptoms associated with his panic attacks as shortness of breath, heart palpitations, nausea, trembling hands, and fear of losing control. The panic attacks usually occur without warning and have been occurring at least once per week for the past year. At this point, Kevin has not been able to distinguish any specific triggers for his panic attacks. While Kevin has already consulted with a psychiatrist and has been prescribed medication, Kevin believes he would benefit from mental health counseling sessions, which his psychiatrist does not offer.

During his initial assessment, a mental status exam was conducted, and observational data was recorded. Kevin was dressed appropriately for the occasion and his motor function appeared unremarkable. His speech was normal, and his affect was congruent. Though Kevin reported symptoms of depression and anxiety, he was quick to smile and had a pleasant demeanor. He appeared to be alert and oriented to person, place, and time. Kevin's insight was good, and he appeared to be a reliable historian. Kevin was cooperative throughout the assessment.

Kevin completed the standard set of psychometric assessments that are given to all new clients at the CCBHC, such as the C-SSRS (Posner et al., 2009) to assess suicidality, the GAD-7 (Spitzer et al., 2006) to assess anxiety, and the PHQ-9 (Kroenke & Spitzer, 2002) to assess depression. The results of the C-SSRS (Posner et al., 2009) indicated no history of suicidal thoughts, ideations, or actions. However, results of both the GAD-7 (Spitzer et al., 2006) and the PHQ-9 (Kroenke & Spitzer, 2002) indicated severe depression and anxiety, respectively.

In addition to Kevin's age (35) and race (Caucasian), the biological assessment revealed that Kevin was not in a relationship and lived with his mother and father. Kevin noted that sleep was not an issue with him, but his diet was less than what he would consider ideal in that he frequently ate fast food when he was not at home and had access to his mother's cooking. Kevin advised that he had an unremarkable medical history and noted no hospitalizations or surgeries. He reported that exercise was not a priority in his life, though he used to walk a significant amount when he was employed as a golf pro at a local country club. Since he left that employment, he noted a weight gain of approximately 25 pounds. Kevin also noted no difficulty reaching developmental milestones. Since Kevin had already retained the services of a psychiatric provider external to the CCBHC, such services were not discussed; however, Kevin's current psychiatric medications were documented. In addition to psychiatric medication, Kevin disclosed that he had been prescribed testosterone supplementation from his primary care provider. No other medications were noted during the assessment.

After the biological assessment, Kevin received a psychological assessment which revealed no history of substance abuse, nor did it reveal any suicidal or homicidal ideations or history. To the best of his knowledge, Kevin was unaware of any family history of substance use

or mental health disorders. Finally, Kevin appeared to be in the fourth, formal operational, stage of Piaget's theory of cognitive development (Papalia & Feldman, 2011).

The social assessment revealed that Kevin lives at home with his mother and father, while his older brother, Charles (age 37) lives on his own. Kevin noted a close relationship with his mother and a distant relationship with his father, who Kevin admitted was also Kevin's employer. Kevin's father owns and operates an electrical contracting firm, for which Kevin is employed as an estimator and works from home. However, his dream job would be as a full-time golf pro at a country club. Kevin also disclosed that his older brother, Charles, will be taking over the business when Kevin's father retires. Kevin advised that he and Charles get along fine but do not have a close relationship. Kevin also reported that he completed four years of college and received a bachelor's degree in business administration. The primary source of Kevin's social support is his mother. In fact, Kevin's mother accompanied him the appointment at the CCBHC and was waiting in the lobby. Kevin appeared to have reached the appropriate stage (stage six) of Erikson's psychosocial stages, intimacy versus isolation; however, further inquiry might reveal that he may still be in the fifth stage: identity versus role confusion (Wong et al., 2021).

A multicultural assessment revealed that Kevin was raised in a predominately white neighborhood and his family had been residents of the United States for multiple generations. Kevin believes he may heritage originating in Germany and possibly the British Isles. Kevin identifies as a heterosexual male. No potential multicultural challenges to counseling were noted.

Kevin noted that he was raised in a Protestant Christian church, but he does not currently practice any religion. Kevin said that he and his family attend church on holidays, but not on a

regular basis. Kevin did not wish to integrate any religious or spiritual practice into his counseling regimen.

Case Conceptualization

For Kevin, ACT was selected as the theory upon which his therapy would be based. His case conceptualization would include the five signature elements of predisposition, treatment goals, treatment focus, treatment strategies, and treatment interventions (Sperry & Sperry, 2020).

Appendix I: Case Conceptualization will discuss the process in more detail.

***DSM-5-TR* Diagnosis**

Within the CCBHC, mental health diagnoses are usually conducted by the resident psychiatrist. However, Kevin has already consulted with an external psychiatric practitioner. Kevin received a diagnosis of generalized anxiety disorder with panic attacks. The diagnosis concurs with the criteria listed in the *DSM-5-TR* (APA, 2022).

Treatment Planning

Kevin's treatment planning adheres to the case conceptualization model offered by Sperry and Sperry (2020) and includes the identification of treatment patterns (challenges), treatment goals, treatment focus, treatment strategy, treatment interventions, treatment obstacles, and cultural aspects of treatment. Kevin's treatment will focus primarily on his anxiety and depressive symptoms, as well as his panic attacks. The goal of his treatment will be the reduction of his symptoms and his return to his normal level of functioning. Kevin's treatment plan is explained in more detail within Appendix II: Evidence-Based Treatment Plan.

Method of Outcomes Assessment During the Treatment Phase

The method of outcomes assessment during the treatment phase for Kevin will include clinical outcome measures, behavioral assessments, functional assessments, patient self-reports

and journals, feedback from other members of the treatment team and those close to the client (such as Kevin's mother), review of goals, and patient feedback. Clinical outcome measures used during the treatment phase will include C-SSRS (Posner et al., 2009) to assess suicidality, the GAD-7 (Spitzer et al., 2006) to assess anxiety, and the PHQ-9 (Kroenke & Spitzer, 2002) to assess depression.

Aftercare/Maintenance Planning

Kevin's aftercare/maintenance planning process begins at the beginning of the treatment. Kevin will be provided with a general roadmap of the treatment process, including how it begins and ends (or maintains long-term). The goal of Kevin's treatment will be for Kevin to return to his normal level of functioning. However, Kevin may require long-term maintenance, such as monthly individual sessions until termination, and will likely remain on a maintenance dose of medication prescribed by his psychiatrist.

Conclusion

While the previous sections outlined and provided detail regarding my theoretical framework for ethical and effective counseling, it should be considered a living document. Though I currently focus on MI, CBT, and ACT, I anticipate learning new techniques and theories and continue to improve and refine what I already know and do. Ethical and effective counseling is a dynamic process, much like a journey implies moving from one point to another.

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Appendix I: ACT Case Conceptualization

Kevin's anxiety symptoms, panic attacks, and depressive symptoms (presentation) seem to be his reaction to the pressures and conflict associated with unmet career goals (current precipitant), as well as the unfulfilled expectations of self-reliance in that he still lives with his parents (continuing precipitants). Throughout his life, Kevin has tried to fulfill the expectations of his parents while sacrificing the attainment of his own goals and aspirations, such as becoming a full-time golf pro (pattern). Kevin's dream job as a golf pro does not align with what his parents and family consider a "stable career" and is not conducive to independence (predisposition). This pattern is maintained by Kevin's reliance on the security of working for his father in a job that elicits no passion, his dependent and pleasing nature, low assertiveness, and the expectations of his parents (perpetuants). Kevin appears to have become fused with thoughts of being "stuck working for Dad," feeling "depressed" and feeling the "weight" of his parents' unvoiced expectations and disappointment. Kevin's symptoms have escalated into experiential avoidance due to panic attacks experienced prior to leaving the house for extended periods of time. Kevin brings several protective factors to therapy including strong familial bonds and social values. Some of Kevin's strengths include his intelligence and previous success as a part-time golf pro. Kevin also has an engaging personality and the ability to find humor in life (protective factors/strengths).

Kevin identifies as an upper middle-class Caucasian male (cultural identity). His acculturation appears to be unremarkable and acculturative stress is not evident (cultural stress and acculturation). Kevin believes that his current problems of anxiety, panic attacks, and depression are rooted in his failure to live up to the examples set by his family (cultural explanation). It would be useful to examine in therapy Kevin's sense of entitlement and his experience of having

all his needs met throughout his life by his parents. It might also be illuminating to examine the relationship with his mother and the evident dependency (culture and/or personality).

The challenge of change for Kevin to function more effectively is to increase his self-confidence and self-worth while remaining respectful of his parents (treatment pattern). Kevin will need to nurture a stronger sense of self that will enhance his social engagement, as well as create goals that are consistent with his values in reference to work. He will also need to reframe his perception of his current employment in his father's business while pursuing his goal of becoming a full-time golf pro (treatment goals). Treatment will be focused on decreasing persistent avoidance of social situations and psychological rigidity and creating psychological flexibility and nurturing acceptance (treatment focus). Kevin's psychological flexibility will be enhanced by addressing his fusion with thoughts, lack of mindfulness, experiential avoidance, development of a stable yet flexible sense of self, and fostering committed action (treatment strategy). For example, treatment interventions will include defusion techniques such as the *Milk, Milk, Milk* exercise will be used to enhance Kevin's ability to defuse words from thoughts and emotions (Hayes et al., 2012). In addition, exploration of the ebb and flow of difficult life experiences from the perspective of genuine curiosity and self-compassion will mitigate Kevin's tendency toward experiential avoidance (Hayes et al., 2012). Treatment obstacles could manifest in the form of Kevin relying on the expertise and criticism of his mother, who is a psychiatric nurse, in lieu of that of his counselor. Kevin might also be reluctant to continue therapy if his symptoms diminish and feels "good enough" (treatment obstacles). No cultural focus seems warranted other than examination of Kevin's entitlement and sense of privilege, as well as his familial relationships. Provided that Kevin engages in the therapeutic process and leverages his strengths, his prognosis is fair to good (treatment prognosis).

Appendix II: Evidence-Based Treatment Plan

Problem or Concern Goal stated as inverse of problem	Measurable Treatment Objective	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)
Problem: Panic attacks Goal: Decrease in panic attacks	<ol style="list-style-type: none"> 1. Fewer episodes of panic attacks through mindfulness-based relaxation techniques, such as mindful breathing and grounding, 2. Fewer instances of anxiety through cognitive defusion exercises, such as <i>Milk, Milk, Milk</i> (Hayes et al., 2012), 3. Reduced persistence of feelings of anxiety with exercises such as <i>the struggle switch</i> (Harris, 2021) 	Motivational Interviewing/ACT with Medically assisted therapy (MAT)	24 weekly sessions	Decrease in occurrence/frequency of panic attacks and experiential avoidance	Monthly individual sessions with client until termination

	4. Reduce experiential avoidance through exercises such as the <i>Chessboard</i> (Hayes et al., 2012).				
<p>Problem: Anxiety</p> <p>Goal: Decrease in anxiety</p>	<ol style="list-style-type: none"> 1. Fewer instances of anxiety through cognitive defusion exercises, such as <i>Milk, Milk, Milk</i> (Hayes et al., 2012), 2. Reduced persistence of feelings of anxiety through exercises such as <i>the struggle switch</i> (Harris, 2021) 	<p>Motivational Interviewing/ACT with Medically assisted therapy (MAT)</p>	<p>24 weekly sessions</p>	<p>Lower GAD-7 score, Client self-report, journal entries</p>	<p>Monthly individual sessions with client until termination</p>
<p>Problem: Depression</p> <p>Goal: Decrease in depressive symptoms</p>	<ol style="list-style-type: none"> 1. Fewer instances of depressive thoughts through defusion exercises, 2. Fewer feelings of hopelessness through practice of the <i>dance metaphor</i> 	<p>Motivational Interviewing/ACT with Medically assisted therapy (MAT)</p>	<p>24 weekly sessions</p>	<p>Lower PHQ-9 scores, Client self-report, journal entries</p>	<p>Monthly individual sessions with client until termination</p>

	(Hayes et al., 2012)				
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