Comprehensive Theoretical Model of Counseling: Part one and two

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Abstract

Building on the philosophies explored in Advance Theory Application (COUC 715), a psychodynamic perspective, is proposed, as a theoretical framework that explains Albert Ellis’ Rational Emotive Behavior Therapy (1955). The inducting of this empirically based psychotherapy would serve as a basic for ethical and effective assessment,

diagnosis, case conceptualization, treatment planning, treatment, treatment outcomes assessment, aftercare planning and a counseling case study, featuring, borderline personality disorder. The evaluation of the client’s bio-psycho-social-spiritual guidance the therapeutic process as it permits for interpretation of client’s information, direction of therapeutic approaches and synthesize clinical documentation reports. The core theoretical principles are to assist the client to achieve symptom reduction and overcome present states to dysfunction through appropriate clinical interventions and techniques.

**Part One:** **Comprehensive Theoretical Model of Counseling**

My theoretical framework was birth out of the Humanistic approach of, Adlerian psychotherapy, also known as, Individual Psychology, developed by Alfred Alder (1870-1937), it’s holistic system focuses on relationships or patterns of interaction between partners (Sonstegard, 1998). I was moved by the Adlerian therapy’s growth model which stresses taking cognitive responsibility and social approach, creating one’s own destiny and finding meaning and goals to give life direction (Corey, 2001, p.8). This comprehensive theoretical model of counseling emphasizes the individual’s strivings for success, purposeful behaviors, connectedness with others, conscious actions, and contributions to society, belonging and social interest (Carlson & Sperry, 2006). What was most outstanding was this model’s ability to not only account for here and now but its focus on unconscious dynamics by studying the childhood experiences (Corey, 2001, p.9). Subsequently, to my formal training, I quickly observed my work required more integrated principles and techniques from other psychoanalytic approaches. To broaden my analytic perspective, I found it useful to transition to an eclectic approach that comprises of more action-based therapies. After narrowing the scope to achieve mastery in my craft, today I proudly maintain Rational Emotive Behavior Therapy (REBT), developed by Dr. Albert Ellis in 1955, as my theoretical model of counseling. REBT offers empirically tested data which demonstrates a statistical significance in the formulation and implementation of the theory and practice results (Ellis, 1994).

**Theoretical Framework**

REBT is an action-oriented approach to managing cognitive, emotional, and behavioral disturbances (Ellis, 1998). Its multifaceted approach encourages, broad application with most-all Diagnostic and Statistical Manual of Mental Disorders diagnosis and International Classification of Diseases - Medical Diagnosis (ICD-11-CM) diagnosis classification, in diverse settings (American Pyschiatric Association 2013; ACA, 2014; Benjamin et al., 2011). The therapeutic process of REBT focuses largely on the client’s thinking about an event and experience(s) in the present which leads to emotional and behavioral upset and irrational patterns of thinking (Corey, 2001, p. 294; Ellis, 1999). With this, I thrive to incorporate a forceful cognitive methodology in the therapeutic process to challenge the client’s unhelpful thinking which creates unhealthy emotions (e.g., unhealthy anger, depression, anxiety, guilt, etc.), maladaptive behaviors (e.g., procrastination, addictive behaviors, aggression, unhealthy eating, sleep disturbance, etc.) and self-defeating/self-sabotaging behaviors that can negatively impact life satisfaction (Brewin, 1996).

To help clients understand the vicious circle of unhealthy internalized belief and need to abandon their irrational ideas, I practice Ellis’ “ABCDEF” mnemonic to teach the basics of rational-emotive behavior therapy. The symbols are as: ‘A’ which stands for the activating event which maybe sparked from a thought, feeling, emotion, or event; ‘B’ is the [irrational] belief, about A; ‘C’ stands for emotional consequences of having those beliefs about A (Ellis & Ellis, 2011). ‘D’, ‘E’ and ‘F’ are more likely found on the client’s treatment plan as it aims to produce change by teaching the counselee to dispute ‘D’ irrational beliefs that will then lead to, ‘E’, new effective philosophies or thinking and ‘F’ for finding a more effective intervention(s) (Corey, 2001, p. 293; Fulkerson, 2015). This model relies heavily on thinking, disputing, debating, challenging, interpreting, explaining and educating through it specific therapeutic techniques. See Appendix 1: REBT Worksheet

Other therapeutic techniques integrated includes humor, logical analysis, confrontation, changing one’s language, modeling, shame-attacking exercises, bibliotherapy, operant conditioning, systematic desensitization and rational-emotive imagery to dispute the client’s nonsensical thinking and behaviors are applied with full acceptance and tolerance (Brewin, 1996; Ellis, 1998; Corey, 2001, p. 305). See Appendix 2: REBT Homework/ Workbook

**Comprehensive Assessment**

To successful apply these therapeutic techniques mention above, REBT treatment, like many others, begins with an intake interview which subsequently folds into the comprehensive rational cognitive behavioral assessment (Jones, 2010). It is at this point, establishing of the therapeutic alliance or working alliance begins. The assessment, a seemingly insurmountable task in my clinical outpatient setting, is a systemic gathering information process while observing what signs and symptoms the counselee is experiencing (Cummings & Kendall, 2011).

REBT provides empirically validated measures to assess cognitive, emotional, behavioral, and social domains in treatment that contributes to successful therapeutic outcomes. Bases on the REBT model, my two-hour procedure entails an in-depth, structured, clinical interview employs several assessment tools that looks for both adaptive (strength) and maladaptive (weakness) of the individual’s belief and behavior.

Beginning with the history of the presenting problem- this section includes other pertinent information about the client and the problems presented: history of the presenting problem, client and family’s diagnosis and treatment history, demographic information (housing status, veteran status, age, ethnicity, gender, and social-relationship history, academic, work history, medical/developmental history, including date of last complete physical examination, alcohol and substance abuse history to rule in and out differential diagnosis (Jones, 2010; APA, 2006). During this section of the assessment the counselee’s cultural formation is assessed, this includes, social support systems, cultural mores, spiritual belief, ethical values and the consideration of systems issues (APA, 2006).

Similar data is captured on the Gavita prescriptive executive coaching (FG-PEC), a 50-item Multi-Rater, Likert Scale Assessment, addressing five domains: (a) behaviors, (b) emotions, (c) thoughts, (d) situational factors, and (e) socio-cultural context, and including five respondents: (a) self, (b) subordinate, (c) superior, (d) colleague, and (e) counselee. This tool is used with employee assistance counselee with limited counseling sessions and e-counseling/telecounseling to receive treatment by means of the internet (Gavita et al., 2012).

Observational data is recorded next as it is an assessment of the counselee’s behavioral and cognitive functioning. I also include a description of the counselee’s appearance and general behavior, interpersonal style, schemas, level of consciousness and attentiveness, motor and speech activity, mood and affect, thought and perception, attitude and insight (Lazarus, 1997; APA, 2006). This occur at this point to capture my first impressions and the counselee’s general presentation to the world.

Following this, there is a risk assessment. Based on the information provided in the presenting problem section of the assessment, this data may be integrated earlier on in the clinical interview session. The risk appraisal aims to determine harm pose to one’s self or others. The collaborative assessment and management of suicidality (CAM) is the tool used to obtain a thorough suicide assessment. The CAM approach is both empirically and theoretically supported which emphasis on the development of a therapeutic alliance as the foundation for effective suicide assessment intervention (Jobes, Wong, Conrad, Drozd, & Neal-Walden, 2005). The CAM is referred to frequently during treatment and is referenced to when working with multidisciplinary teams, clinical formulation, legal and administrative issues in institution (APA, 2006). Two of the several highlights of employing the CAM model is its ability for counselee and I, the helping professional, to collaborate in the development of an individualize safety plan / contract. This can be easily integrated into the treatment plan to address the counselee’s suicide ideation and impulses (Jobes, 2006). The use of diagnostic tests, including psychological and neuropsychological tests assist with narrowing the scope of concern.

In the formulation of the initial making decisions and treatment plan special considerations is given to collateral sources, such as, legal, family members, third party payers and any other social supporting sources (Redelmeier, 1997). It is important to note there that; collateral sources are never contacted without written consent from the counselee. This is to ensure privacy and confidentiality as governed by federal law, as in the Health Insurance Portability and Accountability Act (HIPAA, Parts 160–164, 1996).

Through the identification, evaluation and exploration of the counselee’s problems and goals the case conception process can begin (Flanagan & Flanagan, 2013, p 303).

**Case Conceptualization**

Conceptualizing a counselee’s difficulties provides a clear description of the counselee’s presenting problem. Each case conceptualization is client-centered as its personalized to each counselee’s presenting factors, etiological variables, diagnostic hypotheses and what needs to happen in counseling for the counselee to reach the identified goals (Scherer, 1998). When preparing a case conceptualization, specific to REBT, the ABC model is used (Ellis & Ellis, 2011). Appendix 3: Thinking Worksheet

This model is then added to a case conceptualization framework utilized as a standard at my agency, called the Five P’s of Case Formulation model (Macneil et al., 2012). The P’s model is used to clearly structure and identify the presenting problem (What is the client’s problem list? What are DSM diagnoses?); predisposing factors (Over the person’s lifetime, what factors contributed to the development of the problem? Think biopsychosocial); Precipitants (Why now? What are triggers or events that exacerbated the problem?); Perpetuating factors (What factors are likely to maintain the problem? – Are there issues that the problem will worsen, if not addressed); and finally, the Protective/positive factors (What are client strengths that can be drawn upon? – Are there any social supports or community resources?) (Macneil et al., 2012).

Although this case conceptualization model is not specific to REBT, it supports the A-B-C model by functioning like a roadmap and offers justification of diagnosis and the treatment plan. Even if the diagnosis is provisional, it begins the counselee’s journey of healing and/or recovery.

It is the policy of the mental health settling, I practice, to have the documentation completed within 48 hours however, I often attempt to write or dictate the assessment immediately following my session (Zuckerman, 2010).

**DSM 5 Diagnosis**

With the clinical comprehensive assessment and the case conceptualization completed I transition to identifying an appropriate diagnostic label. Regardless of theoretical model, determining whether an individual is suffering from a mental health and/or substance abuse disorder requires a specific diagnostic procedure (Redelmeier, 1997; Flanagan, & Flanagan, 2013). Based on the diagnostic reliability and validity of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) it is utilized to primary identify diagnoses, secondary and tertiary differentials, prognosis and prevalence. As part of the manual’s diagnostic procedure, the counselee must meet the minimum symptoms criterion, specific to that disorder. It is important to note that a diagnosis should not be better explained by another condition, such as a physical health problem or substance misuse/abuse problem, to be considered.

Case conceptualization offers a therapeutic benefit to the diagnosing process that is invaluable (Eells, 2015). Issuing a diagnosis comes with great responsibility as this informational code becomes a part of the counselee’s permanent records (Jeffrey and Ridley, 2017). Case conceptualization allows for trial and errors. In other words, this is the place to make a mistake, not with the counselee. I can take my best guess of related diagnosis, along with a treatment plan and present it at my clinical supervision meeting for support. Once clinical consultation occurs, I move forward in the diagnostic process confidently as I would now have 10-17 other clinicians backing my clinical recommendation(s). Since both the case conceptualization and diagnosis identification lays the groundwork for planned interventions and informed used of theory and technique, the most important collaborator in this process is the counselee (Flanagan & Flanagan, 2013, p. 333). For the counselee, it can be a big relief to be diagnosed and have an identifiable and perhaps treatable concern answered, thus instilling hope (Mulligann, MacCulloch, Good & Nicholas, 2012).

**Measurable Treatment Planning**

A treatment planning is the blueprint which outlines goals, objectives and interventions or strategies (Scherer, 1998). Objectives are statements of observable and measurable outcome targets. The counselee’s problems are intrinsically linked to counselee’s goals (Jongsma, Peterson & Bruce, 2014). The goals of REBT are to “eliminate irrational thinking and thereby the associated dysfunctional emotions and behaviors” (Murdock, 2009, p. 291). REBT’s A-B-C model is guided by SMART goals, in my agency, which stands for simple/specific; measurable; attainable/Achievable; realistic/results oriented and time limited. This model seeks to offer the counselee and I a logical factor structure, that is, reliable, sensitive to change and allows for outcome measurement assessment. See Appendix 4: Treatment Plan

**Empirically Based Treatment**

Evidence-based treatment promotes effective psychological practice and enhances public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention (APA, 2006). As an evidence treatment, REBT theory, has been criticized as being too simplistic in arguing that just a few classes of rational and irrational beliefs can explain the large variation of mental disorders (David, & DiGiuseppe, 2010). The REBT professionals cogently confront this by arguing that by changing the core general irrational beliefs, one also changes the specific cognitions involved in specific psychological problems which account for a large variation in symptoms and mental disorders (David, & DiGiuseppe, 2010)

Dryden (1999) created the REBT Competency Scale which is used in the evaluation of REBT’s treatment model in clinical and research applications. This protocol consists of 20 separate steps or tasks that can make up the REBT treatment sequence (e.g. the sequence from the basic introduction of the therapist to the counselees, through the problem identification phase, and then the actual problem modification to the final phases of the treatment cycle) (Dryden, 2001). The 20 steps involve skills that is believed to be adequately trained REBT therapist should be able to do (Dryden, 2001).

**Outcomes Assessment**

REBT focuses on cognitive and behavioral learning outcome(s), this assessment is achieved by examining baseline data and comparing it to behavioral modifications over the course of treatment (Ellis, Joffe-Ellis, & American Psychological Association, 2011). This process involved empirically testing the beliefs of the counselee by actively engaging in a Socratic dialogue, carrying out homework assessment, gathering data on assumptions they make, keeping a record of activities and forming alternative interpretations (Freeman & Dattilio, 1994).

The technique systematically keeps the counselee focused on the appearance, sound, feel, and smell of success or improvement (Flanagan & Flanagan, 2013, p. 112). Two additional measures that gather outcome assessment data is the, Mood Wheel, which tracks the counselee’s temperament through a web and/or mobile-based application and the, Manager Rational and Irrational Beliefs Scale (M-RIBS), which measures predictive validity and psychometrics (David, 2013). The use of outcome assessment constructs a perspective of movement that resulted from work invested into behavioral change. Having a visional improvement tailored assessment, it is more likely for positive change to occur (Cummings & Kendall, 2011). I am often exploring counselee motive and seeking supervision when using this technique. Once on the path that may lead to problem ratification, I encourage the counselee to transition their attention to sustainability of desired change. This included drafting an aftercare plan for reducing the likelihood of reoccurring disturbance by maintaining learned coping skills and developed social systems.

**Aftercare Planning**

Aftercare planning begins early in treatment, as it is part of the roadmap, case conceptualization. The REBT treatment plan is a recognition and modeling of growth that is strength base (Scherer, 1998; Mcdermut & Haaga, 2009). The counselee is guided through the maintenance of desired outcome by persistently focusing on the counselee’s strengths, cognitive mappings, experiential activities, willingness to accept things that cannot be changed and modifying behaviors that can be change. How does the counselee’s plan on use the A-B-C model, prognosis or expected course of recovery over the next three months, is discussed and recorded on the treatment plan (Leahy, 2008). Specific recommendations about mental health services and/or referrals, included a low or higher level of care, support group or volunteering at a community center, is also added, once agreeable by both the counselee and I. Finally, a list of supporters is created with their phone numbers as part of the counselee’s accountability check.

**Part Two: Case Study**

Presented there is a case study of …

**Demographic Information**

Alex Clark[[1]](#footnote-1) is a 21- year old Caucasian male who born in South America, Guyana but presently lives, in Brooklyn, New York, with mother, age 48, brother, age 12, and his maternal grandmother, age 77. Alex’s parents suffered a “bitter” divorce (December 2016) after a long separation process, which resulted, in limited contact with his father. Both of Alex’s parents are of Caribbean decent, which has a significantly impacted, his perceptive of the world. Alex is unemployed and listed one job experience, which he held, for three months before being terminated for insubordination. His family is of a middle socioeconomic status and provides Alex with full insurance benefits.

**Presenting Problems**

Alex listed his chief complaints as reckless driving, patterns of bipolar mood swings, a persistent lack of productivity, trouble sleeping and a tendency to overeat, sometimes. He described over reacting as a behavioral outburst of anger, stemming from, feelings of irritability, anxiousness, loud screaming, head banging, skin pinching and scratching, that became increasingly “worst” as he got older. He added these symptoms are often followed for binge eating. Alex reported, nineteen, was the age of noticeable onset and his symptoms last for a few hours a day, for 2-3 days span. impulse control and ing

**Observational Data**

Alex’s outward appears was disheveled as evidenced by, his unkept hair, and unshaven beard. He was casually dressed, in a jeans and polo shirt and appeared to be uneasy in the waiting room. During the clinical interview, Alex’s behavioral functioning was likening to a shy child, as evidenced by, his flat affect, low tone and speaking volume. The mental status examination (MSE, 1990) determined, Alex was alert and oriented to person, place, and time, although, he made limited eye contact. His motor functioning and speech was disorganized as he processes answers. His varying level of attentiveness, sometimes, made it difficult to follow his thought, perception, attitude and insight. Alex struggled to recall specific information, exhibited poor overall concentration and he did not seem to have control over his impulses. Alex displayed difficulties processing a desire to harm others. See Appendix 1

**History of the Presenting Problem**

Alex provided a copy of his medical records from the psychiatry hospital. Per his chart, Alex was given a clinical diagnosis and a case plan that included his referral for outpatient group therapy. Alex’s records confirmed his history of self-mutilative behaviors and placed his age of on-set at eighteen. His primary care physician noted a series of heavy utilization of health care resources and ruled out physical ailments. On his last visit, June 16th, 2017, Alex was denied additional medical care which resulted, in a 13 minutes’ episode of self-harm; which was documented as head banging against the walls in the doctor’s office. He was restrained and hospitalized for several stitches and a fractured hand. Following the treatment of his injuries, Alex was transferred to a psychiatric evaluation and received 3 weeks of residential treatment. During his residential stay, it is reported that Alex’s exhibited self-criticism and separation insecurity behaviors; chronic feelings of hopeless and, was in a dissociative state that was consistence for 2 weeks. Alex shared he struggled to take his prescribed medication (alprazolam 50 milligrams) and admitted he discontinued usages his medication, shorting after being discharged.

**Assessment/Testing Procedure**

The comprehensive assessment, which encompasses several layers, is the point of entry into the therapeutic process. The tools use to gather relevant information during the assessment process included the diagnostic interview, projective personality measure, mental status examination, behavioral observation and, reports from significant, others such as his mother and medical records.

**Biological assessment.** Alex was treated for 1-thyroxine at the age of 12, with 150 milligrams dose. He continues to be test for thyroid every 6 months and at the age of 16 his test results were normal. Alex has no other medical problems. His health screens and physical examination were normal with no irregular abnormalities.

**Psychological assessment.** Alex admitted to suicidal ideations and denied homicidal ideation, with one episode resulting in his hospitalization. Alex denies substance abuse and reportedly “only drank alcohol once”. Alex denied experiencing delusions, hallucinations, obsessions, compulsions, or phobias. Alex denied known seasonal and medical allergies. Alex said this is his first time in an outpatient therapy setting. Alex’s family history of psychiatric disorder, includes his father, who has a history of depression, which is being treated with Citalopram 100 milligrams dose.

**Social Assessment.** Alex said his childhood was happy and that of a “typical kid”. His mother worked as a graphic designer and his father worked at a bank as an asset manager. Alex described struggling academically, he reported being chronic late and chronic absents due to his inability to sleep at nights. Alex supposes this was the reason he had to drop out of high school at the beginning of 11th grade. Alex reported enjoying school at one point and was “actually a good student” but “lost interest” and, “I just didn’t care about people’s feelings”. Alex recalled not getting along well with other students and couldn’t manage to make friends, in his school. He disclosed not having a girlfriend/ partner and exclaimed the questions on the Jongsma’s Detailed Sexual History Form (Jongsma, 2014) were nonapplicable. Alex said he often found himself isolated with feelings of “intense nervousness, tenseness, and panic” when it comes to social relationships. He commented that his identify disturbance and poor self-image becomes intensify when attempted to have interpersonal relationships. Alex discussed feeling at an outcast or outsider from all social circles and emphasized feeling of abandonment from his, father, mother, grandmother and brother.

**Spiritual Assessment**. Alex states he has no spiritual connection at this time.

**DSM-5 Diagnosis**

Borderline Personality Disorder (301.83; F60.3) is the first diagnostic hypothesis. As evidenced by data found on the Personality Inventory for DSM-5 (PID-5) (APA, 2006)*.* Alex’s personality trait facet confirmed problematic areas and self-reports of impulsivity, intimacy avoidance, antagonism, and perceptual dysregulation. Bipolar disorder (296.53; F31.13) and Adjustment disorder (309.4, F43.25) are listed as Alex’s secondary and tertiary differential diagnoses.

**Case Conceptualization**

Alex C. is a 21-year old man who presents for treatment of Borderline Personality Disorder (BPD). There is limited correlating evidence of genetic or biological factors that would have led to Alex’s demonstrated marked impairment of social, academic and work aspects of his life that led him to self-destructive behaviors however, Alex’s, father’s positive family history should not be rules out completely without further investigation. His internal struggles with this disorder has manifested itself in total life disruption. He describes emoting feelings of chronic emptiness, mood swings, unstable self-image and difficulty connecting with others. Behaviorally, Alex describes, the unable to control his angry and impulse control as evidenced by his binge eat and reckless driving behaviors. He also admitted to suicidality and feelings abandonment. Alex is alert with the ability to recall information, person, place, and time. It is important to note Alex’s thyroid history, which may have transitioned to an active stage. A medically screen for this and other ailments should be rules out before his clinical treatment begins.

**Treatment Planning**

Alex’s treatment will start with the least restrictive care with the focus on his harm reduction goals. His counseling, psychotherapeutic approach, is a multimodal plan, applicable to the different schemas of his life. Once beginning treatment, Alex will be assigned a clinical team that comprised of his primary clinician, a case manager, his mother, primary care doctor, psychiatrist and of course myself; working together to develop a personalized, strength-based and structured plan that begins with a collaborative safely goal/agreement to reduce the likelihood of self-harm and potential harm to others. Thus, harm reduce would be the first goal listed on Alex’s plan. The treatment intervention will include dialectical behavioral therapy to commence cognitive restructuring and behavioral training. Administered through individual counseling session, one a week, for a year. Secondly, Alex, should be recommended to re-start his pharmacotherapy. The rational is to help Alex stabilize his emotional dysregulation, impulsivity and interpersonal dysfunction. Lastly, Alex is recommended to group therapy that would include this family into the therapeutic process. The foundation of this would be via psychoeducation to establish healthy expectation, medication management and goal accountability. See Appendix 3

During each treatment modalities, a Liker Scale Assessment (1-10), safety checklist will be given to help Alex connect his action and feelings to events. The justification for this treatment approach is to decrease endangerment, impulsivity, and cognitive distortions. Additionally, by establishing a pattern of thinking Alex can develop a predictive response to be used outside of the therapeutic setting.

Alex’s prognosis would depend on whether he would be able to regain stable, insight and accept this experiences as a difficult process of growth. During his treatment, the clinical team would look for abhorrence toward his father and willing to integrate family therapy into his treatment plan.

**Ethics**

The counseling progress will only begin once Alex consent to treatment and his treatment team. His progress will be over seen by Alex’s primary clinician to ensure best practice and congruence (Gabbard, 2014, pg. 1087). Based on the ethics codes respect for Alex’s inherent rights to personhood, cultural diversity, and autonomy throughout the process is of vital importance (ACA, 2006). This also entails protect the confidential information of prospective and only disclosing information with appropriate consent or with sound legal or ethical justification (ACA, 2006). Ethical considerations will be made if Alex’s lacks capacity however, Alex’s will be informed at his level of understanding and every appropriate measure(s) will be taken to safeguard client confidentiality. (APA, 2006).

**Multi-cultural**

The DSM-5 Cultural Formulation Interviews (APA, 2006) render a bias free evaluation that will transition into the most appropriate treatment for Alex. See Appendix 2

Emphasis is placed on symptoms during the past 2 weeks, however, historical data would be gathered to establish behavioral patterns. In addition, Alex’s strengths and positive contributes is also highlighted as part of his coping and recovering mechanism. Culture embraces an integrative perspective on all aspect of Alex’s life; psychological, physical, cognitive, social and political. This sensitivity extends to Alex’s race, life conditions, ethnicity, socioeconomic status, sexual orientation, education and employment status. Alex was acculturated with a non-western worldview which emphasized community principals verse individualize, and original heritage values verse nuclear family systems. Unless Alex releases inform consent for family, his treatment details would remain confidential.

**Research/Evidence-based treatments**

Due to the nature of the disorder, treatment must be multilayer to achieve significant outcomes (Soeteman et al., 2008). Evidence-based psychotherapies have demonstrated efficacy through its structural framework and goals by significantly decreasing symptoms via various levels of care (Kellogg & Young, 2006). By combining different modalities automatically broadens the range of expectable benefits (Gabbard, 2014, pg. 1091). Slitting treatments is said to diminish non-compliance, drop out and probably self-harm (Beatson, & Rao, 2014). Alex’s treatment plan is supported by several theoretical concepts that aims to address negative emotional stimuli, social isolation and depression that maybe linked to his mental health disorder(s). The three areas of focus for Alex are, harm reduction, medication and behavioral management.

Linehan (1987), Dialectical behavior therapy (DBT) is a theoretical counseling model developed as a directive and intervention-oriented approach tackles parasuicide (intentional, acute, self-injurious behavior sometimes referred to as suicide attempts or suicide gestures, but also including head banging and self-mutilative behavior) (Linehan, 1987). Self-injury behaviors, per Linehan, is an attempt to regulate emotions and this attempt becomes necessary because more usual emotion regulation mechanisms have broken down or never developed adequately (Linehan, 1993). DBT will approach Alex’s treatment in two ways: behavioral problem-solving focus and an emphasis on dialectical processes (Linehan, 1987; Van Orden, and Jr., 2009).

The treatment plan for Alex served as a preventive and developmental means. Its emphasis on therapeutic prevention of emotional or adjustment problems is superlative when working with individual dealing with suicidality and other cognitive distortions is only a part of the bigger picture (Thimm & Antonsen, 2014). The second layer of Alex’s treatment plan comprises of medication management. Medication therapy Management will be combined with Beck’s Cognitive-behavior therapy (CBT); as tools used to address Alex’s medication needs (Leone, 1982; Ellis, Joffe-Ellis, & American Psychological Association, 2011).

Finally, once Alex is stability and is deemed appropriate for group therapy he would be recommended to strive for purposeful behaviors, connectedness with others, conscious actions, belongingness and social interest (Benjamin et al., 2006). Systems training for emotional predictability and problem solving (STEPPS) developed by St. John, and Pfohl (1995) to be will used to treat Alex’s emotional and behavioral dysregulations, with self-destructive behaviors providing temporary relief of emotional distress. STEPPS was designed to educate clients and family members regarding constructive ways to manage stress, promote functional behaviors and discourage ineffective ones, which will serve ideal for Alex and his family. Topic include awareness of illness, emotional management skills training, and behavioral management skills training such as communication, health eating, sleep, hygiene and leisure (Eells, T. D. (2015). The selected module interventions are specific to helps Alex learn to thought and behavior correlation effectively, to develop tolerance to stress and anxiety, and to find satisfaction in working and living with others (Salkovskis, 1996; Corey, 2004).

**Assessment of Treatment Progress**

The next stage of the therapeutic process involves monitoring the theoretical modalities of empirically validated treatments for individual and group psychotherapy and pharmacological treatment strategies. Monitoring of Alex’s progress seeks to find reliable change, indicating symptom improvement and remission. The monitoring process also serve as evidence for adjusting the treatment. Alex’s, age gender and cultural play a significant role in his perception of the problem. Considerations would be regarding Alex’s perspectives on his environmental setting and that his home has now become a single-parent household. Attentiveness to divorce impact on his feelings of neglect and antisocial behaviors. During treatment deliberation emphasis is placed on Alex’s perspective on his diagnosis and disability. Age and conceptually appropriate education would be administered address institutionalized discrimination practices. Actively listening to Alex in a non-judgmental manner provided insights to obstacles and impediments that may prevent him from receiving help. The assessment of Alex’s progress would be on-going and the Level 2, DSM-V, Cross-Cutting Symptom (ACA, 2006) will be used to compare baseline data and treatment progress as he continued his treatment.

**Referral or Adjunct Services**

Alex’s treatment team would meet every three months to monitor his progress to determine suitable levels of care. He will continue to receive on-going psychiatrist for medication evaluation, safety monitoring and overall growth from initial baseline. Referral recommendations will be based on Alex’s progress and these would include completing his General Educational Development (GED), obtaining and maintain employment or a volunteer position and securing a healthy romantic relationship. If Alex has proven to regress the recommendation would be for a higher level of care perhaps partial day treatment.

**Conclusion**

The treatment plan is a living document with the objectives to Alex’s reduce negative distorted thinking, increase his self-worth/ self-image and gain confidence to pursue intimacy. The evidence-based intervention aims to teach cognitive tools to response to Alex’s automatic thoughts to avoidance and increased assertiveness. Some predictive obstacles include unforeseen setbacks, ambivalent or uncertain about treatment, that maybe cause him to discontinue his clinical regimen. This maybe combated, with structured evidence-based treatments and a solid rapport from Alex’s clinical team. Alex’s one-year treatment plan would be strength-based, reconciling therapeutic structure to meet him where he is in the process. Alex will be encouraged to establish and maintain to a psychological stage of readiness for change and recommended various strategies for future stability. His treatment plan entails evidence-based treatments to address his presenting problems, diagnosis, intervention/ goals, and aftercare plan.

References

American Counseling Association (2014). *ACA Code of ethics*. Alexandria, VA: Author.

Retrieved from: https://www.counseling.org.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental*

*Disorders.* 5th ed. Washington, DC: Author.

Beatson, J., & Rao, S. (2014). Psychotherapy for borderline personality disorder. *Australasian*

*Psychiatry, 22(6), 529 - 532*

Beck, A. T., Brown, G., Berchick, R. J., & Stewart, B. L. (1990). Relationship between

Hopelessness and Ultimate Suicide: A Replication with Psychiatric Outpatients. *American journal of psychiatry, 147, 190-195.*

Benjamin, C. L., Puleo C. M., Settipani C. A., Brodman D. M., Edmunds J. M., Carlson, J., &

Sperry, L. (2006). *Adlerian therapy*. Washington, DC.

Binks, C.A, Fenton, M, McCarthy L, Lee T, Adams C.E, &Duggan C. (2007) *Psychological*

*therapies for people with borderline personality disorder: The Cochran Collaboration*. New York, NY: Wiley.

Brewin C. R. (1996). Theoretical foundations of cognitive-behavior therapy for anxiety and

depression. *Annual review of psychology,* 47(1), 33-57.

Centers for Disease Control and Prevention (1999). *Framework for program evaluation in public*

*health.* Atlanta. GA: Author. Retrieved from: <https://www.cdc.gov/eval/framework/index>

*.*htm

Corey, G. (1996). Theory and practice of counseling and psychotherapy. Pacific Grove:

Brooks/Cole Pub. Co.

Corey, G. (2006). *Theory & practice of group counseling* (6th ed.). Belmont, CA: Thompson

Brooks/Cole.

Cummings C. M., & Kendall P. C. (2011). History of cognitive-behavioral therapy in youth.

*Child and adolescent psychiatric clinics of North America*; 20 (2) 179-189.

Dattilio, F. M., & Freeman, A. (1994). *Cognitive-behavioral strategies in crisis intervention*.

New York, NY: Guilford Press.

David, D. (2005). A synopsis of rational-emotive behavior therapy (REBT); fundamental and

applied research*. Journal of rational-emotive and cognitive-behavior therapy;* *23 (3) 175-221.*

David, D., & DiGiuseppe, R. (2010). Social and cultural aspects of rational and irrational beliefs.

A brief reconceptualisation. In D. David, S. J. Lynn, & A. Ellis, A. (Eds.).

Rational and irrational beliefs: *Research, Theory, and Clinical Practice.* New York, NY: Oxford University Press. (pp. 373-386).

David, O. A. (2013). The online prescriptive index platform for the assessment of managerial

competencies and coaching needs: Development and initial validation of the experience sampling mood wheel and the manager-rational and irrational beliefs scale. *Romanian Journal of Applied Psychology*, *15(2), 41–50.*

Dryden, W. (2001). Reason to change: A rational emotive behaviour therapy (REBT) workbook.

Hove: Brunner/Routledge.

Dryden, W. (1999). Rational emotive behaviour therapy: A personal approach. Bicester:

Winslow.

Eells, T. D. (2015). Psychotherapy case formulation. *Handbook of psychotherapy case formulation*, 2nd ed., pp. 3–32. New York: Guilford.

Ellis, A. (1994). *Reason and emotion in psychotherapy* (rev ed.). Secaucus, NJ: Birch Lane.

Ellis, A., Gordon, J., Neenan, M., & Palmer, S. (1997). *Stress counseling*. London: Cassell &

New York, NY: Springer.

Ellis, A., Joffe-Ellis, D., & American Psychological Association. (2011). *Rational emotive*

*behavior therapy.* Washington, DC: American Psychological Association.

Fulkerson, M. H. (2015). *Treatment planning from a reality therapy*

*perspective*. Bloomington, IN: iUniverse.

Gabbard, G. O. (2014). Gabbard’s treatments of psychiatric disorders: DSM-V edition.

Arlington: APA.ISBN-13: 978-1585624423. Edition: 5

Gavita, O. A., Freeman, A., & Sava, F. A. (2012). The development and validation of the

Freeman–Gavita prescriptive executive coaching (PEC) multi-rater assessment. *Journal of Cognitive and Behavioral Psychotherapies*, 12(2), 159–174.

Health Insurance Portability and Accountability Act of 1996, *Pub. L. No. 104-191, 110* Stat.

1936 (Aug. 21, 1996).

Jobes, D. A. (2006). Managing suicidal risk: A collaborative approach. New York, NY: Guilford

Press.

Jobes D. A., Wong, S. A., Conrad, A. K., Drozd, J. F., & Neal-Walden, T. (2005). The

collaborative assessment and management of suicidality versus treatment as usual: A retrospective study with suicide outpatients. *Suicide and Life- Threatening Behavior, 35(5), 487-497.*

Jones, K. D. (2010). The unstructured clinical interview. *Journal of Counseling & Development,*

*88, 220-226.*

Jongsma, A. E., Peterson, L. M., & Bruce, T. J. (2014). *The complete adult psychotherapy*

*treatment planner* (5th ed.). Hoboken, NJ.:Wiley.

Jorn, A. C. (2015). Elements of the biopsychosocial interview of the chronic pain patient: A new

expanded model using rational emotive behavior therapy. *Journal of Rational - Emotive & Cognitive - Behavior Therapy*, 33(3), 284-307.

Kellogg, S. H., & Young, J. E. (2006). *Schema therapy for borderline personality disorder*.

Journal of Clinical Psychology, 62(4), 445-458.

Koutsoukou-Argyrak, A., Frank-Hagen Hofmann, Kreb, V., Sperth, M., & Holm-Hadulla, R.

(2016). The ABCDE-model of counseling and psychotherapy: An integrative approach developed from clinical practice at a counseling service for students, 26.

Lazarus, A. A. (1997). Brief but comprehensive psychotherapy: The multimodal way. *NYo:*

*Springer*.

Leahy, R. L. (2008). The therapeutic relationship in cognitive-behavioral therapy. *Behavioral*

*and cognitive psychotherapy,* 36(6), 769-777.

Leone, N. F. (1982). *Response of borderline patients to loxapine and chlorpromazine*. Journal of

Clinical Psychiatry, 43, 148-150.

Linehan, M. M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*.

Guilford Press New York.

Linehan, M. M. (1987*). Dialectical behavior therapy for borderline personality disorder: Theory*

*and meth McKinley BT, Mulhall BP, Jackson JL. Perceived versus actual medication regimens among internal medicine patients.* Mil Med. 2004;169(6):451–4.od. Bulletin of the Menninger Clinic, 51(3), 261. 29-532.

Nelson K & Schulz S. (2012*). Treatment advances in borderline personality disorder*. Psychiatry

Ann, 42(2): 59–64. doi:10.3928/00485713-20120124-06.

Macneil, C. A., Hasty, K., K, Conus, P., & Berk, M. (2012). *Is diagnosis enough to guide*

*treatment interventions in mental health?*  Using case formulation in clinical practice. BMC Medicine, 10, 111.

Malouff, J. M. (2009). Commentary on the current status of assessment in rational-emotive and

cognitive-behavior therapy. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, 27(2), 136-140.

Mcdermut, W., Haaga, D. A., & F. (2009). Assessment and diagnostic issues in rational emotive

behavior therapy: Introduction to the special issue. *Journal of rational-emotive & cognitive-behavior Therapy*, 27(2), 79-82.

Medication therapy Management in Pharmacy Practice. (2008) *Core Elements of an MTM*

*Service Model*. American Pharmacists Association and National Association of Chain Drug Stores Foundation. Version 2.0.

Mulligann, J., MacCulloch, R., Good, B., & Nicholas, D. B. (2012). Transparency, hope, and

empowerment: A model for partnering with parents of a child with autism spectrum disorder at diagnosis and beyond. *Social Work in Mental Health*, 10(4), 311-330.

Redelmeier, D. A. (2005). The cognitive psychology of missed diagnoses. *Annals of internal*

*Medicine*, 142(2), 115-20.

Salkovskis P.M. (1996). *Frontiers of cognitive therapy*. Guilford Press, New York, NY.

Soeteman, D.I., Hakkaart-van Roijen, L., Verheul, R., & Busschbach, J.J. (2008). The economic

burden of personality disorders in mental health care. *Journal of Clinical*

*Psychiatry; 69:259-265.*

Sonstegard, M. A. (1998). The theory and practice of Adlerian group counseling and

psychotherapy. *Individual Psychology*, 54(2), 217.

Sommers-Flanagan, J., & Sommers-Flanagan, R. (2013). *Clinical interviewing* (4th ed.). New

York, NY: John Wiley & Sons.

Stoffers, J. M., Völlm, B. A., Rücker, G., Timmer, A., Huband, N., & Lieb, K. (2012).

Psychological therapies for people with borderline personality disorder. *The Cochrane Database of Systematic Reviews, (8), CD005652.*

Thimm, J. C., & Antonsen, L. (2014). Effectiveness of cognitive behavioral group therapy for

depression in routine practice. *BMC Psychiatry, 14(1), 292-292.*

Van Orden, K.A, Witte, T.K, Cukrowicz, K.C, Braithwaite, S.R, Selby, E.A, Joiner, TE Jr.

(2010). *The Interpersonal Theory of Suicide*. Psychological Review. 117:575–600.

Van Orden, K. and Jr., T. E. (2009). *Suicide theories. In E. Ingram, The International*

*Encyclopedia of Depression.* New York, NY: Springer Publishing Company.

**Appendices**

1. Name has been changed to protect confidentiality. [↑](#footnote-ref-1)