Theoretical Model and Case Study

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Abstract

A comprehensive understanding of a clinician's theoretical model is vital to the efficacy of clinical practice and professional contribution as leading experts in Mental Health. In this paper, I explicate three theoretical models that align with my core values: Cognitive Behavioral Therapy (CBT), Solution Focused Brief Therapy (SFBT), and Sensorimotor Psychotherapy (SP). Additionally, I provide my current understanding of a format for a thorough assessment and the specific tools used and a new model of creating a case conceptualization called Thematic Mapping is introduced and further explained. A case study of a 48yr old female suffering with trauma and depression is presented to see the steps practically applied from beginning to end with an overall goal of clarifying my professional perspective and identity.

Keywords: case conceptualization, theoretical model, assessment tools, thematic mapping

Theoretical Model and Case Study

The ultimate goal of a counselor is helping clients well. There are a variety of approaches and interventions to achieve this goal and the weight of responsibility lies with the counselor to be well-versed across several theories and effectively implement them. The current climate of mental health demands evidence based assessment, treatment and clinically informed practice. This paper aims to strengthen my theoretical model and practice the process of outlining each step carefully. To counsel effectively, I must stay aware of current research, challenge myself to constantly improve and make further contributions to the ever-growing professional field.

Comprehensive Theoretically Grounded Model of Clinical Counseling

Evidence based theories I apply in counseling

Cognitive Behavioral Therapy (CBT) has proven to be extremely effective in treating a variety of disorders. Although research does not support its singular efficacy over alternative therapeutic models, CBT leads the way with successful outcomes for anxiety and depressive disorders (Tolin, 2016). This information is particularly useful to me, because during a clinical internship last year on the psychiatric ward, there were many clients struggling with depression and anxiety. My future goals of serving The Bahamas well include being adequately equipped to specifically meet the needs.

CBT has three foundational aspects from which all other variations of CBT build. The first aspect is - Access Hypothesis – this refers to the belief that the content and process of our thinking is knowable. CBT firmly believes that people can become aware of their own thinking with appropriate training and attention. The second aspect is - Mediation Hypothesis; this refers to the link between our thoughts about a situation and the emotional and behavioral response toward that situation. This approach does not support the idea that people simply have an emotional response, but rather that the way we think about the event is crucial to the way we feel about it. Thirdly is the Change Hypothesis – this aspect combines the access and mediation hypothesis to conclude that because thoughts are knowable and can mediate our responses, intentional modification of thoughts can occur (Dobson & Dobson, 2018).

CBT has been shown to be effective in over 2,000 studies and is a psychotherapy that emphasizes client's goals that are important to them and obstacles that limit their achievement of such goals. CBT is based on a premise that the way individuals perceive a situation is more connected to their reaction than to the situation itself (Dobson & Dobson, 2018).

Through continuous research, I find a strong link between dysfunctionality and traumatic experiences. A detailed view into some disorders provides the opportunity to identify causes and triggers. Individuals who have experienced trauma without any interventions tend to lack skills of functioning effectively. There are a variety of therapeutic approaches to treat trauma; recently I've learned about Sensorimotor Psychotherapy (SP) and have felt drawn to explore this theory with future hopes of applying it.

Sensorimotor Psychotherapy designed by Dr. Pat Ogden, is rooted in the belief that it takes a body to heal trauma (Leavitt, 2008). After much research in the field of traumatology, Dr. Ogden determined that a whole-body perspective allows a full understanding of the trauma, and the processing of the trauma can be complete (Leavitt, 2008). The body holds onto memories and painful experiences and SP targets the physical sensations first, and the emotions and cognitions later (Ogden & Goldstein, 2017). So much of the trauma revolves around the nervous system and somatic processes therefore Sensorimotor Psychotherapy aims to focus on the physical reality of trauma damage as well as mental aspects (Leavitt, 2008).

SP provides a way to better understand hyper/hypo-arousal and dysregulation as well as employ effective strategies to stabilize children and caretakers in challenged families. Children who experience traumatic events and are left alone to support themselves can develop a chronic and persistent autonomic nervous system (ANS) and emotional dysregulation. SP often experiences success when words are unavailable and is especially effective with children as their cognitive development is limited.

It is a body-inclusive approach that supports the idea of somatic narratives. Therapeutic work with the body occurs through mindfully noticing the feelings and sensations as the client discusses the traumatic event (Fisher, 2019). A major goal is to help clients develop somatic

awareness and understand how their dysregulation manifests in somatic form (Lohrasbe & Ogden, 2017).

When people have had experiences that compromise their typical neurological development, dysregulation occurs. If clients' neurological and physiological dysregulation management are not stabilized initially this may greatly reduce the efficacy of their cognitive abilities and limit their therapeutic gains. Early attention to stabilizing the client also prevents the client's dependence on the therapist for dysregulation management (Lohrasbe & Ogden, 2017).

Interestingly, there is limited empirical research on SP for Trauma clients, however a pilot study conducted on a group of women who all shared a history of child abuse found SP to significantly reduce PTSD symptoms ((Langmuir, Kirsch, & Classen, 2012). I've enjoyed learning about Sensorimotor Psychotherapy and can definitely see how combining both aspects of body and mind can provide complete healing of the trauma. It is important to understand how everything is connected and certainly an experience doesn't just affect the mind but also the body. SP also resonates strongly with me because I truly believe in complete healing. I am excited to continue my research in Sensorimotor Therapy and look forward to including it in my future private practice.

Within my current work setting at a public high school, Solution Focused Brief Therapy (SFBT) is highly recommended as an effective therapeutic approach. SFBT was developed by a small group of therapists under the direction of Steve de Shazer and Insoo Kim Berg. SFBT focuses on a client's strengths and solutions rather than deficits and problems (Gingerich & Peterson, 2012). Additionally there is a strong emphasis on the amount of sessions where significant outcomes are produced in less than six sessions (Gingerich & Peterson, 2012).

The current focus in Mental Health is the efficacy of any treatment; third-party funders are demanding evidence based practices before payment. Along this path SFBT ranks high, as a review of 43 studies comprised of adult mental Health, child academic and behavior problems, marriage and family, occupational rehabilitation, health and aging, and crime and delinquency reported a 74% significant positive benefit from this therapeutic approach (Gingerich & Peterson, 2012).

My comprehensive method of bio-psycho-social/multi-systemic-cultural/spiritual assessment

The therapeutic alliance for both client and clinician is critically dependent on a solid understanding of the client's present and past circumstances. It is imperative that counselors seek to gather all relevant data to create an authentic and complete picture of the client. The factors that should be considered are biological, psychological, social, multi-systemic – cultural, and spiritual.

Biological factors refer to the actual physical health of the client. The Rand-36 is a questionnaire designed to gather the client's perspective on their level of physical health. It has been noted for its internal reliability and validity. The scoring on this survey ranges from 0-100, with 50 being the mean score. If a client measures below 50, they are considered to have poor physical health, and vice versa if a client measures higher, it is an indicator of good physical health (Woods, Priest, & Denton, 2015).

To measure the psychological and social aspect, the five item OASIS questionnaire would be utilized. This is a brief survey that gives an indication of how the client deals with anxiety and social situations. The Quick Inventory of Depressive Symptomatology is a 16-item self-

report questionnaire (QIDS) that seeks to screen for depression and measure the severity of symptoms (Woods, et.al., 2015).

The DSM-5 provides a Cultural Formulation Interview (CFI) assessment to emphasize the importance of clinicians integrating cultural considerations to the counseling journey (Dailey, Gill, Karl & Minton, 2014). CFI consist of 16 questions that cover the cultural implications of the problem, the cultural perceptions of the cause and cultural factors that impact the ability to self-cope and current desire to seek help. It is important for cultural aspects to be considered when formulating a diagnosis (Dailey et. al., 2014).

The FICA assessment tool is an acronym for F – faith or beliefs, I – importance and influence, C – community, A – address. With this assessment, there are directed questions for each area that can open a dialogue; questions such as "Do you consider yourself spiritual or religious? ", or "What gives your life meaning?". These questions provide a gentle approach to exploring spirituality (Saguil & Phelps, 2012).

All of the above assessments provide great information for a skeletal framework, however additional tools help to further define who the client is and what context are they living in. The Personality Inventory is a 25-item survey that American Psychiatry Association states is designed to help clinicians understand personality traits that may be present with their client. The five domains are negative affect, detachment, antagonism, disinhibition, and psychoticism. The survey is scored between 0-75 with higher scores indicating greater overall personality dysfunction.

The Post Traumatic Stress Disorder Checklist (PTSD) for DSM – 5 (PCL) is a 20-item self-report measure to asses symptoms and severity of PTSD. However it cannot be used as a stand-alone measure and should be used in conjunction with a clinician-administered interview (CAPS-

5). The scale for PCL-5 is 0-80 with scores higher than 33 indicating further assessment needed to determine a PTSD diagnosis according to the National Center for PTSD.

The Genogram is an assessment tool that dates back to the 1960's and was first utilized by Murray Bowen and Jack Bradt (Majhi, Reddy, & Muralidhar, 2018). This useful tool serves as a visual representation to help the clinical practitioner gather information and guide the interventions. Both clients and clinicians see and understand the larger picture of family background, roles, and social interactions (Majhi et.al., 2018). Although originally designed for use with family assessment, genograms have been utilized beyond the family dynamics and research supports its efficacy as a beneficial tool (Majhi et.al., 2018).

Throughout the initial intake with the client, the clinician is performing a general observation of the client's level of consciousness, appearance, activity and emotional state. This assessment called the Mental Status Examination (MSE) seeks to deduce if any pathology exists (Norris, Clarke, & Shipley, 2016). Should there be further concerns, additional testing can occur to specify the physical or neurological problems that are presented (Norris, et.al., 2016)

How I synthesize assessment data into an accurate case conceptualization, diagnosis, and measurable treatment plan

An accurate case conceptualization is an integral component to effective counseling, yet there is a diversity of methods, and research suggests that the process is still unclear for most clinicians which allow room for error. Ridley, Jeffrey, & Roberson (2017) coined the term case 'mis – conceptualization', which refers to the clinician's lack of ability to achieve this over-arching perspective after gathering the client's data. Counselors must have a comprehensive understanding of who the client is and the context within that individual is currently living (Zubernis, Snyder, & McFall, 2017).

Working in the school system with multiple time restraints, my common practice includes gathering the necessary data- family background, school and behavioral history; searching for dysfunctional themes that tend to reoccur and working with students on which problems cause the most interruption or creates the most anxiety. This process tends to be less formal and less comprehensive. However preparing for future private practice, I would like a more comprehensive way of synthesizing data for clients.

Thematic Mapping is a method of case conceptualization that helps clinicians gather and integrate the data into identifiable and treatable psychological themes (Jeffrey & Ridley, 2017). Current research shows the deficiency in case formulation where often times there is over - dependence on clinician judgement, and unclear guidelines of how to achieve an accurate case conceptualization. Thematic Mapping aims to fill this gap by providing a thorough and systematic approach to case conceptualization (Jeffrey & Ridley, 2017).

There are three stages of Thematic Mapping which include: theme identification, theme interpretation, and theme intervention. The first stage of theme identification incorporates four core goals: broad data collection, use of induction to identify preliminary behavior patterns, creation of behavior episodes list, and double checking for premature interpretations (Jeffrey & Ridley, 2017).

Theme interpretation moves beyond identifying general behavior patterns and now seeks to identify specific themes and subthemes through deduction. One of the main goals in this second stage is to facilitate clinicians to think critically about their clients outside of a problematic mentality (Jeffrey & Ridley, 2017). Client and clinician collaboration is an important part of the entire counseling journey therefore it is beneficial that stage two of thematic mapping

encourages both client and clinician to share in the discovery of themes and subthemes before the treatment plan and therapeutic goals are finalized (Jeffrey & Ridley, 2017).

Theme Intervention, allows the clinician to view the themes as changes that need to be made to replace dysfunctional patterns. At this stage, a clinician is seeking to utilize therapeutic interventions that are sensitive and match the client's cultures and personal experiences including styles of communication, background and developmental level. This stage also encourages clinicians to monitor the clients' progress, or relapse and continue to work together on their themes. At times, the clinician may need to revisit stage one or two to cultivate initial conceptualizations or make necessary adjustments to selected interventions (Jeffrey & Ridley, 2017).

This model of case conceptualization resonates with me for a variety of reasons. Firstly, it provides a clear outline of steps and the goals of each stage; secondly it views the entire process as on-going rather than a one - time event, and thirdly it is trans- theoretical, regardless of a clinicians' theoretical model thematic mapping can be used. In counseling, dynamics can change so quickly that the clinician must pay close attention to all nuances. It is helpful to have a model that supports that flexibility.

Once all assessments have been completed, there is sufficient data to begin the induction process. This process is best accomplished through a creation of behavior episodes list. Firstly, I would draw on a sheet of paper two columns; one titled behaviors and the other column titled episodes. The episode list refers to notable life events that have occurred across the client's life and relationships and the behavior lists refers to behavioral characteristics that appear to be significant and recurring to the client and observed by the clinician (Jeffrey & Ridley, 2017).

Upon completion of the behavior episodes list, clinicians are continually encouraged to challenge their perspectives, and review their initial interpretations before finalizing themes. I find this step extremely important, because in counseling my perspective matters a great deal and largely determines levels of empathy, congruency and unconditional positive regard. I must be constantly aware of biases and having a model that mandates this double check is most beneficial.

Stage two moves beyond general identification of the data to identifying specific themes and subthemes. The responsibility lies with the clinician to take a step back and carefully analyze what themes emerge from the behavior and episodes list. This is the time that the clinician discusses with the client their thoughts about themes and seeks to collaborate with the client before finalizing the case conceptualization, diagnosis and treatment plan. This collaboration allows the client the opportunity to ask questions about their conceptualization and perspective.

When stage two has been satisfactorily completed, the case conceptualization should provide the information to determine an accurate DSM-diagnosis. Once a clear and collaborative case conceptualization has guided the clinician to a DSM-diagnosis, the therapeutic goals should be finalized at this point, and a treatment plan formulated. Jongsma, Peterson, & Bruce (2014), describe six steps to developing an effective treatment plan: 1. Problem Selection, 2. Problem Definition, 3. Goal Development, 4. Objective Construction, 5. Intervention Creation, and 6. Diagnosis Determination. One of the main points to remember is that objectives must be stated in behaviorally measurable language Jongsma et.al. (2014).

The last stage provides the culmination of establishing the themes as targets of change. It is my goal to bring clients to awareness as to how they can replace their dysfunctional patterns with

adaptive behaviors. At this stage, I would utilize CBT and Sensorimotor Psychotherapeutic Techniques to address dysfunctional thought patterns and reduce negative somatic responses.

Case Study

Case Introduction

Helen is a 48 year old, heterosexual, black female who is in her second marriage to her husband for the past 12 years and has a six year old daughter. She has never received counseling to help her overcome the sexual trauma she experienced during her childhood from close family members who lived in the same household. Helen indicated that although she has tried to mentally block the experiences, her heart will still race and feelings of anxiety and panic will overtake her, if she smells the same scent of her abusers. Helen stated that she has a small social network because she is wary of trusting people and has difficulty connecting to others. She is a high school math and science teacher and holds a bachelor and master's degree in secondary education. This experience has left her desolate and she has finally convinced herself to try therapy.

Presenting Complaints

Helen reported that her primary concern was that she was experiencing flashbacks, shame and rage, and numbness of feelings and body sensation. She gave examples of not sleeping through the night from nightmares, and during the day there could a trigger which would emphasize the shame. She began to anticipate that her life would never be free from the traumatic experience and that she would always be haunted by these events. Due to the traumatic event, Helen stated that at times she has an uncharacteristic mistrust with her husband which causes some interference in their marriage. Although her husband is extremely supportive of her attending counseling, he has refused to attend.

Helen stated that for the last two months, she has found herself tearful, and in a low mood nearly every day. She no longer meets with friends to play scrabble, her appetite has significantly changed and she has reported some weight loss. She stated that lately she seems unable to focus on the simplest of tasks and the insomnia at nighttime is worrying. Helen is worried that she will pass on her negative issues to her daughter and perhaps the cycle would continue. Helen is struggling to balance a professional career, motherhood, family and her cascade of experiences due to the sexual trauma; and she describes herself as feeling depressed.

History

Helen was born in Kingston, Jamaica and was brought up in a very independent home. She is the oldest of three girls and her mother always seemed to rest full responsibility on her for the younger two sisters. Her father relocated to London, and she has had limited interaction with him. During her time of living at home, numerous family members came to live with them and unfortunately one of her male cousin's began to sexually abuse Helen during the night. Helen worked hard in high school and was able to attend an all-girls boarding school. Upon high school graduation, Helen attended the local university in Jamaica and completed her Bachelor's degree in secondary education for math and science.

Helen relocated to Cayman Islands upon a separation from her first husband which ultimately resulted in a divorce. Helen remained living in Cayman Islands and tried to live a quiet unassuming life. Eventually, Helen met a gentleman by the name of Peter and several months later they were married and had a daughter. Despite the positive events in Helen's life, she has stated that she feels low in her mood and at times labeling herself as depressed.

Assessment

During the initial intake, Helen was given a number of assessments to complete. These assessments included: The Rand – 36, FICA – a spiritual assessment, The Personality Inventory for DSM – Brief, The Level 1 Cross-Cutting Symptom Measure – Adult, and On mental status examination, Helen was well-groomed, cooperative and had some display of psychomotor agitation. Her speech was of normal rate and clear and her thought process was logical. She denied experiencing any hallucinations or delusions and her memory appeared to be intact. Helen denied any thoughts about suicide and she was compliant with answering all questions with a simple yes or no.

During the second session, I began with the Cultural Formulation asking Helen to describe how she would explain her problem to her family and friends. This kind of question provides an opportunity for the clinician to understand the dynamics of what Helen feels safe to share and what is culturally appropriate to feel or express. Following the thematic mapping model, this initial stage of gathering data also provides an opportunity for the clinician to lay the groundwork for therapeutic alliance.

Upon completion of her assessments the following Helen scored an average score of 50 on her Rand-36 designed to measure overall physical health. We discussed the FICA assessment and she was more than willing to have her sense of spirituality involved. She scored moderately on the domains of depression, and anxiety meaning three or higher on a 5 point scale for the Level 1 Cross-Cutting Symptom Measure, and she scored mildly on all other domains meaning two or less. Further inquiry of the high score for depression was needed and so Helen completed the Quick Inventory Depressive Symptomatology Inventory (QIDS). Her score was a 16 which

indicates the severe depressive symptoms. Helen completed the PTSD checklist, and scored higher than 33 indicating persistent symptoms of PTSD from the sexual abuse during childhood.

Case Conceptualization

I began the process of formulating the case by creating a behavior and episodes list with Helen. She identified the following significant events as episodes: a. sexual abuse from family members, b. emotional and physical abuse from her mother, c. abandonment from her father, d. marriage to first husband and subsequent divorce, e. attainment of Bachelor's degree, f. relocation to new country, g. marriage to second husband, h. birth of only daughter.

The Behavior list included: a. guilt about protecting herself when needed, b. avoidance of meaningful relationships, c. avoidance of confronting painful events, d. continued experience of depression and anxiety, e. negative self-talk, f. negative self-defeats, g. repeated interactions with abusive figures.

I carefully reread both columns to extract emerging themes. At this point, I'm also checking for my personal bias about the information, and ensuring objectivity. Several themes emerged: Helen had a lifestyle with involuntary episodes of abuse, victimization, and constant blows at key times in life. However even without abusive figures in her life she would beat herself up with negative self-talk, and so the cycle continued. Helen also experienced recurring traumatic symptoms because she's never successfully processed the sexual abuse. She has felt disempowered for so long, it almost feels impossible to regain a secure sense of self. I shared this case conceptualization with Helen and she agreed with the themes I observed.

In stage three, I tentatively assign the diagnosis of PTSD (Post Traumatic Stress Disorder) and Major Depressive Disorder (MDD) as she meets the criteria for both. Helen and I collaborate over her treatment goals which include: a) establish positive thinking to replace

dysfunctional thought patterns, b) actively form healthy interpersonal relationships, c) embrace confidence in her skills and accomplishments, and d) process the somatic responses due to the unresolved abuse (see Appendix A).

Course of Treatment and Assessment of Progress

Based on these treatment goals, I decided to use CBT's writing exercises; ABC worksheets – activating event, behaviors, and consequences, and journaling exercises to reaffirm Helen's strengths and help her to identify cognitive distortions. Helen benefited greatly through these interventions, however they were insufficient in resolving the emotional distress. It became clear that Helen had repressed memories of the abuse and this influenced her perception of the world and personal identity (Jeffrey & Ridley, 2017).

To safely accomplish the goal of uncovering and overcoming the childhood abuse, I integrated Sensorimotor Psychotherapy. One of the main goals in SP is to foster holistic processing by integrating the three levels of our being: cognitive, emotional and sensorimotor (Ogden & Minton, 2000). The body can be used as an entry point for processing trauma, and SP directly treats the effects of trauma on the body which in turn allows for emotional and cognitive processing (Ogden & Minton, 2000). As I began to ask questions about the abuse, Helen started to panic. I began to teach Helen the technique of mindfully tracking her physical sensations as they progress through the body and disregard the emotions and the thoughts that arise. Once the bodily sensations have resolved and the body is stabilized then we can continue. Helen began to understand sensorimotor processing and several sessions later, she could independently manage her own self-regulation (Ogden & Minton, 2000).

Each session Helen learned more about sensorimotor processing and could experience bodily sensations and mindfully track them until they stabilized. This allowed us to now address

the emotional and cognitive aspects to the abuse and Helen could fully express the pain and sadness of being abused. This new experience of integration of emotional, cognitive, and sensorimotor regained Helen's confidence as all three areas were addressed simultaneously (Ogden & Minton, 2000).

Helen's progress was evaluated each week through the completion of the Outcome Questionnaire -45. I observed that Helen's progress was noticeable and correlated with her self-rated weekly report, including a decrease in her frequency of tearfulness, and tensed body language. Helen could identify her engagement with unhealthy relationships and she began to create protective measures for herself.

At the end of counseling, Helen's emotional, behavioral and psychological presentation was strikingly different from the beginning of therapy. She expressed confidence in her ability to recognize unhealthy friendships, increase her self-awareness, administer positive self-talk, and maintain her emotional balance. She found herself embracing her achievements and accomplishments in life and shared her optimistic view about her future with husband and daughter. The termination phase of counseling tends to be riddled with its own set of feelings, and while it has not received much attention in research (Bhatia & Gelso, 2017), it is a vital component to the overall outcome of treatment (see Appendix B).

Follow-up

Once counseling sessions have been terminated, it is strongly recommended to do follow-ups. Although this is a step that some clinicians skip, it is designed to check – in with clients and evaluate the effectiveness of the counselor and the strategies implemented (Okun, 2002). It is important to distinguish between genuine follow-up and a prolonged dependency of client or

clinician. A general recommendation is six months to a year after termination with a telephone call to let the clients know that you've thought about them (Okun, 2002).

I find this step to be so vital to the entire process, starting and ending well is encouraging to both client and clinician. It implies that the therapeutic alliance was authentic, and meaningful. This would definitely be a step that I would strive very hard to include in my practice.

Conclusion

The counseling journey is complex, fascinating, and meaningful. There is power to facilitate genuine change, and impact clients in an extremely positive way. This assignment has challenged, prodded and demanded clarity about my views on each step of the process. The research shows that taking the time to adequately assess, develop the therapeutic alliance, accurately conceptualize the case and provide matched interventions is considered the gold standard. Learning about thematic mapping has provided another avenue to accurately create a case conceptualization.

Sensorimotor Psychotherapy provides that physiological healing that I think far too many individuals are experiencing without ever feeling symptomatic relief. Several pieces of the puzzle have come together to solidify my approach to counseling. In this paper, I've presented aspects of what research support and my personal views on how the journey can begin and end. I am very optimistic of what God has in store for me in the field of Counseling.

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Appendix A

Case Conceptualization

Demographic Information - Helen is a 48 year old, heterosexual, black female who is in her second marriage to her husband for the past 12 years and has a six year old daughter. She currently works at a high school teaching math and biology. Helen's general health is average, she has her yearly physical and her most recent doctor's appointment was related to vision where she is experiencing minor issues.

Presenting Problem - Helen reported that her primary concern was that she was experiencing flashbacks, shame and rage, and numbness of feelings and body sensation. She gave examples of not sleeping through the night from nightmares, and during the day there could a trigger which would emphasize the shame. She began to anticipate that her life would never be free from the traumatic experience and that she would always be haunted by these events.

Helen stated that for the last two months, she has found herself tearful, and in a low mood nearly every day. She no longer meets with friends to play scrabble, her appetite has significantly changed and she has reported some weight loss. She stated that lately she seems unable to focus on the simplest of tasks and the insomnia at nighttime is worrying for her.

Observational Data - On mental status examination, Helen was cooperative and had some display of psychomotor agitation. Her speech was of normal rate and her tone was congruent. She denied experiencing any hallucinations or delusions and her memory appeared to be intact. She presented herself appropriately dressed and was compliant with answering all questions with a simple yes or no.

History of the Presenting Problem - Due to the traumatic event, Helen stated that at times she has an uncharacteristic mistrust with her husband which causes some interference in their

marriage. Although her husband is extremely supportive of her attending counseling, he has refused to attend. Helen is worried that she will pass on her negative issues to her daughter and perhaps the cycle would continue. Helen is struggling to balance a professional career, motherhood, family and her cascade of experiences due to the sexual trauma; and describes herself as feeling depressed.

Assessment/Testing Procedure – During the initial intake, Helen was given a number of assessments to complete. These assessments included: The Rand – 36, FICA – a spiritual assessment, The Personality Inventory for DSM – Brief, The Level 1 Cross-Cutting Symptom Measure – Adult, and The PTSD checklist.

DSM-5 Diagnosis – Post Traumatic Stress Disorder and Major Depressive Disorder

Research/Evidence based Treatments – Evidence-based treatment outcomes indicate that Cognitive Behavioral Therapy is one of the most efficacious treatments for Depressive Disorders (Gabbard, 2014). Most effective psychotherapeutic treatment for PTSD is Trauma-focused CBT, (Gabbard, 2014). Despite lack of empirical research, Sensorimotor Psychotherapy is extremely beneficial (Langmuir et.al., 2012).

Assessment of Treatment Progress – Helen's progress was evaluated each week through the completion of the Outcome Questionnaire -45. I observed that Helen's progress was noticeable and correlated with her self-rated weekly report, including a decrease in her frequency of tearfulness, and tensed body language.

Case Formulation - I began the process of formulating the case by creating a behavior and episodes list with Helen.

Several themes emerged: Helen had a lifestyle with involuntary episodes of abuse, victimization, and constant blows at key times in life. However even without abusive figures in

her life she would beat herself up with negative self-talk, and so the cycle continued. Helen also experienced recurring traumatic symptoms because she's never successfully processed the sexual abuse. She has felt disempowered for so long, it almost feels impossible to regain a secure sense of self. I shared this case conceptualization with Helen and she agreed with the themes I observed.

Treatment goals included: a) establish positive thinking to replace dysfunctional thought patterns, b) actively form healthy interpersonal relationships, c) embrace confidence in her skills and accomplishments, and d) process the somatic responses due to the unresolved abuse.

Course of Treatment and Assessment of Progress

Based on these treatment goals, I decided to use CBT's writing exercises; ABC worksheets – activating event, behaviors, and consequences, and journaling exercises to reaffirm Helen's strengths and help her to identify cognitive distortions Helen benefited greatly through these interventions; however they were insufficient in resolving the emotional distress. It became clear that Helen had repressed memories of the abuse and this influenced her perception of the world and personal identity (Jeffrey & Ridley, 2017).

To safely accomplish the goal of uncovering and overcoming the childhood abuse, I integrated Sensorimotor Psychotherapy. One of the main goals in SP is to foster holistic processing by integrating the three levels of our being: cognitive, emotional and sensorimotor (Ogden & Minton, 2000). The body can be used as an entry point for processing trauma, and SP directly treats the effects of trauma on the body which in turn allows for emotional and cognitive processing (Ogden & Minton, 2000). As I began to ask questions about the abuse, Helen started to panic. I began to teach Helen the technique of mindfully tracking her physical sensations as they progress through the body and disregard the emotions and the thoughts that arise. Once the

bodily sensations have resolved and the body is stabilized then we can continue. Helen began to understand sensorimotor processing and several sessions later, she could independently manage her own self-regulation (Ogden & Minton, 2000).

Each session Helen learned more about sensorimotor processing and could experience bodily sensations and mindfully track them until they stabilized. This allowed us to now address the emotional and cognitive aspects to the abuse and Helen could fully express the pain and sadness of being abused. This new experience of integration of emotional, cognitive, and sensorimotor regained Helen's confidence as all three areas were addressed simultaneously (Ogden & Minton, 2000).

Helen's progress was evaluated each week through the completion of the Outcome Questionnaire -45. I observed that Helen's progress was noticeable and correlated with her self-rated weekly report, including a decrease in her frequency of tearfulness, and tensed body language. Helen could identify her engagement with unhealthy relationships and she began to create protective measures for herself. At the end of counseling, Helen's emotional, behavioral and psychological presentation was strikingly different from the beginning of therapy. She expressed confidence in her ability to recognize unhealthy friendships, increase her self-awareness, administer positive self-talk, and maintain her emotional balance. She found herself embracing her achievements and accomplishments in life and shared her optimistic view about her future with husband and daughter.

Appendix B

Treatment Plan

Problem or Concern	Measurable Treatment Goal	Treatment Interventions (Be Specific)	Expected Number of Sessions Devoted to Reaching This Goal	Measurable Means of Evaluating and Monitoring Progress Toward Treatment Goal	Aftercare Plan/ Follow-Up (Means of maintaining treatment gains) (Include titration of treatment dosage)
Depressed Diminished interest in enjoyment of activities	Alleviate depressive symptoms	CBT's ABC worksheets, Journaling	2-4	Weekly Outcome Questionnaire-45 After 2 sessions administer QIDS	Six-Month Follow-up And One year follow-up
Feelings of hopelessness, worthlessness or inappropriate guilt	Develop healthy cognitive patterns and beliefs about self and the world	Assign the client to write at least one positive affirmation statement daily regarding herself	2-4	Weekly Outcome Questionnaire After 2 sessions Administer QIDS	Six- Month Follow-up And One year Follow up
Displays psychological distress resulting from internal and external clues that are reminiscent of the traumatic event	Eliminate or reduce the negative impact trauma related symptoms have on social, occupational, and family functioning	Teach Sensorimotor processing: Mindful tracking of bodily sensations while encouraging client to discard emotional thoughts	4-6	Clinician evaluates hyper/hypo arousal states in sessions Client self-report on at home self-regulation	Six- Month Follow-up And One year Follow up