Comprehensive Theoretical Model of Counseling  
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Abstract

From the novice counselor to the expert, the counseling process should be well thought out and have proper preparation. The counselor should be several steps ahead of the client in order to provide hope and facilitate change. Being prepared and having a plan will help many aspects of the counseling process from building rapport to aftercare planning. While many counselors can choose many different directions within their counseling process, I have chosen a specific plan and implementation for my own counseling model. The plan will be laid out from the foundation of a theoretical background, proper assessment tools, case conceptualization, diagnosis, treatment planning, outcomes measurement, and aftercare planning. While many of these aspects need much work and refinement from me, the plan laid out here is the ideal that should be reached within my counseling process.

*Keywords:* theoretical background, case conceptualization, diagnosis, treatment planning

Comprehensive Theoretical Model of Counseling

The concept of clinical counseling is one of extreme privilege as well as ultimate responsibility. The simple act of sitting across from an individual, couple, or family and attempting to help them discover themselves is not for the faint of heart or the unprepared. Thus, it should require courage, support, and diligent preparation in order to help any client in their journey. When determining the elements of this counseling journey preparation is perhaps the most crucial. Due to my background in aviation, an illustration of this came to my mind. There is the concept that a pilot must constantly and consciously stay ahead of the aircraft. The idea behind this phrase is that if a pilot ever fails to perceive the subsequent tasks ahead of the task he is on, then the process of flight can quickly become flooded with information and unexpected data. This truth can also be applied to the counseling process. A counselor must remain several steps ahead of the client through preparation in order facilitate the process of counseling with excellence. Therefore, a counselor must be grounded in solid, empirically based theories, choose proper assessment tools, case conceptualize, diagnose, develop a treatment plan, measure the outcomes, and plan for aftercare.

**Theoretical Framework**

The foundation of any counseling journey begins with a theoretical framework of the counselor. How this framework develops can be a fluid process as the counselor grows personally and professionally. Carl Rogers (1959) illustrated this when he likened the theoretical framework growing out of the cultural and personal soil of the counselor. The “soil” from which my theoretical framework has developed is distinctly Christian. Since God is the one who made us, He is the One who knows us the best. Therefore, any model must integrate first with Scripture. Where the Bible is silent, a theoretical model can help with understanding. Three models I draw on in my counseling are (state these).

Cognitive-behavioral therapy is the theory that I believe integrates best with a Biblical worldview. Tan (1987) highlights that this model focuses not just on eliminating symptoms but of progressing in holiness. This model, like myself, affirms that individuals develop beliefs, or schemas, about themselves or the world around them. Understanding of this development can come from the Developmental, Individual-Difference, Relationship-Based (DIR) model (Greenspan, 2007). Additionally, an understanding of the physical qualities of the brain in this development and schema process can be framed by the Interpersonal Neurobiology model (Siegel, 2001). Thus, the theoretical model that I use is an eclectic one. However, Fielder (1950) showed that there are proven similar outcomes across the many theoretical models. These different models help illustrate where problems come from, how to integrate the different aspects of the individual, and how to facilitate change.

Understanding where problems within an individual lie is facilitated through the DIR model as laid out by Stanley Greenspan (1997). Development in emotions and mental abilities only happens within healthy and safe attachments as humans grow into adulthood (Bowlby, 1998). When there is a lack of safe attachment from the primary caregiver, the likelihood of anxiety, distress, and depression begin to be entrenched in the schemas of a child (Bowlby, 1998). While focus on this development and the potential for these problems is important, the therapy process is not focused exclusively on this as is seen in psychotherapy. Instead, insights are gained to understand a person’s development and begin to give problems a name. Once problems are identified and labeled, they can more easily be dealt with. This process is the beginning of integration within an individual.

A model of mind integration has been developed and laid out by Dan Siegel (2010). Within this model, the functioning of the brain as well as its integration with emotions, triggers, and coping skills are all brought together. Siegel argues that looking inward to what emotions, memories, or triggers are affecting a person helps facilitate problem solving skills that the individual already possesses (Siegel, 2010). Emotions, memories, or trauma from the past can produce the “brain stem reaction” of fight, flight or freeze. However, a “rewiring” of the brain is the process that is emphasized in order to access troubleshooting skills within the brain’s prefrontal cortex (Siegel, 2010). Once begun, this process lays the foundation for change to occur within the individual.

Facilitating change within an individual can only take place with a proper understanding of the origin of the problems as well as a beginning fight to “rewire” the brain. Cognitive-behavior therapy begins to take over at this point in order to provide the practical and systemic processes necessary for change and integration of the individual. Emphasis will be centered on attacking the negative schemas, or belief systems, that an individual has which causes distress. Young, Klosko, & Weishaar (2003) developed schema therapy to specifically address the problem seen in cognitive-behavior therapy with chronic or hard to treat clients. In some clients, simple negative thought or behavior change can be beneficial. However, in many clients, entrenched negative beliefs are so powerful that only a targeted approach like schema therapy is effective (Young, Klosko, & Weishaar, 2003).

From a Biblical understanding, the spiritual element can be seen as well. We live in a fallen world with a real enemy who wants individuals trapped in their past and in their own schemas which are deeply embedded lies about themselves, others, and God (Cite). Thus, the counseling process should be understood as a battlefield as well. As a counselor, you are facing not just the individual, couple, or family sitting across from you. You are also facing potential patterns of lies and soul devouring patterns that echo from Eden. Out of this theoretical framework, a plan for battle is laid out. The next step is drawing the lines, making a plan, and joining the clients in perhaps the hardest fight that they have ever had to face.

**Comprehensive Assessment**

Flying a plane with no checklist or going to battle with no armor are similar to counseling without proper assessment. Assessment is necessary to determine the development of the client, the schemas that need to be changed, as well as the support system around the client that can facilitate change. Thus, proper and thorough assessment is critical in the preparation phase and leads to accurate case conceptualization. The DSM-V cross-cutting symptom measure assessment will be the primary method for assessment. Beyond this, each aspect of an individual will be assessed as well.

**Biological**

Before the client ever comes in for the first session, they are given and must fill out a biopsychosocial assessment. This is a quick self-assessment filled out by the client that gives the counselor basic information to know what questions to ask in the initial session. The mini mental status exam (MMSE) will be given in order to quickly assess mental functioning (Tombaugh & McIntyre, 1992). In addition, a medical and physical examination will be scheduled with the client after the initial assessment. Referrals will be given and an evaluation of the medical exam will help determine any physical issues that the mental issues could be a symptom of such as head injury, hormonal issues, or even thyroid problems. A family history of mental or physical illness can also give insight into potential medical solutions to the client’s problems.

**Psychological**

The mini mental status exam (MMSE) will also help assess psychological issues as well. However, a more in-depth look at the mental functioning of the individual is needed. In order to achieve this, a battery of assessments will be used both in session and out of session. First, a schema inventory will be used to identify the core beliefs that the client is allowing to shape how they think about the world around them and themselves. Young’s schema inventory (YSI) will be used to assess these schemas (Young, Klosko, & Weishaar, 2003). Once identified, the attack on these negative schemas can begin through the treatment plan. Other assessments will be used to more specifically target the presenting problem. The Beck Depression Inventory, Burns Anxiety Inventory, and the Marital Satisfaction Questionnaire are all utilized to allow the client to self-assess at the beginning of counseling and periodically throughout the counseling process.

**Social**

It is critical to build a social support structure around a client in order to facilitate positive goal outcomes (Sherbourne & Stewart, 1991). This is hopefully fulfilled in the church through God and God’s people. However, any form of healthy support structure to facilitate good attachment will be sought out. In order to assess the current social structure around the client as well as their past, several assessment tools will be used. First, a Genogram will be used to determine family history, attachment issues, as well as current family functioning (Kuehl, 1995). Once the family system and connections are understood, the client and counselor will work together to draw out a life map for the client. This life map will begin to show the client the highs and lows of their life and bring into perspective the events as well as emotions that have led them to this place. It is critical during this assessment phase that the counselor paints with a broad brush. Problems can arise when there is such a narrow focus on certain problems that the real issues are missed. By doing a genogram and life map, more information can be drawn out of the client that may not be voluntarily given in a normal interview style assessment.

**Spiritual**

Spiritual assessment can be a more difficult task due to the varied views and perspectives on religion as well as God Himself. However, since an individual is not just a physical and emotional being, the spiritual part of a person is critical to understand and assess. One of the ways to simply assess where an individual is spiritually in their relationship to God is to ask the question: to you, who is Jesus? This question has been found to cut to the heart of a person’s belief system and relationship with God (Fay & Shepherd, 1999). A spiritual life map can also be used as necessary for certain clients. Care must be taken as well by the counselor. Individuals may have had religion used as a negative weapon against them or distorted experiences which could cause emotional triggers (Stanard, Sandhu, & Painter, 2000). Thus, a proper assessment of spiritual views can guide the counselor to know how to address the eternal aspect of the client without causing further harm. All of these assessments lay the foundation for a proper case conceptualization.

**Case Conceptualization**

Case conceptualization is perhaps the most important aspect of the preparation a counselor does. It is through case conceptualization that the counselor can “get ahead” of the client. Out of case conceptualization a report is written describing all the aspects of the assessments and lays out the problems and symptoms that the client is experiencing. It is in this report and proper record keeping that the integration of the different aspects of the client begins to happen. Prieto and Scheel (2002) have demonstrated that proper record keeping and a well written report facilitates the integration of the client. The case conceptualization is the expounded definition of the client diagnosis.

**DSM V Diagnosis**

Proper diagnosis is the definition of the presenting issues with the client. Diagnosis will be based upon the DSM-V manual and will determine the proper treatment for the client. While diagnosis is important, there are challenges to labeling or misdiagnosis within the clinical field. Wakefield (2016) argues that there is a “clinician’s dilemma” in which the counselor must find a DSM diagnosis for normal distresses in order to seek insurance reimbursement. Thus, diagnosis can be a difficult task at times for the counselor. However, empirically based treatment can only come from proper diagnosis.

**Measurable Treatment Planning**

Aftercare planning should start at the beginning of the counseling process. Thus, by having a treatment plan that is measurable, both the client and counselor can know if the goals set at the beginning of the counseling process have been reached. Once assessment is complete, a report has been written based on case conceptualization, and a diagnosis is chosen, the client will be shown the process that is laid out in the treatment plan. This treatment plan should be measurable in order to provide hope to the client as well as a way to show small change that the client may not be aware of in the process. The measurable goals will be personalized with the client, which has been shown to improve outcomes over symptom checklists (Lindhiem, Bennett, Orimoto, & Kolko, 2016). An outline of the treatment will roughly include assessment (the first two sessions), treatment planning and case conceptualization (sessions three and four), and treatment and intervention implementation (sessions five through ten). More sessions can be added as needed per the needs of the client. The majority of this process centers on the treatment phase which should have several important aspects.

**Empirically Based Treatment**

Having treatment that is empirically based is important beyond the fact that it is required by the ACA code of ethics (American Counseling Association, 2014). It is critical that a counselor remain up to date on the latest trends and research in the interventions that are chosen for each diagnosis (Norcross & Wampold, 2011). Thus, for each diagnosis, a treatment will be selected that has the backing of research indicating its effectiveness. While there are many interventions that can be used, the case conceptualization as well as the written report help guide the counselor in choosing the most effective treatment. If a treatment is not producing the desired outcomes, the diagnosis and case conceptualization will be revisited in order to evaluate other empirically based treatment. This phase in counseling is a joint venture with the client to achieve desired outcomes.

**Outcomes Assessment**

Evaluating the outcomes of selected treatment should be an ongoing process throughout counseling. Assessing outcomes will be centered on self-efficacy within the client. Self-efficacy has been shown to increase self-awareness and stronger problem-solving skills (Larson et al., 1992). It is the client that is the expert on themselves. Once integration begins to happen and the client is able to access their prefrontal cortex, problem solving and change begins to happen more rapidly (Cite). Inventories based on the diagnosis will be given to evaluate progress from the initial assessment. Further, Likert scaling questions will be periodically used to gauge symptom improvement. If progress in desired outcomes is failing to occur, then the counselor must reassess many aspects of the preparation in counseling. Having a plan in place for “being stuck” is important as well. Just like a pilot cannot prepare for every problem they may face, they have a checklist for when things do go wrong. The client will be asked to concur with the lack of progress, the counselor will reevaluate the diagnosis and case conceptualization, and then a new treatment plan will be issued if necessary. Once outcomes and goals are reached, aftercare planning can begin its final phase.

**Aftercare Planning**

Aftercare planning begins at the outset of the counseling process. The treatment plan lays out the desired end of the counseling process. The goal of counseling should be for the counselor to work themselves out of a job for that client. This can only happen within a social setting for the client with strong support. Change can only happen with God and God’s people. The strength of social support is tied to success following the counseling process (Tardy, 1985). Thus, throughout the counseling process, the client is encouraged to pursue and facilitate a strong support structure. As part of the treatment plan, the client should choose one person who knows that they are in counseling and why. Additionally, one of the goals should also be to develop proper self-awareness in the client to know when they need help from others or counseling in the future. The goal is to graduate the client with hope in the new skills and insights to face whatever life has for them in the future.

Helping a client reach their goals and give them hope for this ideal has no simple answer. If I were honest, there is a large part of me that feels very ill prepared and inadequate entering the counseling room with an individual, couple, or family. However, the truth remains that there is a plan that can be trusted in. The outline given in this paper is the ideal that should be targeted. By being prepared and trusting in the plan, a counselor such as myself can be at least one step ahead of the client. A partnership is formed with them, God, and myself to allow discovery of the problem and allow them to gain peace and hope. This process should not be taken lightly, but with professionalism and understanding of the battle that is about to be waged. Knowing that as the counselor, I am not alone. I have the knowledge and research of many that have gone before me as well as the support and strength that is only found in my relationship with God.

References

American Counseling Association. (2014). ACA code of ethics. Retrieved from <http://www.counseling.org/docs/ethics/2014-aca-code-of-ethics.pdf>

Bowlby, E. J. M. (1998). *Attachment and Loss: vol. 2: Separation: Anger and Anxiety*. Pimlico.

Fay, W., & Shepherd, L. E. (1999). *Share Jesus Without Fear*. B&H Publishing Group.

Fiedler, F. E. (1950). The concept of the ideal therapeutic relationship. *Journal of Consulting Psychology, 14*, 239-245.

Greenspan, S. I., & Lieberman, A. F. (1988). A clinical approach to attachment. *Clinical implications of attachment*, 387-424.

Greenspan, S. I., & Downey, J. I. (1997). *Developmentally based psychotherapy*. Madison, CT: International Universities Press.

Kuehl, B. P. (1995). The solution‐oriented genogram: A collaborative approach. *Journal of Marital and Family Therapy*, *21*(3), 239-250.

Larson, L. M., Suzuki, L. A., Gillespie, K. N., Potenza, M. T., Bechtel, M. A., & Toulouse, A. L. (1992). Development and validation of the counseling self-estimate inventory. *Journal of Counseling Psychology*, *39*(1), 105.

Lindhiem, O., Bennett, C. B., Orimoto, T. E., & Kolko, D. J. (2016). A Meta‐Analysis of Personalized Treatment Goals in Psychotherapy: A Preliminary Report and Call for More Studies. *Clinical Psychology: Science and Practice*, *23*(2), 165-176.

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: research conclusions and clinical practices.

Prieto, L. R., & Scheel, K. R. (2002). Using case documentation to strengthen counselor trainees' case conceptualization skills. *Journal of Counseling & Development*, *80*(1), 11-21.

Rogers, C. R. (1959). *A theory of therapy, personality, and interpersonal relationships: As developed in the client-centered framework* (Vol. 3, pp. 184-256). New York: McGraw-Hill.

Sherbourne, C. D., & Stewart, A. L. (1991). The MOS social support survey. *Social science & medicine*, *32*(6), 705-714.

Siegel, D. J. (2010). *The Mindful Therapist: A Clinician's Guide to Mindsight and Neural Integration*. WW Norton & Company.

Siegel, D. J. (2001). Toward an interpersonal neurobiology of the developing mind: Attachment relationships,“mindsight,” and neural integration. *Infant mental health journal*, *22*(1-2), 67-94.

Stanard, R. P., Sandhu, D. S., & Painter, L. C. (2000). Assessment of spirituality in counseling. *Journal of Counseling & Development*, *78*(2), 204-210.

Tan, S. Y. (1987). Cognitive-behavior therapy: A biblical approach and critique. *Journal of psychology and theology*.

Tardy, C. H. (1985). Social support measurement. *American journal of community psychology*, *13*(2), 187-202.

Tombaugh, T. N., & McIntyre, N. J. (1992). The mini‐mental state examination: a comprehensive review. *Journal of the American Geriatrics Society*, *40*(9), 922-935.

Wakefield, J. C. (2016). Diagnostic issues and controversies in DSM-5: return of the false positives problem. *Annual review of clinical psychology*, *12*, 105-132.

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema Therapy: A Practitioner's Guide*. Guilford Press.

184/200

I enjoyed your paper and appreciate the many insights you shared and evidence based practices you plan to use Brandon.

Let me know if you have any questions about the feedback.

Blessings for much success on your two final projects in the class!