Theoretical Model: Case Study  
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November 10, 2017

Abstract

Only through practical application can a counselor begin to see the benefits or effectiveness of a particular theoretical model. If the goal is to create change within an individual, then a model must be evaluated on that change. The case study presented is dealing with the issue of unwanted internet pornography use by a single, white male in his early twenties. The case presents the demographics of the individual as well as applies the basics of my own theoretical counseling model to his desire for behavior change. The case is conceptualized based on this model and assessments are chosen that focus on three areas: reduction in pornography use, reduction in depression, and increase of social bonds. Treatment is then planned and carried out based on the assessment, case conceptualization, and highlighted by the model presented. The client is shown through seven of the proposed ten sessions of treatment and measurable outcomes are given.

*Keywords:* case study, theoretical background, case conceptualization, treatment

Theoretical Model: Case Study

A theoretical counseling model remains theoretical until it is applied in action. Only when a specific theory is applied in a practical manner towards a specific client can it be evaluated. The theory that I have formed is one based on a Biblical foundation and structured around cognitive-behavioral theory. Developmental models and interpersonal neurobiology have influenced this theory as well. The following is a case study applying my theoretical model to a counseling client.

**Case Example**

The presenting client is a 23-year-old unmarried white male. His presenting problem is unwanted, continual pornography use. He lives alone with no roommates and has worked at a local university for the past two years. The client’s family background and other potential factors were gathered from a psychosocial that the client completed prior to the first session. During the first intake interview session, the details of his presenting problem were explored further. His use of pornography began when he was 16 years old with first exposure being a non-active internet search through Facebook. Caution during this session is important in order to build rapport with the client. Shame and religiosity can play major factors in a client admitting to this behavior within a counseling context (Volk, Thomas, Sosin, Jacob, & Moen, 2016). Thus, providing a safe environment for admission of the presenting problem is crucial. The client also reports levels of depression that are relatively constant. He reports no suicidal ideation or action plan either past or present. His social structure is of other interest noticed in the psychosocial. The only support structure he has is his older brother. He has told no one else about his pornography use yet has tried to stop several times with limited success. Pornography use goes in cycles. There will be several days of daily use followed by a few days or weeks of sobriety. He reports the longest period of sobriety being one month. Motivation for wanting to be free from pornography use centers around his moral incongruence due to having strong religious and Christian principles.

**Assessment**

As stated, the client was given a psychosocial assessment prior to the first session. More information was gathered during the initial intake session. The mini mental status exam (MMSE) was also given at this time in order to quickly assess mental functioning (Tombaugh & McIntyre, 1992). He presented as well kept and his cognitive abilities were strong. The only noted aspect was his lack of eye contact, shyness, and mumbling speech. His last medical exam was nearly two years ago. He reports struggling keeping his weight stable and thinks of himself as “fat.” He does not present as being obese, however, he was referred to a physician for a more recent exam. Following this, the next session was used to complete a genogram, life map, and the concentric circles of social support. He placed no one in his core and only his brother in the next outer shell.

Specific assessments chosen for this client include Young’s schema inventory (Young, Klosko, & Weishaar, 2003), Cyber Pornography Use Inventory – 9 (CPUI-9; Grubbs, Volk, Exline, & Pargament, 2015), and Level 2 Depression Symptom Measure (Narrow et al., 2013). These will be used to develop a baseline during the first session and a determining factor in treatment progress throughout counseling. The schema inventory will be used to gauge what underlying belief systems that the client has which could be fueling the pornography use. The CPUI-9 will be the main assessment to determine perceived addiction of pornography use with the goal of a score reduction. The Level 2 Depression measure will gauge the other presenting problem of depression and gauge the need for medication or if it becomes a comorbid diagnosis. Once assessment is completed, generally within the first two sessions, it lays the foundation for building a case conceptualization.

**Case Conceptualization**

Diagnosis for unwanted pornography use is difficult since there is no DSM-V diagnosis for hyper sexuality. Thus, a DSM-V diagnosis of adjustment disorder with depressed mood will be given. This is based on the fact that treatment of the pornography use (the stressor) will be used to reduce the depression symptoms. Since the client is not using insurance to pay for counseling, this diagnosis should not be a hindrance to the process.

The overall understanding of this client’s presenting problem is multifaceted. The client has severe social isolation and loneliness in which he uses pornography use as a coping skill. This stems from his low self-image identified in his schema inventory and his reference to himself as “weird” and “boring.” Due to his religious background and convictions, the pornography uses causes a major moral dissonance and thus depression. The depression is enhanced with lack of hope of ever having a romantic relationship in the future. He states, “I’ll never get married, so why not get some sexual pleasure this way.” There is research to support these connections as well. Yoder, Virden III, & Amin (2005) seek to link loneliness and internet pornography use. Additionally, Mesch (2009) shows how lack of strong social ties increases pornography use. Thus, treatment will focus on three areas: pornography use reduction, depression reduction, and increased social interaction and structure.

**Treatment Plan**

Based on the case conceptualization, the treatment plan begins to come into focus. It is here where the preparation and work in assessment and case conceptualization begins to pay off. The treatment for this client begins with directly addressing the unwanted pornography use, even though the long-term use reduction will be met by increasing social interaction and healthy coping skills. Structure will be used to learn and harness the client’s motivation for change in pornography use. This cognitive-behavioral approach has shown success in limiting pornography use (Minarcik, 2017). The first few sessions will detail this structure including accountability software, accountability partners, and psychoeducation. The CPUI-9 scale will be the measure used to gauge progress in the goal of reduction in the baseline number gathered in the assessment phase. This assessment will also help gauge the moral incongruence within the client and has shown ability to measure these desired outcomes (Grubbs, Exline, Pargament, Hook, & Carlisle, 2015).

The next phase in treatment is focused on the depression that the client reports. A CBT approach will be continued to be used to change thinking regarding his hope for the future. The old brain “pathways” are done away with in order to develop better ways of thinking. This ability to do this has shown impacts on pornography use as well (Kühn & Gallinat, 2014). Psychoeducation of cognitive distortions and core hurts along with use of the daily thought record will be interventions used in this specific goal. A score reduction in the Level 2 Depression Symptom Measure is the measureable goal.

The final treatment factor is treating the isolation and loneliness within the client. This is an ongoing process throughout treatment and is the main focus of ensuring treatment success as well as relapse prevention. Within this client, much of the pornography use and depression stems from the severe loneliness. This has shown to cause a cycle of loneliness, pornography use, and deeper isolation that can deepen hyper-sexuality (Kim, LaRose, & Peng, 2009). Thus, insights gained from the genogram and concentric circles model will be used to understand and reverse this cycle. The measurable goal will be to have two or more people in the core or level outside the core of the client. Role playing and exposure through various activities will be the preferred method of attaining these goals. Once the client develops good attachments through friends it can add to motivation and structure that will reduce pornography use (Stack, Wasserman, & Kern, 2004).

**Treatment**

The treatment of the client has gone through seven out of a proposed ten sessions and progress is being made. Specific scores of the assessment can be seen in the appendix section along with the specific modules and interventions within each session. The client struggled with the development of social interactions and continued his isolation lifestyle. This is evidenced by the increase in the CPUI-9 score due to a relapse of pornography use before session seven. The depression scale shows the most progress in reducing depression and the client reported “feeling better” throughout his daily activities.

At this point a reassessment of the client is needed. Reevaluating the schema inventory and digging into the client’s hurts or fears will be important. There appears to be something still keeping him from reaching out socially and there could need to be more focus on the social anxiety he is beginning to exhibit on a more intense level. All factors such as rapport, ethics, and cultural considerations will constantly be evaluated in the treatment process. Additionally, there could be confounds to the treatment process such as financial difficulties which the client feels on a regular basis. Additional sessions are needed to reach the desired goal of reduction in isolation.

The aftercare planning begins at the beginning of the treatment process. The client is in high risk for relapse the more isolated and lonely that he becomes. However, by having strong social bonds, preferably through a church due to his religious background, he will have the support to resist and overcome pornography use. Additionally, he will have the insights and skills to know how to eliminate access to pornography and have accountability partners to help him troubleshoot problem areas. This also will give him the peace he desires in his religious beliefs. By relying on others and the skills he gains, he can begin to find healing in his relationship with God.

**Appendix**

**Evaluation Report**

**Demographic Information**

Client is an unmarried 23-year-old white male. He currently lives alone and works at a local college. This is the only constant job he has held since odd jobs in high school. He moved here away from friends and family in order to work at the college and be near his brother who lives nearby. He reports being in good health. His weight does fluctuate over the period of a few months. This is reportedly due to his perceived “laziness” in either eating healthily or not. There is no history of mental illness in the family or any other health concerns. He had his wisdom teeth removed in high school which was his only presenting health procedure.

**Presenting Problem**

The presenting problem is unwanted consistent pornography use. The client reports using daily on and off for bursts of time. He will go about three or four days of use (only one time per day) and then have a few days or even weeks of sobriety. However, this behavior always returns. The use began in high school when he was 16 years old. Depression was also identified as a presenting problem as the client reported “losing hope” for future change. He has a strong religious background which contributes to his moral dissonance. He reports no suicidal ideation or actions both past and present. No other substance abuse was reported and little to no daily caffeine intake is present. Client is currently regulating enough to be little to no risk to himself or others.

**Observational Data**

Client presents with high levels of cognitive functioning but low levels of motivation or positive behavior. Despite his perception of being overweight, the client does not look obese. His appearance is well kept and hygiene appears well. Eye contact is an issue for the client. He rarely makes eye contact and when he does it is only for a brief second or two. Speech is lazy and could be difficult to understand in an environment with other noise. He does report that others view him as “mumbling.” He presents being tired, shy, and with lack of much joy or excitement. His ability to cognitively process information is high, however, it must be prompted. He has good insight into the reasons why he wants to stop pornography use. However, motivation is severely lacking, as is a good self-image or confidence.

**History of the Presenting Problem**

The time of first use for pornography was in high school at 16 years old. Exposure came through an internet search triggered by certain Facebook ads. Use continued to grow to a daily activity until he left to live near his brother. He is the youngest of two with an older brother. He reports being close to his parents who both worked outside the home. His social interactions were of most interest. He only reports having friends who he has known his entire life. Making friends is something he has never had to do and never sought out new relationships. He has never had a romantic relationship either. There is no medical or mental diagnosis in this family history. He had a medical exam 2 years ago before entering college. His home is religious and presents as Christian/Baptist. There was never any alcohol or other substance abuse in his or family history.

**Assessment/Testing Procedure**

Assessment begins with a psychosocial intake form used at the counseling center. Beyond this, the mini mental status exam (MMSE) will be given in order to quickly assess mental functioning (Tombaugh & McIntyre, 1992). Young’s schema inventory (YSI) will be used to assess these schemas (Young, Klosko, & Weishaar, 2003). This is critical to understand the source or cause for the coping behavior of pornography use. A life map (including genogram) and spiritual life map were given to trace significant events and emotions. The DSM-V Cross Cutting Measure instrument will be used to gain an overall assessment of functioning and depression will be specifically evaluated with the Level 2 Depression Symptom Measure (Narrow et al., 2013). This Level 2 measure will be used for constant evaluation of improvement in the depression symptoms. The amount of perceived addiction to the pornography will be assessed and monitored using the Cyber Pornography Use Inventory – 9 (CPUI-9; Grubbs, Volk, Exline, & Pargament, 2015).

**DSM-5 Diagnosis**

Diagnosis of unwanted sexual behavior such as pornography use does not have a current DSM-V diagnostic code. While debate can continue as to the validity of this, there can be seen the impacts that enhance continued pornography use such as depression and social isolation in this client. Thus the diagnosis given will be centered on those factors. A DSM-V diagnosis will be an adjustment disorder with depressed mood. This is due to the concept that treatment of the pornography use will reduce the stressor and eliminate the moral dissonance. Elimination of other differential diagnoses was completed by the assessment in which substance abuse, other mental health disorder, other medical condition, or other circumstantial condition were all eliminated.

**Case Conceptualization**

By gathering the assessment data, it is understood that the presenting problem of unwanted pornography use by the client is directly linked to his social isolation and loneliness. The client has a low self-image that causes him to view himself as “boring”, “weird”, and insignificant. Thus, he exhibits high social anxiety and increasing loneliness. This continued isolation from friends and support groups removes hope from the client from ever having a romantic relationship and a family. This lack of hope is the vessel which carries the depressed emotions. Pornography then is the coping skill he has developed despite a conviction against it to self-medicate his loneliness and lack of hope. In order for the client to reach his goal of eliminating the pornography use, he must increase self-image and his social support to bring back hope for the future. Good pleasures in healthy social interaction will decrease the desire for the use of pornography.

**Treatment Planning**

The treatment plan (see attached chart) will focus on three problems and subsequent goals. First the unwanted pornography use will be a main focus throughout treatment with treatment for the remaining two as facilitators. The goal will be complete sobriety of pornography use and will take the majority of counseling treatment to attain. This will be accomplished via use of accountability, both software and partner facilitated. Psychoeducation on pornography impacts as well as development of the motivational review journal will build motivation where there is little at the outset. Success will be dependent on improvements in the other treatments as well. Second, the depression which is a result as well as a cause of the pornography use will be treated via cognitive behavioral therapy. Negative schemas which are identified in the schema inventory as well as the life map will be identified as cognitive distortions and processed with the daily thought record. Lastly, the social isolation and loneliness will be treated again with CBT and elimination of negative schemas. The concentric circles model will be used to identify potential support groups. Exposure therapy will be used to develop social skills in order to gain confidence in increasing social interactions.

**Ethics**

There are several ethics considerations in working this treatment with this client based on the ACA 2014 Ethics Code. First, there should be consideration with the limitations of the counselor. The code of ethics states that counselors should not counsel beyond their level of expertise (American Counseling Association, 2014). In counseling this client with pornography and masturbation, his use could escalate into needing a sex therapist. Additionally, confidentiality as well as proper evaluation and assessment should be considerations as well.

**Multi-cultural**

There are not many cultural considerations with this client. Since the client is the same race and age of the counselor, there are many similarities in cultural experiences. Even though the client comes from a religious background, there should be some cautions in projecting beliefs and values upon the client. A complete assessment on assumptions and expectations of the client on views of pornography should be thorough in order to grasp and political or cultural undertones. The client does understand the dangers of pornography use and wants to break free from some cultural pressures to accept this behavior.

**Research/Evidence based treatments**

Cognitive behavior therapy will be used at the center of the treatment plan. Davis (2001) details how this therapy can be effective in overcoming problematic internet use. Accountability in both software and partners has shown to be beneficial in treatment as well (Blaszczynski, 2016). Additionally, the link between depression and pornography use in religious individuals has strong support as well (Perry, 2017). CBT has proved to be effective in treating this type of depression as well (Sniewski, Farvid, & Carter, 2017). Loneliness and isolation as well have shown strong links to continued pornography use (Griffiths, 2001). Social support structure development has been successful in treatment of depression and reduction of isolation in many areas (Heaney & Israel, 2008). However, it is problematic from an empirical standpoint with treatment for singles. This client is a single male. The literature is very scarce in determining treatment for isolation and development of intimacy in singles.

**Assessment of Treatment Progress**

The client has just finished the seventh session. The below chart shows the measurable scores for each assessment used throughout therapy. The client is showing progress in some areas but some struggles in others. First, the depression scale has a consistent downward score which shows progression in this factor. The client supported this perception as well. Interestingly, the perception of addiction to pornography score increased from the fourth to the seventh session. This was reportedly due to his increase in use from the sixth to the seventh session. He had a period of sobriety from the second to the sixth session which is indicated by the CPUI-9 score. He also remains stuck in the development of friends as evidenced by his lack of number of friends he would place in the innermost circles in the concentric circle model. This is due to his fear of social interaction and lack of motivation for doing the role playing in session.

Session

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Goal** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| **CPUI-9** | 59 | - | - | 40 | - | - | 45 | - | - | - |
| **Level 2 Depression** | 65 | - | - | 60 | - | - | 50 | - | - | - |
| **Number of friends in CC** | 0 | 0 | 1 | 1 | 1 | 1 | 1 | - | - | - |

**Referral or Adjunct Services Section**

Potential referrals for this client include church groups and other support groups such as the Freedom groups at Thomas Road Baptist Church. Medication can be considered if the depression scores increase or if suicidal ideation becomes present. Working with my supervisor as well as other experts will be critical going forward. No counselor should work in isolation.

**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)** |
| Unwanted pornography use | Elimination (sobriety) of pornography use | * Implementation of internet accountability software * Identification of accountability partner * Motivational review journal * Continued application of following treatments. * Psychoeducation | 10 | CPUI-9 score reduction | Accountability via software and partners |
| Depression | Increasing hope for the future | * CBT * Identification of faulty thinking * Education and use of the daily thought record | 4 | Level 2 Depression Symptom Measure score reduction | Continued use of thought regulation via the daily thought record |
| Social isolation / loneliness | Development of support system via friend group | * CBT to attack negative identified schemas regarding self-image * Exposure therapy via role playing to develop social skills | 5 | Identification of 2 or more friends in the core or outer core segment of the concentric circle model | Healthy involvement in a local church / social group |

**Evidence Base Treatment Protocol**

Session

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Goal** | **1** | **2** | **3** | **4** | **5** |
| **Unwanted pornography use** | Assessment of use and exposure / previous attempts to quit | Identification of triggers / motivational review journal | Development of accountability partners / software | Evaluation | Guardrail evaluation |
| **Depression** | Assessment of depression levels / triggers | Evaluation | CBT of cognitive distortions | Evaluation | CBT with daily thought record |
| **Social isolation / loneliness** | Genogram and history of social support evaluation | Assessment of concentric circles model | Development of accountability partner / social groups | Role-playing | Role-playing |

Session

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Goal** | **6** | **7** | **8** | **9** | **10** |
| **Unwanted pornography use** | Core value bank development | Evaluation | Adjustments / relapse prevention | Adjustments / relapse prevention | Graduation / evaluation |
| **Depression** | CBT application and use | Evaluation | Daily thought record practice / application | Adjustments / relapse prevention | Clients use of skills without prompt |
| **Social isolation / loneliness** | Role-playing | Evaluation | Exposure through social activity | Exposure through social activity evaluation | Relapse / change support |

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