

Final Paper: Clinical Treatment Planning for Families

Lakiesha Gonzalez

Alliance University

SWK 656: Clinical Social Work Practice II with Families (NOS)

Professor Jessica Barrera-Morales

April 29, 2023

Treatment Plan 3.0

Date: April 29, 2023Case/Client #: TJ/001Clinician Name: Lakiesha GonzalezTheory: Solution-Focused

Modalities planned: Individual Adult Individual Child Couple Family Group: _____

Recommended session frequency: Weekly Every two weeks Other: _____

Expected length of treatment: Six months

Treatment Plan with Goals and Interventions

Early Phase Client Goal: Manage crisis; reduce distressing symptoms.

1. Increase engagement in shared, enjoyable activities that worked for the family before TJ entered into high-school and prior to COVID-19 which the family shares was a "good period in their family dynamic" to reduce arguing/blaming.

Measure: Able to sustain positive affect activities for a period of 4 weeks with no more than two mild episodes of arguing per week.

Interventions:

- a. Identify what worked for the family prior to COVID-19 and use scaling questions to begin moving the family in the direction of those prior behaviors/activities.
- b. Formulate first session task to identify what is working for the family.

Working Phase Client Goals: Target individual and relational dynamics using theoretical concepts.

1. Increase emotional intimacy and sexual connection between Rebecca and Thomas Sr. as described in miracle question to reduce irritability, conflict, and hopelessness and increase sexual intimacy.

Measure: Able to sustain emotional and sexual intimacy for a period of 2 months with no more than three mild episodes of not talking or avoiding sex for more than 2 weeks.

Interventions:

- a. Use videotalk to reduce blame and increase positive affect communication and effective communication amongst the Rebecca and Thomas Sr.
- b. Create dedicated time for date night for Rebecca and Thomas Sr. to begin to reconnect without the children present.

2. Increase cooperative coparenting as described in the miracle question to reduce Rebecca and Thomas Sr. arguing and triangulation of the children.

Measure: Able to sustain agreed upon division of parenting task for a period of 2 months with no more than two mild episodes of arguing related to parenting per week.

Interventions:

- a. Use miracle question to identify expectations behaviorally, identify cultural, gender, and family-of-origin issues related to expectations related to partner's behaviors.

- b. Use scaling questions to break goals down into small, easily achieved steps that enables Thomas Sr. to more directly increase his role with the children and reduce Rebecca's triangulation of the children against Thomas Sr.
3. Increase engagement in shared enjoyable activities that TJ and Rebecca enjoyed doing together prior to COVID-19 to reduce blaming/arguing.
Measure: Able to sustain positive affect activities for a period of six weeks with no more than two mild episodes of arguing per week .
Interventions:
- a. Identify what worked for Rebecca and TJ prior to COVID-19 and use scaling questions to begin to move the mother and son in the direction of those prior behaviors/activities.
- b. Create dedicated time for Rebecca and TJ to spend time together so the mother and son could reconnect.

Closing Phase Client Goals: Long term goals or goals set by theory's definition of health.

1. Increase Rebecca and Thomas Sr.'s sense of solidarity as parents and as a couple to reduce to reduce hopelessness, conflict, and irritability.
Measure: Able to sustain positive interactions when it comes to communicating about the children and also when it comes to the needs of their relationship for a period of two months with no more than three mild episodes of conflict .
Interventions:
- a. Use crystal ball question to identify behavioral description of satisfying parenting and couple relationship.
- b. Use scaling questions to identify small steps to move towards this goal.
2. Increase TJ's sense of independence as a teenager to reduce conflict and irritability.
Measure: Able to sustain agreed upon decision making when it comes to weekedn activities for a period of two month with no more than two mild episodes of conflict or arguing with his parents surrounding poor decision making .
Interventions:
- a. Use crystal ball question to identify behavioral description of satisfying making positive decisions and understanding which type of decisions TJ would like to have the independence to make on his own.
- b. Use scaling questions to identify small steps to move towards this goal so TJ could have more independence while making his parents feel comfortable with him having that independence.

Treatment Tasks

1. Develop working therapeutic relationship using theory of choice:
Relationship building approach/intervention:

a. Develop collaborative relationship with all members; inspire hope and optimism, using "beginner's mind" and listening for strengths.

2. Case conceptualization of individual, relational, and community dynamics using theory of choice.

Strategies and techniques:

a. Use miracle question with each person to concretely and behaviorally define solutions in positive terms.

b. Identify exceptions to conflict, times of connection, areas of life not affected by the conflict strengths and resources, supportive relationships, and client level of motivation.

3. Identify needed referrals, crisis issues, collateral contacts, and other client needs.

a. *Crisis assessment intervention(s):* Use time machine question to identify behavioral description of solution; use scaling questions to break down into small steps.

b. *Referral(s):* Identify social support for the family and childcare arrangements to enable couple to focus on relationship. The couple could use incentives for TJ to babysit his younger sister in exchange for TJ being able to hang out with his friends on an alternate night. The family could also utilize family friends as a childcare assistant resource. Refer TJ to get a psychological assessment and follow-up with collateral contacts as needed.

Diversity Considerations

Describe how treatment plan, goals, and interventions were adapted to address each area of diversity:

Age: *Include developmental tasks, cognitive ability, family life cycle, generational differences, etc.:*

Rebecca and Thomas Sr. are similar ages and part of an Italian American generation in which family relationships are the important and they have a great devotion to their Catholic faith. Rebecca and Thomas Sr. are also in a developmental stage in which they are working to develop stable intimate relationships. During this stage of life the parents are striving to nurture things that will outlast them which includes parenting their children. Their family is in a developmental stage that has significant physical, and time demands on parents, especially for working couples.

Gender/Sexual Orientation: *Include specific gender role identity (e.g, working mother, traditional male, male-female transsexual, etc.), sexual orientation, ethnically based gender roles, etc.:*

Rebecca holds strong to her views as the role she is supposed to play in the lives of her children and husband. Rebecca views is that the father is supposed to set order in the home when things are not aligned even if she influences how the order is set. Thomas Sr. believes that as the man/father/husband in the home he is supposed to be heard and the children follow his directives. However, he also refers the children to their mother for various request which could be due to the family dysfunction that is currently taking place. Culturally, when it comes to who took family leave from work to care for TJ when he got sick as well as who is responsible for the maintenance

of the medical appointments is significant, especially with regard to how Rebecca and TJ view possible solutions.

Race/Ethnicity/Religion/Class/Region: *Include race, ethnicity (i.e., Italian American rather than White), immigration-status, religious beliefs, socio-economic status, and geographic region:*

The family is third generation Italian American family. The parents have a strong family background that reinforces the idea that children should do what they are told to do. This is creating a significant internal struggle for the parents because they see how this approach is impacting their family. The family culture, religion, and family background reinforce that parents are supposed to raise their children together and if there is an issue both parents need to be present to fix the issues.

Other factors: *Identify any other significant diversity considerations, such as school, work, community etc.:*

Rebecca and Thomas Sr. has limited accessibility to their family because they live in different states. However, they communicate through Facetime, phone calls, and text messages. To maintain a standard of living that is comfortable for Rebecca and Thomas Sr., they both have to work full-time jobs which requires the children to sometimes be left unsupervised.

Evidence-Based Practice (Optional)

Summarize evidence for using this approach for this presenting concern and/or population: (Gehart, 2013). Solution-based therapies has also been found to have effectiveness with various populations including parenting, troubled youth, and couples which the family is a part of those populations.

Client Perspective (Optional)

Has treatment plan been reviewed with client: Yes No; If no, explain: _____

Describe areas of Client Agreement and Concern: The family is likely to agree with the current family dynamics and the evolution of their dynamics. They would also agree with the onset of the family dysfunction starting during COVID-19 and progressively intensifying.

__Lakiesha Gonzalez__, MSW Intern __ 4/29/23__
Therapist's Signature, Intern Status Date

__Pamela Samaha__, Clinical Supervisor __ 4/29/23__
Supervisor's Signature, License Date

Background Information

The family is comprised of four individuals, a married couple and their two children, who all reside together in a home purchased by the parents, Rebecca and Thomas Sr. The mother, Rebecca, is a 46-year-old heterosexual Italian American female. She is a devoted Catholic and her occupation is a registered nurse at a local hospital. The father, Thomas Sr., is a 49-year-old heterosexual Italian American male. He is a devoted Catholic and his occupation is director of food services at a local hospital. The eldest child, TJ, is a 15-year-old heterosexual Italian American male. He is currently in the 10th grade and is active in multiple sports as well as being an honor student. The youngest child, Katie, is a 10-year-old heterosexual Italian American female. She is currently in the 5th grade and is an honor roll student and plays soccer as her extracurricular activity.

The maternal grandfather has ADHD, depression, and anxiety. Rebecca shared that Thomas Sr. suffers from blood clots when isn't mobile for too long. The parents are currently engaging in marital counseling outside of family counseling and TJ is in individual therapy. Thomas Sr. was previously hesitant to engage in marital counseling and Rebecca initiated the process of speaking with a clinician alone for about three weeks before he decided he would join. Katie is currently seeing her school social worker once weekly as a preventative measure however, Rebecca said she will speak with the school social worker and assess if Katie requires any additional support.

Precipitating Events

Two months prior to initiating treatment CM1 was experiencing excessive vomiting which caused him to have to seek emergency medical treatment three times. Which ultimately led him to have to seek treatment from a gastrointestinal doctor. AM1 and AF1 both had concerns that CM1 was suffering from an eating disorder as he had lost a lot of weight and was refusing to eat. AF1

was concerned that CM1 was purging due to her finding a picture, in his phone, of a girl putting her finger in her throat. CM1 has shared that his mother has been on non-paid family leave since he was sick and not able to attend school. CM1 has reported that his mother has been worried about the family finances since she has been home and is monitoring the consumption of the children's food. CM1 has experienced patterns of excessive sleeping. CM1 has also been experiencing sadness, trouble concentrating, and frustration due to his not being able to interact with his friends as a result of his becoming sick in November 2022. CM1 has been having increased family conflict with AF1 following his medical concerns and it has caused his emotions to be dysregulated on a consistent basis. CM1 is active in multiple sports and uses it as a way to cope with stress which is sometimes too extreme. AF1 and AM1 also had some concerns about CM1 having inappropriate interactions online with his friends and hanging out with the wrong crowd.

Presenting Concerns

AF1: The couple is having marital issues and AF1 has been seeing the marriage counselor individually; AM1 has just agreed to engage in marital counseling within the past few weeks. AF1 is concerned that CM1 has an eating disorder; she feels he is becoming very disrespectful and combative.

AM1: Doesn't feel that the family should be in therapy, however, it is what his wife wants. AM1 is concerned about CM1's behavior in the home towards his mother.

CM1: Is angry that he is seen as the problem when his mother is the one who has to have her way in every situation. CM1 feels the major concern is that his mother is overbearing.

CF1: Doesn't like that her parents argue so much about the children's daily schedules.

Dr. Garcia: Referring doctor: Concerned that CM1 has an eating disorder and is experiencing extreme sadness.

TJ (CM1) presents with symptoms of periods of sadness/hopelessness; most days, periods of irritability and occasional poor impulse control; 1-2 per month, and ongoing conflict with his mother, Rebecca.

Diagnosis of Identified Patient (TJ)

DSM-5 Code	Diagnosis with Specifier
F43.21	Adjustment disorder with depressed mood

Three Theories

The theories/interventions that I have utilized with this family are Cognitive Behavioral Therapy (CBT), Solution-focused therapy, and Strengths-based Perspective. CBT is beneficial to the family as it allows the family to challenge their negative thought patterns and replace them with a more positive thought pattern in a smaller capacity, so it is not so overwhelming. While solution focused therapy allows the family to work towards achieving their goals/solutions and not focusing on the problem that initiated the client's engagement in therapy. Assessing solutions, from a stance of understanding what worked and what didn't work for the family. The purpose is to gain insight into previous things that were functional for the family even if only for a brief period. The strengths-based perspective plays a vital role in allowing the family to see themselves at their best and focus on those strengths instead of their negative traits.

One theoretical orientation to counseling that I feel I have grown to understand and implement in serving this family is cognitive-behavioral therapy. Cognitive-behavioral therapy is founded on the assumption that our thoughts navigate our feelings and actions as such changing our thoughts could lead to changed behavior (Berg-Wegeret al., 2020). Cognitive-behavioral therapy's goal is to educate clients to rebuild contorted reasoning and unrealistic cognitive judgments with realistic and adaptive assessments. This intervention is brief and time-limited however, the family can continually work on behavioral changes even when the professional relationship has ended. Using this approach I'm able to address the family's automatic thoughts through a cognitive conceptualization diagram to get to the underlying issue of where the

automatic thought stemmed from as well as accumulate some coping strategies with the family.

Clients using CBT in a family setting can naturally express their initial responses and then actively work to replace those thoughts with positive thoughts to combat those negative thoughts.

What I found useful with CBT is that the family maintains tangible, intricate, problem-oriented construction. CBT is effective with clients who experience various mental health challenges (Berg-Weger et al., 2020). Furthermore, cognitive behavioral therapy is helpful as an intervention for families and is effective as it is a short-term intervention that was able to help the clients find new ways to behave. With the use of CBT in a family setting clients can challenge their negative thought patterns while gaining support from various perspectives from other family members. Family members are also able to see similarities and differences amongst themselves and develop and change positive automatic thought patterns. The use of CBT also allows family members to take the skills and knowledge from the family sessions to continually improve their lives even when this short-term group therapy has concluded.

One commonality that I found between CBT and solution-focused brief therapy is that they are both relatively brief interventions. Furthermore, the SFBT concept is based on the notion that things can change, and can improve. Incorporating this notion into CBT family counseling provides families with a sense of hope and allows family members to see their problems from a place of being able to find a resolution. SFBT place great emphasis on finding solutions to problems and not dwelling on the problem itself. SFBT focuses on what has been known to work for a particular situation which could relate to CBT when it focuses on challenging the family member's automatic thought, the likely hood it would happen, and realistic outcomes of what they have experienced before. SFBT and CBT take that approach of positive outcomes to situations.

Working with the family using the strengths-based perspective is important and impactful as TJ is struggling to establish his independence with his parents. Utilizing the strengths-based perspective can protect TJ's independence, resilience, and ability to make choices. When it comes to the family as a whole, the strengths-based perspective allows the family to see themselves in the best light which highlights the family's value. This in return allows the family to use that and focus on their strength rather than the problems. According to Berg-Weger et al., (2020), state that being able to assess the client's strengths is the passageway to finding solutions for the family to overcome their current circumstance.

When utilizing family CBT and SFBT it is important to ensure that the therapeutic goals are specific, measurable, action-oriented, realistic, and time-bound (SMART). During the initial stage of CBT and SFBT family work it is of great importance for members to formulate the goals that they want to achieve by the end of the sessions. One important thing I have learned is that in the process of setting therapeutic goals, it is the responsibility of the family members to actively engage and determine their therapeutic goals while the clinician serves as a support. The role the clinician takes in this process is as a guide in the discussion of the goals while family members construct their goals. When I work with the family, in setting goals my approach is to hear what the family has to say and based on the conversation use statements and questions to assist the client with framing their goals in a way that will be SMART, especially in the time frame that is the designation for the family therapy sessions.

Three easily measured and theory-specific goals that skillfully address all issues noted in the case conceptualization based on a solution-focused approach are as follows:

1. Increase cooperative co-parenting to reduce couple arguing and triangulation of children.
2. Increase TJ's sense of independence to reduce conflict and irritability.

3. Decrease family conflict to increase family intimacy.

My hypothesis is that, during COVID-19, AF1 and AM1's marriage was greatly impacted as AF1 was a front-line employee and could not be present in her marriage or in her role as a mother during that time. AM1 was responsible for the daily upkeep of the children, and he was lenient with the children which allowed them to have more freedom and independence. During this time CM1 became closer to AM1 and looked to him for guidance. As AF1 transitioned back into the primary parent for the children daily living she became obsessive with the children and everything concerning them. This could be due to the disconnect in her relationship with AM1. AF1 could possibly feel guilty about not being able to be present in her marriage or children's lives for an extended period so she could be overcompensating to make up for that time missed. CM1 depression could be due to him missing the connection he had with his father as well as him seeing and hearing how his mother interacts with his father on a daily basis. The family is also experiencing financial difficulties which could also impact how the family is able to be maintained and connect to one another. This family struggles with enmeshed and disengaged boundaries that impact their family structure which causes dysfunction.

Cognitive behavioral therapy is aimed at equipping clients with the ability to increase lead self-directed lives and learn to control behaviors. There are various techniques and methods in CBT. CBT is intended for clients to learn to change maladaptive and dysfunctional beliefs, interpretations, behaviors, and attitudes (Corey, 2015). With the use of CBT in a family setting the techniques used are disrupting beliefs, monitoring activities, automatic thought records, relaxation methods, relapse prevention, problem-solving, monitoring moods, risk assessment, Socratic questioning, and developing an arousal hierarchy (Corey, 2015). Clients recognizing their

automatic thought is important as it is the foundation for understanding the client's catastrophic thinking patterns and their thought assumptions.

Working with this family I'm able to openly discuss their automatic thoughts when it comes to extremely negative situations they encounter. We then can process the worst probable results of these negative situations. Then we can learn to engage in more practical thinking by the use of evidence to support or contradict those negative thinking patterns. Once family members can gain insight into the evidence behind their negative thought patterns they come to an understanding that their beliefs aren't accurate and then we can explore an alternative set of beliefs to see if these new sets of beliefs are more accurate and functional for the family members. Family members are then able to test their automatic thoughts against reality by analyzing and considering the evidence on the supporting and opposing sides. Using guided discovery family members can gain insight into the association between their thought patterns and how the family members act and feel.

In using CBT in family therapy I have also found that implementing some techniques from solution-focused therapy has been beneficial. As in solution-focused brief therapy (SFBT), CBT emphasizes the present and the current issues at hand. Solution-focused brief therapy allows family members to use their language to express what they are feeling just as in CBT family members can express their automatic thoughts in their language which supports the family member's ability to understand and ultimately can problem-solve. Furthermore, SFBT like CBT also utilizes giving homework assignments to the participants to allow them the space to practice and reinforce the skills learned in therapy sessions in real life. One thing I incorporate even when using CBT from SFBT is the use of utilization. I incorporate it with the family members when it comes to correlating difficult situations they may be experiencing with a situation that they haven't been able to do well in. This allows me to pull from the family member's strengths and interests to assist

them with constructing change and a plan to come up with solutions to the problems they are facing. This also connects to using the strengths-based perspective as an intervention to pull on the client's resources and strengths of the family rather than their problems. The family has a strong religious connection, which they utilize to stabilize the family. The family has adequate resources and is able to recognize their family's complex patterns.

Conclusion

The theories/interventions that I chose to utilize with this family were Cognitive Behavioral Therapy (CBT), Solution-focused therapy, and Strengths-based Perspective which have been proven to be effective. In cognitive behavioral therapy, members learn to identify, question, and change their negative thought patterns, attitudes, and beliefs related to the emotional and behavioral reactions that cause them dilemmas. Furthermore, cognitive-behavioral therapy, solution-focused brief therapy, and strength-based perspective are considered to be evidence-based practice intervention that is useful in group settings to treat a wide range of diagnoses. From working with this family I've found that at some stages of the process, it was difficult for the members to process the information that was being presented. However, the members understood the benefit of the intervention and wanted to continue the process of learning and developing positive thought patterns. Family members were able to develop new positive core beliefs and learn that their negative thoughts had no concrete evidence behind them. Gradually I was able to notice the reduction of the family member's symptoms as the sessions progressed as well as the increased support they provided to each other throughout the sessions. Cognitive-behavioral therapy and solution-focused behavioral therapy have similarities and differences. However, I've discovered that utilizing some techniques from other approaches could be beneficial for the treatment outcomes.

References

- American Psychiatric Association (2022) Desk Reference to the Diagnostic Criteria from DSM-5-TR, 5TH edition. Washington, DC: Author.
- Berg-Weger, M., Adams, D., & Birkenmaier, J. (2020). *The practice of generalist social work* (5th ed.). New York: Routledge.
- Cognitive Behavior Therapy: Basics and Beyond, Second Edition Judith S. Beck (Author), Aaron T. Beck (Foreword) (2011) Guilford Press, New York, New York.
- Corey, Gerald (2015) (9th Edition). Theory and Practice of Group Counseling.
- Gehart, D. (2013). Mastering Competencies in family therapy: A practical approach to theory and clinical case documentation (3rd ed.). Pacific Grove, CA: Brooks/Cole.