

# **Dunkin' Donuts' Fred the Baker**

## **Introducing the Character**

Fred is the well-known and much beloved Dunkin' Donuts baker featured in the company's print and television advertisements from 1982 to 1997. He was played by long-time character actor Michael Vale, who died at age 83 in December 2005. Dunkin' Donuts is an international retail chain that has been making and selling its own coffee and donuts since 1950. The "It's worth the trip" advertising campaign featuring Fred the Baker first aired in 1982 and was wildly successful. The campaign, was replaced by the equally successful "America Runs on Dunkin'" campaign, which has only recently been supplanted with the "You Can Do It" slogan. Fred was the behind-the-scenes owner of a Dunkin' Donuts bakery who, like his counterparts in the U.S. Postal Service, would rise early in the morning and trudge to work through all kinds of weather because, in his words, "It's time to make the donuts." This trademark slogan became iconic in popular culture, representing the loyalty, perseverance, and passion of the American worker. Interestingly, Dunkin' Donuts customers were actually surveyed in anticipation of Fred's impending retirement, and after receiving their "permission," he was honored in Boston with a parade followed by Free Donut Day on September 22, 1997. The following basic case summary and diagnostic impressions describe the clinically significant distress we believe Fred may have confronted during the life-cycle transition of retirement.

## **Basic Case Summary**

*Identifying Information.* Fred "the Baker" Wozniak is a 72-year-old retired white man of Polish heritage who lives in Boston, Massachusetts. Until recently, he was a career baker. He worked as the sole proprietor of one of the busiest Dunkin' Donuts stores in Massachusetts for 15 years, prior to which he was a company baker at the main plant in Amherst, Massachusetts. Mr. Wozniak lives at home with his wife, Tatiana, to whom he has been married for 46 years.

*Presenting Concern.* Mr. Wozniak was referred through the Dunkin' Donuts employee assistance program (EAP) to the Greater Boston Community Mental Health Center, with a presenting concern of depression. According to his wife, since his retirement, Mr. Wozniak has been "sleeping all day, lying around on the couch, and refusing to even go out." Mr. Wozniak had also shown little interest in visiting long-time friends or family members who live close by. Mrs. Wozniak also noted that during her husband's sleep "he thrashes about, sleep walks, and is always mumbling 'Time to make the donuts.'"

*Background, Family Information, and Relevant History.* Fred Wozniak was born in Worcester, Massachusetts, the first of six children to Stefan and Yadviga Wozniak, first-generation immigrants from Gdansk, Poland. He characterized his parents as "pursuing the American dream" and said that they took great pride in being Americans and honored their countries, both old and new, by having a large family. Fred, their first-born, remembers being "lavished with attention and love" and said he felt encouraged to "make my parents proud." His birth was soon followed in rapid succession by that of five other children, and because his parents had to work long hours in order to support their family, he was typically left in charge. This did not seem to faze Mr. Wozniak while growing up, and he readily embraced the role of big brother and assistant to his parents.

Mr. Wozniak made no plans to go to college and instead put his full energies into his studying and specializing in the high school culinary arts vocational track, from which he graduated with honors. Soon after graduating from high school, Mr. Wozniak enlisted in the military and spent several years overseas as the company cook, where he gained recognition and a reputation for responsibility, diligence, and willingness to feed his fellow man "no matter where we were in battle." After being honorably discharged from the military, Mr. Wozniak returned to Worcester and soon after married his teenage sweetheart, Tatiana. Enthusiastically looking forward to parenthood, the couple had triplets, followed by twins. Although overjoyed to have "a family as large as the one I grew up in," he recalled "not being quite ready to raise that many children." He immediately took a job at the local Dunkin' Donuts factory, working the early morning shift so that "I could be home with my family when the kids got home from school." Mr. Wozniak was a model employee who took

great pride in his product and soon rose to the position of plant manager. Over the next several years, he and his wife raised their children to be close with family, work hard, and “give back to others.”

When Mr. Wozniak was in his mid-50s, both of his parents died tragically in a subway accident. Although shocked and deeply saddened by this loss, Mr. Wozniak recalled thinking to himself, “I never realized how quickly things changed, and I started to worry that I really needed to make sure that my family was well taken care of, just in case something happened to me.”

At age 60, Mr. Wozniak and his wife decided that they would take their life’s savings and purchase a Dunkin’ Donuts franchise. By that time, Mr. Wozniak’s celebrity in the Worcester/Boston area, as well as his skill and dedication, resulted in one of the highest earning franchises in the entire Dunkin’ Donuts chain. He continued to work long hours in order to ensure the success of his shop and received additional monies by playing the role of Fred the Baker on television commercials. However, the long hours standing on his feet, reaching into and out of an oven, and waking up early in the morning as well as his fondness for glazed crullers resulted in Type II diabetes and severe arthritis in his ankles. After working continuously for more than 55 years, Mr. Wozniak sold his beloved donut shop and, along with his wife, decided to “spend the rest of my life with my family,” which by that time had grown to include 13 grandchildren and four great grandchildren. It was with great excitement and anticipation that everyone, according to his wife, “looked forward to Poppa’s retirement.” They were quite surprised when soon after he left formal employment that Mr. Wozniak seemed to lose his interest in living.

*Problem and Counseling History.* Mr. and Mrs. Wozniak both attended his initial session at the Dunkin’ Donuts Employee Assistance Program (DDEAP). The Wozniaks arrived 15 minutes late for the intake session and were clearly distressed. According to Mrs. Wozniak, “You’d think after 50 years working in the city, he’d know how to find his way around.” Mr. Wozniak shot back, “Just point to the donut store and I know where to go . . . I never realized the city was so big.” Mr. Wozniak presented as a tall, heavy-set man who sat rather uncomfortably in his chair, looking around the room, and in particular at the clinician’s diplomas, in which regard he commented, “I never thought I’d end up in a therapist’s office . . . a man lives his life, does his job,

and this is where it all ends up?!” Mr. Wozniak indicated that he had never had a need for counseling and that “my job has been therapy enough for me, but I have to admit, I am feeling a little lost these days.” Mr. Wozniak went on to describe the difficulty he has had adjusting to life without work and described periods of restlessness, irritability, and “this weird feeling like I’ve lost a big part of myself.” He described difficulty falling asleep at night and “not eating much . . . not even my precious vanilla glazed crullers.” Mr. Wozniak, a proud man, asserted that “I think once I find a new routine, something to feel good about, I’ll be a lot better.” Mr. Wozniak denies any suicidal ideation. His recent annual physical exam ruled out any effects of his diabetes or chronic arthritis, or medications treating these conditions, on his mood or behavior.

*Goals for Counseling and Course of Therapy to Date.* Mr. Wozniak reluctantly agreed to return to the counseling center “to make my wife happy.” He did express an interest in joining a local branch of Retired Bakers Anonymous (RBA) so that he could assist others who were having similar difficulties adjusting to retirement. Goals are to assist the client in returning to his previously adaptive levels of mood and functioning and to promote an effective retirement transition.

### **Diagnostic Impressions**

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309.0 Adjustment Disorder, With Depressed Mood; 250.00 (E11) Type II Diabetes; 714.0 (M06.079) Arthritis, Rheumatoid.

Other factors: V62.89 (Z60.0) Phase of life problem, Adjustment to retirement.

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### **Discussion of Diagnostic Impressions**

Fred Wozniak was referred to the Greater Boston Community Mental Health Center through his EAP because of changes in his mood and behavior following his recent retirement. These changes included depressed mood, sleeping throughout the day, and lack of energy and ambition. He described feeling restless and irritable. He also reported some difficulties with sleep and appetite since retiring.

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* Adjustment Disorders all are clinically significant psychological responses to an identifiable life stressor. To meet the criteria for an Adjustment Disorder, the psychological responses must cause marked distress or clinically significant impairment in functioning, must go beyond normally expected and culturally appropriate reactions, and must not be due to another *DSM-5* disorder or a medical problem. Adjustment Disorders can occur with depressed mood, anxiety, disturbance in conduct or behavior, or have a combination of these.

In this case, Fred the Baker presented clinically significant responses to the life cycle transition of retirement, including mildly depressed mood and other signs of mild depression. His changes in mood and behavior arose within 3 months of the onset of the stressor. In the absence of any evidence of substance abuse, and without any evidence that his symptoms meet the criteria for another diagnosable depressive or anxiety disorder, the diagnosis is Adjustment Disorder. Because he reported primarily depressive symptoms, the disorder is specified With Depressed Mood.

Distinguishing among physical, cognitive, affective, and behavioral factors influencing changes in older adult clients' functioning requires the counselor's special attention (Schlossberg, 1995). In this case, one consideration is whether Mr. Wozniak's depressive symptoms are a direct consequence of one of his physical health conditions, diabetes or arthritis. However, these were ruled out during his recent physical exam.

Besides physical health conditions, specific differential considerations when determining an Adjustment Disorder include other relevant mental health diagnoses. However, Mr. Wozniak's experiences did not meet the criteria for any diagnosable Depressive Disorder or Anxiety Disorder. Adjustment Disorder requires that the client's concerns develop within 3 months of the life event's onset; Mr. Wozniak presented increasing symptoms shortly after onset of his recent life stressors. Another consideration is whether the client's reactions are normally expected, culturally appropriate reactions that do not produce excessive distress or cause excessive impairment. However, his concerns were reported to cause clinically significant distress and some impairment in social functioning.

To finish the diagnosis, Mr. Wozniak’s medical condition is listed alongside his mental health diagnosis, and his relevant life stressor is emphasized in the “Other factors” section. This information is consistent with the primary diagnosis indicated.

### **Case Conceptualization**

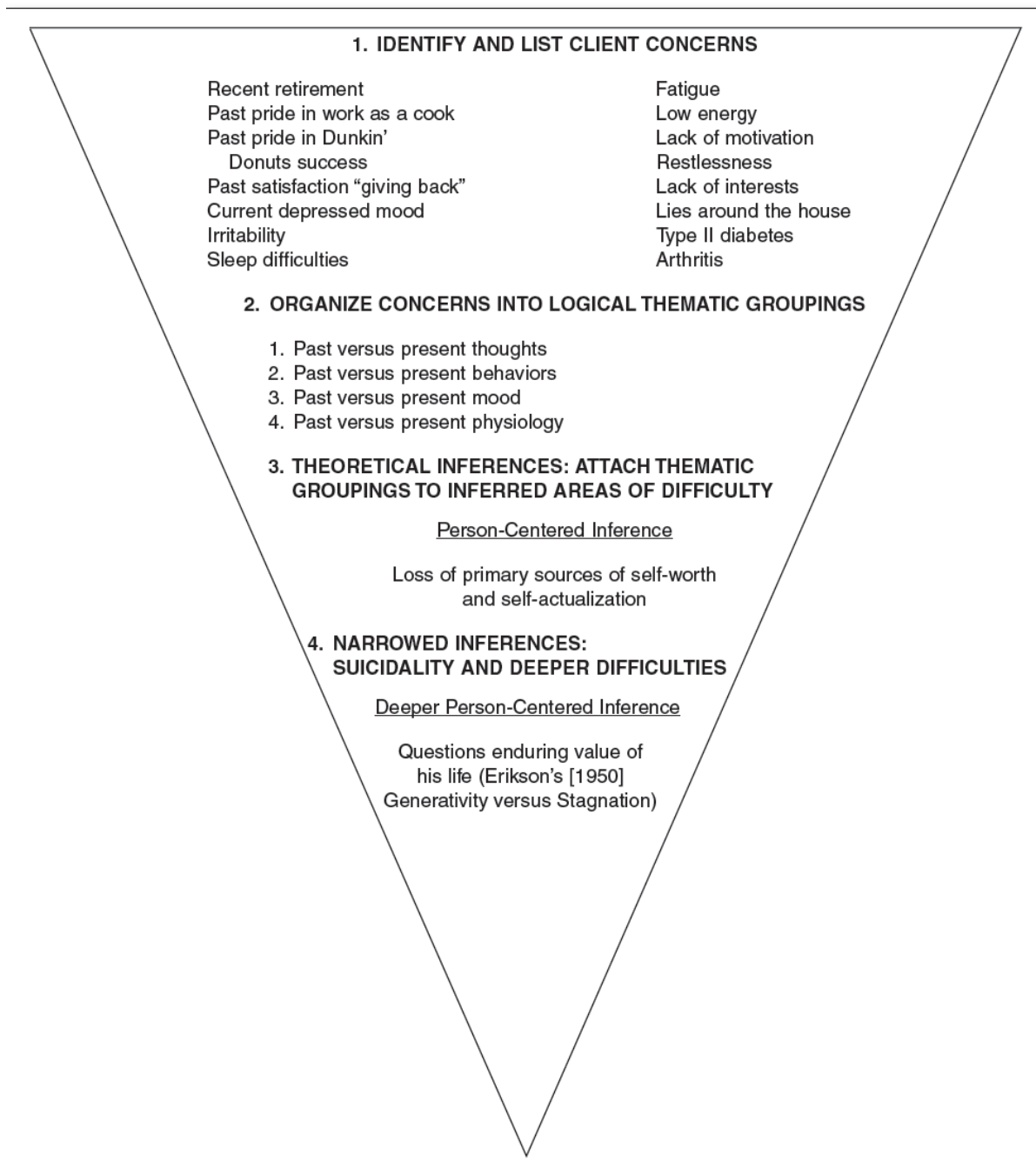
During Fred the Baker’s initial Dunkin’ Donuts EAP appointment, his counselor at the Greater Boston Community Mental Health Center conducted a thorough intake and collected detailed information. The counselor first used this information to develop diagnostic impressions. Mr. Wozniak’s EAP concerns were described as Adjustment Disorder associated with the stressor of retirement. Next, the counselor developed a case conceptualization. Whereas the purpose of diagnostic impressions is to *describe* the client’s concerns, the goal of case conceptualization is to better *understand* and clinically *explain* the person’s experiences (Neukrug & Schwitzer, 2006). It helps the counselor understand the sources of his difficulties and the factors maintaining them. In turn, case conceptualization sets the stage for treatment planning. Treatment planning then provides a road map that plots out how the counselor and client expect to move from presenting concerns to positive outcomes (Seligman, 1993, p. 157)—helping Fred better adjust to retirement.

When forming a case conceptualization, the clinician applies a purist counseling theory, an integration of two or more theories, an eclectic mix of theories, or a solution-focused combination of tactics, to his or her understanding of the client. In this case, Mr. Wozniak’s counselor based his conceptualization on a purist theory, Person-Centered Therapy. The counselor selected this approach because it is the primary counseling method used at the Greater Boston Community Mental Health Center when the clinician believes the client has the capabilities to use the therapeutic experience to gain self-understanding, improve self-direction, make his or her own constructive changes, and act effectively and productively, and when facilitating the client’s own self-directed adjustment seems to be a desired outcome (Rogers, 1986)—as in the case of Mr. Wozniak, who has a lifelong history of successful adjustment.

The counselor used the Inverted Pyramid Method of case conceptualization because this method is especially designed to help clinicians more easily form their conceptual pictures of their clients’ needs

(Neukrug & Schwitzer, 2006; Schwitzer, 1996, 1997). The method has four steps: Problem Identification, Thematic Groupings, Theoretical Inferences, and Narrowed Inferences. The counselor's clinical thinking can be seen in the figure below.

**Fred the Baker's Inverted Pyramid Case Conceptualization Summary: Person-Centered Counseling**



*Step 1: Problem Identification.* The first step is Problem Identification. Aspects of the presenting problem (thoughts, feelings, behaviors, physiological features), additional areas of concern besides the presenting concern, family and developmental history, in-session observations, clinical inquiries (medical problems, medications, past counseling, substance use, suicidality), and psychological assessments (problem checklists, personality inventories, mental status exam, specific clinical measures) all may contribute information at Step 1. The counselor “casts a wide net” in order to build Step 1 as exhaustively as possible (Neukrug & Schwitzer, 2006, p. 202). As can be seen in the figure, the counselor identified at Step 1 all of Fred’s main reasons for his current visit (low mood and other depressive symptoms following retirement); information about his adjustment before the current transition (past feelings of pride, success, etc.); and physical ailments. The counselor went beyond just listing “retirement” as the main reason for referral and was as complete as he could be about the present and relevant past.

*Step 2: Thematic Groupings.* The second step is Thematic Groupings. The clinician organizes all of the exhaustive client information found in Step 1 into just a few intuitive-logical clinical groups, categories, or themes on the basis of sensible common denominators (Neukrug & Schwitzer, 2006). Four different ways of forming the Step 2 theme groups can be used: Descriptive-Diagnosis Approach, Clinical Targets Approach, Areas of Dysfunction Approach, and Intrapsychic Approach. As can be seen in the figure, Mr. Wozniak’s counselor selected the Clinical Targets Approach. This approach sorts together all of the Step 1 information into “the basic division of behavior, thoughts, feelings, and physiology” (Neukrug & Schwitzer, 2006, p. 205).

The counselor formed the following groupings: (a) Past versus present thoughts (combining past satisfaction in giving back, current lack of identified interests); (b) Past versus present behaviors (work as a war cook, franchise ownership, early morning baker, lying around house, restless behavior, low motivation to act); (c) Past versus present mood (pride, depressed mood, irritability); and (d) Past versus present physiology (development of diabetes and arthritis; sleep difficulties, fatigue, and low energy). His conceptual work at Step 2 gave the counselor a way to begin organizing Fred the Baker’s areas of functioning more clearly.



So far, at Steps 1 and 2, the counselor has used his clinical assessment skills and his clinical judgment to begin meaningfully understanding Mr. Wozniak's needs. Now, at Steps 3 and 4, he applies the theoretical approach he has selected. He begins making theoretical inferences to understand the processes underlying the client's concerns as they are seen in Steps 1 and 2.

*Step 3: Theoretical Inferences.* At Step 3, concepts from the counselor's selected therapy, Person-Centered Therapy, are applied to explain the factors maintaining Mr. Wozniak's present adjustment difficulties. The counselor tentatively matches the theme groups in Step 2 with this theoretical approach. In other words, the symptom constellations in Step 2, which were distilled from the symptoms in Step 1, now are combined using theory to show what are believed to be the underlying causes or psychological etiology of Mr. Wozniak's current needs (Neukrug & Schwitzer, 2006; Schwitzer, 2006, 2007).

According to Person-Centered Therapy, individuals are capable of self-understanding and self-direction. Further, under the correct conditions, individuals progressively experience greater self-realization, fulfillment, autonomy, self-determination, and self-perfection as their lives progress, in a process referred to as the actualizing tendency (Broadley, 1999). The needed conditions are empathy, accurate understanding, and positive regard from the important others in our lives (Bohart & Greenberg, 1997; Rogers, 1961, 1977)—along with other situations that create for us a growth-producing climate. In other words, when their interpersonal climate is growth-producing, individuals move forward toward their own self-fulfillment across the life span (Thorne, 2002). Conversely, according to the theory, lack of empathy, accurate understanding, and positive regard from the important others in our lives—and the absence of roles and situations that are growth-producing—can disrupt or derail forward actualizing movement and result in maladjustment (Broadley, 1999; Rogers, 1961, 1977, 1986).

As can be seen in the figure, when the counselor applied these Person-Centered Therapy concepts, he explained at Step 3 that the various issues noted in Step 1 (the various recent and current symptoms of depression, etc.), which can be understood to be themes of past versus present thoughts, behaviors, mood, and physiology at Step 2, together comprise a situation in which Fred is experiencing "loss of primary sources of

self-worth and self-actualization.” According to Person-Centered Therapy inferences, lacking these sources of worth and actualization (i.e., losing important relationships with customers, staff, and business associates that provided empathy and positive regard; losing productive satisfactions and giving back and successes of being an American small businessman and cook) has led to Mr. Wozniak’s changes in mood, thinking, actions, and physical well-being. The theme appears on the figure.

*Step 4: Narrowed Inferences.* At Step 4, the clinician’s selected theory continues to be used to address still-deeper issues when they exist (Schwitzer, 2006, 2007). At this step, “still-deeper, more encompassing, or more central, causal themes” are formed (Neukrug & Schwitzer, 2006, p. 207). Continuing to apply Person-Centered Therapy concepts at Step 4, Mr. Wozniak’s counselor presented the deeper implication of his loss of sources of self-worth from his work life, specifically, “Questioning the enduring value of his life.” The counselor borrows from Erikson’s psychosocial stage model of development (Crain, 1992; Erikson, 1950; Miller, 1993) to infer that Mr. Wozniak is grappling with the question of whether, on one hand, his life will have been of enduring value, he will leave a positive mark on the world through his years of work life and family life, and he will have been an example for others to follow (known as generativity), or, on the other hand, his life has been narrow, and therefore produces letdown and feelings of psychological impoverishment (known as stagnation). According to the theory, solving this question is needed for Mr. Wozniak to return to his progress toward self-actualization. These developmental concepts are compatible and can be helpful when applying the Person-Centered Theory to a client’s life transitions (Rogers, 1986).

When all four steps are completed, the client information in Step 1 leads to logical-intuitive groupings on the basis of common denominators in Step 2, the groupings then are explained using theory at Step 3, and then, finally, at Step 4, further deeper explanations are made. From start to finish, the thoughts, feelings, behaviors, and physiological features in the topmost portions are connected on down the pyramid into deepest dynamics.

The completed pyramid now is used to plan treatment, in which the counselor will engage Mr. Wozniak with congruence, unconditional positive regard, and accurate empathy to promote his transition from past to

present sources of self-worth and self-actualization, and resolve his questions of generativity versus stagnation at retirement.

## **Treatment Planning**

At this point, Mr. Wozniak's clinician at DDEAP has collected all available information about the problems that have been of concern to him and his wife. Based upon this information, the counselor developed a *DSM-5* diagnosis and then, using the "inverted pyramid" (Neukrug & Schwitzer, 2006; Schwitzer, 1996, 1997), formulated a working clinical *explanation* of Mr. Wozniak's difficulties and their etiology that we called the *case conceptualization*. This, in turn, guides us to the next critical step in our clinical work, called the *treatment plan*, the primary purpose of which is to map out a logical and goal-oriented strategy for making positive changes in the client's life. In essence, the treatment plan is a road map "for reducing or eliminating disruptive symptoms that are impeding the client's ability to reach positive mental health outcomes" (Neukrug & Schwitzer, 2006, p. 225). As such, it is the cornerstone of our work with not only Mr. Wozniak, but with all clients who present with disruptive symptoms (Jongsma & Peterson, 2006; Jongsma, Peterson, & McInnis, 2003a, 2003b; Seligman, 1993, 1998, 2004).

A comprehensive treatment plan must integrate all of the information from the biopsychosocial interview, diagnosis, and case conceptualization into a coherent plan of action. This *plan* comprises four main components, which include (1) a behavioral definition of the problem(s), (2) the selection of achievable goals, (3) the determination of treatment modes, and (4) the documentation of how change will be measured. The *behavioral definition of the problem(s)* consolidates the results of the case conceptualization into a concise hierarchical list of problems and concerns that will be the focus of treatment. The *selection of achievable goals* refers to assessing and prioritizing the client's concerns into a *hierarchy of urgency* that also takes into account the client's motivation for change, level of dysfunction, and real-world influences on his or her problems. The *determination of treatment modes* refers to selection of the specific interventions, which are matched to the uniqueness of the client and to his or her goals and clearly tied to a particular theoretical orientation (Neukrug & Schwitzer, 2006). Finally, the clinician must establish how change will be measured, based upon a number of

factors, including client records and self-report of change, in-session observations by the clinician, clinician ratings, results of standardized evaluations such as the Beck Depression Inventory (Beck, 1996) or a family functioning questionnaire, pre-post treatment comparisons, and reports by other treating professionals.

The four-step method discussed above can be seen in the text and is outlined below for the case of Mr. Wozniak, followed by his specific treatment plan.

*Step 1: Behavioral Definition of Problems.* The first step in treatment planning is to carefully review the case conceptualization, paying particular attention to the results of Step 2 (Thematic Groupings), Step 3 (Theoretical Inferences), and Step 4 (Narrowed Inferences). The identified clinical themes reflect the core areas of concern and distress for the client, while the theoretical and narrowed inferences offer clinical speculation as to their origins. In the case of Mr. Wozniak, there are four primary areas of concern. The first, “past versus present thoughts,” refers to the difference between his historic pride in his work as a cook and success in the business world with his current negative and pessimistic thinking and outlook. The second, “past versus current behaviors,” refers to his sleep difficulties, fatigue and low energy, lack of interest, and lying around the house. The third, “past versus present mood,” refers to the difference between his historic optimism, good mood, and even temperament with his current depressed mood and pessimism. The fourth, “past versus current physiology,” refers to the difference between his historic high energy level and calm demeanor with his current irritability and restlessness. These symptoms and stresses are consistent with the diagnosis of Adjustment Disorder, With Depressed Mood, and medical conditions (Diabetes and Rheumatoid Arthritis) (APA, 2013; Casey, Dorwick, & Wilkinson, 2001; Strain et al., 1998).

*Step 2: Identify and Articulate Goals for Change.* The second step is the selection of achievable goals, which is based upon a number of factors, including the most pressing or urgent behavioral, emotional, and interpersonal concerns and symptoms as identified by the client and clinician, the willingness and ability of the client to work on those particular goals, and the realistic (real-world) achievability of those goals (Neukrug & Schwitzer, 2006). At this stage of treatment planning, it is important to recognize that not all of the client’s problems can be addressed at once, so we focus initially on those that cause the greatest distress and impairment. New goals

can be created as old ones are achieved. In the case of Mr. Wozniak, the goals are divided into four prominent clusters. The first, “past versus present thoughts,” requires that we help Mr. Wozniak explore his health and mortality issues and address his self-defeating thoughts. The second, “past versus current behaviors,” requires that we assist Mr. Wozniak improve the quality of his daily activities and motivation to engage in them. The third, “past-versus-current mood,” requires that we explore the basis for Mr. Wozniak’s depressed mood and help him improve it. The last, “past versus current physiology,” requires that we assist Mr. Wozniak in improving his overall health and health care behaviors.

*Step 3: Describe Therapeutic Interventions.* This is perhaps the most critical step in the treatment planning process because the clinician must now integrate information from a number of sources, including the case conceptualization, the delineation of the client’s problems and goals, and the treatment literature, paying particular attention to *empirically supported treatment* (EST) and *evidence-based practice* (EBP). In essence, the clinician must align his or her treatment approach with scientific evidence from the fields of counseling and psychotherapy. Wampold (2001) identifies two types of evidence-based counseling research: studies that demonstrate “absolute efficacy,” that is, the fact that counseling and psychotherapy work, and those that demonstrate “relative efficacy,” that is, the fact that certain theoretical/technical approaches work best for certain clients with particular problems (Psychoanalysis, Gestalt Therapy, Cognitive Behavior Therapy, Brief Solution-Focused Therapy, Cognitive Therapy, Dialectical Behavior Therapy, Person-Centered Therapy, Expressive/Creative Therapies, Interpersonal Therapy, and Feminist Therapy); and when delivered through specific treatment modalities (individual, group, and family counseling).

In the case of Mr. Wozniak, we have decided to use Person-Centered Counseling (Bohart & Greenberg, 1997; Broadley, 1999; Carkhuff, 2000; Raskin & Rogers, 2000; Rogers, 1961, 1977) due to its humanistic emphasis on each person’s inherent capacity for self-determination, growth, and actualization. Given Mr. Wozniak’s past successes and achievements as well as previous positive self-regard, the therapeutic conditions of unconditional positive regard, genuineness, empathy, and congruence would help him understand the unforeseen emotional, behavioral, and cognitive stresses of retirement and the importance of maintaining his

health. Additionally, the nondirective nature of client-centered counseling would facilitate Mr. Wozniak's adjustment to his entirely different life after work and help him plan for as well as enjoy the fruits of his "golden years." The highly supportive nature of this type of counseling with the elderly, particularly those who are coping with retirement (Lowis, Edwards, & Burton, 2009) and medical conditions (Chewning & Sleath, 1996; Eales, Keating, & Damsma, 2001), in conjunction with psychoeducation (Haight & Gibson, 2005) and creative activities (Butler, 2001; Duffey, 2005), has been found to be effective with adults at this stage of life who are coping with issues similar to Mr. Wozniak's. Specific techniques will include life review, retirement planning, health care maintenance, and diabetes group support.

*Step 4: Provide Outcome Measures of Change.* This last step in treatment planning requires that we specify how change will be measured and indicate the extent to which progress has been made toward realizing these goals (Neukrug & Schwitzer, 2006). The counselor has considerable flexibility in this phase and may choose from a number of objective domains (psychological tests and measures of self-esteem, depression, psychosis, interpersonal relationship, anxiety, etc.), quasi-objective measures (pre-post clinician, client, and psychiatric ratings), and subjective ratings (client self-report, clinician's in-session observations). In Mr. Wozniak's case, we have implemented a number of these, including pre-post measures on the Retirement Satisfaction Inventory (Floyd et al., 1992) and Beck Depression Inventory-II (Beck, Steer, & Brown, 1996), client report of improvement in overall life satisfaction, and spouse's report of her husband's improvement in mood, activity level, and outlook.

The completed treatment plan is now developed through which the counselor and Mr. Wozniak will be able to use emotional, behavioral, and cognitive awareness and skills to address mortality issues and enjoy, along with his wife, the retirement years. Fred the Baker's treatment plan follows and is summarized in the table that follows.

## **TREATMENT PLAN**

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**Client:** Fred Wozniak

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**BEHAVIORAL DEFINITION OF PROBLEMS:**

1. Past versus present thoughts—The difference between his historic pride in his work as a cook and success in the business world with his current negative and pessimistic thinking and outlook
  2. Past versus present behaviors—The difference between his past enthusiasm, initiative, restful sleep, and focused/productive behavior with his current sleep difficulties, fatigue, and low energy, lack of interests, and lying around the house
  3. Past versus current mood—The difference between his historic optimism, good mood, and even temperament with his current depressed mood and pessimism
  4. Past versus present physiology—Difference between his historic high energy level and calm demeanor with his current irritability and restlessness
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**GOALS FOR CHANGE:**

1. Past versus present thoughts

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  - Gradual reduction and elimination of self-defeating thoughts
  - Exploration of thoughts regarding retirement
  - Understanding and expression of mortality concerns
2. Past versus current behaviors

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  - Improve the quality of sleep and activities of daily living (ADLs)
  - Develop fulfilling post-retirement activity plan, including leisure and family-related activities
3. Past versus current mood

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  - Exploration of relationship between retirement and current mood
  - Improvement in mood
  - Insight into and elimination of depression
4. Past versus current physiology

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  - Improved physical self-care, including nutrition and exercise

- Strengthen compliance with medical treatment

#### THERAPEUTIC INTERVENTIONS:

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A short-term course of individual client-centered counseling (2–3 months) supplemented with psychoeducational group support.

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##### 1. Past versus current thoughts

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- Engage in life review with focus on accomplishments
- Attend retirement-based psychoeducational support group
- Identify and refute irrational thoughts about productivity and self-worth
- Identify fear-based thoughts related to diabetes and aging

##### 2. Past versus current behaviors

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- Volunteer in the Dunkin' Donuts Entrepreneurial Mentoring Program
- Structured plan to travel and visit with children and grandchildren

##### 3. Past versus current mood

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- Express feelings of disappointment and loss related to retirement
- Verbalize understanding of the relationship between depressed mood and thoughts and feelings regarding retirement and mortality

##### 4. Past versus current physiology

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- Consultation with a nutritionist with specific experience in diabetes management
- Membership in local retiree's exercise group
- Practice relaxation techniques, including guided imagery and focused breathing
- Enlist assistance and support of spouse around medical concerns and care
- Attendance in diabetes support group supplemented with bibliotherapy on diabetes

#### OUTCOME MEASURES OF CHANGE:



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The development of congruence between his ideal and actual self, improved self-esteem, greater capacity for understanding and expression of feelings, healthy attitudes toward retirement, improved mood and energy level, productive and enjoyable use of leisure time, and good health as measured by:

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- Pre-post improvement of scores on Retirement Satisfaction Inventory
  - Client report of improved overall life satisfaction
  - Improved pre-post scores on Beck Depression Inventory II
  - Client self-reported compliance with medical and health-related/exercise activities
  - Spouse's report of improved overall mood, outlook, and activity level
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Fred the Baker's Treatment Plan Summary: Person-Centered Therapy

| <i>Goals for Change</i> | <i>Therapeutic Interventions</i> | <i>Outcome Measures of Change</i> |
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| <p><b><u>Past versus present thoughts</u></b></p> <p>Gradual reduction and elimination of self-defeating thoughts</p> <p>Exploration of thoughts regarding retirement</p> <p>Understanding and expression of mortality concerns</p> <p><b><u>Past versus current behaviors</u></b></p> <p>Improve the quality of sleep and activities of daily living (ADLs)</p> <p>Develop fulfilling post-retirement activity plan including leisure and family-related activities</p> <p><b><u>Past versus current mood</u></b></p> <p>Exploration of relationship between retirement and current mood</p> <p>Improvement in mood</p> <p>Insight into and elimination of depression</p> <p><b><u>Past versus current physiology</u></b></p> <p>Improved physical self-care including nutrition and exercise</p> <p>Strengthen compliance with medical treatment</p> | <p><b><u>Past versus current thoughts</u></b></p> <p>Engage in life review with focus on accomplishments</p> <p>Attend retirement-based psychoeducational support group</p> <p>Identify and refute irrational thoughts about productivity and self-worth</p> <p>Identify fear-based thoughts related to diabetes and aging</p> <p><b><u>Past versus current behaviors</u></b></p> <p>Volunteer in the Dunkin' Donuts Entrepreneurial Mentoring Program</p> <p>Structured plan to travel and visit with children and grandchildren</p> <p><b><u>Past versus current mood</u></b></p> <p>Express feelings of disappointment and loss related to retirement</p> <p>Verbalize understanding of the relationship between depressed mood and thoughts and feelings regarding retirement and mortality</p> <p><b><u>Past versus current physiology</u></b></p> <p>Consultation with a nutritionist with specific experience in diabetes management</p> <p>Membership in local retiree's exercise group</p> <p>Practice relaxation techniques, including guided imagery and focused breathing</p> <p>Enlist assistance and support of spouse around medical concerns and care</p> <p>Attendance in diabetes support group supplemented with bibliotherapy on diabetes</p> | <p><b><u>The development of congruence between his ideal and actual self, improved self-esteem, greater capacity for understanding and expression of feelings, healthy attitudes toward retirement, improved mood and energy level, productive and enjoyable use of leisure time, and good health as measured by:</u></b></p> <p>Pre-post improvement of scores on Retirement Satisfaction Inventory</p> <p>Client report of improved overall life-satisfaction</p> <p>Improved pre-post scores on Beck Depression Inventory II</p> <p>Client self-reported compliance with medical and health-related/exercise activities</p> <p>Spouse's report of improved overall mood, outlook, and activity level</p> |
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