

# ***Juno's Juno MacGuff***

## **Introducing the Character**

Juno MacGuff, a 16-year-old junior at Dancing Elk High School, is the central character in the Academy Award–winning film *Juno* (Reitman, 2007) about a Minnesota teenager and the poignant, occasionally humorous challenges she confronts over the course of her unplanned and unwanted pregnancy. Lauded by some critics as a feminist anthem and described by others as a powerful forum for the prolife/prochoice debate, *Juno* clearly stirred the hearts of millions and won box-office acclaim. Perhaps the sentiments of the film writer, Diablo Cody, best capture her creation. She noted, “You can look at it as a film that celebrates life and celebrates childbirth, or you can look at it as a film about a liberated young girl who makes a choice to continue being liberated . . . or you can look it as some kind of twisted love story, you know, a meditation on maturity.” Our professional counseling view of Juno’s character, including some of our own conjectures about her early years, is described in the following basic case summary and diagnostic impressions.

## **Basic Case Summary**

*Identifying Information.* At the time of her first interview 7 months ago, Juno MacGuff was a 16-year-old white female who resides with her father and stepmother in Minnetonka, Minnesota, and is a junior at Dancing Elk High School. She appeared healthy, appropriately dressed for her age and context, and is of modest height, fair-skinned, and sandy-haired. She very recently revealed to her parents that she was about 2 months pregnant, but to date shows no obvious physical signs that she is pregnant.

*Presenting Concern.* Upon learning of their daughter’s pregnancy 7 months ago, Mr. and Mrs. MacGuff immediately made an appointment for their daughter at the Minnetonka Family Services Center in order to help her decide on the best course of action as well as to provide her with a therapeutic outlet that they believed

would be necessary over the coming months. The parents appeared very concerned for and supportive of Juno, but they also appeared notably distressed regarding their circumstance and, according to her mother, “the devastating effect that this pregnancy is going to have on all of us.” Although Juno sat relatively quietly throughout this meeting, she asserted that “I think I’m old enough to make an important decision affecting my own life.”

*Background, Family Information, and Relevant History.* Juno was born in Minnetonka, Minnesota, the only child of the MacGuffs. At birth and throughout early childhood, Juno experienced health problems, including cardiac and respiratory difficulties that resulted in numerous hospitalizations. According to her father’s report, Juno’s parents often quarreled about their daughter’s care and the resulting tension led to irretrievable marital stress and a divorce that occurred when Juno was 5 years old. By that time, Juno’s father had initiated a relationship with one of his daughter’s nurses at Minnetonka Regional Hospital. The couple married soon after his divorce was final. Juno’s mother left town and has had only sporadic contact with the family for years (such as sending her daughter an annual “Valentine’s Day cactus” in February).

By the time Juno entered third grade, her health had stabilized and she experienced normally expected, successful psychosocial development. Early written reports describe her at this time as a “vibrant, self-assured, and sociable child” who seemed to have grown immeasurably from the medical adversities that marked her earlier years. She was voted “most popular” by her elementary school peers and, by her report, eagerly moved on to Minnetonka Middle School. There, Juno’s social integration was very positive and the older students regarded her as considerably more mature than her peers. She was invited to be involved in the student government and helped to establish charity efforts for the disenfranchised American Indians in the community. Juno was also described as a “fierce defender” of those whom she believed were being unfairly treated within the school and led Minnetonka Middle School’s first-ever rally against bullying. Throughout her middle school years, Juno enjoyed a very close relationship with her father and moderately close relationship with her stepmother, Bren, who she regarded as “an adult who I could usually relate to.”

Near the end of middle school, Juno applied for a competitive slot at Dancing Elk High School, which had a Social Justice program that was very attractive to her. By her description, much to her surprise, although not surprising to her parents, Juno was accepted after the first round. Juno described her first 2 years of high school as “the best in my life.” She had a satisfying number of friends, was active on the school newspaper, and participated in several community-awareness drives. She was described in an interview with a *Twin City Gazette* reporter as “a promising, highly intelligent, funny, and extraordinarily wise young woman who is a leader in her school community.” As she describes the experience, on the night of the release of the interview in the newspaper, Juno and a few of her friends gathered at the gymnasium to celebrate. After the event, she and her best friend and confidant, Paulie Bleeker, had their own private celebration and in recounting that night, Juno noted, “One thing led to another and got out of hand, and before I knew it, we had had sex.” Three weeks later, Juno was pregnant.

Juno reported that during the initial 2 months of pregnancy, she confided only in a few close peers. At 2 months, Juno sought the support of her parents, attended a family session here at the Minnetonka Family Services Center, and consulted her pastor. She also attempted to visit her biological mother; however, she was unsuccessful in locating her. Although not inclined to return to counseling, Juno did so for two additional meetings at the request of her parents but held firmly that “I’m really doing okay, it’s just a real big decision, and I’m not sure what the right thing to do is.”

The outcome was that Juno made a determination to continue her pregnancy and pursue placing the baby for adoption. As she describes it, upon recommendation of her best friend, Juno put an ad in the local *Penny Saver* to see if anyone would be interested in adopting her child should she decide to carry to term. She was fortunate to find a young couple, the Loring, who were very interested in pursuing adoption. However, shortly before the birth of Juno’s child, Mr. Loring left his wife in order to pursue his music career. Three days after her 17th birthday, Juno gave birth to a healthy boy and immediately placed him in the hands of Mrs. Loring who, along with her parents and Paulie, had been in the hospital throughout her labor and delivery.

*Goals for Counseling and Course of Therapy to Date.* Seven months ago, Juno participated at the center in one family session and two individual meetings, which primarily were supportive in nature. At present she has returned for a follow-up, the primary goal of which is to determine remaining needs for counseling during her postpregnancy and postadoption adjustment. Juno arrived with her parents for the follow-up, which included a 30-minute family meeting and a 30-minute individual session. During the family meeting she appeared quiet and subdued. By comparison, in the individual session, she appeared animated and enthusiastic. Near the end of the individual session, she commented: “I think my parents are more upset than I am. . . . I have my whole life ahead of me and I don’t see the need to look back.”

### **Diagnostic Impressions**

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V61.20 (Z62.820) Parent-Child Relational Problem; 650 (O80) Recent child-birth, normal delivery; V61.7 (Z64.0) Problems related to unwanted pregnancy.

Other factors: Problem with primary support group—Recent loss of child to adoption, Problem with primary support group—Stresses of parent-daughter dynamics during adolescent pregnancy and loss of child to adoption.

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### **Discussion of Diagnostic Impressions**

Juno MacGuff came into the Minnetonka Family Services Center because her parents made an appointment after learning of her teenage pregnancy. As she was presented in this case, Juno appeared to be a high-functioning adolescent girl who did not present any clinically significant signs of distress or impairment. Still, her parents were concerned that she receive the support and consultation of a counseling professional with a focus on her pregnancy and its effects and consequences.

Along with all the various diagnosable disorders, a complete diagnosis also lists Other Conditions That May Be a Focus of Clinical Attention. The client concerns contained in this section (appearing at the end of the *DSM-5*, following all of the diagnosable disorders) are not diagnosable mental disorders according to the *DSM* classification system; instead, they are client problems or issues that may be a focus of treatment when the

individual is not experiencing any clinically significant symptoms of distress or impairment, or they are client problems that are a focus of counseling but not a part of the individual's diagnosable mental disorder. Specifically, Relational Problems, Abuse and Neglect, Educational and Occupational Problems, Housing and Economic Problems, Problems Related to Crime or Interaction with the Legal System, and Other Problems Related to the Social Environment or Psychosocial, Personal, and Environmental Circumstances all are included under Other Conditions That May Be a Focus of Clinical Attention. They are listed alongside (or in place of) any diagnosable mental health diagnoses in the formal diagnosis. In our professional counseling view, Juno's experiences were in this category.

Differential diagnoses might include any diagnosable Mental Health Disorder or Personality Disorder; however, no prominent, clinically significant difficulties are present. We therefore only consider Other Conditions That May Be a Focus of Clinical Attention. For example, Problems Related to Other Psychosocial, Personal, and Environmental Circumstances might be listed if Juno's primary counseling focus was on changes in life circumstances due to her pregnancy, if Juno's primary counseling focus was on challenges to her psychosocial identity development resulting from her pregnancy, or if the focus was primarily on faith-based questions or doubts pertaining to decisions about a course of action. Adolescents and young adults commonly experience such concerns, and they often are an important focus of clinical attention (Evans, Forney, & Guido-DiBrito, 1998). However, as this case was written, Juno's primary purpose for counseling was to address interactions with her parents in the context of her pregnancy—rather than other problems.

To finish the diagnosis, Juno's pregnancy is listed alongside her primary diagnosis because it carries with it numerous physical and physiological challenges. Her current stressors are emphasized in the "Other factors" section. The diagnosis is consistent with the life stressors portrayed by Juno in this case.

### **Case Conceptualization**

When Juno and her family first came into the Minnetonka Family Services Center, the counselor fully explored their reasons for coming in and Juno's collateral experiences and concerns. The counselor first used this information to develop diagnostic impressions. Juno's concerns were described as a Parent-Child Relational

Problem with psychosocial stressors of teen pregnancy and loss of the child to adoption. 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 nature of Juno's reason for counseling. 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 Juno better adjust to her relational dynamics with her father and stepmother, and perhaps address her recent pregnancy experiences.

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, Juno's counselor based her conceptualization on a purist theory, Person-Centered Therapy. The counselor selected this approach because it is the primary counseling method used at the Minnetonka Family Services 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 Juno, who apparently is self-directed, achieving, and has natural talents and resources.

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 that follows.

**1. IDENTIFY AND LIST CLIENT CONCERNS**

Unexpected teen pregnancy  
Psychological and physical stresses  
of pregnancy  
Decision to pursue adoption of baby  
Dealing with adopting parent couple  
Relationship conflict with boyfriend

Early history of medical problems  
History of parental divorce  
Absent biological mother  
Blended parenting of father and stepmother  
Adjustments of achieving and gifted student  
Communication difficulties with parents  
Parents' lack of supportive confidence in Juno's  
decision-making abilities  
Lack of affirming from stepmother

**2. ORGANIZE CONCERNS INTO LOGICAL THEMATIC GROUPINGS**

1. Background stresses of being high-functioning adolescent in blended family
2. Pregnancy, adoption, and boyfriend stresses
3. Stresses from parental reactions regarding pregnancy an adoption

**3. THEORETICAL INFERENCES: ATTACH THEMATIC GROUPINGS TO INFERRED AREAS OF DIFFICULTY**

Person-Centered Inference

Lack of conditions of worth by parents

**4. NARROWED INFERENCES: SUICIDALITY AND DEEPER DIFFICULTIES**

Person-Centered Inferred

Implication for Growth

Impeded actualization

*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 Juno’s primary life concerns (pregnancy, adoption, etc.); main reasons for counseling associated with parental relationship (communication difficulties, lack of supportive confident, etc.); all of the important family dynamic factors (divorce, remarriage, absent mother, etc.); and additional life issues (romantic relationship, adolescent adjustment) at Step 1. The counselor attempted to go beyond just listing “pregnancy” as the main reason for referral and to be as complete as she could.

*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, Juno’s counselor selected the Areas of Dysfunction Approach. This approach sorts together all of the Step 1 information into “areas of dysfunction according to important life situations, life themes, or life roles and skills” (Neukrug & Schwitzer, 2006, p. 205).

The counselor grouped together (a) Juno’s ongoing family dynamics into a theme of “background stresses of being a high-functioning adolescent in a challenging blended family”; (b) her recent pregnancy factors into a theme of “pregnancy, adoption, and boyfriend stresses”; and (c) dealing with parental communication, confidence, etc. into a theme of “stresses from parental reactions regarding pregnancy and



adoption.” Her conceptual work at Step 2 gave the counselor a way to begin organizing Juno’s areas of functioning and areas of concern more clearly and meaningfully.

So far, at Steps 1 and 2, the counselor has used her clinical assessment skills and her clinical judgment to begin meaningfully understanding Juno’s needs. Now, at Steps 3 and 4, she applies the theoretical approach she has selected. She begins making theoretical inferences to interpret and explain the processes or underlying Juno’s concerns as they are seen in Steps 1 and 2.

*Step 3: Theoretical Inferences.* At Step 3, concepts from the counselor’s selected theory, Person-Centered Therapy, are applied to explain the experiences maintaining Juno’s present challenges. 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 Juno’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). In other words, under these conditions, 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 can disrupt or derail forward actualizing movement and result in maladjustment (Broadley, 1999; Rogers, 1961, 1977).

As can be seen in the figure below, when the counselor applied these Person-Centered Therapy concepts, she explained at Step 3 that the various issues noted in Step 1 (the current pregnancy-related parent relationship issues, family factors, etc.), which can be understood to be themes of (a) background family stresses and (b) parental reaction stresses regarding (c) pregnancy issues (Step 2), together comprise a situation

in which Juno is experiencing “Lack of conditions of worth by parents.” According to Person-Centered Therapy inferences, lacking these conditions of worth is Juno’s central focus. The theme appears in the figure below.

*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, Juno’s counselor presented the deeper implication of Juno’s lack of conditions of self-worth from her parents, specifically, the possibility of Impeded Actualization. The counselor infers that improving Juno’s experience of conditions of worth (positive regard, accurate empathy, etc.) is needed in order to further her adolescent progress toward self-actualization.

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 Juno with congruence, unconditional positive regard, and accurate empathy to promote her directional process of self-actualizing.

## **Treatment Planning**

At this point, Juno’s clinician at the Minnetonka Family Services Center has collected all available information about the issues that have been of concern to Juno and those around her who performed her assessment. 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 Juno’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 Juno, but with all clients who present important counseling issues (Jongsma & Peterson, 2006; Jongsma et al., 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 the client's 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-II (Beck, Steer & Brown, 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 Juno MacGuff, followed by her 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 Juno, there are three primary areas of concern. The first, “background stresses of being high-functioning adolescent in blended family,” refers to her difficulties adjusting to her parent’s divorce, the absence of her biological mother, and conflictual relationship with her stepmother. The second, “pregnancy, adoption and boyfriend stress,” refers to her attempts to cope with her unexpected pregnancy, its accompanying physical and psychological stressors, the pressure of the adoption process, and the tensions with her boyfriend in relation to all of these issues. The third, “stresses from parental reaction regarding pregnancy and adoption,” refers to communication difficulties with her parents, lack of affirmation by her stepmother (in spite of being an intellectually gifted adolescent), and their lack of support of her decision-making abilities. These symptoms and stresses are consistent with the diagnosis of Parent-Child Relational Problem, and the physical reality of pregnancy is also clinically relevant (APA, 2013; Leitch, 1998; Miller, Benson, & Galbraith, 2000).

*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 issues 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 Juno, the goals are divided into three prominent clusters. The first, “background stresses of being high-functioning adolescent in blended family,” requires that we help Juno to recognize and express thoughts and feelings about her parents’ divorce, address and resolve feelings of loss of her biological mother, express conflictual feelings about her stepmother, identify abandonment issues and their relationship to ongoing family stress, connect thoughts and feelings about divorce with behaviors outside of the family, and validate her intellectual capacities. The second, “pregnancy, adoption and boyfriend stress,” requires that we help Juno to address conflictual thoughts and feelings regarding adoption, identify the physical, emotional, and behavioral stresses related to pregnancy, develop strategies for communicating with her

boyfriend about the adoption plans, and improve her ability to discuss the pregnancy with peers. The last, “stresses from parental reaction regarding pregnancy and adoption,” requires that we improve overall parent-child communications, explore, understand, and resolve conflictual relations with her stepmother, and assist her parents to recognize and support Juno’s competencies and decision-making skills.

*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 Juno, 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 Juno’s intelligence, self-awareness, and decision-making competence, the therapeutic conditions of unconditional positive regard, genuineness, empathy, and congruence would help her and her family work through the stresses of her pregnancy as well as those related to their blended family. Additionally, the nondirective nature of client-centered counseling would facilitate Juno’s self-determination as well as help her parents value her more deeply as an emerging young adult. The highly supportive nature of this type of counseling has been found to be highly effective with teens (Lemoire & Chen, 2005; Taffel, 2005) and useful around issues related to pregnancy

(McBride & Glenapp, 2000). Specific techniques for Juno will include exploration of feelings about her parents' divorce and maternal abandonment, postpregnancy family and career planning, and improving parent-child communication.

*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 Juno's case, we have implemented a number of these, including client and family self-report of improved functioning and communication and pre-post improvement on the Family Adaptability and Cohesion Evaluation Scale—FACES III (Olson & Gorall, 2003).

The completed treatment plan is now developed through which the counselor, Juno, and her family will begin their shared work of improving their relationships with each other, helping both Juno and her parents cope effectively with her pregnancy and plans for adoption as well as assist Juno in the grieving process. Juno's treatment plan is as follows and is summarized in the table that follows.

## **TREATMENT PLAN**

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**Client:** Juno MacGuff

**Service Provider:** Minnetonka Family Services Center

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### **BEHAVIORAL DEFINITION OF PROBLEMS:**

1. Background stresses of being high-functioning adolescent in blended family—Difficulties adjusting to her parents' divorce, the absence of her biological mother, and conflictual relationship with her stepmother
2. Pregnancy, adoption, and boyfriend stress—Attempts to cope with her unexpected pregnancy, accompanying physical and psychological stressors, the pressure of the adoption process, and the tensions with

her boyfriend in relation to these issues

3. Stresses from parental reaction regarding pregnancy and adoption—  
Communication difficulties with her parents, lack of affirmation by her stepmother, and lack of parental support of her decision-making abilities
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#### GOALS FOR CHANGE:

1. Background stresses of being high-functioning adolescent in blended family
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- Explore and resolve thoughts and feelings about parents' divorce
- Alleviate feelings of loss of biological mother
- Resolve conflictual feelings about stepmother
- Reconcile abandonment issues and their relation to family stress
- Connect thoughts and feelings about divorce with behavior outside of the family
- Validate intellectual capacities and otherwise high level of functioning

2. Pregnancy, adoption, and boyfriend stress
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- Resolve conflictual feelings and thoughts regarding adoption
- Decrease the physical, emotional, and behavioral stresses related to being pregnant
- Improve communicating with boyfriend about plans for adoption
- Improve ability to discuss pregnancy and adoption plans with peers

3. Stresses from parental reaction regarding pregnancy and adoption
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- Improve overall parent-child communication
- Explore, understand, and resolve conflictual relationship with stepmother
- Enhance parents' perceptions of their daughter's competencies and problem-solving skills

## THERAPEUTIC INTERVENTIONS:

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A short-term course of individual person-centered counseling and family counseling (2–3 months) supplemented with teen pregnancy psychoeducational group support

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### 1. Background stresses of being high-functioning adolescent in blended family

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- Support clear and open communications between family members
- Explore the changes in roles, boundaries, and communication and expression of affection in blended families
- Address the loss issues related to divorce and remarriage
- Promote balance of independence and reliance on nuclear family
- Bibliotherapy around stepfamily issues

### 2. Pregnancy, adoption, and boyfriend stress

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- Acknowledge feelings of loss with regard to adoption
- Develop and enhance self-care skills for managing pregnancy
- Encourage open and clear communication between client and boyfriend around pregnancy and adoption
- Support and encourage regular medical visits
- Incorporate peer support into individual counseling
- Referral to support group for pregnant teens
- Support post-pregnancy educational and career planning

### 3. Stresses from parental reaction regarding pregnancy and adoption

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- Improve overall family communication skills through family counseling
- Address conflictual parent feelings regarding pregnancy
- Decrease parental reactivity to daughter's behavior
- Assist parents in their understanding of teen pregnancy

## OUTCOME MEASURES OF CHANGE:

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The development of congruence between her ideal and actual self, improved



self-esteem, greater capacity for understanding and expression of feelings, and the development of healthy attitudes toward pregnancy and adoption within the context of open and effective communications within and outside of the family will be measured by:

- Pre-post comparisons of effective family communications within session
- Parents' reports of reduced stress and improved overall relationships within the home
- Improved pre-post scores of overall family adjustment and communication on the Family Adaptability and Cohesion Evaluation Scales IV (FACES IV) Questionnaire
- Client self-reported awareness of ability to express feelings of grief and loss
- Client and boyfriend self-report and clinical observations of open and ongoing discussions about the pregnancy and adoption plan
- Post-only evidence of clear educational and career planning

Juno's Treatment Plan Summary: Person-Centered Counseling

<i>Goals for Change</i>	<i>Therapeutic Interventions</i>	<i>Outcome Measures of Change</i>
<p><b><u>Background stresses of being high-functioning adolescent in blended family</u></b></p> <p>Explore and resolve thoughts and feelings about parents' divorce</p> <p>Alleviate feelings of loss of biological mother</p> <p>Resolve conflictual feelings about stepmother</p> <p>Reconcile abandonment issues and their relation to family stress</p> <p>Connect thoughts and feelings about divorce with behavior outside of the family</p> <p>Validate intellectual capacities and otherwise high level of</p>	<p><b><u>Background stresses of being high-functioning adolescent in blended family</u></b></p> <p>Support clear and open communications between family members</p> <p>Explore the changes in roles, boundaries, and communication and expression of affection in blended families</p> <p>Address the loss issues related to divorce and remarriage</p> <p>Promote balance of independence and reliance on nuclear family</p> <p>Bibliotherapy around stepfamily issues</p> <p><b><u>Pregnancy, adoption, and boyfriend stress</u></b></p> <p>Acknowledge feelings of loss with regard to adoption</p> <p>Develop and enhance self-care skills for</p>	<p><b><u>The development of congruence between her ideal and actual self, improved self-esteem, greater capacity for understanding and expression of feelings, and the development of healthy attitudes toward pregnancy and adoption within the context of open and effective communications within and outside of the family will be measured by:</u></b></p> <p>Pre-post comparisons of effective family communications within session</p> <p>Parents' reports of reduced stress and improved overall relationships within the home</p> <p>Improved pre-post scores of</p>

<p>functioning</p> <p><b><u>Pregnancy, adoption, and boyfriend stress</u></b></p> <p>Resolve conflictual feelings and thoughts regarding adoption</p> <p>Decrease the physical, emotional, and behavioral stresses related to being pregnant</p> <p>Improve communicating with boyfriend about plans for adoption</p> <p>Improve ability to discuss pregnancy and adoption plans with peers</p> <p>Stresses from parental reaction regarding pregnancy and adoption</p> <p>Improve overall parent-child communication</p> <p>Explore, understand, and resolve conflictual relationship with stepmother</p> <p>Enhance parents' perceptions of their daughter's competencies and problem-solving skills</p>	<p>managing pregnancy</p> <p>Encourage open and clear communication between client and boyfriend around pregnancy and adoption</p> <p>Support and encourage regular medical visits</p> <p>Incorporate peer support into individual counseling</p> <p>Referral to support group for pregnant teens</p> <p>Support post-pregnancy educational and career planning</p> <p>Stresses from parental reaction regarding pregnancy and adoption</p> <p>Improve overall family communication skills through family counseling</p> <p>Address conflictual parent feelings regarding pregnancy</p> <p>Decrease parental reactivity to daughter's behavior</p> <p>Assist parents in their understanding of teen pregnancy</p>	<p>overall family adjustment and communication on the FACES IV inventory</p> <p>Client self-reported awareness of ability to express feelings of grief and loss</p> <p>Client and boyfriend self-report and clinical observations of open and ongoing discussions about the pregnancy and adoption plan</p> <p>Post-only evidence of clear educational and career planning</p>
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## References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Beck, A. T., Steer, R. A., & Brown G. K. (1996). *BDI-II, Beck Depression Inventory: Manual* (2nd ed.). Boston, MA: Harcourt Brace.
- Bohart, A. C., & Greenberg, L. S. (Eds.). (1997). *Empathy reconsidered: New directions in psychotherapy*. Washington, DC: American Psychological Association.

- Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry*, *162*, 214–227.
- Carkhuff, R. (2000). *The art of helping in the 21st century* (8th ed.). New York, NY: Holt, Rinehart & Winston.
- Evans, N. J., Forney, D. S., & Guido-DiBrito, F. (1998). *Student development in college: Theory, research, and practice*. San Francisco, CA: Jossey-Bass.
- Jongsma, A., & Peterson. (2006). *The complete adult psychotherapy treatment planner*. New York, NY: Wiley.
- Jongsma, A., Peterson, L. M., & McInnis, W. (2003a). *The adolescent psychotherapy treatment planner*. New York, NY: Wiley.
- Jongsma, A., Peterson, L. M., & McInnis, W. (2003b). *The child psychotherapy treatment planner*. New York, NY: Wiley.
- Leitch, M. L. (1998). Contextual issues in teen pregnancy and parenting: Refining our scope of inquiry. *Family Relations*, *47*(2), 145–148.
- Lemoire, S. J., & Chen, C. P. (2005). Applying person-centered counseling to sexual minority adolescents. *Journal of Counseling and Development: JCD*, *83*(2), 146–154.
- McBride, D., & Glenapp, A. (2000). Using randomized designs to evaluate client-centered programs to prevent adolescent pregnancy. *Family Planning Perspectives*, *32*(5), 227–235.
- Miller, B., Benson, B., & Galbraith, K. (2000). Family relationships and adolescent pregnancy risk: A research synthesis. *Developmental Review*, *21*(1), 1–38.

Neukrug, E. S., & Schwitzer, A. M. (2006). *Skills and tools for today's counselors and psychotherapists: From natural helping to professional helping*. Belmont, CA: Wadsworth/Thomson Brooks/Cole.

Olson, D. H., & Gorall, D. M. (2003). Circumplex model of marital and family systems. In F. Walsh (Ed.), *Normal family processes* (3rd ed., pp. 514–547). New York, NY: Guilford Press.

Raskin, N. J., & Rogers, C. R. (2000). Person-centered therapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (6th ed., pp. 133–167). Itasca, IL: Peacock.

Reitman, J. (Director). (2007). *Juno* [Motion Picture]. United States: Fox Searchlight Pictures.

Rogers, C. R. (1961). *On becoming a person*. Boston, MA: Houghton Mifflin.

Rogers, C. R. (1977). *Carl Rogers on personal power: Inner strength and its revolutionary impact*. New York, NY: Delacorte Press.

Rogers, C. R. (1986). Rogers, Kohut, and Erickson: A personal perspective on some similarities and differences. In J. K. Zeig (Ed.), *The evolution of psychotherapy* (pp. 179–187). New York, NY: Brunner/Mazel.

Schwitzer, A. M. (1996). Using the inverted pyramid heuristic in counselor education and supervision. *Counselor Education and Supervision, 35*, 258–267.

Schwitzer, A. M. (1997). The inverted pyramid framework applying self psychology constructs to conceptualizing college student psychotherapy. *Journal of College Student Psychotherapy, 11*(3), 29–47.

Seligman, L. (1993). Teaching treatment planning. *Counselor Education and Supervision, 33*, 287–297.

Seligman, L. (1998). *Selecting effective treatments: A comprehensive systematic guide to treating mental disorders*. Upper Saddle River, NJ: Merrill/Prentice Hall.

Seligman, L. (2004). *Diagnosis and treatment planning* (3rd ed.). New York, NY: Plenum Press.

Taffel, R. (2005). *Breaking through to teens: A new psychotherapy for the new adolescence*. New York, NY: Guilford Press.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Erlbaum.