Introducing the Character

Peter Parker, who transforms into the fantasy hero Spider-Man, is the creation of Marvel Comics writer and editor Stan Lee and artist and cowriter Steve Ditko. Peter Parker first appeared in the August 1962 issue of *Amazing Fantasy #15*. Since the character’s creation, Peter Parker, also known as Spider-Man, has appeared as a cartoon character on television; in graphic novels; in newspaper comic strips; and most recently in a series of movies starring actor Tobey Maguire, including *Spider-Man* (Avad & Raimi, 2002), *Spider-Man 2* (Avad & Raimi, 2004), and *Spider-Man 3* (Avad & Raimi, 2007).

Peter, an orphan being raised by his paternal uncle, Ben, along with his wife, May, was introduced to the comic strip world as an angst-ridden teen and high school student who, while facile in science and academics, was extremely shy, self-conscious, and uncomfortable with girls, particularly with Mary Jane Watson, his neighbor and love interest. Although early Spider-Man stories pitted the hero against fantasy ne’er-do-wells such as Green Goblin, Dr. Octopus, and Venom, later story lines focused on more reality-based issues such as drug abuse and terrorism.

Peter’s critical transformation into a super hero occurs during a high school field trip to a science museum. There, he is bitten by a radioactive spider, which transforms him into a web-casting, wall-climbing, lightning fast, super-strong, and sensorially acute alter-persona, soon after known to the comic book world as Spider-Man. Up to that point in comic book history, teenagers had been relegated to the secondary role of sidekick (such as Batman’s Robin and Captain America’s Bucky). Spider-Man soon became one of the most popular comic book superheroes—wrestling with crime and criminals by night and the challenges of adolescence during the day. In the basic case summary and diagnostic impressions that follow, we present Peter Parker’s experiences as illustrations of a moderate, recurrent depressive disorder, coexisting with a change in personality due to a medical problem.
Identifying Information. Peter Parker is a 17-year-old white male adolescent who currently is a senior at Midtown High School. He lives at home with his Aunt May, who recently lost her husband, Parker’s Uncle Ben, to gun violence. Parker was referred by his aunt at the urging of his school counselor, who has noticed visible changes in Peter’s behavior and mood. His aunt also reports seeing clear behavioral and mood changes at home. Although ambivalent about participating in counseling, Peter was polite and compliant during the interview.

Presenting Concern. The school counselor referred Peter Parker due to changes she noticed in his mood, beginning about 4 months ago, shortly after the death of Peter’s uncle. Peter was nearby when his uncle was killed. His uncle was a victim of a carjacking and murder. Peter believes he could have heroically saved his uncle and blames himself for his uncle’s death. Correspondingly, Peter was self-reproaching in the interview and described himself as worthless. He says he has had trouble staying asleep at night and regularly is awakened by nightmares centering on violence and death. He volunteered that he is unsure whether he feels “depressed” as suggested by his aunt and school counselor, but he did admit that he has been feeling “angry and irritated almost constantly” since his uncle’s murder. When queried, he said he also is having difficulty taking pleasure in his school work, “even science, which I used to really love,” or enjoying his school newspaper photography, which formerly was one of his special interest highlights. Both his aunt and counselor report that although he continues to perform well academically and is engaged successfully in extracurricular activities as a photographer for the school newspaper, he has begun to struggle to concentrate on his work, is having trouble meeting deadlines, and has missed several homework assignments. He also seems to no longer spend time in the evenings with friends in the neighborhood.

His aunt raised a second concern in addition to Peter’s reaction to the loss of his uncle. She described changes in his behavior and reactions that she has noticed since prior to the shooting, “going back to his field trip last fall at the science museum.” She said that since he returned from the field trip, his behavior has become increasingly unpredictable. She said that persistently since the museum visit his mood quickly changes from
calm to angry to remorseful; sometimes he becomes pushy and aggressive and even seems able to “climb the walls” and “bounce from place to place”; he is increasingly suspicious and worried about being attacked or “found out” by others; and in the evenings he impulsively puts on a costume and goes onto downtown streets “looking for trouble.” His aunt reports all of these are easily noticeable, dramatic changes from his behavior and reactions prior to the field trip.

**Background, Family Information, and Relevant History.** Peter is a high school senior at Midtown High School in Forest Hills, New York, where he had been living with his paternal uncle and aunt, Ben and May Parker, and now lives with just his aunt. He was adopted by his aunt and uncle at the time of his parents’ deaths early in his life. Initially believing that his parents Richard and Mary died in a plane crash when he was 6 years old, he later discovered that they were killed in the line of duty as U.S. Special Forces Operatives.

As a child, Peter was seen in individual play therapy soon after his relocation to his aunt and uncle’s home. At that time, he was experiencing night terrors, enuresis, and breathing difficulties that were later attributed to panic attacks. Although the symptoms subsided within 9 months and he made a good adjustment in his new school, Peter continued to experience mild symptoms of anxiety and generalized but manageable fears during childhood.

Peter said the Parkers raised him in a “traditional Protestant household,” in which he was taught the importance of honesty, hard work, kindness, and loyalty. Peter says he has a small circle of friends, most of whom share his academic and scientific interests and who he says are generally regarded by others as “nerds.” Peter said that while he “has always been shy with girls,” Peter feels very close with his neighbor, Mary Jane Watson, who lives in an abusive household and whom he would like to be able to protect.

Turning to very recent history, Peter was queried specifically about his recent museum field trip event, after which his aunt noticed persistent personality changes. Peter was reticent to respond, but did admit that during the trip to the science museum, he was bitten by an unusual spider. It is Peter’s belief that the bite has slowly transformed him into a person with great strength, speed, and sensory acuity. He said after the bite, he became more able to “just act on impulses.”
In fact, he reported that in order to try to capitalize upon these sudden gifts, he entered a local wrestling match, which he easily won. However, he says he was “cheated out” of his prize money. When a thief soon afterward robbed the wrestling promoter who had “cheated” him out of his winnings, Peter said he was so uncontrollably angry at the promoter that he chose to allow the thief to escape rather than “using my new super abilities to capture him.” Peter believes it was the very same thief who went on to carjack and kill his beloved Uncle Ben.

As the client described it, over the course of the next several months, which has coincided with his final months in high school, Peter has worked diligently to hone his newfound “skills” and apparently views himself as a vigilante who can redeem himself for his uncle’s death by fighting the street criminals he seems to fear. He says he has kept his dual identity a secret, even from those closest to him, and as a result, has become increasingly socially isolated, “misunderstood,” and lonely, spending most of his time “in the darkness and shadows” as well as in the company of other “outcasts” and criminals.

Problem and Counseling History. In our counseling meeting, Peter presented as a conventional appearing teenager. He seemed somewhat suspicious of his environment and could be described as exhibiting a piercing glance through which he seemed to take in everything around him. He expressed himself in a rather mechanical fashion and spoke from an intellectual as opposed to an emotional way. He frequently choked back tears when describing the death of his uncle and the loss of his parents, but he was equally if not more concerned about losing control of his feelings. Although articulate and seemingly self-aware, he was self-effacing.

Peter described ongoing difficulties in relationships with girls whom he worried perceived him to be a bookworm and a nerd. Nevertheless, he attested to a love of science and was thinking about a career in crime fighting. He alluded to the nightmares he had as a child as well as to feelings of sadness over not having known or being able to remember much about his parents. When asked about the recent death of his Uncle Ben, Peter was unable to hold back a torrent of tears that he quickly stifled and replaced with intense anger. He noticed that these mood swings have been more frequent of late and that while he does not drink or use drugs, he has been engaging in what might be considered reckless, dangerous, and thrill-seeking behavior that has put him in direct
contact with criminals. He realized the potential harm this behavior might cause him, but believes that it is “my mission to save people . . . I couldn’t help my Uncle Ben.”

Goals for Counseling and Course of Therapy to Date. To date Peter has had one counseling session and also was referred for one medical examination by his primary care physician. Referral information from his school counselor and results of his initial counseling session appear in this report. Consistent with Peter’s description of receiving a spider bite, chemical screen and neurological testing as part of his medical examination were positive for a spider bite with radioactive venom affecting his frontal lobes and other nervous system sites, resulting in a syndrome characterized by heightened impulsivity, inhibition, and other personality changes. Recommendation is for ongoing psychotherapy to address depressive symptoms and personality effects of radioactive spider bite syndrome.

Diagnostic Impressions

296.22 (F32.1) Major Depressive Disorder, Single Episode, Moderate; Radioactive Spider Bite Syndrome; 310.1 (F07.0) Personality Change Due to Radioactive Spider Bite Syndrome, Combined Type.

Other factors: V62.82 (Z63.4) Uncomplicated Bereavement—Recent death of uncle, history of death of parents at age 6; V62.22 (Z65.5) Exposure to disaster, war, or other hostilities—Exposure to street crime.

Discussion of Diagnostic Impressions

Peter Parker was urged to attend counseling by his aunt and his school counselor, both of whom had noticed changes in Peter’s mood, and personality, in recent months.

All of the diagnoses contained in the DSM-5’s Depressive Disorders section feature “the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual’s capacity to function” (APA, 2013, p. 155). The Depressive Disorders include presentations in which the client experiences unipolar depression. All personality change diagnoses contained in the section
Personality Disorders feature psychological and behavioral symptoms that are directly due to the physiological consequences of the medical problem. One of the conditions appearing in this section is Personality Change Due to Another Medical Condition. Changes in personality that are the direct result of a medical condition can include emotional lability, disinhibition, aggressiveness, apathy, and/or paranoia.

The psychotherapist first evaluated Peter Parker’s mood concerns. Peter described his mood as angry and irritable, although he was unsure whether he felt depressed. He described feelings of self-reproach and worthlessness; reported having difficulty maintaining sleep and having nightmares; said he has little interest in, and finds little pleasure in, the photography and schoolwork that formerly he enjoyed; and is having trouble concentrating. He has experienced these symptoms for more than 2 weeks, and they are interfering with his ability to function at school and elsewhere. Peter’s presentation meets the criteria for a single episode of Major Depressive Disorder.

Peter has experienced no Manic or Hypomanic Episodes; in turn, the diagnosis is Major Depressive Disorder and not a Bipolar Disorder. The current episode is the first that he has experienced, so the course is specified as Single Episode. Finally, his current episode is described. He is experiencing distress along with more than minor impairment in occupational functioning. Conversely, his symptoms are not substantially beyond those needed for the diagnosis and are not causing severe problems with work or social functioning. The best fit among the severity specifiers is Moderate.

One differential diagnosis that might be considered because Peter’s mood change is in reaction to a life event is Adjustment Disorder With Depressed Mood. Whereas Adjustment Disorders With Depressed Mood are negative affective reactions to life stressors in the absence of another diagnosable mental health disorder, in this case, Peter’s symptoms conform to the specific criteria for a Major Depressive Disorder, which go beyond the general criteria set for Adjustment Disorder. Another differential consideration is Acute Stress Disorder or Posttraumatic Stress Disorder (PTSD), since Peter has some symptoms of anxiety, such as difficulty with sleep and concentration. However, his symptoms primarily are in the area of mood rather than anxiety and meet the criteria for a Major Depressive Disorder. It is notable that Peter’s mood is angry and irritable, rather than
depressed; this is consistent with presentations of depression sometimes seen in children and adolescents (APA, 2013, p. 163).

The psychotherapist next evaluated Peter Parker’s changes in personality and behavior. Peter’s aunt reported that in contrast to his behavior prior to his science museum field trip, his behavior had become unpredictable, his mood quickly changed from anger to remorse, he was uncharacteristically “pushy” and aggressive, he was suspicious and worried, and he engaged in impulsive acts like wandering downtown streets at night seeking “trouble” and wearing unusual costumes. These symptoms might be characteristic of a Personality Disorder. Peter did report that he remembered getting a spider bite during his museum visit, and his therapist referred him for a physical exam and toxicology screening along with the counseling intake. Lab test results from the exam revealed biochemical evidence of Radioactive Spider Bite Syndrome, which produces changes in personality. In such cases the diagnosis is a Mental Disorder Due to Another Medical Condition—more specifically: Personality Change Due to Radioactive Spider Bite Syndrome, Combined Type. Combined Type is used because Peter was experiencing a combination of features, including mood lability, poor impulse control, aggressiveness, and paranoid ideation.

One differential consideration is whether these personality changes were severe symptoms associated with Major Depressive Disorder. However, because the therapist expertly referred Peter Parker for a physical exam, evidence was found indicating that personality changes were, instead, the direct consequence of a medical problem. (Damage to the frontal lobe and hemispheric strokes are more common examples of medical conditions that can cause personality change than is Radioactive Spider Bite Syndrome, for which Peter Parker is the only known patient).

To complete the diagnosis, the medical condition associated with the diagnosis is listed alongside the primary mental health diagnoses, and Peter’s relevant stressors are emphasized in the “Other factors” section. This information is relative to and consistent with the primary diagnosis.
Case Conceptualization

When Peter Parker came for his first counseling appointment, his assigned counselor collected thorough information about the symptoms and situations leading to his referral. She collected information about his current symptoms and presentation, recent situational factors, and other events. Based on her thorough intake evaluation, the counselor developed diagnostic impressions, describing Peter’s presenting concerns by a single episode of Major Depressive Disorder, and Personality Change Due to Another Medical Condition, which was a radioactive spider bite. A case conceptualization next was developed. 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 etiology leading to Peter’s depressive disorder and personality change and the factors maintaining these concerns. 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 Peter improve his low mood and related symptoms, and reducing the problematic aspects of his change in personality.

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, Peter Parker’s counselor based her conceptualization on psychotherapeutic integration of two theories (Corey, 2009). Psychotherapists very commonly integrate more than one theoretical approach in order to form a conceptualization and treatment plan that will be as efficient and effective as possible for meeting the client’s needs (Dattilo & Norcross, 2006; Norcross & Beutler, 2008). In other words, counselors using the psychotherapeutic integration method attempt to flexibly tailor their clinical efforts to “the unique needs and contexts of the individual client” (Norcross & Beutler, 2008, p. 485). Like other counselors using integration, Peter’s clinician chose this method because she had not found one individual theory that was comprehensive enough, by itself, to address all of the “complexities,” “range of client types,” and “specific problems” seen among her everyday caseload (Corey, 2009, p. 450).
Specifically, Peter Parker’s counselor selected an integration of (a) Cognitive Behavior Therapy and (b) Reality Therapy. She selected this approach based on Peter’s presentation of intrapersonal mood concerns along with interpersonal personality problems, her knowledge of current outcome research, and suggested best practices with clients experiencing these types of concerns (Critchfield & Smith-Benjamin, 2006; Fotchmann & Gelenberg, 2005; Glasser, 1998, 2001, 2003; Hollon, Thase, & Markowitz, 2002; Westen & Morrison, 2001). According to the research, Cognitive Behavior Therapy is one treatment approach indicated when assisting clients with depressive disorders (Fotchmann & Gelenberg, 2005; Hollon et al., 2002; Westen & Morrison, 2001), whereas an integrated approach emphasizing Reality Therapy can be useful when addressing behavioral and interpersonal choices such as those confronting Peter Parker following his recent experiences (Wubbolding, 2000, 2007). Peter’s counselor is comfortable theoretically integrating these approaches.

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.
1. IDENTIFY AND LIST CLIENT CONCERNS

Angry
Irritable
Feelings of worthlessness
Poor sleep
Nightmares
Diminished school performance
Loss of interest in school and photography
Witnessed uncle's death by gun violence
Self-reproaching and guilty
Feels uncle's death is his fault
Believes he could have saved uncle

Personality and behavior changes
Recent Radioactive Spider Bite Syndrome
Acts unpredictably
Acts pushy and aggressively
Acts impulsively/poor impulse control
Suspicious and worried
Wearing unusual costumes
Adopted clandestine alter-identity
Engages in risky, dangerous vigilantism

2. ORGANIZE CONCERNS INTO LOGICAL THEMATIC GROUPINGS

1. Symptoms of depression due to guilt and self-reproach about causing or not preventing uncle's death
2. Indicators of choosing risky, erratic vigilante behaviors capitalizing on spider bite-induced changes in personality and abilities to repair guilt and self-reproach

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

**Psychotherapeutic Integration**

**Cognitive Behavior Therapy**

Irrational belief:
"It is my fault my uncle is dead and therefore I do not deserve to be happy or to move on with the rest of my life"

**Reality Therapy**

Current behaviors are leading to risky, harmful possible consequences and these behaviors are poor need-satisfying choices

4. NARROWED INFERENCES: SUICIDALITY AND DEEPER DIFFICULTIES

**Psychotherapeutic Integration**

**Cognitive Behavior Therapy**

Deepest faulty belief:
"I must redeem myself for my uncle's death by vigilantism; otherwise I don't deserve to exist"

**Reality Therapy**

Peter is focused on past events rather than making good choices now and learning how to make good choices for the future
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 below, the counselor identified Peter Parker’s various primary concerns (angry mood and all of the other symptoms of major depression; all of the symptoms of personality change); important recent events and situations (loss of uncle, etc.); important medical and clinical concerns (spider bite, Radioactive Spider Bite Syndrome); and related issues, thoughts, feelings, and behaviors (guilt, self-reproach, etc.). She attempted to go beyond just the current, noticeable symptoms leading to Peter’s referral, in order to be descriptive 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, Peter’s counselor selected the Intrapsychic Approach. This approach sorts together all of the Step 1 information about the “client’s adjustment, development, distress, or dysfunction” in order “to show clinical patterns in the ways life events are associated with the person’s personal experience and identity” (Neukrug & Schwitzer, 2006, p. 205).

Peter’s counselor formed two interesting symptom constellations to capture the two intrapsychic patterns and resulting behaviors she attributed to Peter. She grouped together his symptoms of depression, loss of his uncle, guilt, self-reproach about responsibility for his uncle’s death, and so on into Theme 1: Symptoms of depression due to guilt and self-reproach about causing or not preventing uncle’s death. She grouped together his unpredictable personality features and risky vigilante behaviors into Theme 2: Indicators of choosing risky,
erratic vigilante behaviors capitalizing on spider bite–induced changes in personality and abilities to repair guilt and self-reproach. In this case example, the counselor used the Intrapsychic Approach to group together various information about changes in thinking, mood, behavior, and physiology in order to show how external life experiences have been associated with dimensions of Peter’s experience of self.

So far, at Steps 1 and 2, the counselor has used her clinical assessment skills and her clinical judgment to begin meaningfully understanding Peter Parker’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 roots underlying Peter’s concerns as they are seen in Steps 1 and 2.

Step 3: Theoretical Inferences. At Step 3, concepts from the counselor’s theoretical integration of two approaches—Cognitive Behavior Therapy and Reality Therapy—are applied to explain the experiences causing, and the mechanisms maintaining, Peter Parker’s problematic changes in mood and behavior. 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 Peter Parker’s current needs (Neukrug & Schwitzer, 2006; Schwitzer, 2006, 2007).

First, Cognitive Behavior Therapy was applied primarily to Peter’s depressive needs. According to Cognitive Behavior Therapy (Beck, 1995, 2005; Ellis, 1994; Ellis & MacLaren, 2005), irrational thinking, faulty beliefs, or other forms of cognitive errors lead individuals to engage in problematic behaviors and to experience negative moods and attitudes. As can be seen in the figure below, when the counselor applied these Cognitive Behavior Therapy concepts, she explained at Step 3 that the various issues noted in Step 1 (mood and other adolescent symptoms of depression), which can be understood in Step 2 to be a theme of loss and guilt, are rooted in or caused by Peter’s irrational belief, “It is my fault my uncle is dead, and therefore I do not deserve to be happy or to move on with my life.”

Second, Reality Therapy was applied. This second approach was thought to complement the irrational belief as a source of Peter’s depressive symptoms by further addressing his recent problematic changes.
According to Reality Therapy, individuals choose actions in attempts to satisfy their needs—more importantly, relationship needs. Therefore, according to the theory, the counseling focus is on what actions and behaviors clients are choosing and evaluating the degree to which present actions are leading to need satisfaction or other desired consequences (Glasser, 1998, 2001, 2003). The Reality Therapy conceptualization addresses the individual’s present-day wants pertaining to the type of person he or she wishes to be, desires for family, whether and how the person intends to change his or her life, and similar questions about the choices the individual is making and is willing to make for the future (Wubbolding, 2000, 2007). As can be seen in the figure, when the counselor applied these Reality Therapy concepts, she additionally explained at Step 3 that the various Step 1 issues, which can be organized in Step 2 to be indicators of choosing erratic vigilante behaviors to repair guilt, could be understood as follows: Peter’s current behaviors are leading to risky, harmful possible consequences, and these behaviors are poor need-satisfying choices.

**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). Peter Parker’s counselor continued to use psychotherapeutic integration of two approaches.

First, continuing to apply Cognitive Behavior Therapy concepts at Step 4, Peter’s counselor presented a single, most-fundamental faulty belief that she believed to be most explanatory and causal regarding Peter’s primary reasons for referral: the deepest irrational self-statement that “I must redeem myself for my uncle’s death by vigilantism; otherwise I don’t deserve to exist.” Second, continuing to apply Reality Therapy, the counselor presented a single, most deeply rooted Reality Therapy inference: Peter is focused on past events rather than making good choices now and learning to make good choices for the future. These two narrowed inferences, together, form the basis for understanding the etiology and maintenance of Peter’s difficulties.

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.

**Treatment Planning**

At this point, Peter’s clinician at the Midtown High School Counseling Center has collected all available information about the problems that have been of concern to him. 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 Peter’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 Peter, but with all clients who present with disturbing and disruptive symptoms and/or personality patterns (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 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-II (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 Peter, 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 Peter, there are two primary areas of concern. The first, “symptoms of depression due to guilt and self-reproach about causing or not preventing his uncle’s death,” refers to his feelings that his uncle’s death was his fault, feelings of guilt and self-reproach, anger, irritability, feelings of worthlessness, poor sleep with nightmares, diminished school performance, and loss of interest in school and photography. The second, “indicators of choosing risky, erratic vigilante behaviors capitalizing on spider bite–induced changes in personality and abilities to repair guilt and self-reproach refers to headaches, poor sleep, and fatigue,” refers to personality and behavior changes following a recent radioactive spider bite, unpredictable, pushy, and aggressive behavior, impulsivity, suspiciousness, and worry. These symptoms and stresses are consistent with the diagnosis of Major Depressive Disorder, Single Episode, Moderate; and Personality Change Due to Radioactive Spider Bite Syndrome, Combined Type (Andrews, Slade, Sunderland, & Anderson, 2007; APA, 2013; Chuang, 2009; Dobson, 1989; Hollon, Thase, & Markowitz, 2002).

**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 Peter, the goals are divided into two prominent clusters. The first, "symptoms of depression due to guilt and self-reproach about causing or not preventing uncle’s death," requires that we help Peter alleviate his depressed mood and return to previous levels of functioning, appropriately grieve his loss, identify the relationship between his depression, guilt, and the loss of his uncle, identify his irrational guilt-based thoughts, develop healthy cognitive patterns and beliefs, learn and implement relapse prevention strategies, and develop a positive reconnection with memories of his uncle. The second, "indicators of choosing risky, erratic, vigilante behaviors capitalizing on spider bite-induced changes in personality," requires that we assist Peter medically stabilize his condition through compliance with physical treatment, live life to the fullest by learning physical and psychological coping strategies, reduce fear and anxiety associated with the medical condition, accept the physical changes and monitor their impact on his daily functioning, and accept the role of psychological/stress factors in the exacerbation of his condition.

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 Peter, we have decided to use a two-pronged integrated approach to therapy comprised of Cognitive Behavior Therapy and Reality Therapy. Cognitive Behavior Therapy (Beck, 1995, 2005; Ellis, 1994; Ellis & MacLaren, 2005) has been found to be highly effective in counseling and psychotherapy with adults (and adolescents) who experience the symptoms of Major Depressive Disorder related to loss (Fiorini & Mullen, 2006; Neimeyer, 2000; Servaty-Seib, 2004). The approach relies on a variety of cognitive techniques (reframing, challenging irrational thoughts, and cognitive restructuring) and behavioral techniques (reinforcement for and shaping of adaptive behavior, extinction of maladaptive behaviors, systematic desensitization, and exposure with response prevention) (Ball et al., 2006; Frank et al., 2005; Milkowitz, 2008). Peter’s loss-based depression will be addressed through a combination of individual techniques that include identifying and understanding the stages of grief; verbalizing circumstances of loss and identifying related irrational thoughts and feelings; exploring feelings of anger, sadness, and guilt related to loss, and reframing in a non-guilt-inducing manner; imaginal desensitization around the experience of his uncle’s death; developing and engaging in healthy mourning rituals; and scheduling activities that have a high likelihood for stress relief and relaxation.

We have also decided to use Reality Therapy (Glasser, 1998, 2001, 2003) due to its emphasis on client’s recognition of the role of choices in their life, how those choices affect their happiness (and unhappiness), and how they can make healthier and life-affirming choices. The WDEP system (Wubbolding & Brickell, 1998; Wubbolding et al., 1998; Wubbolding et al., 2004) provides the structure for intervention by helping clients identify their wants (W) and their direction (D), evaluate the efficacy of their current direction and its outcome (E), and plan accordingly (P). Given Peter’s general life competencies and past successful adjustment both at home and at school, Reality Therapy’s emphasis on strengthening the client’s internal locus of control as well as fostering insight and change through the therapeutic relationship will assist him reclaim responsibility in and for his life as well as effectively problem-solve. This particular form of counseling/psychotherapy has proven effective in treating a wide range of problems, including anxiety, depression, anger management, and relationship issues (Radtke, Sapp, & Farrell, 1997; Wubbolding, 2000; Wubbolding & Brickell, 1999). Specific
techniques for Peter will include recognizing the medical basis for his changed personality functioning; taking responsibility for the thoughts, feelings, and behaviors that resulted from this condition; using physiological, behavioral, and emotional monitoring to minimize the need to engage in risky and harmful behaviors; recognizing the possible adverse consequences of these behaviors to both himself and others; practicing statements of responsibility and choice; and joining a support group for medical conditions that lead to personality change.

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 Peter’s case, we have implemented a number of these, including improved pre-post measures on the Beck Depression Inventory-II (Beck, Steer, & Brown, 1996), Beck Anxiety Inventory (Beck & Steer, 1990), and Clinical Anger Scale (Snell, Gum, Shuck, Mosely, & Hite, 1995); spouse and client report of improvement in overall life, family and work satisfaction, aunt’s report of Peter’s improvement in mood, activity level, and outlook, and the development of adaptive responses to stress.

The completed treatment plan is now developed through which the counselor and Peter will be able to use the techniques of Cognitive Behavior Therapy and Reality Therapy to reduce Peter’s stressful feelings and eliminate his disruptive physiological, emotional, cognitive, and behavioral symptoms. Peter Parker’s treatment plan appears below, and a summary can be found in the table below.

**TREATMENT PLAN**

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**Client:** Peter Parker  

**Service Provider:** Midtown High School Counseling Center
BEHAVIORAL DEFINITION OF PROBLEMS:

1. Symptoms of depression due to guilt and self-reproach for causing or not preventing uncle’s death—Feeling that his uncle’s death was his fault, self-reproach and guilt, anger, irritability, feelings of worthlessness, poor sleep with nightmares, diminished school performance, and loss of interest in school and photography

2. Indicators of choosing risky, erratic vigilante behaviors capitalizing on spider bite–induced changes in personality and abilities to repair guilt and self-reproach—Personality and behavior changes following a recent radioactive spider bite; unpredictable, pushy, and aggressive behavior, impulsivity, suspiciousness, and worry

GOALS FOR CHANGE:

1. Symptoms of depression due to guilt and self-reproach for causing or not preventing uncle’s death
   - Alleviate depressed mood and return to previous levels of functioning
   - Appropriately grieve his loss
   - Identify the relationship between his depression, guilt, and the loss of his uncle
   - Identify his irrational guilt-based thoughts
   - Develop healthy cognitive patterns and beliefs
   - Develop a health mourning ritual
   - Learn and implement relapse prevention strategies

2. Indicators of choosing risky, erratic vigilante behaviors capitalizing on spider bite–induced changes in personality and abilities to repair guilt and self-reproach
   - Medically stabilize his condition through compliance with physical treatment
   - Reduce fear and anxiety associated with the medical condition
   - Accept the physical changes and monitor their impact on his daily functioning
   - Accept the role of psychological/stress factors in the exacerbation of his condition
• Live life to the fullest by learning physical and psychological coping strategies

THERAPEUTIC INTERVENTIONS:

A short- to moderate-term course of individual Cognitive Behavior and Reality Therapy centered counseling (3–6 months)

1. Symptoms of depression due to guilt and self-reproach for causing or not preventing uncle’s death
   • Identify and understand the stages of grief
   • Verbalize circumstances of loss and identify related irrational thoughts and feelings
   • Explore feelings of anger, sadness, and guilt related to loss and reframe in a non-guilt-inducing manner
   • Imaginal desensitization around the experience of his uncle’s death
   • Identify positive characteristics of lost loved one
   • Schedule activities that have a high likelihood of stress relief
   • Develop and implement program for regular exercise and relaxation strategies

2. Indicators of choosing risky, erratic vigilante behaviors capitalizing on spider bite–induced changes in personality and abilities to repair guilt and self-reproach
   • Recognizing the medical basis for his changed personality functioning
   • Taking responsibility for the thoughts, feelings, and behaviors that resulted from this condition
   • Using physiological, behavioral, and emotional monitoring to minimize the need to engage in risky and harmful behaviors
   • Discussing the adverse consequences of these behaviors to both himself and others
   • Practicing statements of responsibility and choice for his thoughts and actions
   • Joining a support group for medical conditions that lead to
OUTCOME MEASURES OF CHANGE:

The resolution of guilt-driven grief, elimination of depression, and responsible management of his medical condition and its consequences as measured by:

- Improved pre-post scores on Beck Depression Inventory-II
- Client self-report of improved overall mood, with reduced and tolerable guilt
- Client’s report of acceptance of and responsible choices in managing his medical condition
- Clinician observation of client’s decreased stress level
- Incident-free police record for a period of 1 year

Peter Parker’s Treatment Plan Summary: Psychotherapeutic Integration of Cognitive Behavior Therapy and Reality Therapy

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