Skills and Tools for Today's Counselors and Psychotherapists

From Natural Helping to Professional Counseling

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CHAPTER 10

Treatment Planning: Building a Plan for Change

Once the clinician has identified the client's concerns through thoughtful listening, information gathering, and diagnosis, and after the clinician has carefully applied the case conceptualization process, treatment planning is ready to begin. Whereas the professional counselor has an intentional, well-designed plan for directing the change process toward desired outcomes, the natural helper generally "shoots from the hip" when making suggestions for an individual. Occasionally, shooting from the hip can be helpful, but unfortunately, such unplanned responses sometimes can be degrading or harmful to the person.

In this chapter, we first define and explain what treatment planning is. We discuss the purpose of treatment planning and how a good treatment plan is beneficial to our work with clients. We also discuss how a well-documented treatment plan is beneficial to the clinician. Next, we introduce specific steps for building a basic, generic treatment plan: selecting achievable goals, determining what the treatment will be, and establishing how change will be measured. We include case illustrations and practice exercises throughout the chapter to acquaint you with treatment planning. Finally, we discuss the ongoing process of learning how to build treatment plans.

Understanding Treatment Planning

Defining Treatment Planning

Treatment planning is action oriented and goal directed. It moves from knowing what the client's concerns are to deciding what to do about them. Treatment planning provides a "road map" for reaching the desired clinical outcomes and is the tool by which clinicians put their case conceptualization and theoretical perspective into action.

As in the previous chapter, we asked our group of novice counselors—new clinicians just beginning their clinical careers—how they would define treatment planning. Here is what they said:

- "Treatment planning is goal setting and agenda setting."
- "Developing a plan with objectives, strategies, and goals for working with a client in therapy."
- "A written plan of problems, objectives, goals; type of therapeutic interventions; service provider and timetable for bringing about change."
- "Developing an approach to treatment and services based on the client's wants and needs."
- "A process by which the counselor plans out the goals of therapy and how to go about achieving those goals in an estimated number of sessions."

These new counselors agreed that treatment planning provides the therapist and client with a game plan for reducing or eliminating disruptive symptoms that are impeding the client's ability to reach positive mental health and outlines the steps to be taken in helping the client to reach wellness or acceptable coping skills. These responses provide a good snapshot of what treatment planning is all about. Along the same lines as these beginning counselors, an experienced clinician has offered us the following widely accepted definition of treatment planning:

> *[Treatment planning is] plotting out the counseling process so that both counselor and client have a road map that delineates how they will proceed from their point of origin (the client's presenting concerns and underlying difficulties) to their destination, alleviation of troubling and dysfunctional symptoms and patterns, and establishment of improved coping mechanisms and self-esteem.* (Seligman, 1993, p. 288; 1996, p. 157)

In defining treatment planning for this text, we take the position that it is a vital aspect of mental healthcare delivery (Jongsma & Peterson, 2003; Seligman, 1993, 2004). We view competent clinicians as those who move methodically from assessment and case conceptualization to the formulation and implementation of the treatment plan (Jongsma & Peterson, 2003; Schwitzer & Everett, 1997). Thus, our definition of treatment planning includes three aspects: (a) selecting achievable goals, (b) determining treatment modes, and (c) documenting the attainment of goals.

Selecting Achievable Goals

Treatment plans give the therapeutic work structure and direction (Seligman, 2004) by focusing on choosing specific objectives that lead to intervention strategies (Jongsma & Peterson, 2003). It includes selecting achievable goals for change from among the presenting concerns, associated concerns, etiological factors, and/or sustaining factors that are causing the client distress or dysfunction. Clients and practitioners benefit from a clear, written treatment plan that includes specific goals because it reminds both to think of counseling in terms of therapeutic

outcomes instead of waiting for a vague sense of when the client feels as if he or she has improved (Jongsma & Peterson, 2003).

Determining Treatment Modes

Treatment plans include a broad array of activities, or treatment modes. The clinician must make decisions about who will be the service provider (e.g., setting, specific staff), what treatment formats will be employed (e.g., individual, group, couples, family, medication), what therapeutic approach will be used (e.g., person-centered, psychodynamic, cognitive-behavioral), which specific interventions will be employed, and what the duration of the counseling relationship is expected to be. Of course, since issues can change or emerge throughout the helping relationship, and because the clinician gets better insight into the appropriateness and effectiveness of the interventions selected once they are implemented, the treatment plan should be viewed as a road map that will be reviewed and possibly updated periodically (Jongsma & Peterson, 2003). A carefully designed treatment plan, based on research findings and the counselor's clinical knowledge about treatment effectiveness, should increase the likelihood of successfully reaching the desired counseling outcomes (Seligman, 2004).

Documenting the Attainment of Goals

Treatment plans provide documentation of treatment (Jongsma & Peterson, 2003) and, along with posttreatment evaluations, give the counselor a tool to substantiate the work being done (Seligman, 2004). Being able to confirm the efficacy of one's work is important for two reasons in the world of professional counseling. First, collecting payments or funding from third-party payers such as insurance companies, HMOs, and government sources typically is dependent on being able to show what goals were set, what interventions were used, what milestones were reached along the way, and whether the goals were ultimately accomplished. Second, in the current climate of increased patient and client litigation, liability is an important professional concern. Here a treatment plan that documents the process and progress of our work with clients can provide one solid defense against exaggerated or false claims or other types of malpractice suits (Jongsma & Peterson, 2003; Seligman, 2004).

Case Illustrations: Sienna and Janine

To give you a better picture of what treatment planning involves, it is helpful to once again return to our two case examples of Sienna and Janine, who were introduced earlier and discussed in Chapter 9 when we examined case conceptualization. First, we offer an abbreviated treatment plan for Sienna and for Janine, and later in the chapter, after we detail the treatment planning process, we expand on our treatment plans.

For our first illustration, let's return to our client Sienna. Take a moment to reacquaint yourself with the discussions about Sienna presented in Chapters 2 and 9. Then, read Case Illustration 10.1 and try to gain a general picture of what treatment planning comprises.

CASE ILLUSTRATION 10.1 Introduction to Treatment Planning: Sienna

As seen in Chapter 2, Sienna is a 23-year-old college student who came into the counseling center presenting moderate and persistent depression. Sienna also has been dealing with relationship and dependence problems with her boyfriend, mother, and others and with problems achieving adult independence and identity (review the case conceptualization presented in Chapter 9).

A. SELECTING ACHIEVABLE GOALS FOR CHANGE

Sienna sought counseling to reduce her feelings of depression. When the counselor more fully explored all of Sienna's areas of difficulty, three logical themes were conceptualized: (a) her depressed mood, worry, sleep trouble, poor appetite, poor concentration, and low energy; (b) dependence problems and conflicts in important relationships; and (c) identity confusion.

The treatment plan developed was to address Sienna's symptoms of depression and her dependence in relationships. Specific goals written in the treatment plan included:*

- Alleviate Sienna's depressed mood and have her return to her previous level of effective functioning
- Decrease Sienna's level of dependence and conflict in her relationships with her mother and with her boyfriend

B. DETERMINING TREATMENT MODES (E.G., SERVICE PROVIDER, TREATMENT FORMAT, THERAPEUTIC APPROACH, THERAPEUTIC INTERVENTIONS, AND DURATION OF COUNSELING)

According to the case conceptualization from a humanistic perspective, Sienna's themes were seen to be rooted in low self-esteem, an underdeveloped sense of self-worth, and diffusion of identity. Correspondingly, the treatment of choice would be individual counseling using humanistic (or person-centered) interventions. Specifically, the plan would be to "develop improved self-esteem and increased self-worth, which would lead to alleviation of depressive symptoms, alleviation of dependence in important relationships, and an increased sense of identity (knowing who she is)."

To do this, the counselor would:

- See the client 1 hour weekly for person-centered counseling
- Develop a nurturing supportive environment where Sienna could feel free to honestly assess her current level of functioning
- Promote client insight through the use of person-centered skills (e.g., empathy, unconditional regard, genuineness)
- Encourage the client to record her thoughts, feelings, and behaviors and examine her role in significant relationships

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C. DOCUMENTING ATTAINMENT OF GOALS

The goal of developing healthy feelings of self-worth and accurate perceptions of self that lead to the alleviation of depressive symptoms, the alleviation of dependence in relationships, and an increased sense of identity would be measured by:

- The client's self-reported success in replacing negative feelings related to poor self-esteem with positive feelings of self-worth
- The client's self-reported success in alleviating depressive symptoms
- The client's self-reported success in reducing dependence needs and conflict
- A decreased score on a test of depression and an increased score on a test of self-esteem
- Overall improvement as reported by the client and viewed by the clinician as measured on the GAF Scale

* Identity confusion was seen as partly developmental, and it was felt it might be alleviated by addressing the first two goals. If not, it can be added to the treatment plan later.

Notice that in the first step, although Sienna presents depressive symptoms, relationship dependence, and identity confusion, the counselor determines that the main treatment goals will be to reduce or eliminate the symptoms of depression and to reduce or eliminate the relationship conflicts and dependence and has selected not to directly address the identity confusion issues at this point. Next, notice that the counselor, guided by a specific theoretical orientation and case conceptualization, determines that humanistic psychotherapy will be utilized to address the fragile self-esteem and underdeveloped self-worth believed to be "causing" the depression and maintaining the client's relationship-dependence problems. This is followed by the counselor determining that change will be assessed by observations of the client in their sessions together, by client record and self-reports, by positive changes in GAF scores (return to Chapter 8, if needed, to review the GAF), and by pre–post changes in mood and behavior as measured by psychological testing. Now try Exercise 10.1.

EXERCISE 10.1 **Developing Your Treatment Plan for Sienna**

Sienna's treatment plan gives just a cursory illustration of the treatment planning process. At this point, we certainly don't expect you to have a complete understanding of how to build a treatment plan. However, as an exercise, think about what goals you would set for Sienna and what therapeutic approach you might use if you were her counselor. Specifically, consider the following questions and then discuss them in small groups.

1. What areas of difficulty do you believe would be most important to address?
2. What would be your goals for change?
3. What conceptual approach and which interventions would you plan to employ to help Sienna change?

For our second example, let's return to our community counseling client Janine, who was introduced in Chapter 8 and discussed in the previous chapter. Here again, as you read through this second illustration, consider what treatment planning might involve. Take a moment to reacquaint yourself with the discussion of Janine presented in Chapters 8 and 9 and then read Case Illustration 10.2.

CASE ILLUSTRATION 10.2 Introduction to Treatment Planning: Janine

As seen in Chapter 9, Janine is a 48-year-old White woman who came into a rural community mental health center. Like Sienna, Janine was experiencing low mood and other symptoms of depression. Janine has also been dealing with unemployment and a recent diagnosis of adult-onset diabetes (review the case conceptualization presented in chapter 9).

A. SELECTING ACHIEVABLE GOALS FOR CHANGE

Janine sought counseling to eliminate her feelings of depression. When the counselor more fully explored all of Janine's areas of difficulty, two logical themes were conceptualized: (a) her feelings of depression and sadness, social isolation, loss of appetite, lack of energy, loss of interest in pleasurable activities, difficulty concentrating, and short-term memory problems—all of which fit with symptoms of a depressive disorder; and (b) problematic relationships with her father, brother, and son—or collectively, family conflicts.

The treatment plan developed was to first address Janine's symptoms of a depressive disorder. Although important, reducing the family conflicts and psychosocial stressors were not immediate goals of counseling, as the depression was seen as an overriding problem that needed to be addressed prior to these other issues. These other issues can be addressed in a modified treatment plan or in the future. Specifically, the goal that was selected was to:

- Alleviate depressed mood and return to previous level of effective functioning

B. DETERMINING TREATMENT MODES (E.G., SERVICE PROVIDER, TREATMENT FORMAT, THERAPEUTIC APPROACH, THERAPEUTIC INTERVENTIONS, AND DURATION OF COUNSELING)

According to the case conceptualization, from a cognitive perspective, the therapist linked Janine's low mood to a negative view of self, negative interpretations of life experiences, and negative beliefs about the future.

Correspondingly, the treatment of choice would be individual psychotherapy using cognitive interventions. Specifically, the plan would be to:

- Develop healthy cognitive patterns and beliefs about self and the world that lead to the alleviation of depressive symptoms

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To do this, the counselor would:

- See the client for individual counseling 1 hour weekly
- Assist the client in analyzing her cognitive self-talk to assess dysfunctional thinking
- Assist the client in replacing negative and self-defeating talk with realistic and positive cognitive messages
- Meet with a psychiatrist for possible antidepressant medication as an adjunct to therapy

C. DOCUMENTING ATTAINMENT OF GOALS
The goal of developing healthy cognitive patterns and beliefs about self and the world that lead to alleviation of depressive symptoms, achieved through assessing and changing negative self-talk, would be measured by:

- The client's self-reported success in learning to replace self-defeating thoughts with positive thoughts
- The clinician's observation of the client's success in learning to replace self-defeating thoughts with positive thoughts
- Alleviation of depressive symptoms, as measured by observation and psychological testing
- Increased GAF score
- Decrease in antidepressant medication dosage if prescribed

Notice that in the first step, although Janine presents (a) a depressive disorder, (b) family conflicts, and (c) psychosocial stressors of unemployment, medical diagnosis of diabetes, and lifelong problems with poverty, the counselor determines that the primary treatment goal will be to reduce or eliminate the symptoms of depression. Next, guided by a specific theoretical orientation and case conceptualization, the counselor determines that cognitive therapy will be utilized to address the faulty thinking believed to be "causing" the depression. Then, the counselor states change will be assessed by: observations of the client, pre–post changes in mood as measured by testing, increased GAF scores, and decreased medication dosage. Now try Exercises 10.2 and 10.3.

EXERCISE 10.2 **Developing Your Treatment Plan for Janine**

Janine's treatment plan gives just a cursory illustration of the treatment planning process. At this point, we certainly don't expect you to have a complete understanding of how to build a treatment plan. However, as an exercise, think about what goals you would set for Janine and what therapeutic approach you might use if you were her counselor. Specifically, consider the following questions and then discuss them in small groups.

1. What areas of difficulty do you believe would be most important to address?
2. What would be your goals for change?
3. What conceptual approach and which interventions would you plan to employ to help Janine change?

Exercise 10.3 **How Comfortable Are You with Professional Decision Making?**

The responsibility for clinical decision making and treatment planning—deciding on goals, interventions, and indicators of change—is an important clinical responsibility. It can feel empowering and professionally exciting, it can feel like an overwhelming responsibility for the welfare of another person, and some counselors feel negatively, or at odds, with the clinical need to map out such a specific behavioral plan for treatment. To see where you fit into this part of the path from natural helper to professional counselor, consider the following questions. First, make some mental or written notes answering each of these questions as completely as you can and then discuss your responses in pairs or small groups.

1. What immediate feelings, thoughts, reactions do you have when you think about being in the clinical role of treatment planner?
2. What will interest or excite you about this part of being a professional helper?
3. What concerns do you have?
4. What ethical considerations or reservations do you have?

Building a Treatment Plan

> *The process of developing a treatment plan involves a logical series of steps that build on each other much like constructing a house.* (Jongsma & Peterson, 2003, p. 4)

The foundation of the treatment plan is assessment, appraisal, and conceptualization of the client's concerns, and this foundation leads to the selection of achievable goals for change. After goals are chosen, the clinician, in consultation with the client, will determine what treatment or interventions will be used. The final logical step, then, is to establish exactly how change will be measured—in other words, to establish how you and the client (and other interested parties) will know that the goals have been accomplished. Although there are a variety of paper-and-pencil formats used in clinical treatment planning, all formats in today's world of professional counseling focus on three steps: selecting achievable goals for change, determining the treatment, and establishing how change will be measured. Expanding on the discussion earlier in this chapter, what follows is a step-by-step process for building a treatment plan.

Step 1: Selecting Achievable Goals for Change

An accurate understanding of the client's needs is required before a decision can be made about which problems to address. This requires effective work by the clinician in the earliest stages of the helping relationship. During Stage 1, rapport and trust building, the clinician must establish good rapport and begin listening carefully to understand the client's presenting concerns.

During Stage 2, problem identification, the clinician must accurately identify and describe the client's broader set of needs. This includes accurately assessing not only the client's presenting concerns (e.g., feelings of worry and anxiety) but also associated concerns (e.g., social difficulties, work problems), etiological factors leading to the concerns (e.g., punitive, critical family experiences while growing up), and sustaining factors maintaining the concerns (e.g., poor self-esteem, self-defeating

thinking, verbally abusive boss). Further, the clinician must gain an accurate appraisal of the client's level of distress and/or dysfunction resulting from the various concerns. Diagnosis is used to define and describe the client's difficulties, and case conceptualization is used to understand and tie together the presenting and associated concerns and etiological and sustaining factors.

During Stage 3, goal setting and treatment planning, the clinician selects achievable goals for change. It is an outgrowth of all previous clinical activity in Stages 1 and 2. This process involves selecting the problems to address, assessing the urgency and dysfunction of the problem, using case conceptualization, assessing client motivation for change, understanding the impact of real-world influences on setting realistic goals, and using behaviorally measurable goals.

SELECT THE PROBLEMS Although the client may discuss a variety of issues during the early assessment stages, the clinician must sort out the most significant problems to be the targets of counseling. Usually, a primary concern will be identified, along with several secondary or other concerns. An effective treatment plan can only address a few selected concerns, or it will lose its effectiveness (Jongsma & Peterson, 2003). The clinician must prioritize the issues for which the client is seeking help to select treatment that will address the client's greatest needs.

URGENCY AND DYSFUNCTION The first consideration when selecting problems to be addressed is the magnitude of the person's difficulties (Seligman, 2004). Issues causing the most concern—that is, those that cause the greatest psychoemotional distress or the most disruption in everyday functioning—typically require more immediate attention. Some issues receive priority and require immediate attention, such as suicidality and other forms of self-harm (e.g., anorexia or compulsive self-mutilation); potential for harm to others; the diagnostic "red flag" problems of delirium, dementia, amnestic and other cognitive disorders, and mental disorders due to a general medical condition; schizophrenia and other psychotic disorders; substance abuse; and any other problem causing substantial distress or disruption.

CASE CONCEPTUALIZATION The next consideration in problem selection is case conceptualization. The clinician must use his or her professional judgment to decide whether the most important targets for treatment involve (a) individual symptoms or concerns, such as those recorded in Step 1 of the inverted pyramid method of case conceptualization (e.g., sleep problem, concentration problem; see Chapter 9); (b) groups or constellations of symptoms, such as those represented by a *DSM-IV-TR* diagnosis (e.g., all the symptoms of posttraumatic stress disorder) or those recorded in Step 2 of the inverted pyramid method of case conceptualization (e.g., a client's anger management problems at home, at work, and elsewhere—all addressed together; see Chapter 9); or (c) inferred difficulties such as "poor self-esteem" or "faulty thinking" as noted in Step 3 of the inverted pyramid method (see Chapter 9). Any of these targets—specific symptoms, groups of symptoms, or inferred difficulties—may be written into a treatment plan as the defined problem for which change is expected.

CLIENT MOTIVATION Although treatment planning requires the clinician to take on the role of trained expert, the clinician must actively collaborate with the client in selecting the focus of counseling to achieve his or her commitment to the change process. Clients may be self-referred, referred by family or others close to them, or mandated to counseling by the courts or another authority. The client's motivation to take part in counseling and cooperate with treatment during the work stage depends largely on whether he or she believes the treatment will address his or her greatest needs and will resolve the problems of greatest interest. The client's collaboration is required when deciding which symptoms, symptom groups, or inferred difficulties will become the defined problems according to the treatment plan.

REAL-WORLD INFLUENCES The problems selected must lead to achievable goals that are realistic and reasonable within all of the constraints of the helping relationship and are appropriate for the agency or counseling setting. For example, school counselors typically should not set goals that require intensive personal psychotherapy to achieve. Similarly, outpatient therapists should not set goals requiring extensive longer term therapy if the client can only make a commitment for a few sessions (Robbins & Zinni, 1988). Both client and counselor should understand the real-world constraints of the relationship when determining what problems will be the focus of treatment.

BEHAVIORALLY MEASURABLE GOALS A specific operational (or behavioral) definition is required for each problem that is identified for inclusion in the treatment plan. The exact symptom pattern, as it is experienced by the individual client, should be described in clear, precise language. For example, a client's problem with anger management could be described as follows (Jongsma & Peterson, 2003): "overreactive hostility to insignificant irritants, use of abusive language, and history of explosive aggressive outbursts out of proportion to any precipitating stressors leading to assaultive acts or destruction of property" (p. 16).

In turn, the goals for change also should be written in clear, exact, operational, behavioral language. This description will be used to assess whether the expected change has been achieved at the end of counseling. For example, the end goal for a client with an anger management problem could be written behaviorally as follows (Jongsma & Peterson, 2003): "Decrease overall intensity and frequency of angry feelings, and increase ability to recognize and appropriately express angry feelings as they occur" (p. 16). It takes practice and experience to write clear, specific, behaviorally explained problems and goals when treatment planning (see Box 10.1).

Step 2: Determining the Treatment

Prioritizing and selecting the problems to be addressed and deciding on clear, operational, measurable goals for change form the foundation of the treatment plan. Determining what the treatment will be naturally follows. In this step, three questions must be answered: Who will be the service provider? What treatment formats will be employed? What interventions will be used? In addition, the treatment approach must be stated in behavioral terms.

BOX 10.1

Summary of Step 1: Selecting Achievable Goals for Change

The clinician collaborates with the client to select achievable goals for change from among the presenting concerns, associated concerns, etiological factors, and/or sustaining factors that are causing the client distress or dysfunction.

SELECT THE PROBLEMS TO BE ADDRESSED
Prioritize the issues for which the client is seeking help to select treatment that will address the client's greatest needs.

URGENCY AND DYSFUNCTION
Consider the urgency and amount of dysfunction when choosing goals. The following in particular should be addressed:

- issues of suicidality and other forms of self-harm or potential for harm of others
- the diagnostic red flag problems of delirium, dementia, amnestic and other cognitive disorders, mental disorders due to a general medical condition, and schizophrenia and other psychotic disorders
- substance-related concerns
- any other problem causing substantial distress or disruption

CASE CONCEPTUALIZATION
Use your case conceptualization and theoretical orientation to choose goals.

- individual symptoms or concerns, such as those recorded in Step 1 of the inverted pyramid method of case conceptualization
- symptom groupings, such as those represented by *DSM-IV-TR* diagnoses or those recorded in Step 2 of the inverted pyramid
- inferred difficulties, such as those recorded in Steps 3 and 4 of the inverted pyramid

CLIENT MOTIVATION
Consider whether client believes the treatment will address his or her greatest needs and will resolve the problems of greatest interest.

REAL-WORLD INFLUENCES
Choose realistic goals.

- appropriate for the agency or counseling setting
- achievable within existing session limits

BEHAVIORALLY MEASURABLE GOALS
Choose goals that can be clearly defined and measured.

- exact symptom pattern should be described in clear, precise language
- goals for change also should be written in clear, exact, operational, behavioral language
- these descriptions will be used to assess whether the expected change has been achieved

SERVICE PROVIDER In determining the service provider, the clinician must consider what would be the most appropriate counseling setting, which types of mental health professionals are best suited to the client's needs, and whether an outside referral is indicated.

Setting

Deciding who will be the service provider begins with determining which agency or counseling setting is best suited to address the client's needs. Some general settings include inpatient hospitalization, marriage and family counseling centers, outpatient mental health settings, private practices, schools, college counseling centers, and so forth. Other settings include more specialized centers designed for special populations such as the needs of women, children, low socioeconomic clients, and so on. Still other settings provide services tailored to specific issues: suicide crisis centers; centers for depression or anxiety; clinics for sleep disorders, eating

disorders, and so forth. When designing the treatment plan, the clinician must be sure that the counseling setting can provide the "therapeutic repertoire" needed to meet the client's greatest needs (Jongsma & Peterson, 2003, p. 6; Seligman, 2004).

Mental Health Professional
Deciding who will be the service provider also means determining which type of mental health professional is best equipped to address the client's needs. Some problems can be addressed within the repertoire of generalist professional counselors or psychotherapists. Other problems may be better suited to the unique family systems training of licensed family counselors, clinical social workers, or the doctoral-level education of clinical psychologists. Specialized services such as psychological testing and assessment may require the work of a licensed professional with expertise in testing, such as a psychologist. Similarly, diagnosis and appraisal for medication may require the services of a psychiatrist. Further, individual staff's training, clinical experience level, areas of expertise, clinical repertoire, and professional dynamics must be considered when assigning clients to a specific clinician's caseload.

Outside Noncounseling Referral
Some client issues are better suited for referral to service providers outside the counseling arena. For example, concerns associated with physical health, poverty, unemployment, environmental problems, legal-criminal problems, financial and debt issues, custody issues, and religious doctrine questions may be more effectively addressed by referral to health services, social services, legal services, financial counseling, child protection services, clergy, or other noncounseling services.

TREATMENT FORMATS There are a number of treatment formats that can be used when working with clients, and the clinician must decide which would be most efficacious for positive client outcomes. Often, the decision about treatment format is made concurrently with choosing the service provider. Common outpatient treatment formats include individual counseling or psychotherapy; structured workshops, support groups, specialized counseling groups, and group psychotherapy; and couples, marital, and family counseling. Crisis or emergency services, or other support services, also may be required for those involved in outpatient therapy. Other specialized counseling formats, such as career counseling, academic counseling, and so on, might be required for some clients, while psychological assessment, psychiatric intervention, and medication also are commonly needed by clients. When inpatient services are required for substance treatment or serious mental disorders, the following is often employed: individual, family, and group therapy; assessment; medication intervention; and milieu therapy (combining different approaches within the inpatient environment).

INTERVENTIONS The treatment plan specifies exactly what type of "work" will take place during the work stage of counseling relationship. Any interventions that are

used should be matched to the uniqueness of the client, the goals for change, and the theoretical orientation to be used, and they must take into account the effects of real-world constraints.

Matched to the Uniqueness of the Client
The chosen intervention must be appropriate for the client and his or her characteristics (Seligman, 2001). Thus, it should be well matched to the person's age, developmental level, intellectual capacity, and personality style. It should seem reasonable enough to the client to engage in and motivate him or her.

Matched to Goals
Whether the problem and eventual goals are based on presenting symptoms, symptom constellations, or inferred, underlying, etiological, and sustaining factors, the intervention ultimately chosen should be well matched to the stated goals. For example, stress management and relaxation training could be selected when the stated goal is to reduce specific symptoms of anxiety such as panic attacks, while cognitive therapy could be selected when the stated goal is to reduce the negative self-talk that is inferred to be causing a client's anxiety problems.

A Function of Theoretical Orientation
Intervention techniques should be based on the clinician's theoretical orientation in conjunction with the case conceptualization. Today, psychotherapists can come from an array of different theoretical approaches. For instance, some may adhere purely to one of the major theoretical orientations, such as client-centered, cognitive-behavioral, or psychodynamic; other clinicians integrate a preferred approach with important elements from various orientations; and some counselors use an eclectic, ad hoc mixture of techniques.

Treatment plans will give an estimate of the duration of the counseling relationship, and ultimately, this estimate will be based on the theoretical approach of the clinician and the intervention techniques chosen. Due to real-world constraints on the number of sessions available to clients, one's theoretical orientation can affect whether or not the clinician would be able to work with a particular client. For instance, a psychodynamic purist might insist on long-term counseling. Thus, this clinician would have a difficult time justifying seeing a client who is struggling with a substantial concern and who has only 15 sessions of payment from an insurance company and is unable to afford treatment by another means. On the other hand, a counselor using a behavioral approach might be able to work within a strict session limit.

Affected by Real-World Constraints
The intervention chosen must work within the real-world constraints of the counseling relationship. In general, when client motivation or ability to commit to counseling is low, or when therapeutic contacts will be very limited, more direct, active, symptom-management approaches often are selected. When client motivation and ability to commit to counseling are higher, and

BOX 10.2

Evidence-Based Treatment

How does the clinician decide which approach or combination of approaches to use? Today's clinicians look to several sources to guide their intervention planning. For counselors in training and new counselors, one important source of guidance is more experienced professionals—clinical supervisors, clinical faculty, and cotherapists or other well-trained staff. For more experienced counselors, their own previous clinical work experience—analyzing what has and has not worked well in the past with particular sorts of clients and particular sorts of concerns—provides further guidance.

In addition, today's clinicians look to the evidence: Effective counseling professionals want to know what clinical studies and other research suggest as the best courses of treatment for certain client situations and presenting concerns and which intervention approaches have been shown less effective or ineffective for certain client situations. This can be referred to as evidence-based intervention planning.

There are two types of evidential counseling research. The first type of research is used to show "absolute efficacy" (Wampold, 2001, p. 58), or the overall effectiveness of counseling and psychotherapy in general, compared with no treatment at all. As we discussed in Chapter 2, solid evidence collected over the past several decades has ended the absolute efficacy debate—research analysis tells us clearly that counseling and psychotherapy work (cf. Wampold, 2001). In fact, a review of all the evidence suggests that counseling is a "remarkably beneficial activity" (Wampold, 2001, p. 119) through which up to 80 percent of clients improve.

The second type of research is used to examine "relative efficacy" (Wampold, 2001, p. 72). Studies of relative efficacy compare different approaches—for example, psychoanalytic versus behavior treatment or cognitive therapy versus client-centered counseling—to help us understand which approaches are best for which client needs. There is a growing amount of research looking into the relative efficacy of psychotherapeutic approaches, and reports from new medical-model clinical trial studies (Henry, 1998; Wampold, 1997) and other types of studies to explain the changes derived from counseling methods (Hanna & Puhakka, 1991; Hanna & Ritchie, 1995) are published on an ongoing basis.

Therefore, counseling professionals must keep up with the research literature to be sure they are aware of the latest evidence when planning treatment.

when therapeutic contacts can be more extensive, symptom-management techniques, interventions to address inferred etiological and sustaining factors, or a combination can be used. Finally, as noted earlier, the clinician's theoretical orientation will influence the intervention used and can be a factor in deciding whether or not a specific clinician can work with a client.

BEHAVIORALLY STATED TREATMENT APPROACH When reading the treatment plan, it should be clear what will take place during the work stage of the counseling relationship, and this is accomplished by using a behavioral description of the intended intervention(s). For example, when treating a client's anger management problems using a cognitive-behavioral approach, some clearly stated interventions listed in the treatment plan might include (Peterson & Jongsma, 2003):

- During group and individual sessions, have group members and the clinician point out angry outbursts to client.
- Have client join an 8-week assertiveness-training class.

BOX 10.3
Summary of Step 2: Determining the Treatment

The clinician determines what the treatment will be, including who will be the service provider, what treatment formats will be employed, and what therapeutic approach and which interventions will be employed.

WHO WILL BE THE SERVICE PROVIDER?
- clinicians should consider the agency or counseling setting that is best suited to address the client's needs
- clinicians should refer to the mental health professional who is best equipped to address the client's needs, assigning clients to a specific clinician's caseload
- clinicians should consider whether the client's issues are better suited for referral to service providers outside the counseling arena

WHAT TREATMENT FORMATS WILL BE EMPLOYED?
- common outpatient treatment formats: individual and group counseling or psychotherapy; couples, marital, and family counseling
- emergency services or other supports for outpatients
- specialized formats such as career counseling and academic counseling
- psychological assessment, psychiatric intervention, and medication
- common inpatient treatment formats for substance abuse or mental disorders are individual, family, and group therapy; assessment; medication intervention; and milieu therapy

WHICH INTERVENTIONS WILL BE USED?
- matched to the client's unique personality, intellect, developmental level, age
- well matched to the problem and goals defined earlier in the treatment plan
- outgrowth of the clinician's theoretical and conceptual orientation
- workable within the real-world constraints of the counseling relationship

BEHAVIORALLY STATED TREATMENT APPROACH
- specific behavioral description of the intended interventions and approach

- Teach client, through role-playing, more effective ways of responding to irritants and self-defeating ways that client handles anger.
- Have client chart each angry outburst as well as its level of intensity. Then, have client lower the intensity and number of angry outbursts over 2 months. Chart will be examined weekly (see Boxes 10.2 and 10.3).

Step 3: Establishing How Change Will Be Measured

The completed treatment plan must specify how change will be measured and indicate the extent to which progress has been made toward realizing the stated goals. Of course, measuring change in the field of counseling and psychotherapy is a difficult task. However, keep in mind that the purpose of such measurement is not to conduct a controlled laboratory research study but to document as accurately as possible whether the client is experiencing some improvement.

Change can be assessed by a combination of subjective and objective measures (Jongsma & Peterson, 2003; Seligman, 2004). The most commonly used methods include client record and self-report, in-session observation, clinician rating and clinical estimate, and pre–post comparisons of client problem using such tools as

checklist ratings and psychological testing results. Some treatment plans include measures of end goals as well as designated milestones or short-term gains; other treatment plans measure only end goals.

Client Records and Self-Report

To state the obvious, clients themselves provide one source of subjective information about the success of treatment. The treatment plan should explicitly state when client records or self-reports will be used as one measure of change.

CLIENT RECORDS Client records are written accounts documenting change. They include such items as periodic client self-reflective notes, diaries, structured logs and checklists requiring specific information at regular intervals (e.g., asking clients to record thoughts, feelings, behaviors, and physiological reactions on an hourly or daily basis), or other written records kept by the client between sessions.

CLIENT SELF-REPORT Client self-report refers to the client's self-report during the session about functioning between sessions. The counselor may use open-ended interviewing or structured questions to solicit the client's feedback about how change is being accomplished. For instance, the clinician might solicit information regarding reductions in symptoms or distress level, improvements in functioning or adjustment, and utilization of new information and behaviors learned through the counseling work.

IN-SESSION OBSERVATION Client records and self-reports mainly provide information about between-session adjustment. The client's thoughts, feelings, behaviors, and physiological reactions during individual, group, couples, or family counseling provide the clinician with direct observations about client functioning and change.

Different theoretical models may emphasize different aspects of in-session client functioning. For example, cognitive and cognitive-behavioral approaches may emphasize the client's reduction in negative self-statements over the course of counseling or the expression of fewer irrational fears. Psychodynamic approaches may emphasize improvements in the client's relationship with the therapist. For example, does the client become less dependent on the counselor to lead the session as therapy progresses? Person-centered approaches may emphasize the client's affect and self-esteem. For example, does the client make fewer negative self-attributions as counseling moves along? Regardless of theoretical approach, counseling sessions provide an opportunity to collect observational and other information about client change in the direction of stated goals, and the treatment plan should explicitly state what client changes will be observed during sessions as a measure of change.

Clinician Rating and Clinical Estimate

Along with direct observations of in-session behavior, the clinician's rating of the client's progress is often used as one measurable estimate of change. We recommend using the Global Assessment of Functioning (GAF) Scale found in the *DSM-IV-TR* (American Psychiatric Association, 2000). The GAF Scale provides one global rating of

the client's overall functioning in important life roles and overall distress or psychoemotional well-being. An advantage of the GAF is that it is widely recognized by various mental health professionals and therefore is a powerful method of communicating the clinician's estimate of how the client is doing. Using the GAF, the clinician can provide a clinical estimate of the client's functioning at some set of regular intervals, such as at the first and last session, after each session, once monthly, and so on. You can revisit Chapter 8 for a review of the GAF.

Pre–Post Comparisons

Many treatment plans rely on comparative measures to support the client's records and reports and the clinician's in-session observations and clinical estimates. One subjective outcome measure is the comparison of the client's responses to a problem checklist, or problem rating worksheet, at intake and again near the end of or soon after the termination of counseling. Comparing psychological testing results at the beginning and end of therapy provides an objective method for confirming change. Psychological testing may be used to measure global changes in functioning (e.g., with the MMPI-II) or changes in specific areas of interest (e.g., the Beck Depression Inventory, Eating Disorder Inventory, a self-esteem inventory, or career decidedness measures).

It should be stated in the treatment plan if changes in client responses to problem checklists and ratings, or in psychological testing results, will be used as a measure of counseling outcomes. We also should note that client responses to problem checklists and psychological testing results can be obtained at the end of counseling even if these measures were not used at intake; however, post-only results provide less clear information about whether counseling has had an impact on reaching the goals for change.

Milestones or Short-Term Gains

Most clinicians will not want to wait until the end of the helping relationship to find out if counseling has been effective. Therefore, today, most counselors include in their treatment plans measures of change at several points along the way. These milestones or short-term gain measurements can use any of the assessment methods previously described. When intermediate change will be measured, the timetable for these measurements should be specified in the treatment plan. For example, client behavior will be assessed weekly, after three sessions, or after each month, and so forth (see Box 10.4).

Another Look at Our Case Examples

We began this chapter by defining treatment planning and then illustrating a general treatment plan for two case examples: Sienna and Janine (Case Illustrations 10.3 and 10.4). Now that we have explained in more detail the steps involved, let's take a second look at our two case examples. Notice in these follow-up illustrations that for each case: (a) the problem now is more clearly defined and goals are more clearly stated in behavioral, operational terms; (b) treatment is clearly explained; and (c) measures of change are provided in detail.

BOX 10.4

Summary of Step 3: Establishing How Change Will Be Measured

The clinician establishes how change will be measured, including how to know whether the goals are ultimately reached by the end of the counseling relationship and what intermediate milestones or short-term gains will be indicated along the way.

CLIENT RECORDS AND SELF-REPORT
- self-reflective notes
- diaries
- structured logs and checklists
- client report of progress to clinician
- other?

IN-SESSION OBSERVATION
- clinical observation of changes
- perceptions of types of changes may be a function of theoretical orientation

CLINICAL RATING AND CLINICIAN ESTIMATE
- GAF
- other?

PRE–POST COMPARISONS
- problem checklists and ratings
- psychological testing
- post-only measurements

MILESTONES OR SHORT-TERM GAINS
- keep tabs on gains made intermittently in addition to gains made at the end of treatment
- write the timetable in treatment plan

CASE ILLUSTRATION 10.3 Revisiting Sienna's Treatment Plan

The example below illustrates a comprehensive treatment plan comprising the three steps discussed in this chapter. Step 1 is selecting achievable goals for change. Step 2 is determining the treatment. Step 3 is establishing how change will be measured. As we recall from Case Illustrations 8.1, 9.1, and 9.3, the client, Sienna, initially sought counseling for the problem of persistent, moderate depression. As we saw in Case Illustration 10.1, the counselor began to build a general treatment plan with goals to alleviate depression and decrease relationship dependence, employing primarily a humanistic treatment approach integrated with cognitive behavioral methods, and measuring change by a variety of methods. In the following illustration, the treatment plan is fully developed.

TREATMENT PLAN
Client: Sienna
Service Provider: College Counseling Center: Assigned to Staff Counselor

BEHAVIORAL DEFINITION OF PROBLEMS
1. Depression: Depressed affect, feelings of worry, sleeplessness, loss of appetite, poor concentration, lack of energy

(*continued*)

(continued)

2. Dependence: Inability to become self-sufficient without relying on parents, feels easily hurt by criticism and is preoccupied with pleasing others (boyfriend, mother, roommate), inability to make decisions or initiate action without excessive reassurance from others

GOALS FOR CHANGE

1. Depression:
   - Develop ability to recognize, accept, and cope with feelings of depression
   - Develop healthy cognitive patterns and beliefs about self and the world that lead to alleviation of depression symptoms
   - Alleviate depressed mood and return to previous level of effective functioning
2. Dependence:
   - Develop confidence in self so that she is capable of meeting her own needs
   - Achieve a healthy balance between healthy independence and healthy dependence
   - Decrease dependence on relationships while beginning to meet her own needs, build confidence, and practice assertiveness

THERAPEUTIC INTERVENTIONS

Short-term counseling lasting less than or up to one academic semester, integrating person-centered intervention approach with cognitive-behavioral techniques.

1. Depression:
   - Explore how depression is experienced in client's daily life
   - Encourage discussion of depressed feelings and negative thoughts to clarify them and gain insight into causes
   - Explore experiences from client's family contributing to current depression
   - Assist in developing awareness of cognitive messages that sustain hopeless and helpless feelings
   - Assist client to develop coping strategies to reduce feelings of depression (e.g., more physical exercise, less internal focus, more social involvement, more assertiveness)
   - Refer for evaluation to rule out need for medication
2. Dependence:
   - Explore client's history of psychosocial dependence beginning with unmet needs in family of origin to current boyfriend and other relationships
   - Assist client to identify the basis for fear of disappointing others
   - Assist client to identify and implement ways of increasing independence daily, and process results (e.g., speaking her mind, saying no, being assertive)
   - Assign client to psychoeducational group with the focus on support and training in assertiveness and/or time management group to increase adjustment skills

(*continued*)

- Alleviate depressed mood and return to previous level of effective functioning

THERAPEUTIC INTERVENTIONS
Intermediate to longer term counseling estimated to last 12–20 sessions, using cognitive psychotherapeutic approach.
Depression:

- Explore how depression is experienced in client's day-to-day living
- Identify cognitive self-talk that is sustaining depressed mood
- Assist client to develop awareness of cognitive messages reinforcing feelings of hopelessness and helplessness
- Teach client to identify negative automatic thoughts associated with depression
- Keep a daily journal of experiences, thoughts, and feelings to clarify instances of distorted negative thinking or perceptions that precipitate depressive emotions
- Replace negative and self-defeating self-talk with verbalization of realistic and positive cognitive messages
- Monitor compliance with psychiatric referral

MEASURES
The development of healthy cognitive patterns and beliefs about self and the world, leading to the alleviation of depressive symptoms, will be measured by:

- Client weekly records of decreased negative self-statements, increased number of positive independence/assertiveness behaviors, and decreased depression symptoms each week
- Clinician observation of increased healthy self-statements and increased mood in sessions
- Improvement in Beck Depression Inventory (BDI) score from moderate depressed range at intake to minimal depressed mood range at termination
- Gradual increase in clinician rating of client function to GAF > 71 and rating of symptoms as no more than mild

Using Popular Characters to Explore Treatment Planning

A well-constructed treatment plan provides the road map for applying theory to practice during the work stage of the professional helping relationship. It does this by clearly articulating which problems will be addressed and what the goals for change will be, how treatment will proceed and what interventions will be used, and what methods will be used to measure progress toward the stated goals. As with diagnosis and case conceptualization, becoming skilled at treatment planning requires familiarity, experience, and practice. The following practice clients should give you an opportunity to begin to hone these skills.

Our Four Practice Clients

In the following section, we want to return to our four practice cases that were borrowed from popular culture (Schwitzer et al., 2005): Scarlett O'Hara, Maya Angelou's Maguerite Johnson, Hansel, and the Wicked Queen. In Chapter 9, we prepared case conceptualizations for each popular character client. In this chapter, each case demonstrates how to practice treatment planning using popular characters (Schwitzer, et al., 2005) (see Exercise 10.4).

EXERCISE 10.4 **Practicing Treatment Planning**

The characters in the following four treatment plans were introduced in Chapter 9 by four novice counselors when we were examining the case conceptualization process. For each case, if needed, first review the case conceptualization in the previous chapter. Then,

1. Develop your own treatment plan that includes a behavioral definition of the problem(s), goals for change, therapeutic interventions, and an indication of how change will be measured.
2. Meet in small groups and develop a team treatment plan.
3. Read the treatment plan given, critique it, and critique your team treatment plan and your individual treatment plans. Share your team plan in class.

SCARLETT O'HARA Drawn from the novel *Gone with the Wind* (Mitchell, 1964), Scarlett O'Hara came into the counseling center presenting stress in her marriage, grief over the death of a close friend, and feeling "out of step" with societal expectations. She reported various symptoms of stress and recurring nightmares (see Practice Client 9.1 for a review) (see Exercise 10.4).

PRACTICE CLIENT 10.1

Scarlett O'Hara

TREATMENT PLAN

Client: Scarlett O'Hara

Service Provider: Community Center for Women: Assigned to Staff Counselor

BEHAVIORAL DEFINITION OF PROBLEMS

1. Grief and Loss: Unresolved grief at death of only close friend and feelings of loss of love relationship with husband
2. Loss of Self-Confidence/Diminished Social Adjustment: Lack of satisfaction with past achievements in spite of successes, feelings misunderstood and unaccepted by peers, and lack of direction for the future

GOALS FOR CHANGE

1. Grief and Loss:
   - Begin healthy grieving process around loss of friend
   - Develop an awareness of how avoiding grief experience has negatively affected life

- Begin process of accepting and letting go of the lost friend
- Resolve loss and begin renewing old relationships and initiating new contacts with others
- Evaluate changes and perceived losses in marital relationship
- Commit to a decision to either (a) accept termination of the relationship or (b) develop the necessary skills for effective, open communication and mutually respectful and satisfying companionship within the relationship

2. Loss of Self-Confidence/Diminished Social Adjustment:
   - Increase understanding of the influence of oppressive, sexist society beliefs and practices
   - Learn to trust and act on her own experiences and intuition
   - Elevate self-esteem
   - Develop a consistent, positive self-image

THERAPEUTIC INTERVENTIONS:

Intermediate counseling with weekly sessions, lasting up to 6 months, using an existentialist-feminist approach.

1. Grief and Loss:
   - Identify the losses that have been experienced in life
   - Facilitate the identification and expression of feelings connected with the losses
   - Facilitate client understanding as to how she depended on the lost friend and intimacy of husband
   - Facilitate expression of feelings of abandonment and aloneness
   - Assist client in resolving feelings of abandonment and aloneness through expression of feelings and/or through client development of an action plan
   - Conduct a couples session to explore beginning to work on a decision to either (a) accept termination of the relationship or (b) develop the necessary skills for effective, open communication and mutually respectful and satisfying companionship within the relationship

2. Loss of Self-Confidence/Diminished Social Adjustment:
   - Explore the client's assessment of self
   - Challenge and reframe client's self-disparaging comments in social context
   - Educate the client about self in society and societal influences on women's roles, attitudes, behaviors, and experiences of self
   - Assign client to read *Women Who Run with the Wolves: Myths and Stories of the Wild Woman Archetype*
   - Discuss, emphasize, and interpret client's social experiences and how they have impacted her feelings about self
   - Assist the client to form more realistic, positive messages to self in interpreting life experiences, and reinforce these changes

MEASURES

The resolution of feelings of grief and loss, clarification regarding marital relationship, and development of increased healthy feelings of self-worth will be measured by:

- Client weekly records of increased ability to express and manage grief and loss feelings
- Clinician observation of client's increased ability to critically examine the society in which she lives

- Client report of lessened feelings of grief and alienation
- Client report of increased clarification regarding loss feelings in marriage
- Significant increase in score on the GAF Scale showing 10–15 points

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MARGUERITE JOHNSON The main character of Angelou's (1969) autobiographical novel, *I Know Why the Caged Bird Sings*, Marguerite Johnson came into the counseling center to address feelings about abandonment by her parents and childhood sexual abuse. She reported a variety of childhood and adolescent traumas, avoids strong negative emotions, and sometimes acts on feelings in a passive-aggressive manner (see Practice Client 9.2 for a review).

PRACTICE CLIENT 10.2

Maya Angelou's Marguerite Johnson

TREATMENT PLAN

Client: Marguerite Johnson

Service Provider: Midcity Psychotherapy Center: Assigned to Staff Psychotherapist

BEHAVIORAL DEFINITION OF PROBLEMS

Adult difficulties with childhood trauma, sexual abuse, and abandonment: avoids conflict and hurt, self-blame, denial, depressed mood, feelings of numbness, inability to form close relationships, social isolation

GOALS FOR CHANGE

Adult difficulties with childhood trauma, sexual abuse, and abandonment:

- Develop an awareness of how her childhood experiences impacted and continue to impact her life
- Identify and express wide range of painful and other feelings associated with the major traumatic incidents occurring in her childhood
- Identify and express wide range of painful and other feelings associated with her mother's role in her negative childhood experiences
- Develop ability to accurately experience thoughts and feelings
- Alleviate depressed mood
- Increase client's level of trust of others, displayed by increased social interactions and increased tolerance for intimacy in relationships with others

THERAPEUTIC INTERVENTIONS:

Long-term extended psychotherapy in weekly or twice weekly sessions. The client has not addressed her reactions to her negative childhood experiences consciously, and they are therefore being managed unconsciously (in a dysfunctional manner). The corresponding therapeutic need is to bring her unconscious experiences to consciousness. Therefore, a psychodynamic approach will be used.

Adult difficulties with childhood trauma, sexual abuse, and abandonment:

- Free association: uncover repressed material locked in unconsciousness by assisting client to report and discuss feelings and thoughts immediately after censoring them
- Interpretation: explain and teach meaning of behavior
- Analyzing resistance: point out and interpret instances of resistance in therapeutic relationship at a pace tolerable to client
- Dream analysis: interpret disguised meanings in nightmares and dreams related to childhood traumas
- Interpreting transference: point out and interpret instances in which client acts out current expressions of early feelings toward childhood perpetrators of harm in the therapeutic relationship at a pace tolerable to client

MEASURES

Healthy awareness of negative childhood experiences, accurate experience of current thoughts and feelings, increased trust level and capacity for social relationships and intimacy, and alleviation of depressed mood will be measured by:

- Clinician observation of increased experience and expression of wide range of thoughts and emotions about past experiences and regarding the present
- Client record and self-report of increasing instances of forming social relationships and intimate relationships
- Gradual increase in clinician rating of client function to GAF = about 80 and rating of symptoms as no more than mild

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HANSEL Hansel, who has a sister, Gretel, in the Grimm Brothers' fairy tale (Marshall, 1990), is a young boy brought into the counseling center by his father with symptoms of posttraumatic stress following a narrow escape from being cooked and eaten by an evil hag after being abandoned in a deep forest. The father reports that Hansel has been having recurring nightmares, avoids going into the woods to gather firewood, has difficulty concentrating on his usual games, and becomes quite agitated around gingerbread houses (see Practice Client 9.3 for a review).

Practice Client 10.3

Hansel

TREATMENT PLAN

Client: Hansel

Service Provider: Village Child Counselor: Private Practitioner

BEHAVIORAL DEFINITION OF PROBLEMS

Posttraumatic stress disorder: exposure to threatened death that resulted in an intense emotional response of fear, helplessness, and horror, with disturbing dreams associated with the traumatic event; physiological reactivity when exposed to external cues that symbolize the traumatic event; avoidance of places associated with the traumatic event; inability to recall some important aspects of the traumatic event; lack of participation in significant activities; and lack of concentration; all present for more than a month.

GOALS FOR CHANGE

Posttraumatic stress disorder:
- Reduce the negative impact the traumatic event has had on many aspects of client's life
- Recall the event without becoming overwhelmed with negative emotions
- Implement behaviors that promote healing, acceptance of past events, and ability to participate constructively in relationships with others

THERAPEUTIC INTERVENTIONS:

Eclectic child psychotherapy, including play therapy and psychodrama, three sessions weekly moving to once weekly for up to 6 months, with reevaluation at 6 months.

Posttraumatic stress disorder:
- Refer for psychiatric evaluation or psychological testing to assess presence and severity of PTSD symptoms
- Gently explore client's emotional reaction at time of trauma
- Use play therapy and psychodrama to explore client's emotions associated with traumatic event, facilitating gradual reduction in the intensity of the emotional responses
- Use art therapy to explore dream objects
- Teach imagery techniques appropriate to client's age to assist sleep transitions
- Teach developmentally appropriate cognitive and behavioral coping strategies to manage reactions
- Increase and reinforce positive beliefs about self
- Collaborate with school counseling to assist in treatment plan and assure follow-through

MEASURES

Reduced negative impact of the traumatic events on the client's life, increased ability to recall event without being overwhelmed, and increased resolution of reactions will be measured by:
- Clinician observation that the client begins to demonstrate trust in the therapeutic relationship demonstrated by sharing fears about abandonment and thoughts and feelings about trauma
- Pre–post comparison of presence and severity of PTSD symptoms assessed by psychiatric evaluation or psychological testing
- Clinician observation of increased healing and acceptance, fewer feelings of being overwhelmed, and increased interest in normal developmentally appropriate activities
- Observation and report from school counselor concerning decrease in PTSD symptoms and increase in developmentally appropriate behaviors
- Client's report and father's observations of improved sleep (sleep uninterrupted by nightmares associated with trauma), return to normal play and other activities, and observable reduction in psychoemotional distress associated with traumatic event

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WICKED QUEEN The Wicked Queen, portrayed in the Disney movie *Snow White and the Seven Dwarfs* (Grimm, 1972; Hollis & Sibley, 1987), was referred to the counseling center for treatment of auditory and visual hallucinations in which a magic mirror began speaking to her after her husband's death. She also experiences self-absorbed narcissistic thoughts and feelings. In addition, difficulties with antisocial behaviors may be present, such as poisoning Snow White and harming others (see Practice Client 9.4 for a review).

Practice Client 10.4

The Wicked Queen

TREATMENT PLAN

Client: Wicked Queen

Service Provider: Community Services: Assigned to Doc

BEHAVIORAL DEFINITION OF PROBLEMS

1. Hallucinations: Visual and auditory perceptual disturbances
2. Traumatic Early Childhood Experiences: History of abuse and abandonment
3. Antisocial Behaviors: Refusal to follow rules, poor impulse control, failure to conform with law, suspected of repeated antisocial and criminal acts
4. Low Self-Esteem: Lack of meaningful relationships, poor self-image
5. Narcissism: Paranoia and undue preoccupation regarding physical appearance, jealousy, grandiosity, lack of acceptance of responsibility for events and actions

GOALS FOR CHANGE

1. Hallucinations: Control or eliminate active psychotic symptoms such that supervised functioning is positive
2. Traumatic Early Childhood Experiences: Develop an awareness of how childhood issues have affected and continue to affect her family life
3. Antisocial Behaviors: Become more responsible for behavior and keep behavior within the acceptable limits of the rules of society
4. Low Self-Esteem: Develop a consistent, positive self-image
5. Narcissism: Improve method of relating to world by accepting responsibility for own actions

THERAPEUTIC INTERVENTIONS AND CORRESPONDING MEASURES OF CHANGE

Eclectic solution-focused and problem-solving interventions focusing on symptom reduction and alleviation, while attempting to minimize resistance to treatment. Interventions are grouped by symptoms, and in this case, outcome measures would be a reduction of the symptoms of hallucinations, antisocial behaviors, and narcissism and an increase in self-worth and trusting behaviors as noted via clinician's observations and client self-report. In addition, intermediate significant increases on the GAF Scale and after 1 year of treatment an overall increase from a GAF score of 30 to a score of at least 60.

1. Hallucinations:
   - Accept and understand that symptoms are due to mental illness as measured by verbal statements
   - Evaluate for antipsychotic medications and monitor for adherence to taking medication by report of client and castle servants
   - Focus on the reality of the external world versus distorted fantasy as reported by client for four consecutive sessions

2. Traumatic Early Childhood Experiences:
   - Verbally describe what it was like to grow up in such an environment
   - Identify at least five feelings associated with major traumatic events
   - Increase levels of trust for others as shown by more social interactions and greater intimacy tolerance by self-report
3. Antisocial Behaviors:
   - Verbally describe history of illegal and/or unethical behavior without attempts at minimization, denial, or projection of blame
   - Develop a list of behaviors and attitudes to be modified to decrease conflict with authorities and process list with therapist
   - Make a commitment to live within the rules of society and do so for a period of at least 6 months
4. Low Self-Esteem:
   - Acknowledge feeling less competent than others
   - Increase insight into at least three historic and current sources of low self-esteem
   - Demonstrate an increased ability to identify and express personal feelings based on the use of at least four feeling statements per session
   - Form realistic, attainable goals for self in all areas of life as measured by self-report when processing with therapist
5. Narcissism:
   - Develop a list of behaviors and attitudes that must be modified to decrease her conflict with others and process list with therapist
   - Increase number of statements of accepting responsibility by at least one per session for four sessions
   - Verbally recognize own responsibility to meet the needs of others in at least five relationships

Afterthoughts about Our Practice Cases and Additional Exercises

As we discovered in Chapter 9, practice cases using popular characters can introduce important clinical issues for consideration. Exercises 10.5 and 10.6 present additional questions to ponder regarding the cases discussed and offer suggestions regarding new cases for which you can develop treatment plans.

EXERCISE 10.5 **Afterthoughts about Our Practice Cases and Treatment Planning**

For each of the following questions, first consider your own responses to the issue presented and then discuss your responses in small groups or with the class.

1. Scarlett came to the Community Center for Women for help, and this is reflected in the treatment plan, built from a feminist perspective on the relational psychology of women theoretical approach. How did her choice of counseling center affect the treatment she will receive? How might this compare with the treatment for grief and loss and loss of self-confidence that she might receive in another setting that has a behavioral or cognitive-behavioral perspective that does not include a feminist perspective?

(*continued*)

EXERCISE 10.5 *(continued)*

2. Scarlett's counselor conceptualized her marital concerns as part of grief and loss issues. Do you agree with this conceptualization? How would you address Scarlett's concerns about losing her attachment with her husband in your own treatment plan?
3. According to her counselor's assessment, Angelou's Marguerite Johnson's adult difficulties with childhood trauma, sexual abuse, and abandonment are present in unconscious form because the client has not consciously addressed her negative childhood experiences. Therefore, the counselor has built a psychodynamic treatment plan that brings unconscious reactions to consciousness. How does this compare with a problem-solving or solution-focused approach with direct symptom relief as the goals for change?
4. Hansel's symptoms are diagnosed as posttraumatic stress, and his counselor's treatment plan calls for child psychotherapy using humanistic, play therapy, and psychodrama interventions. How would you go about building treatment plans that are appropriate for your own clients' age and developmental level? Consider how your treatment might differ for younger children, adolescents and young adults, middle-aged adults, and geriatric clients.
5. One outcome measure in the treatment plan built for Hansel is his father's observations of change. What issues do you think might come up when relying on parents or caregivers to report on client change?
6. In Practice Client 10.4, we saw that, using the inverted pyramid method, the counselor conceptualized the Wicked Queen's difficulties using a humanistic perspective. In the conceptualization, the counselor inferred that the Wicked Queen's hallucinations, history of abuse and abandonment, antisocial behaviors, low self-esteem, and narcissism were associated with deeper concerns related to fragile self-esteem, difficulty forming relationships, and underlying undeveloped self-worth. However, the treatment plan built for the Wicked Queen uses a solution-focused, problem-solving approach focusing on direct symptom reduction and alleviation, without resolving the inferred causes of these symptoms. One rationale for this approach is that the Wicked Queen, who was court-referred to counseling, is resistant about seeking assistance and is unlikely to fully engage in the helping process.

   What do you see as the benefits and drawbacks of approaches that directly focus on symptom reduction versus approaches intended to resolve the underlying causes of symptoms? How will you decide how to match your own treatment plans to the needs, interests, and motivations of different clients?
7. The counselor's treatment plan for working with the Wicked Queen suggest that the measures of change will be the clinician's observations of the client's decrease of maladaptive behaviors for each intervention noted. What do you see as the advantages or disadvantages of this treatment plan design? For which theoretical intervention approaches is it best suited—eclectic, integrative, solution-focused and problem-solving, behavioral, cognitive or cognitive-behavioral, humanistic or existential, psychodynamic, and so on?

EXERCISE 10.6 **Additional Treatment Planning Practice Using Popular Character Clients**

Practice using popular character clients will help you develop skill and confidence using clinical tools. Select one or more popular character clients from literature or fiction writing, biography, television, movies, or another media and do the following:

1. Write a brief introduction to the character that brings out the most important elements of the person's life.
2. Write a brief case summary that presents the character as a counseling client.
3. Formulate a start-to-finish inverted pyramid method case formulation.
4. Build a start-to-finish treatment plan, including behavioral definition of problems, goals for change, therapeutic interventions, and measure of change. In class, share your efforts, discuss your work, and obtain feedback.

LEARNING TO BUILD TREATMENT PLANS: An Ongoing Process

Treatment planning requires that you apply theory to practice and answers the question: "What will the client and *I do* to bring about desired changes?" The ability to think through and write a treatment plan is essential for today's professional counselors and psychotherapists. As with diagnosis and case conceptualization, developing competence using the clinical tool of treatment planning requires advanced coursework, practice, clinical experience, and ongoing supervision (Glidewell & Livert, 1992; Loganbill, Hardy, & Delworth, 1982). You can take several steps to help with your learning, including practicing with popular character clients, becoming familiar with the work of practicing clinicians, and exploring published treatment planners.

Practice Clients

As we have demonstrated in this and the previous chapter, you don't have to wait until you have your own extensive caseload to work on treatment planning skills. Instead, start by thinking through and writing treatment plans for some of your favorite practice clients drawn from your reading, television, movies, or other popular media. Continue to use the format illustrated in this chapter: behavioral definition of problems, goals for change, therapeutic interventions, and measures. Share your work with instructors, peers, and supervisors to learn from their feedback. Eventually, you will develop your own style for building treatment plans that is based on your theoretical approach in conjunction with the real-world issues that you will face in your clinical settings (e.g., session limits).

Clinical Exposure

In this chapter, we provided a format for a generic treatment plan that is more or less transferable to any mental health setting. However, different counseling specialties, individual agency settings, and third-party reviewers often have their own unique formats for writing treatment plans. Therefore, it is a great advantage to gain exposure to the treatment planning work of as many different clinicians and settings as possible. Look for opportunities to join case conferences, case staffings, and grand rounds wherever possible. Look for opportunities to sit in at training clinics, supervising agencies, and professional development programs. During your supervised field experiences, review case files; have discussions about treatment planning with your supervisors, mentors, and additional staff; and learn how various agencies and different clinicians go about treatment planning.

Dictionaries and Published Planners

There are a variety of books to help you learn the language needed to be a good communicator when operationalizing treatment plans. For instance, dictionaries of psychological, counseling, and psychiatric terms can be a valuable reference for terms and their meanings (e.g., see Gladding, 2001). Written treatment planners may be even better resources than counseling dictionaries. Written planners provide extensive suggestions for how to define the problem, what short-term and long-term goals to set, what interventions to use, and what behavioral outcomes to expect (e.g., see Jongsma & Peterson, 2003).

At this point, we recommend that you pause reading, turn to the DVD, and take another look at the section entitled:

Working Stage Interview.

While viewing this segment, pay particular attention to how a treatment plan is implemented.

Chapter Summary

This chapter introduced the clinical tool of treatment planning. First, we defined treatment planning and noted that it is action oriented and goal directed and helps us move from knowing what the client's concerns are to deciding what to do about them. In other words, we described treatment planning as a road map for reaching desired clinical outcomes. We highlighted the fact that treatment planning comprises three main elements: (a) selecting achievable goals, (b) determining treatment modes, and (c) documenting the attainment of goals. Next, we offered the cases of Sienna and Janine to examine how these three elements are addressed during treatment planning. We then expanded the description of treatment planning by offering a detailed description of a three-step treatment planning process based on the elements just noted.

When discussing Step 1, selecting achievable goals to be achieved, we noted that the clinician must first accurately select the problems to be addressed, determine the urgency and dysfunction of the problem(s) and make a judgment about which should be addressed first, use case conceptualization in determining appropriate goals, assess client motivation toward reaching various goals, be cognizant of real-world influences that might affect goal attainment, and use behaviorally measurable goals.

Step 2, determining the treatment, involves a number of elements. First, the clinician should determine who the service provider will be, including decisions about which setting or agency and which mental health professional or whether the client should be referred to a nonclinical service provider. The clinician should determine the treatment format, which could include such modalities as individual and group counseling or psychotherapy; couples, marital, and family counseling; emergency services or other supports for outpatients; specialized formats such as career counseling or academic counseling; psychological assessment, psychiatric intervention, and medication; or inpatient services. The clinician also should make a judgment about which interventions should be used as a function of such considerations as the client's unique personality, intellect, developmental level, and age; problems and goals as defined earlier; the clinician's theoretical and conceptual orientation; and real-world constraints affecting the helping relationship.

Finally, for Step 3, establishing how change will be measured, it was suggested that clinicians use a behaviorally stated treatment approach that involves specific

behavioral descriptions of the intended interventions and approach. In measuring client gains, it was suggested that clinicians should use client records and self-report, such as self-reflective notes, diaries, structured logs and checklists, client reports of progress to clinician, and so forth; in-session observation, such as clinical observation of change (keeping in mind that this can vary as a function of the clinician's theoretical orientation); clinical ratings and estimates, such as the GAF Scale; and pre–post comparisons, such as problem checklists and ratings and psychological testing. Finally, it was suggested that many clinicians might want to keep tabs on gains made intermittently in addition to gains made at the end of treatment.

As the chapter proceeded, we expanded on the two case illustrations of treatment planning introduced earlier in this chapter. We will explore these cases again in Chapter 11 when we look at case management. Near the end of the chapter, we returned to four practice cases that were drawn from popular media. We provided illustrations of treatment plans for Scarlett O'Hara, Maya Angelou's Marguerite Johnson, the fairy-tale character Hansel, and Snow White's Wicked Queen. We suggested ways that you could practice using these and other cases drawn from popular media.

We concluded the chapter by discussing how to continue the ongoing process of learning to build and write treatment plans. We suggested that you continue to practice with fictional cases to gain skill and confidence, gain as much exposure as possible to the formats used by experienced practitioners in different settings, and use professional dictionaries and published treatment planners to sharpen your treatment planning skills.