The Merrill Counseling Series

2ND EDITION

TREATING THOSE WITH MENTAL DISORDERS

A Comprehensive Approach to Case Conceptualization and Treatment

VICTORIA E. KRESS | MATTHEW J. PAYLO

Second Edition

Treating Those with Mental Disorders

A Comprehensive Approach to Case Conceptualization and Treatment

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This book is dedicated to my clients. Thank you for allowing me to witness your stories. It has been a privilege. ~VK

To Katie ~ MP

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PREFACE

When we were students in graduate school, we learned information that was foundational to counseling, such as various counseling theories and basic techniques for use with clients. With regard to clinical issues, we learned about the *DSM* system of diagnosis as well as treatments that could be used to address different disorders and problems in living. However, when faced with our first clients, we struggled to know how to proceed. As we first start out, most counselors-in-training feel flooded with information that they need to digest and figure out how to apply. As new counselors, we are challenged to apply years of acquired information to the conceptualization of the client, knowing this information will inform how we proceed in treatment planning, and in the implementation of treatment approaches and interventions. But how do you take years of formal education and apply all of that information to counseling someone and to helping that person to make the changes that he or she needs to live optimally? In writing this text, our aim was to develop a resource that would help counselors feel empowered to thoughtfully and deliberately assist their clients in tackling their complex issues and difficulties.

Throughout our careers, we have repeatedly heard that counselors value strength-based, contextually and culturally sensitive approaches to counseling, yet no one taught us how to integrate this way of thinking with the reality of clinical practice—a reality that requires counselors espouse, to some extent, to a medical-model approach and diagnose and "treat" mental disorders. Of fundamental importance to us in developing this text was our desire to create a treatment-planning model that incorporated a strength-based and contextually sensitive approach to counseling and treatment planning. What resulted was the formation of our conceptual framework model (i.e., I CAN START), which consists of essential case conceptualization components and addresses treatment planning from a strength-based, contextually sensitive perspective. This conceptual model is detailed in Chapter 1 and is utilized in conceptualizing each of the case studies presented throughout the text.

Our clients deserve to receive the most efficacious treatments available. As such, this text will provide readers with information on evidence-based treatment approaches that can be used in treating a variety of mental disorders. There is a paucity of research on treating some of the mental disorders described in this text. In these situations, we have made every attempt to provide the reader with the most comprehensive, rigorous assimilation of all of the current treatment literature, along with a summary of any emerging approaches that may warrant further consideration and research.

Multiple interventions are associated with the evidence-based approaches discussed in this text. There are also hundreds of different ways these interventions can be applied, illustrated, and woven into the fabric of counseling. We frequently hear our students and supervisees comment that they want to better understand what it "looks" like to apply various theories and/or treatments. To illustrate the varied means for applying treatment interventions, each chapter includes two creative applications of treatment interventions. These creative interventions are intended to illuminate treatment interventions and help readers understand the variety of vehicles that can be used in applying interventions (e.g., art, play, movement).

To support our effort to create a treatment planning textbook that is practical, Chapter 1 focuses on information that is foundational to real-world treatment planning practices. This chapter addresses the foundations of "good" treatment planning. Factors that influence counseling and treatment outcomes, and information related to the practical realities of treatment planning, are addressed. Additionally, the I CAN START case conceptualization and treatment planning model is presented in Chapter 1.

In Chapter 2, practical considerations that counselors must face when diagnosing and treating are provided. First, a discussion of third-party payers and how this relates to treatment planning is provided. Next, there is a discussion of cultural and ethical matters and how they relate to treatment planning.

Chapter 3 includes a discussion of select safety-related clinical issues that must be addressed as a part of effective treatment planning. An emphasis is placed on practical steps counselors can take to promote and support their clients' safety. The clinical issues selected are those that counselors encounter with the greatest frequency, as well as those that invite the most serious potential for risk to clients, counselors, and/or members of the community. These clinical issues include suicide, homicide, and interpersonal partner violence.

In Chapters 4 through 15, brief discussions of the mental disorders (as defined by the *DSM-5*) are presented, along with a discussion of counseling considerations and treatment approaches. Each of these chapters has a unified structure, with chapters beginning with a case and ending with a treatment application (to the case) using the I CAN START treatment model. Each chapter also begins with an overview of information related to the category of disorders and then funnels to more detailed information about the specific disorders, their associated counseling considerations, treatments, and prognoses.

New to This Edition

The following updates and additions have been made to this edition of the text:

- A new chapter on culture and ethics and treatment planning—Chapter 2—was added to the text
- Additional clinical toolbox features were added to each chapter.
- Each chapter now contains an additional practice case that students can use to practice applying the I CAN START treatment planning model.
- Additional information was provided on the "I"—Individual—aspect of the I CAN START model.
- Additional applications and examples were provided throughout the text.
- Treatment discussions were updated to reflect the most current research literature.

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Thank you to Dr. Renee Sherrell for providing helpful suggestions that served to develop the text.

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VK Acknowledgments

Writing a book necessarily requires sacrifice, not only from the authors but also from the people who surround them. My profound thanks go out to my husband, Rob, and my children, Ava and Isaac, who did without my presence for many days as I sat clicking away at my computer.

Matt, thank you for being such a wonderful co-author! There is no one else in the world with whom I would have rather journeyed. Kate, Hudson, Kennedy, Weston, Genevieve, and Blaise, thank you for your many sacrifices!

I also want to acknowledge those who have taught me the most about problems in living and how to overcome them, or what we necessarily had to refer to in this book as mental disorders and their treatment: my clients. When I became a counselor, personal transformation as a result of my work was not something I anticipated. My clients have taught me about the resilience inherent in the human spirit. Their ability to not only endure but to thrive even in the face of adversity, barriers, and injustices has forever changed me and how I see the world. No book can teach what they have taught me, but I hope that some of the strength-based perspectives and contextually sensitive practices I have developed because of what my clients have taught me translate in this text.

MP Acknowledgments

The process of completing a book is time consuming and filled with sacrifice, challenges, and intense deadlines. It is also full of highs and lows, and I would not have survived these if it were not for a number of people who would never allow me to quit or second-guess my abilities; to them, I am forever grateful.

I want to thank my co-author, Vicki. I appreciate you more than I can ever put into words. You have taught me so much about being a counselor, an educator, a writer, and a person. I am indebted to you for your supervision, patience, guidance, warmth, and mentorship. I would gladly take this journey again with you!

I want to thank my children, Hudson, Kennedy, Weston, Genevieve, and Blaise, for tolerating all those early mornings and late nights when I was less than available. You are my joy and inspiration!

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CHAPTER 1

Developing Effective Treatment Plans

CASE STUDY: TERIKA

Terika, a 16-year-old African American female, is brought into a treatment facility by her mother. She reports that she is a Baptist (Christian) and states that she lives in a section of town known for its high crime rate and poverty. She appears slightly disheveled and considerably overweight. Her clothing has noticeable stains, and her hair is unkempt. After some silence, she reports that she is here because she is "not doing so well" and it will "get her mother off her back" if she comes to counseling. Terika states she recently attempted suicide when she mixed her mother's antianxiety medication with a significant amount of alcohol; she did not tell anyone about this suicide attempt and woke up the next morning with a headache. She denied any additional suicide attempts. Additionally, she reports she sometimes uses drugs and alcohol with friends. Slowly, Terika begins to discuss her situation in more depth. She expresses feelings of sadness, rejection, worthlessness, and isolation. Suddenly, she is barely able to talk and breaks into tears. She rubs her eyes, and she then pulls her sweatshirt hood over her head and becomes unresponsive.

The counselor decides to meet with Terika's mother to garner more detail about Terika's history. She reports that Terika has been unable to care for herself for the last 6 months and has moved back into her mother's one-bedroom apartment. Prior to moving back into her mother's home, Terika was living in her aunt's home. Terika began living with her aunt secondary to an altercation with her mother over a past boyfriend. Her mother states that Terika has been discussing the option of dropping out of school and obtaining her GED. Her mother, who reports she did not graduate from high school, states that her daughter's grades are mostly Cs this academic year, but she used to get As and Bs. Terika's mother reports that Terika's father has never been involved in Terika's life. Her mother adds that more recently Terika has been eating more than normal and she seems to be up at all hours of the night.

Terika decides that she wants to continue talking. She reports that she has always been emotional, but more recently she is finding her emotions difficult to control. She states that she continues to go through what she calls "crying spells," and she recently stopped socializing with friends and has even started refusing to go to school. Terika indicates she struggles to "fit in" and she "has insecurities" around boys and romantic relationships. She also expresses concerns about her future and what she will do after high school.

Terika loves animals, and prior to the onset of these symptoms, she would volunteer at a local animal shelter where she walked dogs. Historically, she enjoyed spending time with her friends. The counselor also notes that prior to the onset of her symptoms, Terika was very curious and loved to learn. For example, Terika talked about how several years ago—with her saved-up allowance—she had purchased a set of encyclopedias from a local thrift store and would read voraciously.

When discussing the frequency, intensity, and duration of her symptoms, Terika suggests that the onset of these symptoms started about four months ago. She notes the symptoms have increased in severity over time. Terika also reports that she feels "weighted down" and sometimes finds it is impossible to get up from the couch. She states she has no idea why this happened, and she does not feel confident that talking with someone will help.

Terika's case is layered and complex. When reading a case like this, it is normal for neophyte counselors to wonder where to begin helping her move forward. However, this complex presentation is not unique to counselors working in the counseling field. Daily, counselors are required to quickly develop a thoughtful clinical picture of a client's situation (i.e., case conceptualization) that leads to the formulation of an accurate diagnosis. This ability to appropriately conceptualize a client's situation and provide a diagnosis is instrumental in developing an appropriate treatment plan. If a counselor has a poor understanding of the client's situation, applies an inaccurate diagnosis, or selects an inappropriate treatment approach, the client will suffer.

In order to engage in effective treatment planning, counselors must understand the evidence-based factors that influence treatment outcomes. In other words, counselors must understand the foundations of "good" treatment planning. In this chapter we review the essentials of good treatment planning and the factors that influence counseling and treatment outcomes. Next, practice principles that can be used in treatment planning are discussed. Later in the chapter, the I CAN START treatment planning model is presented. The I CAN START model is a comprehensive, strength-based treatment planning model that can be used by counselors in conceptualizing clients and focusing counseling.

THE FOUNDATIONS OF EFFECTIVE TREATMENT

Factors That Influence Counseling/Treatment Outcomes

In order to develop effective treatment plans, counselors need to be able to answer this question: Do counseling and psychosocial treatments (i.e., those that involve psychological and/or social factors as the focus of intervention) work, and if so, what makes them work? In this section we will explore these questions and discuss what we know about the foundations of effective treatment planning. More specifically, we will review the literature related to the factors that influence counseling outcomes, or counseling success. This presentation will culminate in suggestions that counselors can use in developing treatment plans.

If counselors are to understand how to develop "good" or effective treatment plans, they must be mindful of the factors that will impact counseling outcomes (i.e., the end result of counseling). A great deal of research has addressed the topic of factors that influence counseling and treatment outcomes. The factors that influence counseling outcomes can be conceptualized as being related to counselor variables and characteristics, client characteristics, and the relationship between the counselor and client within a treatment setting (i.e., treatment variables). These three clusters of variables influence counseling outcomes and therefore need to be monitored and considered throughout the counseling process. Monitoring these factors will provide clients with the most effective treatment and the best possible conditions to evoke change.

COUNSELOR VARIABLES Counselor variables are everything seen and unseen that a counselor brings to the counseling relationship and into counseling sessions. These include the counselor's demographics, experience, personality, and way of viewing the world (i.e., worldview). Counselor variables are often grouped by either what is seen (i.e., observable) or unseen (i.e., inferred) and what qualities (i.e., traits) or stances (i.e., states) the counselor possesses (Baldwin & Imel, 2013; Beutler et al., 2004). What follows are four commonly identified categories of counselor variables:

- *Observable traits* of the counselor (i.e., a counselor's age, sex, race/ethnicity)
- *Observable states* of the counselor (i.e., a counselor's professional discipline, training, professional experience, interpersonal style, directiveness, intervention style, and use of self-disclosure)
- *Inferred traits* of the counselor (i.e., a counselor's general personality, coping style, emotional well-being, values, beliefs, and cultural attitudes)
- *Inferred states* of the counselor (i.e., therapeutic relationship and theoretical orientation)

With regard to a counselor's observable traits, there appears to be little evidence that a counselor's age, sex, or race and ethnicity affect counseling outcomes. In exploring observable states, meta-analytic studies have also indicated no consistent treatment outcome differences among the counseling-related

disciplines (i.e., counselor, social worker, marriage and family therapist, psychologist, and psychiatrist) or, interestingly, with regard to training or professional experience (Baldwin & Imel, 2013; Beutler et al., 2004).

Inferred traits, such as counselor intervention style (i.e., insight oriented versus symptom oriented, emotive versus supportive), counselor directiveness, and counselor self-disclosure, do not equally benefit all clients in all situations (Baldwin & Imel, 2013; Beutler et al., 2004), thus highlighting the importance of tailoring treatments and interventions to a client's unique needs. Inferred states, such as the strength of the therapeutic alliance, are consistently linked with counseling outcomes. The therapeutic alliance is an area that counselors can significantly impact.

Counselor theoretical orientation is a much more difficult variable to measure. This may be due to the inherent differences in the ways various theoretical orientations approach, define, and measure change within their conceptual framework (Baldwin & Imel, 2013; Beutler et al., 2004) and because of the varied ways that counselors apply different theories.

CLIENT VARIABLES Client variables are everything that a client brings into the counseling relationship and into sessions (e.g., experiences, concerns, expectations, mental illness). A counselor must consider that clients are not just the passive recipients of treatment or interventions but are active, independent variables in the treatment process (Bohart & Wade, 2013). Clients come into treatment with their own lived experiences, strengths, difficulties, expectations, readiness for change, and relationship contexts.

Typically, what brings clients into treatment is some identified difficulty or concern; something is not going the way they want it to or they are unable to do something they hoped or wished to do. These concerns often range in severity and can be related to situations, relationships, or difficulties due to the direct or indirect effects of a mental health disorder. The severity of a mental disorder, impairment in level of functioning, and/or problem of a chronic nature all lead to a poorer prognosis and more negatively impact counseling outcomes (Clarkin & Levy, 2004). Clients with more severe issues often require more restrictive settings and more sustained treatment to reach clinically significant, sustained improvements. However, even those individuals who are under the greatest levels of distress can experience considerable change. Clients' initial distress can serve as a positive motivator and promote a desire to actively engage in counseling (Bohart & Wade, 2013).

Client expectations for change have been deemed influential to counseling outcomes; if clients expect change to occur, they have hope and are thus open to change. Frank (1961) contended that clients' confidence in the process and their counselor was critical for a positive counseling outcome. Counselors need to consider clients' expectations for the consequences of treatment (i.e., outcome expectations) and their expectations about the process, nature, and course of treatment (i.e., treatment expectations; Constantino, Glass, Arnkoff, Ametrano, & Smith, 2011).

A client's outcome expectations are linked to positive counseling outcomes (Constantino et al., 2011). Those who enter treatment with an optimistic and hopeful attitude about the eventual outcomes (e.g., consequences) are more likely to reach their intended goals than those with more negative outcome expectations.

A client's readiness or motivation to change is one of the most important client variables that impact counseling outcomes. For client change to occur, a client must be aware of a problem, open to the consideration of change, and willing to make the needed changes to alter his or her situation. It is not surprising that clients' readiness to change is essential in predicting counseling outcomes. The Stages of Change model (Norcross, Krebs, & Prochaska, 2011) consists of the following stages that can be utilized as an assessment tool as well as a mechanism to prepare clients for change:

- In the **precontemplation stage**, a client is not aware that a problem exists and typically has little motivation to change any aspect of his or her current situation. For example, a client who self-injures may say things like "I don't have a problem . . . my parents are the ones with the problem . . . it is no one's business if I want to self-injure." Many young clients enter counseling at the request of adults in their lives, and as such they are often at this precontemplation stage.

- In the **contemplation stage**, a client is able to acknowledge that a problem exists but is apprehensive about making changes. The client feels as though he or she is at a crossroads because both pros and cons of the behaviors are evident. For example, a client who self-injures may say "I really know I should stop self-injuring. I know it is really hurting my relationship with my parents, and I hate the scarring, but it makes me feel better."
- In the **preparation stage**, a client is getting ready to change. More ownership of personal responsibility is evident in his or her speech. For example, a client who self-injures might say "I've really got to do something about this self-injury . . . this is serious . . . something has to change. I am sick of these scars and the kids at school think I am nuts."
- In the **action stage**, a client begins to change his or her behaviors. The client believes that change is possible and acts on this belief. For example, a client who self-injures might say "I am ready to change. This self-injury is a problem. I am going to stop. When I want to self-injure, I am going to use my distraction skills, and if those don't work, I will use my relaxation skills or call a friend." The client then follows through on using these preventative skills and is better able to control and thus prevent the behavior.
- In the **maintenance stage**, a client continues to maintain productive behavioral changes. During this stage a client must avoid the temptation to slip back into the old habits and prior ways of being. A client in this stage needs to continually remind him- or herself how much change has occurred and how the change has been positive. Clients at this stage must learn and use new skills to avoid relapsing into prior behaviors. For example, a client who self-injures might say "I have made these changes, and I have the self-injury on the run, but I know I need to keep using what I learned in counseling or I might begin to self-injure again."
- The **termination (or relapse) stage** occurs when the client returns to older behaviors and abandons the new changes. In these situations, clients are encouraged to pick up where they left off. Ideally, if a client relapses into old behaviors, he or she will be back at the preparation or action stage again and not the precontemplation stage.

Counselors need to be aware of clients' level of motivation to change and must continually assess their readiness for change. Resistance to change may arise at any point in the counseling process. This is not necessarily good or bad—just a part of the ebb and flow process of change. Counselors do not necessarily need to directly address this resistance but can roll with the resistance, attempting to aid clients in understanding their ambivalence and eventually exploring both sides of the issue or behavior. Utilization of the therapeutic relationship in this way allows the client's ambivalence to be the focus of treatment until the client is able to choose to change. These are essential components of motivational interviewing and a motivational-enhancement approach (Miller & Rollnick, 2012). A counselor must consider ways he or she can gently help move clients forward in these stages of change, thus facilitating better counseling outcomes (see Table 1.1 for information about the Stages of Change model). When a client is motivated and ready to change, treatment processes move more quickly and better counseling outcomes are achieved. Most treatments of mental disorders are founded on the assumption that clients are motivated to want to change, thus all clients' motivation to make changes and engage in treatment should be assessed. For example, in order for a client to apply cognitive behavioral therapy to stop self-injuring, the client's motivation to want to change must be assessed first, as the client will most likely not follow through on using the skills learned in counseling if he or she does not wish to stop self-injuring.

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Table 1.1 Stages of Change and Associated Counseling Goals and Tasks

Stage of Change	Overview and Counseling Goal(s)	Counselor Tasks	Examples of Possible Questions
Precontemplation	**Overview:** People in this stage are unaware or unwilling to make changes to their behaviors. **Goal:** They will consider the possibility that they might have an issue, difficulty, and/or problem.	Assess overall health and well-being Establish rapport through empathy Address safety issues Enhance awareness of self, the problem, and patterns of behaviors Actively listen to concerns and reflect change talk Enhance awareness of the advantages of changing Highlight client doubts about problematic behaviors Provide education on the risks of behavior Assess strengths, skills, and any cultural issues	What about your (issue/problem/behavior) do you or others see as a reason for concern? In what ways has this been a problem for you? Why would you want to make this change? What makes you think you need to change? In what ways do you think you or others have been harmed by your (problem/behavior)? What difficulties have you had in relation to your (problem/behavior)? Any issues at school, with friends, or with your parents? What are some of the things you don't like about your (problem/behavior)? On a scale of 1 to 10, how much does your (problem/behavior) concern you (e.g., 1 [not at all] and 10 [extremely])? Does your (problem/behavior) ever get in your way? Has it ever stopped you from doing something you wanted to do?
Contemplation	**Overview:** People in this stage are becoming aware that an issue, difficulty, or problem exists, yet they have made no commitment to change or take action. **Goal:** They will increase their own awareness of their problem (e.g., impact, observation [frequency, duration, intensity]).	Emphasize free choice and responsibility (e.g., introduce the idea that they are capable of changing) Assess cultural issues Acknowledge strengths, skills, and values Validate lack of readiness Normalize the change process Encourage a discussion of pros/cons of behavior Elicit client's self-motivational statements Provide specific feedback (e.g., risk factors, educational information)	What makes you think you can change? Have you ever changed? What might work for you if you decided it was time to change? What do you think would happen if you decided not to change? Let's write these down. What are two reasons you shouldn't change? What are two reasons you should? Can you think of any more reasons (for or against)? I can see you're feeling stuck here. What needs to change so you can make a decision (i.e., change or not)?

(*Continued*)

Table 1.1 Stages of Change and Associated Counseling Goals and Tasks (*Continued*)

Stage of Change	Overview and Counseling Goal(s)	Counselor Tasks	Examples of Possible Questions
Preparation	**Overview:** People in this stage are intending to make a change or to take action but have only made small steps toward addressing their issue, difficulty, or problem. **Goal:** They will begin to make a commitment to change through small steps with a significant supportive encouragement.	Identify options and barriers to change Discuss previously utilized options and resources Assist in establishing realistic expectations Empower and aid a client to construct manageable goals or action Brainstorm small steps to help a client begin to make changes (e.g., develop treatment plan) Provide additional information and ideas on possible strategies Introduce coping strategies and skills Identify a network of social support	What is one thing you can do right now to make things better for yourself? Concerning this (problem/behavior), what have you tried before? How helpful was that? Did it work sometimes? Can you name some other (things/steps) you'll need to do to make this change? What are some of the things you do when you need to make a hard decision? Do you go through any steps? Name some people who listen and care about you. Who could help you as you prepare for this? Can you share any of these first steps with them?
Action	**Overview:** People in this stage are making changes and taking action in their behavior, experience, and/or environment to address their issue, difficulty, or problem. **Goal:** They will create and implement an action plan with the use of support and reinforcements (e.g., internal and external).	Develop an action plan with a timeline Keep steps incremental and achievable Practice and review coping strategies and skills Reinforce any efforts or any "small success" (e.g., verbal praise) Affirm strengths and skills Reiterate long-term benefits Enlist help (increase social support)	How will you make this change? Why are you making this change again? What are you going to do instead of the (problem/behavior)? What might work for you? I will write this down for you. If you were making a step-by-step list, what steps do you need to take to make this change? When will you try to do this (each step) by? Is this doable for you? How will you reward yourself for all your work? Who should we ask to be part of your plan (to help you out with this plan)? How will you keep this plan moving? What might make this hard? What can you do to keep momentum?
Maintenance	**Overview:** People in this stage are working to maintain their change/action and to prevent relapse. **Goal:** They will review counseling gains and plan for potential difficulties.	Review progress of goals, along with overall health and well-being Review coping strategies and skills Plan for follow-up support (e.g., referrals, recommendations) Reinforce internal rewards Continue to identify supports (e.g., friends, family, community) Discuss and plan for the future (e.g., reviewing warning signs of relapse)	Is there a chance you might go back to the (problem/behavior). If so, why? How can we plan so you'll be ready for that situation? What might get in your way in the future? How will you know if you need to come back to counseling? What would need to happen?

Source: Adapted from Norcross, Krebs, & Prochaska (2011).

One final client variable that requires counselors' consideration is clients' ability to form and maintain social relationships. Since counseling involves an interpersonal interaction between the counselor and the client, the client is required to possess some rudimentary ability to form, interact in, and maintain a social relationship. If clients have significant social impairments, especially a rigid or enmeshed personality, attachment issues, long-standing difficulties in relating to others, and/or deficits in interpreting social interactions, they will not only find the process of building a therapeutic alliance with a counselor to be difficult but may find it challenging to manage in-session behaviors, thus creating a significant impact on their ability to tolerate sessions, remain in session, complete treatment, and ultimately have positive counseling outcomes (Clarkin & Levy, 2004).

TREATMENT VARIABLES Not only do counselors and clients impact the counseling outcomes but so does the structure of treatment as well as the social interaction between the counselor and client within sessions. Counselors need to be mindful of these variables as they will affect counseling outcomes.

Treatment duration is an important treatment planning consideration. Lambert (2013) suggested that most clients will show improvements within seven counseling sessions. He also suggested that 75% of clients only show significant changes, under the strictest of rigor, after about 50 sessions, thus suggesting that more sessions can be beneficial (Lambert, 2013). The reality of clinical counseling practice is that clients are often afforded a limited number of sessions annually (e.g., 15–20 sessions). Additionally, most clients expect to be in counseling only until their presenting problems are resolved, with most expecting to attend approximately eight sessions (Lambert, 2013). Therefore, counselors must have a comprehensive, time-efficient model in place for the diagnosis, case conceptualization, and implementation of treatment approaches if they wish to maximize counseling outcomes.

Another treatment consideration is the social, working interaction between the counselor and the client. This therapeutic alliance (i.e., a counselor's ability to form and maintain a working relationship with the client) is one of the most influential factors in counseling outcomes (Lambert, 2013; Zuroff, Kelly, Leybman, Blatt, & Wampold, 2010). With over 50 years of consistent research, the therapeutic alliance continues to be highly correlated with counseling treatment outcomes across all theoretical treatment approaches (i.e., behavioral, psychodynamic, cognitive-behavioral, humanistic) and modalities (i.e., individual, group, couple, and family; Norcross et al., 2011). A therapeutic alliance is strengthened by an active, warm climate of collaboration, in which the counselor attempts to reach a mutually agreeable set of treatment goals, as well as a consensus on the goals and course of treatment (Bordin, 1979). This collaborative relationship often inspires trust and instills a sense of hope and optimism in the process and utility of treatment, thus creating better counseling outcomes. Related to this idea, highly successful counselors consistently ask clients for feedback on the direction, focus, approach, and interventions utilized in treatment, thus reinforcing the importance of the therapeutic alliance and collaboration throughout treatment (Norcross & Wampold, 2011).

All three of the aforementioned clusters of variables (i.e., counselor, client, and treatment) affect the efficiency and effectiveness of counseling outcomes and must be addressed in any effective treatment approach. These sets of variables should be consistently evaluated, monitored, and considered throughout the treatment process. The next section addresses this question: What is "good" treatment planning? Information on counselor, client, and treatment variables are considered in developing our formulation of "good" treatment planning.

What Is "Good" Treatment Planning?

The intention of mental health treatment is to maximize clients' adaptive functioning by developing and building upon their strengths and assets while concurrently addressing the problems and difficulties that clients bring to counseling. Accurate diagnosing and appropriate treatment planning for individuals with mental disorders promote health and client empowerment, prevent future problems from developing, and support productive living.

Without an accurate mental health diagnosis and a thorough understanding of each client's unique situation and circumstances, appropriate treatment approaches cannot be selected. Additionally, when

counselors neglect to use evidence-based approaches (i.e., the most up-to-date, relevant, research-based approaches and interventions) for treating mental disorders or other client-presenting issues, clients are not provided with the quality of care that they deserve.

The process of diagnosing, conceptualizing cases, and treatment planning is a time-limited endeavor. This process is time sensitive because of the limitations of third-party payers (i.e., funding issues) and because of the time expectations of clients (i.e., most clients prefer to attend counseling for a limited amount of time, usually until their presenting problems have been alleviated). In considering the rising costs of health care and the increasing restraints on treatment (i.e., approaches, number of sessions) by managed-care agencies, counselors are charged with adopting an effective and comprehensive approach to client treatment in a limited amount of time. With accountability becoming increasingly more relevant to counselor practice and treatment planning, counselors must adopt a process of "good" treatment planning. A comprehensive, atheoretical approach to treatment planning must incorporate evidence-based approaches and, at a minimum, should be composed of the following components (Jongsma, Peterson, & Bruce, 2006):

- Problem selection (i.e., a clearly stated treatment focus)
- Problem definition (i.e., a concrete, operationally defined problem)
- Goal development (i.e., the long-term positive outcomes or consequences of treatment)
- Objective construction (i.e., short-term, behavioral goals that are attainable and measurable, delineating when treatment is completed)
- Interventions (i.e., connecting at least one intervention with each goal)

These components, while not exhaustive, provide a general framework for treatment planning considerations. Counseling processes must be based on evidence-based research, which provides robustness to external scrutiny and third-party payer questioning. Therefore, "good" treatment planning requires, after an accurate diagnosis, an individualized, culturally and contextually sensitive, strength-based framework that implements evidence-based approaches and interventions with a specific mental health disorder. The following sections address aspects that are important to good treatment planning.

EVIDENCE BASED A critically important question that all counselors must ask is this: What is known about the overall effectiveness of counseling? Meta-analytic studies conducted over the past three decades (e.g., Lambert, 2013; Lipsey & Wilson, 1993; Smith, Glass, & Miller, 1980) have confirmed that what we do as counselors is effective and that counseling is significantly more beneficial for clients than nontreatment or placebo effect conditions. Not only is counseling more beneficial than nontreatment, but it often produces clinically meaningful changes for most individuals who suffer with mental disorders and clinical concerns or issues (Lambert, 2013). Therefore, counselors can safely assert the utility and effectiveness of counseling in aiding and alleviating the distress and discomfort of individuals with mental health disorders. This is great news for counselors: As a profession, we are providing a service that works with most people most of the time! Establishing this foundational cornerstone is critical if we are to move to the next pressing question: Which approaches within counseling treatment are most effective with which clients, with which mental disorders, and under what conditions? One of the paramount aims of this book is to provide counselors with the most up-to-date, evidence-based approaches and interventions for use with the mental disorders defined by the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychological Association [APA], 2013).

What does the term *evidence-based practice* (EBP) mean? Simplistically, EBPs are research-based treatments and interventions for use in treating various mental disorders and presenting problems. EPBs and interventions should reduce clients' symptoms, improve their level of functioning, and/or improve their ability to function well within their communities (e.g., create a reduction in their need for more restrictive services such as hospitals, residential treatment, or emergency visits). EPBs have been supported as effective by the gold standard for clinical health care research: randomized controlled trials (RCTs). RCTs are scientific experiments that are controlled (i.e., they have a control group or a nontreatment group that the treatment group is compared to) and are randomized (i.e., a participant has an equal or random chance of being assigned to any of the treatment groups or the control group). To conduct an RCT is a time-consuming and resource-intensive undertaking.

Another treatment-planning consideration is that many clients have co-occurring disorders (i.e., more than one mental health diagnosis), and as such, choosing an evidence-based approach can be difficult. Typically, to minimize the influence of extraneous variables, established evidence-based approaches have been tested on participants possessing one mental disorder. As such, it is known only that the treatment for the disorder worked for people who had just the one disorder. But would that same treatment work with people who have more than one disorder? And what treatment do you use if someone has more than one disorder? For example, when working with a client who has borderline personality disorder and a substance-use disorder, it may be difficult to know how and when to begin applying the most evidence-based treatments that apply to each disorder.

Additionally, there are "gaps" within the research literature. Gaps refer to a lack of evidence-based approaches and interventions for certain mental health disorders; some have received little research support and may have no known evidence-based treatments at this time. Because of a lack of RCTs as related to the treatment of some disorders, not all of the treatments or treatment research presented in this book are based on RCTs. In the cases where a given disorder lacks a solid treatment research base, the literature was consulted to find emerging treatments that appeared to provide the best, most informed treatment approaches, interventions, and counseling considerations.

INDIVIDUALIZED Knowing that a particular treatment is evidence based does not necessarily mean that it should be used with a given client. Additional factors should be considered before utilizing evidence-based approaches and interventions. Considering each client as a unique person who experiences distinct contextual factors will assist a counselor in determining the appropriateness of each treatment approach with each client.

In order for counselors to individualize treatment and be effective, it is important that they receive ongoing client feedback. Clients' voices should be amplified throughout the treatment process so as to increase positive counseling outcomes. Individualized treatment involves counselors listening to clients as they continually monitor and evaluate the course and directions of treatment (Bohart & Wade, 2013). Client feedback should be solicited throughout the diagnosis, conceptualization, treatment planning, and treatment implementation processes.

When individualizing treatment, counselors must construct individualized treatment plans that not only highlight clients' goals and objectives but also highlight their strengths, assets, and resources. Additionally, individualized treatment plans should identify strategies and methods that will be implemented to address clients' specific issues and concerns. Individualized treatment plans should also provide clients with a systematic timeline outlining when each goal and objective will be addressed and by which team member (i.e., counselor, psychiatrist, direct-care staff, case manager). By highlighting a client's individualized needs, strengths, and concerns, a counselor can enhance a client's sense of collaboration, reach consensus on therapeutic goals, and reduce the risk of a client's early departure from treatment (Bohart & Wade, 2013).

RELATIONAL When counselors and their clients have a strong relationship, it is manifested in an individualized treatment plan that is sensitive to clients' specific goals and objectives, and it takes into consideration clients' culture, sexual orientation, gender, spirituality, socioeconomic status, and developmental considerations (i.e., physical, psychological, sexual, cognitive, learning styles). A strong therapeutic relationship significantly contributes to treatment outcomes and should be part of any evidence-based approach (Norcross et al., 2011). Counselors must stay connected to the idea that they are serving complex, unique human beings and that they themselves are unique and complex (Sommers-Flanagan & Sommers-Flanagan, 2009). As such, the counseling relationship must be constantly monitored.

Research supports the idea that a strong relationship is required for treatment to be the most effective, and in fact it is one of the most important treatment factors that counselors can influence (Norcross & Lambert, 2011). A strong therapeutic relationship has an effect on clients' satisfaction with counseling services, their level of disclosure, their optimism in the process of counseling, and their sense of hope that their situation can change (Norcross et al., 2011).

A counselor's ability to convey relationship-building characteristics such as empathy, congruence, positive regard, and affirmation in the counseling relationship has long been associated with positive