

PREFACE

When we were graduate students, we learned the foundations of counseling, including theories and basic techniques for use with clients. We learned about clinical concepts, the *DSM* system of diagnosis, and treatments that could be used to address different disorders and problems in living. However, when faced with actual clients, we struggled to know how to proceed. Like many other counselors-in-training, we felt flooded with information that we needed to digest and determine how to apply. New counselors are challenged to apply years of acquired information to their conceptualization of clients, knowing that information will inform how they proceed in treatment planning, and in the implementation of treatment approaches and interventions. But how does one take years of formal education and apply that information to counseling clients and to helping them to make the changes they require to live optimally? In writing this text, our goal was to develop a resource that would help counselors feel empowered to thoughtfully and deliberately assist their clients in tackling their complex struggles 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 which requires that we 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 CAN START***, which consists of essential case conceptualization components and addresses treatment planning from a strength- and evidence-based, contextually sensitive perspective. This conceptual model is detailed in Chapter 2, 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 also provides readers with information on evidence-based 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.

There are multiple interventions that 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. The ***Creative Toolbox*** feature found in chapters 4–15 highlights the varied means of applying treatment interventions. These interventions, which include art, play, and movement, are intended to illuminate the treatment concepts, and help readers understand the variety of vehicles that can be used to apply interventions.

To support our goal of creating a practical treatment planning text, Chapter 1 focuses on foundational real-world treatment planning practices, factors that influence counseling and treatment outcomes, and the practical realities of treatment planning.

Chapter 2 presents principles that counselors can use to guide the treatment development process. The ***I CAN START*** case conceptualization and treatment planning model is also presented in chapter 2.

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

Chapters 4 through 15 provide a brief discussion of mental disorders (as defined by the *DSM-5*), and counseling considerations and treatment approaches which apply to each disorder. Each chapter has a unified structure and begins with a case study and an overview of information related to the category of disorders discussed in the chapter. Next, more detailed information about the specific disorders, and their associated counseling considerations, treatments, and prognoses is provided. Finally, each chapter concludes with a case treatment application using the ***I CAN START*** treatment model.

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Victoria E. Kress

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Matthew J. Paylo

The Foundations of Treatment Planning: A Primer

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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. The first half of the chapter addresses the factors that influence counseling and treatment outcomes. The second half of the chapter focuses on information related to the practical realities of treatment planning, or the common real-world demands placed on counselors. The information provided in this chapter serves as the foundation for the I CAN START treatment model, which will be presented in Chapter 2.

THE FOUNDATIONS OF EFFECTIVE TREATMENT

In order to develop effective treatment plans counselors need to be able to answer the 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.

Factors That Influence Counseling/Treatment Outcomes

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 the 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 considerably impact (this topic will be more fully covered later in this chapter).

Counselor theoretical orientation is a much more difficult variable to measure. This may be due to the inherent differences in the ways differing 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 actually 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 an active, independent variable in the treatment process (Bohart & Wade, 2013).

Counselors 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 situation-related, relationship-oriented, and/or highlight a difficulty 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 a 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 in 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 five stages of change that can be utilized as an assessment tool as well as a mechanism to prepare clients for change. These stages are briefly described here:

- *Precontemplation* (i.e., a client may have a lack of awareness that a problem or difficulty is even present and has no intention of changing).
- *Contemplation* (i.e., a client is becoming more aware that a problem exists, may verbalize it and even desire change, but has made no plans to change or act).
- *Preparation* (i.e., a client has moved from a place of increased awareness to the planning of small incremental changes; intention to change is present, but the individual has not begun this process).
- *Action* (i.e., a client is implementing the action plan by modifying his or her behaviors; this is the most active and challenging part of the change process for clients).
- *Maintenance* (i.e., a client continues to maintain his or her stabilization and prepares to thwart relapse opportunities)

Counselors need to be aware of clients' level of motivation to change and 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, a motivational-enhancement approach (Miller & Rollnick, 2012). (See Chapter 8 for a discussion of utilizing motivational interviewing with substance use disorders as well as a case demonstration.) 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 needs to 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.



Voices from the Trenches 1.1: In the Pearson etext, click here to watch a video of a counselor providing practice suggestions for using motivational interviewing.

TABLE 1.1 Stages of Change (Based on Norcross et al., 2011)

Stages of Change	Activities for Counselor to Promote	Considerations
<i>Precontemplation</i>	Consciousness raising	Increasing awareness of the advantages of changing Increasing awareness of self, disorder/difficulty, and patterns of behaviors Dealing with dramatic relief (i.e., the sadness of giving up the behavior/pattern)
<i>Contemplation</i>	Client evaluation of present and future	Questioning self-perception and what client may want to become in the future Envisioning a healthier, happier future/self
<i>Preparation</i>	Client empowerment	Increasing client's sense that he or she possesses the power to actually make the needed change Providing choices in treatment to aid in client's sense of ownership
<i>Action</i>	Reinforcement of steps towards change	Environmental evaluation: Moving the focus from external reinforcers to internal ones Counterconditioning (i.e., replacing less healthy behaviors with healthier ones)
<i>Maintenance</i>	Relapse prevention	Preparing ahead for situations that may induce relapse

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. Though he also suggested that 75% of clients only show significant changes, under the strictest of rigor, after around 50 sessions thus suggesting that more sessions can be beneficial (Lambert, 2013). The reality of clinical counseling practice is that clients are often only 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 only 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 the 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 promotes health and client empowerment, prevents future problems from developing, and supports 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 (see Chapter 2 for a more detailed discussion of these issues), 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 need to 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 evidenced-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: 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; 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 is: 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 text is to provide counselors with the most up-to-date, evidenced-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., meaning they have a control group or a nontreatment group that the treatment group is compared to), and are randomized (i.e., meaning that 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 exist what are referred to as “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 text 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 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 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 evidenced-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 for treatment to be the most effective, a strong relationship is required, 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 counseling outcomes (Norcross et al., 2011). Clients need to feel they are understood by their counselors and that their counselors feels genuine compassion for them and their situation. Additionally, clients need to perceive counselors as being congruent (i.e., real, authentic) and perceive that they present an accurate sense of self, which is displayed by the counselor's thoughts, behaviors, and emotions. In this affirming stance, the counselor is open, honest, and genuine with the client. Assuming a

nonjudgmental stance, viewing clients in a positive light, and attempting to appreciate them without conditions of worth, creates a sense of equality in an otherwise unequal relationship in which the counselor possesses a great deal of power. Empathy, congruence, and positive regard create a climate of collaboration and cooperation in the counseling relationship, thus increasing the probability of goal consensus (i.e., agreement on the direction of change) and change (Bohart & Wade, 2013). If they are congruently counseling clients, counselors should be able to move beyond a pathology-saturated view of their clients and connect with clients' innate strengths and capacities.

STRENGTH-BASED A lens, in the context of treatment planning, is a way of conceptualizing the client, the client's situation, and the client's treatment plan. A strength-based lens is a paradigm shift from the prescriptive, medical model approach typically taken when treating mental disorders. A traditional medical model approach involves counselors "treating" clients or otherwise doing something to clients to help them change. A traditional medical model approach to treating clients typically assumes an underlying neurological or biochemical cause for client problems and is rooted in a deficit-based narrative or problem conceptualization. It is therefore assumed that mental disorders occur apart from what is happening in the family or in the client's broader social contexts.

A strength-based lens is grounded in the assumption that the development and amplification of strengths and assets within and around the individual provides clients with a greater sense of resiliency against mental illness and future difficulties (Smith, 2006). When counselors work from a strength-based perspective, they actively engage in the process of enhancing, developing, and highlighting clients' resources, strengths, times of resiliency, and their ability to cope and persevere, thus enhancing clients' sense of esteem by increasing their sense of self-determination, mastery of life, and internal fortitude.



Clinical Toolbox 1.1: In the Pearson etext, click here to review questions that counselors can consider in assessing their value of a strength-based counseling approach.

A strength-based approach is firmly situated in the assumption that counselors should not only explore disease and weakness, but that they should invest equal time and energy in exploring a client's assets and strengths, providing a more holistic and balanced approach to treating each individual. Working from this type of clinical perspective, counselors can instill hope through the building of personal competencies, and they can enhance growth through building upon strengths, all while concurrently addressing aspects of the individual that may be perceived as being deficits of well-being (Smith, 2006). The use of a strength-based lens does not preclude the utilization of evidenced-based approaches; they can be applied concurrently.

A strength-based approach also holds to the idea that in building clients' strengths, counselors provide clients with the resources they need to prevent the development of additional problems, at present and in the future. In this way, a strength-based approach is preventive in that it develops and identifies strengths and can be used not only to address current struggles, but to help insulate clients from developing additional problems. To be more concrete, counselors can work from a strength-based perspective by identifying the unique strengths that an individual has and amplifying those strengths.



Clinical Toolbox 1.2: In the Pearson etext, click here to read about an activity that helps clients connect with gratitude and integrate it into their lives.

Counselors might further focus on any activities or engagements that enhance positive subjective experiences and positive individual traits. Counselors can intervene early with prevention programs that teach cognitive and coping skills in order to decrease the risk of depression, anxiety, and violence. They may also honor and promote such client virtues and character strengths as responsibility, gratitude, nurturance, altruism, civility, moderation, tolerance, and work ethic (Seligman, 2012).

Resilience, or the ability to resist against difficulties, is another essential consideration when working from a strength-based approach. Counselors can attempt to foster resiliency in their clients by enhancing their individual competencies within the following areas (Benard, 2004): (a) social competence, (b) problem solving, (c) autonomy, and (d) sense of purpose. Counselors should not just highlight these strengths, but should also seek to amplify these strengths throughout the counseling process, in an attempt to build a client's resilience against illness and future difficulties.

While a strength-based lens is a part of the orientation and philosophy of some helping professionals (e.g., professional counselors, social workers), there is a paucity of literature describing how clients' strengths can be identified and used in counseling and more specifically, in treatment planning. In fact, we could only find one article in the peer-reviewed literature (written by this text's first author) that explicitly addressed the topic (i.e., White, 2002).

In this text, a strength-based lens is integrated into our treatment planning model, and we challenge all counselors to connect with clients' strengths and use these to help them overcome their struggles. The treatment plans presented in this text incorporate clients' strengths, capacities, and resources. To aid counselors in their identification of client strengths, the following resource material is provided in this chapter's appendices: Appendix 1.1 provides a description of categories of client strengths, capacities, and resources that can be used as a tool in identifying client strengths; Appendix 1.2 provides examples of specific character strengths, capacities, and resources that can be identified and integrated into a client's treatment plan; and Appendix 1.3 provides detailed interview questions that can be used to assess clients' strengths, capacities, and resources.

CULTURALLY AND CONTEXTUALLY SENSITIVE Professional counselors have an identity that is unique. In the last section, we discussed the value of a strength- and competency-based perspective. Another important aspect of counselors' professional identity is sensitivity to contextual and cultural considerations. A focus on sensitivity to context ties into the importance of individualized treatment, and it relates to what we know from treatment outcomes research: Clients need to be understood in the context of their unique situation if counseling is to be effective.

Context refers to the interrelated conditions in which clients' experiences and behaviors occur, or any factors that surround their experience and throw light on their situation. As previously stated, many traditional understandings of mental disorders focus on a pathology-, deficit-based perspective of mental disorders. In considering clients' situations from a contextual perspective, culture, gender, and various developmental factors are just a few of the important factors that should be considered.

Culture, and as a part of this gender, are exceptionally important contextual considerations; culture defines, expresses, and interprets the beliefs, values, customs, and gender-role expectations of a social group (Bhugra & Kalra, 2010). Multicultural considerations can have a significant impact on counselors' diagnostic decision making and the treatment process. The American Counseling Association's (ACA) *Code of Ethics* (in press) emphasizes that culture influences the way that clients' problems are understood, and this must be considered throughout the counseling and treatment process. Related to this, the ACA's *Code of Ethics* (in press) also indicates that counselors should recognize social prejudices that lead to client misdiagnosis and the overpathologizing of clients from certain populations. Counselors are also encouraged to consider the role that we can play in perpetuating these prejudices through our diagnostic and treatment methods (ACA, in press).

Professional counselors place a premium on understanding culture and its impacts on clients and on our means of helping clients reach their goals. It is impossible to understand clients' unique situations and how to best help them if cultural considerations are not considered. An understanding of clients' culture in relation to treatment planning includes understanding cultural explanations of illness experiences and help-seeking behavior, the cultural framework of clients' identity, cultural meanings of healthy functioning, and cultural aspects that relate to the counselor–client relationship (Eriksen & Kress, 2005).

Wide variations exist among people from different cultures in their perspectives about “normal” behavior. For example, clients often present to counseling with relationship problems, and how interpersonal relationships should be navigated is largely based on cultural norms and expectations. Culture may influence what symptoms are permitted as expressions of suffering, and how individuals are allowed or encouraged to manage distress. Culture also determines how one's friends, family, and community respond to distress or problematic behaviors; in particular, deciding the type and severity of the problem that must be evident before intervention is deemed necessary. Culture determines acceptable help-seeking behaviors and interventions, and who may—and may not—intervene. Appendix 1.4 provides detailed interview questions that can be used to assess clients' cultural context.

Socioeconomic status and social position also influence how people manifest and respond to mental health problems both within and across cultures. Counselors must consider not only the interaction of culture, race, ethnicity, and gender when considering the development, maintenance, and treatment of problems, but also the influence of socioeconomic status on problems of language and communication barriers, minority status, experiences of prejudice, and social and economic disadvantages (Kress, Eriksen, Dixon-Rayle, & Ford, 2005).

Gender-sensitive and culturally sensitive counselors are also aware that those with less power in society experience a greater quantity of life's difficulties and are more likely to be vulnerable to mental health struggles than are those from the dominant race, ethnicity, age, sexual orientation, or gender. They also realize that those from nondominant cultural groups garner fewer of society's resources, and thus, often acquire treatment later in their problem cycles; because those with less power are less likely to seek help, they may come to the attention of mental health providers only when the problems have reached a greater intensity.

Overall, culture and gender influence clients in multiple ways, including their experiences of problems, their internal sense of distress, their interpretations of problems after experiencing symptoms, and their presentation of complaints (Eriksen & Kress, 2008). Culture and gender also impact counselors' perceptions of mental disorders, their style of interviewing, and their choice of theoretical perspectives and treatment approaches.

Development is another important aspect of client context. Counselors value a developmental perspective which holds that many people's problems in living are rooted in disruptions to normal developmental processes, the unblocking of which can foster healthy transitions; or in normal developmental transitions that they are presently traversing. For example, a first-generation college student who has just left home to move across the country to attend college may struggle with feelings of sadness and loss secondary to this transition. Considering this situation from a developmental perspective, loss and sadness would be considered a normal reaction, the resolution of which will provide an opportunity for this person to become better connected with his or her sense of resiliency.

A developmental focus depicts people as dynamic, rather than static organisms and highlights people's natural inclinations toward growth and health. Developmental perspectives offer hope because client problems or positions are not permanent; instead people are constantly changing and growing. Inherent in a developmental perspective is the understanding that people have the capacity to move forward, to change, to adapt, to heal, and to attain optimal mental health.

For counselors, fully actualizing relevant knowledge, skills, and awareness with regard to cultural, gender, and developmental issues can be challenging. Contextually sensitive diagnosis, case conceptualization, and treatment in particular, are easier to talk about than to actually do. The case conceptualization model presented in this text will be presented in Chapter 2, and as part of this model, counselors are encouraged to think about the contextual considerations discussed in this section.

Not everyone who pursues counseling has a mental disorder. In fact, some people seek counseling to help enhance their personal development and to live more optimally. However, many who seek counseling services experience challenges within varied developmental and contextual areas. These contextual areas need to be considered in the diagnostic and treatment planning process. In the *DSM-5*, "other conditions that may be a focus of clinical attention" or V-codes (Z-codes in the ICD-10; APA, 2013, p. 715) are suggested as additional issues that may be "encountered in routine clinical practice" (p. 715). These issues consist of difficulties stemming from interpersonal issues (i.e., parent-child, sibling, partner distress), issues with abuse and neglect (e.g., partner abuse, child abuse, maltreatment), issues with education or occupational difficulties, problems with housing and finances, difficulties within their social environment (e.g., phase of life, acculturation, target of discrimination), legal issues, and other personal circumstances (e.g., nonadherence to treatment, obesity, borderline intellectual functioning). While these areas can be the direct focus of clinical attention, they often exacerbate and complicate the diagnosis, prognosis, and treatment of other mental health disorders. Because of space constraints, the treatment of these conditions will not be addressed in this text. However, they should always be considered as important and relevant to the treatment planning and treatment process.



Clinical Toolbox 1.3: In the Pearson eText, click here to read about contextual and developmental considerations that relate to mental health functioning and treatment.

When developing treatment plans, there are also a number of practical considerations that must be addressed. In a perfect world, counselors would have no external demands placed on them, and clients would have open access to any care they required;

sadly, this is not the case. The next section reviews the practical realities that must be considered when engaging in treatment planning.

THE PRACTICAL REALITIES OF TREATMENT PLANNING: WORKING WITH AND WITHIN SYSTEMS

Chapter 2 of this text presents a treatment planning model for use in addressing clients' mental disorders and problems in living. This presentation, just like other authors' presentations of treatment planning, gives the illusion that treatment planning is a linear process. However, in real-world practice, the development of treatment plans, or what is commonly referred to in counselor practice environments as individualized service plans or ISPs, is quite complex.

Just as clients and their needs are diverse and layered, so are the systems in which counselors practice. The demands of these systems are riddled with regulations and evolving practice expectations. As such, when developing treatment plans with clients a variety of practical issues need to be considered. These practical issues can complicate the treatment process and require counselors to be adaptable and fluid in their case conceptualization and treatment planning processes.

In order for counselors to be effective at treatment planning, they must be aware of the expectations and restrictions of the systems they work not only in, but with. Counselors must learn how to navigate and function within these systems. Not only do counselors need to adapt clients' treatment plans as new needs emerge, they also need to be adaptable and responsive to the constantly changing systems in which they practice.

This section of the chapter addresses the practical realities of treatment planning. This discussion is intended to help counselors develop a greater understanding of the foundational considerations that dictate treatment planning in real-world settings. We spotlight the gray areas that often emerge when creating and implementing treatment plans, and we explore issues associated with various treatment constraints. These include managed care restraints related to issues such as reimbursement policies and their relationship to diagnosis and treatment, and limitations of the settings in which counselors practice.

MANAGED CARE SYSTEMS

Many of the treatment planning restraints discussed in this section are rooted in, or are in response to, managed care initiatives. As such, it is important that readers have a basic understanding of the historical context of managed care, as this informs the present-day context in which most clinical counselors practice.

Over the last two to three decades, significant changes in mental health service reimbursement and administration have had a profound impact on the way counselors practice. The dominance of managed care companies in behavioral health care management and reimbursement has had perhaps the greatest impact on counselors' practice. Since nearly all providers who accept third-party payers operate from a managed care foundation, managed care principles have become the norm in mental health treatment. Counselors' work in private practice settings, residential treatment, crisis stabilization, hospitals, community mental health centers, and increasingly, even college counseling centers, is rooted in managed care principles.

Managed behavioral health care developed in response to the rising costs associated with rapid growth in the utilization of mental health and substance abuse services in the 1970s and 1980s. The impact of managed care systems was further reinforced when mental health parity was granted under the Mental Health Parity Act of 1996 (Moniz & Gorin, 2009). Under this act, the long-held practice of insurance providers providing less insurance coverage for mental disorders than for physical health-related disorders ceased.

More recently, the Patient Protection and Affordable Care Act (ACA) was signed into law (on March 23, 2010; many of the important aspects of the ACA go into effect in 2014) to create a health care system that provides coverage for all Americans. The ACA was designed to expand access to health insurance coverage to all Americans, establish consistent rules and consumer protections for the private health insurance system, and reduce the rate of growth of health care spending. As such, moving into the future, the ACA ensures that a managed care approach to health and behavioral health care is here to stay and foundational to behavioral health treatment in America. Now, more than ever, counselors need to understand how to develop treatment plans based on managed care principles and how to work within managed care systems.

What exactly is managed care? Managed care is an approach to delivering and financing health care that seeks to control costs and ensure the quality and consistency of care provided to clients. To achieve this end, managed care systems use a variety of methods including provider network management, utilization management, and quality assurance. Provider network management is used to determine whether the provider meets the standards set forth by the managed care company and includes standards related to credentialing and practice standards or benchmarks. Utilization management involves monitoring the use of covered services, including how often each service is utilized and whether it is medically necessary. If it is medically necessary, a review is completed at specified intervals to determine the ongoing need for the service. Quality assurance is the process of collecting data related to what and how services are utilized and the performance or effectiveness of services. This includes the use of outcome measures (e.g., progress made in treatment) and client satisfaction surveys.

When a managed care system or organization is established in an area or a network, a predictable series of events typically unfolds (Goodman, Brown, & Deitz, 1996). Service providers often consolidate with other community providers and agree to eliminate overlapping services. Managed care organizations also typically enter into contractual agreements with individual practitioners or agencies who have agreed to offer a specified fee-for-service package. The managed care organization will also try to cut their costs by working with providers to reduce clients' stays in hospitals, increase the utilization of outpatient treatment, and encourage partnering with practice groups, agencies, and hospitals to achieve reduced health care costs. The managed care organization receives bids on contracts from provider agencies (e.g., a bid to provide inpatient acute/crisis psychiatric stabilization to clients as needed). The managed care company typically elects to work with the agencies that provide the most cost-effective services and comply with and support their cost-saving measures.

As previously indicated, the relationships between managed care organizations and service providers are dynamic. Their practices change based on consumers' needs, the needs of payers, governmental bodies, national and regional laws (e.g., the Affordable Care Act and the Mental Health Parity Act), accrediting bodies, other managed care organizations, other service providers, and professional associations' expectations for care.

The Mental Health Parity Act and managed behavioral health care has provided opportunities for counselors as their services are increasingly reimbursable. However, along with these opportunities have come a myriad of new demands with which counselors must comply to be reimbursed. Counselors have been faced with unprecedented demands in terms of documentation and record keeping. Historically, authorizations for mental health treatment sessions, and even treatment reports, either were not required or were completed by individuals not directly involved in the care of health center clients (e.g., office staff members).

In managed care environments, counselors have also been charged with assuming more responsibility for justifying their services and clients' need for intervention. Demonstrating the need for mental health services can be subjective and as such, counselors can find this task to be challenging. As will be discussed later in this chapter, an increased emphasis on the assessment of client impairment and on outcome evaluations has become a necessity as this demonstrates the clients' need for services.

Because managed care companies are involved with reimbursement for mental health services, authorization for mental health services has also become a necessity, with payers wanting to ensure that treatment is necessary and is efficient. Managed care companies have established stricter requirements for the authorization of mental health services and are requesting that counselors report on clients' progress before additional visits are even approved.

The advent of managed care environments has also created dramatic changes in the financing and service provision of mental health treatments, and these changes will continue to evolve. Secondary to the emergence of the aforementioned managed care demands, when planning treatment counselors are challenged to understand and navigate a number of third-party payer expectations, which are couched in a managed care environment. These changes have required counselors to develop the knowledge and practice skills needed to establish economically viable practices.

This discussion is intended to help counselors understand these expectations and how they relate to the development, implementation, and maintenance of treatment plans. The term *agency* will be used to describe the business or organizational setting in which counselors work and render their services. Examples of agencies where counselors practice include hospitals, community mental health centers, private practice counseling centers, college counseling centers, prisons, and residential treatment centers.

As discussed in the previous section, it is important to understand what variables impact client treatment and what makes a good treatment plan. However, the reality of clinical practice is that counselors are required to work within complex, ever-evolving systems that dictate the types of treatment, levels of care, and quantity of care a client can receive. The next section explores these real-world realities in the context of treatment planning.

SYSTEM TREATMENT RESTRAINTS

When developing treatment plans, there are a number of treatment restraints that must be considered. The counseling agency's accrediting body may have requirements that dictate treatment plan specifications. Also, counselors must consider the session and service limits applied by third-party payer sources. Issues associated with a client's diagnosis and its potential for reimbursement are important. Related to this, the level of care and/or

services that will be approved by third-party payers are based on the diagnosis. Finally, counselors are often called upon to work as part of a team. In this capacity they will need to adapt their treatment goals to those established by team consensus. All of these considerations impact the types of approaches used, the levels of services that are an option, the number of sessions provided, and subsequently, the types of treatment theories and models that can be applied and considered as part of the client's treatment plan.



Voices from the Trenches 1.2: In the Pearson eText, click here to view a video of a mental health agency director discussing how financial considerations relate to treatment planning.

Accrediting Bodies

When developing treatment plans, accreditation standards and accrediting bodies' requirements are an important consideration. Treatment plans must contain all of the elements required by the agency's accrediting bodies. Most agencies (e.g., community mental health agencies, hospitals, residential treatment facilities) that provide mental health treatment are required to be accredited by a body that oversees and regulates the types of treatments and services provided. There are a number of bodies that accredit agencies. The three primary accrediting bodies for behavioral health organizations include the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission International (JCO), and the Council on Accreditation (COA). JCO accreditation is primary sought by hospitals and medical treatment facilities (many provide and include behavioral health care services). CARF accreditation is traditionally sought by community-based health and human services organizations. COA accredits child welfare and human services organizations.

All three are nonprofit international organizations that accredit both nonprofit and for-profit organizations with a focus on enhancing the quality of services provided to consumers. All three accreditation bodies' focus is on enhancing the quality of services provided to consumers of services. The overall areas that they focus on are sound business practices; ethical and involved governance; processes for acquiring and utilizing input from consumers, families, and stakeholders; agency leadership; safe facilities; effective information management; and most importantly, performance improvement and performance management processes. Each clinical specialty area, such as substance abuse, outpatient mental health, crisis stabilization, or residential services, has its own standards of care. Agencies pay for accreditation reviews and for the maintenance of the accreditation, but the accreditation enhances the perceived quality of the program and affords the agency with various opportunities and benefits. For example, nonprofit mental health agencies often seek CARF or JCO accreditation because it provides them with a deemed status. This deemed status translates into an assumption by payer sources such as Medicare and Medicaid that the agency meets their requirements, and thus precludes additional layers of review by these payer sources.

Agencies may choose the accreditation (and thus the accrediting body) they prefer to use. Each accrediting organization has unique standards that need to be met. An

agency can choose to use whichever accrediting agency they prefer. It is likely that they will choose the organization that is more dominant in their discipline.

Regardless of the accrediting body an agency elects to seek accreditation from, they must fulfill all the standards and pass accreditations and reaccreditations as outlined by the accrediting body. For example, CARF may accredit all the programs at a given community mental health agency, but all programs will also need to undergo periodic review (e.g., every three years) to maintain accreditation. Each accrediting body has its own set of standards that agencies must follow to be in compliance and receive accreditation.

There are also state-level governing bodies (e.g., the Ohio Department of Mental Health [ODMH], Ohio Department of Alcohol and Drug Addiction Services [ODADAS]) that have licensing and certification standards that agency programs must meet in order to receive the credentials they provide. So again, if agencies want to receive funding from a federal program such as Medicaid or Medicare, they need to comply with this state-level certification. This funding is essential to the sustained functioning of agencies that provide various mental health counseling services. The licensing standards are based on state or federal laws with the same intention as the licensing standards for individual practitioners. They are meant to protect the public and ensure certain minimum standards of care are maintained, that the organization has established business and governance practices, and it is a safe environment for consumers.

A given agency may be accredited by two different groups and have different expectations for practice that they need to meet. Each accrediting body has unique requirements related to a variety of treatment considerations, among those being treatment plans. For example, some require a counselor to update the client's treatment plan every 90 days, while others require behavioral health counselors only annually update and modify treatment plans. Should it be found that the agency or certain providers failed to comply with these requirements, it would likely result in the agency having to pay back money provided for services, as the services provided without the up-to-date treatment plan would be considered out of compliance. Failure to comply with the accrediting bodies' standards could also result in the termination of an agency's certification.

Accrediting bodies and governing agencies also specify the criteria that need to be addressed in the treatment plan. For example, most accrediting bodies require that the client's goals and objectives relate to the needs, preferences, and obstacles identified in the preliminary mental health assessment. They also require that the treatment plan reflect the client's involvement in goal development, and that the goals and interventions be tailored to the client's preferences and needs. They typically require that goals be objective, and thus measurable. They usually require that counselors document a time frame for achievement of the goal (e.g., three months), and that the therapeutic interventions, frequency of services, and the provider responsible for service delivery are indicated on the treatment plan. Finally, they also typically require that the treatment plan include a consideration of the client's strengths and resources, and how these can be included in treatment. The I CAN START model presented in this text addresses all of these considerations and more.

Agency Settings and Available Services

Related to agency accreditation, the type of setting (e.g., psychiatric unit, crisis stabilization unit, outpatient behavioral health, private practice) also influences the selection of goals and interventions. The treatment goals selected must take into consideration the available

services as well as the nature of the setting. For example, outpatient counseling goals are longer-term and evaluated over a longer duration of time (e.g., three months), and the duration of time between evaluation periods will depend on the agency policy and regulating body standards (e.g., three months, annually). In an acute care setting, crisis or emergency goals are developed to address the current stressor and acute mental health symptoms (e.g., achieve medication compliance). These goals are usually meant to be obtained in three to five days. As such, the services provided focus on helping the client stabilize (e.g., providing a secure setting, medication management, case management services), and any treatment goals will focus on short-term objectives (e.g., 0 episodes of self-harm, cessation of heroin use, 0 episodes of physical aggression), with psychosocial treatments pulling on brief treatment approaches that address behavioral change (e.g., solution-focused brief therapy).

Even if a counselor's agency does not provide services a client needs, ethically counselors have a responsibility to connect the client with needed services. Conversely, just because an agency provides certain services they should not be included in a client's treatment plan unless they are deemed necessary.

The types of services available not only at the agency, but also in the client's community, also factor into treatment planning. For example, a counselor might determine that a client could benefit from medically assisted treatment for an opioid addiction. However, the community may have no such programs or physicians available to provide such treatment. Counselors should also attempt to help clients secure access to treatment resources they need even if they are not available at the counselor's agency.

Diagnosis and Reimbursement

A client's diagnosis directly informs the client's treatment plan and suggests the nature of the treatment the client will require, as well as the likely duration of treatment. As such, an accurate diagnosis is essential to effective treatment planning. However, as with all aspects of client treatment, the interplay of considerations associated with diagnosis and treatment are complex, and there are a number of third-party payer considerations that relate to counselor reimbursement and client diagnosis.

In some situations clients may self-pay for services; but most often, to be reimbursed for services counselors need to apply and present to payer sources a diagnosis based on either the most up-to-date edition of the *DSM*, or the International Classification of Diseases (ICD). This diagnosis communicates to third-party payers (e.g., federal payers such as Medicaid, Tricare, and Medicare; private insurance companies) what types of struggles the client is having and what types of services and/or levels of care are indicated. For example, a diagnosis of an adjustment disorder would likely not be sufficient to justify a third-party payer paying for an acute care hospital stay. However, a diagnosis of major depressive disorder (severe) may warrant an inpatient hospital stay.

As previously mentioned, there are a number of different payer sources that may include, but are not limited to, private insurance, county levy funding, federal programs (e.g., Medicaid, Medicare), and grants. Each payer source has its own standards related to clients' diagnosis and reimbursement, as well as the number of sessions they will provide based on the diagnosis. Payer sources will, however, only reimburse for certain specified diagnoses. The payers also use the diagnosis to determine the treatments, services, and number of sessions for which they will reimburse. For example, for a diagnosis of major depression, a federal program (e.g., Medicaid) may approve 52 hours of counseling in

one year, while a private insurance payer may approve only eight hours of counseling in a calendar year. A federal program may reimburse for services provided to people diagnosed with an adjustment disorder while certain private insurance payers may not.

Many third-party payers will not reimburse for services to treat autism spectrum disorders, adjustment disorders, substance-use disorders, personality disorders, and other disorders that may be the focus of clinical attention (i.e., “V-codes” such as childhood sexual abuse). As such, practically speaking, counselors may find that they need to tailor their treatment to co-occurring disorders. For example, when treating a client with borderline personality disorder and major depression, the treatment plan may need to focus on the treatment of depression and not address the personality disorder per se. Despite this, counselors must take care to develop a comprehensive case conceptualization that factors in all relevant issues and co-occurring disorders.

Related to this, not all diagnoses are reimbursed equally by third-party payers. Private insurance companies and government agencies (e.g., Tricare, Medicaid, Medicare, county mental health boards, county substance abuse boards) all accept different diagnoses as billable or reimbursable. For example, a county mental health board that provides financial support to a local mental health agency may not reimburse for a substance abuse diagnosis, while a county substance abuse board may not reimburse for a mental health diagnosis.

This selectivity on behalf of third-party payers puts counselors in a bind: On the one hand, there is an ethical responsibility to provide an accurate, least restrictive diagnosis and the least restrictive diagnosis, yet on the other hand, depending on the client’s diagnosis, this may leave the client unable to receive services because the accurate or least restrictive diagnosis may not be reimbursable.

A severe and persistent mental illness diagnosis designation is required to qualify for more intensive services (e.g., access to health homes), and the qualifications to meet this classification vary by state. This designation is not based on a diagnosis, but rather on identified criteria that relate to the client’s functioning. People with more severe disorders may require access to the types of services that these disorders can provide. For example, a person diagnosed with schizophrenia who also has a history of mental health treatment that includes multiple hospitalizations may qualify for Social Security benefits (which provides them with a small income and health insurance access).

Many counselors are taught to ascribe the least restrictive diagnosis for which diagnostic criteria are met. Some even advocate downcoding or avoiding certain diagnoses that may harm the client in some way (e.g., the client is a parent involved in a child custody case; see Kress, Hoffman, Adamson, & Eriksen, 2013, for a discussion of these issues). However, in real-world practice, many counselors feel forced to upcode, or give a more restrictive diagnosis, to ensure service delivery (e.g., adjustment disorder with depressed mood is most accurate, but not reimbursable, so the client is diagnosed with a major depressive disorder, mild, single episode, which is more restrictive, but reimbursable). Ethically, counselors should apply the diagnosis that best describes the client’s symptoms (see Eriksen & Kress, 2005, for a discussion of these issues).

In summary, a client’s diagnosis is the starting point in determining the types and levels of service that a third-party payer will reimburse. The diagnosis guides the treatment plan, as it is used to determine the level of care and treatment goals. Most payer sources request the client’s diagnosis and use it to determine how much (e.g., number of sessions) and what type (e.g., counseling) of services are approved for

reimbursement. Counselors need to be aware of these issues and how they will impact the nature and extent of services they provide, as these issues are central to treatment planning.

Payer Source, Session Number, and Service Restraints

Many discussions of treatment planning assume that clients have an unlimited number of counseling sessions, and in a perfect world, clients would be eligible for an unlimited number of mental health services. However, along with the issues associated with diagnosis, the payer source's policies help determine the number of available units (e.g., hours) a client can receive per year, as well as the types of services the client can receive. The allotted amount of services are often fewer than what a counselor would recommend the client receive. A client can elect to self-pay for services that are not reimbursed by the payer source, but for most people, self-pay is not a realistic option. The payer source determines if a client can receive counseling, community psychiatric support (i.e., case management), pharmacological management services, emergency services, crisis stabilization, inpatient treatment, intensive outpatient programming, employment services, education services, and partial hospitalization.

If approved for a type of service, the payer source determines how much of that service a client can receive. For example, Ohio Medicaid reimburses for 52 hours of counseling—annually—per client (interestingly, regardless of diagnosis). This amounts to one hour of counseling services per week, which is likely not enough for someone who needs intensive services (e.g., someone with a severe and persistent mental illness who requires frequent psychiatric hospitalizations), yet it may be more than is necessary for someone with, say, an adjustment disorder. Many private insurance companies will only approve eight hours of counseling at a time, which is not enough time to treat many mental disorders. Another example is the number of days a person may be approved for if admitted to a psychiatric hospital (e.g., a private insurance company may only agree to pay for three days of inpatient hospitalization, and this treatment may also depend on the client having a certain diagnosis). If a longer stay is needed for psychiatric stabilization, then the client will likely be responsible for the payment for additional days.

Payer sources often have “care managers” who (a) follow up with providers to see if clients attended their appointments, (b) make determinations on levels of care that will be reimbursed, and (c) determine if additional services or sessions are warranted. Realistically, the number of sessions a client is approved for, whether eight or 52, must be considered when developing a client's treatment plan. The number of sessions approved for client treatment will impact the development of the treatment plan, including the theory and interventions selected for use by the counselor. For example, if a client is approved for eight sessions, a brief therapy model with refined short-term goals may be most appropriate. The goals will likely address symptoms and circumstances that can be changed in a brief amount of time. If a client is approved for 20 sessions, different theoretical approaches may be appropriate, and long-term goals that address underlying factors contributing to the disorder may be addressed in a client's treatment. Session limits will also impact the goals that are selected to be addressed in treatment, as well as the amount of progress that can be realistically expected. For example, in 52 sessions, a client may be able to overcome all symptoms of depression, reporting a decrease in self-reported symptoms from 10 to 1 on a 10-point scale. The same individual may only

realistically be able to achieve 8 out of 10 on a 10-point scale if only eight counseling sessions are approved.

Ethically, clients need to be made aware that if they are relying on payer sources for the cost of their treatment, their treatment will be limited by the regulating standards of the payer. Counselors then have an ethical obligation to communicate to their clients their recommendations and what the third-party payer will cover, and come to an agreement on the treatment plan and on the number of sessions they expect to meet. For example, a counselor may recommend 20 hour-long sessions of counseling using cognitive behavioral therapy to treat depression, but the payer source may only agree to reimburse for eight sessions.

Treatment Teams

Depending on the setting in which counselors work and the behavioral health services provided within that setting, counselors may be required to work in a team environment. The type of behavioral health services provided at the counselor's agency and the members of the treatment team (e.g., psychiatrist, community psychiatric support provider, physician) will impact the services readily available to clients and can impact the clients' treatment goals. For example, if a counselor has a client with borderline personality disorder, and the agency where the counselor works has a dialectical behavior therapy (DBT) program, the client may have an option to receive this treatment, and the counselor may subsequently be called on to be a part of the DBT treatment team for the client.

When working as part of a team, a counselor may not be the person who develops the client's treatment plan; it may be developed by another member of the team with the counselor working with the client to address one aspect of the treatment plan. Counselors also need to be mindful of the treatment plan goals being addressed by various treatment team members. The treatment plans of all treatment team members should be similar, and the team should collaborate with the client to develop an individualized plan. A counselor may need to adapt his or her treatment plan to align with the treatment decisions of the team. Counselors must be aware of their role and function on the treatment team. Counselors should also be mindful of who the team leader is and what his or her role is on the team. Often, a physician or a psychiatrist is deemed to be the team leader and is the final authority on matters related to the client's diagnosis and treatment. For example, if the psychiatrist diagnoses a client with schizophrenia and recommends inpatient hospitalization, the counselor cannot treat the client for depression in an outpatient setting, even if the counselor believes that this is a more appropriate diagnosis and level of care. These discrepancies between provider perceptions of care can place counselors in an awkward situation that needs to be carefully navigated under the guidance of a supervisor or through peer consultation.

Voices from the Trenches 1.3: In the Pearson etext, [click here to view a video of a counselor discussing the importance of working effectively as a part of a treatment team.](#)



Summary

This chapter provided information that is foundational to understanding treatment planning, and presented what is known about what works in counseling. Additionally, the chapter discussed what “good” treatment planning looks like, based on the research literature on treatment.

This chapter also addressed the practical treatment restraints counselors need to consider as they develop and maintain clients’ treatment plans. These realities are infrequently addressed in academic journals and books, but are important for counselors

practicing in real-world settings. These restraints are couched in a managed care context, a context that defines the landscape in which counselors practice. Treatment constraints related to accrediting bodies, session and service limits applied by third-party payer sources, limits related to clients’ diagnoses and reimbursement, and the importance of working in a team approach were discussed. These considerations suggest certain practice guidelines that may be useful when developing treatment plans, and these will be explored more in Chapter 2.

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Appendix Summary

Appendix 1.1

Categories of Client Strengths, Capacities, and Resources

Appendix 1.2

Examples of Character Strengths, Capacities, and Resources to be Identified and Integrated into Treatment Plans

Appendix 1.3

Interview Questions to Assess Clients' Strengths, Capacities, and Resources

Appendix 1.4

Interview Questions to Assess Clients' Cultural Context



Appendix 1.1: Categories of Client Strengths, Capacities, and Resources

I. Client Strengths and Resources

- a. Identity**—self-image, ability for introspection, set of values and beliefs, sense of meaning, religious and spiritual affiliations, cultural identity, roles (e.g., teacher, mother), self-confidence
- b. Interpersonal Relationships**—supportive and healthy relationships with significant others, family members, friends, peers, coworkers, and other members of the community
- c. Social Skills**—relationship-building skills, communication skills, manners, listening skills, empathy, sensitivity to other’s feelings, conflict management abilities, problem-solving skills, tolerance, ability to connect with people of different cultural backgrounds, leadership abilities
- d. Conflict Management**—problem-solving abilities, can effectively regulate emotions, resolves conflicts without use of violence, willing to apologize for wronging others, able to forgive others
- e. Environmental Resources**—basic needs (food, water, shelter, clothing), health care, financial support, education, employment opportunities, transportation, other community resources
- f. Good Character**—integrity, bravery in standing up for beliefs, advocates for others, honest, can identify strengths and use them to help others

- g. Responsibility**—takes responsibility for actions, able to be responsible for completing tasks or for taking care of something/somebody, internal locus of control, able to plan for future, decision-making skills, sense of social responsibility
 - h. Optimistic Outlook**—positive view of own future and life situations
 - i. Connectedness with Surroundings**—sense of belonging with peer group/family/community/world, being a part of something greater than oneself, altruistic activities (e.g., volunteerism, social service)
 - j. Resistance to Social Pressure**—maintains beliefs and behaves in accordance with values even when they are unpopular, resists participation in dangerous or delinquent activities
 - k. Motivation**—motivated to achieve in school/work/hobby, seeks opportunities to better himself/herself in this area
 - l. Past Accomplishments and Achievements**
 - m. Flexibility**—able to accept life’s uncertainties, willing to make changes to plans/actions/beliefs
- II. Family Strengths and Resources**
- a. Family Relationships**—interactions are healthy, family functioning is adaptive, level of respect between members, members have a sense of belonging
 - b. Familial Support**—family members provide each other with encouragement, positive feedback, love, and support
 - c. Family Guidelines**—rules and guidelines are established, family is not too controlling in members’ lives or too disconnected
 - d. Communication**—family communicates feelings and thoughts to each other, regularly converses, feels safe going to each other to solve problems or make decisions
 - e. Bonding Time**—regularly spends time together doing particular activities (e.g., going to church, sitting down for dinner each night, playing games), may take time to practice a skill (e.g., baseball) or complete homework together
 - f. Family Involvement and Interest**—family encourages individual to perform well and praises accomplishments, attends extracurricular activities, meets with teachers (if a child)
 - g. Modeling**—a family member that serves as a role model of adaptive, responsible, appropriate behavior and positive traits
 - h. Traditions**—occasions and routine events that the family observes (e.g., dinner with extended family on Sundays), may include religious/ethnic/other cultural observances
- III. School Strengths and Resources**
- a. Supportive Staff**—teachers and school staff are supportive and interested in helping students to succeed, attentive to unique needs of children, create a caring and inclusive school environment, working relationship with parents
 - b. Communication Network**—teachers and school administrators have communication with one another, students’ parents, and other professionals as needed (e.g., social workers, counselors)
 - c. Academic Interest**—child desires to learn, active during class, engaged in learning, and challenged appropriately

- d. Homework Completion**—child demonstrates dedication, responsibility, and accountability by completing homework on time
 - e. Rules and Regulations**—clear guidelines are established and adhered to
 - f. Relationship to School**—child feels a sense of belonging at school, cares about the school, has a collective identity with the other students at the school, participates in extracurricular activities at school
 - g. Peer Support**—child has friendships with others, spend time with friends who model positive behavior
- IV. Community Strengths and Resources**
- a. Supportive Organizations**—organizations that provide help, resources, or support to those with specific needs (i.e., poverty, disabilities, illnesses) or dealing with a specific struggle (e.g., alcoholism, drug addiction, recovery from trauma)
 - b. Neighborhood Support**—neighborhood is a safe environment, healthy relationships with neighbors, neighbors monitor behavior in neighborhood
 - c. Religious Community**—supportive members and religious leaders that can be trusted and are supportive, contribute to the community and help others
 - d. Cultural Community**—derive strength and pride out of a shared cultural identity and shared cultural experiences
 - e. Co-workers**—have working relationships with others at work who are dependable
 - f. Support Groups**—groups that provide support for a specific group of people (e.g., those who are alcohol dependent)
 - g. Programming and Activities**—positive activities in the community (e.g., summer camp, volunteer groups, sports teams, clubs)



Appendix 1.2: Examples of Character Strengths, Capacities, and Resources to Be Identified and Integrated into Treatment Plans

Accepting	Conscientious
Adventurous	Considerate
Affectionate	Constructive
Alert	Cooperative
Altruistic	Courageous
Ambitious	Creative
Appreciative	Curious
Aspiring	Decisive
Attractive	Dedicated
Aware	Determined
Brave	Devoted
Calm	Disciplined
Capable	Educated
Caring	Efficient
Cheerful	Empathetic
Committed	Empowering
Compassionate	Encouraging
Confident	Energetic

Enthusiastic	Moral
Ethical	Nurturing
Exercises	Observant
Expressive	Open-minded
Flexible	Optimistic
Focused	Organized
Forgiving	Patient
Friendly	Persistent
Generous	Personable
Gentle	Persuasive
Graceful	Physically fit
Grateful	Playful
Handy	Positive
Hard-working	Powerful
Helpful	Practical
Honest	Problem solver
Hopeful	Prudent
Humble	Punctual
Humorous	Rational
Hygienic	Relaxed
Imaginative	Reliable
Independent	Religious
Industrious	Resilient
Innovative	Respectful
Insightful	Responsible
Inspirational	Self-confident
Intelligent	Self-esteem
Interested	Self-regulated
Intuitive	Selfless
Knowledgeable	Sensitive
Leadership	Sincere
Logical	Skilled
Loving	Social
Loyal	Spiritual
Mastery	Spontaneous
Modest	Strong-willed
Motivated	Successful

Supportive
Sympathetic
Tactful
Talented
Tenacious
Thoughtful

Thrifty
Tolerant
Trusting
Trustworthy
Wise
Work-oriented



Appendix 1.3: Interview Questions to Assess Clients' Strengths, Capacities, and Resources

INDIVIDUAL STRENGTHS

How do you go about making friends?

With whom do you usually share problems?

How did you usually go about solving problems (e.g., physical, emotional, educational, occupational)?

Talk about a situation in which you took a risk.

Tell me something that you are proud of.

Have you ever won any awards or received any honors? How did this make you feel about yourself?

When you're faced with a challenging situation, what helps you to maintain perspective?

When confronted with a frustrating or disappointing situation, how do you tend to respond?

What enables you to maintain an inner equilibrium when you're faced with difficult circumstances?

Do you have any skills/talents?

What are the most rewarding activities in your life? What other activities do you most enjoy?

Who do you most admire? What is it that you most admire about that person?
What are your short-term goals? How can you use your abilities to achieve them?
Who can help you?
What are your long-term goals? How can you use your strengths to achieve them?
Who can help you?
Talk about your plans around how to reach your goals.
How do you work well with others?
How do you participate as a part of a team?
Have you ever been a leader?
What are your best traits and abilities?
Talk about your sense of humor.
Do people seek you out for help with tasks or problems?
Do you have any hobbies?
Can you think of a time when you were able to use your abilities to help others?
What academic classes or job activities are you most interested in?
If you could improve an area of your life that you have control over, what would it be?
Are you able to apologize when you have hurt another person?
Are you able to forgive others who have hurt you?
Do you accept responsibility for your actions?
When are you the most relaxed/happy/satisfied?
Do you complete your work on time?
Do you do well on assignments and exams?
Do you try to the best of your abilities in your work/school?
Do you treat others with respect and fairness?
Are you genuine and honest?
What are some of your favorite memories? What made them so special?
Are you supportive of others (i.e., family members, friends, significant other)?
Do you have any special responsibilities (e.g., chores, taking care of sibling/pet)?
What makes you feel good about yourself?
When do you feel the most confident?
What are some things that you are good at?
What makes you special/sets you apart from others?
Do you know how to interact well with others at social events?
Have you ever helped another person who didn't fit in?
Have you ever included a person who was being left out?
Do you enjoy close relationships with others? If so, tell me about those relationships.
Are you creative?
Are you accepting of life's uncertainties?

How do you manage stress?

What do you find fascinating?

What do you enjoy learning about?

Do you find it easy to make decisions? Have you ever helped anybody else make a decision?

How do you solve problems?

Do you finish tasks that you start?

Are you persistent in working toward your goals even when you meet challenges?

What areas interest you?

How do you spend your free time?

If you could spend your free time doing anything you wanted, what would it be?

Have you ever stood up for your beliefs?

Have you ever confronted somebody who you felt was bullying you/somebody else?

Do you ever do favors for others without expecting anything in return?

Do you do any volunteer work?

Do you have any special cause that you identify with?

If you could go back and start your life from the beginning, what would you keep the same?

Have you ever been responsible for the welfare of another (e.g., a pet, a person)?

Are you able to become comfortable in situations where the places, people, and occasions are unfamiliar?

Have you ever been supportive or encouraging to another person?

Talk about how you engage in self-discipline.

Talk about how you control your emotions in stressful situations.

Has there ever been a time when you have treated someone kindly who has not been kind to you?

What are some things for which you are grateful?

What positive things do you expect to happen in the future?

What are your dreams for the future?

Do you thank others when they have helped you?

Do you have relationships that bring meaning to your life?

Do you feel that your life has purpose/purposes?

Do you seek to find meaning and purpose in life?

Can you view challenges as an opportunity to learn and grow?

Do you try new activities, even if they frighten you a bit?

Do you seek opportunities to learn and enhance yourself?

Do you consider other people's feelings when interacting or before making decisions?

Do you notice others' emotions?

What conditions of your life are you the most satisfied with?

What are some things in your life that you wanted and were able to obtain?
Can you think of a situation when you were a good friend to somebody?

FAMILY OF ORIGIN STRENGTHS

Who in your family do you most admire?
What was the role of grandparents in your family?
What role do other close family members play in your family?
How frequently do you have contact with family?
What kinds of values were stressed in your family?
Who are the special people in your life? What makes them special to you?
What are some things you like about your family members?
What are some strengths of your family?
In what ways have your family members positively impacted your life?
What are some important helpful lessons you learned from your family?
Can you look to any family members for support if you want to talk or need help?
How is your family unique? Do you have any special traditions or values?
Do you have a family member whom you trust?
Do you feel that you “belong” in your family?
How have your family members supported you in the past?
How does your family solve problems?
When have you felt encouraged by your family members?
Have you ever collectively worked toward a goal as a family?
How can your family members be helpful to you now?
How has your family successfully dealt with a challenge together?
How do you contribute to your family?
How does your family help you in your daily life?
What have you done to bring pride to your family?
Are you proud of any family members?
What activities does your family enjoy doing together?

COMMUNITY/CULTURAL STRENGTHS

What is valued in your community?
What kinds of social groups existed in your home community?
In what ways does your community support social justice? Work to offset various forms of oppression?
What resources have you used in the community?
How do you contribute to your community?

What are some special or unique traits from your culture?
What are some aspects of your culture that you value?
How have you helped others within your community?
Who are some individuals you admire in the community/from your culture?
What resources are available in the community that might help you to achieve your goals?
How have others in the community helped you to grow and develop?
How can you reach out to others for support in the community?
Can you think of any ways that you can use your talents, abilities, or traits to help others in the community?
What do you value about your community?

SPIRITUAL STRENGTHS

What types of things do you consider of highest importance?
In what ways do you experience meaning in your life?
What role does religion play for you? In what situations might you turn to religion?
What kinds of things help you to feel that you're living your life to the fullest?
In what ways do your religious views provide comfort in times of suffering or sorrow?
How can you use spirituality or religion in helping you to achieve your goals?
Do you have members of your religious community whom you can trust/depend on/talk to in a time of need?
How have members of your religious community helped you or others in the past?
What special memories do you have involving your spirituality/religion?
How have your spiritual/religious beliefs enhanced your life?
What positive traits have you developed from your religious/spiritual beliefs?
Is meditation or prayer a part of your life? If so, how?
Are there any regular religious rituals in which you take part? How often?
If so, are the rituals as part of a community, or are they more personal or within the family?
What religious values do you espouse?
Do you share these values with many other members of your home culture?
Do you incorporate those values into your current beliefs and behavior?
How do you go about making difficult decisions? What values do you rely on to help you in this process?
Do you feel a sense of connectedness with others or the world around you?
What are some strengths of having religious/spiritual beliefs in your life?
How can you use your beliefs to contribute to the world?
How do your beliefs positively impact your interactions with others?



Appendix 1.4: Interview Questions to Assess Clients' Cultural Context

GETTING THE CLIENT'S CULTURAL BACKGROUND

How do you identify yourself (i.e., age, race, ethnicity, culture, SES, sexual orientation, disability/ability)?

What is your country of origin?

Where were your parents born? Where were your children born?

Where do you call home?

Have you always lived in the United States? If not, when did you come to the United States?

What was life like before you came to the United States?

What was it like when you first came to the United States? How is it now?

Why did you leave your country of origin?

What languages do speak? What languages do you prefer to speak? What language is spoken at home/with your family members/in your community?

How would you describe your culture, ethnicity? What are your foundational values and beliefs?

How would you describe your family? Who are the members of your family?

Who raised you? Do you have children? Do you (or does someone else) raise them?

Do you want your family or other important members included in treatment? Would you like me to talk with any of them?

- In what ways does your family impact and support you?
- How would you describe your community? Do you belong to any groups or organizations?
- What do you view as important sources of support?
- What activities are you associated with or participate in?
- Is religion and/or spirituality important to you?
- Are you comfortable talking about values, beliefs, and spirituality with me?
- Is religion or spirituality an important aspect of treatment you wish to address?
- Is there a religious, spiritual, or healing person who should be part of treatment?
- Do you feel that other have discriminated against you because of your culture? Have you seen this at work, in the community, in relationships, or in other settings?
- Have you ever felt intolerance due to your religious, spiritual, political, or ethnic worldview?
- Have you ever been discriminated against due to your race, social-economic class, sexual orientation, gender, disability, or for any other reason that you would like to talk about and make me aware of?
- What is your sexual orientation? How would you describe your gender identity?
- What is your political ideology? Is that similar or different from your spouse, family members, friends, or others within your community?
- How would you define your social-economic status?
- Do you have any customs or practices that you would like to do in here?

UNDERSTANDING THE PROBLEM

- How would you describe what is going on with you? How would you define the problem?
- How might your spouse, family members, friends, or others within your community define the problem?
- What is the most troubling part of the problem?
- What would you like to be doing that you are not able to do?
- Have you sought help for this problem in the past? If so, from whom? What parts were helpful? What parts were not?
- Have you ever had times when you thought you would have the problem, but did not?
- How would you name or label what is happening to you?
- Are there any beliefs or cultural considerations that you would like to discuss concerning the problem?
- Is there anything you are afraid of, or fear?
- Does your spouse, family members, friends, or others within your community support your decision to seek help?
- What do you think caused or is causing this problem?
- What would your spouse, family members, friends, or others within your community say is causing your problem?

Is there any kind or type of support that makes the problem diminish, more tolerable, or better?

Do you feel supported by spouse, family members, friends, and others within the community?

What seems to exacerbate or inflame the problem? What stressors make the problem more difficult to deal with or tolerate?

How have you dealt with the problem in the past?

Has anything been helpful?

How are you currently coping with this problem now?

BARRIERS TO TREATMENT

Has anything ever gotten in your way of seeking help for this problem?

What barriers have prevented you from seeking treatment in the past?

Are you aware of the services here and do you feel they will aid you?

Do you see any potential challenges in your receiving the treatment you desire?

Considering what you know about counseling, is there anything you feel uncomfortable about?

TREATMENT

How have you dealt with the problem in the past?

Has anything been helpful?

How are you currently coping with this problem now?

PREFERENCES OF TREATMENT AND TYPE OF WORKING RELATIONSHIP

What kind or type of help is most useful to you?

What kinds of help would your spouse, family members, friends, or others within your community deem as most useful?

What would you like from me in this relationship?

What expectations do you have for me in this relationship? What expectations do you have for yourself in this relationship?

How do you see treatment progress? What type of pace is ideal?

What would indicate to you that treatment or this counseling relationship is not working?

Do you have any reservation that I will not understand your situation, your culture, or your lived experience?

Do you feel that I will be able to provide you the care and type of help you want/need?

Is there anything I have failed to ask you that would be helpful in facilitating treatment and a working relationship?