1

Clinical Thinking Skills

Diagnosis, Case Conceptualization, and Treatment Planning

Introducing Chapter 1: Reader Highlights and Learning Goals

Individuals who choose careers as mental health professionals—including counselors, psychotherapists, social workers, counseling and clinical psychologists, psychiatrists, and those in similar career paths—often enter the counseling field because earlier in their lives, in their families of origin, in their schools and neighborhoods, and among their friends and peers, they found themselves in the role of good listener, intelligent analyzer, or effective problem-solver when those around them encountered life's difficulties (Neukrug & Schwitzer, 2006). In other words, many people already are "natural helpers" when they decide to become professionals (Neukrug & Schwitzer, 2006, p. 5). As natural helpers for friends and family, they have relied on their intuition, personal opinions, and natural inclinations as they spontaneously listen, support, analyze, encourage, push, or make hopeful suggestions.

However, the demands of professional counseling work go beyond the qualities needed by natural helpers. Compared with the spontaneous nature of natural helping, professional counseling requires us to rely on purposeful skills and to systematically guide the counseling relationship through a sequence of organized stages, intentionally

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aiming to achieve specific client outcome goals (Neukrug & Schwitzer, 2006). That is, professional counseling requires us to become competent at using clinical thinking skills "to facilitate [the] provision of mental health treatment" (Seligman, 1996, p. 23). These skills include diagnosis, case conceptualization, and treatment planning. The goal of our textbook is to help you understand and become competent at these three important clinical thinking skills. The text explores each skill in detail. In Chapter 1, we introduce all of the key concepts and then in Chapters 2, 3, and 4, we discuss them more fully.

In the current chapter, first we discuss the role that clinical thinking skills play in counseling and psychotherapy. Next, we define *diagnosis, case conceptualization,* and *treatment planning*. Following our definitions, we relate these skills to caseload management, explain how they fit into the stages of the professional counseling process, and summarize. We then will be ready to explore each skill more fully in the separate chapters that follow.

At the end of this chapter, you should be able to:

- Discuss the role of clinical thinking skills in counseling and psychotherapy as they are practiced in today's professional mental health world
- Define diagnosis, case conceptualization, and treatment planning
- Distinguish among these skills and caseload management
- Summarize the stages of the professional counseling relationship and discuss where diagnosis, case conceptualization, and treatment planning fit into the process
- Be ready to move on to the three specific chapters that follow, dealing in detail with diagnosis, case conceptualization, and treatment planning

The Use of Clinical Thinking Skills in Counseling and Psychotherapy

The transition from natural helper to professional counselor can be a daunting one. We become aware that a client's decision to seek counseling is an important "investment in time, money, and energy" (Vaughn, 1997, p. 181). We realize that when clients choose us as professional consultants for their therapeutic "journey," it takes substantial determination for them to stay the course with us "when the going gets tough" (Vaughn, p. 181). We learn that counselors are responsible for helping the individual understand his or her own view of himself or herself and his or her life, discover new choices, create a new view of himself or herself, and bring about his or her own changes (Weinberg, 1996). We recognize that when counseling succeeds, our clients should be better able to form their own insights and apply the benefits of psychotherapy to new life situations when they arise (Vaughn, 2007). To accomplish these tasks, we make

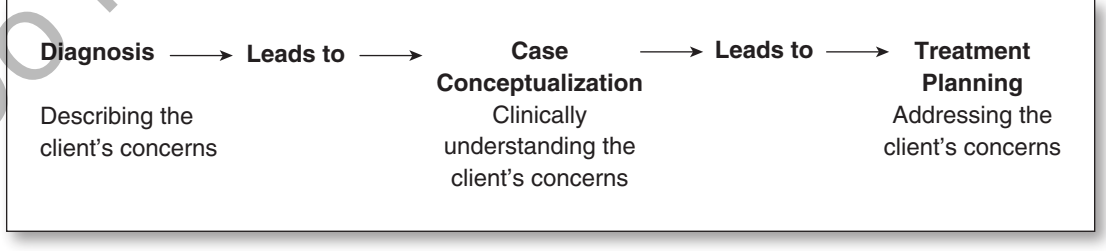
judgments about our clients, decide what goals seem reasonable and feasible, consider how we will communicate with our clients, and determine how to implement the change process (Basch, 1980). Further, we must pay attention to what we know about empirically supported practice, evidence-based practice, and other best practice information (Wampold, 2001). Basch (1980) referred to all of this as "listening like a psychotherapist" (p. 3). It means that a lot of decision-making responsibility rests on our shoulders.

Correspondingly, to accomplish the shift from natural helper—giving advice at the dinner table or comforting a coworker who is upset—to counseling professional—meeting in a therapeutic setting with child, adolescent, young adult, adult, couple, family, or group clients who are in need—a set of tools is required with which to describe the client's functioning, gain an understanding of the person's situation and needs, identify goals for change, and decide on the most effective interventions for reaching these goals. This set of tools is summarized in Figure 1.1. Specifically, diagnosis is a tool for *describing* client needs, case conceptualization is a tool for *understanding* these needs, and treatment planning is a tool for *addressing* these needs to bring about change. When employed by counseling professionals, the treatment plan follows directly from the case conceptualization, which builds on the diagnostic impressions. All three of these clinical thinking skills are required competencies for today's counseling and psychotherapy professionals (Seligman, 1996, 2004).

Defining Diagnosis

In today's professional counseling world, diagnosis refers to the use of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*; American Psychiatric Association [APA], 2013) to identify and describe the clinically significant patterns associated with our clients' distress, impairment, or risk. Certainly, there are other mental health diagnostic systems besides the *DSM-5*. The World Health Organization's (WHO) *International Classification of Diseases, Tenth Edition* (*ICD-10*) is an important example. Further, some fields of counseling and psychotherapy maintain their own systems of diagnostic formulation; for instance, there are psychoanalytic systems for diagnosing client personality structures

Figure 1.1 Clinical Thinking Skills



(McWilliams, 1994, 1999). However, it is the *DSM-5* that is the widely accepted, official nomenclature for making a mental health diagnosis in today's clinical practice. It is used throughout the United States and, increasingly, around the world. The *DSM-5* has been translated into more than 14 languages. As mental health professionals who work with multiple constituencies and colleagues of various disciplines, mastering the *DSM-5* is a professional survival skill for counselors and psychotherapists in all settings and contexts.

Specifically, the *DSM-5* is a classification system that divides client presentations into mental disorders based on sets of criteria that are made up of observable features. In other words, diagnoses of mental disorders in the *DSM-5* are *criterion-referenced*. This categorical approach stems from the traditional scientific/medical method of organizing, naming, and communicating information in as objective a fashion as possible. The job of the counselor is to find the best match between what the clinician observes the client to be experiencing and the various criteria for the different clinically significant patterns found in the *DSM*. This type of diagnosis can help us determine the primary focus of counseling. For example, a focus on a mood problem might need different counseling responses than a focus on anxiety complaints, and a focus on an adjustment problem would be addressed differently than a focus on long-term life problems like personality disorders.

The *DSM-5* provides several hundred separate diagnoses. It includes disorders of infancy, childhood, adolescence, and adulthood; describes both short-term client concerns, such as adjustment disorders, and longer-standing problems, such as intellectual disability and personality disorders; covers a wide range of behavior, from substance abuse to sleep disorders to bereavement; and pays attention to characteristics of thought, mood, behavior, and physiology. A fully formulated, start-to-finish *DSM* diagnosis requires several different types of information, each of which helps the counselor to describe what the client is experiencing or presenting. The different types of information include clinical disorders of children and adults and other conditions that may be a focus of counseling; medical conditions; psychosocial stressors and environmental problems encountered by the client; and an assessment of a person's vulnerabilities and functioning. Further, the criteria—or requirements—for each clinical diagnosis derived from the *DSM-5* has four parts: (1) client behaviors, thoughts, mood, and physiological symptoms; (2) the frequency and duration of the person's concerns; (3) the severity of the distress or life dysfunction the person encounters as a result of his or her concerns; and (4) the ruling out of other possible conditions that might account for the person's needs. As an illustration, the criteria that must be met for a diagnosis of Generalized Anxiety Disorder include excessive anxiety, worry, and physical stress (thought, behavior, mood, and physiological features) present at least 6 months (duration) that are interfering with daily functioning (severity) and are not due to substance use or a medical problem (ruling out differential diagnoses). In addition, the system has severity specifiers, course specifiers, and subtypes that are used to describe individual client variations within a diagnosis.

The primary purpose for making a *DSM-5* diagnosis is to describe and communicate with other professionals who are familiar with the system. Having all mental health

Skill and Learning Exercise 1.1

Taking a Look at a *DSM-5* Diagnosis

Find the case of the vampire anthology's Edward Cullen appearing in our popular culture caseload, located later in Chapter 5 in this text. Find the fully completed *DSM-5* diagnosis describing Cullen's presenting concerns. Working alone or with a partner, refer to your copy of the *DSM.* What thoughts, feelings, behaviors, or physiological symptoms must Edward be experiencing to suggest a diagnosis of Persistent Depressive Disorder? Have any medical problems or environmental problems been identified in the fully formulated diagnosis? By what means did the counselor estimate Edward Cullen's levels of severity, vulnerability, or functioning?

professionals using the same diagnostic system is intended to enhance agreement among clinicians about the client picture they are seeing and should improve the sharing of information about client presentations and client needs. By itself, a diagnosis does not reflect any specific theoretical perspective (such as person-centered counseling or cognitive-behavioral therapy) or indicate any specific mental health field (professional counseling, psychology, etc.); rather, the *DSM-5* diagnoses are theory-neutral and do not reflect any one orientation. As a result, using *DSM-5* categories and descriptions allows clinicians to describe client needs and communicate with mental health colleagues across disciplines—and then later apply their own professional viewpoint and theoretical approach during case conceptualization and treatment planning.

Defining Case Conceptualization

Following diagnosis, which provides a method for describing and communicating about client presentations, effective treatment in today's mental health world next requires that we use case conceptualization to evaluate and make sense of the client's needs (Hinkle, 1994; Seligman, 2004). Conceptualization skills provide the counselor with a rationale and a framework for his or her work with clients—and with today's emphasis on briefer counseling approaches, extensive use of integrated and eclectic psychotherapy models, and greater focus on evidence-based best practices, efficient case conceptualization has become essential (Budman & Gurman, 1983; Mahalick, 1990; Neukrug, 2001; Wampold, 2001). Specifically, case conceptualization is a tool for observing, understanding, and conceptually integrating client behaviors, thoughts, feelings, and physiology from a clinical perspective (Neukrug & Schwitzer, 2006).

Case conceptualization involves three steps (Neukrug & Schwitzer, 2006): First, the counselor thoroughly *evaluates* the client's concerns by observing, assessing, and measuring his or her behaviors. Second, the clinician *organizes* these observations, assessments, and measures to his or her *patterns and themes* among the client's concerns. Third, the therapist selects a *theoretical orientation* to interpret,

explain, or make clinical judgments about what the client is experiencing. When the case conceptualization is completed, the counselor should have a picture of what he or she believes has led to the client's concerns (etiology) and what features are maintaining or perpetuating the problem (sustaining factors). Understanding the etiology and sustaining factors will then lead to treatment planning, which uses the case conceptualization to decide how to best address, reduce, manage, or resolve the client's issues.

Naturally, the first component of case conceptualization is assessment, measurement, or appraisal of the client's presenting problems or reasons for referral. As mentioned earlier, behavioral, cognitive, affective, and physiological components all are taken into account. For instance, while the experience of a depressive disorder is most clearly associated with low mood and feeling sad or "down," it is typical for clients with depressive disorder to simultaneously experience cognitive symptoms of depression like hopeless or helpless pessimistic thinking, physical symptoms like sleep or appetite difficulties, and behavioral problems such as losing interest in everyday activities. All of these components of the presenting problem contribute to the case conceptualization.

However, in order to form a full case conceptualization, effective clinicians also go beyond the presenting concerns or reason for referral. They evaluate additional issues with work, school, or other major life roles and with social and personal-emotional adjustment; they examine developmental and family history such as current and past family and parental relationships, previous school and work experiences, and previous peer and social experiences; they make in-session observations; they make clinical inquiries about present and past medical, psychiatric, substance use, and suicidal experiences; and they collect formal psychological assessment data, that is, psychological tests.

Once the clinician has collected as much information as possible, his or her second step in the case conceptualization process is to begin organizing the various client data. The counselor uses his or her conceptual skills to weave together the different pieces of information about the client's adjustment, development, distress, or dysfunction into logical groupings that elucidate the person's larger clinical concerns, the problematic themes underlying the person's difficulties with life situations or life roles, or critical problems found in the person's intrapsychic or interpersonal approach to his or her world. Later on, these themes help form the targets for change that will be addressed by treatment planning.

After organizing themes that meaningfully sort together the different pieces of client information that have been collected, the counselor's third step is to apply a theoretical approach to infer, explain, or interpret the identified themes. Today's clinicians are expected to match the best counseling approach for addressing the client's needs (Wampold, 2001). This means that when forming a case conceptualization, today's counselors might apply to their understanding of the client's themes and patterns one of the many well-documented purist theoretical approaches (such as Cognitive Behavior Therapy, person-centered counseling, or Reality Therapy), an integration of two or more theories, an eclectic mix of theories, or a brief solution-focused approach

(Corey, 2009; Dattilo & Norcross, 2006; de Shazer & Dolan, 2007; Norcross & Beutler, 2008; Wampold, 2001). In other words, part of the counselor's job is to decide which theoretical approach is a good fit with the client's needs, and then use that approach to finish the case conceptualization.

Skill and Learning Exercise 1.2

Comparing Theoretical Approaches to Case Conceptualization

Find the cases of Naruto, *West Side Story*'s Maria, Cleveland Brown, and the *Revolver* album's Eleanor Rigby located later in Chapter 5 in this text. Find the section of each case discussing case conceptualization. Working alone or with a partner, consider the following: What theoretical approach did the counselor select to explain Naruto's, Maria's, Cleveland's, and Eleanor's concerns? Did the counselor select a purist theory, integration of two or more theories, eclectic mix of theories, or brief solution-focused approach? What was the counselor's rationale for his or her selection?

Inverted Pyramid Method of Case Conceptualization

Taken together, a start-to-finish case conceptualization begins with learning about the client's concerns (first step), moves on to meaningfully organizing this information into patterns and themes (second step), and finishes by explaining the patterns and themes using our choice of theory or theories (third step). As with learning diagnostic skills, learning to form this type of case conceptualization can be overwhelming for beginning counselors and trainees (Neukrug & Schwitzer, 2006). Beginning clinicians often experience ambiguity and feel confused when they start the process of forming reliable, accurate case conceptualizations for each new client they encounter (Loganbill, Hardy, & Delworth, 1982; Martin, Slemon, Hiebert, Halberg, & Cummings, 1989). In fact, over the years, students in training sites (Robbins & Zinni, 1988) as well as newly employed therapists and counselors (Glidewell & Livert, 1992; Hays, McLeod, & Prosek, 2010) consistently have reported lacking confidence in their case conceptualization skills. By comparison, more experienced therapists are able to systematically apply a consistent set of clinical thinking skills to the different problems presented by each new client.

In turn, to help you more easily develop case conceptualization skills and become more confident in your abilities, in this textbook we use a step-by-step method specifically designed to assist new counselors in becoming consistent, accurate, case conceptualizers. This method, known as the *inverted pyramid* (Neukrug & Schwitzer, 2006; Schwitzer, 1996, 1997), gives you a specific way to form your conceptualizations of clients. The Inverted Pyramid Method is presented later in the text and is illustrated in all 10 case examples.

Defining Treatment Planning

Once our earlier clinical thinking is completed, a treatment plan is built that integrates the information from the diagnosis and case conceptualization into a coherent plan of action. Treatment planning is a vital aspect of today's mental health care delivery (Jongsma & Peterson, 2006; Jongsma, Peterson, & McInnis, 2003a, 2003b; Seligman, 1993, 1996, 2004), and competent clinicians are expected to be able to move methodically from conceptualization to the formulation and implementation of the treatment plan (Jongsma & Peterson, 2006; Schwitzer & Everett, 1997). Whereas natural helpers typically "shoot from the hip," counseling professionals are expected to carefully select achievable goals, determine what intervention approach will be used, and establish how change will be measured (Neukrug & Schwitzer, 2006, p. 224). A widely accepted definition of treatment planning is as follows:

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

As Seligman indicated, the treatment plan maps out a logical and goal-oriented strategy for making positive changes in the client's life. It is a blueprint for the counseling process that is based on the clinical themes identified, and the theoretical approach used, in the case conceptualization.

A basic treatment plan comprises four steps (Neukrug & Schwitzer, 2006). First, the clinician *behaviorally defines* the counseling problems to be addressed. Second, *achievable goals* are selected. Third, the modes of treatment and *methods of intervention* are determined. Fourth, the counselor explains *how change will be measured* and how outcomes will be demonstrated.

More specifically, the behavioral definition of the problem consolidates the case conceptualization into a concise hierarchical list of issues and concerns that will be the focus of treatment. Achievable goals are selected by assessing and prioritizing the client's needs into a hierarchy of urgency that also takes into account such factors as the level of dysfunction the person is experiencing, the client's motivation for change, and real-world influences on the client's needs. Urgency typically increases for issues of suicidality, potential for harm to self or others, certain diagnostic red flags, substance use concerns, and other issues causing substantial distress or impairment in daily functioning. At the same time, the client's own motivations and ability to engage in the therapeutic process influence the goals that are agreed on, as do real-world factors such as the client's availability to attend counseling, session limits, and the like. Treatment modes and methods of intervention are selected by taking into account the client's particular dynamics and then applying the specific theoretical orientation or clinical approach that is to be employed. Decisions about treatment modes often center on: who the service provider will be, including what type of counseling professional will provide

services and who specifically will be the clinician; what type of outclient or inpatient setting the client will visit; and what types of individual counseling or group psychotherapy formats the person will attend. Methods of intervention are derived from the specific theoretical approach, integration of two or more theoretical approaches, eclectic mix of theories, or solution-focused intervention approach we endorse for our work with the client; these decisions should be made based on our knowledge of best practices, evidence about treatment efficacy, and other professional knowledge. *Changes and outcomes* that are achieved can be demonstrated using various sources of information such as client report, counselor observation, pre-post treatment comparisons, and other means of documenting the results of our counseling work.

Skill and Learning Exercise 1.3

Taking a Look at a Basic Treatment Plan

Find the case of *The Color Purple's* Miss Celie appearing in Chapter 5, located later in this text. Find the fully completed treatment plan and the treatment plan summary table. Working alone or with a partner, consider the following: What are the goals for treatment listed for each clinical concern? Are they behaviorally defined? What are the modes of treatment and methods of intervention? These come from an integration of which two theoretical approaches? Do the outcome measures seem appropriate? Are they likely to show the counselor and Miss Celie whether progress has been made toward her goals? Overall, how successful is the treatment plan at providing the counselor with structure and direction for her work with the client?

The use of a treatment plan that selects the goals for change, determines the counseling methods for achieving change, and presents ways of measuring the changes that are produced provides structure and direction to the counseling process. It helps the counselor and the client track their progress and determine the degree to which goals are being met and allows the counseling professional to demonstrate accountability and effectiveness (Seligman, 1996). When the treatment plan is completed, the counselor should have a clear picture of what the goals are, how to reach the goals, and how to know when they have been reached.

Clinical Thinking Skills and Caseload Management

So far in this chapter we have introduced and defined the three clinical thinking skills that are the focus of our text. Along with diagnosis, case conceptualization, and treatment planning, students and new professionals also often are exposed to another term that is important to the practice of professional counseling and is related to these

clinical tools: *caseload management*. In this brief section of the chapter, we want to explain what comprises caseload management and how the three clinical thinking skills fit in. Caseload management "encompasses the knowledge, skills, and activities involved in managing an entire [client] caseload" (Woodside & McClam, 1998, p. 4). Being skilled at managing our overall load of clients includes using all of the tools needed to move the individuals with whom we are working "through the service delivery process from intake to closure" (Woodside & McClam, 1998, p. 3). Novice counselors who are new to their professional work settings report having discovered that caseload management involves "the paperwork and documentation for each client on your caseload" and "handling the records, files, communications, supervision, working with other staff on a case, and everything else you do in the office besides sit down with the client himself or herself" (Woodside & McClam, 1998, p. 3). In sum, new counselors have commented that caseload management "isn't just filling out paperwork—it's how you handle every phone call, insurance form, scheduling, information request, follow-up, time management, and giving good client service" (Neukrug & Schwitzer, 2006, p. 257). More specifically, caseload management comprises each of the following elements (Neukrug & Schwitzer, 2006):

- Documentation
- Supervision, consultation, and collaboration
- Communication with stakeholders
- Business-related activities
- Time management, schedule management, and caseload tracking

Several of these elements of caseload management fit together closely with the use of our clinical thinking tools.

First, *documentation* involves all of the record-keeping involved in professional counseling work. This includes our note-taking, monitoring, and documenting of all client information, and storing of records. Included are pre-interview and intake materials, case notes, termination materials, testing data, billing and payment-related materials, including insurance forms, and other materials. Naturally, our diagnostic impressions, case conceptualization notes, and written treatment plans are part of documentation. These clinical thinking products all are components of the client's or patient's record—and accurately recording and keeping these records is extremely important in today's professional mental health world (Kleinke, 1994; Reynolds, Mair, & Fischer, 1995). Although often we refer to professional documentation as being "the client's record" or "belonging to the client," in actuality all of the clinical documents in the caseload file are clinical tools used by the clinician and are the property of the agency or counseling setting in which the therapist is working. Therefore, diagnosis, case conceptualization, and treatment notes all must be prepared carefully and professionally, with an awareness that they will contribute to the client's record and may be used by a variety of people for a wide range of professional purposes (Reynolds, Mair, & Fischer, 1995). Further, clinicians must prepare their clinical thinking documents to adhere to agency rules, ethical guidelines, and legal statutes, including Health Insurance Portability and Accountability Act (HIPAA)-related materials.

Second, clinicians rely on *supervision, consultation, and collaboration with other professionals* as they manage their caseloads in an effort to provide effective client services. Ethical codes for essentially all of the mental health professions as well as state statutes and other regulations require that clinicians practice within the limits of their competence. In turn, much of our work occurs with the support of others.

Among these supportive professional relationships, counseling supervision is most prominent. Counseling *supervision* is an intensive, interpersonally focused relationship in which one person is designated to facilitate the professional competence of one or more other persons (Loganbill et al., 1982). Students rely on supervision for intensive support and extensive expert advice as they begin learning to be a counselor; interns and licensure residents rely on supervision to provide moderate support and solid expertise as they continue building their skills; and even licensed and experienced clinicians rely on supervision for expert guidance, to learn new approaches, and for help with special client challenges. Regarding clinical thinking, earlier in their training, students, trainees, and novice counselors tend to rely extensively on their supervisors for help and advice making diagnostic decisions, moving through the steps of case conceptualization, and formulating and writing out a treatment plan. Often, the novice's supervisor provides expert advice about which theoretical perspective, evidence-based approach, or best practice to match with the client's needs. Correspondingly, clinical thinking often is a major component of early counseling supervision (Bernard & Goodyear, 2004). Later, over the course of one's professional development, the responsibility for diagnosis, case conceptualization, and treatment planning gradually shifts from supervisor to supervisee (Bernard & Goodyear, 2004; Loganbill et al., 1982).

SNAPSHOT

Professional Perspective 1.1

Using Counseling Supervision

Supervision can be useful throughout our professional lives. One of the authors (Schwitzer) has returned to supervision on more than one occasion to update his skills. He sought supervision at one time for specialized support understanding and conceptualizing Mexican and Mexican American family dynamics when he relocated to the state of Texas and found that Hispanic clients comprised a significant portion of his caseload. He later returned to supervision when he was interested in adding elements of clinical hypnosis to his counseling repertoire and required an expert in hypnosis to help him learn the needed skills and make decisions about when to include them in the treatment plan. The other author (Rubin) has become interested in the use of Narrative Therapy with child, adolescent, and adult clients, toward which end he has attended numerous workshops on the topic and sought out individualized supervision with a clinician who is highly experienced in this modality.

Compared with supervision, which is an intensive, ongoing professional relationship, *consultation* is a time-limited relationship through which the counselor seeks the advice, expert opinion, or professional support of another professional about the needs of a specific client. Very often, consultation provides us with needed guidance pertaining to our clinical thinking about a client situation. The counselor sometimes meets directly with the consultant to discuss a case situation—or, alternatively, refers the client to meet with the consulting professional, who then provides his or her diagnostic, conceptual, or treatment impressions. Commonly used consultants include (a) another, more expert or more specialized mental health professional who can add to our exploration, understanding, and formulation of the client's dynamics and needs; (b) a medical consultant such as a physician (or another medical practitioner like a nutritionist) who can conduct physical exams or medical evaluations and provide us with information useful to our diagnostic, conceptual, or treatment decisions; and (c) specific discussions with or referral to a psychiatrist in order to rule out certain diagnoses or evaluate for psychiatric medication as a component of the treatment plan. Effective caseload management includes recognizing when consultation would be beneficial to our clinical thinking—outside opinion about a diagnosis, input regarding etiology and underlying causes of a conceptualized concern, advice about the interventions that will form the treatment plan—and to the provision of counseling that results from our clinical thinking.

In addition to supervision and consultation, through which we rely on third-party professionals for guidance, caseload management also sometimes involves direct *collaboration* with a colleague. Common collaborations include cotherapy, in which two or more clinicians work together directly with the same client—for example, providing play therapy, group coleadership, couples or family cotherapy, and other roles such as coleading a workshop. When these formats are used, the colleagues must agree on their clinical thinking as it pertains to the client, coming to a collaborative understanding of the diagnosis, conceptualization, and plan for treatment. The various modes of collaborative counseling in which the client will participate also must be documented in the treatment plan.

Third, when counseling professionals *communicate with stakeholders* besides the client or *conduct business matters,* they often confront questions about, and staked interest in, their clinical thinking. Common stakeholders are parents and legal guardians, spouses, and other family members; referral sources such as teachers and other school personnel, or employers and other workplace personnel; courts and other criminal justice personnel; and individuals making inquiries pertaining to employment checks and background investigations. Common business situations include interactions with third-party payers such as insurance company representatives, health maintenance organization staff, and governmental agency personnel. Counseling generally operates confidentially; however, when it is ethically suitable, or when legally required to do so, counseling professionals might find themselves communicating verbally or in writing about a client with any of these stakeholders. In fact, those interested in the client's well-being often place a lot of pressure on us as professionals to discuss private information about the client. Further, generally speaking, parents and legal guardians have easy access to their minor children's records, and some counselors, such as those working in military settings with service members, do not have the same confidentiality

protections as in other settings. Such communications with stakeholders and business representatives sometimes include sharing the written materials that are a part of the client's agency records. In turn, we must carefully and thoughtfully prepare, and professionally word, all of our written clinical thinking materials—and be cognizant that any diagnostic notes, conceptualizations, or treatment plans we prepare could potentially be seen by individuals outside our office, who may or may not be other mental health professionals, and may or may not have the same client interests as we do. As a result, for new counselors, documentation, communication with stakeholders, and the conducting of business matters often become another important focus of clinical supervision, as we begin learning how to carefully but accurately communicate our clinical impressions of clients (Bernard & Goodyear, 2004; Hall & Sutton, 2004).

Time management, schedule management, and caseload tracking round out this chapter's brief discussion of caseload management as it relates to clinical thinking. It is sufficient here to mention the following points: Time and schedule management includes the timely completion of all record-keeping. In turn, intake materials for clinical use and business purposes, such as diagnostic impressions, case conceptualizations, and treatment plans when any of these are required, should be completed in time to be useful as guides to the implementation of counseling. Further, the counselor's case notes, including the treatment plan and subsequent documentation of counseling outcomes and measure of progress and change, should be prepared so that they are easily usable for caseload tracking—including describing front-end diagnostic and conceptual impressions, measures of progress throughout the counseling process, and evidence of outcomes and final impressions at the conclusion of the psychotherapy relationship. A clinician's collection of case materials should provide a clear, ongoing snapshot of his or her current caseload.

This final aspect of caseload management also means paying attention to our ability to manage our various workplace demands. For example, we must be able to recognize when our caseloads might be too large, become too emotionally demanding, require too many weekly contacts, or involve too many competing roles. Ideally, we can use our clinical thinking—the diagnostic impressions, theoretical conceptualizations, and plans for treatment pertaining to our caseload—to help us monitor and track the nature, content, and strenuousness of the work we are doing. The bottom line is that our clinical thinking tools should be helpful for caseload management. That is, effective clinical thinking practices should help us more carefully track and manage our clinical efforts, professional responsibilities, and office practices, and more closely follow the needs and progress of our individual clients.

Clinical Thinking Skills and Stages of the Change Process

This chapter has so far focused on the role of the three most important clinical thinking tools in professional counseling practice. The final point to be made is that for counseling and mental health practitioners, diagnosis, case conceptualization, and treatment planning occur in the context of an unfolding, more-or-less sequential professional counseling process. Generally speaking, the prototypical counseling

experience follows several logical stages, as follows (Neukrug, 2002, 2003): The earliest steps include pre-interview preparation, first contacts with the client or referral sources, and initial meetings with the client. The next early steps include a period of rapport and trust-building and problem identification. This typically is followed by another early period of deepening understanding of the client's needs and goal-setting. At this point, often referred to as the work stage, the counseling interventions or treatment approach is fully implemented. Finally, the later steps include closure or termination, which is the ending and consolidating phase of the counseling relationship, and then follow-up or other office practices that finish up and close out the process.

In today's mental-health world, counselors are expected to work quickly and efficiently to form initial diagnostic impressions, formulate useful case conceptualizations, and build effective treatment plans early on in the process; monitor and revise their diagnostic impressions and conceptualizations as needed, and provide intermediate measures of counseling effectiveness, during treatment implementation; and reevaluate diagnoses and revisit case conceptualizations and provide evidence of the outcomes achieved at the point of termination and closeout of a case (Budman & Gurman, 1983; Jongsma & Peterson, 2006; Mahalick, 1990; Neukrug, 2002, 2003; Neukrug & Schwitzer, 2006). Table 1.1 provides a generic summary of the prototypical counseling process as it is usually described by today's authors and clinicians.

As can be seen, although the professional counseling relationship is somewhat front-loaded with diagnosis, case conceptualization, and treatment planning tasks, these tools are used throughout the process. During the middle working period, we are expected to monitor, revise, and update our formulations as needed as we come to better understand and evaluate our client's experiences and presentations. We also assess our progress, as operationalized by the treatment plan, throughout the process. We then heavily rely on our diagnostic skills, and our treatment plan measures, again as we terminate and wrap-up. In sum, being skilled at diagnosis, case conceptualization, and treatment planning will be of benefit from start to finish in the transition from natural helper to counseling professional.

Table 1.1 Generic Summary of the Professional Change Process: Clinical Thinking Tools in Context

Stage of Counseling Process	Counseling Relationship Tasks	Primary Clinical Thinking Tasks
Very Earliest Stages	Pre-interview preparation First contact with client or referral source Initial meetings with client Rapport and trust-building Problem identification	Conduct assessment and evaluation Facilitate intake and screening

Stage of Counseling Process	Counseling Relationship Tasks	Primary Clinical Thinking Tasks
Moderately Early Stages	Continued relationship-building Deepening understanding of client needs Goal-setting	Form initial diagnostic impressions Develop case conceptualization Prepare treatment planning
Work Stage	Implementation of treatment plan Planful counseling intervention	Monitor, update, or revise diagnosis Provide ongoing measures of change Update case conceptualization Adjust treatment plan
Later Stages	Closure Consolidation of change Relationship termination Follow-up or other office wrap-up	Reevaluate diagnosis at termination Revisit case conceptualization Demonstrate outcomes achieved

Skill and Learning Exercise 1.4

Diagnosis, Case Conceptualization, and Treatment Planning in a Professional Setting

Select a professional counseling setting in which you are interested, such as a community mental health agency, independent psychological practice, school counseling office, college or university counseling center, inpatient hospital or residential treatment center, or another setting. Interview a staff member to find out what roles diagnosis, case conceptualization, and treatment planning play in his or her daily work. What is expected or beneficial during initial client contacts and early in counseling relationship in the setting? What documents are required? What is expected or beneficial during the working stage when counseling is implemented? How is progress measured? What is expected or beneficial during the final stages, at closure and during follow-up or wrap-up? What final documents are included in the client record at termination? Which diagnostic, case conceptualization, and treatment planning skills are most important or most essential in this setting at the beginning, middle, and end of the counseling relationship? You may want to share your findings in class or discuss your findings during clinical supervision.

Chapter Summary and Wrap-Up

In this chapter, we introduced the primary skills and tools that are the focus of our text: mental health diagnosis, counseling case conceptualization, and psychotherapeutic treatment planning. Each of these skills will be addressed more fully in the remaining three chapters of this section.

First, we introduced the perspective that, for many learners, education and training in the fields associated with professional counseling can be characterized as a transition from one's background experiences as a successful natural helper in one's everyday interpersonal relationships, to a formal career in today's world of professional practice. We believe that mastering the tools that are the focus of this text is critical to the transition.

Next, we defined each of the three tools. We approached diagnosis as a tool for describing client needs, case conceptualization as a tool for understanding client needs, and treatment planning as a tool for addressing client needs—and summarized their interrelationship in Figure 1.1. Looking first at diagnosis, we indicated that clinical diagnosis in the mental health fields refers to using the *DSM-5,* which is a criterion-referenced classification system for organizing and naming what we see and hear our clients experiencing, to form multicomponent diagnoses. We introduced each element of a fully formulated diagnosis, including diagnosable mental disorders and other conditions that might be a focus of counseling, which is the main element and forms the core of the diagnosis; medical conditions and health concerns relevant to the mental disorder diagnosis; environmental problems and psychosocial stressors relevant to the client's clinical presentation; and assessment of problem severity, as well as client vulnerabilities, resiliencies, and functioning. As we indicated, the primary purpose of such a diagnosis is to describe client concerns and communicate about them with other clinicians.

Looking next at case conceptualization, we indicated that case conceptualization in professional counseling refers to a process of evaluating client behaviors, organizing these presentations into patterns and themes, and then applying a selected theoretical orientation to interpret, explain, or make sense of the etiological factors (features leading to or causing the client's concerns) and sustaining factors (features maintaining the concerns, that is, keeping them going). As we discussed, via case conceptualization, contemporary clinicians select one of the pure counseling theories, a psychotherapeutic integration of two or more theories, an eclectic mix, or a brief solution-focused approach. We will use these distinctions throughout the text when we discuss and illustrate case conceptualization. As we mentioned at the beginning of the book, throughout our text we will be applying the Inverted Pyramid Method, which was developed especially for use by new trainees and emerging professionals.

Looking then at treatment planning, we indicated that psychotherapeutic treatment planning involves plotting out a road map for the counseling process to be undertaken by the counselor and client. It gives a picture of the strategy to be used to facilitate change. We summarized treatment planning to include four steps: behaviorally defining counseling problems or targets, setting achievable goals, selecting the

methods of intervention to be employed, and identifying how outcomes change will be shown. We explained some of the many factors that contribute to the selection of goals and determination of modes of intervention, and we emphasized that the client themes and patterns that are derived and the theoretical perspective that is selected during case conceptualization form the basis for developing the treatment plan. We offered three skill-building and learning exercises to further familiarize readers with the three tools and the text's case illustrations.

Finally, we offered some context: We discussed the relationships among diagnosis, case conceptualization, and treatment planning and several aspects of caseload management as it is practiced in professional settings. These included how the clinical thinking tools contribute to documentation; the reasons the tools are the focus of clinical supervision and consultation, and a point of discussion during professional collaborations; the ways in which the tools become topics of communication with stakeholders and when taking care of business activities that are auxiliary to our actual time spent in the counseling session; and how they are associated with daily management of our client workloads. Likewise, we briefly discussed where the tools fit into the start-to-finish stages of the counseling relationship. Table 1.1 provided a summary of the stages and where the tools are used most heavily. This should help you understand how diagnosis, case conceptualization, and treatment planning connect to the overall counseling process with which you are becoming familiar. We now are ready to examine each tool in detail!