Treatment Plan and Progress Monitoring

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The field of clinical mental health is located in a niche between hard and soft sciences. It relies on quantitative and qualitative research to inform valid and reliable assessment and treatment methodologies (Balkin & Kleist, 2017). Simultaneously, it relies on interpersonal communication and connection that ebbs and flows in a nuanced and undeterminable manner. This cross between the informed practice and instinctual responsiveness ultimately gets placed into a treatment plan, with which an effective mental health counselor should use to provide treatment. Each plan, while following a similar structure, should be highly specific to each patient and be carried out accordingly (Schwitzer & Rubin, 2014). Effective treatment planning should include a diagnosis, a problem description, goals, objective, interventions, and a general timeline; problem identification, diagnostic decision making, theoretical approaches, and progress monitoring should also be considered when planning. In other words, a treatment plan incorporates information from the initial diagnosis and case conceptualization into a single plan of action to address the patient's presenting problems (Schwitzer & Rubin, 2014). To further explore effective treatment planning, this writing will consider the case of Eliza.

Treatment Plan

Eliza is a 19-year-old woman currently attending university and majoring in engineering. She comes from a family of successful engineers, all of whom live three hours or more away. She was referred to counseling when she was caught with alcohol in her dormitory on a dry campus; police were involved, as she is currently under the legal drinking age. Briefly, her presenting problems including excessive consumption of alcohol, increasingly frequent self-harm, and a struggle to socialize and maintain academic responsibilities. More recently, she was admitted to the hospital after having made a suicide attempt and drinking to the point of blacking out.

The initial diagnoses include 300.02 (F41.1) Generalized Anxiety Disorder (GAD) and 303.90 (F10.20) Alcohol Use Disorder (AUD). Eliza's treatment plan includes the reduction of alcohol consumption to zero upon discharge from the hospital and conducting weekly check-ins for the next three months to increase likelihood that abstinence continues. This will be attained by avoiding situations that involves alcohol immediately upon discharge and submitting to regular searches by her RA and university police for the rest of the semester. Eliza will also make an effort to cultivate a community and adequately address academic issues (specifically by raising GPA to a B average) by attending tutoring and support groups on and around campus multiple times per week. Some of these are specifically as a result of her over-consumption of alcohol while on university grounds; however, these will be incorporated into treatment to serve a specific purpose over the course of the semester.

Regarding the specifics of some of the goals and interventions, it is clear that Eliza is feeling both overwhelmed and isolated. Addressing these issues may help to alleviate her reliance on alcohol has a coping method. Operating under this assumptions requires that focus be directed to building community and alleviating the stresses and demands of her academic performance. While Eliza may hate that she is being forced to attend a variety of tutoring and classes, these present an opportunity for her to build a community. Social support is key in building and maintaining proper psychological help and reducing symptoms of loneliness and stress (Ozbay et al., 2007). Within the structure provided by these classes and groups, there is a shared mission and common ground that eases the stress of socialization and facilitates greater connection (Cloutier et al., 2019).

Problem Identification and Diagnostic Decision-Making

To reach any conclusion regarding treatment planning, it is helpful to use the American Psychiatry Association's Level 1 cross-cutting symptom measurement tool. This tool was not

developed as a specific screening or diagnostic tool (Clarke & Kuhl, 2014). Rather, this tool exists to give clinicians a quantitative rating scale that helps to characterize presenting problems for patients as useful and clinically meaningful for treatment decision-making (Berry et al., 2011). The results of this questionnaire would provide a specific domain of treatment which provides direction to narrow in on a diagnosis within that domain. For example, Eliza's results would likely meet the threshold for further inquiry on anxiety and substance use. Referencing the *Diagnostics and Statistical Manual* (*DSM*) further and probing specific diagnoses in these domains can provide further clarity on a singular diagnosis. A counselor can also use Level 2 cross-cutting questionnaires, if applicable. In Eliza's case, there is a Level 2 questionnaire for both anxiety and substance use (though this does not include alcohol).

As previously mentioned, Eliza's initial diagnoses includes 300.02 (F41.1) Generalized Anxiety Disorder (GAD) and 303.90 (F10.20) Alcohol Use Disorder (AUD). Eliza is presenting with moderate symptoms of GAD including excessive worrying, restlessness, fatigue, difficulty concentrating, and irritability. These are all impacting her ability to meeting social and academic expectations (American Psychiatric Association, 2013). She is also presenting with severe symptoms of AUD including excessive worrying, restlessness, fatigue, difficulty concentrating, and irritability. These are all impacting her ability to meeting social and academic expectations. This occurs more often in a week than it does not, and these problems have been presenting for more than six months (American Psychiatric Association, 2013). Additional assessments can be used to confirm or disprove a diagnosis, which will be briefly explored later.

Theoretical Approach

While treatment planning may begin with problem identification and diagnostic decision-making, the responsibility of the counselor continues by proceeding with treatment and facilitating the plan effectively. While counselors may specialize in specific areas and favor

some theoretical approaches over others, a competent counselor is generally prepared to implement a variety of techniques and approaches (Drapela, 1990). In the case of Eliza, there seem to be feelings of displacement, social isolation, anxiety, and familial disappointment. This is causing more than surface-level stress; rather, the presenting problems are a manifestation of the conflict that exists between an adolescent Eliza and a young adult Eliza. There is a lot to makes sense of, and a counselor can help her do this.

Consider the role of a therapist as co-constructivist. As Meichenbaum (1993) writes, the constructivist approach generally relies on the idea that humans actively construct their own representations of the world from which meaning may be derived; as co-constructivist, a counselor can help patients alter their personal stories, reframe stressful live events to normalize their own reactions, and establish helpful narratives that spur problem-solving behaviors and proper coping. Validating and empathizing with Eliza's symptoms as reactions to her current situation will alleviate feelings of shame (specifically those that may be connected to a sense of failing her parents). This shift should happen at a fundamental level, causing Eliza to see her own problematic behavior as a process and the process of reflecting on it as an intentional project on its own, rather than a manifestation of something wrong with her that merits shame and guilt (Winter, 2015). This alleviation would also help to address her alcohol dependency, as her feelings of guilt and anxiety have clearly contributed to her worsening dependence.

Progress Monitoring

A treatment plan is not a tool that can be set in motion and abandoned. Instead, it is reasonable and responsible for a counselor to monitor progress on a consistent basis. One assessment that can be used is the Level 2 cross-cutting measurement tool; these Level 2 tools serve as an extension of the Level 1 questionnaire to measure the presence of symptoms but over a specific domain. Inn Eliza's case, this tool would specifically measure anxiety and is referred

to as PROMIS Emotional Distress Anxiety Short Form Questionnaire. This tool measures the number of times a patient felt fearful, anxious, worried, et cetera in the past seven days. A patient receiving proper treatment should see these symptoms occur less often over time. If not, it may be a sign that there is a flaw in the treatment plan.

It's helpful and authoritative to utilize more than one assessment tool, particularly when navigating a robust treatment plan. One such measurement tool for anxiety is the Beck Anxiety Inventory (BAI). This 21-item self-report instrument measures the severity of anxiety in adolescnets and adults (Steer & Beck, 1997). It's a heavily researched and widely used test that provides valid and reliable results across populations and adult age groups and patients, with some studies finding an internal consistency of α=0.90, weekly test-retest correlation of r =0.75, and high correlations with states of anxiety at r =0.60 (Toledano-Toledano et al., 2020). Using this test during initial assessment can help to establish a baseline, and retesting using the same tool will provide a consistent timeline as to the effects of treatment. Obviously, the hope is that anxiety symptoms will decrease over time.

Communicating this with Eliza and her family takes intentionality and nuance. An important factor in navigating this is to personalize the communication, particularly should this communication involve her family. The core purpose behind this treatment place is that Eliza is suffering. Patient-center communication keeps the focus on providing direction and alleviation for the patient and reduces the external conflict for the sake of the patient's success (Sharma & Gupta, 2022). More specific techniques to communicate are specific to the patient but may include the prioritization of the therapeutic relationship, privacy, reflection, clarification, and more (Sharma & Gupta, 2022). These techniques apply both when communicating with a patient regarding their diagnosis and assessment results as well as throughout the planning and

monitoring process. Patient involvement and feedback is essential to effective treatment planning, as it is ultimately the individual that will carry out the bulk of the plan itself. Creating a plan that neglects their strengths, weaknesses, interests, and reality will likely result in failure. Should a plan's integrity start to waiver, communication between the counselor and patient can occur throughout the monitoring process to update accordingly.

Conclusion

Treatment planning is not a simple process of checking boxes or winding up a clock toy car to run on its own. It requires collaboration, cooperation, maintenance, attention, and intentionality to properly create and execute a treatment plan. This is a far cry from the oversimplification of therapy often portrayed in media, where a counselor is often little more than sounding board prattling on about existentialism. While perhaps that has a place, there are many patients seeking practical help and direction. This is the case with Eliza: facing down an alcohol dependency issue and a growing sense of anxiety and isolation, her situation called for direct intervention and behavior change to prompt slow and steady progress and, eventually, relief; using a constructivist approach and relying on cognitive behavior therapy, a counselor can play a part as co-constructivist and empower Eliza to heal from her recent difficulties over time.

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