

# INTRODUCTION

Since the early 1960s, formalized treatment planning has gradually become a vital aspect of the health care delivery system, whether it is treatment related to physical health, mental health, child welfare, or substance abuse. What started in the medical sector in the 1960s spread into the mental health sector in the 1970s as clinics, psychiatric hospitals, agencies, and so on, began to seek accreditation from bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to qualify for third-party reimbursements. With the advent of managed care in the 1980s, treatment planning took on even more importance. Managed care systems *insisted* that clinicians move rapidly from assessment of the problem to the formulation and implementation of the treatment plan. The goal of most managed care companies is to expedite the treatment process by prompting the client and treatment provider to focus on identifying and changing behavioral problems as quickly as possible. Treatment plans must be specific as to the presenting problems, behaviorally defined symptoms, treatment goals and objectives and interventions. Treatment plans must be individualized to meet the client's needs and goals, and the observable objectives must allow for setting milestones that can be used to chart the client's progress. Pressure from third-party payors, accrediting agencies, and other outside parties has therefore increased the need for clinicians to produce effective, high-quality treatment plans in a short time frame. However, many mental health providers have little experience in treatment plan development. Our purpose in writing this book is to clarify, simplify, and accelerate the treatment planning process.

## PLANNER FOCUS

*The Group Therapy Treatment Planner* was conceived as a way to facilitate the treatment of specific therapeutic problems in the group

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setting. At a time when managed care organizations are becoming the norm in health care and mental health benefits are being severely restricted, there is enormous pressure to treat problems in as cost-effective a way as possible. Focal group therapy is an effective, cost-reducing alternative to individual therapy.

Focal groups, in contrast to more traditional transference-based models of group therapy, are characterized by their homogeneity, their high degree of structure, their goal orientation, and their high educational function. Most are time-limited, though in this *Treatment Planner* the specific length of each group is left up to the individual clinician to determine. Also left up to the individual clinician are the issues of group size and the specific screening procedures she or he will use in determining eligibility for the group, apart from meeting the behavioral definitions listed for each specific problem.

Because most problems encountered in life are problems of relationships with others, from the family to the workplace to social activities, dealing with specific problems in the group format allows clients to work on their issues in the mode that often feels most familiar and comfortable to them. In a group setting, client problems can be acted out directly, as opposed to symbolically, and thus addressed more effectively. Furthermore, group members can share their resources and their insights and develop new self-perceptions as they see themselves interacting in different ways.

*The Group Therapy Treatment Planner* outlines many treatment issues, the specific goals for treating them, and a range of interventions for reaching those goals. It is important to remember, however, that this treatment planner cannot substitute for either good clinical training and judgment or experience with groups. Both criteria must be met in order for the material in this book to be most effectively used.

This second edition of *The Group Therapy Treatment Planner* contains several significant changes:

- Five new presenting problem chapters have been included: Attention-Deficit/Hyperactivity Disorder (ADHD)—Adult, Borderline Personality Disorder, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder (PTSD), and Stepparenting.
- Refinements to previous treatment plan statements—Each item from the first edition was carefully reviewed to clarify the language, reduce redundancies, and sharpen the focus of interventions coordinated with objectives.
- Improved chapter layout—Interventions are now listed directly across the page from the Objectives with which they are associated.

## DEVELOPING A TREATMENT PLAN

The process of developing a treatment plan involves a logical series of steps that build on each other much like constructing a house. The foundation of any effective treatment plan is the data gathered in a thorough biopsychosocial assessment. As the client presents himself or herself for treatment, the clinician must sensitively listen to and understand what the client struggles with in terms of family-of-origin issues, current stressors, emotional status, social network, physical health, coping skills, interpersonal conflicts, self-esteem, and so on. Assessment data may be gathered from a social history, physical exam, clinical interview, psychological testing, or contact with a client's significant others. The integration of the data by the clinician or the multidisciplinary treatment team members is critical for understanding the client, as is an awareness of the basis of the client's struggle. We have identified six specific steps for developing an effective treatment plan based on the assessment data.

### Step One: Problem Selection

Although the client may discuss a variety of issues during the assessment, the clinician must ferret out the most significant problems on which to focus the treatment process. Usually a *primary* problem will surface, and *secondary* problems may also be evident. Some *other* problems may have to be set aside as not urgent enough to require treatment at this time. An effective treatment plan can deal only with a few selected problems or treatment will lose its direction. This *Planner* offers 33 problems from which to select those that most accurately represent your client's presenting issues.

As the problems to be selected become clear to the clinician or the treatment team, it is important to include opinions from the client as to his or her prioritization of issues for which help is being sought. A client's motivation to participate in and cooperate with the treatment process depends, to some extent, on the degree to which treatment addresses his or her greatest needs.

### Step Two: Problem Definition

Each individual client presents with unique nuances as to how a problem behaviorally reveals itself in his or her life. Therefore, each problem that is selected for treatment focus requires a specific definition about how it is evidenced in the particular client. The symptom pattern should be associated with diagnostic criteria and codes such as those

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found in the *Diagnostic and Statistical Manual (DSM)* or the *International Classification of Diseases (ICD)*. The *Planner*, following the pattern established by *DSM-5*, offers such behaviorally specific definition statements to choose from or to serve as a model for your own personally crafted statements. You will find several behavior symptoms or syndromes listed that may characterize one of the 33 presenting problems.

### **Step Three: Goal Development**

The next step in treatment plan development is to set broad goals for the resolution of the target problem. These statements need not be crafted in measurable terms but can be global, long-term goals that indicate a desired positive outcome to the treatment procedures. The *Planner* suggests several possible goal statements for each problem, but one statement is all that is required in a treatment plan.

### **Step Four: Objective Construction**

In contrast to long-term goals, objectives must be stated in behaviorally measurable language. It must be clear when the client has achieved the established objectives; therefore, vague, subjective objectives are not acceptable. Review agencies (e.g., JCAHO), HMOs, and managed care organizations insist that psychological treatment outcomes be measurable. The objectives presented in this *Planner* are designed to meet this demand for accountability. Numerous alternatives are presented to allow construction of a variety of treatment plan possibilities for the same presenting problem. The clinician must exercise professional judgment as to which objectives are most appropriate for a given client.

Each objective should be developed as a step toward attaining the broad treatment goal. In essence, objectives can be thought of as a series of steps that, when completed, will result in the achievement of the long-term goal. There should be at least two objectives for each problem, but the clinician may construct as many as are necessary for goal achievement. Target attainment dates may be listed for each objective. New objectives should be added to the plan as the individual's treatment progresses. When all the necessary objectives have been achieved, the client should have resolved the target problem successfully.

## Step Five: Intervention Creation

Interventions are the actions of the clinician designed to help the client complete the objectives. There should be at least one intervention for every objective. If the client does not accomplish the objective after the initial intervention, new interventions should be added to the plan.

Interventions should be selected on the basis of the client's needs and the treatment provider's full therapeutic repertoire. This *Planner* contains interventions from a broad range of therapeutic approaches, including cognitive, dynamic, behavioral, pharmacologic, family-oriented, and solution-focused brief therapy. Other interventions may be written by the provider to reflect his or her own training and experience. The addition of new problems, definitions, goals, objectives, and interventions to those found in the *Planner* is encouraged because doing so adds to the database for future reference and use.

Some suggested interventions listed in the *Planner* refer to specific books that can be assigned to the client for adjunctive bibliotherapy. Appendix A contains a full bibliographic reference list of these materials. The books are arranged under each problem for which they are appropriate as assigned reading for clients. When a book is used as part of an intervention plan, it should be reviewed with the client after it is read, enhancing the application of the content of the book to the specific client's circumstances. For further information about self-help books, mental health professionals may wish to consult *The Authoritative Guide to Self-Help Books* (1994) by Santrock, Minnett, and Campbell (New York: Guilford Press).

Assigning an intervention to a specific provider is most relevant if the client is being treated by a team in an inpatient, residential, or intensive outpatient setting. Within these settings, personnel other than the primary clinician may be responsible for implementing a specific intervention. Review agencies require that the responsible provider's name be stipulated for every intervention.

## Step Six: Diagnosis Determination

The determination of an appropriate diagnosis is based on an evaluation of the client's complete clinical presentation. The clinician must compare the behavioral, cognitive, emotional, and interpersonal symptoms that the client presents to the criteria for diagnosis of a mental illness condition as described in *DSM-5*. The issue of differential diagnosis is admittedly a difficult one that has rather low inter-rater reliability. Psychologists have also been trained to think

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more in terms of maladaptive behavior than in disease labels. In spite of these factors, diagnosis is a reality that exists in the world of mental health care and it is a necessity for third-party reimbursement. (Recently, managed care agencies have shown more interest in behavioral indices that are exhibited by the client than in the actual diagnosis.) It is the clinician's thorough knowledge of *DSM-5* criteria and a complete understanding of the client assessment data that contribute to the most reliable, valid diagnosis. An accurate assessment of behavioral indicators will also contribute to more effective treatment planning.

### HOW TO USE THIS PLANNER

Our experience has taught us that learning the skills of effective treatment plan writing can be a tedious and difficult process for many clinicians. It is more stressful to try to develop this expertise when under the pressure of increased client load and the short time frames placed on clinicians today by managed care systems. The documentation demands can be overwhelming when we must move quickly from assessment to treatment plan to progress notes. In the process, we must be very specific about how and when objectives can be achieved, and how progress is exhibited in each client. *The Group Therapy Treatment Planner* was developed as a tool to aid clinicians in writing a treatment plan in a rapid manner that is clear, specific, and highly individualized according to the following progression:

1. Choose one presenting problem (Step One) you have identified through your assessment process. Locate the corresponding page number for that problem in the *Planner's* table of contents.
2. Select two or three of the listed behavioral definitions (Step Two) and record them in the appropriate section on your treatment plan form. Feel free to add your own defining statement if you determine that your client's behavioral manifestation of the identified problem is not listed. (Note that while our design for treatment planning is vertical, it will work equally well on plan forms formatted horizontally.)
3. Select a single long-term goal (Step Three) and again write the selection, exactly as it is written in the *Planner* or in some appropriately modified form, in the corresponding area of your own treatment form.
4. Review the listed objectives for this problem and select the ones that you judge to be clinically indicated for your client (Step Four). Remember, it is recommended that you select at least

two objectives for each problem. Add a target date or the number of sessions allocated for the attainment of each objective.

5. Choose relevant interventions (Step Five). The *Planner* offers suggested interventions related to each objective in the parentheses following the objective statement. But do not limit yourself to those interventions. The entire list is eclectic and may offer options that are more tailored to your theoretical approach or preferred way of working with clients. Also, just as with definitions, goals, and objectives, there is space allowed for you to enter your own interventions into the *Planner*. This allows you to refer to these entries when you create a plan around this problem in the future. You will have to assign responsibility to a specific person for implementation of each intervention if the treatment is being carried out by a multidisciplinary team.
6. Several *DSM-5* diagnoses are listed at the end of each chapter that are commonly associated with a client who has this problem. These diagnoses are meant to be suggestions for clinical consideration. Select a diagnosis listed or assign a more appropriate choice from the *DSM-5* (Step Six).

*Note:* To accommodate those practitioners who tend to plan treatment in terms of diagnostic labels rather than presenting problems, Appendix B lists all of the *DSM-5* diagnoses that have been presented in the various presenting problem chapters as suggestions for consideration. Each diagnosis is followed by the presenting problem that has been associated with that diagnosis. The provider may look up the presenting problems for a selected diagnosis to review definitions, goals, objectives, and interventions that may be appropriate for their clients with that diagnosis.

Congratulations! You should now have a complete, individualized treatment plan that is ready for immediate implementation and presentation to the client. It should resemble the format of the “Sample Treatment Plan” presented on page 8.

## **A FINAL NOTE**

We have put together a variety of choices to allow for thousands of potential combinations of statements that join to make a completed plan for treatment. Clinicians using their good judgment can easily select statements that are appropriate for the individuals they are treating. Each statement can be modified as necessary to more directly

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apply to a specific individual client. Finally, we believe from our experience that the *Planner* method of treatment plan construction is helpful in that it stimulates creative thoughts by clinicians. New ideas for all components of a treatment plan may come to mind as the *Planner* statements are reviewed. Clinicians can add to the *Planner* by writing in new definitions, goals, objectives, and interventions.

## SAMPLE TREATMENT PLAN

### PROBLEM: ANGER CONTROL PROBLEMS

- Definitions:** History of explosive aggressive outbursts out of proportion to any precipitating stressors.  
 Overreacts with hostility to insignificant irritants.  
 Uses verbally abusive language.  
 Recognizes and admits to negative consequences of poor anger control (in terms of relationships, health, work life, etc.).
- Goals:** Express anger in a controlled, respectful manner with reasonable judgment regarding time and place.

#### OBJECTIVES

1. Keep a log of circumstances surrounding the experience of anger.
  
2. Verbalize an understanding of the two-step model of anger.

#### INTERVENTIONS

1. Assign the group members to keep an anger log to facilitate self-observation. Entries include date, time, the situation, anger-triggering thoughts, emotional arousal (on a scale of 1 to 10), and aggressive behavior (on a scale of 1 to 10).
  2. Review the members' anger logs and have members share with the group insights gained.
1. Teach the group that anger is a two-step process, requiring both (1) experience of pain (physical or emotional), and (2) use of trigger thoughts (attributions that blame others for the painful experience) to discharge arousal.
  2. Facilitate a group discussion about anger's self-perpetuating cycle of anger: anger-trigger thoughts—more anger; encour-

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1. Elicit the members' beliefs about the value of venting anger; then correct misperceptions by teaching that ventilation increases rather than dissipates anger.
3. Verbalize an awareness of the futility of ventilation as an anger-control tool.
4. Use imagery to demonstrate the coping skills of relaxation and positive self-talk in low-anger situations.
  1. Lead the group through the entire combined relaxation program: progressive muscle relaxation (without tension), followed by safe place visualization, and finally deep abdominal breathing using cue words; assign them to practice the entire sequence daily during the week and report on their progress the following week.
  2. Facilitate the group development of a list of self-talk statements for each category of trigger thought and a list of general coping statements ("I can stay calm and relaxed," "Getting mad won't help"); make copies for each group member.
5. Verbalize an understanding of active and passive Response Choice Rehearsal (RCR).
  1. Teach the group three *active* (when the client is feeling anger) Response Choice Rehearsal (RCR) opening statements (McKay and Rogers): (1) ask for what you need/want ("I'm feeling \_\_\_\_, and what I think I need/want in this situation is \_\_\_\_."); (2) negotiate ("What would you propose to solve this problem?"); (3) use self-care ("If this continues, I'll have to \_\_\_\_ in order to take care of myself.").

2. Teach the group three *passive* (when other person is feeling anger) RCR opening statements (McKay and Rogers): (1) get information (“What do you need in this situation?” “What concerns you?” “What’s bothering you in this situation?”); (2) acknowledge (“So what you want is \_\_\_\_;” “So what concerns/bothers you is \_\_\_\_.”); (3) withdraw (“It feels like we’re starting to get upset;” “I want to stop and cool off for awhile.”).
6. Verbalize own need statements, negotiating statements, and self-care solutions assertively, not aggressively.
7. Demonstrate flexible use of the six RCR responses in role-play situations.
  1. Help each member develop appropriate, assertive need/want statements, and self-care solutions; emphasize positive voice control (e.g., no sarcasm or anger).
8. Demonstrate flexible use *in vivo* of the six RCR responses in low-, medium-, and high-anger situations.
  1. Assign triads of members to role play low-, medium-, and high-anger scenes (with one person the provocateur, one practicing the RCR responses, and the third coaching); facilitate group discussion about role-play experiences.
  1. Assign the members to practice *in vivo* RCR with a low-risk person with whom they’ve had conflict; have them plan ahead their need/want statements, a fallback position, and a self-care solution.
  2. Ask the members to report back to the rest of the group their success with *in vivo* RCR situations.

**Diagnosis:** F63.81 Intermittent Explosive Disorder