CHAPTER 3

TREATMENT PLANNING USING A PHASE APPROACH

Treatment planning involves mapping not only the direction taken to meet the needs of the clients but also the tools used along the way. Planning also involves formulating expectations about how much change is anticipated and how quickly it should occur. A number of clinicians have emphasized the importance of treatment planning (e.g., Galasso, 1987; Makover, 1992, 1996), and these days many managed care organizations require it. As Heinssen, Levendusky, and Hunter (1995) described, "Focused, well-articulated treatment plans [improve] communication with managed care agencies because each client's presenting problems, treatment goals, and interventions are specified in understandable terms" (p. 530). Contemporary mental health care providers are usually bound by significant time constraints, so they must focus treatment strategies to accomplish as much as possible in just a few sessions. Given these constraints, treatment planning is a necessary element of accountable practice. Creating a Treatment Plan can help to organize a client's problems into a set of measurable goals and intervention strategies that maximize the efficiency of practice.

Nonetheless, treatment planning may be difficult for some practitioners to embrace, perhaps because it appears to be incompatible with the artistry and spontaneity that attract many individuals to the prac-

tice of psychotherapy. Makover (1996), who noted that an "anti-planning bias" has permeated the culture of psychotherapy over the years, argued for setting aside this bias, in part because it is based on three questionable assumptions: (1) human behavior is mysterious and unpredictable; (2) humans are too complex to be subject to rational planning; and (3) the relationship in psychotherapy is more important than the therapeutic activity. Makover suggests instead (and we agree) that psychotherapy is understandable, teachable, and amenable to a planning process. Although human behavior is complex and often unpredictable, contemporary practice of clinical psychology, clinical social work, and psychiatry involves identifiable therapeutic strategies that can be specified or sketched out in advance. A positive therapeutic alliance appears to be necessary for good therapy outcomes, but it is not the only critical element (Bergin & Garfield, 1994).

FROM PROBLEM IDENTIFICATION TO PROBLEM SOLVING

Once the Problem List is created (as detailed in Chapter 2), the therapist moves from problem identification to problem solving, an iterative process in the PACC model. After cataloguing the client's problems, the therapist specifies aims that represent short-term goals related to the most pressing problems and are targets of the initial stage of intervention. The therapist then outlines treatment strategies to achieve these aims, measures how effectively the client is progressing toward them, and regularly reviews progress to determine whether the treatment should change, remain the same, or end. In short, treatment planning is a systematic way to move through the Problem List.

TREATMENT PLANNING AS THE THERAPIST'S MAP

Of course, it is impossible to address all of the client's problems at once. In our own practices, we weigh the options, often in collaboration with the client, to come up with a tentative "map" of the treatment process—essentially a brief plan of priorities and interventions. The challenge for the therapist is to synthesize the data that have been gathered from the initial interview and to formulate a case conceptualization that targets the treatment to the particular problems and strengths of the client. As we have discussed in Chapters 1 and 2, the therapist need not be constrained by a single therapeutic orien-

tation, but can instead use an integrative approach that flexibly adapts the initial Treatment Plan based on the client's response to the intervention. By combining an evidence-based approach to selection of treatment strategies with ongoing measurement of progress, the therapist can avoid falling into the trap of offering all clients the same treatment, regardless of the nature of their difficulties (see Lewis & Usdin, 1982).

The case formulation bridges the Problem List and the Treatment Plan, acting as "the clinician's compass" (Sperry et al., 1992) to guide treatment. As discussed in Chapter 2, effective case formulation includes descriptive components ("What is happening to the client?"), explanatory components ("Why did it happen?"), and treatment–prognostic components ("What can be done, and how effective is it likely to be?"; Sperry et al., 1992). Whereas the formulation is the therapist's compass, the Treatment Plan is the map, detailing where the therapy is headed and likely paths to reach the destination. The therapist uses the case formulation's descriptive, explanatory, and treatment–prognostic components to help integrate the biological, psychological, and social underpinnings of the client's difficulties. This groundwork informs the order in which problems are best addressed, the expectations for change, and the treatments that are most likely to be helpful (Lewis & Usdin, 1982).

For example, a client who is dissatisfied with her marriage may seek treatment for a number of reasons. Understanding why she is dissatisfied is not only the explanatory component of the case formulation, but it also influences the therapist's selection of interventions and his or her expectations for treatment. If the client's marital dissatisfaction is grounded in her belief that she is unlovable, the therapist is likely to choose initial interventions to address such beliefs. On the other hand, if the dissatisfaction appears to be due to the client's lack of identity outside of marriage, the therapist is likely to choose different interventions. If the dissatisfaction comes from the client's inability to be assertive and to communicate effectively with her spouse, the interventions will be different still. The degree to which the client is coming to treatment to "fix" the marriage versus "escape" it is also a part of the formulation that helps to dictate expectations for change. If the client comes from a background in which divorce is common or accepted, the expectations may be slightly different than if she believes that divorce is unacceptable. There is no right or wrong answer to how the formulation should guide treatment planning, and different clinicians have their own preferences as to where to begin an intervention.

Nonetheless, the formulation helps therapists to prioritize goals and create plans for change.

Realistic Goal Setting

Task performance is greatly enhanced by setting goals related to the task. This is one of the most robust and replicable findings in psychology (Locke, Shaw, Saari, & Latham, 1981). A client who works toward a goal is more likely to make productive use of the therapy sessions and of the time between sessions. Furthermore, goal setting enhances the tendency of the client to persist in the face of inevitable obstacles, and focusing on the goals encourages the client and therapist to develop creative strategies to attain the goal.

An important factor influencing the type of goals set is the client's efficacy expectations. As Bandura (1977) described, an *outcome expectation* is a person's belief that certain behaviors will lead to certain outcomes (e.g., "Exercise will improve my mood and make me feel good about myself"). An *efficacy expectation* is the person's belief that he or she will successfully carry out the behavior (e.g., "I can meet my goal of exercising three times a week"). Often, the client may expect good outcomes but have low confidence in his or her ability to carry out the planned changes. For example, "I know spending time with my friends will make me feel better, but I simply can't bring myself to pick up that phone and dial." Efficacy expectations are critical because the strength of clients' convictions in their own effectiveness is likely to affect whether they will even try new strategies for coping with their problems (Bandura, 1977). As a consequence, even therapists who use a very collaborative style may need to take the lead in setting goals if a client is demoralized because of low efficacy expectations.

Goal Acceptance and Commitment

Motivation to establish goals in psychotherapy comes from within the client as well as from external sources (e.g., family, therapists, agencies). Nevertheless, even the most agreeable and motivated clients may have difficulty maintaining commitment to established goals. (Indeed, this is often part of the problem that brings clients to treatment.) As therapists, how can we help boost clients' motivation and commitment to achieving therapy-related goals? Setting concrete goals that are challenging yet realistic is one way to help make this happen (Locke et al., 1981). Encouraging clients to make a public commitment to the goal

also increases goal commitment (Hollenbeck, Williams, & Klein, 1989). The simple act of discussing treatment aims with a therapist (or with other members of a treatment group) can function as a public commitment, or clients can go further and discuss goals with trusted friends or family members. We recommend looking into motivational interviewing (Miller & Rollnick, 1991) for specific strategies to evaluate and enhance commitment to change for those clients who need a motivational boost.

TREATMENT PHASES

The PACC approach views treatment as a series of phases rather than as a single overall target or intervention. In general, it is only possible to work on a limited number of problems at once. Some clients with relatively straightforward and circumscribed problems may need only one phase of therapy, but more complicated clients will progress through several phases. Within each phase, the therapist (usually in collaboration with the client) defines aims that are to be the focus of that particular section of therapy, develops a measurement plan for those aims, and specifies the intervention strategies to be used within the phase. See Figure 3.1 for a blank copy of the form we use for this aspect of treatment planning.

The client should be included in the decision-making process to determine where to focus treatment initially. Consider the case of Peter, a 15-year-old high school sophomore, who had been experiencing panic attacks for the past year. Peter had been taking antianxiety medication prescribed by his primary care physician who was a family friend. In March of his sophomore year, Peter's panic attacks became so severe that he was spending every day in the nurse's office rather than attending his classes. His guidance counselors became increasingly concerned, and Peter began to feel isolated and hopeless about his condition. In April, he took an overdose of Tylenol and was hospitalized. Although his parents were reluctant to acknowledge that Peter had emotional problems, they nevertheless enrolled him in a short-term residential treatment program for adolescents. During this therapy, Peter revealed that he not only experienced panic attacks but also had a fear of vomiting that prohibited him from eating regular, balanced meals. In the 2 months leading up to his hospitalization, Peter had lost over 20% of his body weight, putting him at risk for multiple health problems.

Peter's problems crossed multiple domains of concern, including his depression and suicide attempt, panic attacks, agoraphobia, fear of vomiting, severe weight loss, and his parents' tendency to minimize his problems (which could undermine treatment progress). Not all of Peter's problems could be addressed at once. Instead, using a phase model, the treatment team at the residential program worked with Peter and his family to create a plan of action. Obviously, the high-risk problems, including Peter's suicidality, had to be addressed before his other problems could be tackled in subsequent phases of treatment. Conceptualizing treatment in terms of phases requires a degree of patience and an open acknowledgment to the client (and in Peter's case, to his parents) that not everything will get better at once.

The assumption that therapy can only target a limited number of problems at one time means that the "current" aims of treatment will shift over time. In Peter's case, the initial treatment aims were to minimize suicide risk and improve his depressed mood. Once Peter's mood was stabilized, the treatment aims changed. Although there were a number of possible problem areas to target (e.g., family relationships, panic attacks, weight loss through food avoidance), the therapist and Peter chose to focus on his panic attacks and avoidance of school. This issue was a priority for Peter because summer school had begun and, having been a high-achieving student, Peter wanted to begin making up the work he had missed due to his illness. Simultaneously, Peter's therapist arranged for a consultation with a nutritionist to partially address his weight loss. In this way, Peter worked on multiple problems concurrently without detracting from the focus on his panic. See Figure 3.2 to see how Peter's therapist completed the Aims portion of the Treatment Plan for the first two phases of therapy.

The number of phases clients will need depends on several factors, including the number and severity of their problems. Some clients come to therapy to work on a discrete problem, such as a specific phobia. Others come to treatment with multiple, complicated problems, such as a first psychotic break within the context of ongoing substance abuse, job loss, and an unsupportive home environment. Still other clients come to treatment in the midst of a depressive episode, and the true extent of their problems may not be apparent until some of the depressive symptoms subside. In contemporary models of treatment delivery, it is likely that one clinician will not be responsible for delivering all phases of care to a client. In Peter's case, for example, his primary clinician was a psychologist, but he also had sessions with a nutritionist as well as some family sessions with a social worker.

Treatment Phase I Date:

Aims: **1.**

2.

3.

Measures: (attach graph) **1.**

2.

3.

Strategies: **1.**

2.

3.

Date for Phase I Progress Review:

Treatment Phase II Date:

Aims: **1.**

2.

3.

Measures: (attach graph) **1.**

2.

3.

Strategies: **1.**

2.

3.

Date for Phase II Progress Review:

(continued)

FIGURE 3.1. Treatment Planning Worksheet.

Treatment Phase III	Date:
Aims:	**1.**
	2.
	3.
Measures: (attach graph)	**1.**
	2.
	3.
Strategies:	**1.**
	2.
	3.
Date for Phase III Progress Review:	
Treatment Phase IV	Date:
Aims:	**1.**
	2.
	3.
Measures: (attach graph)	**1.**
	2.
	3.
Strategies:	**1.**
	2.
	3.
Date for Phase IV Progress Review:	

FIGURE 3.1. *(continued)*

Treatment Phase I	Date: April 17, 2002
Aims:	**1.** Reduce frequency of suicidal ideation.
	2. Reduce hopelessness.
	3. Reduce level of depression.
Measures: (attach graph)	**1.**
	2.
	3.
Strategies:	**1.**
	2.
	3.
Date for Phase I Progress Review: June 21, 2002	
Treatment Phase II	Date: June 23, 2002
Aims:	**1.** Reduce frequency of panic attacks.
	2. Reduce fear of having more attacks.
	3. Eliminate avoidance of school and social situations.
Measures: (attach graph)	**1.**
	2.
	3.
Strategies:	**1.**
	2.
	3.
Date for Phase II Progress Review: September 25, 2002	

FIGURE 3.2. Aims of Phase I and II Treatment Plan for Peter.

EFFECTIVENESS OF PHASE MODELS OF PSYCHOTHERAPY

Rogers (1958) was among the first clinicians to describe distinct phases of psychotherapy, noting an early phase in which clients struggle to identify problems, and a later phase in which clients feel a heightened sense of self-awareness and confidence. Although the specific objectives of each phase of treatment may depend upon the clinician's background and training, the notion that psychotherapy proceeds in stages is a common heuristic tool that transcends theoretical orientation (Beitman, Goldfried, & Norcross, 1989). Empirical evidence corroborates the belief that repeated "doses" of brief therapy have the same or better effect as a time-unlimited, single phase of therapy, even when treating severe and chronic conditions (Budman & Gurman, 1988). In contemporary mental health care, multiple doses (i.e., phases) of treatment are also frequently a practical reality (Haas & Cummings, 1991) due to the unavailability of sustained long-term care.

Experienced therapists often develop their own implicit system for thinking through the anticipated phases of treatment with different clients. In carrying out the PACC approach, we encourage clinicians to make this process explicit. For example, Heinssen et al. (1995) have developed a therapeutic contracting model that is compatible with ours, in which they propose a series of treatment phases with specified aims (i.e., short-term goals) and strategies. Data evaluating the effectiveness of their contracting program suggest that, across treatment settings (e.g., private and public psychiatric hospitals, outpatient settings), the program enhances treatment compliance, achieves positive therapeutic outcomes, and provides long-term, cost-effective, multimodal treatment. See Heinssen et al. (1995) for a review.

Conceptualizing treatment as consisting of distinct phases can also be useful in the treatment of Axis II disorders, even borderline personality disorder. Zanarini and Frankenburg (1994) proposed three separate phases based on their interpretation of theoretical work by writers such as Gunderson (1984), Masterson (1972), and Volkman (1987). The first phase is called "Reframing" and involves treatment strategies such as teaching clients to reframe their complaints and actions (e.g., suicidal gestures) as efforts to express intense psychological pain. Zanarini and Frankenburg (1994) argue that by the end of the first phase of treatment, one should see a decrease in the client's reliance on self-destructive behaviors and complaints, an increase in the ability to articulate the pain he or she is feeling, and an increase in his or her goal-directed activity (as indicated by a return to work or school).

In the second phase of treatment, "Validation," treatment strategies include helping clients to verbalize chaotic life experiences and allowing them to accept their emotional responses to these experiences. In the "Mourning" phase of treatment, Zanarini and Frankenburg (1994) suggest strategies that include helping clients experience and tolerate emotions (such as sorrow) associated with how others have hurt them and how they have hurt themselves and others. This model illustrates the feasibility of effectively planning therapy even for complex, long-standing problems by specifying the expected concrete changes for each phase of treatment.

The PACC approach is intended to be adaptable, enabling movement from one therapy phase to another to allow treatment to be tailored to the individual client based on his or her progress. Thus, the initial Treatment Plan is not an end product but is instead an iterative, dynamic agenda. Although many therapists will be able to foreshadow future treatment phases, there is also flexibility inherent in a phase model to accommodate the inevitable "surprises" that arise in psychotherapy. By moving the client from one phase to the next, the therapist is able to respond to unforeseen challenges and adjust to a client's changing needs, rather than adhering to a rigid approach or feeling that treatment has been derailed. We now describe our conceptualization of phases within the PACC approach.

PHASES IN THE PACC APPROACH

Each phase of treatment within the PACC approach addresses three distinct components of treatment planning: Aims, Measures, and Strategies (see Figure 3.1). We discuss treatment aims and strategies in this chapter and then describe measurement issues in Chapter 4. Briefly, aims are the short-term, specific goals set at the beginning of a treatment phase. The client and therapist may also discuss long-term, abstract treatment goals (e.g., improve life satisfaction), but these are different from treatment aims. The aims are concrete and measurable objectives that usually vary from one phase of treatment to the next. Taken as a whole, aims can be thought of as the components that contribute to an overarching treatment goal. Treatment strategies are the means by which the therapist goes about helping the client to reach the aims. In other words, strategies are the specific interventions and techniques used within the therapy session. Measures are the tools (some standardized and others tailored for a given client) that assess how much progress is being made toward a treatment aim.

These components are illustrated in the Treatment Plan for Marjorie, a 57-year-old woman who sought treatment for depression that had begun 8 years earlier, following the death of her son. Marjorie was socially isolated and lonely, and she had lost interest in most things. She had also struggled with hypothyroidism, which was being successfully managed with medication at the time she began psychotherapy. Nevertheless, she had gained about 60 pounds in the previous few years, which only deepened her sense of demoralization. Marjorie's primary goal was to stop feeling so depressed, and she also hoped to return to her former weight.

In the first phase of treatment, the therapist proposed aims that would be manageable for Marjorie and provide some momentum built on success. These aims included increasing Marjorie's social activity level, beginning a program of walking (which Marjorie said she used to enjoy), and learning to keep a diary of her automatic thoughts. Although these aims may seem modest, Marjorie's long-standing depression made them feel challenging, and Marjorie initially viewed them as weak substitutes for her real goal of feeling less depressed. Nevertheless, when the therapist explained the rationale of the Treatment Plan (that achieving these small aims would contribute to progress on her larger goal), Marjorie responded positively to having her problems broken down into manageable parts that would be addressed one by one.

OUTLINING EXPECTATIONS FOR PROGRESS WITHIN PHASES

In planning each phase of treatment, we have found it helpful to schedule an actual date for review of progress on the aims of that phase. The review date reflects the therapist's expectations about the rate at which change ought to occur relative to the specific aims in a given phase. Depending on the nature of aims in a given phase of treatment, we generally schedule Progress Reviews at least every 3 months. (See Chapter 6 for a discussion of factors affecting this flexible time line.) If the therapist does not expect change to occur in that time, then the aims should be honed to represent smaller steps of progress. Measurement of progress occurs regularly and is not limited to review dates. In this way, measurement data can be used in treatment planning both for the next phase and for specific strategies within each session. Bernstein (1992) eloquently describes the rationale for this kind of continuous Progress Review:

> One might fear that a competency-based approach to therapy would present extra difficulty in cases where the client fails to progress in treatment. The opposite is true. With a competency-based approach to treatment, the structure of the therapeutic process forces both client and therapist to recognize a failure when it has occurred, rather than dodge the issue. This is tremendously helpful because with recognition there is an opportunity for corrective action and new learning. Rarely does learning occur without failure, and therefore, there is rarely successful therapy without failure. (pp. 272–273)

During the review, the therapist examines the degree to which the aims of the preceding phase have been met (based on the data collected over time during the phase). He or she then decides what to do for the next phase. A new phase may represent moving on to new aims when the current aims are accomplished, changing the strategies used, or switching to a problem that has become more pressing than the one targeted in the previous phase.

Returning to the example of Marjorie, the therapist reviewed progress on the aims of the initial phase of treatment after five sessions of therapy. Marjorie's depression had diminished somewhat, with Beck Depression Inventory scores moving from 26 to 22, but she was still quite depressed. Although initially resistant, she had begun taking 20-minute walks around her neighborhood about three times a week. Furthermore, although her social network had dwindled during her years of depression and social isolation, Marjorie had begun to strike up conversations with colleagues, neighbors, and strangers. She rediscovered that talking to people could be enjoyable. At the fifth session, her diary of social interactions showed that she was having about one social conversation each day, a vast improvement over the initial evaluation. The therapist, satisfied with the initial progress in helping Marjorie to get activated, moved on to a new phase of treatment, developing aims related to Marjorie's negative automatic thoughts about herself, other people, and her future.

TREATMENT AIMS

We distinguish aims as small steps toward a larger overarching treatment goal. Bandura and Simon (1977) made a similar distinction between *end goals* (i.e., overarching goals) and *subgoals* (i.e., aims). Overarching end goals serve a general, directive function toward an

aspiration (e.g., a more satisfying life), but they appear to have little impact on what individuals actually choose to do in the here and now. Subgoals (or aims) play a more central role in immediate behaviors and in how hard individuals will work on these behaviors (Bandura & Simon, 1977).

Even if end goals appear incredibly difficult to reach, people can maintain a high level of motivation through a progression of subgoals. Bandura and Simon (1977) argued that subgoals are most satisfying and motivating when they are somewhat challenging but still attainable. For many clients like Marjorie, it may be impossible to imagine that an end goal of "feeling better" will ever come to pass, because it is hard to imagine how to begin on the road to achieving that goal. However, gradually increasing pleasant activities seems more attainable, in part because of the greater specificity of these aims. In setting goals, the clinician's objective is to replace the overwhelming burden of wanting to feel better with a sense of working toward a manageable set of subgoals or aims.

The therapist works with the client to translate issues on the Problem List into realistic steps for treatment that represent the aims of each phase. Aims should be specific, concrete, and measurable. Hayes, Barlow, and Nelson-Gray (1999) suggest a variety of strategies to help clients refine the Problem List and move from abstract ideas to quantifiable objectives. These include asking clients to identify how they or someone else would know that their goal had been accomplished, or having them describe a *current* typical day versus an *ideal* typical day. Minimizing the discrepancy between these descriptions can serve as a treatment aim. Nelson (1981) recommends identifying either partial or instrumental goals rather than emphasizing a global objective. She describes an example in which the client's overall goal for treatment was to increase self-esteem, but the treatment initially focused on (and measured) the more instrumental aim of getting a raise at work.

Concrete aims are more likely than "vague intentions" to lead to actual behavior change (Bandura & Schunk, 1981). For example, Marjorie's therapist translated her overall goal of being less depressed into a number of aims, such as increasing her physical activity, regulating her sleep and eating schedules, improving her social support, and identifying and challenging her negative automatic thoughts. As we discuss in Chapter 4, another critical component of the PACC model is ongoing assessment, which requires measurable aims. Unless the aims are measurable, the client and therapist will have difficulty knowing when or if improvements are being made. Ideally, treatment aims

should be relevant to the client's highest priority problem. Although the therapist and client can sometimes easily agree on which problem is the highest priority, at other times this can be challenging.

For example, Sid, a young adult newly diagnosed with bipolar disorder, began taking lithium approximately 2 months before entering psychotherapy. When asked to describe his goals for treatment, Sid replied, "To get off medication." The medication was a constant reminder of his illness, decreased his energy level, and made concentration difficult. His parents were also encouraging him to "stop putting chemicals" into his body. Sid was fairly responsive to the therapist's urging that he put off his decision about the medication until his body had time to adjust fully to the side effects and he had time to explore what it means to have bipolar disorder. The overarching goal of treatment shifted from "getting off medication" to "understanding bipolar illness."

In this case, the aims of the first phase of treatment included increased knowledge of medication and its side effects, psychoeducation about the etiology and prognosis of bipolar disorder, and the implementation of beneficial lifestyle changes, such as maintaining a regular sleep schedule. Sid pursued these aims using strategies such as reading psychoeducational materials, identifying and challenging negative appraisals about taking medications, exploring the impact that bipolar disorder was having on his hopes for the future, and exploring the impact that bipolar disorder was having on his relationships with others (e.g., family, friends, girlfriend).

Number of Aims

Although the number of aims is likely to vary per client, we generally suggest having about three aims in each phase of treatment. When a client and therapist have trouble generating more than one aim, the aim may not be specific enough. The therapist's challenge in such cases is to come up with concrete, specific aims when the client's treatment goal is vague (e.g., to feel "happier," "less anxious," or "more in control").

Having more than three aims, although not impossible, can be somewhat burdensome to the client and therapist, particularly if the aims cover numerous domains of functioning. For example, Sally, a 60-year-old woman, sought treatment for a depressive episode in the context of an impending separation from her partner. Her partner's primary reasons for wanting to separate were Sally's angry outbursts and

verbal abuse. Sally reported a different perspective, seeing herself as weak, dependent, and unable to assert her own opinions. She also described herself as a failure, unable to hold down a steady job or maintain friendships. The therapist and Sally initially agreed upon four aims for the first phase of treatment shown in Figure 3.3.

When they began working on these aims, Sally and her therapist found themselves being pulled in multiple directions, ranging from discussions of the pros and cons of maintaining Sally's romantic relationship to her low self-esteem and inability to initiate new social contacts, to her increasing depressed mood and inability to get out of bed in the morning. After a few weeks, her therapist realized that it would be preferable to step back and work on one problem at a time. The therapist accordingly discussed with Sally the possibility of focusing just on her depressive symptoms at first, with the specific aims of regulating her sleep–wake cycle, pursuing pleasure and mastery activities, and identifying the beliefs that reinforced her negative self-view. Sally agreed not to make any major decisions about her future with her partner until some of her depressive symptoms had subsided. Over the next month, Sally was better able to focus her energies on alleviating

Treatment Phase I		Date: January 3, 2002
Aims:	**1.** Learn new communication skills and implement them with partner.	
	2. Reduce daily anger outbursts.	
	3. Seek out new forms of social support, such as making new friends.	
	4. Increase involvement in activities that give pleasure and a sense of mastery.	
Measures: (attach graph)	**1.**	
	2.	
	3.	
Strategies:	**1.**	
	2.	
	3.	
Date for Phase I Progress Review: March 31, 2002		

FIGURE 3.3. Aims of Phase I for Sally.

her depressed mood, and by the second phase of treatment, she began to work effectively on anger management and communication skills in the context of her relationship.

Disagreement about Aims

Some clients come to the first therapy session with aims for treatment that are different from those the therapist would advocate. Negotiating effective treatment plans with such clients can be difficult, sometimes resulting in the therapist walking a fine line between supporting versus contradicting the client's wishes. For example, Jane, a 20-year-old woman, presented with a 4-year history of bulimia nervosa, current major depression, and a recent suicide attempt. Jane's therapist was primarily concerned about her depressed mood, hopelessness, and ongoing suicidal thoughts. Jane, however, was interested only in the aim of maintaining or reducing her current body weight (which was average) and eliminating her binge-eating episodes.

In this case, the therapist believed that Jane's own treatment aims were secondary in importance to her depression and suicidal ideation. To foster a therapeutic alliance and productive working relationship with the client, the therapist was invested in developing a treatment aim that would be acceptable to Jane. In choosing to be open about the dilemma, she phrased it as follows:

> "I understand that the reason for your being in treatment right now is to maintain your current weight and to get rid of your nightly binges. I hear you saying how important these goals are, but I'm feeling worried because I am seriously concerned for your safety given your recent suicide attempt, and your feelings of sadness and hopelessness. I wonder if we could reach some sort of compromise in our aims for this phase of our treatment? In other words, could we agree to work at least initially on reducing your feelings of sadness and hopelessness and then turn to your binge eating and body image?

Jane agreed that this was a reasonable direction for the early phase of treatment. She contracted for safety with the therapist and agreed to make some behavioral changes (e.g., engaging in pleasant activities and keeping mood records) designed to change her depressed mood. She also made a commitment to begin eating three balanced meals a

day as a step toward decreasing her urges to binge in the evenings. Although Jane never made a commitment *not* to focus on her weight, monitoring body weight was not included in the first phase of treatment. Over the course of this first phase, Jane's depressive symptoms decreased significantly. Her episodes of binge eating became somewhat less frequent, but her purging continued on an almost daily basis. Not until the second phase of treatment did Jane and her therapist begin working on the aims of improving her body image, eating a balanced diet, and reducing bingeing and purging overall.

Jane's case illustrates how the aggregate of aims over the course of multiple treatment phases can lead to achieving the larger treatment goal. In order to alleviate Jane's depressed mood as well as address her eating disorder, the therapist generated a variety of aims that were likely to cover multiple phases of treatment. The ultimate goals of Jane's therapy may have included eating more healthfully, being less critical of her body, and feeling happier, but progress toward such goals were made gradually, one step at a time.

TREATMENT STRATEGIES

When a practitioner takes the time to articulate the strategies to be used in pursuit of a given therapeutic aim, the strategies serve as guideposts to assist in staying focused. Explicitly planning strategies for each phase of treatment also facilitates the process of informed consent by helping clients to be aware of the approach the clinician is using and clarifying the rationale for its expected effectiveness. The more specific the treatment strategy, the better. Simply indicating "cognitive therapy" is not necessarily informative; entire books have been written on the different strategies this approach comprises. Instead, the therapist should attempt to articulate as concretely as possible what he or she will do to help the client make progress on the specified aims.

Selection of Treatment Strategies: The Use of Practice Guidelines

Once the clinician has established aims for a particular phase of treatment, how does he or she choose (or develop) a strategy to achieve them? One approach we favor, on both a convenience and scientific basis, is to apply a treatment guideline or tested treatment protocol. Although the research literature does not cover the rich complexity of all

clinical issues, researchers have shown pretty conclusively that selected available treatments effectively ameliorate some specified disorders and problems. Furthermore, we can improve quality of care by using what we know from research about which interventions work better than others, and under what circumstances (O'Keefe, Quittner, & Melamed, 1996).

Professionals across the range of health care fields have begun to develop treatment guidelines in recognition of the need to use the research literature as a foundation of treatment planning. Hundreds of guidelines have been developed by professional organizations such as the American Psychiatric Association (e.g., American Psychiatric Association, 1993), by government initiatives such as the Australian Quality Assurance Project (e.g., Quality Assurance Project, 1982, 1985), and by provider organizations (e.g., managed care organizations, hospitals, and large group practices).

Other groups have provided lists of well-tested treatments for specific problems (e.g., Chambless et al., 1998). (This report is also available at *http://pantheon.yale.edu/~tat22//est_docs/ValidatedTx.pdf*. A user-friendly version with links to informative websites is located at *http://www.apa.org/divisions/div12/rev_est/index.shtml*.) The Cochrane Collaboration has steadily expanded its user-friendly database on reviews of treatment literature to include topics in mental health (it does not actually prepare practice guidelines but systematically reviews the empirical literature to guide practitioners in their choices). The Cochrane Library is accessible from most university libraries at *www.update-software.com/cochrane*. An analogous and helpful database that has been developed by the Campbell Collaboration (see *http://campbell.gse.upenn.edu/*) includes a set of systematic reviews of studies on the effects of social and educational policies and practices.

We strongly encourage the use of empirically supported treatments where they are available. The treatments are often a basis for practice guidelines, which ideally rely on the research literature and also take into account the setting and practical constraints. For example, the treatment with the best research support for a given problem may also require expertise that is unavailable in a particular setting, or the cost of a particular treatment may place it out of reach in some settings. Practice guidelines are good resources for busy practitioners, because they do not require synthesizing the research literature in order to have a scientific basis for practice (Kirk, 1999). We have found practice guidelines particularly helpful for the PACC approach, because they offer clear recommendations about which treatment strategies to use.

Shifting Strategies over the Course of Treatment

Therapy is liable to take a number of unexpected twists and turns, often prompted by a client's life events, such as job loss, death of a loved one, or breakup of a romantic relationship. If the change is particularly dramatic, the therapist and client may decide to begin a new phase of treatment, complete with a new set of aims and strategies. However, if the change is compatible with the current treatment aims, then it is often beneficial to continue with the same set of aims but slightly revised treatment strategies.

Consider the following case example illustrating revision of strategies during a therapy phase. Beth, a 30-year-old woman, entered therapy to address feelings of worthlessness and uncertainty about her future with her boyfriend. Her primary aim during the first phase of treatment was related to her romantic relationship. Specifically, she placed a high priority on being "less of a pushover" with her boyfriend and feeling "more confident" as a romantic partner. One of the initial treatment strategies was to help Beth identify her own desires and needs in the relationship and to practice talking about these needs with her boyfriend. When she and her boyfriend broke up, Beth and her therapist felt that she should continue to practice skills related to assertiveness with other people in her life. The earlier treatment strategies were modified to be compatible with Beth's current situation.

Specifically, the therapist began to teach more general communication skills (e.g., active listening, use of "I" statements), so that Beth could work on assertiveness in the context of other relationships (e.g., coworkers and friends instead of her boyfriend). In some cases, a few sessions may be needed to build the bridge between the current crisis and the Treatment Plan. Beth spent two sessions exploring emotions related to her breakup, affirming that the decision to break up was a healthy one that enhanced rather than impeded her treatment goals. The transition back to the original Treatment Plan was relatively smooth, and Beth was actively involved in the treatment-related decision-making process.

Flexibility of Treatment Strategies

Sometimes therapists need flexibility in the type of strategy used to accomplish the treatment aim. For example, a patient with panic disorder may have a paradoxical reaction to progressive muscle relaxation; that is, although relaxation training is intended to reduce anxiety overall, some clients actually become more, rather than less, anxious during

this exercise. In response, the therapist may attempt another treatment strategy, such as diaphragmatic breathing, in order to reduce anxiety. If the client has a paradoxical reaction to diaphragmatic breathing as well (as do some of our clients), the treatment strategy may then need to be changed to guided imagery of relaxing scenes. In subtle variations in the type of strategy to accomplish the aim of the current phase of treatment (e.g., relaxation training), it is not necessary to change phases of treatment or to make major changes in the Treatment Plan. Instead, new strategies can be added to the current phase of treatment.

The strategies can branch across theoretical orientations. The PACC approach encourages flexibility in the types of aims and strategies used in treatment, and it is our belief that one's theoretical orientation need not prohibit use of these treatment-planning techniques. The goal is to use an evidence-based approach to select the first line of treatment strategies, rather than feeling restricted by a particular theoretical orientation. Naturally, case conceptualizations from some orientations will more readily translate into specific measurable aims, but for the reasons discussed earlier, we believe the effort to specify aims and strategies is worthwhile in all cases.

CHOOSING AIMS AND STRATEGIES: CASE EXAMPLE

Jean, a hairdresser, presented to the clinic reporting trouble controlling her spending. Despite being able to control spending for food and clothing for her family, she had spent $4,000 over the past year on paraphernalia associated with basketball and stuffed animals for her home. She also mentioned that her shopping was having a negative impact on her marriage. Based on Jean's initial evaluation, a Treatment Plan was developed to reduce her impulsive spending through cognitive and behavioral interventions. Specifically, the first aim was to reduce the number of impulse purchases Jean made per week, with the expected goal of cutting her purchases by 50% from baseline within 6 weeks (see Figure 3.2). A review date was scheduled for this 6-week time point, and weekly progress on this aim was graphed for easy visual reference. The strategies to meet this aim included developing cognitive counters to her automatic thoughts about the imperative of buying things sold at a good price, as well as initiating behavioral interventions to limit cues and opportunities for buying. For example, Jean agreed not to carry a credit card, to restrict her time in stores, and to make lists of acceptable purchases as a way to help set limits.

Both Jean and her therapist agreed to this treatment plan. However, just a few weeks into treatment, it became apparent that her marriage was in serious trouble, and the spending was only one of the problems impacting her relationship. Jean was able to bring her shopping under control faster than anticipated, but she was having great difficulty with her spouse. Although the review date had not yet arrived, the therapist reformulated the Treatment Plan to reflect the new information and Jean's changing priorities with respect to the difficulties with her marriage. The plan for the second phase focused on fostering assertive communication patterns with her husband (while continuing to monitor spending behaviors for signs of a lapse), and the therapist established a new review date.

Jean's rapid transition to a new treatment phase illustrates the need to shift the treatment focus when a problem ranked low in priority becomes more pressing than the one previously targeted. In addition, this shift emphasizes the need to choose aims relevant to the highest priority problem presented by the client. Furthermore, this case illustrates the need to return to the Problem List, set new aims, plan new measurement approaches, and implement new therapeutic strategies when the focus of treatment changes. Figure 3.4 shows the full Treatment Plan for Jean in these two phases.

CHALLENGES IN IMPLEMENTING THE TREATMENT PLAN

Pursuing a Collaborative Endeavor

Collaboration with clients, a central feature of many models of psychotherapy, is certainly compatible with the PACC approach to treatment planning. Although collaboration involves challenges, the benefits are numerous. Some evidence indicates that operating in a more collaborative style leads to measurably better treatment outcomes (Whiston & Sexton, 1993) and that clients benefit from open discussion of their role in therapy (Eisenberg, 1981; Friedlander, 1981). Furthermore, clients who are treated as partners in the therapeutic endeavor are more likely to experience a sense of agency in the pursuit of their goals. Using data from his own protocol for treatment planning, Bernstein (1992) writes, "I have been particularly impressed with the many innovative ideas the clients have contributed to their own treatment designs. Rather than feeling restricted (as I had feared) by the concreteness of their treatment plans, their awareness of the process stimulated their curiosity and problem-solving abilities" (p. 272).

Treatment Phase I **Date:** January 20, 2002

Aims:
1. Reduce the frequency of impulse purchases per week.
2. Reduce believability of maladaptive ideas like, "I must take advantage of sale prices."
3. Reduce time spent ruminating about money.

Measures: (attach graph)
1. Amount of money spent on impulse purchases per week
2. Y-BOCS Compulsive spending checklist
3. Self-reported distress (on a 0–100 scale) and time spent thinking about money

Strategies:
1. Develop cognitive counters to Jean's automatic thoughts about buying.
2. Limit buying cues & opportunities (*e.g.*, no credit cards, restrict time in stores).
3. Make lists of acceptable purchases to help Jean set limits.

Date for Phase I Progress Review: March 2, 2002

Treatment Phase II **Date:** February 10, 2002

Aims:
1. Reduce anxiety level and rumination about marital relationship throughout the day.
2. Communicate more assertively with husband.
3. Maintain gains made in reducing spending behavior.

Measures: (attach graph)
1. Daily average anxiety level and time spent ruminating about the relationship
2. Positive–negative weekly checklist of assertive responding
3. Amount of money spent on impulse purchases per week

Strategies:
1. Identify and challenge negative automatic thoughts about marital relationship.
2. Use assertiveness training to meet her needs without escalating conflict.
3. Teach progressive muscle relaxation in order to reduce overall anxiety level.

Date for Phase II Progress Review: April 20, 2002

FIGURE 3.4. Phase I and II Treatment Plan for Jean.

A collaborative approach to treatment planning can also empower the client. Clients who adopt a problem-solving attitude toward treatment become more actively engaged in therapy and experience a better outcome (Luborsky, Crits-Cristoph, Mintz, & Auerbach, 1988). Most individuals enter therapy when they find themselves confused about their problems or unable to take action to address them. Through an open negotiation of treatment goals, the therapist can foster the client's potential to deal with problems more effectively (McConnaughy, DiClemente, Prochaska, & Velicer, 1989). Therapeutic outcome improves when clients perceive they have a choice in the therapeutic process and are knowledgeable about therapy options (Brehm & Smith, 1986). Furthermore, clients are more likely to adhere to treatment and maintain health-related behaviors when they feel a personal commitment to the Treatment Plan (Putnam, Finney, Barkley, & Bonner, 1994).

Of course, sharing the treatment-planning process with clients and maintaining their commitment to the treatment goals can be difficult depending on the characteristics of the client. Persons (1989) recommends that therapists refrain from discussing the Treatment Plan in great detail with people with obsessive personalities, because these clients are likely to retard progress by focusing too much on minute details of the plan. With obsessive clients, it may be best to present the Treatment Plan one therapy phase at a time (Bernstein, 1992).

Collaborative treatment planning can also be challenging with clients who begin therapy with unrealistically high expectations for change and a rigid desire to tackle multiple domains at once. One strategy for facing such challenges is to incorporate the client's difficulties with unrealistic expectations and rigidity into the Treatment Plan. For example, Lea, a client who began a new phase of psychotherapy with high expectations for change and perfectionistic standards, was a 40-year-old, single woman with a history of four inpatient hospitalizations for bipolar disorder. After Lea's most recent hospitalization, she attended a day treatment program emphasizing psychoeducation and cognitive and behavioral problem-solving skills. This form of treatment was new to Lea, but it appealed to her.

After completing the day treatment program, Lea began working with a new individual therapist. When asked to describe her goals for treatment, Lea produced a list of 30 items, including "eliminating my drive for perfectionism," "learning to see the glass as half full rather than as half empty," and "increasing self-confidence in interpersonal interactions." Lea had great difficulty prioritizing the goals on her list.

She said, "Each item is just as important as the next. I can't imagine picking one goal over the other, because I'm not sure which will help me the most, and I have to prevent myself from going downhill again." Continued discussion over the next two sessions allowed Lea to identify how her perfectionistic standards were preventing her from narrowing down her expectations. Setting a limited number of reasonable goals for herself at the beginning of each week became one of Lea's aims in the first phase of treatment.

Challenges in sharing the treatment-planning process can also arise with clients who have difficulty identifying overarching treatment goals or for whom all problems appear to have an external explanation. For example, Neal, a 25-year-old male with an atypical anxiety disorder and a narcissistic personality style, came to treatment with the goal of "managing anxiety." Collaborative treatment planning became challenging, however, when Neal described his anxiety as being due mostly to his concern with "other people's issues." Specifically, Neal described himself as "independent" and "insightful" and other people as "passive" and "troubled." At the start of treatment, Neal was uninterested in examining his interactions with others or his thoughts about the roles he played in other people's lives. Instead, he was committed to the idea that if he could get the people around him to change how they behaved, then his own anxiety would subside. Neal and his therapist were able to agree that one step toward relieving his anxiety was to identify when and under what circumstances his anxiety was at its worst. Two of Neal's treatment aims were to recognize interpersonal triggers of anxiety and to reduce time spent ruminating about interpersonal relationships.

Many clients do hold unrealistic goals for treatment. Whereas Lea's unrealistic goal setting appeared to come from her perfectionistic standards, Neal's unrealistic goals came from his lack of insight into his own role in his relations with other people. Another difficulty that sometimes arises in collaboratively setting goals occurs when clients are not yet prepared or committed to make changes. In this case, the therapist's initial aim is for the client to become motivated and ready to change, but the client may not yet be aware of his or her ambivalence toward change.

Motivation and Readiness for Change

Not all clients are intrinsically motivated to make changes in their lives. Sometimes the reasons for resistance to change are clear, such as when an individual is court-referred or sent to treatment by a parent or

guardian. Resistance is especially common in addiction problems, domestic violence, and problems in which at least some of the symptoms are considered to be positive by the client (such as low body weight in anorexia).

An important consideration in collaborative treatment is the client's readiness for change (DiClemente, 1991; DiClemente, Prochaska, & Gilbertini, 1985; Prochaska, DiClemente, & Norcross, 1992). As DiClemente (1991) describes, "A therapist can be understood as a midwife to the process of change, which has its own unique course in each case. Skillful therapists will best facilitate change if they understand the process of change and learn how to activate or instigate the unfolding of that process" (p. 191). In part, the therapist's job is to recognize a client's ambivalence and tailor the intervention to the client's stage of change.

Various modifications of the stages of change model have occurred since its initial development by Prochaska and DiClemente (1982); research has supported the predictive utility of the more recent version (Prochaska & DiClemente, 1992). In the *precontemplation* stage, the individual has no plan to change behavior in the near future (typically, the next 6 months) and may lack awareness about the severity of his or her problem. Direct attempts to change behavior at this stage will frequently be met with resistance. During *contemplation*, the individual acknowledges the existence of the problem and is seriously thinking about taking steps to work on it, but he or she has not yet made a commitment to take action. At this point, it is common for the client to struggle with a cost–benefit analysis of maintaining versus finding a solution to the problem.

In the *preparation* stage, the person not only intends to change (typically, within the next month) but also has made some actual attempt to change the behavior during the previous year. Usually, individuals in this stage have already made a small reduction in the problem behavior (e.g., smoking five fewer cigarettes per day) but are not quite ready to take effective action. In contrast, during the *action* stage, individuals modify their behavior, experiences, or environment to overcome their problems. This process usually requires overt efforts to change that involve substantial time and energy. Finally, in the *maintenance* stage, the individual works to stabilize the changes made during the action stage and to prevent relapses from occurring. This stage signifies a continuation of change rather than a static phase or final event. It is not unusual for clients to repeat these five stages in a spiral pattern before the maintenance phase is sustained.

Stage models of change may be useful as a heuristic to help guide

treatment planning. Prochaska (1991) urges clinicians to match the therapeutic intervention to the client's stage of change. For example, Prochaska suggests that if a client is in a precontemplation stage, then the wisest course may be therapeutic intervention that focuses primarily on consciousness raising. In contrast, if this person is in an action stage, behavioral procedures are likely to capitalize on client readiness. In the context of treatment planning, the types of aims and strategies that the client is likely to find appealing will shift over time, perhaps as readiness for change shifts over time. Clients experiencing symptoms for the first time (e.g., a client who is experiencing his first manic episode) or those in treatment only to appease others or to satisfy a mandate (e.g., from the court) are least likely to be ready to change. The effectiveness of treatment may depend upon first enhancing the client's commitment to therapy.

Miller and Rollnick (1991) argue that it is detrimental to the treatment-planning process to conceptualize a lack of motivation as "denial," "resistance," or "a personality problem." Instead, they describe motivation as a state that fluctuates across time and situations. Motivation, when thought of as a state rather than a trait, can be influenced. Miller and Rollnick argue that assessing and influencing motivation is "an inherent and central part of the professional's task" (p. 19). These authors have developed a protocol for motivational interviewing that we have found very helpful in getting clients "unstuck" from their ambivalence, so that they can make positive changes.

Axis II Factors and Conditions

Some clients have long-standing interpersonal styles or personality traits that result in resistance to changing an Axis I problem. For others, the style or trait may itself be the problem that is the focus of treatment. Personality disorders are relatively common, with prevalence estimated at 10–18% for the general population (see Turner & Dudek, 1997), and perhaps higher among outpatients at mental health clinics. Practitioners have long observed the complexity and challenge presented by patients with personality disorders. Because Axis II problems are by definition central to the person's identity (representing pervasive and enduring ways of thinking and behaving), changes occur more slowly than changes in Axis I problems. This reality has a direct impact on treatment planning. Assessments of clients being treated for Axis II disorders are likely to be spaced farther apart, and changes may be more subtle and cumulative.

Although measurement of Axis II conditions has proven more difficult and unwieldy than assessment of Axis I symptoms, reputable indices and even core testing batteries do exist. For example, Strupp, Horowitz, and Lambert (1997) include reviews and recommendations regarding several useful assessment tools. We encourage clinicians to consider measuring Axis II conditions even if they are not the explicit focus of clinical interventions. By monitoring Axis II conditions, clinicians will have a clearer idea of the possible explanations when a treatment for Axis I problems proves ineffectual.

SHORTCUTS FOR THE BUSY CLINICIAN

Generating treatment aims and strategies may be more straightforward in some cases than others. Many clinicians juggle large caseloads, and developing a written Treatment Plan may initially seem to be an unmanageable burden. To assist with this process, we have generated an initial (though certainly not comprehensive) list of treatment aims and strategies for the busy clinician, based on the biopsychosocial Problem List described in Chapter 2 (see Table 3.1). Earlier in this chapter, we included information for accessing several websites that provide information on empirically supported treatments. Information about access to treatment manuals for some of these treatments is available at *http://pantheon.yale.edu/~tat22//est_docs/ValidatedTx.pdf*. Finally, we recommend consulting *A Guide to Treatments That Work*, edited by Nathan and Gorman (2002), for additional direction in selecting empirically supported aims and strategies, and also *Treatments of Psychiatric Disorders*, edited by Gabbard (2001), developed by the American Psychiatric Association.

TABLE 3.1. Examples of Treatment Aims and Strategies across Domains of Functioning

Problem domain	Treatment aims	Treatment strategies
Clinical Crises	Reduce frequency and intensity of suicidal thoughts.	Develop a crisis plan including warning signs, coping strategies, and emergency supports.
	Reduce frequency and intensity of homicidal thoughts.	Develop a crisis plan including triggers, coping strategies, and emergency supports.
	Reduce frequency of self-injurious behavior.	Create an impulse control plan.
School/ occupational functioning and finances	Make short-term career choices and take steps to pursue career goals.	Consider pros and cons of potential career choices.
	Increase weekly attendance at job/school.	Develop a weekly schedule including rewards for meeting obligations.
	Decrease spending sprees and increase financial independence.	Create a budget and develop strategies to diminish buying urges.
Family functioning	Reduce frequency of arguments with family members.	Improve understanding of interpersonal dynamics fueling conflicts.
	Improve marital communication.	Learn to express needs and desires assertively.
	Understand (and limit) impact of trauma history on current family functioning.	Learn safety cues and discuss impact of trauma on current view of self.
	Increase parenting self-efficacy and reduce the use of corporal punishment.	Learn parenting management skills.
Extrafamily interpersonal functioning	Enhance sense of self as an independent and competent individual.	Practice making autonomous decisions daily.
	Decrease social isolation.	Phone one friend each week.
	Decrease social anxiety.	Practice relaxation techniques and gradual exposure daily.
	Improve social network by exploring community resources.	Visit one new community organization weekly.
	Cope with interpersonal stressors of separation and loss.	Explore spiritual and existential avenues of making meaning out of loss.

(continued)

Problem domain	Treatment aims	Treatment strategies
Behavioral health	Increase physical fitness and exercise frequency.	Join an athletic club; develop an exercise routine and exercise three times a week.
	Improve nutrition and food choices.	Receive psychoeducation about nutrition.
	Maintain a regular eating schedule.	Plan daily menus and use food records.
	Reduce frequency of binge or purge episodes.	Implement regular eating, decision delay strategies; understand interpersonal dynamics fueling eating disorder.
	Improve health-seeking behavior (e.g., medical treatment compliance, psychiatric consultation).	Make appointments to meet with health care professionals.
	Increase compliance with medication.	Create a behavioral schedule that includes medication.
	Improve stress management skills.	Learn relaxation techniques and practice daily.
	Reduce frequency of legal drug use (e.g., caffeine, nicotine, prescription drugs, diet medications).	Create behavioral targets; attend relevant support groups (e.g., smoking cessation).
Risky behaviors	Decrease alcohol use by 50%.	Examine triggers for drinking; attend support group meetings (e.g., AA) weekly.
	Abstain from drugs.	Monitor urges and cravings; identify triggers and warning signs; practice relapse prevention skills.
	Decrease frequency of risky sexual behaviors.	Receive psychoeducation about safer sexual behaviors.
	Decrease frequency of gambling episodes.	Set a spending limit for gambling each week.
	Decrease risky or thrill-seeking behaviors.	Develop an impulse control plan and practice skills daily.
Cultural, spiritual, and moral development	Increase acceptance of the role of cultural challenges in current functioning.	Speak with close family members about their own struggles with cultural identity (e.g., biculturalism, acculturation, ethnic identity).
	Develop a renewed sense of self as a spiritual individual.	Increase–decrease involvement with religious institutions.
	Enhance understanding of existential issues.	Keep a journal describing existential questions and challenges.
	Gain confidence in coping with moral dilemmas and issues.	Learn decision-making skills and apply them to moral dilemmas and issues.