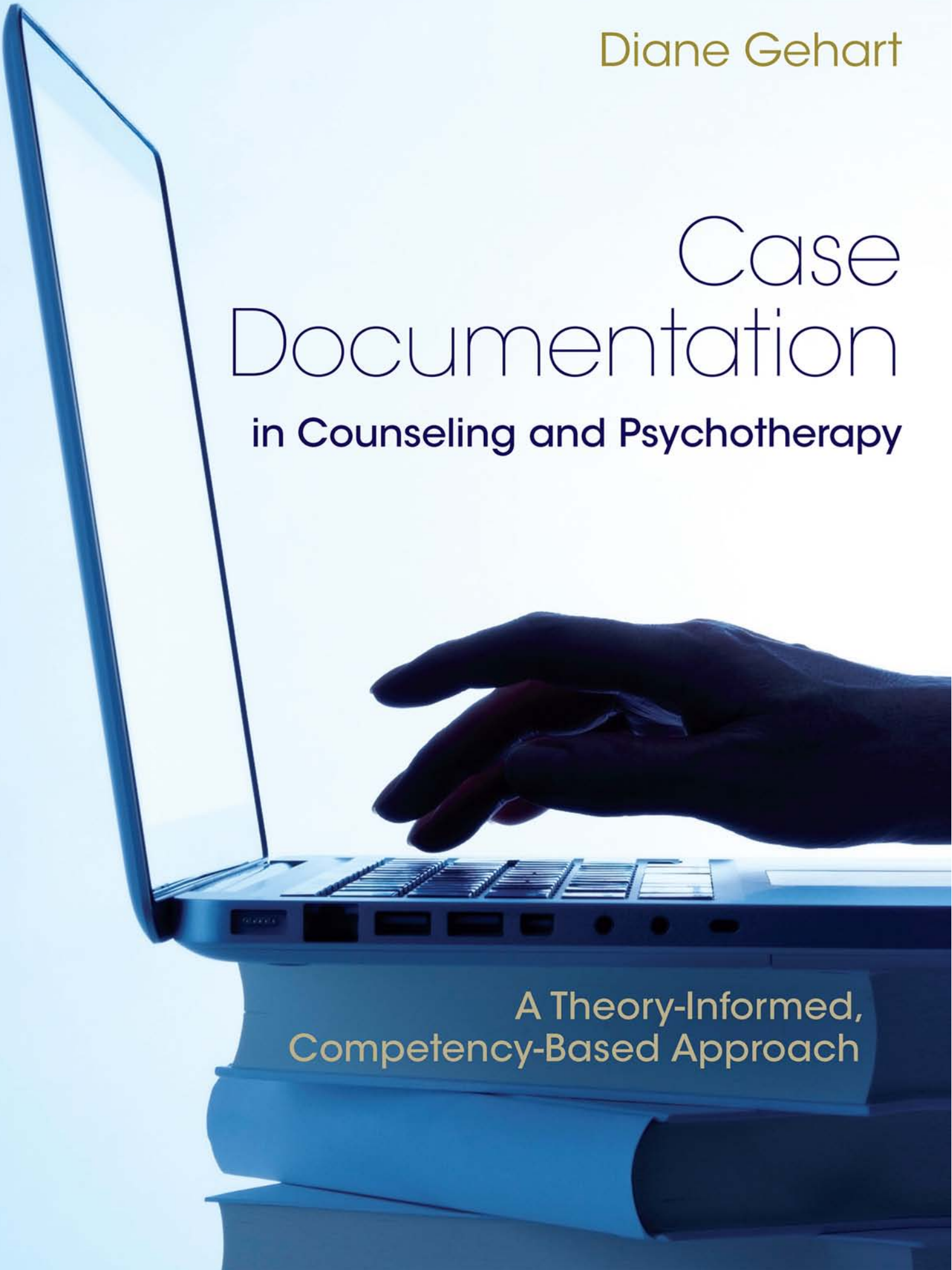
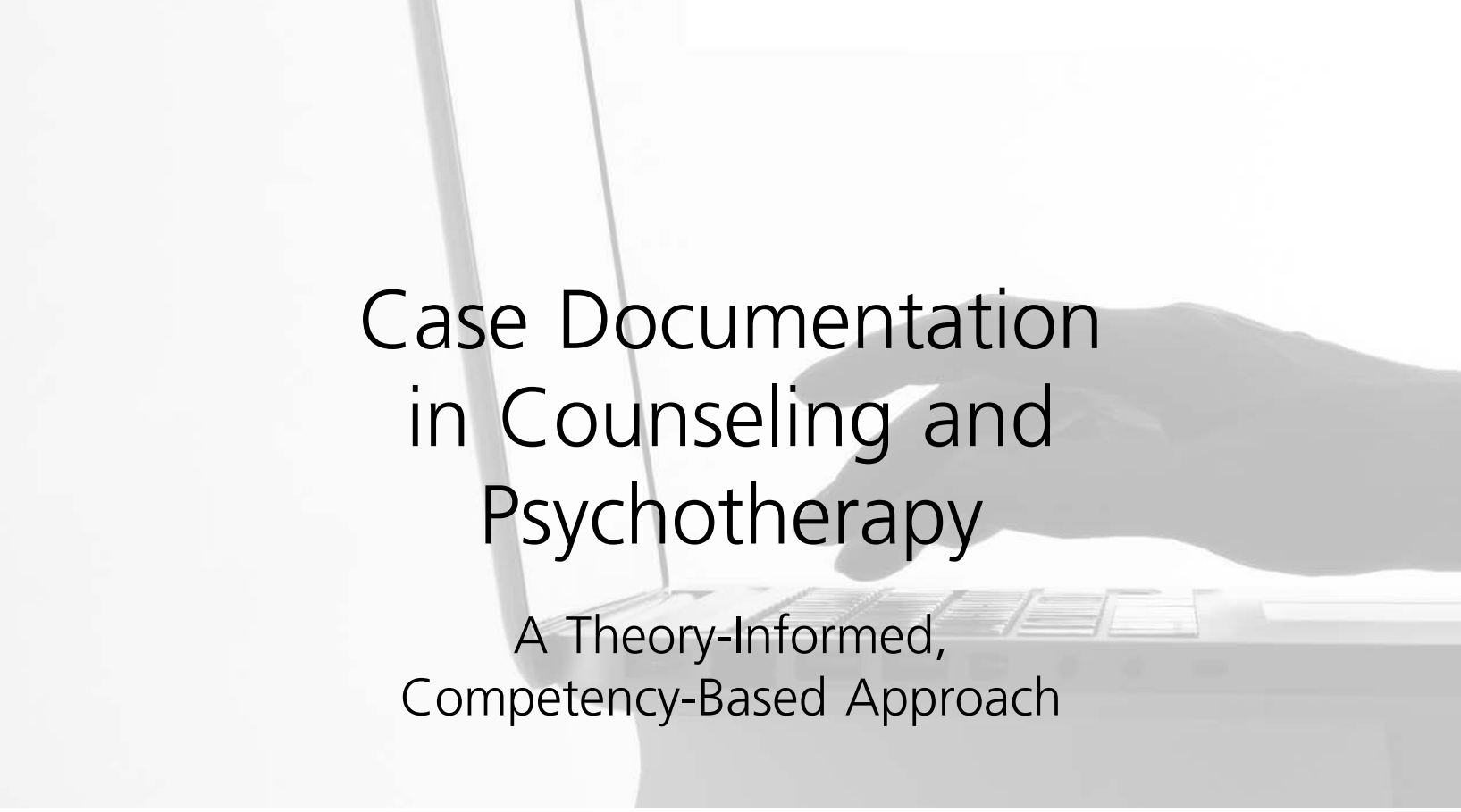
Diane Gehart

Case Documentation

in Counseling and Psychotherapy



A Theory-Informed, Competency-Based Approach



Case Documentation in Counseling and Psychotherapy

A Theory-Informed, Competency-Based Approach

DIANE R. GEHART, Ph.D.

California State University, Northridge

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Dedication

This book is dedicated to the counselors and therapists
who dedicate their lives to reducing the suffering
of others. Your efforts are a gift to us all.

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Preface

Text Overview

Part of the *Mastering Competencies* series, *Case Documentation in Counseling and Psychotherapy* teaches counselors and psychotherapists how to apply counseling theories in real-world settings. The text provides a comprehensive introduction to case documentation using four commonly used clinical forms: case conceptualization, clinical assessment, treatment plan, and progress note. These documents are uniquely designed to incorporate counseling theory and help new practitioners understand how to use theory in everyday practice. Seven comprehensive case studies with diverse clients illustrate how to complete documentation using a single counseling model: psychodynamic, Adlerian, humanistic, cognitive-behavioral, family systemic, solution-focused, and postmodern/feminist. Furthermore, readers learn about the evidence base for each theory as well as applications for specific diverse populations. Unlike a typical textbook, this book can be used as a clinical reference manual to assist mental health professionals in their practice settings for years to come, providing practical overviews of theories, conceptualization, treatment planning, and documentation.

Using state-of-the-art pedagogical methods, *Case Documentation in Counseling and Psychotherapy* is part of a new generation of textbooks designed to produce measurable results that have value beyond the classroom. The text employs a learning-centered, outcome-based pedagogy to engage students in an active learning process that enables them to apply theory using case documentation. These case documents were created using national standards for counseling, family therapy, psychology, and social work. Students demonstrate their learning using these forms, which instructors can then use to easily measure educational outcomes. These assignments empower students to apply theoretical concepts and develop professional skills as early as possible in their training, resulting in faster mastery of the material.

The author uses a down-to-earth style to explain concepts in clear and practical language that contemporary students appreciate. Instructors will enjoy the simplicity of having the text and assignments work seamlessly together, thus requiring less time in class preparation and grading. The extensive set of instructor materials—which include syllabi templates, detailed PowerPoints, test banks, online lectures, and scoring rubrics designed for accreditation assessment—further reduce educators' workloads. In summary, the book employs the most efficient and effective pedagogical methods available to teach case documentation and counseling theories, resulting in a win-win for instructors and students alike.

Text Features

- *Clinical Forms:* The book provides a comprehensive set of four clinical forms that can be used in practice environments, either in university training clinics or community agencies:
  - Theory-informed case conceptualization
  - Clinical mental health assessment and DSM-5 diagnosis

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    - Treatment plan that includes theory, diversity, and evidence-based practice
    - HIPAA-compliant progress notes
- *Outcome-Based Pedagogy:* This text teaches the skills and knowledge outlined in accreditation standards for counselors, psychologists, social workers, and family therapists.
- *Assessment of Student Learning:* Using four clinical documentation forms, this text enables faculty to easily measure students' mastery of competencies and learning outcomes, which are now required for both regionally accredited university boards (WASC, SACS, etc.) and professional accrediting bodies (APA, CACREP, COAMFTE, and CSWE). Assessments with scoring rubrics correlated to each discipline's competencies are part of the ancillary materials.
- *Comprehensive Treatment Model:* A comprehensive five-step model for competent treatment provides students with a clear map for their work. The model includes (a) theory-informed case conceptualization, (b) clinical assessment (diagnosis) and case management, (c) treatment planning, (d) evaluation of progress, and (e) progress note documentation.
- *Theory-Based Case Conceptualizations:* A cross-theoretical case conceptualization form enables counselors to do a comprehensive case conceptualization for clients; the form can also be used in segments to create theory-specific conceptualizations.
- *DSM-5 Clinical Assessment:* A clinical assessment form uses the DSM-5 diagnosis format and includes mental status exam, crisis assessment, safety plan, and case management.
- *Theory-Specific Treatment Plan Templates:* Each theory chapter provides practical treatment plan templates for use with individuals struggling with depression or anxiety. These templates will better enable therapists to develop thoughtful, theory-based treatment plans for their clients.
- *Theory-Specific Progress Note:* Detailed introduction to HIPAA-compliant progress note format, including CPT codes.
- *Theory Considerations and Adaptations with Diversity Clients:* The diversity sections in each theory chapter include specific, practical applications of the theory with specific populations. Each chapter contains a discussion of ethnic/racial diversity and sexual identity diversity. Expanded sections on specific populations provide students with detailed suggestions, adaptations, and cautions for using a given theory with a specific population, including African Americans, Hispanic/Latinos, Asian Americans, Native Americans/First Nation/Aboriginals, and LGBTQ individuals.
- *Practical Applications to Diversity:* Each clinical form requires students to identify specific ways that the treatment will be adjusted to address diversity issues, including the formation of a counseling relationship, assessment, and intervention.
- *Research and the Evidence Base:* The evidence base and research foundations for each theory are reviewed, and numerous evidence-based treatments are highlighted throughout the book.
- *Practice and Reflection:* Throughout the text, readers are provided instructions and prompts for practicing clinical skills, with or without a partner. In addition, reflection and discussion questions invite readers to engage thoughtfully with the material.
- *Readable:* The author uses an engaging writing style that speaks to—and at times may even entertain—today's students.

Organization

This book is organized into three parts:
Part I: Introduction to Case Documentation details the five steps to competent therapy described at the beginning of this chapter:

- Case conceptualization
- Clinical assessment

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- Treatment planning
- Evaluating progress
- Progress notes

Part II: Theory-Informed Case Documentation: The next section of the text reviews key concepts of each of the major counseling theories and provides a detailed case study with all four elements of case documentation presented in the book: counseling case conceptualization, clinical assessment with DSM-5 diagnosis, treatment plan, and progress note. Case documentation is presented for the following theories:

- Psychodynamic
- Adlerian
- Humanistic
- Cognitive-behavioral
- Family systems
- Solution-focused therapies
- Postmodern/Feminist

Part III: The Competent Supervisee: The last chapter introduces you to the paradigm of the competent supervisee and provides guidance for how to approach the supervisory relationship. If you have already started seeing clients, you might want to begin here; otherwise, this chapter will get you ready for doing so. This chapter includes elements such as:

- Managing initial anxiety
- Your role as supervisee
- Your supervisor's role
- Getting the most out of supervision
- What to do if things get bumpy

Appropriate Courses

A versatile book that serves as a reference across the curriculum, this text is specifically designed for use as a primary or secondary textbook in the following courses:

- Introductory or advanced counseling theories courses
- Pre-practicum skills classes
- Practicum or fieldwork classes

Assessing Student Learning

The learning assignments in the text are designed to simplify the process of measuring student learning for regional and national accreditation. Each case document in the book comes with scoring rubrics, which are available on the student and instructor websites for the book at www.CengageBrain.com. Scoring rubrics are available for all major mental health disciplines using the following sets of competencies:

- *Counseling:* Council on the Accreditation of Counseling and Related Educational Programs (CACREP) standards
- *Marriage and Family Therapy:* MFT core competencies
- *Psychology:* Psychology competency benchmarks
- *Social work:* Council for Social Work Education accreditation standards

Rubrics are provided correlating competencies for each profession to the skills demonstrated on the four learning assignments: case conceptualization, clinical assessment, treatment planning, and progress notes.

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Instructor's Supplements

Instructors will find numerous resources for the book online on the Cengage website (www.cengage.com) or the author's websites (www.masteringcompetencies.com; www.dianegehart.com).

- Online lectures by the author
- Sample syllabi for how to use this book in pre-practicum skills class, practicum, or fieldwork class
- PowerPoints for all of the chapters
- Digital forms for the case conceptualization, clinical assessment, treatment plan, and progress note
- Test bank (available from your Cengage representative)
- Webquizzes
- Scoring rubrics precorrelated for national accreditation bodies
    - *Counseling:* Council on the Accreditation of Counseling and Related Educational Programs (CACREP) standards
    - *Marriage and Family Therapy:* MFT core competencies
    - *Psychology:* Psychology competency benchmarks
    - *Social Work:* Council for Social Work Education accreditation standards

Instructors can access these materials through their "Instructor Bookshelf" at Cengage Learning (https://login.cengage.com/cb), which can be created by completing a brief online registration form. Instructors can add the ancillaries for this title, and others, to their virtual bookshelves at any time.

Student Supplements

Students will find numerous useful resources for the text on the Cengage website (www.CengageBrain.com) and author websites (www.masteringcompetencies.com). These include:

- Online lectures: mp4 recordings of yours truly discussing content of select chapters
- Digital forms for the case conceptualization, clinical assessment, treatment plan, and progress note
- Scoring rubrics for each assignment
- Links to related websites and readings
- Glossary of key terms

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About the Author

DR. DIANE R. GEHART is a professor in the Marriage and Family Therapy and Counseling Programs at California State University, Northridge. Having practiced, taught, and supervised for over 20 years, she has authored/edited the following:

- *Theory and Treatment Planning in Counseling and Psychotherapy*
- *Mastering Competencies in Family Therapy*
- *Theory and Treatment Planning in Family Therapy*
- *Mindfulness and Acceptance in Couple and Family Therapy*
- *Collaborative Therapy: Relationships and Conversations That Make a Difference* (coedited with Harlene Anderson)
- *The Complete MFT Core Competency Assessment System*
- *The Complete Counseling Assessment System*
- *Theory-Based Treatment Planning for Marriage and Family Therapists* (coauthored)

She has also written on postmodern therapies, mindfulness, mental health recovery, sexual abuse treatment, gender issues, children and adolescents, client advocacy, qualitative research, and counselor and marriage and family therapy education. She speaks internationally, having given workshops to professional and general audiences in the United States, Canada, Europe, and Mexico. Her work has been featured in newspapers, radio shows, and television worldwide, including the BBC, National Public Radio, Oprah Winfrey's *O* magazine, and *Ladies' Home Journal*. She is an associate faculty member at three international postgraduate training institutes: the Houston Galveston Institute, the Taos Institute, and the Marburg Institute for Collaborative Studies in Germany. Additionally, she is an active leader in state and national professional organizations. She maintains a private practice in Agoura Hills, California, specializing in couples, families, women's issues, trauma, life transitions, and difficult-to-treat cases. For fun, she enjoys spending time with her family, hiking, swimming, yoga, meditating, and savoring all forms of dark chocolate. You can learn more about her work at www.dianegehart.com

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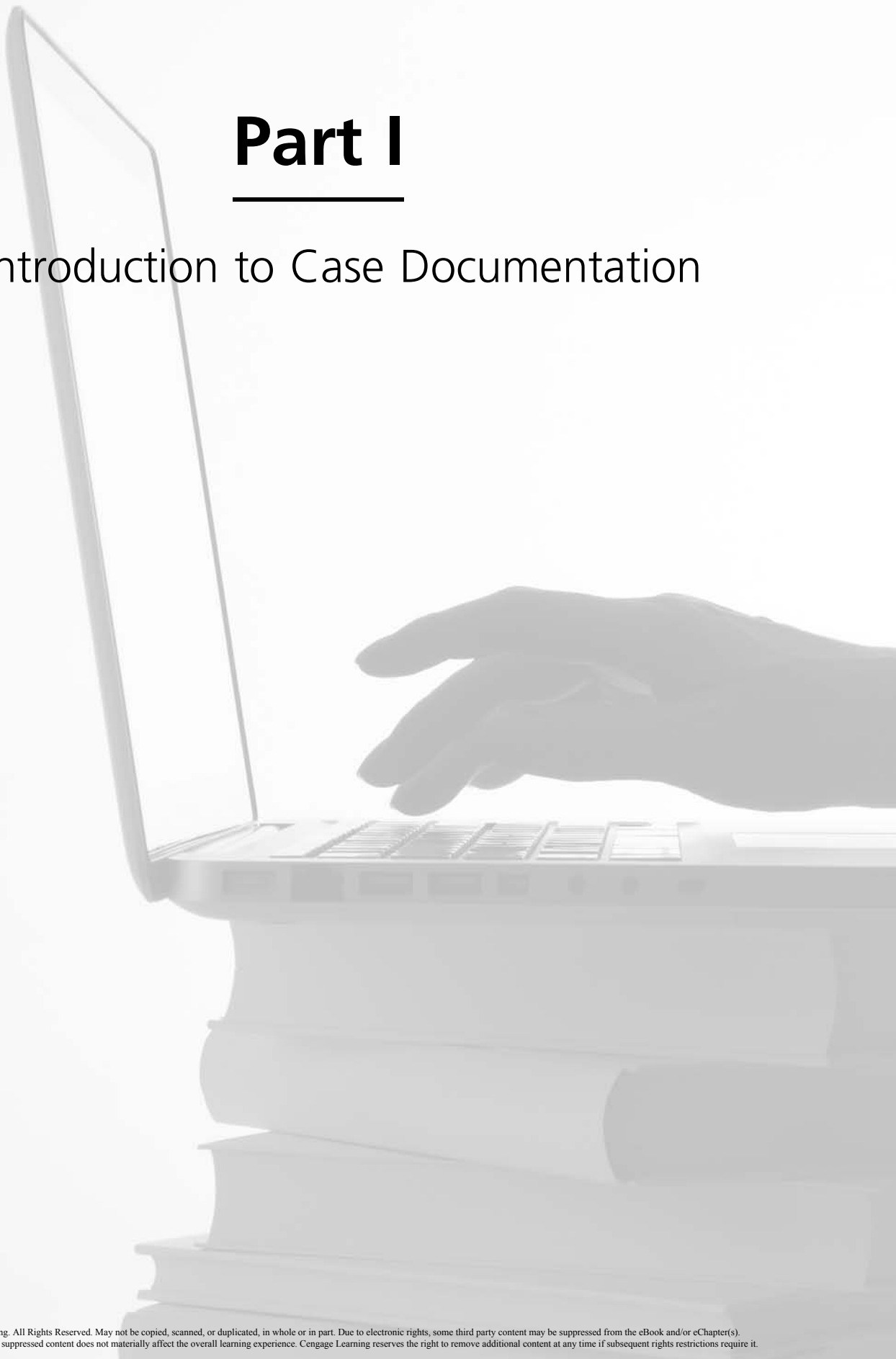
Part I

Introduction to Case Documentation



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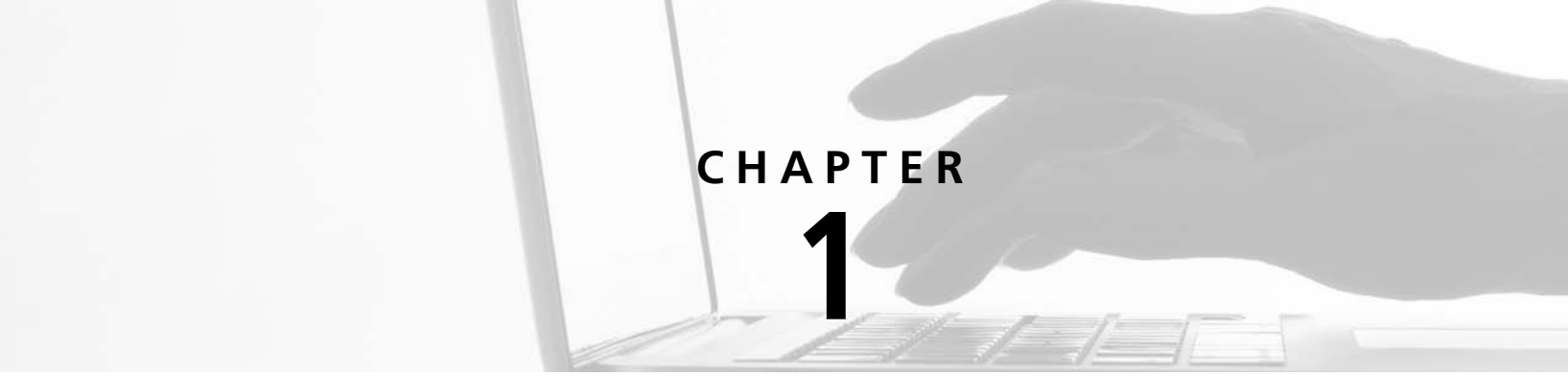

CHAPTER

1

Introduction to Case Documentation

Making a Difference—Competently

"I want to help others."
"I want to give back to my community."
"I want to make a difference."

Those who seek to become counselors and psychotherapists typically say they are drawn to the profession to help others with their struggles and to do something that makes the world a better place (Bager-Charleson, Chatterjee, Critchley, Lauchlan, McGrath, & Thorpe, 2010; Barnett, 2007; Hill et al., 2013). Many want to give back what they themselves have found life-transforming. Most envision days spent in meaningful conversations that are reflective, intimate, and life-altering.

Often, those drawn to the field find inspiration for this profound form of altruism and caring in the work of Carl Rogers (1961). Rogers proposed that accurate empathy, unconditional positive regard, and counselor genuineness were necessary and sufficient conditions for promoting change in clients. Although research over the years has not substantiated his proposition that these conditions alone are sufficient to promote change in all clients, mounting research suggests that they are typically necessary for virtually any form of counseling or psychotherapy to be successful (Kirschenbaum & Jourdan, 2005). In fact, the quality and strength of the counseling relationship is one of the best predictors of change in the counseling process (Miller, Duncan, & Hubble, 1997). However, an empathetic and caring relationship is only one piece of the puzzle; more is required to be considered *competent*, especially in contemporary mental health practice.

Over the past decade, mental health professionals have witnessed a transformation in their approach to training and conceptualizing what they do. External third parties, such as insurance companies, regulatory boards, and client families, want to more precisely understand what all counselors and therapists are expected to know and do. To address these demands, mental health professionals have develop detailed lists of competencies: specific areas of knowledge and skill sets that one must possess in order to be considered "competent" to practice independently (Gehart, 2011; Hoge et al., 2005; Nelson, Chenail, Alexander, Crane, Johnson, & Schwallie, 2007; Urofsky, 2013). Although each mental health profession has its own set of competencies—counselors, family therapists, clinical and counseling psychologists, clinical social workers, psychiatric nurses, and psychiatrists—the core features are, thankfully, more similar than different. This book helps readers

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understand and ultimately master mental health competencies that relate specifically to the counseling and psychotherapy process: *what competent counselors do, think, and say in session with clients*. These competencies are based on the foundational theories of the field, which provide a road map for professional counseling and psychotherapy.

The Other Half of Competence

To those less familiar with the field, it appears that competent counseling primarily involves good in-session skills: building a relationship, listening well, and offering helpful and well-timed interventions. However, those with more practical experience know the other half of the story: all of those subtle in-session assessments and interventions need to be carefully documented in writing. In fact, from the perspective of third-party stakeholders—insurance companies, clinic directors, and in some cases even supervisors—the written half of the job often trumps the verbal elements in terms of importance. Without clear, written documentation of one's work, there is no evidence that competent care was rendered—or that payment is due. In fact, in modern practice environments, documentation is the primary means of demonstrating proficient counseling. Thus, to be considered competent one needs to know not only what to think, say, and do with clients but also how to document what transpired.

Historically, these two sets of competencies have been thought of and taught separately (Wiger, 2005). However, in this book, we are going to explore these skills as two halves of the same process. The experience of my students is that the two sets of competencies—in-session skills and documentation—are interrelated and work synergistically together. The more competent you are in-session, the better able you are to document what you do. The clearer you document what you do, the clearer you become with words and actions in session. It becomes a virtuous cycle that leads to greater and greater competence. The case documentation presented in this book has evolved over the past two decades and has been constantly revised to simultaneously and efficiently develop both in-session counseling and documentation skills. So, you will be traversing a relatively new yet well-traveled bridge between two formerly separate worlds.

The Road to Competent Counseling

To conceptualize the numerous and sometimes seemingly contradictory elements of competent counseling, we will use a five-step map to competent counseling. This map provides a compact yet comprehensive guide to navigating the often-bumpy road of the 50-minute psychotherapy hour. Each step is solidly grounded in an essential clinical case document. Using this map, you will learn to link what you think, do, and say in session directly to what you write in your formal case files. Although they may seem like several complex steps in the beginning, with a little practice you will be zooming along from the first step to the last.

The Five Steps to Competent Counseling

The Five Steps to Competent Counseling: Mapping a Successful Counseling Journey

Step 1: Map the Territory: Conceptualize the situation using counseling and psychotherapy theories.

Step 2: Identify Oases and Obstacles: Assess client's mental status and strengths and provide case management.

Step 3: Chart a Course: Develop a treatment plan with treatment tasks—including how to build a working counseling relationship—and measurable client goals.

Step 4: Leave a Trail: Document your work with progress notes.

Step 5: Track Your Progress: Evaluate client response to the counseling process.

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The five steps above follow a classic method used by all explorers in uncharted territory. And that's what each new counseling process is: uncharted territory, an unknown region, a *terra incognita*. It may seem at first that clients can be easily lumped into groups—anxious clients, divorcing couples, conduct-disordered children, for example—but any experienced counselor can tell you that each counselee's journey is unique. The excitement—and secret—to competent counseling is mapping the distinctive terrain of each client's life and charting a one-of-a-kind journey through it.

The first step is to delineate as much of the terrain as possible: to get the big picture. What are the contours of early development? Where are the comfort zones? Where is the well-traveled terrain? Is there a page marked "Here Be Dragons"? As with all maps, the more accurate and detailed the record, the easier it is to move through the actual territory. In counseling and psychotherapy, our maps are our *theoretical case conceptualizations*, assessments of the client using mental health theories. Although considered the most essential part of most approaches, in one study over 94% of practitioners failed to include a well-developed conceptualization in their formal case reports (Abbas, Premkumar, Goodarzi, & Walton, 2013). Now that you have this book in hand, you have a good chance of being in the most competent 6%.

Once you have a map, you identify the significant landmarks, the oases and the obstacles. Notice where the rest stops are and identify what dangers lie ahead. In counseling, you can recognize the *oases* as *client resources*: anything that can be used to strengthen and support the client. The *obstacles* appear as those potential or existing hindrances to creating change in the client's life. Are there really dragons in that region, or is the region just unfamiliar? Like a cartographer surveying the landscape, counselors assess potential obstacles carefully, ruling out potential medical issues in consultation with physicians, identifying psychiatric issues by conducting a *mental status exam*, and considering basic life needs such as a lack of financial and/or social resources through *case management*. By addressing actual or probable impediments early in counseling through a process called *clinical assessment*, the therapeutic journey is likely to proceed more easily and smoothly.

Once you have your conceptual map with oases and obstacles clearly identified, you can confidently chart a course toward the client's chosen destination or *goal*. If you have done a good job mapping, you will be able to choose from among several different courses, depending on what works best for those on the journey: namely, you and the client. This translates to being able to choose a counseling theory and style that suits all involved and that research indicates is likely to be helpful given the client's situation. Seasoned clinicians distinguish themselves from newer counselors in their ability to identify and successfully navigate through numerous terrains: forests, seas, deserts, plains, paradises, and wastelands. The greater a counselor's repertoire of skills, the better able the counselor is to move through each terrain. Once a preferred path is chosen, the counselor generates a *treatment plan*, a general set of directions for how to address client concerns. Like any set of travel plans, treatment plans are subject to change due to weather, natural disaster, human error, and other unforeseeable events, otherwise known as "real life." Counselors should be aware that unexpected detours, delays, and shortcuts (yes, unexpected good stuff happens, too) will be part of any counseling journey.

Once you select a course of action, you need to leave a trail to track where you have been. Leaving a trail always helps you find your way back if you get lost. It allows others (as well as yourself) to see why and how you proceeded. Counselors leave a trace of their path with *progress notes*, formal documentation of what happened in a given session. In addition to being the essential travel log, progress notes are also helpful with three highly prized aspects of professional counseling and psychotherapy: getting paid by third-party payers (i.e., insurance), avoiding lawsuits (i.e., the state lets you practice), and maintaining a license. By making it clear where you have been, you can help others—as well as you and the client—better understand your specific route of treatment.

Finally, you need to check frequently to make sure that you are on the right road. In counseling, this translates to *assessing client progress* along the way. If the client is not making progress, the counselor needs to go back and reassess (a) the accuracy of the map (conceptualization and clinical assessment) and (b) the wisdom of the plan.

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Most always, it is easy to make improvements in one or both areas that will get things back on course again. The key is assessing client progress often enough to notice when you are off course as soon as possible.

These five steps of competent counseling cover quite a bit of terrain; so it will take some time to get comfortable with all the steps, and even longer to become nimble with linking the steps together. However, as you practice putting these steps together, you will find that working with clients becomes increasingly easier: you will become clearer about what to focus on, what to say, and what to do. This book is designed to help you move through these five steps more effectively, whether you are just starting out or have been counseling for years.

Engaging Case Documentation Mindfully

The five steps of competent counseling are organized around essential case documentation forms for a simple reason: these are the only concrete evidence of the counseling and therapeutic journey. However, for numerous reasons, many clinicians and educators would prefer to avoid them. In fact, clinical case documentation is readily identified as one of the most neglected educational tasks in the field, and also as a correlate to professional counselor burnout after graduation (Cianfrini, 1997; Elliott & Schrink, 2009; Prieto & Scheel, 2002). Completing long forms that require numeric codes, austere language, and painful detail leaves most warm-hearted counselors frozen with dread. Those who have not learned how to make documentation clinically relevant complain that the burden of paperwork detracts from their true mission: to help real people with real-life problems: "How can completing a form help a client? In no way can it possibly help me do my *real* job." This book will teach you to have a more productive and enjoyable relationship to case documentation—and learn to use it as a tool to support and further your true mission.

When mindless paperwork is completed as part of an endless churning bureaucracy, it can easily detract from being a good counselor. However, I propose that when approached mindfully and thoughtfully, case documentation paperwork can significantly enhance not only counselors' effectiveness but it can ultimately—once they have enough practice to do it quickly—make their jobs easier. How? Essentially, well-done case documentation helps clinicians think more clearly and precisely about that they are doing, which translates to being more focused and on-target in the counseling room (Abbas et al., 2013; Prieto & Scheel, 2002). So, my humble goal with this book is to help you befriend case documentation—if not for the idealistic goal of being a highly competent counselor, at minimum for the more realistic practicalities that involve getting paid and staying out of trouble.

Clear Writing=Clear Thinking

Writing skills have repeatedly been linked to better analytical and reasoning skills (Flateby, 2011; Hunter & Tse, 2013; Preiss, Castillo, Flotts, & Martín, 2013). Through writing, one has a chance to "see" one's own thinking more clearly and precisely. Often patterns and insights emerge on the page that are not imaginable when the same information stays in the head. This is the reason so many clients benefit from journaling, especially when the writing is focused on cognition and facts in addition to emotions (Borkin, 2014; Ullrich & Lutgendorf, 2002).

For counselors and psychotherapists, the particular gift of writing is enabling the practitioner to link in-session experiences to theory, research, and the knowledge base of the field. Case documentation is the one place where all of these worlds have the possibility to come together. When done well, case documentation quickly becomes a form of self-supervision, a reflective process that provides the type of insight and guidance one might expect from a clinical supervisor (Morrissette, 2001).

I would be the first to agree that not all case documentation achieves this end: some forms of documentation are too far removed from what is actually happening in session and others are too heavily weighed down in bureaucratic minutia that the larger clinical parts get lost (e.g., productivity logs). In this text, I introduce readers to a set of four

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clinical documents that have significant clinical utility and also meet contemporary documentation standards. This documentation aims to closely integrate theoretical and research findings of the field with real-world practice to create a system of documentation that enables counselors to meaningfully reflect upon and focus their work.

Documentation Practicalities

If clearer thinking does not inspire your enthusiasm for mastering case documentation competencies, then perhaps you will appreciate more traditional reasons. The first reason most clinicians cite for doing paperwork is the legal and ethical requirement (Wiger, 2005). Increasingly, "standard care" has come to mean maintaining specific written records that document client concerns and the course of action counselor's take to address them. When counselors do not maintain such records, they are increasingly found "negligent" when ethics review boards or legal entities become involved. In the past, the legal and ethical requirement for case documentation was less clear. However, after the implementation of the federal HIPAA privacy act in 2004, more systematic requirements have been established (see progress notes in Chapter 6). Although there is still wide variability in the form and level of detail and complexity of case documentation, increasingly the basic content is similar across clinicians and worksites, with greater consistency across the mental health disciplines in general—which is all a good thing for those learning case documentation.

The other common motivation for doing progress notes is financial. If you hope to be paid for your work, you will find that most employers and third-party payers require a significant amount of case documentation in order to pay you (Wiger, 2005). Although most in the field are motivated largely by compassion and selflessness, in the end counselors need to eat and pay their bills like everybody else. Employers need to document to third-party payers the fact that competent and appropriate services were provided.

Finally, short of observing sessions, case documentation is the easiest way to ensure competent care is being rendered. Rather than ask for videos of our sessions to prove our competence, third-party payers such as insurance companies instead verify our competence with our written case documentation. Clinical case documents, such as treatment plans and progress notes and assessments, are used to efficiently provide evidence that counselors are doing something worthy of reimbursement.

Developing In-Session Competencies Using Case Documentation

The majority of my students agree that the most cringe-inducing and humility-inspiring training technique is watching your own counseling videos: personally witnessing your awkward expressions, reexperiencing the uncomfortable silences, and hearing your rambling or off-target responses. A close second is transcribing and then analyzing those same videos. Both are excellent for developing humbleness and a greater understanding of the counseling process. I am hoping that writing the theory-informed case documentation in this book will provide similar learning outcomes without the humbleness factor. By taking the time to write a theory-informed case conceptualization, counselors more quickly develop a sophisticated clinical picture and a clear sense of where and how to best intervene with the client. Similarly, by taking time to identify the theory-specific interventions used in each session and the client's response to these interventions, counselors can quickly adjust what they say and do in session to help clients.

How This Book Is Different and What It Means to You

Case Documentation in Counseling and Psychotherapy is a different kind of textbook. Based on a new pedagogical model, learning-centered teaching (Killen, 2004; Weimer, 2002), this book is designed to help you *actively learn* the content and develop real-world competencies, rather than simply to provide information to be memorized. This book teaches real-world skills that you can immediately use to better serve your clients. Thus, learning activities are a central part of the text so that you have opportunities to apply and use the information in ways that facilitate learning. The specific learning activities in this book are (a) case conceptualization, (b) clinical assessment, (c) treatment

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planning, and (d) progress notes. These activities translate the theory learned in each chapter to practical client situations.

This book is different in another way: it is organized by key concepts rather than general headings with long narrative sections. This organization—which evolved from my personal study notes for my university and licensing exams—facilitates the retention of vocabulary and terms because of the visual layout. Each year I receive numerous emails from enthusiastic newly licensed counselors and therapists thanking me for helping them to pass their licensing exams—they all say that the organization of the book made the difference. So, spending some time with this text should better prepare you for the big exams in your future (and if you have already passed these, you should be all the more impressed with yourself for doing it the hard way).

Lay of the Land

This book is organized into three parts:

Part I: Introduction to Case Documentation: The first section details the five steps to competent counseling described at the beginning of this chapter:

- Case conceptualization
- Clinical assessment
- Treatment planning
- Progress notes
- Evaluating progress

Part II: Theory-Informed Case Documentation: The next section of the text reviews key concepts of each of the major counseling theories and provides a detailed case study with all four elements of case documentation presented in the book: counseling case conceptualization, clinical assessment with DSM-5 diagnosis, treatment plan, and progress notes. Case documentation is presented for the following theories:

- Psychodynamic
- Adlerian individual psychology
- Humanistic-existential: Person-centered, Gestalt, and existential
- Cognitive-behavioral
- Family systemic-structural
- Solution-focused
- Postmodern: Collaborative, narrative, and feminist

Part III: The Competent Supervisee: The last chapter introduces you to the paradigm of the competent supervisee and provides guidance for how to approach the supervisory relationship. If you have already started seeing clients, you might want to begin here; otherwise, this chapter will get you ready for doing so. This chapter includes elements such as:

- Managing initial anxiety
- Your role as supervisee
- Your supervisor's role
- Getting the most out of supervision
- What to do if things get bumpy

Where to Start Reading

This book is designed to be a versatile text for use in different class settings or for use by those in clinical practice. Thus, depending on a person's needs and primary learning goals, it can be read in different order. Some options include:

Pre-Practicum Course with Case Documentation as Primary Focus

- Part I: Introduces students to case documentation
- Part II: Provides review of documentation for each theory
- Part III: Prepares students for transition to seeing clients

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Pre-Practicum Course with Skills as Primary Focus
- Part II: Provides review of assessment and intervention for each theory
- Part I: Introduces students to case documentation
- Part III: Prepares students for transition to seeing clients

Fieldwork Course
- Part III: Provides practical framework for conceptualizing supervisee role and for managing common problems
- Part I: Teaches foundational case documentation skills
- Part II: Provides examples of how to write case documentation for student's theory (ies) of choice

Counseling Theories Course
- Part II: Provides foundational instruction in counseling theories and methods
- Part I: Provides overview of case documentation
- Part III: Prepares students for transition to seeing clients

Theory Review

The chapters in Part II are designed to *briefly review* key concepts from each theory that are most applicable to case documentation; more thorough discussions of the theories are provided in *Theory and Treatment Planning in Counseling and Psychotherapy* (Gehart, 2013). These theory-review chapters are organized in a user-friendly way to maximize your ability to use the book to support you when developing case conceptualizations, writing treatment plans and progress notes, and designing interventions with clients. Theory chapters follow this outline:

Anatomy of a Theory

In a Nutshell: The Least You Need to Know

The Juice: Significant Contributions to the Field: If there is one thing to remember from this chapter it should be…

The Big Picture: Overview of the Therapy Process

Making Connection: The Therapy Relationship

The Viewing: Case Conceptualization

Targeting Change: Goal Setting

The Doing: Interventions

Try It Yourself: Exercises for Practicing Clinical Skills

Putting It All Together: Treatment Plan Template

- Treatment Plan Template for Individuals with Depression/Anxiety Symptoms

Tapestry Weaving: Working with Diverse Populations

- Ethnic, Racial, Gender, and Cultural Diversity
- Sexual Identity Diversity

Research and Evidence Base

Online Resources

Reference List

Case Example: Vignette with a complete set of clinical paperwork described in Part I, including case conceptualization, clinical assessment, treatment plan, and a progress note.

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