An assessment of the client's safety, and the safety of others, should be integral to the interview. Many initial assessment forms explicitly prompt the counselor to ask the client if he or she is having, or has had, thoughts of harming or killing self and/or others. Some beginning counselors are uncomfortable with asking about the risk of suicide or other dangers, and may believe that asking about suicide increases the client's risk. This is simply not so. Asking clients about suicidal or homicidal thoughts or intentions gives them permission to express thoughts and feelings that they may have otherwise considered taboo. It might be a great relief for clients to know that it is acceptable for them to talk about suicide, and students should learn to perform a suicide risk assessment (Schwartz & Rogers, 2004).

Based on the information obtained, the counselor can generate a broad list of potential diagnoses, then begin systematically begin narrowing the list (the process of differential diagnoses) by using various techniques. One popular, and fairly user-friendly, technique for differential diagnosis is the use of algorithms or decision trees, as described by Morrison (2007). The *DSM-IV-TR* (2000) also provides decision trees for differential diagnosis. Finally, social and cultural factors, whether or not they fit into the *DSM* paradigm, should be brought into the diagnostic picture.

Developing a Counseling Treatment Plan

The ACA *Code of Ethics* (2005) requires that counselors and their clients work collaboratively in the development of counseling plans that "offer reasonable promise of success and are consistent with abilities and circumstances of clients" (p. 4). Furthermore, counselors should periodically review counseling plans, again in collaboration with clients, in order to determine whether they are viable and effective. This provision, along with the principle of informed consent, should be guiding forces in the development and implementation of counseling treatment plans. The client has a right to accept or refuse to enter into, or continue, a counseling treatment plan except in situations of clear and foreseeable risk of harm to the client or others. Therefore, collaboration with the client is not only desirable, it is ethically mandated (Dougherty, 2005; Eriksen, Hoffman, & Kress, 2010).

A counseling treatment plan may be fairly simple—for example, a limited number of sessions of cognitive-behavioral interventions for a simple phobia—or quite complex, such as long-term counseling and psychiatric care for a person with a major depressive disorder. While the extent and severity of the client's problems are obvious factors in devising a treatment plan, so are other factors.

First, does the client want long-term counseling with the hope of resolving deeper issues that contribute to his or her distress, or does the client prefer short-term intervention for symptom management? Second, what kind of counseling or other treatment is the client capable of engaging in? This requires consideration not only of the client's current mental status, but of other resources as well, such as money, insurance coverage, and access to adequate social support. Finally, what kind of counseling are you able to offer the client, based on variables such as your agency or facility guidelines and your own level of experience and competence?

Prioritizing Problems

If a client has several problems, such as a formal diagnosis (or multiple diagnoses) as well as other problems such as relationship issues, threats to safety, employment problems,

and physical health problems, where should you begin? A sound guiding principle in such a situation is to prioritize problems based on their degree of threat to the client and the extent to which the problem can be readily resolved. For example, a client with a long-standing history of schizophrenia who is currently homeless and without money for food needs a social services referral for emergency food and shelter before delving into his or her mental health issues.

Considering Individual Strengths and Resources in the Treatment Plan

The client's strengths, talents, and resources should be actively integrated into the counseling plan. For example, a client who likes art might use that modality as a means of emotional expression, especially for expressing feelings that are difficult to verbalize. A client who is open to approaches such as meditation and relaxation training will benefit more from these interventions than will someone who dismisses them as hocus-pocus. Family and community support, when appropriate and welcomed by the client, can contribute to the client's well-being and decrease the sense of isolation that often accompanies the experience of emotional distress.

Another facet of a strengths-based approach is in how we interpret the client's current symptoms as, perhaps, once-effective means of coping with challenges. For example, a woman who was sexually abused in childhood may have developed the ability to dissociate as a means of "escaping" a situation over which she had no control. As an adult, the dissociation is no longer useful and may be a source of problems, but can still be acknowledged and honored as a creative coping strategy. Unlinking responses such as dissociation from a disease framework can be very valuable in forging a mutually respectful and constructive client–counselor relationship.

Re-evaluation, Modification and Ongoing Evaluation of the Counseling Plan

A counseling treatment plan, however well-designed, must be re-evaluated periodically in order to evaluate its effectiveness and make modifications as indicated. As in the original plan, the client's collaboration and informed consent is central to the process.

Consultation and Referral

It is incumbent upon the counselor to recognize when a client's needs and problems fall outside of the counselor's scope of practice, qualifications, and experience. When this is the case, the counselor should consult with a supervisor or appropriate peer, and/or refer the client to the appropriate practitioner (ACA, 2005). In order to prevent misinterpretation on the part of the client, the counselor should be sure to explain that the reason for the referral is not to "get rid" of the client but to ensure the proper care.

SIDEBAR 12.7 Self-Awareness: Assessing Your Own Abilities

Imagine that you begin working with a client, Valerie, who has a history of childhood sexual abuse. At first, her symptoms of posttraumatic stress are within your comfort zone as a student counselor, and your clinical supervisor agrees. One day,