Part III – Defining Treatment Goals and Gauging Client Motivation

It is important that the client's key problem areas can be translated into some clear treatment goals. Therapists should note the degree to which the client can articulate their treatment goals. Is the client able to describe in specific terms what they would like to be different in their life, and what they would like to work on from a personal perspective? Similarly, how motivated is the client to pursue these goals? The therapist should enquire about the client's fears and feelings (short-term and long-term) if they do versus do not work on these issues. What are the motivating factors? Did they decide to attend of their own volition, or has someone else in their life encouraged them or made an ultimatum to motivate them to attend therapy? Do any of their goals clash with those of other family members? Are the client's goals linked to their presenting issues? To what degree is the client exercising a sense of autonomy by engaging in therapy or considering change? Below are some key questions and considerations that might guide the schema therapist in understanding the client's treatment goals and motivation for change.

What Stage of Change Might the Client Be In?

In Figure 3.1 we have mapped schema therapy objectives and interventions onto the stages of change model [32]. How ready/able is the client to set long-term vs. short-term goals? Are their goals focused on short-term relief or on long-term contentment and fulfilment? Is the client seeking a 'quick fix', or do they require psychoeducation to help them recognise the

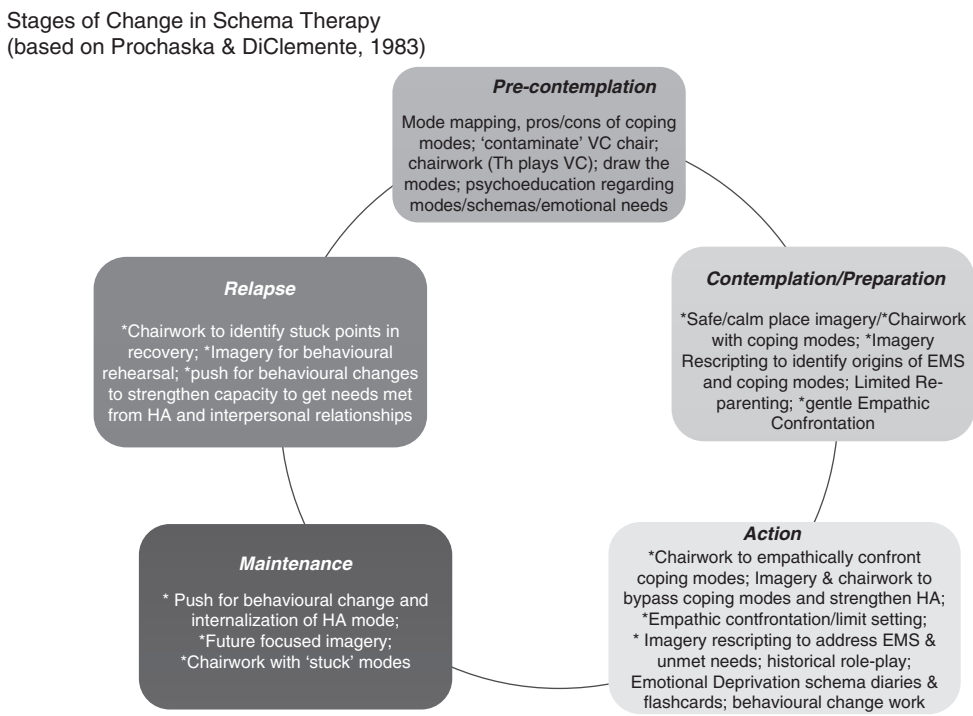

Figure 3.1 Stages of change model and schema therapy interventions [32]

intense work and commitment that comes with long-term therapeutic change? How willing are they to tolerate short-term stress or difficult emotions to achieve their longer-term goals? How might they envisage their life evolving in five and ten years' time if their goals were achieved? What barriers do they anticipate that might block their progress at this early stage? Is there anything that can be learned from previous therapy relationships about what might trigger blocks to treatment engagement, adherence, and progress (e.g., a tendency to be suspicious as soon as the therapist forgets to do something they had promised, whilst assuming that all therapists are just like everybody else and don't really care about them)?

Explore Client Treatment Goals That Relate to Presenting Issues

Over the course of treatment, the client's capacity to self-reflect and consider more possibilities may allow their goals to evolve. It can be useful to revisit and fine-tune goals to ensure that they cover a broad range of life domains. This might include relationships and connections (to self, others, nature), work, spirituality, bodily and mental well-being, or any domain that is significant to the client. Clients who are aware of their distress, such as those with BPD, are more likely to be able to describe their current difficulties in detail and to formulate goals linked to these. For those with Cluster C and NPD, the presence of strong coping modes can interfere with the person's capacity to recognise or describe their underlying suffering. These clients can easily lose sight of their reasons for attending therapy, increasing the risk that sessions will be dominated by 'downloading' details, general chatting, or a space for intellectualising or self-aggrandising (depending on dominant modes). With the ultimate goal of bypassing coping modes, it is therefore crucial to link treatment goals with the client's underlying (and sometimes hidden) experience of vulnerability. Treatment goals should to some extent be linked to these areas of vulnerability (e.g., to reduce feelings of suicidality or loneliness, and to learn healthy ways of getting needs met). For clients with narcissistic and highly avoidant presentations, the clear identification of difficulties and goals will later be a source of leverage to motivate the client to engage in experiential work that will mitigate their emotional suffering. For clients with more chaotic symptom presentations, the goals will serve as a compass to which both therapist and client can return, to ensure that working with crises and schema activation on a week-to-week basis remains consistent with the overarching goals. For those with more rigid and compulsive presenting issues, regularly revisiting the goals will serve as a beacon that brings hope and motivation to work on bypassing stuck – and seemingly impenetrable – coping modes, to facilitate healing work with the child modes.

What Length of Treatment Might Be Appropriate or Realistic?

Schema therapists must ensure that they are available to provide longer-term therapy, especially when working with clients who require extensive trauma-processing work. However, this may be flexible to some degree by incorporating phase-based schema therapy [33] and/or a combination of group and individual therapy. Short-term (~20 sessions) schema therapy has also been found to be effective for many client groups (see Chapter 1: From Core Emotional Needs, to Schemas, Coping Styles, and Schema Modes for details). Goal setting can then be planned around phases and/or length of treatment to ensure that it is realistic and achievable within this time frame.