THE GUILFORD FAMILY THERAPY SERIES
Michael P. Nichols, Series Editor

Recent Volumes

Essential Assessment Skills for Couple and Family Therapists
Lee Williams, Todd M. Edwards, JoEllen Patterson, and Larry Chamow

The Adolescent in Family Therapy, Second Edition: Harnessing the Power of Relationships
Joseph A. Micucci

Essential Skills in Family Therapy, Second Edition: From the First Interview to Termination
JoEllen Patterson, Lee Williams, Todd M. Edwards, Larry Chamow, and Claudia Grauf-Grounds

Doing Couple Therapy: Craft and Creativity in Work with Intimate Partners
Robert Taibbi

Doing Family Therapy, Second Edition: Craft and Creativity in Clinical Practice
Robert Taibbi

Collaborative Therapy with Multi-Stressed Families, Second Edition
William C. Madsen

Working with Families of the Poor, Second Edition
Patricia Minuchin, Jorge Colapinto, and Salvador Minuchin

Couple Therapy with Gay Men
David E. Greenan and Gil Tunnell

Beyond Technique in Solution-Focused Therapy: Working with Emotions and the Therapeutic Relationship
Eve Lipchik

Emotionally Focused Couple Therapy with Trauma Survivors: Strengthening Attachment Bonds
Susan M. Johnson

Narrative Means to Sober Ends: Treating Addiction and Its Aftermath
Jonathan Diamond

Couple Therapy for Infertility
Ronny Diamond, David Kezur, Mimi Meyers, Constance N. Scharf, and Margot Weinshel

Short-Term Couple Therapy
James M. Donovan, Editor

Treating the Tough Adolescent: A Family-Based, Step-by-Step Guide

Essential Assessment Skills for Couple and Family Therapists

LEE WILLIAMS
TODD M. EDWARDS
JoELLEN PATTERSON
LARRY CHAMOW

Series Editor's Note by
MICHAEL P. NICHOLS

THE GUILFORD PRESS
New York London

A Division of Guilford Publications, Inc.
72 Spring Street, New York, NY 10012
www.guilford.com

Printed in the United States of America

This book is printed on acid-free paper.

Last digit is print number: 9 8 7 6 5 4 3 2 1

Library of Congress Cataloging-in-Publication Data is available from the Publisher.

ISBN 978-1-60918-079-9

About the Authors

Lee Williams, PhD, is Professor of Marital and Family Therapy at the University of San Diego and does couple therapy with veterans at the VA San Diego Medical Center.

Todd M. Edwards, PhD, is Associate Professor and Director of the Marital and Family Therapy Program at the University of San Diego and Assistant Clinical Professor in the Department of Family and Preventive Medicine at the University of California, San Diego.

JoEllen Patterson, PhD, is Professor of Marital and Family Therapy at the University of San Diego and Associate Clinical Professor in the Department of Family and Preventive Medicine and the Department of Psychiatry at the University of California, San Diego.

Larry Chamow, PhD, is Clinical Professor of Marital and Family Therapy at the University of San Diego and is in full-time private practice at the Pacific Family Institute in Carlsbad, California.

CHAPTER 13

From Assessment to Treatment (and Beyond)

Imagine Tom and Maria have come to you for marital therapy. Both are in their mid-40s and have been married for 10 years. Tom is white, while Maria is Hispanic. When asked why they are coming to therapy, Maria tells you there is no passion in the relationship, which she describes as more like "brother and sister." She says there has never been much passion in the relationship, and wonders whether Tom is the right person for her. Tom tells you he has trust issues with his wife because he suspects that she has been unfaithful, although he does not know for sure. Both report stress and conflict over finances. The couple denies any physical violence. They both express doubts about remaining in the marriage.

Maria does not work outside the home, while Tom works in an administrative position that he describes as being very stressful. Maria has a number of health problems, including arthritis, fibromyalgia, migraines, and chronic foot pain. Tom complains of poor sleep. Both admit to being depressed. Tom is not currently taking any medications. Maria states she feels fine in the morning, but she then becomes depressed in the afternoon. She has been taking Wellbutrin for several months but reports no benefits from it. She also admits that she has difficulty controlling her anger. In session, she presents as energetic and has a fast-paced speech pattern. Tom, in contrast, is reserved.

When doing the relationship history, you learn that Maria had 15

months of sobriety from drugs and alcohol when the couple first met. The couple did relatively well the first few years of marriage, although they did seek out some counseling. Things changed significantly after a move to the Northeast. Tom became very involved in his career at that point and had little time for his wife. Maria compensated for this by getting involved with friends and other activities. After the couple returned to California, their problems seemed to get worse. At this point, Maria became depressed.

During her individual history, Maria reports that she was the oldest of three in her family, which resulted in her having a lot of responsibility for her younger siblings. She was molested by her father, but also has many fond memories of her family doing activities together (including with her father). Beginning in high school, Maria developed alcohol and amphetamine dependence and was sexually very active. She has been sober and clean for 13 years.

In his individual history, Tom reports being raised in a very traditional home. His father worked long hours and did not have a close relationship with him. His mother did not work outside the home. He feels that his parents gave his sister more attention to support her athletics.

If you were seeing Tom and Maria, what kind of treatment plan would you follow? Most beginning therapists find developing a treatment plan a struggle. They often have difficulty taking all of their various hypotheses and shaping them into a concise and workable treatment plan. In this chapter, using Tom and Maria as an example, we describe a process to help you create a treatment focus for your cases.

Assessment, however, does not conclude once the treatment plan has been formulated. You must also assess how the client is responding to treatment. Does your treatment plan continue to make sense as you learn more about your clients? Even if you have confidence in your conceptualization of the case, you must evaluate how effective your interventions are in addressing the issues. Finally, you must be able to assess when your clients are ready for termination. These issues are also explored in this chapter.

TRANSFORMING ASSESSMENT INFORMATION INTO A TREATMENT PLAN

Developing a treatment plan requires that you take the assessment information and transform it into therapeutic goals—goals or changes

you would like to see the clients work on in therapy. Therapeutic goals are different from the client goals defined in the initial interview. Client goals state what the end result should be, while therapeutic goals state what needs to change in order for the client goals to be achieved. For example, a couple's goal may be to reduce conflict and feel more connected. Therapeutic goals may include interrupting the couple's interactional cycle, reducing substance use, and increasing the number of pleasurable activities that the couple engages in together. For therapy to be successful, there must be a connection between the therapeutic goals and the client's expected outcome or goals.

Multiple factors may inform a therapist's treatment plan (see Figure 13.1). Obviously theory is an important component. Indeed, a therapist's theoretical approach both informs what questions are asked and how the information is interpreted. A transgenerational therapist, for example, will take an interest in family-of-origin influences for both Tom and Maria.

Research can be another important influence on the development of a treatment plan. Evidence-based practice encourages therapists to think about which treatments have empirical evidence supporting their effectiveness. Research can also inform our understanding of certain problems, which may shape how we conceptualize a case. When Carol began to work with Douglas, a 14-year-old boy recently diagnosed with Asperger syndrome, she surveyed the research because she lacked a strong understanding of the disorder. After reading the literature, Carol

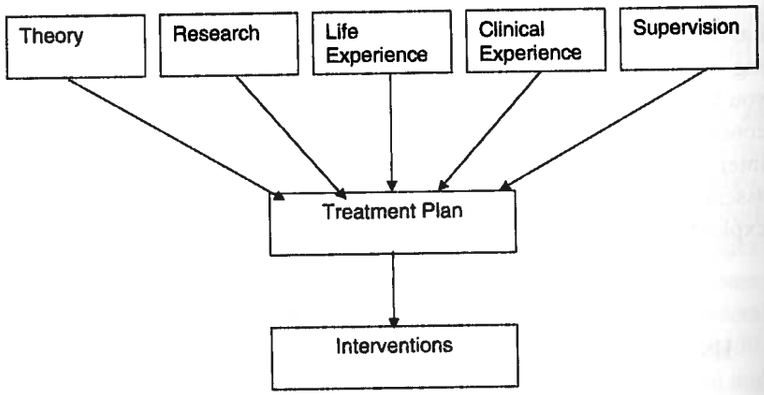

FIGURE 13.1. Factors that can influence treatment planning.

realized that she would need to help Douglas strengthen his social skills, which became a focus in therapy.

Life experience and clinical experience also inform how one conceptualizes a case. If we have had to face a challenge similar to that of our clients, we can use the knowledge we gained from our life experience to help formulate a treatment plan. Similarly, clinical experience can provide us insight into what works (or does not work) in addressing certain issues or problems. This is one reason why beginning therapists initially have such difficulty developing treatment plans. They do not have the clinical experience that more seasoned clinicians have. This is why supervision can be so important when developing a case formulation or treatment plan.

We recommend explicitly writing out each of the steps when developing a treatment plan. We have found that beginning (and experienced) therapists often benefit from this process. The steps are as follows:

- *Step 1: List problems.* In the initial step, you will list all the problems that have been identified through assessment. This will include any symptoms that have been described or observed by either the client or therapist. Listing symptoms may be important in hypothesizing about possible mental illness. Table 13.1 shows the list of problems and symptoms that could be listed for Tom and Maria, the couple presented at the beginning of the chapter.
- *Step 2: Develop and list hypotheses.* In the second step, you write down all of the most relevant and realistic hypotheses. Table 13.2 shows

TABLE 13.1. Step 1: Description of Problems (and Symptoms) for Tom and Maria

- Depression for Tom
- Depression for Maria (unresponsive to Wellbutrin, declining mood in the afternoon)
- Tom reports difficulty sleeping
- Health issues for Maria (arthritis, migraines, fibromyalgia, chronic foot pain)
- Financial conflict
- Maria reports marriage lacks passion
- Maria reports being bored and lonely
- Both considering divorce
- Tom reports significant job stress
- Tom suspects his wife has had an affair
- Disagreement over physical affection

TABLE 13.2. Step 2: Developing Hypotheses for Tom and Maria

- Maria has bipolar disorder (depression, cycling of moods during the day, high-energy, pressurized speech pattern, problems with anger).
- Maria's depression is due to health issues (chronic pain, fibromyalgia, etc.).
- Maria's depression is due to her marital dissatisfaction (lack of closeness in the marriage).
- Tom's complaints about sleep are due to his depression and stress.
- Tom's depression is due to work stress.
- Tom's depression is due to biological causes.
- Both partners' lack of satisfaction reflects a lack of cohesion in the marriage.
- Moving uprooted Maria from the people and activities that filled her emotional needs in the absence of her husband. Thus, her symptoms (and the marriage) worsened when the couple relocated.
- Tom is preoccupied with his job in order to gain recognition for achievement he never received in his family of origin (competition with sister for parental attention).
- Tom has allowed the couple to overextend themselves financially in order to appear successful (self-esteem issues).
- Tom has allowed the couple to overextend themselves financially in order to meet the traditional gender expectation that the husband will be a good economic provider.
- Tom's fears are legitimate because Maria did indeed have an affair, but she is afraid to admit it.
- Tom's concern that Maria has had an affair reflects his own insecurity or self-esteem issues (and not Maria having actually had an affair).
- Maria chose a nonpassionate man because she wanted someone "safe" given her history of sexual abuse. Conversely, Tom chose Maria because she was "dangerous" and would make his life more exciting.
- The couple's thoughts of divorce reflect a lack of hope, and are not an indicator that they actually want out of the relationship.

a possible list of hypotheses for Tom and Maria. At this point of the process, you may have a long list of hypotheses. This is fine, since you will be narrowing the treatment focus in the next step.

Therapists working from different theoretical perspectives may have different hypotheses, or may define the issues using different terms. When you generate a list of hypotheses, you may even find that you have included hypotheses from different theories. Since many therapists work from an integrative perspective, this does not necessarily reflect a problem.

A biopsychosocial-systems model encourages us to look at the problems from different angles. Some therapists may assume that low sexual desire is due to relational problems for the couple. Although this is a hypothesis that should definitely be considered, it is also important to be alert to the possibility that low sexual desire may be due to depression, illness (e.g., thyroid problem), or a side effect of medication (e.g., SSRI antidepressants).

When developing hypotheses, it is helpful to consider the extent to which they are descriptive or causal in nature. If you notice that a client reports irritability, difficulty sleeping, and a lack of appetite, then a legitimate hypothesis is that he or she is depressed. However, this hypothesis is at a rather descriptive level, and does not address *why* the client may be depressed. Hypotheses that are more causal in nature (e.g., the client is depressed because of low marital satisfaction) are more effective at guiding treatment.

To move from a descriptive to a more causal level, it is helpful to keep asking, "Why?" For example, start by asking, 'Why is the client depressed?" If you hypothesize that a client's depression is caused by low self-esteem, then a good question to ask is "Why does my client have low self-esteem?" You might hypothesize that your client struggles with low self-esteem due to some negative schemas internalized from his or her family of origin. Challenging these negative schemas might then be one of your therapeutic goals. Using a chain of "why" questions in this way can lead you to hypotheses that are less vague and suggest more concretely how treatment should proceed.

- *Step 3: Develop a treatment focus.* Beginning therapists are often good at generating hypotheses. Where they can get stuck is in narrowing and consolidating their hypotheses into a workable treatment plan. We strongly recommend that your treatment plan not exceed two or three therapeutic goals at any one time. Otherwise, it is too easy to lose focus and feel pulled in many directions. When it comes to maintaining a treatment focus, your mantra should be "Do more with less." Table 13.3 shows the therapeutic goals for Tom and Maria at two different stages of treatment—the preliminary and middle stages.

As Table 13.3 illustrates, the therapeutic goals will likely change as therapy evolves. As some goals are accomplished, new goals may become the focus. This may require the therapist to prioritize certain therapeutic goals over others. In the case of Tom and Maria, the therapist focused on building couple cohesion early on in treatment. The

TABLE 13.3. Step 3: Developing a Treatment Focus for Tom and Maria

Initial treatment plan	Later treatment plan
1. Build couple's cohesion.	1. Address trust cycle.
2. Rule out bipolar disorder for Maria.	2. Rebalance work/family for Tom.
	3. Improve self-care for Maria.

therapist hypothesized that this would help build a sense of hope and strengthen the couple's bond, which might make it easier for them to do the emotionally difficult work of examining trust issues. As they began to regularly go out on dates, they reported feeling better about the relationship and developed a renewed sense of hope. The therapist could now revise the therapeutic goal from building cohesion to focusing on trust issues.

The fact that therapeutic goals change over time does not mean that they keep changing from session to session. If this happens, it is usually a sign that the therapist has not developed or committed to a treatment focus. Writing down the therapeutic goals for each case and reviewing them prior to each session can help keep you on task. If you have done a good job developing therapeutic goals, you can often take the material your client brings into each session and use it to address one of your therapeutic goals.

Sometimes an initial treatment goal may reflect the need to do further work to rule out a hypothesis. In this case, the therapist suspected that Maria could be suffering from bipolar disorder based on her symptoms (e.g., cycling of mood during the day, difficulty with anger, poor response to Wellbutrin). If Maria indeed did have bipolar disorder, then she may have needed a different medication to adequately control her mood. Interventions included psychoeducation with Maria so she could assess if her experience fit with that of someone having a bipolar disorder, as well as a referral to a psychiatrist to help rule out such a disorder. It was later ruled out, which suggested that other underlying causes of depression should be targeted.

When developing a treatment focus, it is sometimes possible to combine or link multiple hypotheses into a single therapeutic goal. For example, one of the therapist's goals was to help Tom rebalance his priorities with regard to work and family. The therapist believed that in order for the marriage to improve, Tom would need to devote more time to the marriage and cut back on the time he spent at work.

Rebalancing the time he spent at work and at home would tie together several of the hypotheses that the therapist entertained. Reducing his time at work might lower Tom's stress level, perhaps alleviating his depressive symptoms. It would also likely involve looking at why Tom felt so compelled to work excessive hours, which the therapist hypothesized was due to his strong need for recognition (based on family-of-origin dynamics). Obviously, it would it also make him more available to his wife, which could reduce her sense of isolation and loneliness.

As family therapists, we attempt to understand the relational context of an individual's behavior. Thus, many of our therapeutic goals should reflect an interactional understanding as to why the problems exist. In Tom and Maria's case, the therapist eventually came to recognize how the couple's dynamics helped create and perpetuate their issues around trust. Tom's accusation that Maria had had an affair hurt her deeply, leading her to begin withdrawing from him. Her withdrawal, however, fueled Tom's insecurities about the relationship, including his suspicions that she was having an affair.

In an effective treatment plan, therapeutic goals often reinforce each other in a synergistic manner. Rebalancing Tom's work and family commitments made him more available to Maria. It also led him to become happier, not only in his marriage, but in his life in general. Furthermore, Maria found it easier to be with him since he was less depressed, which reassured him of her love. Maria learned to practice better self-care, both as a way to cope with her numerous health issues and also to make her less dependent on Tom for her emotional needs. By practicing better self-care, Maria became less reactive to Tom's moods, enabling her to stay more engaged.

ASSESSMENT DURING TREATMENT

Assessment does not end with the development of a treatment plan. As stated in the first chapter, assessment is intervention, and intervention is assessment. As you begin to intervene with clients, it is important to assess how clients respond to treatment. This, in turn, may give you a better understanding of your client and of how to intervene more effectively.

Measuring Change

As you proceed through therapy, it will be important to assess how much progress your clients are making. Measuring client progress raises the difficult question "What does change look like?" Do you need to see a change in the couple or family dynamics to consider it real change, or is elimination of the presenting problem sufficient? Is behavioral change necessary for a successful outcome? Or, can a change in perception, such as greater acceptance of the problem, also be considered a success?

Whose perception of change should take precedence? If a client believes that things are better, but the therapist has observed little change, whose perspective counts the most? Conversely, if a therapist sees changes, but the client does not recognize them, does that constitute real change? How you answer these questions will shape how you define and measure success in therapy.

We believe resolving the presenting problems and observing changes in relational dynamics are both important. Although we generally seek to change relationship dynamics, it is possible that some presenting issues can be resolved without changing couple or family dynamics. Ideally, change will be evident both behaviorally and on the perceptual (cognitive and/or emotional) level. However, we recognize how one views the problem or situation is often a powerful form of change in itself, and that behavioral change is not always present.

In general, we believe the client should be the primary authority on whether successful change has occurred. Ultimately the clients must live with whatever changes are made or not made, so we look to them to answer the question of whether their lives are better for having received our services. Still, we do not automatically discount our own perspective. We may be the first to notice the changes the client is making, and can use this to draw attention to what we want the client to continue to do. In some cases, it may be appropriate to challenge the client to make additional changes to reduce his or her vulnerability to problems reoccurring in the future.

Due to its complexity, you may want to use multiple ways of assessing change. Fortunately, you have a number of tools at your disposal. Asking clients about changes they have observed in their lives is an appropriate place to start. This can be done in a variety of ways. One might ask clients directly through open-ended questions, such as "What changes or improvements in your life/relationship have you observed?"

Clients might also be asked periodically to rate on a scale from 1 to 10 how well they are doing, and comparisons made with how they were doing before. Although clients are in the best situation to observe if changes are happening in their lives, there are potential problems of which you should be aware. Clients may be tempted to say they are doing better than they really are to look good (social desirability) or to protect the therapist's feelings (demand characteristics).

You can also use your own powers of observation to note if changes are happening. Clients who are feeling better about themselves or their relationship may have a different presence about them (e.g., lighter, less depressed affect). You may also notice that family members or partners are interacting differently within the session. These are often good indicators of change. In some cases, you may observe the changes before the client is consciously aware of them. However, it may be difficult for you to recognize change if it has occurred primarily at a perceptual rather than a behavior level.

Occasionally, clients will comment that others have pointed out changes in them. One man noted that coworkers began to ask him what was going on because they had noticed his mood was more positive. This is another powerful indicator of change. Therefore, it can be important to ask clients if others have noticed or commented on how they seem different.

Pencil-and-paper assessment instruments can also be used to measure change. If you had clients complete instruments that measure individual, couple, or family functioning as part of your initial assessment, then these instruments could be readministered later in therapy to determine if there has been change. For example, a couple who completed the Dyadic Adjustment Scale at the beginning of therapy could retake it later in the course of therapy. This could help you determine not only if the relationship has improved, but also if their scores have moved into the functional or nondistressed range.

Lambert and Hawkins (2004) recommend that clients fill out assessment instruments throughout therapy to monitor their progress rather than only at the beginning and end of treatment. If the client is not making progress early in therapy, then you can identify what factors may be barriers to change (see the following section). For brief therapy, you might consider giving the clients a weekly assessment, particularly in the beginning. For clients who remain in therapy for a longer period of time, a monthly assessment may be sufficient. Obvi-

ously, this approach is most practical if the instruments are brief and easily completed by the client. Even a brief form that asks the client if things are significantly better, somewhat better, the same, somewhat worse, or significantly worse compared to last week can help you assess if positive change is occurring.

Lambert and Hawkins (2004) recommend the BASIS-32, the Brief Symptom Inventory (BSI), and the Outcome Questionnaire (OQ-45) as outcome measures widely used in the literature and relevant to clinical use. The BASIS-32 (Eisen, Grob, & Klein, 1986) is used to assess mental health status among clients receiving psychiatric care. In addition to a total score, the BASIS-32 yields scores on five subscales—Relation to Self/Others, Depression/Anxiety, Daily Living/Role Functioning, Impulsive/Addictive Behavior, and Psychosis. The BSI (Derogatis, 1993) is a 53-item inventory that can be used to measure psychological distress. It consists of nine symptom subscales that include Somatization, Obsessive–Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. It also has three global indexes, the Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total Index. Norms exist for normal, outpatient, and psychiatric populations. The OQ-45 (Lambert et al., 2004) is a 45-item scale that measures client progress in therapy, and includes three subscales that measure symptom distress, interpersonal relations, and social role functioning. The Youth Outcome Questionnaire (Y-OQ) is a version of the OQ-45 suitable for youth (Burlingame et al., 2005).

Other instruments for measuring client progress have also been developed. The Systemic Therapy Inventory of Change (STIC) can be used to track client change for adults, couples, families, or children (Pinsof & Chambers, 2009). Two forms of the STIC exist. The Initial STIC, which is administered before the initial interview, consists of six parts, which assess: (1) demographics, (2) individual functioning, (3) family-of-origin recollections, (4) couple functioning, (5) family functioning, and (6) child functioning. Clients fill out all the parts that apply to them based on their demographics. The Intersession STIC, which was developed to be administered each therapy session, typically takes clients 5 to 7 minutes to complete. The Intersession STIC includes shorter versions of the questionnaires used to measure individual, couple, family, and child functioning. It also includes brief measures that assess

the therapeutic alliance between the therapist and clients in individual, couple, or family therapy.

Two other measures that are used together to measure client progress are the Outcome Rating Scale (ORS; Miller, Duncan, Brown, Sparks, & Claud, 2003) and the Session Rating Scale (SRS; Duncan et al., 2003). Both scales include only four items apiece, so they can be administered quickly. The ORS is given at the beginning of every session to measure change, while the SRS is administered at the end of each session to assess the therapeutic alliance. The Child Outcome Rating Scale (CORS; Duncan, Sparks, Miller, Bohanski, & Claud, 2006) and the Child Session Rating Scale (CSRS) are child versions of the scales, appropriate for youth ages 6–12 years. Miller, Duncan, Brown, Sorrell, & Chalk (2006) found that obtaining client feedback using these scales improved client outcomes and reduced client drop outs.

Assessing Barriers to Change

If there does not appear to be satisfactory movement in therapy, then it is important to assess what might be contributing to the lack of progress. One area to explore is the therapeutic relationship, since it is essential to the success of therapy. Have you been able to develop a strong therapeutic relationship? You should continue to monitor the relationship throughout therapy. Do you see any signs that a client feels the relationship has been damaged in some manner? Instruments such as the Intersession STIC and the SRC, described above, can help you assess the therapeutic alliance. When you are working with relational systems such as a couple or family, do all members feel that you are being balanced and/or fair when challenging or supporting individuals within the system? Or, do individuals feel that you are aligned with a particular family member? At times, individuals will state this concern directly. However, often these concerns may be addressed less directly. For example, if a parent argues that you do not see through an adolescent's manipulation, the parent may be expressing concern that you are too aligned with the adolescent.

If progress is not being made, then you may need to reevaluate whether you have a good contract for therapy. Some therapists, in their eagerness to bring about change, forget to clearly establish client and therapeutic goals. Are you clear on what concerns are motivating your clients to come to therapy? Do you understand where they feel the most

pain, which is usually what motivates individuals to risk change? Have you clearly articulated to your clients what therapeutic goals you are striving to accomplish? Do they agree with these therapeutic goals as the focus of therapy? If clients express ambivalence or disagreement about your therapeutic goals, then you may need to reformulate your treatment plan.

Sometimes treatment can become stuck if the wrong modality is being used (e.g., individual versus couple or family). For example, a therapist may find that movement is slow when working primarily with a child. This may suggest that more work needs to be done with the family. With couples, it may be necessary to suggest one or both partners do some individual therapy before couple therapy can be optimally effective.

As you begin to intervene with your clients, ask yourself if they are responding well to the interventions you are using. One therapist began to realize that her client was not benefiting from an insight-oriented approach to therapy. Recognizing that this client was very concrete in her thinking, she began to incorporate more behavioral interventions, which were more successful in promoting change. It is also important to assess how receptive your clients are to direct suggestions. Some clients strongly resist being told what to do. One husband stated that he did not like being assigned homework because he hated being told to do it as a child. The therapist and couple agreed to call the assignments "relationship enhancement activities" to avoid this negative connotation. The therapist also emphasized that the activities were suggestions that the clients were free to do or not to do, and that they could have as much input as they wanted in designing them. This helped bypass the husband's resistance.

Finally, it is important to consider if you have overlooked some important barriers to change (see Chapter 3). Clients may have specific fears about change that need to be determined and overcome. You will need to help clients assess the extent to which these fears are realistic or not. Clients may also encounter unanticipated costs or consequences that hinder them from making the necessary changes. Family members may not like changes that a client is making, and put pressure on the individual to go back to his or her old pattern of doing things. Throughout the process, you need to consider possible negative consequences to change that your clients may face.

ASSESSING READINESS FOR TERMINATION

As clients make progress in therapy, the question of when to terminate becomes inevitable. In some cases, the client will be the first to raise the question. However, in more cases than not, it will be the therapist who will need to initiate the discussion. How will you know when it is time for termination?

There are a number of possible signs that your clients may be ready for termination. Obviously it should be considered once the client's goals have been met. This will be easier to evaluate if the goals have been clearly defined. Thus, how goals are set in the beginning may make it easier to determine when termination is appropriate. As clients become less distressed by their problems, they may start becoming less consistent in attending sessions. An increase in cancellations or no-shows may signal clients are ready to end therapy. Clients who are less distressed may also have less to talk about in therapy. They may engage in more social talk at the beginning of the session and take longer to transition to talking about their issues.

If you propose the idea of possible termination to your clients, it is important that you assess their reaction to termination. Some clients will express relief that the topic has been brought up, and will admit to having had similar thoughts. Other clients may be uncomfortable with the thought of ending therapy.

If clients seem uncomfortable with termination, it is important to determine why. Some clients will see the suggestion of termination as a sign of rejection, so you need to be attuned to any signals that your clients are interpreting your suggestion in this manner. Some clients can acknowledge that progress has been made but fear that the gains are fragile and will be lost if they discontinue therapy. In these situations, it may be prudent to consider spacing out therapy sessions to build confidence in their ability to maintain the gains they have made. Some clients, however, may feel that the suggestion to terminate is premature because they do not feel that they have accomplished as much as they need. It will be important to explore why there is a discrepancy between your perspective and those of your clients. Some clients will be extremely reluctant to end therapy because you are their primary source of social support. This may lead clients to overstate or even manufacture problems in order to maintain their relationship with you. This

issue is best dealt with by anticipating it as a potential problem in the beginning of therapy. Clients with little or no social support are likely to have greater difficulty with termination (Patterson et al., 2009). If you recognize this risk early on, it may be feasible to expand their social support network to ease the pain of termination when it occurs.

CONCLUSION

Therapists often view assessment as something that is done at the beginning of therapy. However, as this chapter has illustrated, assessment is a process that never stops. Ongoing assessment is necessary to confirm our conceptualization of the case, and the effectiveness of our treatment interventions. It also helps us determine when clients have made sufficient progress to consider terminating therapy.

APPENDIX

Summary of Assessment Tools, Instruments, and Mnemonics

ADULT ASSESSMENT

Assessment Tools

Listing and categorizing stressors (Chapter 5): control/no control; can be changed/no change possible; acute/chronic; normal/catastrophic; individual/family stressors

Kahneman Day Reconstruction Method for assessing well-being (Chapter 5)

Six rule-out rules (Chapter 6)

Mental status exam (Chapter 6)

Decision trees in DSM-IV-TR Appendix A (Chapter 6)

Screening questions for anxiety disorders (Chapter 6)

Structured Clinical Interview for DSM Disorders (SCID) (Chapter 6)

Assessment Instruments

Stress scales (Chapter 5): Perceived Stress Scale (PSS), Life Experience Survey (LES); Schedule of Recent Experiences

Happiness scales (Chapter 5): University of Pennsylvania scales, Positivity Self Test

Depression (Chapter 6): Beck Depression Inventory II (BDI-II); Center for Epidemiologic Studies Depression Scale (CES-D); Cornell Scale for Depression in Dementia; Geriatric Depression Scale; Hamilton Rating Scale for Depression; PHQ2 and PHQ9; Zung Self-Rating Depression Scale

Anxiety (Chapter 6): Beck Anxiety Inventory; Duke Anxiety–Depression Scale