WORKBOOK

THERAPEUTIC ASSESSMENT & CASE CONCEPTUALISATION

Dr Alvina Grosu

INTRODUCTION

The aim of the workshop will be to provide the opportunity for participants to review their existing therapeutic assessment structure/content and practice case conceptualisation to develop it further towards evidence-based reflective practice.

The framework for the workshop delivery is routed within existential traditions and will be based on interactive engagement and experiential learning.

Participants will be invited to:

- share the background of their existing practice in relation to therapeutic assessment;
- identify their own counselling style/approach and underpinning principles;
- review the existing assessment structure and content within theoretical grounding;
- choose appropriate modern tools and frameworks to enrich their own practice;
- expand professional networks to support peer-led reviews in clinical practice.

SESSION 1

THERAPEUTIC ASSESSMENT

"Clients, not therapists, make therapy work." Duncan et al., (2004:12)

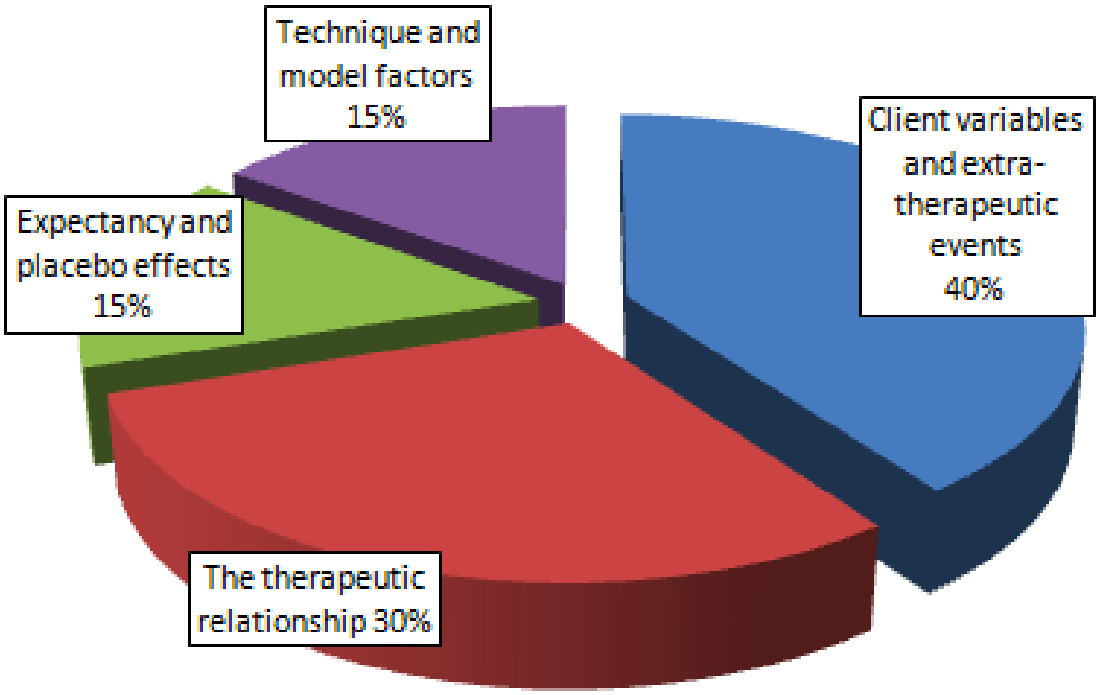


Figure 1. Percentage of improvement in therapy clients as a function of therapeutic factors (Asay and Lambert, 1999)

Lambert's pie (1992), shows that around 40% of the therapeutic improvement is due to 'client variables and extra-therapeutic events' – the rational for therapeutic assessment

ASSESSMENT AND CASE FORMULATION

·“When a therapist undertakes an assessment of a client and his or her problem (s), it is necessary to balance the need to maintain the quality and continuity of this relationship against the therapist's possible need to develop a full and appropriate picture of the client as an aid to case conceptualization and therapeutic planning “(Milner and O' Bryne, 2004).

·Assessment is normally undertaken during the first session or so, and if assessment forms part of the therapist's approach, then it is helpful for the client to know this in advance so that he or she is suitably prepared (Palmer and McMahon, 1997).

·There are exceptions. Rules and normal practice are 'made to be broken' if the situation or the needs of the client demand it, and it is not unethical.

·The physical, mental or emotional state of the client, or difficulties in establishing communication or rapport, can sometimes rule out or postpone an assessment process.

ASSESSMENT AND CASE FORMULATION

PRACTICAL CONSIDERATION

- Therapists employed by an agency might be constrained by the agency's procedures, which may include the completion of standard forms or questionnaires.
- ·Therapists employed by an agency might be constrained by the agency's procedures, which may include the completion of standard forms or questionnaires.

- ·In private practice, therapists still have accountabilities - under the law, to their codes of ethics and practice, to whichever professional body they belong.

- ·Such accountability may include their clinical supervisor, who has responsibility for monitoring clinical and ethical standards,

- ·A failure to assess presenting problems and keep appropriate records can be construed as unprofessional and a robust defence would be needed to refute such a charge (McMahon, 1994).

- ·some form of assessment is both necessary and desirable

ASSESSMENT AND CASE FORMULATION

THE RISK OF SKIPPING THE ASSESSMENT

- ·If the approach does not include assessment it is difficult to avoid some form of subjective evaluation or internal assessment of clients and their needs.

- ·“The evaluation of situations and people is a process learned from an early age as a necessary survival technique.”

- ·Basic information needs to be gathered (for contact purposes)

- ·“Arguably, unless you are a 'super-therapist' trained in every possible technique, including medical and psychiatric assessment, and are able to deal with psychotic and/or violent clients, you will be obliged to make a judgment, evaluation or assessment as to whether you and the client can work successfully together.

- ·Thus, some form of assessment seems unavoidable. The question is one of extent, formality, the 'when' and 'how'

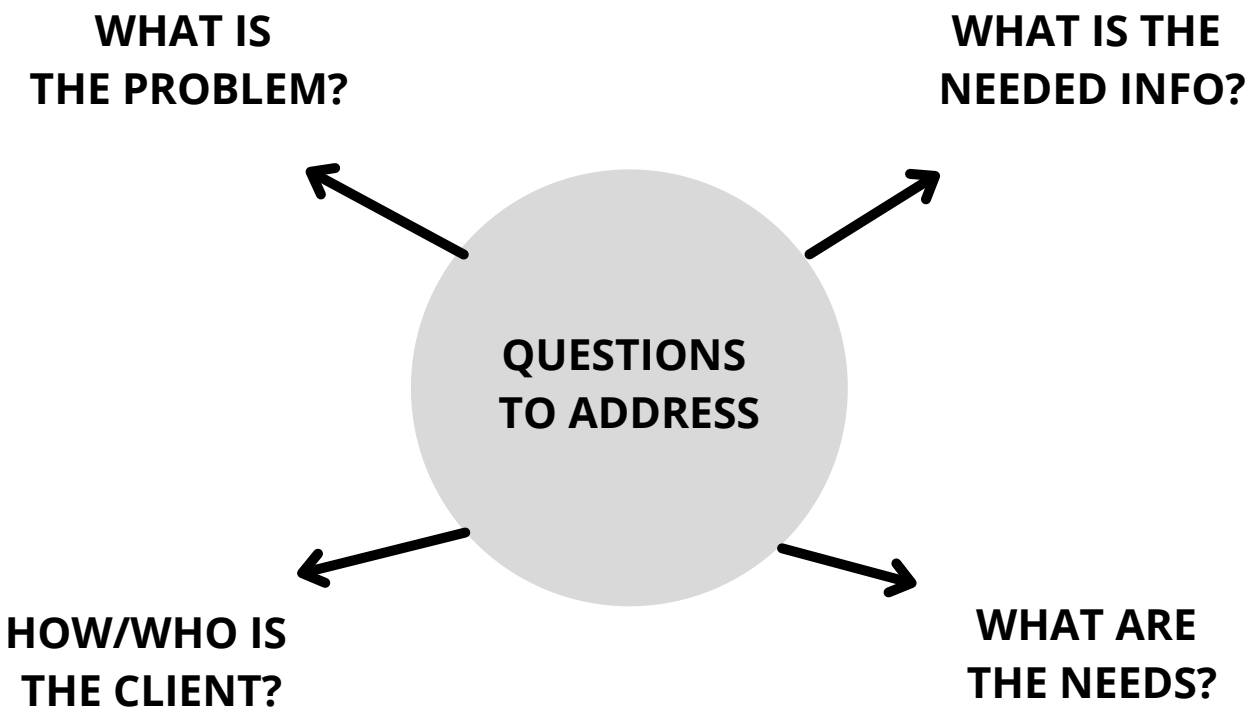
ASSESSMENT AND CASE FORMULATION

WHEN DOES ASSESSMENT TAKE PLACE?

- Assessment starts with the receipt of any information concerning the client through: self-referral, referral letters, case records or an initial telephone contact, etc is completed with more reliable info within the first therapy session

- ·it is helpful for the client to know in advance something about the therapist and the fact that the first session is likely to be devoted to assessment.

- ·To reduce uncertainty on behalf of the client as to where she is going, how she will get there, who she will see and what she might expect, a brief information pack, together with a very basic client details form, which can be completed before or at the end of the first session, may prove helpful



ASSESSMENT AND CASE FORMULATION

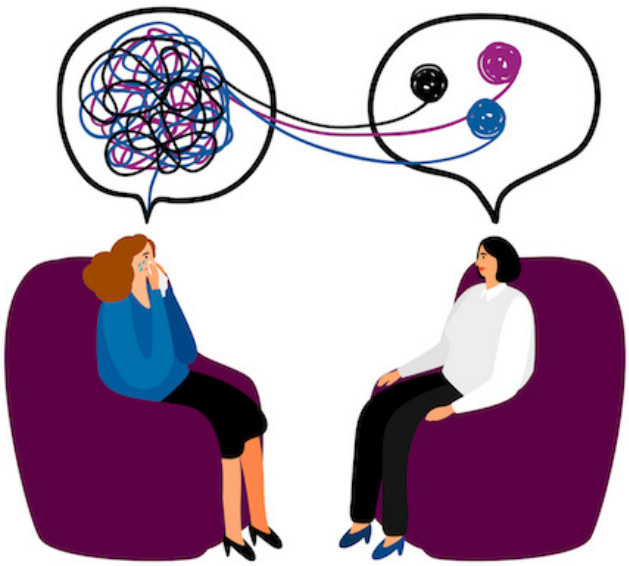
THE THERAPEUTIC ORIENTATION OF THE THERAPIST WILL INFLUENCE THE TYPE OF ASSESSMENT AND THE TYPE OF INFORMATION SOUGHT.

- ·For example, psychodynamic psychotherapists will seek to identify aspects such as the client's defence structure, core conflicts and ego strength, with greater attention being given to early life experiences and influences.

- ·Person-centred therapists will see their main task as 'being' with the client and establishing the most helpful therapeutic climate to enable the client to facilitate change rather than seeking information about the client's history or problems.

- ·Cognitive-behavioural therapists, however, are more likely to focus on 'here-and-now' problems, underlying schemas and self-defeating behavioural patterns.

- ·In addition, systems-based family therapists will assess the way the family interacts and the roles each person enacts to enable the system to operate.



THEORY & APPROACHES TO ASSESSMENT

PSYCHODYNAMIC

COGNITIVE BEHAVIOURAL

HUMANISTIC EXISTENTIAL

ECLECTIC INTEGRATIVE

Feltham, C. & Horton, I. (2006) Handbook of Counselling and Psychotherapy.

THE FIFTH FORCE - MULTICULTURAL AND PSYCHOTHERAPY (MCT)

Thus assessment can be a two-way process and not just something a counsellor or psychotherapist 'does' to a client. Whether we like it or not, clients will assess the quality of the therapeutic relationship and the effectiveness of any therapeutic plans, though some may be more able and objective than others in doing this.

PSYCHODYNAMIC APPROACHES

- Adlerian Therapy (Alfred Adler, 1870-1937)
- Analytical Psychology (Carl Gustav Jung, 1875-1961)
- Psychoanalytic Therapy (Sigmund Freud, 1856-1939)
- Psychodynamic Therapy (Malanie Klein, 1882-1960)
- Attachment Theory (John Bowlby 1907-1990)

THEORY & APPROACHES TO ASSESSMENT

COGNITIVE-BEHAVIOURAL APPROACHES

- Behavioural psychotherapy
- Cognitive therapy (Aron Beck, 1921-)
- Personal Construct Counselling & psychotherapy (George A. Kelly, 1905-1967)
- Rational Emotive Behavioural Therapy (Albert Ellis, 1913-)

HUMANISTIC-EXISTENTIAL APPROACHES

- Existential C&T
- Gestalt Therapy (Frederick Peris, 1893-1970)
- Narrative Therapy (White & Epson)
- Person-centred C&P (Carl R. Rogers, 1902-1987)
- Primal Therapy/Integration (Arthur Janov, 1924-)
- Psychodrama (Jacob Levy Moreno, 1889-1974)
- Psycho synthesis Therapy (Roberto Assagioli, 1888-1974)
- Transactional Analysis (Eric Berne, 1910-1970)

ECLECTIC-INTEGRATIVE APPROACHES

- Cognitive Analytic Therapy (Anthony Ryle, 1927-)
- Multimodal Therapy (Arnold A. Lazarus, 1932-)
- Neuro-linguistic programming (Bandler & Grinder)
- Skilled helper Model (Gerard Egan, 1930)
- Solution Focused Therapy (Shazer & Berg)

HISTORY TAKING

- While the client is telling her story, the therapist will be an active listener. In her preparation for the assessment, the therapist should have examined whatever background information was available.
- This information, together with the client's story, provides a partial picture. A more complete picture at this can be obtained with questions of who, what, when, where and how, but it may not be helpful to use questions involving motivation which may be premature

HOW WILL YOU REMEMBER ALL THE CLIENT TELLS YOU?

- This is a matter of what works best for you and your clients and whether you are obliged to follow externally imposed procedures. It can also depend on the client and how she is likely to react to a record being made at the time.

- At one extreme, a video camera can be used to record not only every word spoken, but also every physical movement, expression, appearance, gesture, etc., but this is rarely, if ever, done.
- It is also common practice for some therapists to tape record sessions, whereas others believe this be intrusive. At the other extreme, no notes or recording of any sort may be undertaken.
- If records are made during or after the assessment, the client needs to be aware of the purpose of keeping such notes, as well as access and storage issues and the boundaries relating to client confidentiality.

HISTORY TAKING

- During the assessment session it is likely that a wealth of information will have been gleaned and there Are a number of ways in which this information can be written up: unstructured or structured, brief and focused or wide-ranging and detailed.
- Unstructured records will look very different for each client and reflect the emphasis and priority given by the therapist to the information given or elicited.
- Briefed and focused records will tend to concentrate on the presenting problem (s), with a minimum of relevant background information.

- Structured records follow a number of standard headings or answers or observations to a list of standard questions. In turn, the list of headings or questions can be fairly short or very long and wide-ranging.

EXAMPLES OF STRUCTURED RECORD HEADINGS MIGHT INCLUDE:

- Occupational and educational background
- Family and personal relationships, past and present
- Medical and psychiatric history
- Previous therapy outcomes
- Ethnicity , sexuality and disability
- Client goals
- Related problems
- Recurring themes (for further detail see Palmer and McMahon, 1997)

MENTAL STATE EXAM

- Mental State Exam can be used, based directly on the therapist's observations. The Mental State focuses on the client's appearance, speech, emotions, thought processes and content, sensory reception, mental capacities and attitude towards the therapist.
- A detailed set of questions under each heading aims to help the assessor form impressions of the client's possible state of mind

  Lukas, 1993).

The SAGE Handbook of Counselling and Psychotherapy Mental State Exam

APPEARANCE

- How healthy does the client look?
- Is the client disabled?
- How is the client dressed (clothing, cleanliness, etc.)?
- What do you notice about the client's body language (e.g. eye contact, facial expression, etc.)?

SPEECH

- Pacing, pitch, etc.?
- Speech impairment?

EMOTIONS

- Client’s predominant mood?
- Client's predominant emotion?
- Does the client's emotion vary?

MENTAL STATE EXAM

THOUGHT PROCESSES AND CONTENT

- Does the client demonstrate loose associations or flight of ideas?
- Does the client exhibit delusions, persecution, thought broadcasting, etc.?
- Are there any obsessive thoughts, compulsive behaviour or is the client phobic?
- Indications of suicidal ideation?

SENSORY PERCEPTION

- Does the client have significant hearing or sight problems?
- Does the client suffer from illusions or hallucinations?

MENTAL CAPACITIES

- Is the client oriented to time, place and person, memory or judgement problems?
- Does the client appear to be of average intelligence, have a capacity for concentration?
- Client's sense of self-worth?
- Does the client appear to have a capacity for insight?

ATTITUDE TOWARDS THE INTERVIEWER

- Client's attitude towards the therapist, including changes?
- Client's ability to empathise?

MENTAL STATE EXAM

- Of course it may not be possible for a full assessment to be carried out after just one session. Time and judgement may not allow for a number of questions to be asked and answered. The advantage of any structured form of assessment is that any outstanding gaps are visible to the therapist and are not just overlooked.

- The therapist's preferred theoretical perspective will tend to influence the content of the assessment session (or whether, in the case of person-centred therapy, an assessment is undertaken at all) and the emphasis given to the different aspects of the client's personality, situation and presenting problem.

- The Mental State Exam contains a number of general areas of observation and has also been seen as a useful tool for assessing children, provided it is adapted to their developmental level.

- For a therapist using an integrative approach, choosing an appropriate perspective to fit the client and the client's situation, a more extensive coverage of relevant client information is likely to be required before such a choice is made.

- Upon completion of an adequate client history, probably in written format, the therapist is obliged to consider the next steps: case conceptualisation and therapeutic planning.

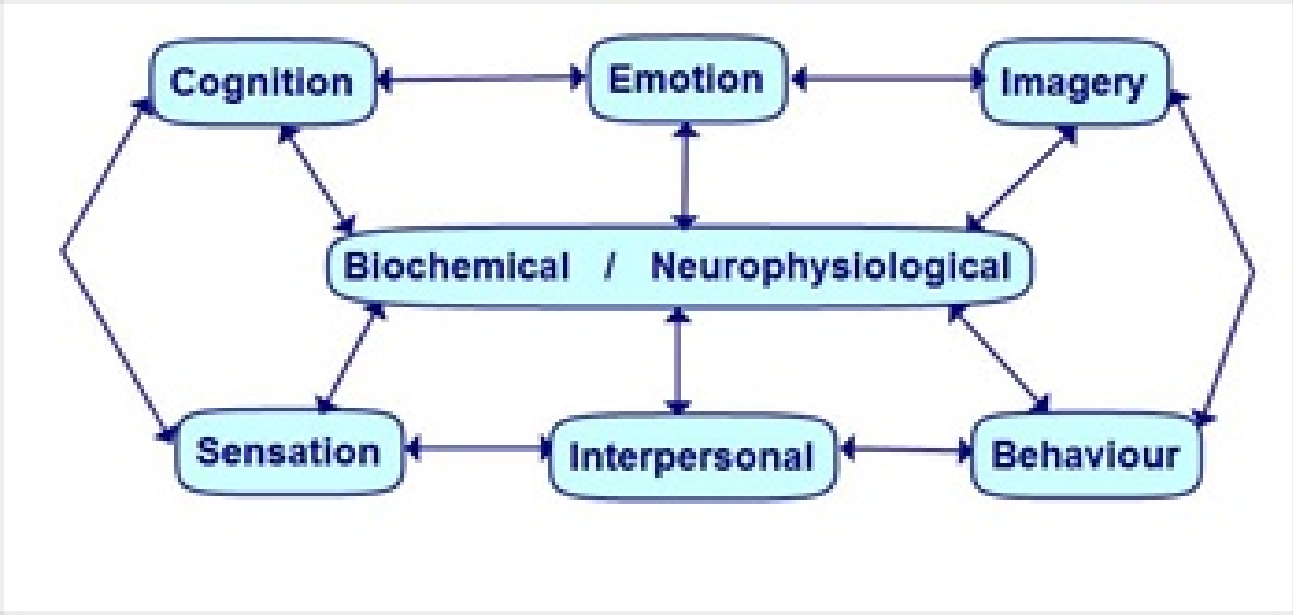
THE MULTIMODAL WAY

BRIEF BUT COMPREHENSIVE PSYCHOTHERAPY: THE MULTIMODAL WAY,

BY ARNOLD A. LAZARUS, PHD

THE MULTIMODAL APPROACH HAS 6+1 DIMENSIONS (BASIC I.D.) BASED ON NEURO-PSYCHOSOCIAL BIOCHEMICAL FRAMEWORK:

The Multimodal Life History Inventory (MLHI) :Lazarus and Lazarus, 1991) is another example of assessment tool. This is a highly detailed and comprehensive questionnaire extending over 15 pages it could be completed by the client, usually after the first session. The MLHI is based on seven modalities of personality: Behaviour, Affect, Sensation, Imagery, Cognition, Interpersonal and Drugs/biology, BASIC ID).



SESSION 2

CASE CONCEPTUALISATION

We are caught up in a paradox, one which might be called the paradox of conceptualisation. The proper concepts are needed to formulate a good theory, but we need a good theory to arrive at the proper concepts.

Abraham Kaplan

- When a therapist has a preferred theoretical approach, he or she is likely to conceptualise the client's problems in terms of that orientation and it could be said that the client is 'fitted' to this orientation.

- When a cognitive-behavioural therapist is referred a client who is experiencing a range of difficulties, the therapist uses the assessment session to undertake a 'collaborative case conceptualisation' (Padesky and Greenberger, 1995), using this to assist both parties understand what has happened (see Figure 3.5.4).

EARLY EXPERIENCES

- Father left when client was 6 years old
- Mother found it difficult to cope and was treated for depression
- Mother relied on client for support and was very critical

FORMULATION OF CORE BELIEFS

- I am a failure
- I am a bad person- Formulation of conditional assumptions
- If people like me, then I am okay
- If I work hard, I will succeed

CRITICAL INCIDENT

- Not getting a promotion- Beliefs/assumptions activated

- I should have worked harder and I am a failure
- I did not try hard enough to make an impression
- I am a failure

Negative automatic thoughts

- I must have been really bad not to have got the job • It's not fair, I worked really hard • What did I do wrong?
- Behavioural 10 units alcohol Avoiding colleagues Avoiding deadlines Emotion Anxiety Depression Shame
- Cognitive They think I am stupid What's wrong with me? Doesn't matter how hard I try
- Physiological Tired Difficulty sleeping Physically tense

(ABC) APPROACH

Many therapeutic approaches are trimodal (ABC) addressing :

FOR EXAMPLE:

In the case of a client with a history of violence, a behavioural approach is likely to focus on an analysis of symptoms and immediate life circumstances. Recent violent episodes would be relatively easy for the client to recall, together with the antecedents and consequences. Therapy would tend to focus on developing anger control and learning new patterns of Behaviour.

A psychodynamic approach is likely to focus on the unconscious psychological conflicts which give rise to such violence. An exploration of the distant past may be necessary to provide an understanding of how an aggressive lifestyle has developed as a means of coping with everyday problems. Adaptive Behaviour can then follow the client's insight into unmet and unrecognised needs.

APPROACHES TO CASE CONCEPTUALISING

An alternative approach, utilizing the information already generated about the client and the client's presenting problems, would be to select a particular focus bearing in mind the capabilities of the client to respond to the approach, the immediacy of the problems and the time available for therapy.

·This approach takes the view that no single perspective can provide a total 'truth' about the client, although each may still provide a valuable insight into the client's problems. This approach could be said to 'fit' the orientation to the needs of the client.

·This second approach can only realistically be adapted by practitioners who have been trained in more than one orientation or in cases where they are able to refer clients to a colleague who does possess knowledge and experience in the selected orientation.

In case conceptualisation, consideration should be given to the ease and understanding with which it can be read at a future date, possibly by a third party.
Again, a standard structure may be helpful in this as well as imposing discipline on the therapist
Two components are required:

- an overview of the client written from the chosen theoretical perspective
- and the supporting material which backs up the overview.

APPROACHES TO CASE CONCEPTUALISING

The overview can come either at the beginning of the written case conceptualisation, which makes for quick and easy reading, or at the end, where it will tend to be seen as the logical conclusion drawn from the supporting material.

The overview of the client should be concise, provide an analysis of the client's core strengths and weaknesses, and tied to the assumptions of a stated theoretical perspective.

The supporting material is likely to be more extensive and to provide all the evidence on which the overview is based. The supporting material will also include an in-depth analysis of the client's strengths and weaknesses (again from the same theoretical perspective). Relevant information will be included from the client's past and present histories.

A WELL FORMULATED (CCM) CASE CONCEPTUALISATION MODEL:

- give direction to both assessment and treatment decision making;
- identify developmental, precipitating and maintaining factors that
- contribute to maladaptive behaviours and adjustment difficulties and that reduce quality of life;
- provide information about the developmental, familial, contextual risk and protective factors;
- highlight cultural, racial and gender specific risk and protective factors;
- Identify individual, social and cultural strengths and evidence of resilience that can be incorporated into the treatment decision making;
- provide a means to collaboratively establish the short term, intermediate and long term goals and the means by which they can be achieved;
- identify, anticipate and address potential individual, social, and systemic barriers that may interfere with and undermine treatment effectiveness;
- provide a means to assess the client's progress on a regular basis;
- consider how each of these objectives need to be altered in a developmentally, culturally, ethnically and racially sensitive fashion
- provide feedback to client and significant others in order to nurture hope in both the client, family members and the treatment team
- facilitate communication and coordination among colleagues/ staff members

GOAL SETTING

John Norcross is a researcher that has been studying goals and change for many years, and defines a goal as "a mental representation of a desired outcome that a person is committed to".
In regular language, a goal is

- Identifying something that you want and
- Are willing to stick with a course of action to achieve.

This is different from a "value," because a value is something we find important, but does not have a specific course that we are committed to.
For example, you can value being healthy and make some choices that are in line with that, but a goal related to health would be to "lose 10 pounds by December 31st.“
Research shows that actually setting a specific goal makes us more likely to achieve the things we want, and is important especially when we want to make a change.
The best news is that setting and striving for a goal, even if you don't make it, will make you happier.

CONCLUSION

- ·Berman (1997) clearly states that case conceptualisation and treatment planning aims to integrate theory with clinical practice; that the aim is to provide quality care; and that material can be reworked in the light of new information or a change of direction in the therapy.
- ·Treatment planning is an attempt to meet client needs as accurately as possible, yet effective therapy seeks to help clients help themselves.
- ·The therapist's main task is to bring together the respect for the therapeutic relationship with the discipline of treatment planning.

REFLECTION

WHERE THE EXPECTATIONS MET?

WHAT ARE THE NEW THINGS LEARNED?

WHAT WOULD BE THE FOLLOW UP?