TOUR 5

Applying Theory

Assessment and Conceptualization

During this tour you will have opportunities to

- View assessment as integral to counseling
- Learn essential elements of case conceptualization
- Recognize that conceptualization is guided by established counseling theories
- Compose outcome goals

By this juncture of your journey, you have likely identified a theory or elements of a few theories that you particularly like. You also have a general knowledge of other theories, and you are beginning to accumulate a repertoire of empirically supported and theory-based interventions. Despite your preferences, however, it is important to consider the needs of each client with whom you work (Berman, 2010).

Counselors' theoretical understanding provides (a) a guide to assessment, (b) a framework for organizing and making sense of client information, and (c) data necessary for making diagnoses and treatment plans. Tour 5 begins with a description of various forms of assessments used to consider the needs of clients. Focus changes to case conceptualization, which guides counselors in accurately identifying problems, factors that contribute to problems, resources for resolving those problems, and strategies for assisting in the resolution of the problems.

Monitoring progress creates a feedback loop for clients and counselors. Documentation contributes to continuity. The combination of conceptualization, planning, progress monitoring, and documentation results in unified, internally consistent, coherent work. You will have opportunities to increase your awareness of these elements of professional practice as we move toward our final tours.

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ASSESSMENT

Assessment is integral to counseling. It begins with the first client contact or review of a file. Assessment includes formal aspects that lead to a diagnosis combined with informal elements, such as observation of posture, demeanor, and nonverbal communication. Assessment is sometimes focused on counselors' ability and preparation for working with clients. At other times it is focused on clients. Assessment also encompasses the counselor–client relationship and the progress of therapy. It is both formative and summative. Again, assessment is integral to counseling.

Counselor-Focused Assessment

You started your journey on Tour I with self-evaluation, self-monitoring, and reflection, which are components of counselor-focused assessment. We suggested that dedicated counselors continue reflection and self-evaluation throughout their careers. It is important to remain alert to aversive reactions to clients, discomfort during and after sessions, confusion, and so forth. Successful and satisfying sessions also warrant reflection.

Counselors must assess their preparation for working with each client. Counselors-in-training may not have knowledge and experience for clients who present with concerns such as suicide ideation, thoughts of harming others, hallucinations, delusional thinking, personality disorders, substance abuse, and other complex problems. When counselors are not adequately prepared to work with clients, they consult with their supervisors or make referrals to other mental health providers.

> You have probably learned about the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5, American Psychiatric Publishing, 2013) and mental status examination protocols in other classes. Judicious understanding of the diagnostic framework and procedures is essential for competent practice.

Client-Focused Assessment

Agencies typically adopt structured intake protocols that guide formal assessment for new clients. Additionally, professional counselors request records from clients' previous counselors, the persons making the referrals, and other appropriate sources (with clients' written authorization, of course). Regardless of the procedural framework, counselors address a variety of questions in order to achieve a clear understanding of clients, their challenges, their resources, and their goals. Ultimately your person-to-person experiences with your clients will be the major source of information that will guide diagnostic procedures, goal setting, and treatment planning.

Questions to consider in the assessment processes include the following:

- How does the *client* want things to change? Notice that the language differs from the usual "What is the presenting problem?" The problem may be stress, depression,

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substance abuse, mental illness, a relational problem, and so forth. Identification of those factors is important; however, verification of the *client's* desire to make changes related to those problems is crucial. Is someone other than the client the complainant? Has the individual come for counseling because other people want him or her to change? Is the client coming because of personal choice or to fulfill a requirement established by someone else (e.g., a judge or probation officer)?

An electronic search using *counseling intake forms* and *counseling assessment forms* yields a variety of examples, such as "Life Works Client Intake Form" found at http://www.lifeworkscounseling.info/pdfs/client_intake_form.pdf. A variety of forms are available at Run River Counseling's website, http://www.runrivercounseling.com/intake-forms.html and at the GoBookee website, http://www.gobookee.net/sample-of-intake-counseling-assessment-form.

Counseling contracts are between counselors and clients even when someone else recommends or requires it. Responsibilities to the third party must be clearly articulated and understood by clients, counselors, and appropriately involved third parties. Clients must always authorize counselors to report assessment results, content, and progress to another person or agency.

- What are the client's strengths? When has the client succeeded? What are the client's talents? What does he or she enjoy? Strengths can also be identified within a wellness framework, exploring each of the dimensions (physical, social, emotional, intellectual, occupational, or spiritual). Does the client engage in activities that contribute to wellness in each of the dimensions? In which dimensions can resources and strengths provide transferable resources, habits, knowledge, and skills?
- How well is the client functioning? Several areas warrant consideration. Is the client physically healthy or under a physician's care? What medications is the client taking? What behaviors are self-defeating? How well does the client negotiate relationships? Is the client depressed? Is there potential danger for harm to self or others? Are there indicators of serious and persistent mental illness? Are indications of substance abuse or addiction present? This information is usually requested on a written intake form; however, it is important to verify and explore such factors directly with clients.

As you have likely learned in other classes, professional counselors must remain vigilant in listening for clues that might indicate depression and suicide ideation. When we suspected even a possibility of risk, we often used language such as "When people experience as much stress and disappointment as you have, they sometimes think about suicide. How has that been for you?" We also segued into formal suicide risk assessment with questions such as "You have mentioned that you just want to give up and that you don't see any way out of this situation. I'm wondering if you are thinking about killing yourself." It is always important to discuss risk-assessment protocols and procedures with your supervisor, and to follow that guidance explicitly.

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- To what extent has the client mastered developmental tasks? Areas to consider include cognitive, career, psychosocial, and moral development.
- What values and beliefs guide the client's behavior?
- What resources does the client have? Resources include supportive friends, relatives, spiritual advisors, finances, access to activities or organizations that provide helpful services, and so forth. Resources are often connected to strengths and areas of wellness; indeed, clients' strengths provide access to resources.
- What environmental factors may be contributing to the difficulties? Environmental conditions may include abuse, workplace aggression, discrimination, and various other oppressive situations.
- What has the client tried to do in order to address the problem?
- How strong is the client's motivation for change? This could also be phrased as "How receptive is the client to counseling?" Ambivalence is not unusual. Clients often want to change; however, they also experience interpersonal or intrapersonal pressure to maintain status quo. Change can be frightening, albeit desirable. Questions that might elicit the ambivalence include "What reasons might you have for not changing?" and "What will you lose if you do change?"

Steve de Shazer (1988) informally assessed clients' motivation and commitment within three categories, none of which should be considered pathological or "bad." Neither are they discrete; in fact, clients may vacillate from one category to the other. In de Shazer's framework, *visitors* may be exploring possibilities; however, their investment in change is minimal. Intervention and treatment for visitors are usually premature. *Complainants* may focus on their challenges and readily engage in discussions about problems; however, they typically believe that sources and solutions for those challenges are external and not within their own control. Typically, complainants want other people to change. Interventions should be posed as tentative and completely within clients' control. *Customers* are essentially ready to roll up their sleeves and go to work.

Relationship-Focused Assessment

In Tour 3, we emphasized the importance of facilitating a strong working alliance with clients. We concur with Arthur C. Bohart and Karen Tallman (2010) who wrote that clients are "anything but passive recipients of therapeutic wisdom. On the contrary, they continuously evaluate what is happening in therapy and then actively work to arrange events to suit their purposes" (p. 89). Thus, judicious counselors encourage clients to overtly participate in evaluating the productivity of the counseling relationship and the counseling process.

Counselors sometimes invite clients to discuss their experiences at the end of sessions with questions such as "How was today's session for you?" or "I'd like to hear your thoughts about the work we did today." At first, clients may feel compelled to say "Fine." However, in time, they become more confident and able to discuss their reactions to sessions.

Counselors also often invite clients to complete surveys at the conclusion of sessions. The survey can be used to monitor client satisfaction, agreement with the counseling process, motivation, and the counseling relationship. A survey I (Ken) used is shown in Table 5.1.

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Table 5.1 Session Evaluation

Circle a number from 1 to 5 that indicates your agreement with the statement on the left (1 = do not agree, 5 = agree).

Statement					
1. I think the counselor understood me and my situation.	1	2	3	4	5
2. I felt respected.	1	2	3	4	5
3. This session was helpful.	1	2	3	4	5
4. The plan for working together will be helpful.	1	2	3	4	5
5. I am motivated to work on improving my situation.	1	2	3	4	5

During this session, I wish we would have ______________________________

Next session, I would like to ______________________________

Something I didn't like during this session was ______________________________

Something I liked during this session was ______________________________

Other comments: ______________________________

ILLUSTRATION OF FUNCTIONAL BEHAVIOR ASSESSMENT

A few years ago, I (Sandy) was asked to conduct a Functional Behavior Assessment (FBA) for an elementary child whose name will be Bobbi for this illustration. The principal's primary concerns related to disruptive behavior and defiant responses to adults' redirections. Even though I was in the role of consultant, I followed case conceptualization procedures. I carefully documented each step I took during observation and conceptualization just as I would have if I were providing direct services.

I observed Bobbi and her classmates during spelling, handwriting, math, and music. I also observed while the classroom teacher read to the students. I attended to teachers' actions, classmates' responses, and Bobbi's behaviors. All together, I was with Bobbi and her class for approximately three hours. I also asked teachers to complete a questionnaire that included an item that was repeated three times: "When Bobbi __________, I felt __________."

I returned to my office and endeavored to make sense of the various behaviors and interactions I had observed. I "tried on" a variety of theoretical lenses, hoping to find an explanation that would lead to interventions—plausible hypotheses that I could present during a meeting with teachers, the counselor, the school nurse, and the principal.

I began by thinking from an Adlerian perspective and asked myself several questions. What could the goals of Bobbi's behavior be? Is she seeking undue attention? Is she trying to get power? Could it be that she is seeking revenge? Does she have relationships with adults and peers? What about natural or logical consequences? Does she perceive herself as capable? What about courage?

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My response compelled my attention. “This kid is not afraid of anything!” This was a poignant reminder to bracket and monitor my own reactions and remain neutral.

I returned to possible goals of Bobbi’s behavior. Could her behavior be related to attention? I didn’t think so. Based on teachers’ responses to Bobbi’s actions and a variety of things that she had said, I considered possibilities of power or revenge-seeking strategies. I observed that she had made an irrelevant, though caustic and potentially hurtful, comment to a guest who was leading an activity the other children obviously enjoyed. When I mentioned that observation, other adults said Bobbi had made similar verbally attacking comments to them.

Bobbi’s parents had suggested that Bobbi’s behaviors were related to problematic peer relationships. Was Bobbi trying to achieve connections with her peers? Does she perceive herself as having significance in her group? It appeared to me and to the teachers that Bobbi had friends and connections at school. I didn’t observe conflict with peers, but I needed to remember the parents’ hypothesis and guard against discounting it.

I began to think from developmental theories. Bobbi appears to be quite bright, yet she doesn’t present the level of maturity we’d expect. She is smaller than her peers. Her behavior doesn’t fit what we would expect for moral development. I wondered about her birth and physical development, particularly prior to age 2. Did she learn to trust? Has there been trauma in her life? Could these behaviors be manifestations of prenatal issues? Does she have brothers and sisters? Did she attend preschool? Does the school nurse have information that would be helpful?

That led me to consider biochemical explanations. Could she have attention deficit hyperactivity disorder (ADHD)? What other “medical model” and deficit model explanations could help? With or without pharmacological intervention, we would still need to consider behavioral explanations and interventions. What is reinforcing the behavior? What might occasion behavior? How might we manipulate the environment to shape the behaviors that Bobbi needs to acquire in order to achieve success in school?

As I considered reinforcements and contingencies (from a behavioral perspective), I was perplexed. I reflected on the day and asked myself, “What *does* reinforce this child’s behavior? What *is* reinforcing for Bobbi? What consequences matter to her? What purposes does her behavior serve? What is the function of Bobbi’s behavior?” If I work from a frame that people engage in behaviors for a reason, I need to have a fairly accurate idea about those reasons. Yet what could they be?

And what about exceptions (drawing from solution-focused brief therapy, SFBT)? When *does* she follow instructions? When *does* she complete her work? How will we know that she has overcome these challenges? How will we know we have helped her begin to make progress? What interventions have been tried? Which were successful, or even partially successful? How have we worked with other students with similar behaviors and personalities? If I am able to answer any of these questions, it might provide clues to solutions for helping Bobbi acquire skills for learning as well as interacting with adults and her peers.

As I prepared for the meeting with the school counselor, principal, and teachers, I traced my conceptualization processes and listed questions. Clearly, I needed more information. Yet I was ready to propose a *tentative* hypothesis: the goal of Bobbi’s behavior could be power. Within an Adlerian framework, I recommended that the adults at school provide forced choices such as “You may choose to complete your work at the table with your classmates or you may choose to work at the table in the back of

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the room" or "You have chosen to sit on the step rather than with your classmates. You may choose to sit on the step and participate or you will choose to go to the office." I suggested that they use this strategy *only* as an experiment with attention to Bobbi's responses. I also asked for more information from the teachers and suggested that the school nurse meet with the parents to explore early childhood developmental factors.

CONCEPTUALIZATION

The FBA required an extensive commitment of time—time that was well invested. As Pearl S. Berman poignantly wrote, the absence of intentional and thoughtful conceptualization may result in "treatment chaos" (2010, p. 2). Without clear understanding of clients' situations and specifically identified measures of success, counselors run the risk of employing random, incoherent interventions that may not even be appropriate for the presenting problems. It is important to consider many aspects of a client's context in order to develop the best hypotheses. In other words, you must "complicate your thinking." Rather than relying on one preferred explanation (e.g., "She must have ADHD"), examine the evidence from multiple perspectives, and select the explanation that represents the best fit. Otherwise, your thoughts might reflect something like "Hmm. I'll try [this]. . . . That didn't work. . . . I'll try [this]. . . . Oh. That didn't work. . . . I'll try [this]."

The example of an FBA illustrates how assessment is integral to case conceptualization, which, in turn, guides the treatment process. Conceptualization includes a concise identification of the presenting problem and consideration of the etiology and history of the situation, goals, and procedures for facilitating the attainment of those goals. In this process, attention is given to development, culture, context, accomplishments, behavior, family dynamics, relevant history, and resources. Factors that contribute to or maintain the problem are identified. Hypotheses regarding resolution of the situation are generated. Professional counselors consider what theories provide the most useful explanation for the situation. They review evidence-based interventions for presenting problems. They also draft a potential sequence for treatment.

> The goal of conceptualization is to produce an internally consistent, yet flexible, plan for helping clients resolve challenges and achieve their goals.
>
> The process provides responses to three questions:
>
> 1. How did this person get into this situation?
> 2. What is this person's ticket out?
> 3. How can I most effectively and efficiently help?

> **Cassandra** will accompany you on this tour. In fact, you will be working with her (albeit theoretically and indirectly). Cassandra is 35 years old. She and her husband of 5 years are separated by virtue of a mutual decision. She is enrolled in a program to acquire skills and credentials to be a court recorder.
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Presenting problems: difficulty sleeping, loss of appetite, mood shifts, inability to concentrate, irritability, and general absence of happiness

*Risk factor*s: none identified

Initially stated goals: to feel happier, cry less, and find pleasure in activities

Following is an example of how theory-based exercises posed in the next section could be answered. The sample answers are in italics.

- Assume a professional counselor whose work is informed by individual psychology (i.e., Adler's theory) learned about Cassandra. What information (in addition to standard intake responses) might the counselor consider?

    Experiences during and memories of her first five years of life

    Goals (e.g., attention and connection) that might occasion her symptoms and behavior

    Mistaken beliefs that might occasion her symptoms and behavior

    Personal priorities (e.g., comfort, control, superiority, perfection) that might occasion her symptoms and behavior

    Attainment of life tasks (i.e., love/intimacy, work/productivity, belonging/friendship)

    Perception of herself in relation to others and life in general (i.e., lifestyle)

    Meaning she has attributed to life

    Engagement in social interest

Following are three other theory-based exercises for counseling with Cassandra.

Assume a professional counselor who works solely from *cognitive-behavioral therapy* (CBT) *approaches* learned about Cassandra. What information (in addition to standard intake responses) might he or she consider?

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Assume a *solution-focused brief therapy*-based professional counselor works with Cassandra. What information (in addition to standard intake responses) might he or she consider?

Assume a *reality therapy-based* professional counselor works with Cassandra. What information (in addition to standard intake responses) might he or she consider?

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Although our focus is on essential skills for developing counseling relationships, other critical elements such as the following must be considered:

- What procedures will you follow to assure that you meet all legal and ethical guidelines for informed consent? Laws and standards of care vary across states, regions, and agencies. It is important to be fully informed about all facets of this important part of counseling.
- How will you explain the process of counseling to your clients? (We revisit this task in Tour 6.)
- How will you arrange your office?
- What will you do if you suspect that a client is at risk for suicide?
- What procedures does your supervisor expect when clients are depressed and potentially at risk for suicide?
- What procedures are in place to assess risk for violent behavior?
- How is confidentiality protected in your agency?
- What procedures are in place for challenges you might encounter during your first sessions (e.g., client who refuses to participate, child who cries and does not want to enter your office, client who is skeptical of counselors)?

What additional questions seem pertinent to you?

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During your first session with Cassandra you learn that she is ambivalent about the future of the relationship with her husband. Additionally, she is worried about successfully completing program requirements. She expresses concern that her anxiety has significantly interfered with performance on tests. She is afraid that she will fail the classes in which she is enrolled and be required to repeat them. She remains committed to her goal of becoming a court recorder.

She identified personal strengths such as participation in a regular self-care regimen (including exercise). Prior to the separation, she had performed well in her classes and enjoyed the program. She has support from her mother and one male friend.

Imagine that you are preparing for your first session with Cassandra. Where are you and she meeting? Where do you sit? Where does Cassandra sit? What does Cassandra look like? How is she dressed? What is her demeanor? Your initial and continued observations of Cassandra and experiences as you work with her are important factors to consider in the assessment, conceptualization, and planning.

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Essentially Cassandra wants to

- Achieve clarity regarding the relationship with her husband and the future of their marriage
- Learn strategies to manage anxiety specifically related to performance in her program
- Overcome her depression

Again, we provide an example of how the next series of questions could be answered by a professional counselor working solely from an individual psychology perspective.

- Assume you are a professional counselor who works solely from individual psychology.

  What will you consider as you plan your work with Cassandra?

  What procedures and interventions might you use?

  How will you know when your work with Cassandra is done?

Preliminary considerations

1. The counselor would consider the history and manifestations of Cassandra's anxiety and depression. Listening and relationship-building skills would be paramount in this component of the work.
2. The counselor would consider Cassandra's lifestyle, including factors such as developmental milestones, early childhood experiences, perception of herself vis-à-vis her siblings, family of origin, roles she assumed among her family members and peers, earliest memories, recurring dreams, and view of herself in the world.

Representative procedures and interventions

1. The first priority would be to facilitate Cassandra's telling of her story on her terms and to cultivate a solid working relationship.
2. Assessment would begin from the first encounter between the counselor and Cassandra. The counselor would conduct a lifestyle assessment, either formally or informally. The counselor would also ask "The Question" with language such as "What would you be like if you were not depressed right now?" or "What would you be doing if you were not depressed or anxious right now?"
3. The counselor would tentatively share his or her conclusions (interpretations) derived from assessment, which would include mistaken beliefs, assets, and general elements of Cassandra's lifestyle.

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4. Counseling would feature educational components that will contribute to Cassandra's understanding herself, recognition of ineffective strategies for accomplishing her goals, and adoption of more effective strategies.
5. The counselor would intentionally encourage Cassandra (but not praise her) and would endeavor to empower Cassandra and contribute to her faith and hope.
6. The counselor might ask Cassandra to act "as if" the depression has lifted for set hours or times between sessions.
7. Other homework strategies would likely be employed.

Indicators that work is completed

Consolidation will be indicated when she is symptom free and her goals are met. Additionally, she will be actively engaged in social interest and satisfied with her work/productivity and relationships. She will have the courage to be imperfect. She will express confidence and optimism in her ability to meet challenges she will encounter.

We often concluded our first session with a summary, statement of goals, our sense of the potential for achieving those goals, and our recommendations. We typically said, "If you choose to work with us, we would ask that you contract for six sessions. We would formally evaluate progress at the end of the fifth session, and decide together if our work is done, or if we need to alter our plans." If clients seemed reluctant, we encouraged them to think about our proposal and call to let us know their decision.

Respond to the following theory-specific application questions (CBT, SFBT, or Reality).

Assume you are a professional counselor who works solely from cognitive-behavioral approaches.

What will you consider as you plan your work with Cassandra?

What procedures and interventions might you use?

How will you know when your work with Cassandra is done?

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Assume you are an SFBT-based professional counselor.
What will you consider as you plan your work with Cassandra?
What procedures and interventions might you use?
How will you know when your work with Cassandra is done?

Assume you are a reality therapy-based professional counselor.
What will you consider as you plan your work with Cassandra?
What procedures and interventions might you use?
How will you know when your work with Cassandra is done?

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DEFINING GOALS

Conceptualization provides a foundation for planning the work you will do with Cassandra. Counseling is more profitable when clients and their professional counselors agree on the goals and plans. Thus, we encourage you to take a collaborative stance, regardless of the theories that guide your work.

The crafting of goals warrants investment of thought and time. Goals should be framed in clients' language when possible. They should be specific, measurable, achievable, realistic, and timely.

Essentially, goals respond to the question "How will you know when our work is completed?"

Useful goals define the measurable outcome. Intermediate goals identify steps toward that outcome.

Goals are productive when

- Clients want to achieve the goal
- Clients are willing to do the work required to achieve their goal
- Clients have the capacity to achieve their goal
- The goals are specific, concrete, observable, and measurable
- The goals include a schedule for completion

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Some professional counselors incorporate assets with language such as "I will use my strength(s) of __________ to __________." Others simplify objective statements with language such as "Beginning tomorrow and continuing through next Friday, I will ____________."

We prefer a format that includes clients' general goals with successful outcome indicators, followed by intermediate goals that will lead to a successful outcome. An example for Thor would be

Outcome Goal #1: By Labor Day, I will acquire skills to manage my anger.

I will know I am successful when I refrain from any angry outbursts, at home or at work, for 10 consecutive days.

Thor's intermediate goals might include "I will practice making I-statements every day for the next week" and "During the next week, I will keep a journal to document feelings of anger, thoughts that I have prior to feeling angry, expressions of anger, and options I might have considered."

> Notice that Thor's intermediate goals reflect a cognitive-behavioral orientation. The intermediate goals identify strategies he will employ to self-monitor and skills he will learn in the process of managing his anger.

We generally recommend having no more than three goals, sequenced according to which will be most readily achieved. Certainly, you may have more than three goals for a client; you can note additional goals and modify your plans as appropriate.

As you consider Cassandra's situation and the things she reported during her first counseling session, what do you anticipate will be logical goals? In other words, how do *you* hope Cassandra will be different at the conclusion of the time during which she works with you? How will you arrive at the goals? What goals and language will most likely be acceptable, even invitational, to Cassandra?

Compose two outcome goals with success indicators and intermediate goals for Cassandra.

> We typically incorporated SFBT language as we endeavored to collaboratively define goals with our clients. We often introduced goal setting during the first session by saying, "I want to be sure that I provide the kind of service that my clients want, and that they get their money's worth. [Pause] That being the case, I'd like you to imagine that we have worked together for six sessions, perhaps seven, maybe five. After the session, you walk out the door and say, 'I am so glad I decided to work with [name of counselor]. My life is so much better now.' What will be happening in your life so that you will be able to say that?"

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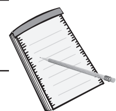

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PREPARING FOR TOUR 6

With clear direction defined by goals, your next step is to plan the approach(es), strategies, and interventions you will use. How will you assist the client in achieving his or her goals? What modalities (e.g., group counseling, parent consultation, individual counseling, family therapy, psychoeducation) will you include? What interventions do you envision using? To what extent will you address career development? (We will continue this process in Tour 6.)

> Tours 4 and 5 have been dense and less defined than the previous tours. Sometimes the activities and choices have been ambiguous. We've invited you to begin activities that have not been completed and likely won't ever be "complete." We've identified challenges. We've provided frameworks for time intensive tasks that must be completed even though they don't demand your attention with knocks, rings, and e-mail.

What's going on with you now? Please take a few moments to journal your thoughts and feelings.

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TOUR 5 RECOMMENDED RESOURCES

Berman, P. S. (2010). *Case conceptualization and treatment planning: Integrating theory with clinical practice*. Thousand Oaks, CA: Sage.

University of Colorado Denver Student and Community Counseling Center. (n.d.). *Goal setting questions.* Retrieved May 15, 2013, from http://www.ucdenver.edu/life/services/counseling-center/Documents/Goal-Setting-Questions.pdf

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