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The first session with a new client: five stages

Robert Bor, Sara Chaudry and (the late) Riva Miller

> If therapy is to end properly, it must begin properly – by negotiating a solvable problem and discovering the social situation that makes the problem necessary. (Haley, 1978)

There are seldom two chances to 'get it right' with a new client in a first session. Making a positive and empathic start to therapy, is an absolute requirement for the client if he or she is to open up and to begin to engage in the process. Irrespective of the therapy approach used, your confidence as a therapist or the problem the client brings to therapy, it is the therapist's role and responsibility to especially manage the first session and to provide an appropriate context and structure for therapy

The initial session with a client sets the direction and tone for future therapeutic engagement and outcome. Sometimes it will be a one-off consultation session, and, in itself, will have the potential to be very helpful to the client. It is more usual, however, ongoing contact with clients will be indicated. The first session nevertheless has the potential for being the only meeting between the client and therapist in some case (it might be sufficient; the client may not be able or wish to return, the therapist might assess that he/she is unable to help and might refer the client elsewhere). Consequently, the therapist needs to be adept in engaging the client, making an assessment and starting to intervene therapeutically to help the client – all in the same session (Bor et al., 2004). This can be a daunting assignment for trainees and also engender a degree of anxiety for both client and therapist prior to the first encounter. This chapter focuses on the important aspects of the first interview from both the therapist's and the client's perspective – the aspects that can help to establish an effective therapeutic relationship.

The development of a therapeutic relationship between client and therapist is dependent on many factors. The context of the first session (hospital, GP practice, private practice or counselling agency) as well as client groups (children, adolescents, adults and individuals, couples and groups) have an important bearing on how the client's problem is defined and what the future direction and steps in therapy sessions might be. The physical surroundings can also play some part in facilitating or indeed constraining an effective encounter between client and therapist.

What therapists choose to address in a first session will be partly determined by the theory that informs their practice. Therapists are inevitably influenced by their experience, supervision and training. The challenge is to listen to, and endeavour to reach an understanding of, the client's problems in such a manner that one's prior experience, among other factors does not close you off from the possible meaning of the client's description of their experience.

Effective therapy in any context needs a clarity of purpose. This purpose is defined by the context in which therapy takes place, the issues surrounding the referral, and the objectives subsequently agreed between the therapist and client about how issues and problems will be considered. Whatever the context or theoretical stance, there are basic concepts and steps that will help guide the first session. Most experienced therapists will follow much of these automatically. Nevertheless all therapists need to give thought to what to do in session, its order and to what purpose, especially when time is to be used most judiciously (i.e., a limited number of sessions, first sessions, crisis intervention). This framework can lead to:

more effective use of therapy sessions

closer collaboration between client and therapist (Bor et al., 2004; Larner, 2004)

- fewer misunderstandings about how therapy can (and can't) help and reduced attrition from therapy

more accurate assessment of client problems and needs

- increased client satisfaction with therapy

clearer set of criteria against which the efficacy of therapy can be evaluated.

An overview of some of the theoretical ideas and practical steps and stages that can make this first encounter effective from an assessment and treatment perspective is outlined in this chapter.

Engaging the client

There is an existing body of research that demonstrates that it is during the initial stages of contact with the therapist that the client will be more likely to disengage (Barrett, Chua, Crits-Christoph & Gibbons, 2008). This naturally has powerful implications for the early stages of therapy and, in particular, for the initial assessment or interview which can be pivotal for determining whether the client chooses to engage in the therapeutic process. A weak therapeutic alliance has been strongly associated with client drop out, which informs us that careful attention to the nurturance of the relationship between therapist and client is paramount from the outset to decrease the chances of a client withdrawing from the therapy process.

With this in mind, the initial stages of therapy should focus on engaging the client and building a solid working alliance based on conveying the principles of empathy, warmth, acceptance, understanding, genuineness and trust. Moreover, the alliance should serve as a tool for facilitating the collaborative work of both therapist and client. Lambert and Ogles (2004) note that progressing too rapidly into action plans, techniques or exploration of painful or traumatic experiences or emotions can be a risk factor for increased client drop out, so therapy should be carefully paced. Thus, at the stage of the initial interview, it is important to focus on building rapport by providing a safe, trusting and containing environment.

Engaging the client may be achieved by:

- Taking a lead in the opening session
- Asking questions which facilitate a dialogue and encourage the client to tell their story
- Focusing attention on the building of a bond through acceptance and validation of a client's behaviour (does not mean unquestioning approval of behaviour!)
- Making appropriate use of warmth and empathy (using both verbal and non-verbal communication)

The opening session and use of questions:

The therapist can take the lead in the initial encounter by enquiring about the nature of the problem using questions and appropriate probes to encourage the client to talk freely and concretely about the situation/difficulty that they are navigating. Probing skills can be used to define the problems and assess priorities and to facilitate a systematic inquiry whose purpose it is to gather some understanding of the different angles encompassing the problem in order to gain some perspective. Further guidelines on the appropriate use of questions can be found later in this chapter.

Providing a climate to facilitate rapport:

The relationship between empathy and effective psychotherapy practice has been vigorously supported in a breadth of research (Elliott, Bohart, Watson and Greenberg, 2011). Mearns and Thorne (2013) view empathy as one of the central tenets of the therapeutic relationship and consider it to be a process of being willing to be with the client in their experience of distress by using emotional sensitivity to access their personal frame of reference or, in other words, 'wear the other's shoes'. This process has the impact of allowing the client to feel better understood.

Acceptance has been otherwise known as 'unconditional positive regard' and refers to the therapist conveying an attitude of respecting and accepting a person as they are, or valuing them as a fellow human and person of worth separate from their actions or behaviour. Through actively engaging with an authentic curiosity, and by carefully listening to the client's story, the counsellor can convey respect, interest, acceptance and validation to the individual. Acceptance may also be effectively achieved through paying attention to the idea of the client in context by considering developmental issues, how the individual makes meaning/sense in their world and by paying close attention to how that individual's personality affects their way of thinking about and approach to life. It is also important that the therapist is able to monitor their personal internal dialogue in relation to the client and what they bring to the initial session, and to be aware of any personal biases or judgements that may potentially impede the development of an effective working alliance.

Premature discontinuation of therapy

Premature termination from therapy refers to discontinuing engagement from the therapeutic process without meeting the goals initially set out for treatment. This can be a problem in therapy which not only applies to trainees but also to skilled and experienced therapists. Swift and Greenberg (2012) have identified that premature attrition from therapy is more likely to happen with trainees as opposed to more experienced therapists. They also acknowledge that discontinuation seems to be more prevalent with clients presenting with either

eating disorders or personality disorders and clients who are younger. Whilst there may be a number of wide-ranging factors which contribute to premature drop-out from therapy, it seems appropriate to consider important factors within the therapist's control which can enable a positive initial therapeutic encounter. Swift, Whipple, Greenberg and Kominiak (2012) have suggested further practice recommendations to address misconceptions about what the process will entail and in so doing, reduce the chances of early termination from therapy. These can all be comfortably woven into the initial consultation.

- Providing the client with realistic information about the duration and course of therapy – so, getting them to think about what the process might entail, look like
- Address expectations about the role of therapist and client throughout the process – so what the client can expect from the counsellor and what will be expected from the client e.g. commitment to homework activities between sessions
- Consider the client's preferences for treatment if they have a particular aversion to a therapeutic model – not necessarily accommodating their preferences but rather imparting knowledge in relation to the most efficacious form of treatment for a particular presentation
- Strengthen the client's hope by instilling confidence through presenting an intervention, providing a brief causal explanation of the problem alongside an explanation of how the therapy can address the problem
- Explain the intention to make routine assessments of treatment progress and outcomes

Instigating an early exploration of the client's preconceptions about therapy at the outset of the process, providing education around client motivation and the expected duration of therapy and presenting some rationale for the chosen course of intervention may help contribute to a greater sense of confidence in the therapeutic process thus reducing the risk of client discontinuation.

The first session with a new client presents challenges and anxieties not only for the trainee therapist, but also for any therapist, including experienced ones. Clients can experience some anxiety and apprehension prior to this first meeting, with many being unfamiliar with the notion or process of therapeutic counselling. Most trainees can find the first session difficult as they try to achieve a balance between establishing a rapport, describing the context and framework for therapy, obtaining a clinical and personal history, exploring the problem and establishing a plan for ongoing work and even intervening to facilitate

change should this be indicated. A number of factors will contribute to this apprehension and the major ones are listed below.

Trainees will sometimes perceive an internal or external pressure to ‘succeed’ and ‘get it right’. For the trainee this pressure is compounded by a lack of experience and having to succeed for the supervisor, themselves, the client, and the referring person, if there is one. A feeling of being judged by the client, supervisor and referrer can be a constraint and may interrupt rapport and the flow of conversation. Other difficulties relate to whether this ‘success’ is to be achieved by meeting the referring person’s expectations of the trainee or by attending to a client’s problems. Consider a situation in which a GP wants the therapist to treat a client’s anxiety about a medical procedure, but has not yet given the client a full diagnosis and prognosis. Knowledge of this can make it hard for the trainee, especially if the expectations of the GP have not been clearly defined and balanced with the realities of the client’s situation before starting the session.

The first encounter with a new client is a time when a diversity of factors will converge, but it is above all a time when theoretical aspects have to be translated into practice. Most trainees will be learning and applying new skills and may feel self-conscious, which can then interrupt the flow of conversation during the session. You may understandably feel that your ‘patter’ is uneven and at times frankly clumsy but this is normal for a trainee, especially at the start of your client sessions.

The therapist should take a lead in starting, continuing and ending the session. This can also be daunting as the different stages of therapy will present different challenges. therapist may have various questions in mind, such as:

- How do I greet the client?
- How will I start?
- What if I get stuck?

- How will I keep going?
- Which theoretical approach shall I take?
- What if it doesn’t seem to fit or be working?
- Will I know when to stop? How will I end?

The number, nature and complexity of problems presented by clients may at first seem overwhelming. Having structure and guidance on how to contain and examine issues in the first session can help to reduce this anxiety for the therapist.

The number of clients who attend the first therapy session can relate to the setting or training and may sometimes pose difficulties for trainees. Trainee family therapists may consider it is an advantage to have the whole family present in this session. If the family does not attend, the trainee may feel unsure of how to proceed. If the whole family does come, however, it is not always clear with whom to start, even if the trainee has been taught which steps to take.

The mood of the client when first greeted may transfer itself to the trainee therapist and set the emotional tone – a situation which may need to be addressed. Uncertainty about how to respond in the session to the client’s anger, sadness, anxiety or depression can be inhibiting. In some circumstances, matching the response may be quite appropriate; for example, if the client is confident and outwardly cheerful it would be inappropriate to appear sombre before establishing a relationship. However, if the client is withdrawn and silent there may be more onus on the therapist to attempt to relax the atmosphere in the room.

Age and gender differences are also potential inhibitors to developing a therapeutic relationship. Trainees may for example be required to deal with much older clients. When working with children and adolescents, on the other hand, the therapist may be much older than the client and this can equally be

difficult. In some cultures accepting a different gender counsellor may be difficult for the client to accept.

Defining the time available and methods of payment (if applicable) may prove a challenge for the less experienced therapist. Trainees should have been given guidance as to the length of the session prior to engaging with clients. Trainees may also experience a pressure to deal effectively with everything that is raised by the client and feel uncertain about what can be left until another time. For others, the 45 minutes or so may seem difficult to fill. Some therapists may not set any rigid time limits other than stating when the session must end.

Training, experience and ongoing supervision can help therapists to meet these challenges. Having a theoretical basis for thinking about and specific skills for executing the first therapy session may also facilitate the process. This also helps to focus on what might be changed through therapy, and what may not be amenable to change (Seligman, 1995)

Theoretical concepts

The approach to therapy described in this chapter has been adapted from techniques developed by the Milan Associates (Selvini-Palazzoli et al., 1980) which will enable therapists to develop a map of therapeutic practice and to conceptualize problems in a systemic framework. A salient feature of this approach is the *structure* to the therapy session which helps to ensure that important issues are addressed in the first session (Bor et. al. 2009). This framework can be adapted for use with a range of theoretical approaches and is equally appropriate for subsequent sessions, in a modified format. It is not intended to be prescriptive but rather facilitative.

Guiding principles

Whatever theoretical approach is followed, having some overall guiding principles is fundamental to thoughtful, effective practice, helping the therapist to focus on the tasks. These include the principles listed below.

- Avoid making assumptions about a client's concerns, reactions, beliefs or wishes.

- Have small, achievable goals for each session.

- Use language carefully as everything said during the session has an impact and may alter perceptions and responses.

- Accept that clients cannot be completely reassured about a large number of issues, even though certainty and reassurance may be sought by them.

- Be realistic about the client's situation (what can be achieved from a therapy point of view, the therapist's availability, and so on).

- Recognize and respect the client's capabilities and unique ways of dealing with issues.

- Seek regular consultation and supervision to enhance skills, avoid burn-out, audit practice and determine effectiveness. (Bor et al, 2004)

Aims of therapy

Clarity about the aims of the first therapy session helps to:

- develop a relationship with the client by not raising false expectations about what therapy may achieve

- dispel misunderstandings (such as that therapy is a friendship relationship)

- reduce any myths about what may happen in the session. (eg: a couch for free association)

The main aims for the first session include the following:

1. Establishing a rapport with a client through conversation and engagement (talking, listening and noting what is not said).

Accommodating to the unique style or bearing of the client can sometimes help to foster a therapeutic relationship .

2. Conducting the session so that the client begins to gain confidence in the therapist's confidence by:

   - starting the conversation
   - keeping a focus when confronted by difficult or challenging situations
   - bringing closure to the session.

3. Eliciting and giving information, as required, by establishing:

   - what a client may expect from the session
   - their views and wishes relating to the therapy.

4. Defining the problem, exploring its implications, and considering how therapy can help address the issues that emerge in accordance with the client's initiatives, desires or wishes.

5. Considering relationships (family, friends, employers and other professionals) by also considering:

   - who else knows about the problem
   - who might be affected and in what way
   - who they might least want to be involved.

6. Assessing the severity of the client's concerns by reviewing what has been said and how the client has reacted.

7. Helping clients manage their concerns by:

   - enabling informed decision making

- facilitating them to view their situation from different perspectives, such as through reframing, thereby increasing their perceived options and choices.

Practice guidelines: five stages

The first session has five stages:

8. Preparation for the initial contact.
9. Meeting and engaging the client.
10. Defining, clarifying and assessing the client's situation.
11. Making decisions and ending the session.
12. Post-session reflection and tasks (Weber, McKeever and McDaniel, 1985).

Within each stage, steps can be clarified which will serve as a 'map' to guide the session. The principles, aims and techniques referred to earlier are woven into the steps. This format for a first session with an individual client may be adapted in style when sessions are held with couples or families and for follow-up sessions.

Excerpts from a case are used to illustrate the points made at each stage and are woven into the explanatory text. The example case is that of a 45-year-old married man referred by his general practitioner who thought that the patient was depressed as he had recently been diagnosed as having diabetes.

Stage 1: preparation for the initial contact

This first stage includes receiving the referral, dealing with the initial contact, considering the practical factors (location, privacy and length of time available) and dealing with issues pertaining to the referring person. It involves two basic steps:

13. planning how the first contact will be made

14. thinking about the session – that is, making an hypothesis about what the issue or problem may be.

Making the first contact

Consider how the first contact will be made with the client including:

- the date, time and location of appointment
- some reference as to how the referral came to the therapist and any details related to fees if applicable
- contact details for a confirmation or cancellation

whether this contact is to be made by telephone, letter or email. If contact is to be made by telephone, consider carefully who will make the telephone call (the therapist or a receptionist/ secretary). If it is the therapist who makes the call, clearly defined parameters about limiting the conversation have to be established. The main aim of the initial contact is to make an agreed contract for the first session, which may mean obtaining a *brief* description of the problem from the client. You don't want the first telephone contact to turn into a whole session!

Making an hypothesis

Think about the session beforehand and in order to anticipate the unique issues and problems for each client. Traditional approaches to therapy will define the start of the therapy process as the first meeting between the therapist and client. The systemic approach recognizes that this process begins when a referral is being considered or discussed (Selvini-Palazzoli et al., 1980). The consideration process clarifies:

- the referring person's perceptions of the client's problem
- what the referring person is requesting for the client (therapy/consultation) and is expecting the therapist to achieve
- the agreement about subsequent feedback to the referrer following the session.

The hypothesis takes into account the client's:

- stage of life (age)
- stage in relation to 'family' (married, single, divorced, caring for elderly parents, living alone or away from home)
- health background and any previous medical or psychiatric problems
- social and cultural context or background (ethnic, cultural, religious) and the setting of the therapist (specialist unit, GP practice, mental or physical health, education, etc).

Stage 2: meeting and engaging the client

If prior thought has been given to what might happen or be covered in the first session, it will be easier to start and keep focused. Practical factors (guiding the client to a chair) and communication skills are equally important for starting the session well. The initial focus is on gathering, assessing and formulating information at a pace that engages the client and builds sufficient rapport to engender confidence in the therapist. Clients can fear that 'things will get out of control'. The therapist should to be able to contain the emotional situation sufficiently to allow the problem to be spoken about freely without the client feeling that there is any prejudgement or prejudice on the part of the therapist.

Location or Setting

Consider the context of the therapy session. Privacy is important as the contents of the discussion may give concerns about confidentiality. If there are interruptions, this may send a message to clients that time has not been set aside for them and boundaries are not respected.

Consideration might also have to be given to the necessity for therapy at a bedside and in less than favourable conditions, perhaps alongside busy medical clinics. Providing thought has been given to achieving the optimum comfort and privacy, it is possible for effective therapy in all these situations. For example, although drawing curtains around a bed

on a ward does not obliterate the sounds coming from busy surroundings, it does give an atmosphere of greater privacy.

The positioning of chairs can also facilitate or deter discussion, for example:

- placing chairs directly opposite each other allows for eye contact, but can seem confrontational
- sitting behind a desk can set a physical and emotional barrier between therapist and client
- chairs placed at an angle to each other allow for eye contact as well as the freedom to look away.

Opening the interview/session

Begin the session by greeting the client by name and inviting him or her to sit down. Go on to clarify:

- who you are
- your context and role in the agency
- your task in relation to the client: 'I am a therapist who works closely with Dr Brown'
- the purpose of the meeting: 'We are meeting to find out about your present difficulty and to consider what steps you might want to take next'
- the time available: 'We have 50 minutes together'
- the need to take notes, and also identify and address any concerns related to this that may be felt by the client: 'I will be taking some notes during the session about our conversation and the decisions that we take together at the end. You are welcome to view them at any time"

Building rapport

Engage the client (build a rapport) by:

- taking the lead in opening the session
- asking questions which facilitate a dialogue and encourage them to tell their story.

Example A

Therapist: What is your understanding about Dr Smith's referral to me as a therapist?

Client: I'm not at all sure what you can do.

This response can have an impact on the therapist who may immediately take on this feeling from the client and lose confidence in how to proceed. Putting the question back to the client is a way of gaining time, moving the conversation forward, engaging the client and clarifying the purpose for them.

> *Therapist:* What might you want to achieve if it was possible?
>
> *Client:* I suppose I'd like to tell you about my problem and you to have some solution!

Here the therapist again feels a pressure to succeed and that he will be judged if he does not come up with a solution. Using the client's words helps to address this challenge.

> *Therapist:* Well, I cannot be sure about solutions. However, if you were to begin to tell me about your problem and what it is that you might like to achieve by the end of the session, would that be a start?
>
> *Client*: I am still not sure. [Listening carefully and considering the client's responses.]

Whatever a therapist says at the beginning gives a clue to the client as to how receptive or otherwise they are being with the client. In the above dialogue the client expresses some scepticism or possibly anxiety. Picking this up rather than passing it by can facilitate the early stages of the session.

> *Therapist:* I hear that you are not sure what might come out of our meeting. How would you like to start?
>
> *Client:* Well, today is a bad day.

Engage and assess the client early in the session by:

- keeping eye contact for most of the time – this helps to engage the client. However, this has to be done sensitively as there is a difference between staring and keeping eye contact. By looking away or straying off full vision and then coming back when listening or asking questions, emphasis can be given to the point being made or the concentration.
- being alert to verbal and non-verbal clues (the client looking away, sitting nervously on the edge of the chair or leaning back with folded arms).
- facilitating the dialogue with verbal ('Tell me more') and non-verbal prompts (nodding, moving posture).

Set small, achievable goals

Give a focus to the session by setting small, achievable goals. If all the client's problems are voiced and the therapist tries to address them all, neither of the participants is likely to feel anything much has been achieved. The client will leave feeling unclear about what has been achieved, and may be subsequently frustrated and dissatisfied. The therapist will leave feeling overwhelmed and with the knowledge that the client's needs have not all been met. Setting small goals for the session

is one way to achieve maximum benefit: solving one problem can lead to an ability to address other difficulties more easily.

Example B

The therapist still feels unsure how best to begin the dialogue so resorts again to using the client's words to form the next question.

Therapist: So today is a 'bad day'. Tell me what is bad.

Client: I have so many problems. My marriage is a disaster. My work is stressful and I'm really worried about how I'm treating the children, never mind the mess I'm in financially and medically.

Identify the client's main concerns

Identify the client's main concerns early in the session to enable the most pressing issues to be addressed in the time available. During this first phase it is easy to 'get lost' in the amount of information that is gathered. The aim of the session can be difficult to achieve unless techniques are used to keep a focus.

Example C

Therapist: If there was one thing you wanted to concentrate on in our meeting today, what might it be?'

Client: I'm not sure. There is also my diabetes which is new to me.

Prioritize the client's concerns

Rank concerns in order of their importance or severity to:

- help clients to be specific and relevant
- reduce their anxiety to manageable proportions
- give individuals a sense of control by setting small achievable goals. (If problem solving is successfully applied to one issue it will often highlight and give experience about how to tackle other difficulties.)

Example D

Therapist: Of all your concerns that you have mentioned – your marriage, your wife's illness, your depression, your financial and recent medical troubles – which is of the most concern to you today?

Client: The relationship with my wife.

Therapist: Which is the least important to you right now?

Client: Perhaps my jealousy of the children.

Therapist: If your relationship with your wife is the most important, what is it about that relationship that you find the most unbearable?

The therapist is trying to get a pattern for this relationship and to help the client be specific.

Client: Well, I suppose how we talk to each other.

Therapist: Can you be more specific?

Client: Well, we never put aside time, and avoid raising things that hurt us.

Therapist: Do you know what might hurt her?

Client: I think so.

Therapist: Could you see a way of starting a conversation about this hurt in the way we have been talking?

Client: I could say to her that we avoid talking about hurtful things I suppose, and that I think we need to in order to get on better.

Use language with care and thought

Choose your words carefully to reduce or avoid misunderstandings as everything that is said will have some impact on the client. Meanings are created by language and how it is understood between people. The therapeutic conversation refers to an endeavour in which there is a mutual search for understanding through a dialogue about problems and their possible solutions. Using people's words when exploring feelings, beliefs or concerns is a technique that:

- helps the therapist to gain time when he or she feels stuck: 'You say you are depressed all the time. How much of the time is all the time? Are you ever not depressed?'

- builds a rapport with clients as it confirms that they have been heard and helps the counsellor to move at their pace: 'You say that you feel depressed. How does that affect you?'

- facilitates the discussion of sensitive or unfamiliar issues: 'You say that you fear rejection sexually by your wife. What is it about this rejection that you fear most?'

Stage 3: defining, clarifying and making an assessment

After gathering some information, it can be difficult to decide where to go from there as many strands may have been elicited from a client's story. However, it is necessary to move into a different phase of the session. The goal is to begin to make connections that will help in understanding the client's problem. The client and therapist can work together on some small, achievable goals by following a series of steps as discussed below.

Begin to elicit more information

Use different methods to ascertain more information about the problem. If there is more than one person in the session it is important to gather

information from all those present about a particular issue. The main areas of exploration should include:

- defining the problem and considering its origin through different questions, for example: ‘Tell me about how you see the problem.’; ‘How does it affect you?’; ‘When did the problem start?’
- helping the client to be specific and to give examples of the problem’s impact on their daily living activities (sleep, work concentration, eating, social activities with others, and so on)
- identifying any critical events or changes that might have precipitated the problem (illness, death, changes in who is in the family or who has left, occupational shifts, and so on). Questions about any possible precipitating or triggering event or events should be woven into the conversation so they do not distract from the focus on the problem being given by the client. The answers can give clues about possible life events that may have influenced or are affecting the presenting problem. For example: ‘What made you decide to seek help right now?’; ‘Tell me, have you had any recent events in the family such as an illness or death, or has anything else happened that you can remember?’
- considering the impact of the problem on relationships, particularly in behavioural terms, by describing how the problem shows itself; for example: what kind of behaviour indicates that the client is depressed; who notices it; and what effect it has on relationships. This can prompt the client to think about the problem from another perspective, as shown in the example below.

Example E

Therapist: Who else knows that you have come for counselling?

Client: No one at this point.

Therapist: Is there anyone who you might want to be made aware of your problem?

Client: Well, my mother, so she would understand better why I don't see her so often, but I don't want to worry her.

Therapist: So when you are depressed who notices it?

Client: My wife might. I don't know.

Therapist: If she notices something what does she do?

Client: Well, she fusses or even avoids me.

Therapist: How do you react to the fussing or avoiding?

This conversation uses questions to link behaviour with relationships and beliefs. The client's belief is that he protects his mother from worry and has not perhaps given any thought to the effect his behaviour has on his wife.

It is important not to offer advice or interpretations at this stage, however compelling it may be to offer solutions. Rather, use approaches or skills that will help to bring the problem to the fore so that both the client and therapist gain a clearer picture of the repetitive patterns of behaviour that may serve to keep the problem going or make it seem intractable for the client.

Seek an understanding of the client's beliefs

Identify beliefs about the problem by using carefully constructed questions that will help discover those areas of difficulty where beliefs impinge on the problem. It is vital to bring into clearer focus the client's beliefs about the problem that are often maintained because of firmly held ideas. Solutions cannot and are unlikely to be considered, unless clients wish to move from the position that they are in at a specific moment. Many therapists fall into a trap by offering ideas that are not part of, or are even out of tune with, the client's beliefs. This is

particularly the case if the therapist's goals for therapy are to help the client change their situation in some way. If the need to change is not in accordance with the client's innate wishes, therapy is unlikely to succeed. Some general questions to reach these beliefs include:

- 'What is your view about how therapy might alleviate some of your problems?'
- 'Are there any issues that you believe would be helpful to discuss?'
- 'You say you are not sure. Is there anything that you would rather not discuss or explore in the session?' (The response to this question can give a great deal of information.)
- 'Despite your difficulty/problem what is it that you believe keeps you going as well as you have been?'

The dialogue in the example below illustrates this point.

Example F

Therapist: What is your belief about the origins of your depression and the difficulties in your marriage?

Client: When the children came along my wife seemed disinterested in me.

Therapist: What gave you that idea? How did she show it?

Client: Well, you know. Always tired at night, and sometimes even openly putting the children first.

Therapist: What is your belief in how families with young children should solve these sorts of problems?

Client: I suppose they muddle along.

Therapist: Tell me, despite feeling depressed and having difficulties in the marriage, what is it that keeps you going?

The therapist was tempted to offer an interpretation, but instead continued to explore beliefs, guiding the client to his own solution.

Offer relevant information

Give information when it is appropriate, depending on therapy context. In medical and educational settings there may be relevant information affecting the client's problem. Some ways of giving information are more effective than others. If the client's knowledge and understanding are first explored through questions, this allows misinformation to be corrected and the gaps in knowledge to be filled at the client's pace. When people are anxious or afraid it is not uncommon for them not to hear what has been said, so checking on what the client has understood once information has been given is important.

Example G

Therapist: So you recently heard that you had diabetes. What do you know about it?

Client: Only a little.

Therapist: What is the little that you do know?

Help clients to manage their concerns

It can be daunting for trainees to make this move. However, this step has to be taken during this stage as it leads to focusing on decision making and ending the first session. Explore the client's attempts to deal with the problem as this gives some clues to their responses and can impact on the approach to be taken by the counsellor. In some situations there may also be other therapists involved, which may then influence the discussion and future plans, for example, 'As you have been seeing another therapist, how do you see our meeting in relation to the help that you are seeking?' An example of helping the client to manage concerns follows.

Example H

Therapist: What have you tried so far to lessen your difficulties?

Client: I have tried to ignore my wife when she nags.

Therapist: How much did this help?

Client: Not much.

Therapist: What made any difference?

Client: Just that I didn't lose my cool immediately.

Therapist: Was there anything that made ignoring your wife worse for you?

Client: Yes. It is the same in a way. It all gets bottled up and I feel like exploding.

Re-frame problems to enable clients to consider their predicament from a different perspective. This may ultimately help them to cope better on a day-to-day basis, while at the same time being realistic about the nature of the problem – whatever it is – and its effect on relationships. An example of a reframe (re-definition) of 'not telling' as being 'protection' follows.

Example I

Therapist: In choosing not to tell your mother about your marital difficulties it seems that you are protecting her from hurt and disappointment, and shielding your wife from your mother's disapproval. Maybe you are protecting yourself from her anxiety about your future.

Identify any resources that are available to clients (how they have coped with past difficulties, and how they might cope in the future, who is around to help).

Example J

Therapist: Have you ever had to cope with other difficulties in the past?

Client: Well, yes, but I was younger then.

Therapist: You might have been younger, but can you remember what helped you then?

Client: My optimism.

Therapist: What place does that optimism have now?

Client: Some I suppose.

Therapist: If the problem continues how might you cope in the future?

Using hypothetical, future-orientated questions moves the client on to think about possible solutions.

Client: Ultimately we couldn't continue living together.

Therapist: Who do you think might be the first to think about living separately?

Client: I hadn't thought about it that way. Who knows? My wife might already be thinking that way.

Maintain a neutral relationship

It can be challenging to maintain a level of neutrality and boundaries as the sessions continue and unfold. Self-disclosure can lead to a crossing of the boundaries and loss of neutrality. As a trainee, you may become drawn into a client's problems and be tempted to indicate understanding by some self-disclosure to do with your own similar experiences and situations. In some circumstances, this disclosure can be appropriate, however, careful thought has to be given as to how to do this, for what

purpose and how such a revelation might impact on the future relationship between trainee therapist and client. As a trainee, it is therefore better advised not to use self-disclosure unless given support from your supervisor.

Maintaining a position of relative neutrality can be facilitated by being mindful about the impact of what is said and what happens during the session. For example, if the client starts crying and the therapist becomes uncomfortable and offers consolation through touching the client, this in itself will have an impact. It should not be done without very careful thought about how the client might interpret this gesture. Some clients do not want to be touched, and no assumptions should be made about their wishes.

Not showing shock or surprise, asking questions, and not giving a very one-sided opinion are other ways of maintaining a neutral stance. For example, ‘You say that you feel like giving up all efforts to improve the relationship with your wife. What do you think the effect of that will be on the future of your marriage?’

There is a difference between showing one’s feelings as a therapist in reaction to what a client is sharing and offering a view or opinion. It is not necessary to be neutral to obviously distressing information shared, such as an abusive relationship. But it is helpful and necessary to be neutral to a client’s preferences, such as to remain in a relationship which is abusive, when the client is seeking to bring their partner to therapy for help.

Formulation

Make a formulation towards the end of the session based on what has been seen and heard during the discussion. A formulation is based on the client’s state of physical health and their psychological resilience. This step has to be gone through before ending the session and often it will only entail the therapist thinking through the session as a mental exercise. The formulation leads up to decision making in the final stage

with the client. For example, the therapist might reflect silently: ‘Mr W. has diabetes and is under considerable stress, but seems on the whole to be able to manage his problems and has been able to give his story’.

Hypothetical, future-orientated questions that aim to explore how clients might cope, and who else is around, are especially useful evidence that will help in making a formulation. If suicide risk becomes evident, a more detailed discussion needs to ensue in order to clarify the seriousness of intent. Chapter XX addresses, in more detail formulation skills.

Stage 4: making decisions and ending the session

There are important parts of this penultimate stage for the trainee therapist to consider and these will help to end every session. Ending well is as important as beginning well. Knowing *when* to end is an important aspect of any session. Although some therapy sessions will have a time indication or boundary, for example 50 minutes, sometimes successful therapy can be spoilt by therapists feeling impelled to fill all of the preordained time. Sometimes extending a session can decrease intensity and interfere with rapport, or it can blot out important turning points in a session by blurring any sharp focus that may have been achieved. Knowing when to stop is something that requires skill and expertise, both of which will develop over time with practice and increasing confidence. (Bor. et. al. 2004)

The main goals of this final stage are to reach some decisions about future sessions and to summarize the session – which can serve as a re-frame or reflection of what has been discussed. The following steps lead up to the end of the session.

Reaching decisions

Making decisions is part of the process for both therapist and client. It can be easier to gather and order information than to come to some clear decisions that will include whether therapy should continue, and what

communication there should be between the therapist and the referrer. The decisions for the client include a consideration of:

- whether or not to come back to the therapist
- which issues should remain private and which can be shared with others

Decisions for counsellors include:

- whether or not they consider that therapy should continue
- what kind of feedback would be appropriate for the referrer
- whether they are suited or matched to being the ‘right’ therapist for the client
- what the frequency of sessions should be
- who else should be involved in the therapy (family, couple,)
- what time interval between sessions would be most appropriate?

This final point depends on the theoretical stance of the therapist. Some therapists arrange sessions more than a week apart to allow for the interactions that took place during the session to take some effect. Other therapists would make a contract with the client for a fixed number of sessions. Yet others would require the client to come in daily or weekly with no fixed ending. Yet another approach is to discuss with the client, towards the end of the session, what his/her view is about when and if to return. This enquiry helps to evaluate the meaning, and possibly the value, of the session for the client, and also helps the therapist to gauge an appropriate interval before the next session. A decision under these circumstances must be based on a dialogue that reaches an agreement between therapist and client.

Client questions or comments

Ask clients if they have any questions or reflections to make towards the end of the session. This opportunity:

- changes the atmosphere and clarifies that the session is coming to an end
- ensures that the client feels they have control and a chance to raise outstanding issues
- indicates an understanding that there may be issues that the client might not have had an opportunity to raise.

Asking the client to reflect should be done in a way that avoids inviting them to reiterate the whole session. Rather this question should be used to give the client an opportunity to say anything that has not been covered and is still on their mind.

Example M

> *Therapist:* Before we end is there any comment you would like to make? Or is there anything that you would like to say that we have not discussed so far?

In asking this question, the therapist should attempt to hear the issue and include it in the summary, rather than addressing another complex problem late in the session when time is running out. This will depend on the nature of the issues raised and its relation to what has been discussed. Use of the word ‘say’ does not imply an agreement to address the issue raised. The therapist should remember that earlier in the session a question was asked about the main concern for that time, so the client will have already had an opportunity to raise issues.

Client feedback

Obtain some feedback about the session towards the end to ensure that a collaboration between therapist and client has been achieved. Obtaining feedback also helps you to judge whether further sessions are needed. Enquiring about issues not covered in the session could be one way or what might be addressed in a future session. Another way is to ask, for example, 'What would you tell your wife about this meeting?' or 'If you were to take one idea away with you from this meeting, what would it be?' Another question might be: 'Have we covered issues that are important to you, and in a way that is helpful to you?'

Using interventions

Consider appropriate end-of-session interventions. These can play an important part in ending (Allman and Sharpre, 1992). Interventions can take the form of reflections, summaries or homework tasks, all of which should capture issues and relationships that have been brought to the session. For example, if the client is unsure about a relationship, a task might be to ask them to list, at home:

15. those aspects of the person that he/she feels sure about and likes
16. consider those characteristics and behaviours that he/she might be unsure or ambivalent about
17. reflect upon two or three aspects, of the relationship they might miss if it were to end and any they might welcome

The aim of any intervention is for the client to leave the session with a clearer sense of their issue/s and possibly different feelings about them. These changes may come about with changing perspectives and not necessarily removing or resolving the presenting problems. (Mooney and Padesky, 2000).

Summary of the session

Summarise what has been seen and heard in session by validating and balancing identified personal strengths with any difficult feelings. If an emphasis is placed only on the positive aspects of the client's situation, this may not be realistic and the client may feel that their real concerns have not been sufficiently appreciated and understood. The summary is a means for the client to hear the therapist's perceptions; in order to be consonant with the client, therefore, it should relate to what the client brought to the session. Phrases and words used the client should be included as hearing their own words repeated can make the session more engaged and real for clients. It provides clients with an opportunity for a reflection on actions, responses and the future. Summaries can be used during the session as a reflection or re-frame, and thus are itself an intervention. They can also be used to clarify the understanding between client and therapist as well as to ascertain whether the client has been able to discuss issues that are relevant to them. Included in the summary should be a reference to the follow-up arrangements. The client is not necessarily asked to comment, but to take the ideas away with them.

Example N

Therapist: From what I've heard and seen today you have many worries, but you seem to have thought about some solutions and some people who might help. However, something is stopping you. Maybe you are not ready to make a decision to leave your wife. You may be protecting her in a way that you used to do when you first met. Maybe you are also protecting yourself from feeling dependent, or facing up to your changed state of health. It seems that you will probably know when the time is right to take a move towards making a decision and getting the support you want. *[At this point the client looks up which gives the sign that the words have meant something.]* I suggest that we meet again in two weeks at the same time to follow-up this session. What do you think about that?

Client: Yes. It seems about right to me.

Therapist: I will also contact your GP to say that we have met and plan to meet again.

Client: [Nods.]

Communicate any follow-up

Indicate what follow-up there will be. This is important as it reduces the likelihood of unplanned and unexpected phone calls or visits between sessions, and is a natural way of ending the session. If there is to be an ending and no follow-up, this should also be clarified. Details about the follow-up should include:

- how you can be contacted between sessions if this is necessary and how this can be done
- a consideration of the time between sessions (if clients are seen too frequently they could be given a message that they cannot manage on their own; if the time between sessions is too long the threads of help may be weakened)
- a discussion about communication and feedback to the referrer.

Closing the session

Think carefully about an appropriate mode of finally ending and parting, such as standing up at the end of the session and shaking hands, or making only a verbal exchange (‘Thank you’, ‘Goodbye’) and seeing the client to the door.

Stage 5: post-session reflection and tasks

Once the session has ended, the therapist will usually make some reflective notes about the content and process in the session. This will help ensure that the next session is well prepared for and is linked to the previous one. This final stage is where the therapist can revisit and possibly revise the original hypothesis or formulation of the client’s problem.

Record the salient details of the session

These important aspects of the session include:

- the source of referral
- who attended
- the client's identified problems
- the client's clinical presentation and neutral state
- any particular concerns for the therapist (excessive alcohol/drugs, abuse, stress, depression, suicidal ideation etc)
- a summary of what was discussed
- agreed future actions
- any interpretations, hypotheses, formulation, impressions

The notes you produce – as with all patient records – should be made with careful thought given to every word used. Patients have access to their records in the UK and may request access to them at any time. Use verbatim quotes, for example, 'The patient said he hated his wife'. Using a description of an impression, for example, 'The patient gave the impression of being very nervous as he was sweaty and fidgeted throughout the session', is preferable to a straight opinion, 'The patient was nervous'. The latter comment is making an assumption that could be misinterpreted or contested unless supported by evidence.

Feedback to the referrer

This is important from several perspectives. It clarifies future actions, facilitates open communication between client and referrer (if this is appropriate for the future), and may also pave the way for future referrals. Consider whether the feedback is to be done by letter, verbally on the phone, face to face or by using a mixture of methods. Consent from the client for an exchange of information with the referrer or anyone

else (such as other agencies) must be obtained (preferably in writing) at this time or at any other appropriate time in the session.

Consultation and supervision

These are an essential part of the growth and development of the skills and techniques that will enhance and ensure effective therapy. Consultation and supervision also serve as a support for the therapist and are a requirement for registration as a practitioner.

Practice guidelines: the role of questions

Techniques for using questions

All sessions will have a beginning, middle part and ending. As the session develops, the order of the steps you have planned to take in any session will depend on the flow of conversation which, in turn, will be guided by questions. Questions used by the therapist are a key technique for guiding the session: obtaining and giving information; identifying and re-defining problems; and thinking about their resolution or reduction. Questions are also used to help clients define and reflect upon problems. Through this the therapist introduces a genuine curiosity (a stance of always being 'informed' by the client) about the client's defined problems – which is entirely of course different to an interrogation. Questions are particularly important when learning about the client's problems and the impact it has on them and may be a part of any theoretical approach and can easily be adapted to the style and preferences of individual therapists.

Questions can be used purposefully to facilitate the interaction between client and therapist by:

- not making assumptions about the client or their problem or beliefs or feelings.
- helping them tell their story and share their experience of their problem

- keeping a focus and giving a structure to the session
- identifying concerns, wishes and beliefs
- ranking concerns or problems in order of their severity
- clarifying the meaning of what is said by helping clients to be specific: 'You say you are depressed. Can you say more about that? How does it show?'
- linking people with ideas and other people who they had not previously considered: 'When you are depressed who else notices it?'; 'What impact does it have on your wife?'; 'When she withdraws, what effect does it have on you?'
- facilitating a discussion of difficult or painful issues: 'When you say you are frightened of death, what exactly is it about death that frightens you most?
- exploring ideas or hypotheses by bringing into the open something unknown and unforeseen which subsequently opens up possibilities for a change of perspective

Types of question

There are different types of questions that can be used to achieve a variety of responses.

Linear or 'closed' questions

These questions lead to 'yes' or 'no' answers and do not readily open up ideas for discussion. In some circumstances their use can be appropriate, for example, 'Did you agree with your doctor that you should have some therapy?'

Circular questions

Circular questions link ideas, beliefs and relationships in a way that helps people to view problems from different perspectives. A circular question

taken from a stance of ‘unknowing’ might be: ‘What did you think about your doctor’s idea that you should have some counselling?’

Other examples of circular questions are: ‘What do you think your husband might most want to discuss today? Would it be the same or different from that which you would choose?’; ‘Where do you get the idea that you always have to take the opposite stance to your husband?’

Questions prompting differentiation and linking over time

Questions that show a *difference* between the present, the past and the future help people to make connections over time. For example, ‘How have you coped with difficult situations in the past?’; ‘How do you think you might manage in the future if the problem persists?’; ‘What ideas do you have for how you might you cope right now?’; ‘How is it different for you having to face your wife’s anger now from when you were first married?’

Hypothetical, future-orientated questions

This type of question includes the words ‘if’, ‘when’, ‘what if’, ‘how might’. Their use helps to explore the perceptions of others, address difficulties and prepare for the future by linking ideas that may not have otherwise been considered. Such questions address future concerns while the reality of these situations is some distance away and possibly therefore not as threatening. Examples include: ‘If you were to decide to leave your wife what might be your main concern?’; ‘Who might help most?’; ‘Is there anyone or anything that might make it more difficult?’; ‘If you decided to leave your husband is there any aspect of your life that might be easier for you?’ (Penn, 1985).

Reflective questions

These questions help to re-frame problems by introducing another perspective. For example, ‘So you might see yourself as protecting your husband by not telling him that you are here today?’

Conclusion

Some aspects covered in this chapter may seem obvious as they are the steps that experienced therapists usually go through automatically. Having them laid out can help trainees to have a framework within which to unravel the stress and complexity of client work.

Clarity how the aims of therapy can give therapists the confidence to focus on the tasks when dealing with clients' problems and their complex repercussions for relationships (Bor, et al. 2004). Having a structure or 'map' for the session enables the maximum to be achieved in a relatively short period of time. Newly trained therapists will often find it difficult to start sessions and may be unsure about how to continue and some may have difficulty in deciding how and when to end sessions. It is hoped that this chapter will go some way towards helping to facilitate this process.

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