The key concepts in engagement and assessment

The primary theory of Cognitive Behavioural Therapy or C. B. T. is that what an individual thinks, affects their mood, how they feel physically and therefore how they behave (Williams and Garland, 2002) It also takes into account a clients past experiences, current environments and genetic influences (Grant, Townend, Mills and Cockx, 2008). Therefore the main aim of the C. B. T. assessment is to develop an understanding of the clients difficulties and collaboratively build a formulation and treatment plan (Hawton, Salkovskis, Kirk and Clark., 1989). This is possible through the gathering of information from the client about their problem and the difficulties that they are facing. This is done through a structured assessment process that involves questioning the client around their thoughts, physical feelings, behaviours and emotions and the impact that these are having on different aspects of their life. It is also essential to establish any triggers for the particular episode or problem and recognise what maintains the symptoms discussed. It also is very important to address any risk issues at the assessment stage of therapy, such as suicidal ideation or self harm and to respond appropriately to the level of risk identified.

The assessment also gives the therapist an opportunity to educate the client around their specific problem, the appropriate treatment approaches and begin to facilitate the

process of change (Hawton et al., 1989).

There are many different aspects of the C. B. T. assessment. For this particular assignment I will be analysing and focussing on the engagement of

the client in therapy, by reflecting on and critically analysing a recent assessment that I have completed in practice.

Client X was a male in his 50s who was referred for CBT by his General Practitioner (G. P.). He had been suffering with depression following the breakdown of his marriage five years ago. He has since been living alone with minimal contact from his children or grand-children. He is currently unemployed having lost his own business as a result of his marital break up. He presented tearful and lethargic throughout the assessment. He complained of experiencing low mood, loss of enjoyment, reduced activity levels, loneliness, sleep problems and hopelessness. He further admitted to fleeting thoughts and plans of suicide, but stated his children and his religion as strong protective factors in preventing the plans turning to real intentions. Finally, he was not aware of any family history of mental health problems.

The beginning of an encounter is extremely important, is well remembered by clients and is a fundamental part in developing engagement. (Newell, 1994). Therefore, the greeting and setting of an agenda is the first element of engaging the client and orientating them to the consultation (Newell and Gourney, 2004). I felt here that I showed warmth and genuineness towards the client to help them feel at ease from the onset of the session. When introducing myself I shook Client X’s hand and smiled. When introducing the assessment and when setting the agenda, I tried to avoid using jargon as much as possible, which can be a barrier in communication. According to Williams (2002) non-professional terms should be used that the client will understand. Otherwise, the client could begin to feel inferior to the therapist which will therefore have a negative effect on the engagement process of

the relationship. Although I attempted to refrain from the use of jargon as much as possible, I was aware at the beginning of the session that I used the abbreviation “ C. B. T” instead of saying the full title “ Cognitive Behavioural Therapy.” The client did question this as he did not understand. Therefore, I had the opportunity to apologise and explain what I had meant in more appropriate, understandable language. Despite the effects of the use of jargon on engagement, I thought the client’s feedback was useful and showed that they were engaging to the session at a level from the onset.

Another important aspect of engaging the client is the style of questioning used throughout the assessment. There are two main types of questions, open and closed. Open questions allow the client to describe their problem in their own words, and therefore any patterns or triggers can be established (Gamble and Brennan, 2000). Closed questions are used to elicit facts and can usually be answered with a “ yes” or “ no” (Sutton and Stewart, 2002). The method of questioning is a very important part of the assessment and if carried out incorrectly, can have a detrimental effect on engagement and therefore the therapeutic alliance between client and therapist.

For instance, too many closed questions can lead to the client feeling interrogated (Burnard, 1997) and they also, according to Hames and Joseph (1986), restrict the individual from expressing their true thoughts and feelings.

As with closed, open questions also have their limitations. They are broad in scope and answers are unpredictable in direction therefore some information can be omitted (Van Servellen, 1997). Furthermore, Northouse and

Northouse (1985) argue that assessments that use a series of open questions alone, can result in lengthy, time consuming appointments. This was reflected in the assessment carried out with Client X. I found it difficult to gather information in an organised manner without the Client going off on a tangent on many occasions. Therefore, on reflection it is necessary to undertake a good balance of both open and closed questions to illicit the appropriate information about the client's problem and to engage fully with the individual. I also felt that on a few instances, due to my own anxieties with carrying out the assessment, I asked multiple questions at once. This would have impeded the flow of the assessment and also according to Williams (2002) these questions confuse the client. This is because they must remember what they have been asked and then formulate and answer for each one in quick succession. Thus according to Ley (1977) a major source of clients disengaging within sessions is the clinician's poor interviewing skills. I also recall that on a few occasions I was aware of asking leading questions which Faulkner (1998) states should be avoided as they imply a preferred answer and are inappropriate in the engagement process.

Skilled questioning is only as good as the active listening that accompanies it (Forster, 2001) which is a very important factor in client-therapist engagement. Arnold and Boggs (2003) believe listening not only requires the act of hearing with the senses but also an active interpretation of what is heard through verbal and non-verbal communication. It is important that clients feel listened to in order for them to engage with the therapist. When reflecting on the assessment with Client X I felt my non-verbal gestures, such as eye contact, open body language, gestures (such as nodding) and note

taking helped to enhance the engagement process. However, when it came to verbal communications, such as reflecting back and summarising to the client what had been said, I felt that this was an area of my interviewing skills that needs to be developed further. Looking back I rarely utilised this tool which could have aided in engaging the client at a more deeper level which according to Beck (1995) if a client doesn't fully engage at the start of therapy, it is possible that they would not return for the follow up session.

Active listening and reflecting are necessary for a clinician to show empathy towards a client. Rogers (1957) suggested a warm empathic relationship is a necessity when engaging client. A definition of empathy by Beck, Rush Shaw and Emery (1979) is:

" Accurate empathy refers to how well the therapist can step in to the patient's

world and see and experience life the way the patient does." (page 47).

Within C. B. T. therapists should empathically pay attention to the client's problem and provide a non-judgemental environment where clients feel comfortable on openly discussing their thoughts, feelings and behaviours (Josefowitz and Myran, 2005).

Client X disclosed some painful and shameful thoughts and behaviours in the assessment, which Thwaites and Levy (2007) believe a client wouldn't admit to or discuss unless they felt a certain level of empathy from the therapist. The warmth, genuineness and non-judgmental attitude I showed throughout the session is reflected in the open and honest responses from Client X. He

admitted to never disclosing the thoughts and behaviours that he was experiencing which gave me a level of feedback that he felt that to a level I was able to understand his feelings. At certain points during the session the client became tearful and distressed. Here I remained calm, allowed for silence and sometimes used statements such as ” I understand that this is difficult for you, please take your time” which showed an empathic understanding to the client. However, as mentioned earlier to fully empathise with an individual I should have reflected back what the client had said to confirm to him that I understood what had been disclosed. On reflection at times I believe I showed sympathy rather than empathy which if overused can leave clients feeling pitied. This feeling of pity can reinforce the feeling of hopelessness and low self esteem, especially in clients suffering with depression such as Client X, therefore in future I need to be more aware of the use of sympathy versus empathy.

To conclude, I felt that overall I did engage with Client X to a reasonable level, however I do feel that there were some areas of the engagement process that could be improved. I think my main strengths were creating warmth, genuineness and empathy with the client which helped form a good base for a therapeutic relationship. I also think that despite the use of jargon in a few instances during the introduction, I set the agenda well and involved the patient in decision making which is important for the foundations of a collaborative alliance.

However, on reflection, there are some areas that have room for improvement. Firstly, the use of questions throughout the assessment could be improved so that the interview flows well and the appropriate information

is gathered. Briddon, Richards and Lovell (2003) explain that to engage a client fully and to gain an accurate picture of the clients presenting problem, the session should begin with broad open questions, specific open questions and then closed questions. This process is known as “ funnelling”, which I aim to apply in future initial interviews.

Secondly, my use of reflecting back to the client could be improved in future assessments. Although I felt I was concentrating on listening to the client from a personal perspective, reflecting what the client had said back to them would give them the assurance and confirmation that I was hearing and processing what they were disclosing, thus improving client-clinician engagement. This is a tool that I plan to use more of in therapy. However, as with the use of questioning the use of reflection must be carefully balanced. If over used it can appear unnatural and noticeable (Faulkner, 1998) and can lead to the client becoming agitated as they may feel mimicked (Collins, 1977).

This also links in with improving engagement through the empathic relationship. As mentioned I believed that I showed a good level of empathy with Client X throughout the assessment process. However, this could have been improved further through the use of empathic reflection (Josefowitz and Myran, 2005). Accurate reflection helps to maintain the ’empathic bridge’ according to Gilbert and Leahy (2007) therefore is necessary for true engagement with a client.

Using a reflective model allows me to assess my own performance and pin point areas that need to be worked on to help increase the level of

engagement with clients. I aim to improve the aspects of assessment covered in this assignment through feedback and advice from my clinical supervisor, practise through the use of role play, reflective practice using recording equipment and through my own experiences in clinical practice.

Finally, despite there being several areas for improving my engagement with future clients in the initial assessment, Macneil, Hasty, Evans, Redlich and Berk (2009) believe that although seeming very significant in the first stage of contact, engagement is an ongoing process throughout treatment. Therefore, continuous effort and attention is required to maintain the therapeutic relationship.