Counselling Skills in Action

4th Edition

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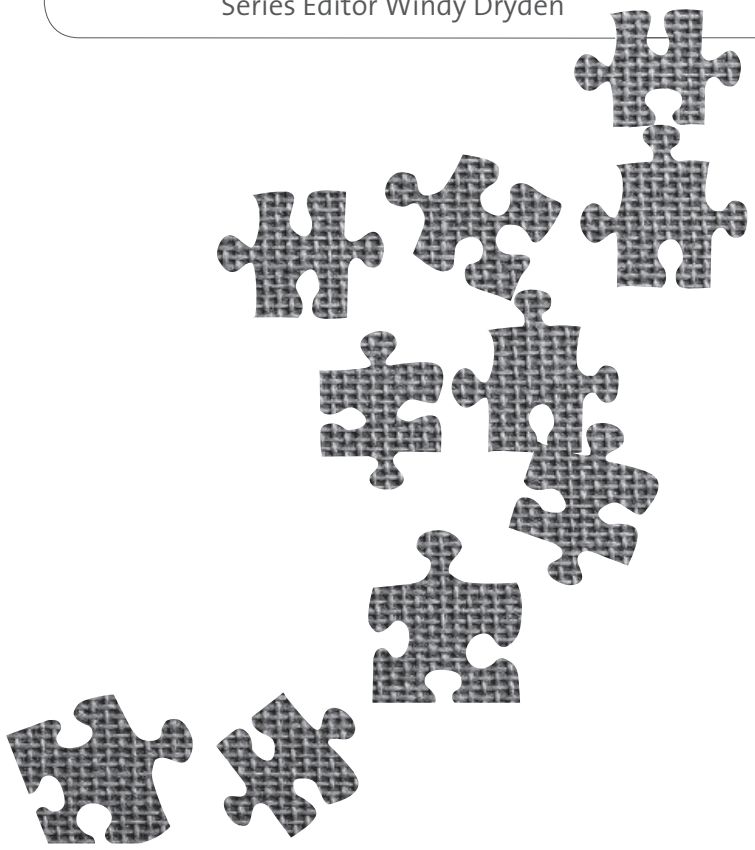

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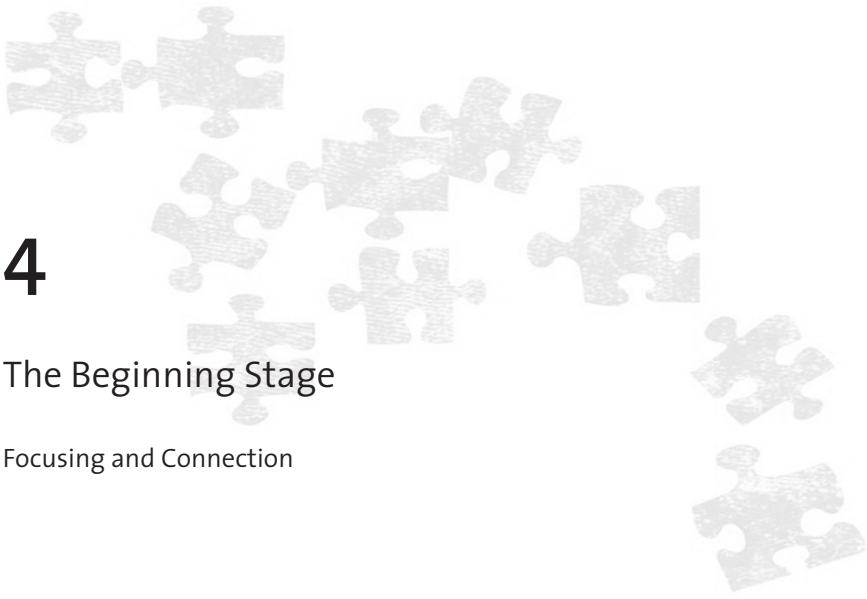

4

The Beginning Stage

Focusing and Connection

Chapter contents

This chapter covers:

- Aims, plans and skills for the Beginning Stage
- Establishing a therapeutic alliance
- Conducting an assessment
- Agreeing a working therapy contract
- Preparing for and managing your first session
- Checklist and worksheet for preparation and management of the first session
- Further resources

Introduction

In this chapter we discuss the aims appropriate to the Beginning Stage of the therapeutic process. We consider the plans you will implement in order to realize these aims, and the skills you will employ to help you do this. We also include a section on preparing for, planning and managing your first session with a new client.

The key theme for the Beginning Stage of the work is 'focusing'. This reflects the key activities of the work at this stage – defining, pinpointing and prioritizing the client's presenting issues and how you will collaboratively address them, as well as drawing your attention towards beginning to develop your relationship with the client. Your main intention behind this focus, at this stage, will be to create a sense of trust, positive regard and warmth. Hence the relational focal point at this stage is defined as 'connection'.

Aims, plans and skills for the Beginning Stage

Aims

The following three aims characterize the work of the Beginning Stage:

1. To establish a therapeutic alliance
2. To conduct an assessment
3. To agree a 'working therapy contract'

Plans

Let's look at the plans you will need to develop and implement in order to achieve your aims for the Beginning Stage, considering each aim in turn.

To establish a therapeutic alliance

As we discussed in Chapter 1, therapy is fundamentally a human activity. While this relationship has much in common with other relationships – for example, close friendships – it is a unique relationship with specific characteristics that distinguishes it from other forms of support. In the Beginning Stage of your work with a client you will be starting to form this special kind of relationship. For many therapists, the therapeutic relationship is the central agent of change, growth and healing. As Yalom (1989) writes, 'It's the relationship that heals, the relationship that heals, the relationship that heals' (ibid.: 91). Research demonstrates that psychotherapy outcomes are influenced, to a considerable extent, by the therapeutic relationship (Norcross and Lambert, 2019) and hence the establishment of a good, collaborative relationship with your client is an essential feature of the work you enter into together.

In the Beginning Stage, you will plan to establish a 'therapeutic alliance' (or 'working alliance'), a key component of the therapist–client relationship. This is a concept that describes the quality and strength of the relationship between therapist and client, and degree of collaboration that exists between them. Bordin (1979) proposed the therapeutic alliance (what he called the working alliance) as a pan-theoretical construct, which is now widely adopted within the field of counselling and psychotherapy, wherein the alliance is measured in terms of an agreement about the therapeutic goals of the work, unanimity on the therapeutic tasks, and the development of a relationship bond.

The therapeutic alliance

This can be defined as:

- **Goals**. The purpose of the therapeutic work, what can be achieved and what the outcome(s) might look like
- **Tasks**. What will happen in therapy including in-therapy behaviours and processes
- **Bond**. The experience of a positive emotional bond between therapist and client, including attributes such as the degree of trust, respect and sense of affinity between them.

For Flückiger et al. (2018: 318), 'the alliance represents an emergent quality of mutual collaboration and partnership between therapist and client [and] infuses every interaction throughout psychotherapy'. It is therefore not an endpoint, goal or outcome of therapy. Rather, it unfurls over time, being forged, shaped and sculpted according to each unique dyadic encounter and interaction. Planning to develop a therapeutic alliance is imperative for the success of counselling and psychotherapy (Flückiger et al., 2019) as it is 'the part of the client–therapist relationship that enables [them] to work together even when [they] experience some desires to the contrary' (Clarkson, 1995: 31) Numerous research studies show that a robust and positive relationship exists between the therapeutic alliance and therapy outcomes (e.g. the degree to which people feel better, symptom alleviation, wellbeing and drop-out rates) (Flückiger et al., 2018).

To conduct an assessment

Planning an assessment is an integral part of any counselling and psychotherapy process. There are competing perspectives on assessment (and diagnosis) in the psychotherapeutic world. In our view, the most recent and significant contribution from the field comes from the work of Lucy Johnstone and Mary Boyle (2018), *The Power Threat Meaning Framework*. It is not within the scope of this book to discuss in depth the wide variety of approaches and techniques available to therapists undertaking an assessment. However, we present a basic introduction and overview to the assessment process in order to help you plan this part of your work.

Assessment is an important aim for the Beginning Stage, although it is an ongoing, continuous process featuring at every stage of the work. It is not a linear activity – clients' views of themselves, others and their problems often change as the work progresses and they gain new insights. During the preliminary assessment, it is therefore important to hold this in mind and keep decisions and hypotheses under review. Supervision will help you to maintain an open perspective and iteratively evaluate your judgements. The methods you will employ to help you conduct an assessment can vary and most therapists will draw on a mixture, including semi-structured interviews, questionnaires, current research, intuition, listening to the narrative process and observation. Here we outline the key elements you will need to consider in your assessments and encourage you to access the resources provided at the end of this chapter for further support.

To agree a working therapy contract

A 'working therapy contract' can be defined as a specific commitment from both therapist and client to a clearly defined course of action. Using counselling and psychotherapy skills requires the assent of the client to be effective. This means that the client actively engages with the opportunity to reflect on an issue or problem in greater depth, and more systematically than is usually the case when receiving informal support from friends and relatives.

It is important to plan to negotiate and agree with your client the working therapy contract that your subsequent work with them will rest upon. This contract will formalize some of the key differences between relationships that provide informal support and their relationship with you, their counsellor or psychotherapist. As discussed in Chapter 1,

some of these differences include a purpose and agenda for the work which is predetermined, setting clear boundaries and clear role specification. A 'working therapy contract' is important to the client psychologically, therapeutically, ethically and possibly legally because it manages client expectations and provides criteria by which you can both assess what is happening as the work progresses and to decide when the work is completed. Contracting is empowering for clients when negotiated collaboratively.

The process of discussing the working therapy contract with your client will also involve determining the tasks and goals of the work, both of which contribute to the therapeutic alliance (see above).

Skills

We now turn to the skills that you will need to learn in the Beginning Stage to support your work, meet your aims and put your plans into action. We consider each aim in turn.

Skills needed to establish a therapeutic alliance

We will first consider what is needed to develop a relational bond. An agreement about tasks and goals is discussed in the section below on 'defining the focus, process and direction of your work'. You will be building on your core skills in order to develop a relational bond, in particular listening and communicating skills. These will be expanded on in the ways discussed below.

Much has been written about how to develop the kind of intense personal connection necessary for therapeutic work to proceed. Carl Rogers (1902–1987) described an effective therapeutic relationship as characterized by certain core qualities. While these qualities have been variously described, the common thread is the significance and worth ascribed to clients themselves, their experiences and our contact with them. In the Beginning Stage you will plan to demonstrate certain attitudes and ways of experiencing and being with your client that encapsulate these qualities. In particular, we consider here three qualities, which are, 'values and attitudes, but also skills which can be taught, learnt, practised and supervised' (Clarkson, 1995: 40):

- Empathy
- Acceptance
- Genuineness

The skills you employ to demonstrate these qualities will build on the core skills outlined in Chapter 3. The purpose of communicating these qualities is to facilitate a transformative relationship that engages the client in the therapeutic process. It is not enough to expect clients to know that you accept and understand them. You will need to demonstrate and communicate these values both verbally – in what you say – and non-verbally – in how you say what you say, and how you orientate yourself towards them.

It is important to note that empathy, acceptance and genuineness are not stage-specific – they are fundamental throughout the work. However, we introduce them here

as they are enormously influential in developing a good rapport and sense of connection with your client.

Empathy

Empathy is 'the capacity to think and feel oneself into the inner life of another person' (Kohut, 1984: 82). It is about deeply understanding another person and attempting to grasp as fully and accurately as possible the messages they are trying to convey verbally and non-verbally. For Rogers (1980: 142), who wrote extensively on the subject and considered empathy to be one of six 'necessary and sufficient conditions' for change, empathy was a process rather than a state. It was 'a way of being' with another person:

> It means entering the private perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive, moment by moment, to the changing felt meanings which flow in this other person, to the fear or rage or tenderness or confusion of whatever that he or she is experiencing. It means temporarily living in the other's life, moving about in it delicately without making judgements.

Empathy involves striving to sense your client's world from their perspective, and to be open, sensitive and aware of their experiences. It is a cognitive, emotional and embodied vicarious imagining. Empathy is therefore different from sympathy. Sympathy can be seen as an experience of similarity or agreement with another, to feel compassion, commiseration or support for them. Sympathy often also involves an assumptive understanding of what is happening for the other person. It is about 'looking on' (experience-distant) rather than 'looking from within' (experience-near), which is what you are attempting to do when you empathize. Let's consider an example:

> Jermaine has sought therapy, with a therapist called Liz, to help him understand his feelings about his girlfriend's pregnancy. While he and his girlfriend had recently talked about wanting children in their future, they hadn't made any decisions or plans, and the news is unexpected.

Jermaine: I'm still in a state of shock. On the one hand I'm really excited, on the other I'm *so, so* scared … sometimes I feel nothing at all, like it's not quite real, like is it true? Is she really having a baby?

Example 1: Expressing sympathy

Liz: I understand completely. I would be shocked too. Everyone feels some degree of shock when they realise they're going to have a baby.

Example 2: Communicating empathy

Liz: I can really hear what an impact this news is having on you … you're feeling all sorts of different emotions, which sound overwhelming at times. And sometimes you feel none at all. You're asking yourself, 'Is this really happening?'

In the first example, the therapist, Liz, has some sense of accord with Jermaine. Her response is sympathetic in the sense that it identifies some commonalities that often (but not definitely) exist for expectant parents and uses them to try to offer something supportive. However, in expressing her sympathy Liz makes presumptions about Jermaine by drawing on what she thinks she knows happens generally, rather than focusing specifically on Jermaine's individual, unique experience. In the second example, Liz draws out the features of what Jermaine shares specifically, in an attempt to enter his private perceptual world and look from within his experience.

Empathy is almost universally understood to be central to therapeutic understanding. This is supported by research investigating effective elements of the therapeutic relationship, which has demonstrated that empathy is a robust predictor of client outcome (Elliot et al., 2018).

Because we are all separate, unique beings, it is impossible for us to understand our clients completely. We cannot experience another person's life just as they do, because of the uniqueness of each individual's experiences; however, empathic understanding is an essential component for building rapport. It demonstrates 'communicative attunement' – an intentional, active engagement with the client's experience moment to moment (Elliot et al., 2018). Empathy opens up a reflective space for your client – being understood and affirmed provides the support and safety needed for self-expression and exploration (DeYoung, 2015). Clients no longer feel alone or alien because they have someone moving alongside them in their experience. From this perspective empathy can also be seen as a way of normalizing your client's experiences. Through empathic understanding you are able to show them that there is nothing shameful or unnatural in human distress.

Acceptance

Acceptance is akin to what Rogers (2004) termed 'unconditional positive regard' (UPR), what Egan (2006) referred to as 'respect' and what Mearns and Cooper (2018) described as 'affirmation'. Essentially, acceptance means valuing and affirming others because they are human. Mearns and Thorne (1988: 59) write, 'The counsellor who holds this attitude deeply values the humanity of her client and is not deflected in that valuing by any particular client behaviours. The attitude manifests itself in the counsellor's consistent acceptance of and enduring warmth towards her client' – that is, an attitude of acceptance is not conditional, rather it is inherently non-judgemental. Accepting another human being as they are stems from an underlying belief that we all have reasons for behaving, thinking and feeling as we do. It is also an acknowledgement that the way our clients behave, think and feel may be reflective of the means they have found to survive, cope and adapt to life's challenges, disappointments and pain. Even if these behaviours, thoughts and feelings do not seem to serve them well, they are manifestations of 'creative adaptations' to the world around them. Acceptance is not about colluding or agreeing with everything your client says, does and feels – colluding and agreeing are intrinsically judgemental acts after all. Rather, it is about respecting and being open to the whole person sitting in front of you, not just those parts of the person that you understand, like or feel resonance with. Let's return to the work with Jermaine to tease out how Liz might demonstrate her acceptance for who he is and where he finds himself with the unexpected pregnancy:

Jermaine shares with Liz that, on receiving the news that his girlfriend was pregnant, he felt angry and started an argument with her. He blamed her for not taking precautions. The disagreement escalated and he stormed out.

Jermaine: In that moment all I could feel was anger and I just started shouting all this horrible stuff ...

Liz: Your first feeling was anger and you reacted to it – you lashed out.

Jermaine: Yes exactly [*sighs deeply*].

Liz: That's a big sigh, I wonder what's happening for you right now? Now you're reflecting on that moment?

Jermaine: I'm feeling frustrated with myself that I behaved like that. I don't really blame her, it's not her fault – it's no-one's 'fault'. I should never have said the things I did!

Liz: You felt angry in the moment and now you're regretful of how you behaved as a result. I wonder whether there were other feelings involved too that might help us make sense of what happened? Earlier you described yourself feeling scared …

Jermaine: I am scared. I just don't know how I'm going to support us. It's such bad timing – I'm in between jobs, what if I don't get another one? It's a frightening prospect.

Liz recognized that his behaviour towards his girlfriend didn't serve him well. His behaviour may even have been evocative or challenging to hear. However, Liz attempts to resist judging Jermaine's behaviour, without suggesting she approved of it either. She does this by acknowledging the feelings Jermaine reported to experience. She tries to demonstrate her acceptance by working with her belief that there were reasons underlying his behaviour, as yet unacknowledged and out of awareness to either of them, that reflected his distress in the moment of hearing the news. She does this by being open to the whole person sitting in front of her, including the Jermaine that is sitting across from her sighing deeply and able to reflect on what happened with hindsight. This includes accepting that Jermaine has multiple feelings that may appear in conflict with one another and yet are all valid.

Clients may experience a variety of emotions at the prospect of discussing what concerns them. For example, they may feel ashamed, fearful, sad or antagonistic. Often, they judge themselves harshly and anticipate criticism from others. We believe that clients who feel judged or blamed are unlikely to feel secure enough to begin exploring concerns and disclosing painful issues. It is therefore vital that you aim for, and work to maintain, a relationship that is accepting of who they are. However, it would be absurd to suggest that you are, or can become, judgement-free. Firstly, in order to work effectively with your clients, you will need to be continually hypothesizing and making assessments. This will involve making judgements about the content your clients bring, their process, and the process between you. Secondly, as therapists we bring our subjective self into the room which influences how we listen, experience and respond to our clients (see Chapter 3). What we can do, however, is approach our work with clients from a place of empathic understanding and with an appreciation that

clients – just like us – are doing the best they can and therefore deserve neither blame nor condemnation.

Acceptance is a key aspect of an effective therapeutic relationship. Research in this area suggests a significant correlation between therapists' unconditional acceptance for their clients and positive outcomes (Norcross and Hill, 2004), with studies indicating that the experience of a 'warm' and 'positively regarding relationship' are among some of the most valued aspects of therapy (Cooper, 2008).

To accept clients means appreciating and celebrating their differences and acknowledging the validity of their perceptions. Acceptance is neither a bland nor a resigned attitude. It is a strong, potent quality that recognizes the worth of your clients, receives and gives credence to what they disclose to you and believes in their ability to change.

Genuineness

Analogous to congruence and sincerity, genuineness is about how real we are as people in response to, and in relationship with, our clients. This quality demands authenticity, openness and 'visibility' without hiding behind a professional role. As Tolan (2017) writes, 'Congruence is that aspect of ourselves that is open and flexible – not given to distortion and denial' (ibid.: 44). The genuine therapist is, 'freely and deeply himself' (Rogers, 1957: 97).

Genuineness does not carry an imperative to voice all our feelings and thoughts about our clients. It is not an act of promiscuous self-disclosure. Rather, to be genuine in a therapeutic relationship means being aware and connected to your internal responses. Clients do sometimes act in ways that we don't like or get on with very well leaving us feeling, for example, irritated, frightened or bored. Having an awareness and connection with your inner feelings means that if you feel impatient with a client, you can identify and locate your impatience; if you feel angry with a client, you can own your anger. Genuineness is about being able to reflectively and reflexively consider the impact your client is having on you, paying close attention to the patterns and themes that emerge. Crucially – and this is one of the reasons why supervision is so helpful – it means separating what belongs to you and what belongs to clients. From this place of internal integrity and integration you are able to make choices about what you communicate about your internal responses to your clients, and what you do not. These choices involve sharing relevant aspects of your experience of clients with them in ways that they can both accept and use (Mearns and Thorne, 2007). This should be at the heart of your disclosures. This is discussed in greater depth in Chapter 5.

In the example of Jermaine's work with Liz, communicating her genuineness Liz might share something like this:

Liz: You know Jermaine, on hearing about how you reacted to your girlfriend with anger and blame, I found I was responding with some anger myself. I also felt a little frightened. I wonder if these feeling tell us anything about what was happening between you both?

Jermaine: I think she felt angry too … she shouted right back at me. I think I really hurt her … and the argument was frightening for us both. We've never argued like that before.

Research in this area has found that there is a significant relationship between the 'real relationship' (i.e. the extent to which therapist and client are genuine with one another and perceive each other in ways that are realistic) and therapy outcomes, suggesting that therapists need to attend to and strengthen this aspect of the therapeutic relationships with their clients (Gelso et al., 2018).

Being genuine and transparent promotes trust and safety. Some research studies have found that therapists' 'trustworthiness' is considered by clients to be one of their most important qualities (Cooper, 2008). In a genuine encounter, clients learn that their experience with you is trustworthy. This in turn cultivates a sense of trust in their own perceptions (Tolan, 2017). When clients trust in themselves, they can begin to learn more about the real 'inner me'. Genuineness also provides important modelling for clients. As you demonstrate authenticity, you implicitly provide your clients with opportunities for connecting to and expressing their own authenticity. Futhermore, as Evans (1994) argues, clients will pick up inauthenticity early and may withdraw. There is no 'fake it till you make it' in therapy – we cannot give our clients the impression of one thing (e.g. strong and authoritative) if we are actually feeling something quite different (e.g. frightened), imagining this to go unnoticed and as without impact. Clients are more likely to sustain their work with you if they have confidence in you and experience you as genuine.

The interrelatedness of the three qualities

Empathy, acceptance and genuineness are inextricably bound together, and we have abstracted them here for the purposes of discussion. They are the fundamental values that you will need to express explicitly and implicitly in order to build a strong therapeutic alliance. Clients may arrive in therapy feeling inept, powerless and unworthy. However, a relationship in which they are empathically understood, respected and acknowledged, and experience another human being as genuinely interested in them can be powerful. This frees clients to become engaged authors of their own wellbeing and help them to move from a position of alienation from both themselves and others to one of intimacy.

Empathy, acceptance and genuineness are not without challenges. Empathy requires us to not be afraid to feel – we must actuate our courage and resilience (De Young, 2015). To be accepting of our clients requires us to start with acceptance of ourselves (Tolan, 2017) and this is not always an easy task for many of us. Additionally, acceptance means meeting another exactly where they are and holding the creative tension between being a facilitator of change and having no expectations or conditions around that change. Genuineness demands a high level of self-awareness and honesty. This is why personal therapy, considered critical to the training process by all accredited training courses, can be so useful. Self-awareness and honesty may involve confronting aspects of ourselves that are uncomfortable or painful: 'For therapists as well as clients, therapy is a place where shadows can be confronted' (Bager-Charlson, 2010: xiii). These qualities are not about being perfect either – this would be an impossible and even unhelpful aspiration. In fact, 'misattunements' in therapy, which are followed by a process of repair and 're-attunement', teach us that we can not only survive

moments of difficulty and pain, but also return to a psychological and physiological state of calm with a renewed sense of resilience and courage (Schore, 2011). Clients do not need the perfect therapist; they need a relationship in which the other is available, open, understanding and reliable.

Finally, while your aim at the outset will be to create a therapeutic alliance, attending to the relationship will be a continuing and important task extending throughout your work together. This relationship will change as your work progresses. You may experience unsteady beginnings or go through periods of confusion and turmoil before free and open dialogue can begin. Your relationship will be one of the most valuable sources of information that you both have. Clients will show you much by the manner in which they relate to you about the shape and patterns of other relationships in their lives. In the Beginning Stage of working together you will be laying down secure foundations from which to stand, grow and thrive.

Skills needed to conduct an assessment

Assessment starts from the moment you and your client are in contact and begin forming ideas about one another. As well as making an assessment of what your client needs and whether you can help them, your client will of course be making an assessment of you. Your ability to build a good rapport and the quality of your developing relational bond will be important aspects of assessment, as these things will indicate to you both something about how you will work together. Therefore, you will be building on the skills outlined in the previous section, as well as the core skills outlined in Chapter 3 – in particular, attending, using the integrative framework for listening, listening to your internal responses and considering your listening filters. As the development of a relational bond has been discussed in the previous section, we focus here on other important aims of assessment. These are pictorially represented in Figure 4.1.

- What is the presenting issue?
- What are the contextual issues?
- How motivated is the client?
- Are there any risk issues to consider?
- Do you have the right level of competency to work with this client?

What is the presenting issue?

You will first need to understand and establish the issue(s) your client is bringing. By 'presenting issues' we mean issues which are uppermost in the client's mind. They may or may not be clear about their issue(s), or they may feel confused or overwhelmed by them. You will need to be able to tolerate these feelings and help the client towards greater clarity. This means neither seeking to neatly package clients' concerns nor assuming responsibility for defining the issues for them when frustration or anxiety builds. Rather, it requires embracing uncertainty, staying with complexity and ambiguity, being open to new information, and avoiding premature actions and conclusions based on minimal exploration. Equally, when clients present their problems in a precise manner it should not deter you from seeking further clarification. You will need to provide the

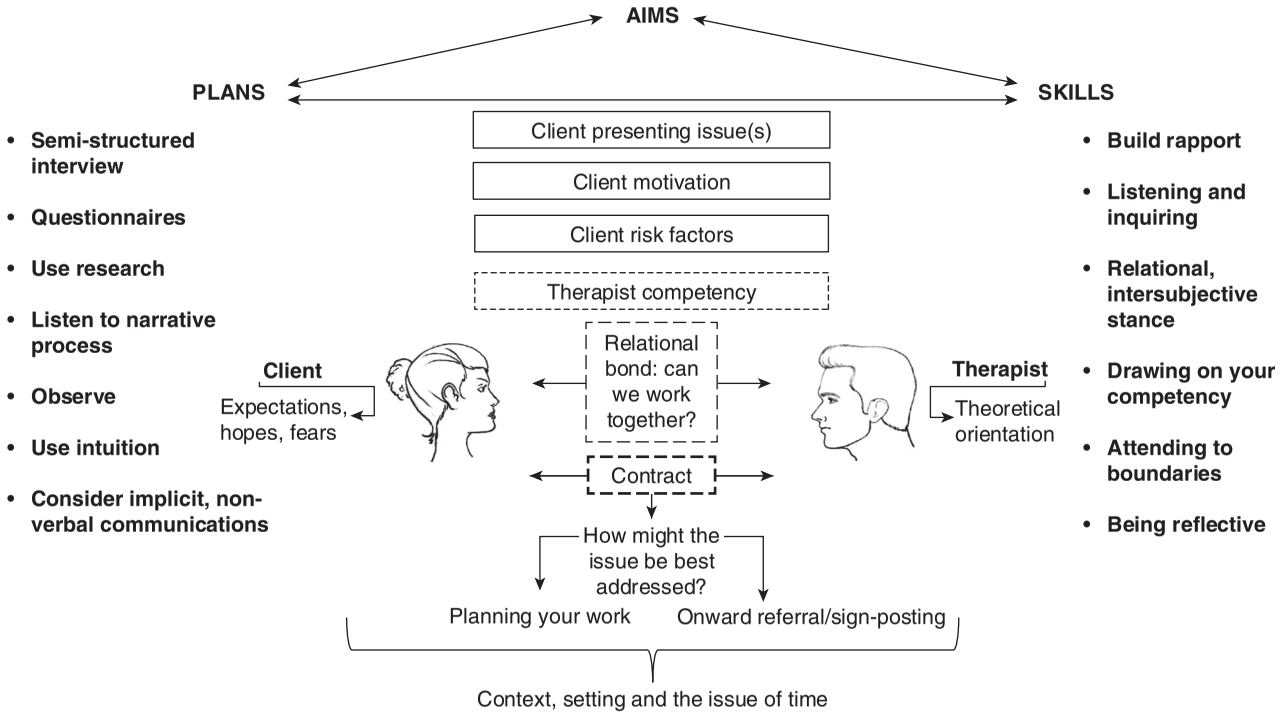

FIGURE 4.1 *Assessment and contracting*

time to explore their opening statements. Clarifying and reaching a common, working understanding with clients is an important activity, begun at the outset and forming the basis for subsequent deeper exploration, goal-setting and action.

Understanding your clients' presenting issue(s) will include understanding the particular meanings and beliefs they have about them, how they view themselves and how they feel they are impacted by them. This can be enhanced by obtaining contextual information (see below) and a history of the issue(s).

You will also need to be alert to signs of significant emotional and physical distress that may point to needing either the involvement of, or a referral on to, another professional such as a psychiatrist or medical professional (Palmer and McMahon, 1997; Daines et al., 2007). For example, if someone refers to physical pain, dizziness or headaches that do not have an obvious explanation in their account, it is worth asking if they have had a medical assessment and encouraging them to obtain one. Persistent feelings of anxiety or depression – especially if accompanied by changes in patterns of sleep or eating, repeated acts of self-harm, suicidal ideas or possible delusions – may indicate the need to involve another mental health professional. This is not to assume a pathology. Rather, it is to recognize that some coping mechanisms are more or less functional and may require the involvement of different kinds of support. Clients may be understandably anxious about seeking medical or psychiatric assessments. They may have chosen to discuss their concerns with you because you are 'outside' the medical world and they wish to explore alternative ways of addressing their problems. Care needs to be taken about raising the issue of further assessments in order that your client feels supported and respected.

Questions to help you understand your client's issue(s) include:

- How does the client define and describe the issue, and what do they share about its duration, persistence and possible trigger(s)?
- How does the issue affect the client?
- Are there any issues the client may be avoiding, dismissing or overlooking?
- What does the client believe about themselves, others and life?

What is the context?

Understanding the context within which your client lives means learning about their cultural context; current circumstances, including such things as whether they are in work and what their current living circumstances are; whether they have close and supportive relationships; and what is important to them. This is a good point at which to assess what resources they have, and lack, and what their current coping mechanisms are. As Joyce and Sills (2014: 191) write, 'The fact that our clients have survived so far means that they have already found enough resources to manage their situation and symptoms to some extent, even if these resources carry a heavy "downside"'. Their resources and ways of coping can help shed light on their issues, and also help you identify 'gaps' and strengths to build upon. It also means gaining some information about their past including their childhoods, previous relationships, history of health issues, and any events they ascribe particular significance to.

Questions to help you understand contextual factors during assessment include:

- How does the client invest their time and energy?
- What is important to know about their cultural context?
- What support systems does the client have (or lack)?
- What events, past and present, are important to them in terms of how they understand their current issues?

How motivated is the client?

Client motivation is a crucial element of the change process in counselling and psychotherapy and has been shown to be strongly associated with positive therapeutic outcomes (Cooper, 2008). You will need to develop an understanding of how driven your client is towards making changes in their lives. This is often a hugely complex area for evaluation as clients may desperately long for things to be different while simultaneously feel fearful about what change will involve and how it will affect their lives and relationships. This is understandable – therapy shakes things up! As well as being potentially healing, positive and transformative, it can have far-reaching consequences that can be challenging to manage. It will be useful to find out what has brought the client into therapy at this time and how realistic the changes they would like to see happen actually are. It will be equally important to evaluate the client's sense of personal responsibility around making changes, the support they have around them, and what they are expecting to happen in therapy and from you.

Questions to help you understand your client's motivation to change include:

- Why now? What has prompted the client to seek therapy?
- What are they expecting therapy to be like and how will they make use of it?
- How might they stop themselves from getting what they want?
- What have they previously tried to do to resolve their issues?

Are there any risk issues to consider?

'Risk' in counselling and psychotherapy refers to the risk of harm a client poses to themselves and/or others. This includes risk of self-harm or suicide. It is an extremely important element in any assessment as it helps you to make decisions about how to work safely with clients within a psychotherapeutic relationship (van Rijn, 2015). As with the assessment literature in general, it is beyond the scope of this book to discuss risk assessment at depth; however, we provide an overview here of some of the salient features of a risk assessment.

The *Cross-Government Suicide Prevention Workplan* (HM Government, 2019), led by the Department of Health, identifies groups of people who are at high risk of suicide. These include men, people in care of mental health services, those in contact with the criminal justice system and people with a history of self-harm. In addition, specific occupational groups have been found to be at greater risk of suicide than the national average for those within the age range 20–64 years. They include males working in the lowest-skilled occupations; individuals in culture, media and sport occupations (particularly females); females in health professions, particularly nursing; and male and female carers (Office for National Statistics, 2017). Non-fatal deliberate self-harm is more prevalent than suicide, but is also

associated with increased risk of suicide (Christiansen and Jensen, 2007; Hawton et al., 2003). Larkin et al. (2014) identified several factors that consistently showed associations with repetitious self-harm, which included previous self-harm, a diagnosis of personality disorder or schizophrenia, a sense of hopelessness, a history of psychiatric treatment, alcohol or drug abuse/dependence and living alone. Van Rijn (2015) suggests that an assessment of risk always needs to consider whether your client belongs to any of these at risk groups; whether your client is experiencing high levels of stress and how they are coping with that stress; and what protective factors play an active role in your client's life. These are factors which change, in some way, a person's response to the aforementioned areas of risk and act to guard against harm, such as personal resilience or having a reason to live.

Questions to help you assess your client's level of risk include:

- Does your client belong to any groups of individuals considered to be the most vulnerable to risk?
- Has your client experienced any stressful life events in their recent past?
- In terms of severity, how would your client describe their problems?
- What are your client's usual coping strategies, and what are their planned strategies for coping with the issues they have reported?

Do you have the right level of competency to work with this client?

As discussed in Chapter 3, therapist competency refers to the knowledge, skills, abilities and ethical understanding needed to work therapeutically. Questions and thoughts you may have around your level of competency to work with any particular client should be considered in supervision. As part of an assessment, you will need to be considering what you are able to bring to the work with the individual client sitting in front of you, and what your limits of competence are. These may include such things as needing specific training and experience with a particular issue (e.g. addiction), your capacity to work within a multidisciplinary team of professionals (e.g. working in particular settings such as the NHS) or an understanding of particular cultural values important to your client (e.g. understanding certain religious beliefs your client holds). Assessing your own competency with ethical awareness also requires you to consider what clients you feel you couldn't work with at the current time for personal reasons. These may be temporary (e.g. you may decide that while you are dealing with your own bereavement, you would struggle to work with another person's) or fundamental (e.g. you feel that the values you hold around animal welfare mean you are unable to work with someone who is cruel to animals). Paying close and candid attention to the impact the client has on you will invariably provide you with valuable insight into your level of competency.

It will also be important to consider your client's preferences for the kind of therapy they are looking for and assessing whether you are able to offer it, and if not what that may (or may not) mean for your work together. The client's preferences may include therapy method, format, therapist's relational style and characteristics, and therapy length (Norcross and Wampold, 2010). In light of the research suggesting that client preferences are linked to the success of therapy, Norcross and Wampold (2002) suggest explicitly discussing a client's strong preferences whenever it is practically possible to do so.

Questions to help you assess your competency to work with a client include:

- What kind of knowledge and/or experience will you need to work with the issues the client is presenting?
- Do you feel the client needs any form of specialist input for the issues they have brought?
- Does the client express any strong preferences for a particular style or type of therapy or therapist?
- What do you feel about this client and the issues they have brought?

Assessment is not and should not be viewed as a procedure that is 'done to' clients as passive recipients. It typically involves intensive and extensive exploration, during which clients will hear themselves describe themselves, their concerns and their lives, perhaps for the first time. It is important to foster an environment in which they feel able to be participants in this process, engaged to a greater or lesser extent, and remain mindful that, as a result, they may be affected and challenged by what you are discussing. Involving clients may be accomplished not only by using your skills and clinical experiences but also more concretely by encouraging them to develop self-assessment and self-monitoring techniques (Nelson-Jones, 2008). While assessment is intended to lead to working hypotheses and a plan for the way you work together, it is important that you preserve an open and flexible view of their issues. The most effective assessments are the result of collaboration between client and practitioner. It is important to remember that clients will also be making assessments of you, and this is an opportunity for them to see if you feel like the right therapist for them.

Assessment at the Beginning Stage means that both you and your client are working towards a shared 'good enough' understanding of what the issues and concerns are for them. It is an opportunity for the client to become clearer about their concerns as they put them into words to an attentive listener. It also means that you have started to acquire enough relevant information about how the client sees themselves and their concerns in order to make a preliminary assessment and to facilitate contracting.

Reflection point

'Ian'

Consider the following client referral:

Ian is a 40-year-old father of two, currently working as a scaffolder. Recently, he consulted his GP because of persistent low mood over the previous four months. He was prescribed anti-depressants and his GP referred him to the community counselling and psychotherapy service within which you work. A brief assessment was conducted over the telephone by one of your colleagues. Ian provided them with the following information.

(Continued)

Along with 'low mood', Ian also says he has been struggling to get to sleep at night despite feeling 'exhausted' by the end of the day. He also reported feeling 'really stressed out' about his working life as he may be facing redundancy.

Ian and his wife separated a year ago. Ian says he has often 'felt lonely' now that he lives alone. The only accommodation Ian could afford when he moved out of the family home was on the other side of town, further from both his children (aged six and nine) and many of his friends. He sees his children every other weekend and misses them a great deal. At the weekends he is pleased to have a break from work, but simultaneously he doesn't know how to spend his time when he isn't visiting his children. He used to enjoy playing football on a Sunday with his local team, but he doesn't feel motivated to join in anymore. He has two close friends who he meets with once a month. They frequently invite him to meet more often, but Ian says he doesn't want to 'intrude' on their lives and imagines them to be 'far too busy' to make time for him in reality.

Ian would like to 'feel normal again instead of constantly down and depressed, or stressed out'. He has never been in therapy before and doesn't know what to expect, but he is 'willing to give anything a go if there's a chance it will help'.

The colleague who is managing Ian's referral has asked you if you are available to meet with Ian for a formal, in-person assessment with a view to working with him should therapy seem appropriate.

- What do you understand to be Ian's presenting issues and what else do you need to ask him to clarify them?
- What features of Ian's story so far are you noting in terms of important contextual factors?
- What kinds of questions might you ask in order to establish Ian's motivation to be in therapy and to engage in change? Is there anything in your colleague's report that already speaks to that?
- Does Ian fall into an at risk group? If so, how might you use that information to inform the questions you ask him?
- Based on the information your colleague has provided so far, how do you feel about the prospect of working with Ian in therapy?
- What other questions do you find you are asking yourself about this prospective client?

Skills needed to agree a 'working therapy contract'

A discussion about the working therapy contract should involve at least three elements:

1. The type of help you are offering
2. The focus, process and direction of the work
3. The practicalities of your work

In order to do this, you will be building on the core skills already outlined, with a particular focus on working collaboratively with clear boundaries. Let's look at each element of your contract in turn.

Agreement for the type of help you are offering

What will probably matter most to your client is that you are trustworthy. You will begin to speak to this by being explicit and clear about interpersonal boundaries and exactly what kind of support and help you provide as a counsellor or psychotherapist. This may require you to clarify what you are offering and avoiding confusion with other types of relationship – for example, friendship, a sexual relationship, or one that offers support or assistance in the form of advice or practical action. Potential clients may have little direct experience of therapy and this aspect of a contract should entail clarifying what is likely to be involved for them should they decide to work with you. This will also involve being clear about the confidential nature of the work, including the limits of confidentiality. Confidentiality is one of the basic conditions of counselling and psychotherapy. It is essential for enabling someone to talk openly and freely about personally sensitive issues. The boundaries of confidentiality need to be stated clearly and, where appropriate, negotiated with clients. You will need to be alert to the non-verbal clues (body language, hesitancy, facial expression) that may communicate the client's desire for further discussion or information about this aspect of the contract.

A clear general statement on confidentiality might sound something like this:

> *Therapist:* What you say and do here is confidential. However, I want to say something to you that I say at the outset to every client. If I think you are in danger of harming yourself or anyone else, I may take steps to involve others. I will, if possible, discuss this with you first. Are there are any questions you want to ask me about that?

After responding to any questions or comments about how you will respond to risk issues, you may wish to open up discussion to anyone who may be routinely informed about your work together. For example a receptionist, or anyone involved in providing you with professional support on a confidential basis, such as your supervisor or experienced colleagues. These are all people who might be thought of as falling within a 'circle of confidentiality' that support your practice and for whom it would be impractical to seek a client's consent every time the client might be discussed.

> *Therapist:* There are a small number of people with whom I may discuss our work together on a strictly confidential basis in order to provide you with the best possible work. They are … Are there any questions you would like to ask? Are you willing for me to do this?

It is so much better for trust building to be clear at the earliest possible opportunity about how confidentiality will be managed and to have given the client an opportunity to raise any issues that concern them.

If you are working in an agency setting, the limits to confidentiality may be clearly outlined in policy and practice guidelines that will inform how you approach discussing confidentiality with your clients. It is important to familiarize yourself with important ethical issues on confidentiality and we have included suggestions for further resources below.

Clients will arrive with their own hopes, fears and expectations. Typically, clients will be asking themselves: Can I be confident that this therapist will be putting my best interests first? Will this therapist work to good standards of care and competence? Can I trust this therapist to respect the sensitivity of any personal information I share? Equally, clients may not be able to articulate their hopes, fears and expectations this neatly, but have more vague fears and hopes as to what it will be like to be in therapy and to work with you. These are all matters which can be considered and discussed explicitly and sensitively when negotiating the working therapy contract.

Defining the focus, process and direction of your work

The second aspect of the contract, defining focus, process and direction, is twofold. Firstly, you will need to determine what clients want to achieve (the goals of the work). Secondly, you will need to discuss the process of the work (the tasks). These are two key elements of the therapeutic alliance. We discuss each below.

Goals Agenda-setting and ordering of priorities are typical features of goal setting because clients often have multiple issues to deal with or problems with many facets. Client goals may be interpersonal (e.g. to develop greater intimacy in relationships, to find support from a therapist during a crisis), symptom related (e.g. to manage anxiety, to sleep better) or related to personal growth (e.g. to increase self-awareness, to identify and express feelings). Goals should be orientated to the client – that is, they are goals the client wants to achieve as opposed to goals you think they should have or other people in their life want for them. This may mean helping clients to discover what they want and value most. Making changes takes time and energy, and we are all more likely to work harder for goals that are our own, and less likely to sustain our investment in pursuing ends we do not value or which we see as imposed upon us. For example, a client's engagement and motivation towards achieving the goal 'My partner wants me to start working part time' will be fundamentally very different from their engagement and motivation towards the goal 'I really want to start working part time.'

At the start, clients may be vague about what concerns them. For example, they may know they are feeling uncomfortable but be unable to discriminate further, or they may have hunches that some of their behaviour is unhelpful or self-defeating but be unclear why. They may also use vague statements to protect themselves from the discomfort they anticipate they will experience when they describe in specific terms what their problems are. For example, a client might begin by stating, 'My partner and I don't see eye to eye any more and that's the problem' when what they want to say is, 'Our sex life is grim. We don't have sex as often as I would like and when we do it's boring. I'm thinking of leaving him.'

Two important things to keep in mind when considering a client's goal are: How realistic is the goal? and How will you know when the goal has been achieved? One way to help you and your client start to think about these questions is the SMART goal setting system, an acronym to help you assess how **S**pecific, **M**easurable, **A**chievable, **R**elevant and **T**imely the goal is.

Clients will need to distinguish what they can control from what they cannot and take responsibility for themselves and their actions. This is not to deny that clients have legitimate grievances and very real constraints, such as lack of money, poor housing or lack of qualifications, or that the social/cultural/familial context to which a client belongs should be ignored. Clients do not live in a vacuum and helping them to focus on themselves does not mean discounting the contexts in which they live and work.

It is not possible for clients to deal with every concern at once, and they will often need to prioritize. The following questions may be helpful in assessing priorities:

- What concern is causing the most distress?
- What concern would, if tackled, lead to the greatest positive outcome?
- Are there any concerns that could be relatively easily addressed immediately, and subsequently might give the client a greater sense of control and success?
- Which concerns can be dealt with through individual counselling or psychotherapy, and which may need to be addressed elsewhere (e.g. with a social worker, a GP, a psychiatrist, a physiotherapist, a lawyer)?

Ideally, priorities should be agreed in collaboration with the client and kept under review. As clients explore what is important to them, their priorities may change. They may also experience positive or unwelcome changes in their lives that necessitate some re-ordering.

Reflection point

Thinking about goals in therapy

Can you think of a goal you would like to set yourself, perhaps related to your interest and/or training in counselling and psychotherapy, or related to another aspect of your life? Try applying the SMART goal setting system to help you articulate your goal and assess your progress.

Specific: What exactly do you want to achieve?

Measurable: How will you measure goal achievement? (What will you see, think, feel, know or hear once the goal has been reached?)

Achievable: Is your goal genuinely and realistically attainable?

Relevant: Is this goal orientated to what you need and want, and is the focus of the goal you and your actions, thoughts and behaviours?

Timely: What timeline are you setting yourself for reaching your goal (and is this realistic?)?

Tasks The second element of defining this part of the contract involves a discussion and an agreed, mutual understanding of the process and 'in-therapy behaviours' of the work – that is, the *tasks*. These might include who takes the lead and sets the agenda for the session, the therapist's degree of directiveness, how much challenge the client wants or needs, or whether there will be any exercises for the client to do outside of the sessions such as completing a questionnaire. Because the tasks of the work also include an agreement on a commitment to meet, how frequently and over what period of time, there is some overlap between agreeing tasks and negotiating some of the practical elements of your working therapy contract.

Let's look at how a client Amal and her therapist Gayle considered the goals and tasks of their future work together.

Amal begins by telling Gayle that her relationship with Julia has been going through a 'rough patch'. They have been together for nine years, but for the last two years things between them have felt 'increasingly platonic'. She tells Gayle, 'I love Julia very much, but we feel more like friends than girlfriends these days.' Amal says they no longer have sex, they rarely socialize together and she can't remember the last 'date night' they enjoyed with one another. Amal has felt anxious about trying to talk to Julia about these issues as she has the strong impression that Julia is unconcerned, holding the belief that all long-term relationships end up this exact same way. Amal is aware that Julia's job is causing her a lot of stress and her low wage leaves her financially dependent on Amal to pay many of their bills. This all leaves Amal feeling guilty whenever she contemplates ending the relationship as she worries about how Julia will cope without her. Gayle begins by asking Amal what she would like for herself.

Amal: [*Sighs deeply*] I would like our entire relationship to change. I'd like to go back to how things were when we first met – we were all over each other back then. We had so much fun – travelling, festivals, dinners out with friends …

Gayle: Amal, I can really understand how much you must yearn for how things were … and yet I'm thinking about the place you find yourself in now and what you might realistically be able to do in the present.

Amal: I know, I know … can't turn back time, can we?

Galye: [*Smiles appreciatively*] Alas, no – therapy can't turn miracles.

Amal: Ok. Well, I guess I *do* want our relationship to change. Not to go back in time, but to become 'unstuck' and move forward. Whatever forward looks like – either together, or … ugh! This is really hard, but maybe even apart.

Gayle: Right, so I can hear you want your relationship with Julia to change. As Julia isn't here with us – this is individual therapy for you – I'm wondering what we need to focus on in *you* that might help you to feel less 'stuck'. You have talked about feeling guilty, for example, whenever you think about leaving the relationship …

Amal: Yes, I think my guilt would be an important thing to understand more. At the moment it's like I'm responsible for everything which feels unfair. I end up feeling a weird mixture of resentment and … like, sort of afraid – I find it so hard to talk to Julia about how I'm feeling.

Gayle: I wonder if we can be even more specific? You would like to examine your sense of responsibility in your relationship which at the moment feels one sided. You would also like to feel able to have an honest conversation with Julia about your feelings. How does that sound to you – about right, or do we need to tweak those goals?

Amal: Yes, that's it. Exactly.

Gayle: So, the next question is, how will we know when you have reached these goals? When I ask that I'm wondering, how will Amal feel? What thoughts will she have? How will her life be different?

Amal: I guess I'll feel like a weight has been lifted – freer! And I won't be having these awful thoughts about how I'm ruining Julia's life … I'm not sure what life will look like, but at a minimum I guess I will have had a conversation with Julia about how I'm feeling.

Gayle: I'm aware we have 12 sessions planned Amal. To your mind, do these sound like realistic aims within that timeframe?

Amal: I think so. I mean, I'd like to start by talking about how guilty I've been feeling and my sense of responsibility towards her.

Gayle: How about we start there and in a few sessions time, we check in to see how you're doing?

Amal: That sounds good.

Gayle: Ok. So Amal, in terms of how I work, I usually take my cue from clients – that means, I allow you to set the agenda for each session and we go from there. Therapy isn't about giving advice, it's more about exploring and thinking together. How does that sound?

Amal: That sounds OK … although I'm aware I have a tendency to go off on tangents. I managed to avoid a lot of difficult stuff with my previous therapist! I would appreciate it if you could 'rein me in'.

Gayle: I'm happy to try and identify, and tell you, when I think you or I have lost focus. How does that sound?

Amal: Good. And – will I have to do anything in between our sessions?

Gayle: I don't give you any concrete exercises to do … but it can be really helpful if you could find time to reflect on our sessions and share any thoughts you've had in between them. As we'll be meeting on a weekly basis, on the same day and at the same time, that'll mean committing some of your time to reflection every week. Does that sound feasible?

In this example, the therapist, Gayle, used the SMART goal-setting system to guide Amal in setting out her aims for therapy. Amal began with an unrealistic goal to go back to how things were when she met Julia, and Gayle makes an important point – 'therapy can't turn miracles'. This may seem obvious, but clients frequently arrive in therapy imagining that therapy, or the therapist, will be able to wave a magic wand. Arguably we can all be susceptible to longing for a magic fix to our problems, and this can often be seen in the therapy room. Gayle then prompts Amal to consider how relevant her aims are ('this is individual therapy for you – I'm wondering what we need to focus on in *you* …'), and when Amal talks about her feelings in response

to her situation (guilt, responsibility, fear) she helps Amal specify exactly what she wants to achieve ('I wonder if we can be even more specific?'). Gayle then turns to considering how Amal can measure her progress towards her goals ('how will we know when you have reached these goals?') and whether Amal feels it's reasonable to expect these goals to be achieved in the time they have available. Once Gayle has a 'good enough' sense of their mutually agreed upon goals for the work, she prompts a discussion about the tasks of their work. She does this by sharing with Amal a bit about how she normally works and aims to make this collaborative by checking out what Amal's thoughts are ('How does that sound?') and by taking into account Amal's request to help her stay focused.

Agreeing the practicalities of your work

This is sometimes referred to as the 'business contract' because it specifies the terms on which you will work together. However, in a working therapy contract it represents far more than that. The practicalities of working together, on which you agree, speak to the boundaries of your work and your relationship, albeit in a different way to the interpersonal boundaries. The way you both commit and adhere to them will contribute to the sense of mutual trust, safety and respect you have for the work you are undertaking together. These practicalities include: when and where you will meet; the frequency of your sessions; the fee; any administration that may need to be completed; the length of time you will work together (if this can be predetermined) and whether you will schedule review points in advance; your cancellation and holiday policy; and how you manage communication between sessions, including electronic communication.

Some or all of this aspect of your contract may be predetermined by the setting you are working in. Community counselling services and the NHS, for example, will have their own policies and procedures which you will need to adhere to and communicate to the client. The essential elements of a basic contract can be found in any relevant professional codes and ethical guidance. Remember that contracts are neither engraved in stone nor something to keep clients in line. You will need to be mindful about the power dynamics in your relationship with your client. Whether we like it or not, clients often see us as ideal, powerful and expert. Some clients may need to invest you with power, while others might want to compete with you. You will need to be sensitive to that when making an agreement with them; do so in the spirit of negotiation rather than imposition.

Preparing for and managing the first session

In this section, we propose a framework to guide you in preparing for and conducting your first session with a new client. The framework contains three broad components:

1. Consideration of client and therapist expectations
2. Making contact
3. Managing the first session

Consideration of client and therapist expectations

Prior to your first meeting, in the mind of your prospective client, you may have been given a form and a personality; they may have imagined themselves in a relationship with you and have fantasies about you as an individual. Clients are likely to have a plethora of expectations, including hopes and anxieties, about the therapy process (Oldfield, 1983; Mearns and Dryden, 1990). They may, for example, hope for a quick solution, advice or the 'right' answer. They may believe that you are the only person who can help them, or that no one can help them. Clients also experience feelings of relief and a renewal of hope and energy at the prospect of resolving their problems. Deciding to contact a specific therapist or accept a referral is often the start of a client taking control of their life.

It is important to acknowledge these expectations and provide opportunities for your client to explore them. They often provide valuable clues to understanding a client's internal world and how they might use the opportunity to work with you. For example, a client who expects you to have all the answers may be hampering their own progress by regularly looking externally, to others, to solve their problems.

Equally, as therapists, we are not immune to pre-meeting expectations, including hopes, fantasies and anxieties. We will probably imagine what clients will be like and how it will be to work with them. Our fantasies might begin with a voice on the telephone ('sounds angry') or might be fuelled by remarks made on referral – for example, 'This is a really difficult case. I thought of you immediately because you'll be able to help him through!' You will need to be aware of your own fantasies, the pressures you place on yourself, and the expectations of others such as referral agencies. Separating all this out as far as is possible will free you to connect honestly with clients and work with them to meet their needs for development and change. (For a discussion of transference see McLeod, 2009.)

Making contact

While you may establish the first session as the 'assessment session', it is worth observing the process of the client making contact with you and noting anything that may contribute to your overall sense of them. For example, if you have the opportunity to talk over the telephone in advance of your first meeting, you will be listening not only to what they say but also to the ways in which they are speaking – for example, are they hesitant or tearful? Pre-session contact is also an opportunity to consider with clients what they want, and to communicate to them that you are an empathic, accepting listener.

You may also want to encourage clients to use the time between your initial telephone conversation and the first face-to-face meeting by inviting them to do some pre-session work (Elton-Wilson, 1996; Dryden and Feltham, 2006) – for example:

- 'Will you give some thought to what you want to get from therapy. If it helps to write it down and bring the notes along with you, that's fine.'
- 'Between now and when we meet, will you notice the times when you feel more or less stressed out and what was happening at those times. It could be useful to our work if you noted down your observations.'

These kinds of interventions encourage clients to become more aware of themselves and their behaviours, thoughts and feelings. It is also possible that these kinds of interventions foster and promote their participation in, and responsibilities within, the process of therapy.

Managing the first session

You will have numerous responsibilities to attend to in the first session. Below we provide a 'Checklist and worksheet for preparation and management of the first session' which is intended to guide you through this process (Table 4.1). We begin by detailing the process. Firstly, you will need to *help your client feel welcome* and as settled as they can. This may include acknowledging any anxiety they are feeling in meeting you, or the importance of their decision to enter therapy. This demonstrates a level of respect which we feel is essential in building the foundations of a good therapeutic alliance. Settling in questions, such as asking them about their journey to your place of practice, or how they are feeling about arriving, can help to alleviate any anxieties. Starting in this way can also help set the pace for the session and avoids launching into discussing difficult and painful experiences too quickly.

Secondly, it is helpful to *provide the client with an overall sense of what your session will look like*, including the plan and aims for the first meeting. This removes any sense of mystery, decreases uncertainty (which may in turn decrease anxiety) and sets boundaries around your time together. You might say something like this:

> *Therapist:* We have 50 minutes together today. The purpose of this first meeting is to get to know each other a little. I would like to hear about what has brought you here today, and in turn you may have questions for me. I suggest we use the last ten minutes or so to discuss some of the practicalities of working together, but feel free to ask me any questions you might have as we go along. By the end of the session today I would like you to have a good idea of what having therapy will involve so some of your questions for me might be related to that.

In this introduction, the therapist sets out the time boundaries, plan and aims for the session. They attempt to ensure the client is very much part of the process of assessment by inviting them to ask questions. The therapist also leaves the discussion of practicalities to the end of the session and in this way the first session starts with what is most important – the client and the issues they bring.

A third task of this first meeting is to *acknowledge any pre-meeting contact you have had*, or information you have been given about the client from a referrer. This communicates a level of transparency in the process, which invites trust and offers a sense of safety. It will be important to keep the client at the heart of the process and remain mindful of the influence of any pre-session expectations you may have. It is therefore useful to start in the here-and-now and begin the process of exploration from there. You might do this in the following way:

Therapist: I know that you have already met with … and I was given some notes about your meeting. However, I would really like to hear about what brings you here today in your own words.

Alternatively, if you have absolutely no information about your client, you will need to acknowledge this too. In this way you are immediately responding to any expectations they might have about what you know about them:

Therapist: This is not only the first time we are meeting face to face, but also the first opportunity I have had to learn anything about you. It would be useful to start with what brought you here today.

It is important to bear in mind that clients may not know how or where to start. Reading and hearing about others' experiences is very different from actually being a client. There are problems with saying things like say 'start where you like' or 'start where you feel comfortable' because clients may neither like what they are doing nor feel very comfortable. These sorts of questions may also be *too* open and so broad they are difficult to answer. A client may begin with, 'I don't know where to start', or 'What do you need to know about me?' Responses that help them to begin the process of sharing something about themselves and exploring their issues include:

- 'What would be useful for me to know about you?'
- 'It's difficult for you to begin now that you're here. It might be helpful to start with something specific – perhaps you could tell me how you found out about this service?'
- 'You said you wanted help with … so perhaps you could begin with that?'

A fourth task for the first meeting is to *provide your client with some information about you and the therapy you offer*. Clients may want to know what theories you espouse or what techniques and strategies you use. They may have clear ideas about what they want from a therapist. For example, they may favour an active approach that focuses on what they can do now to resolve their problems and do not want to focus on their early past. They may have concerns about particular approaches or have previous experience of similar kinds of therapy and found it unhelpful. You will need to be able to describe how you work clearly, concisely and without recourse to jargon. You will need to be prepared to answer clients' questions meaningfully and non-defensively. It is worth considering how you might describe your work in advance of your first session. You might say something like:

Therapist: I'm interested in helping you to find ways of handling what is troubling you. I can best describe the way I work as listening carefully to what concerns you as well as what you are already doing to cope. I think that by talking your concerns through in some depth and having the opportunity to stand back from them, together we'll be able to find options for doing something positive about them and making changes.

Rather than:

> *Therapist:* Well, basically I have humanistic/existential/psychodynamic/CBT orientations (have you heard of any of these?), although not totally, so I borrow from other approaches if needed. In the early stages, I'll be empathizing with you and later on I'll confront any distortions I pick up. I'm really interested in the work of Freud/Klein/Rogers/Pearls. Lately I've become more interested in facilitating goal-directed behaviour. The research around this is really interesting …

The latter is confusing rather than clarifying. It is about the therapist's interests rather than what is going to be useful for the client. Jargon and technical language may be meaningless to potential clients and make you sound like a textbook. It also distances you from clients, and language that obscures can make already vulnerable clients feel even more intimidated. A good rule of thumb is – keep it simple.

A fifth task of the first session is to *formulate a provisional agenda or plan moving forward*. This will require discussing priorities with clients and negotiating the focus for the immediate work. The balance to be struck here is between developing a workable broad aim and subsequently formulating some interim or sub-goals that help clients to move towards that aim. The decision to work together along with aspects of the provisional agenda and the broad aim for the work will form an important element of your working therapy contract (see above).

The sixth and final task of the first session is to *manage the end of the session*. This needs to be done in such a way that you communicate your commitment to them moving forward. Acknowledge the effort, and for many courage, they have shown in attending. Set clear boundaries from the outset. Provide clarity on what happens next. And begin to give clients a positive experience of ending. This can be achieved in the following ways:

- Remind clients of the time available and give some notice of the ending. Covert glances at a clock do not signal open communication. Instead, you might say, 'We're doing fine, we have 15 minutes left. Let's recap on where we've got to so far.'
- Confirm the days and times for subsequent sessions.
- Make a commitment to begin with a particular issue in the next session – for example, 'That feels important to discuss. Let's pick that up next week.'
- Discuss and agree any interim tasks – for example, completing any administration.

The ending of the first session is a strategic moment in working together in which the therapist's respect for the client and the possibility of purposeful progress can be affirmed. This is a temporary ending until the next session.

There is a balance to be struck in the first session to ensure you are attending to the various tasks in hand. You will need to provide information and ask relevant questions, but also avoid talking too much yourself and ensure that the focus remains on your client. You will also need to respond to their questions in such a way that they remain involved and encouraged. You may also want to state explicitly that any decisions made, goals set or action taken will be theirs, that you will be helping them and not deciding for them or acting on their behalf.

TABLE 4.1 *Checklist and worksheet for preparation and management of the first session*

Pre-session Consideration of any information I have prior to the first in-person meeting (e.g. a conversation I have had over the phone with the client, or referral information I have received from a colleague or other professional): • What features of this client's story have I been struck by? .... • Is there specific information I need to clarify with them? .... • How have I been reflecting on this client? What expectations do I have of them? How have I been feeling about meeting them?	☐
In-session tasks The things I need to do during the session are: ☐ Be clear about the structure of the session, including the amount of time available ☐ Provide information about confidentiality ☐ Ensure the client has enough time to talk through their most pressing issues ☐ Establish the notion of shared responsibility for working together ☐ Provide information on how I work ☐ Discuss and/or clarify the fee, scheduling of future sessions, administrative tasks and any relevant policies	☐
Post-session Consider all the information I have obtained during the meeting, and reflect on the following ready for my next supervision session: • How have I understood the client's key issues and did we have a shared understanding of those? .... • Are there any risk issues I need to think about with my supervisor?	☐

(Continued)

TABLE 4.1 *(Continued)*

• Did I feel we made a reasonable connection? Do I feel we have the potential for a good therapeutic alliance? .... • Is there any information I think I need about this client that I didn't manage to obtain? .... • How do I feel about working with this client?	

Summary

This chapter has been concerned with the Beginning Stage of the therapeutic work, which is principally about establishing a therapeutic working alliance, conducting an assessment and agreeing a working therapy contract. In this chapter we have introduced some key concepts for working therapeutically in this early stage with a client. These have included the relational (or therapeutic) bond, and the qualities of empathy, acceptance and genuineness. We have discussed how the skills you employ to demonstrate these qualities will build on the core skills outlined in the previous chapter. We have also outlined important areas to consider when undertaking assessment, including presenting issues, context, client motivation, risk factors and your own competency. In addition, we considered how to agree a working therapy contract, which we divided into three areas for discussion with your client: the type of help you are offering; the focus, process and direction of the work; and the practicalities of your work. This included a discussion on therapeutic tasks and goals. Finally, we looked at how you might prepare and manage your first session with a client and we have offered a 'Checklist and worksheet for preparation and management of the first session' to help guide you in this process. In the next chapter we consider the Middle Stage of the work and helping clients to explore their concerns in a purposeful way.

Further resources

- Johnstone, L. and Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. and Read, J. (2018) *The Power Threat Meaning Framework: Towards the Identification of Patterns in Emotional Distress, Unusual Experiences and Troubled or Troubling Behaviour, as an Alternative to Functional Psychiatric Diagnosis*. Leicester: British Psychological Society.
- Rogers, C. (1980) *A Way of Being*. New York: Houghton Mifflin Company.
- Safran, J.D. and Muran, J.C. (2000) *Negotiating the Therapeutic Alliance: A Relational Treatment Guide*. New York: The Guilford Press.
- Van Rijn, B. (2015) *Assessment and Care Formulation in Counselling and Psychotherapy*. London: SAGE.

Online resources

Visit https://study.sagepub.com/staffordandbond4e to watch:

Video 4.1 Can You Help Me? – Scenario

Video 4.2 Can You Help Me? – Discussion

Video 4.3 Contracting – Scenario

Video 4.4 Contracting – Discussion

Video 4.5 Being Non-Judgemental

Video 4.6 Client Autonomy – Scenario

Video 4.7 Client Autonomy – Discussion