THIRD EDITION

Clinical Psychology for Trainees

Foundations of Science-Informed Practice

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Werner G. K. Stritzke
and Peter M. McEvoy

CAMBRIDGE Medicine

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Chapter 1

A Science-Informed Model of Clinical Psychology Practice

There has never been a better time to train as a clinical psychologist for three reasons. First, there is an increasing response to the recognition of the unmet need in mental health which is resulting in an increase in the number of clinical psychology jobs. Second, clinical psychology is enjoying a privileged position in mental health care because of its ability to provide an evidence-base for the services it offers (Newnham & Page, 2010). Thus, despite the expense incurred by the provision of psychological services, we can show that their effectiveness assures savings that offset those costs. Third, the pandemic associated with COVID-19 has put the spotlight on evidence-based decision-making in health-care. It has been possible to model the impact of various public health interventions and some nations and states have used this to guide decision-making to good effect. Some areas have made decisions based on criteria other than the health evidence and the impact on health at the state and national level has been evident. In addition to the impacts of the disease itself, the pandemic has drawn attention to many existing unmet needs in the area of mental health (Marques et al., 2020) and ongoing, technology-driven changes have been accelerated in therapy delivery modalities and legal and reimbursement codes for therapy at a distance. The pandemic has also pointed to the need for a flexible and responsive attitude to the data. For example, some of the early dire predictions of the impact of COVID-19 on suicide have not been supported (Pirkis et al., 2021), and reminded many that we neglected older data showing that national crises can be protective against suicide, arguably due to improved social cohesion (Botchway & Fazel, 2021)). This is the exciting challenge facing the graduates of today's programmes: how will you shape clinical psychology?

Considering the first of these points, governments across the world are acknowledging the need to deal effectively with mental health. Within the United Kingdom, the response has been the development of an Improving Access to the Psychological Therapies (IAPT) (NHS, 2021) programme. This initiative aims to deliver interventions for people with depression and anxiety disorders that have been approved by the National Institute of Health and Clinical Excellence (NICE). In the United States, the Affordable Care Act (ACA) aims to improve equitable access to an improved quality of mental health care. In Australia, the Better Outcomes in Mental Health Care (Department of Health, 2021) programme improves community access to quality primary mental health care by providing access to allied psychological services which enables general medical practitioners to refer consumers to allied health professionals who deliver focused psychological strategies. Thus, the desire being expressed internationally (and tailored to the specific contexts of each nation) is to increase access to

mental health services. This desire is leading to an increasing demand for mental health professionals who are able to provide the treatments required.

Second, there is a common theme across the international initiatives to increase the quantity of mental health care; namely a focus on quality. Funding agencies want to ensure that they receive value for money. Consequently, funding is often limited to treatments that have a strong evidence base. Private and public funders are looking to allocate scarce health care resources to areas where there is an assurance that treatment is effective and efficient (McHugh & Barlow, 2010). The profession of clinical psychology has enjoyed a privileged position as a result of these pressures because it has a long history of accountability (Lilienfeld, Ammirati & David, 2012). Its professionals are trained in the critical skills required to evaluate evidence and research methods to generate data on both existing and new treatments (Pachana et al., 2011). The status afforded to clinical psychologists, by virtue of their long history in demonstrating the accountability of their treatments, has meant that the profession as a whole benefits from the research base documenting the efficacy, effectiveness and efficiency of psychological treatments (Barlow, 2010; McHugh & Barlow, 2010).

We are at a juncture when clinical psychology will carve out a path that will affect the profession as it goes forward (Barkham, Hardy & Mellor-Clark, 2010; Castelnuovo et al., 2020; Gruber et al., 2020). The decision facing the profession is: will science-informed practice inform the future practice of clinical psychology? The perception that psychology is scientific is not universal (Lilienfeld, 2012). Thus, will science continue to inform the future practice of clinical psychology (see Lilienfeld & Basterfield, 2020; Safran et al., 2011; Stewart, Chambless & Baron, 2012)? To contextualize this decision, we will now discuss a revision of the psychiatric classification system.

Allen Frances chaired the committee responsible for the fourth revision of the American Psychiatric Association's diagnostic system; the *Diagnostic and Statistical Manual of the Mental Disorders* (DSM-IV). After the publication of the fifth revision (i.e., the DSM-5) he wrote a book, *Saving Normal* (2014), in which he cogently critiqued the new taxonomy and the malign forces which he believed to be responsible for the errors. As a psychiatrist writing from retirement, he was excluded from any decision-making, but there is another level on which the book can be read. Much of his invective is directed at the multinational pharmaceutical companies who, in his opinion, control the agenda and directly and indirectly influence the formation of diagnostic categories and the uses to which they are put. However, what is clear is that Frances has seen (perhaps too late) the predicament that psychiatry has found itself in. In recent years, the number of prescriptions for medications used to treat mental health conditions has increased to meet the rising demand. Since the number of psychiatrists has remained relatively static, general practitioners have taken over the role of key provider of psychopharmacology. Psychiatrists have been relegated to the position of small players in a big market and their voice, once pre-eminent, has become one among many. For example, the head of the Royal Australian and New Zealand College of Psychiatrists echoed the same sentiment in an interview (ABC, 2014) where he noted that some groups in the community were increasingly more likely to seek advice from their GP rather than a psychiatrist. Thus, psychiatry is realizing that its pre-eminent position in mental health care has been eroded. As society has realized that the burden of mental health care is far larger than psychiatry can ever manage, it has sat by while other professions have stepped up to the task.

This cautionary tale provides clinical psychology with a window of opportunity. In the coming years the profession of clinical psychology will be settling itself down into the new mental health care environment. Clearly there are not enough clinical psychologists to meet the mental health care needs of the twenty-first century; clearly, there will never be enough (Kazdin, 2011). The appropriately stringent and lengthy training of the profession will always be a limiting factor. Therefore, the exciting challenge for clinical psychologists is how to adapt themselves to this new environment. If the profession continues in the way it has been operating, it risks losing its pre-eminent role, just as psychiatry has. The remainder of the book will outline one possible future, where we will argue that clinical psychology must be a science-informed practice. By continuing to develop, evaluate and offer evidence-based treatments; by delivering treatments in a monitored error-correcting clinical practice (Lillienfeld & Basterfield, 2020; Scott & Lewis, 2015); by training other mental health professionals in evidence-based treatments; and by fostering skills that complement (rather than duplicate) those of our colleagues in other professions, clinical psychologists will bring to the mental health team an expertise that will ensure them a continuing strong future (Barlow, 2010; Ward et al., 2018; Youngstrom et al., 2017).

These are both exciting and challenging times and the profession of clinical psychology has a bright future ahead. We are confident because psychologists know that the best predictor of future behavior is past behavior. If we consider the history of clinical psychology, we can see that a science-informed approach to practice has served the profession well. Last century, Hans Eysenck (1952) threw down the gauntlet to clinical psychologists when he reviewed the 24 available studies and concluded provocatively that individuals in psychotherapy were no more likely to improve than those who did not receive treatment. Although the conclusion itself was questionable given the extant data (Lambert, 1976), the field responded assertively and effectively to these criticisms (e.g., Meltzoff & Kornreich, 1970). Perhaps the most effective response came from Smith, Glass, and Miller (1980). Using meta-analytic statistical techniques to review 475 studies, they provided *quantitative* support for the conclusion that psychotherapy was superior to both no-treatment and placebo control conditions (see also Andrews & Harvey, 1981; Prioleau, Murdock & Brody, 1983). More recently, reviewers in the USA, the UK and Australia have sought to take the next step and identify criteria for empirically supported treatments, thereby providing listings of treatments that are "effective" for particular disorders (e.g., Andrews et al., 1999; Chambless & Hollon, 1998; Nathan & Gorman, 2015; Roth & Fonagy, 2004; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). In parallel, other reviewers have collated evidence regarding the effective components of psychotherapy relationships (e.g., Norcross & Lambert, 2019; Norcross & Wampold, 2019; Orlinsky, Grawe & Parks, 1994; Orlinsky, Rønnestad & Willutzki, 2004). Together, these two lines of research provide a strong response to Eysenck's criticism. While people continue to debate the relative merits and contributions of the psychotherapy relationship and the specifics of particular therapies (e.g., Asnaani & Foa, 2014; Laska, Gurman & Wampold, 2014; Norcross & Lambert, 2019; Norcross & Wampold, 2011; Wampold, 2001), the conclusion that psychotherapy is better than no treatment, and better than a supportive caring relationship alone, is strongly supported.

Thus, Eysenck's provocative comments spurred a spirited and methodical response that allowed clinical psychology to clearly defend itself against general criticisms of

ineffectiveness. In addition, the profession is able to identify, with increasing precision, the relational and specific therapeutic factors that mediate clinically meaningful change. Why was clinical psychology able to respond so effectively?

The Scientist-Practitioner Model

Arguably, the manner and effectiveness of the response owes a debt to the origins of clinical psychology within the scientific discipline of psychology and to an early and sustained commitment to a scientist-practitioner model (Eysenck, 1949, 1950; Raimy, 1950; Shakow et al., 1947; Stewart, Stirman & Chambless, 2012; Thorne, 1947; see Hayes et al., 1999; Pilgrim & Treacher, 1992 for historical reviews). From the establishment of the first clinical psychology clinic by Lightner Witmer, it was clear that science and practice were strategically interwoven (Norcross & Karpiak, 2012). For instance Witmer (1907, p. 9) wrote,

> The purpose of the clinical psychologist, as a contributor to science, is to discover the relation between cause and effect in applying the various pedagogical remedies to a child who is suffering from general or special retardation ... For the methods of clinical psychology are necessarily invoked wherever the status of an individual mind is determined by observation and experiment, and pedagogical treatment applied to effect a change.

Although there has been much written about the scientist-practitioner model, the broad principles are that clinical psychologists, as scientist-practitioners, should be *consumers* of research findings, *evaluators* of their own interventions and programmes, and *producers* of new research who report these findings to the professional and scientific communities (Hayes et al., 1999). The commitment to an ideal of combining research and practice has infused the profession of clinical psychology to such a degree (e.g., Borkovec, 2004; Martin, 1989; McFall, 1991) that the response to Eysenck's scepticism (see also Peterson, 1968, 1976a, 1976b, 2004) was not an appeal to the authority of a psychotherapeutic guru, nor a rejection of its legitimacy followed by attempts to ignore it; rather, the profession produced and collated empirical data to refute the claim (Butler et al., 2006).

Despite the success of the scientist-practitioner model in shaping clinical psychology as a discipline committed to empiricism and accountability, advocates of the model have not been blind to its failure to achieve the ideal (Hayes et al., 1999; Nathan, 2000). Shakow et al. (1947) of training individuals who could not only be scientists and practitioners, but could blend both roles in a seamless persona. They sought to achieve this goal by giving an equal weighting to research and practice in training programmes. However, ensuring the mere presence of these two equally weighted components did not by default produce an integrated scientific practice and did not win the hearts and minds of many graduates. In the words of Garfield, "unfortunately, (psychologists in training) are not given an integrated model with which to identify, but are confronted instead by two apparently conflicting models – the scientific research model and the clinical practitioner model" (Garfield, 1966, p. 357; Peterson, 1991). More recently, there have been renewed efforts to provide a concrete instantiation of scientific practice (Borkovec, 2004; Borkovec et al., 2001; Scott & Lewis, 2015). Hayes and colleagues (1999) attributed the apparent lack of better science-practice integration to two factors: First, the "almost universally acknowledged inadequacies of traditional research methodology to address issues important to practice", and second, the "lack of a clear link between empiricism

and professional success in the practice context" (p. 15). Our goal in the remainder of the book is not to address the first of these concerns (see Hayes et al., 1999; Neufeldt & Nelson, 1998; Seligman, 1996a), but to speak to the second. Our goal is to articulate ways that a scientific clinical psychology can be practiced.

The Aim of This Book

Our aim is to assist the student of clinical psychology to contemplate a scientific practice and to develop a mental model of what a scientist-practitioner actually *does* to blend state-of-the-science expertise with quality patient care. Our goal is not to describe a model of clinical practice (e.g., Asay et al., 2002; Borkovec, 2004; Edwards, 1987), nor to outline a broad conceptual framework for a scientist-practitioner (see Beutler & Clarkin, 1990; Beutler & Harwood, 2000; Beutler, Moliero & Talebi, 2002; Fishman, 1999; Hershenberg, Drabick & Vivian, 2012; Hoshmand & Polkinghorne, 1992; McHugh & Barlow, 2010; Nezu & Nezu, 1989; Schön, 1983; Spencer, Detrich & Slocum, 2012; Stricker, 2002; Stricker & Trierweiler, 1995; Trierweiler & Stricker, 1998; Yates, 1995), or even to portray a scientifically grounded professional psychology (Peterson, 1968, 1997), since each of these has been effectively presented elsewhere. Our aim is to consider each of the core competencies that a trainee clinical psychologist will acquire with the following question in mind: "how would a scientist-practitioner think and act?" The value of the scientist-practitioner model as a sound basis for the professional identity and training of clinical psychologists lies in its emphasis on generalizable core competencies, rather than specific applications of these core competencies to each and every client problem or service setting (Shapiro, 2002). Accordingly, we will first describe our conceptual model of the core elements of science-informed practice. Then, in the remainder of the book, we will illustrate how this model allows individual practitioners to provide value for money in a competitive health care market indelibly shaped by the forces of accountability and cost-containment (see also Detweiler-Bedell et al., 2003; Fishman, 2000; Kraus et al., 2011).

A Science-Informed Model of Clinical Psychology Practice

The starting place for any action in clinical psychology practice is the client and his or her problems. Therefore, the discussion of a science-informed model needs to begin with the client. In addition, the meeting of client and therapist involves a relationship, so that at its heart the interaction is relational. The beginning of the relationship involves the presentation of the client's problems to the clinical psychologist. As shown in Figure 1.1, this information is conveyed to the clinician (depicted by the thin downward arrows) and some of it passes through the "lens" of the clinical psychologist. This lens comprises the theoretical and empirical literature as well as clinical (and non-clinical) experience and training. It serves to focus on the information about the client. Continuing with the lens metaphor, not all the information passes through the lens (indicating by some arrows missing the lens) because clinicians will be limited by the level of current psychological knowledge, their theoretical orientation and the extent of their experience. The client might also not disclose important information that would otherwise influence clinical decision-making. For example, the client might not initially see the relevance of particular information or may not be aware of it in the initial phases of treatment. Information may also be intentionally withheld because of shame, at least until trust has

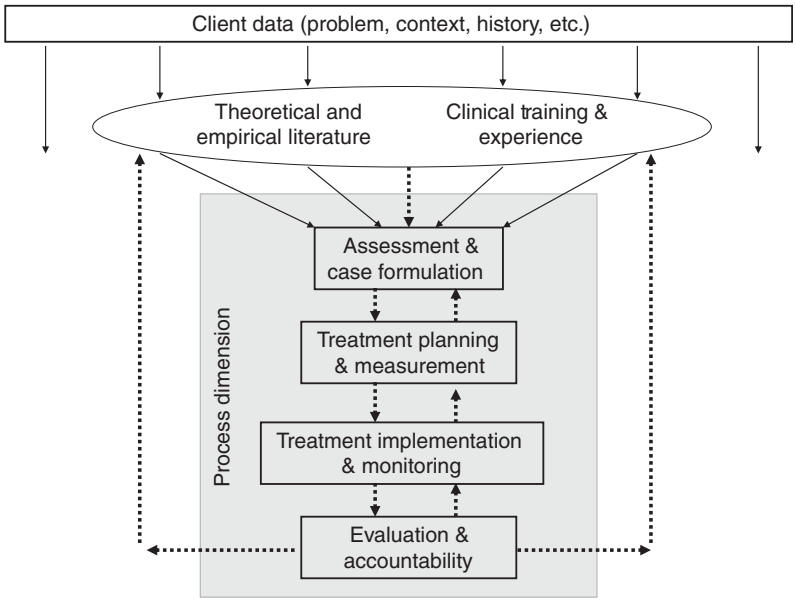

Figure 1.1 Linking client data to treatment decisions using case formulation.

been developed in the psychologist. The clinician needs to be alert to relevant new information that emerges during therapy so that it can be integrated into the treatment plan.

As with all metaphors, the notion of a lens filtering client data is limited in that it does not capture the dynamic nature of the interaction between client and clinician. The client is not analogous to a light source passively emitting illumination, but a client actively engages in an interactive dialog with the clinician so that the information elicited is influenced by the clinician's responses, and the material the client proffers in turn influences how the clinician chooses to proceed. Thus, the interaction between client and clinician is a rich and dynamic dialogue, but while it has the potential to be a free-ranging and unconstrained discussion, the process has an "error correcting" mechanism, whereby the clinician focuses on the information and channels it into diagnosis and a case formulation. The case formulation, described later, provides direction to the decisions that a clinical psychologist, together with the client, makes about treatment (indicated by the dotted arrows), which are then implemented and their outcomes measured, monitored and evaluated. These processes involve feedback loops, so that information garnered at each stage feeds back to support or reject earlier hypotheses and decisions in a cycle of error correction.

Finally, there are processes associated with the public accountability of clinical practice. The results of treatment are fed forward by the clinical psychologist to modify the theoretical and empirical bases of practice. In addition, the results will be fed back to inform the person's clinical experience that will guide future clinical practice. Dissemination of evaluations of clinical practice outcomes serves not only to demonstrate that the practice is accountable, but also ensures the sustainability of clinical psychology. In the same way that logging forests without replanting new trees is unsustainable because

it starves the timber industry of its raw material, if clinical psychology fails to replenish its resources (effective assessment and treatment), then it will be unsustainable. Other professions will step forward with potentially more efficient and effective alternatives to those that are presently available. To stretch the logging metaphor further, trees will grow stronger over time if weaker branches are removed so that finite resources and energy can be redirected towards strengthening the trunk. Likewise, psychologists' iterative use of evidence-based practice and practice-based evidence provides new knowledge about less effective or efficient approaches that need to be cleaved off so that therapeutic time and effort can be redirected into approaches that have demonstrated the strongest and most rapid effects. Thus, we would agree with Miller (1969) that, "the secrets of our trade need not be reserved for highly trained specialists. Psychological facts should be passed out freely to all who need and can use them in a practical and usable form so that what we know can be applied by ordinary people" (pp. 1070–1071). We can "give psychology away" in the sure knowledge that we are capable of generating new knowledge at least as fast as we can disseminate existing knowledge.

Operating alongside the skills associated with each of the elements of linking client data to case formulation to inform treatment planning and implementation is the process dimension, upon which all therapeutic content is superimposed. The "superimposed" nature of therapeutic content on therapeutic process is reflected in Figure 1.1, where process is shaded behind assessment, treatment planning and measurement, treatment implementation and monitoring, and evaluation and accountability.

Process refers to the interactions between therapists and clients. Clients come to therapy with a range of experiences, relational patterns and beliefs that will play out during therapy sessions. For example, clients with a history of maltreatment or abuse may expect further maltreatment from others, including the therapist. Strategies clients use in an attempt to prevent these feared outcomes will differ (e.g., overly compliant and eager to please, defensive, or sarcastic interaction styles), but they aim to serve a common protective function. Freud (1912, cited in Parth et al., 2017) initially coined the term *transference* to capture the idea that clients may transfer or re-enact patterns of relating to others learned in the context of developmental relationships into the therapeutic relationship. The term *countertransference* reflects all of the responses therapists have to their clients. For example, a client who is meek and overly apologetic ("client stuff") may initially elicit nurturance and support followed by frustration and rejection from others, and the therapist may also experience these feelings as therapy progresses. On the other hand, therapist-induced countertransference occurs when the client triggers the therapist's own problematic beliefs or relational patterns ("therapist's stuff"). For example, a therapist might feel resentful or dismissive of a client who reminds them of a parent with whom the therapist has a problematic relationship.

Although the concepts of transference and countertransference initially derived from psychoanalytic theory, the idea that clients' (and therapists') relational styles contribute to therapeutic outcomes is pan-theoretical and is supported by empirical evidence (Cartwright, 2011; Gelso, 2014; Parth et al., 2017). Cognitive therapists can easily accommodate these concepts within cognitive theory by referring to constructs such as core beliefs and schemas (Cartwright, 2011). Therapists will benefit from an ability to identify and formulate the process dimension, but in some instances they may choose to circumvent process issues during therapy. For example, in very brief therapies there may not be time for significant process issues to emerge between the therapist and client, or

the therapy may be focused on teaching specific skills and addressing broader relational styles may not be a priority or necessary. In these instances, therapists may simply use their awareness of process issues to formulate their own reactions to the client and to use this knowledge to guide the way in which they relate to the client to optimize engagement so that process issues (e.g., ruptures) are less likely to interfere with therapy outcomes (Cartwright, 2011; Gelso, 2014; Parth et al., 2017) . Therapists who are unable to identify, formulate and respond effectively to clients' interpersonal styles are at risk of replicating and reinforcing these problematic patterns. Effectively responding to unhelpful relational styles can reduce the risk of ruptures in the therapeutic alliance, non-adherence to treatment and client dropout. This book will draw readers' attention to potential process issues that may emerge at each stage of therapy, and how these can be understood and managed by trainee clinicians, to optimize effectiveness.

Stakeholders in the Practice of Clinical Psychology

In the previous section we outlined how the foundations of science-informed practice rest on the clinical psychologist assuming three interrelated roles. Clinical psychologists are consumers of research, in that they draw on the existing theoretical and empirical literature, they are evaluators of their own practice, and they are producers of new practice-based research and knowledge. However, the style of research and type of research product varies according to the stakeholder. Three classes of stakeholders can be identified (see Figure 1.2). The first stakeholder is the *client* (included in this category are the client's family, friends and supporters). The second class of stakeholder is the *clinician*, including the professional's immediate employment context (e.g., clinic, hospital, government department). The final class of stakeholder includes the broader *society* comprising individual members of society, government agencies, professional groups, academics and the private sector. The type of research that each group will be interested in is displayed schematically in Figure 1.2

Clients have a legitimate interest in efficacy studies. Efficacy studies demonstrate in randomized controlled designs the superiority of a clinical procedure or set of procedures, presented in a replicable manner (e.g., using a treatment manual) over a control condition. The research has clearly defined inclusion and exclusion criteria, with an adequate sample size, and participants are evaluated by assessors blind to the experimental condition. Collating information across a group of efficacy studies permits the identification of evidence-based or "empirically supported treatments" (e.g., Andrews et al., 1999; Chambless & Hollon, 1998; Nathan & Gorman, 2015; Roth & Fonagy, 2004;

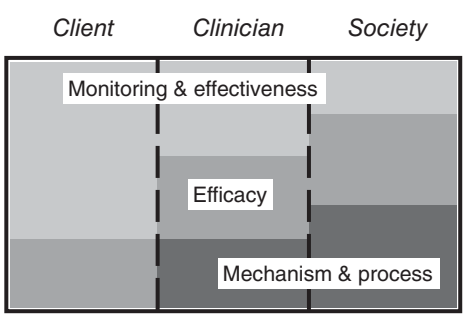

Figure 1.2 The relevance of three types of research activity in clinical psychology for three classes of stakeholder. The larger the area, the greater the relevance for a particular group.

Task Force on Promotion and Dissemination of Psychological Procedures, 1995). Clients may find this information useful in deciding which treatment has a good probability of success for carefully selected groups of individuals with problems like their own.

Clients will have an even greater interest in the effectiveness of a given treatment and ongoing monitoring of their own condition. That is, effectiveness research evaluates treatments as they are usually practiced. In contrast to the treatment described in efficacy studies, clients who present for treatment may have multiple problems, may not meet all diagnostic criteria and will choose (rather than being randomly assigned) to receive a particular treatment whose duration is aimed to match their needs. The clinician may modify treatment based on a client's response. Within this class of research one can include studies that examine the generalizability of efficacious treatments to "real-world" settings (e.g., Peterson & Halstead, 1998), consumer surveys (e.g., Seligman 1995, 1996a, 1996b), as well as information on the outcomes of a specific clinic or clinician. Effectiveness can also be used broadly to refer to the measurement of change (e.g., pre- and post-treatment) within the client in question, the ongoing and idiographic monitoring of the client's problems (see Dyer, Hooke & Page, 2014; Hawkins et al., 2004; Howard et al., 1996; Lyons et al., 1996; Newnham, Hooke & Page, 2010a; Sperry et al., 1996 for examples) and issues concerning service delivery. Arguably, as the data become more personal, they become more relevant to the particular client and those who may be involved in the client's care. Thus, in the left-hand box in Figure 1.2, proportionally more space is allocated to monitoring and effectiveness (light gray), than efficacy research (gray) to reflect the interests of an individual client.

Moving to the far right-hand side of Figure 1.2, the interests of society are depicted. In contrast to the individual client, society will have a general interest in knowledge about the effectiveness of treatments but will have no particular interest in monitoring the progress in treatment of a particular individual. Thus, the relevance of monitoring and effectiveness studies (light gray) is less for society in general than the individual, indicated by the smaller proportion of the right hand rectangle devoted to it. Society will have a greater interest in knowing the results of efficacy studies, so that governments and investors can make rational planning and funding decisions and services can be efficiently and effectively managed. Additionally, society takes an interest in a research agenda that may have little interest to individual clients, namely the research on the mechanisms and processes of disorders and treatment (dark gray). Included within this category of research endeavor are investigations of descriptive psychopathology and the etiological mechanisms that initially cause or maintain a set of client problems as well as those mechanisms involved in client change (e.g., O'Donohue & Krasner, 1995). The category also includes research into the process of psychotherapy (e.g., Norcross & Lambert, 2019; Norcross & Wampold, 2019); that is, research on the relationship variables critical to client improvement.

Standing between the clients on the one hand and society on the other, is the clinical psychologist. Clinical psychologists share the interests of both the client (in the monitoring and measurement of each client's particular problems and the delivery of the most efficacious treatment) and society (in understanding the fundamental mechanisms involved in each problem a client may present with and knowing which treatments are efficacious for a particular problem, and the degree to which these treatments translate into practice). For example, for the present authors, when we manage our clinic's smoking cessation (Stritzke, Chong & Ferguson, 2009) and anxiety disorder

programmes (Andrews et al., 2003; Page, 2002a) we not only want to know that the programs are empirically supported, that they are effective outside the centres where they were tested on carefully selected samples, but we need to be able to demonstrate that the outcomes of our clinicians running our programs are comparable to those in the published literature. Studies that compare effects from a psychologist's clinical practice to past clinical trials can be used to confirm that outcomes are meeting international benchmarks (e.g., McEvoy et al., 2012, 2015a) Likewise, while a single case study may not be publishable unless it reveals particularly important information about a novel case presentation or application of an intervention, it provides an excellent way for individual practitioners to demonstrate to themselves and to a client the degree of improvement (Fishman, 2000).

Drawing together the themes discussed (and portrayed in Figures 1.1 and 1.2), the scientific practice of clinical psychology exists in a social network that ripples outward from the individual client, with a research agenda that becomes more generalizable. Thus, there is probably not one single science-informed model of clinical psychology, but an array of ways that science informs practice and vice versa. The knowledge generated by large-scale efficacy studies (e.g., Elkin et al., 1989) exists alongside the knowledge generated by an individual clinician tracking the Subjective Units of Discomfort (SUD) of a phobic progressing through an exposure hierarchy. Both can appropriately be considered the products of a scientific practice of clinical psychology. Acknowledgement of diversity in the type of research product across different stakeholders is not to imply that there are no boundaries to a scientific clinical psychology, just that it is broader than is often characterized.

It is worth noting that specification of the different stakeholders helps to clarify what information needs to be presented to which groups and by whom. Individual clients will be interested in feedback about how they have performed on psychological tests relative to appropriate normative samples and about the rate and extent of progress, both referenced against their pre-treatment scores and relevant norms (see Crawford et al., 2011; Woody et al., 2003). Further, the results of therapy may be communicated to other stakeholders in ward rounds, clinic meetings, training workshops and other clinical settings (cf. Castonguay, 2011; Haynes, Lemsky & Sexton-Radek, 1987; Mitchell, 2011). In contrast to the local presentation of individual client data, professional societies and funding bodies will seek information about the most cost-effective ways to treat specific disorders of all clients who present for treatment. They will require reliable answers, based on studies comprising good internal and external validity that point to answers that can be generalized to particular populations. Thus, an important skill for clinical psychologists is not only to be able to produce evidence, but to know how to generate and present research outcomes relevant to the target stakeholder.

One example of the targeted presentation of research evidence is the way that clinical psychology is responding to the increasing industrialization of health care. Health care costs began to rise dramatically during the 1980s and it became clear that both the private and public sectors needed to be more assertive in the management of health funds. Employee Assistance Programmes (EAPs) were one of the first responses, offering corporations targeted services of early identification and minimal, time-limited interventions followed, if necessary, by appropriate referral. In the US, managed (health) care organizations evolved with the development of Health Maintenance Organizations (HMOs; where individuals or companies contract an organization to provide all health

services), Preferred Provider Organizations (PPOs; who reimburse a panel of providers on a fee-for-service basis, typically with some form of co-payment), and Individual Practice Association (IPAs; in which providers organize themselves to contract directly with companies to provide health services). Although the particular structure of health care varies markedly across different countries, all Western nations face the same problems of increasing costs of health care (compounded by a growing aged population) and share the same need of third-party payers (i.e., insurance companies and governments who pay the health bills) to rein in health care costs. Increasing costs have focused attention more than ever upon efficient and effective health care and thus the need for clinical psychologists to be able to demonstrate that their assessment and treatment processes are not only effective, but they can be targeted, delivered in a timely manner and offered in a definable and reproducible manner. Thus, in the past the rationale for a scientific-informed practice was promoted within the discipline by professional organizations (e.g., the American Psychological Association, the British Psychological Society) and foresighted individuals (e.g., Thorne, 1947), but in recent times the rationale has become increasingly externally motivated, in the form of third-party payers who are demanding cost-effective health care. Whereas in the past the scientist-practitioner model could be seen as a luxury representing an ideal worthy of pursuit, in the present era of accountability it is a necessity ideally suited to demonstrate the value that can be returned for every health care dollar invested in clinical psychology services (Schoenwald et al., 2010). Stepped-care approaches, where lower-intensity psychological interventions (e.g., brief focused interventions) are first delivered by generalist psychologists, with clients only referred to clinical psychologists if they do not recover, aim to maximize the number of people who can be assisted within finite workforce resources and without compromising outcomes. Lower-intensity interventions can also be helpful for reducing the burden on clients (e.g., travel time, time away from work). The aim is to match the level of care to clients' needs – no more, no less. As consumers seek to purchase quality services at cheaper prices, there will be a market edge to those who are able to demonstrate that their products are both effective and economical.

In sum, science-informed clinical psychology does not have a single product to market, but it produces many different outputs relevant to diverse audiences (Castonguay, 2011). Clients will be interested in their personal well-being, whereas society will be interested in the broader issues of descriptive psychopathology, etiological models of disorders, treatment processes and outcomes, as well as efficient and effective health care (Kazdin & Blase, 2011). The individual clinical psychologist requires the skills to collect and present data relevant to particular stakeholders. Not all clinical psychologists are employed in the same capacity and the stakeholders each person deals with are different, and therefore it is better to conceptualize the implementation of a science-informed model of clinical practice as not being epitomized by a particular instantiation, but as a strategic commitment to a scientific approach at the core of clinical practice. Priority of strategy over procedure is essential, because the evidence base will always be incomplete. The core competencies of a scientist-practitioner are most needed when the evidence is equivocal or lacking (Newnham & Page, 2010; Shapiro, 2002). In the remaining chapters we outline ways that a person with a commitment to the application of science to clinical practice might approach the many tasks clinical psychologists engage in. The first of these activities will be the difficult task of developing a strong therapeutic relationship.

Chapter 2

Relating with Clients

Imagine sitting face to face with your first client. What is the best thing to do or say? What if you open your mouth and say the wrong thing?

This is an appropriately daunting image because you want to do the best for your client and the stakes are high. Minimally, a therapist must aim to do no harm, but how is one to exert a positive influence? One common response among students is to seek technical guidance in the form of a treatment manual. There are published lists of evidence-based treatments (e.g., Nathan & Gorman, 2015; NICE, 2021) that identify the relevant treatment manuals and it makes sense to find the manual that matches the client's problem and to begin therapy. Furthermore, this seems reasonable because the practice is scientific in that you can base your clinical decisions on the scientific literature. Other students respond to the challenge of exerting a positive influence upon clients by seeking to focus on the therapeutic relationship (Norcross & Lambert, 2019; Norcross & Wampold, 2019). Once again, this is not an unscientific strategy, since there is a substantial body of literature identifying aspects of the therapeutic process beneficial to outcomes (e.g., Beutler et al., 2004; Bohart & Wade, 2013; Castonguay & Beutler, 2006; Norcross, 2010; Orlinsky, Rønnestad & Willutzki, 2004). This approach has a long history, with Frank (1973) suggesting that psychotherapy is an encounter between a demoralized client and a therapist aiming to energize the client. Frank placed less emphasis on *what* was done in therapy, and more emphasis upon *how* it was done; specifically, he emphasized the therapist's ability to mobilize a client's motivation and hope.

Thus, there are sound reasons for identifying an evidence-based treatment best suited to a client, but there are also good reasons for fostering the therapeutic relationship. The clinical psychologist will begin therapy by thinking about how best to manage the relationship with the client to foster change and will be constantly reviewing it, and responding to it (see Figure 2.1). This still leaves you with an apparent dilemma as a new therapist: What is the best thing to do or say? However, the dilemma is easily resolved if one understands that the two approaches are not mutually exclusive, but complement each other.

Borkovec (2004, p. 212) spoke to this issue as he outlined his vision of an integrated science and clinical practice. In answer to the question, "What is the empirical evidence for what you do with a client?", he commented that,

> Certainly research on relevant empirically supported treatments (ESTs) is part of this review process, but it goes further. The professional commitment of clinical psychologists is to be *knowledgeable about, and guided by, the empirical foundation of everything they do during the therapy hour*, and the psychological literature contains far more information relevant to this

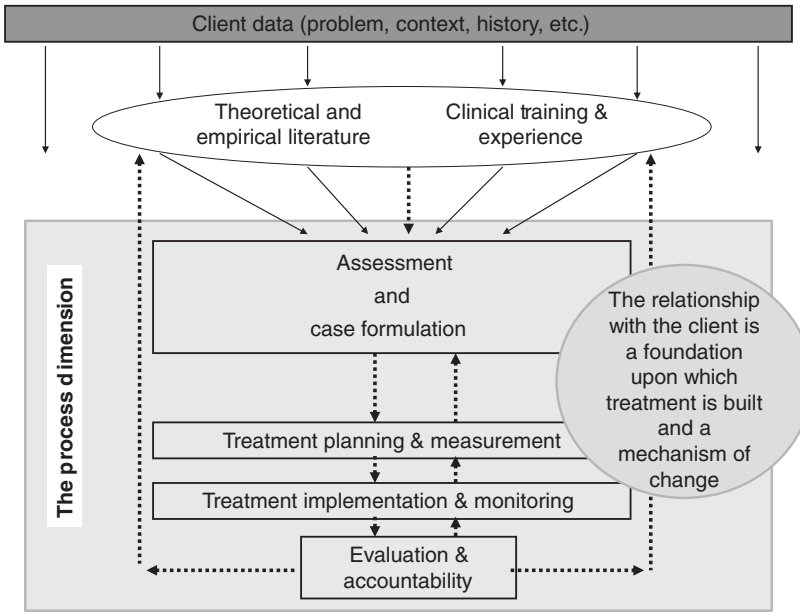

Figure 2.1 The therapeutic relationship is central to change in psychotherapy.

potential foundation than merely (though importantly) therapy outcome studies documenting the efficacy of specific protocol manuals (italics added).

The empirically-based choice of the best treatment programme is one component of a scientific practice of clinical psychology, but it is not the whole of it. To use a culinary metaphor, scientific practice is not a garnish sprinkled onto clinical psychology, but it is like salt that, once added to food, permeates the whole dish. The scientific practice of clinical psychology and the use of evidence-based treatments do not abdicate a clinician from the responsibility of fostering a therapeutic relationship in the best interest of the client. We will later consider some components of evidence-based treatments, but first we will review evidence-based components of the therapeutic relationship. The separation is not intended to imply that these are alternative options of conducting psychotherapy. Both aspects are integral parts of a strategic approach to provide an empirical foundation for everything that happens in a therapy hour.

Empirical Foundations of the Therapeutic Relationship

The promulgation of treatment manuals could give the false impression that a therapist's behaviour exerts little influence over and above the specific ingredients of the manualized therapy. A series of studies by Miller and colleagues highlights how this conception would be false (Miller & Baca, 1983; Miller, Taylor & West, 1980). They found that a treatment programme for problem drinking was equally effective when delivered by therapists or in a self-help format. However, when they further explored the data, they found considerable variability within the therapist-administered treatment programme. Specifically, two-thirds of the variance in drinking outcomes at six months post-treatment was predicted by the degree of therapist empathy. Even two years after the

completion of therapy, still one-quarter of the variance in drinking outcomes was predicted by therapist empathy. Thus, there were some therapists who administered a standard treatment programme with outcomes that far exceeded those achieved with self-help, but there were other therapists whose clients would have been better off if they had read the book by themselves. Therefore, scientist-practitioners will need to identify and cultivate those therapeutic behaviors that reliably relate to positive client outcomes (e.g., Miller & Rollnick, 2012).

One way to identify evidence-based therapeutic behaviours is to determine which behaviours that occur during treatment are positively correlated with therapeutic outcomes. These were reviewed by a task force of Division 29 of the American Psychological Association (Ackerman et al., 2001; see also Orlinsky et al., 1994, 2004; Norcross, 2010; Norcross & Wampold, 2011). They divided the behaviours into those that were demonstrably effective and those that were promising and probably effective. Of the demonstrably effective behaviours they identified the therapeutic alliance (or cohesion in the context of group therapy), empathy, and having goal consensus and a collaborative relationship. Of promising and probably effective behaviours they identified establishing a relationship where there is positive regard for the client, the therapist interacts in a manner where they are genuine (i.e., their manner of presentation is congruent with who they really are), elicit feedback about the psychologist's behaviour, repairs ruptures to alliance (an issue we will return to in subsequent chapters), occasionally and appropriately discloses information about themselves, while managing their own issues so that they do not adversely impact on therapy (i.e., manages countertransference).

From the review it is clear that process variables can be divided into the three categories, namely those related to the client, the therapist and the relationship. In addition, Norcross and Wampold (2011) noted a variety of ways that therapy can be adapted to individual clients that may enhance outcomes. Their review noted that outcomes could be improved when therapists adapted therapy in response to factors such as the resistance expressed by the client, the preferences for therapy, the client's cultural background, the client's religious beliefs and spiritual values, as well as the client's typical coping style and the person's stage of change. We will return to the methods of adapting therapy in light of the client's response to therapy and their particular attributes later in the book, but for now we will focus on the general issues concerning the client, the therapist and their relationship. Bearing in mind the caveat that the actions of a client and therapist affect each other reciprocally, it is possible to draw a number of lessons from these reviews of the literature.

First, the quality of the therapeutic relationship is related to outcome and both client and therapist behaviours are involved. Thus, it is relevant to consider what activities enhance the therapeutic bond. Second, clients possess a variety of qualities that are positively associated with outcome. While there will be individual differences in these qualities, it behoves the therapist to maximize the extent to which these behaviors are exhibited during treatment. For instance, client conversational engagement is positively correlated with outcome and, although clients will vary in terms of their levels of verbal activity, the therapist should be mindful of strategies to maximize client verbal activity. Third, a novice therapist may take some comfort from the observation that although therapist credibility is related to outcome, the size of the effect is weaker than many other factors. That is, even if you feel unsure when you are seeing a client, remember that this variable is not among the largest predictors of therapeutic outcome.

Thus, certain client behaviours as well as specific therapist behaviours should be maximized to enhance outcome. Outcomes will be enhanced when the therapist creates an environment in which the client is able to discuss their problems collaboratively in an open and easy manner. The therapist will be working hard to maximize the therapeutic bond, by showing empathic affirmation (acceptance, warmth, positive regard) of the client. In a nutshell, the therapist will work hard to develop the therapeutic alliance.

Building a Therapeutic Alliance

Broadly speaking, the therapeutic alliance involves three components (Bordin, 1979). First, the client and therapist agree on therapeutic goals. Second, the therapeutic alliance involves the assignment of a task or set of tasks for the client, which can occur within the therapy session or between sessions. The final component is the development of a therapeutic bond. As Ackerman and Hillensroth (2003) noted, despite much research focusing on the relationship between the therapeutic alliance and outcome (e.g., Bohart & Wade, 2013; Martin, Garske & Davis, 2000; Norcross & Wampold, 2019; Orlinsky et al., 1994, 2004), much less research has addressed the particular behaviours of the therapist that foster and strengthen the alliance. Based on a review of the existing literature, they identified a set of therapist attributes and techniques that are positively related to a strong therapeutic alliance. Their work suggests that in terms of personal qualities, a good alliance is associated with therapists who present with *warm* and *friendly* manner, and who appear *confident* and *experienced*. Therapists with a good therapeutic alliance will be *interested* in and *respectful* towards their clients, and they will relate with *honesty*, *trustworthiness* and *openness*. During therapy, they will remain *alert* and *flexible*. In terms of providing a safe environment for clients to discuss their issues, therapists will be *supportive* and use *reflective* listening skills, *affirm* the clients' experiences and demonstrate an *empathic understanding* of each client's situation. Therapists will *attend to the clients' experiences* and *facilitate the expression of affect*, to enable a *deep exploration* of concerns. In terms of the practice of therapy, clinicians with a positive alliance provide *accurate interpretations* of clienta' behaviours, are *active* in treatment and *draw attention to past therapeutic successes* (Ackerman & Hillensroth, 2003).

Drawing together the themes evident from the preceding reviews of therapy processes and the therapeutic alliance, a number of general conclusions can be drawn about the conduct of a therapy session. First, in terms of the therapist, it is important to be warm, empathic and genuine. Second, the client needs to be actively engaged in therapy, with a good understanding of what is occurring. Third, the relationship between the client and therapist needs to be collaborative, with a good rapport. We will now illustrate the specific behaviours that can strengthen the alliance by describing how they may be appropriate at different points in an initial session with a client.

Relating with a Client to Build an Alliance

It is useful to begin a session with a polite introduction, making an effort to be warm and friendly. Therefore, make sure that you make eye contact as you say the client's name and permit time for the small talk that often follows an introduction (e.g., a discussion of parking difficulties or problems finding the clinic). However, the small talk must not detract from attention to the problem, so to convey a genuine interest in the client you need to shift focus swiftly to the client's main concerns. Thus, invite the client to sit down

with chairs arranged so that you sit side on, but still facing the client, at a comfortable distance. Before asking the client to describe their concerns, it is important to discuss issues of confidentiality (see Chapter 11). Briefly, there are two aspects to this. On the one hand, you want to make it explicit that material raised remains confidential. On the other hand, confidentiality is not absolute and there will be occasions when you may be legally or ethically bound to inform a third party. It is prudent to draw the client's attention to these circumstances (e.g., when there is an explicit threat to harm the self or another specified person, when a child is in danger or when subpoenaed by a court of law) verbally or in written documentation. Although it may seem a little awkward to raise these issues, it is easier to raise them at this point and it also allows clients a few moments to settle themselves.

Once the preliminaries are over, it is time to ask the client to introduce the problem. Since you are trying to be respectful and affirming, it is useful to let the client provide this introduction. On some occasions you will have referral information or prior case notes and therefore you may want to begin by indicating to the client that you would "like to hear it from you first". In asking about the client's difficulties, you are aiming to create a sense of openness. One way to do this is to begin by asking, "What seems to be the problem?" or "What brought you along today?" In so doing do not impose a structure, but let the client raise the issues as they would like to (but see Chapters 7, 8 and 16 for circumstances when it is important to impose structure right away; for example, in many medical settings, time constraints often require rapid assessment skills, and a purposeful structure is essential for eliciting as much information as possible in the limited time available). Ask questions, but permit the client to define their problems. Sometimes you will have prior information and it can be helpful to mention this. For example, "You mentioned on the phone that you were having difficulty with 'depressed mood', could you tell me about it?"

On occasions clients are reticent at the outset of therapy and it may be useful to acknowledge some of the discomfort, perhaps by saying, "People are often concerned about seeking professional help, but I'm glad you came to see me. It is the first step in doing something about your difficulties."

In asking a client questions, the form of questions can be closed or open. Closed questions can be answered in a few words or even with a simple "yes" or "no" (e.g., "Do you live with your family?"). They are useful for focusing an interview and obtaining specific information, but used to excess they constrain the client and place the burden of directing the session upon the therapist. Open questions are those that take many words to answer and in so doing, encourage the client to provide the maximum amount of information (e.g., "What is your relationship with your family like?"). Thus, open questions are preferable as ways to begin an initial interview with a client, but relatively more closed questions may be used to begin a session later on in therapy (e.g., "Last week we talked about managing your tension while asserting yourself. How did you go with that?").

As the client is talking you need to reflect upon how you are coming across to the client. First, be aware of your eye contact. Make sure that you look at the client. Although you will normally look away more often when you are speaking than when you are listening and eye contact is rarely a continuous stare, you need to be able to watch the client for behavioural signs relevant to their problems (e.g., breaks in eye contact, shifting in their seat). In addition, eye gaze is an important implicit cue in communication used

to signal turn taking (i.e., a speaker will restore eye contact to signal that a communication is complete) or to seek confirmation (e.g., a speaker will look to a listener when expecting a response to their communication). It is also important to be aware of cultural differences in eye contact (e.g., Australian Aboriginal people tend to avoid contact when discussing serious topics). One trap for the novice therapist to avoid is excessive note taking. The client is not a topic to be studied, but a person with whom you are relating. Therefore, jot down an occasional aid to memory rather than a transcript of the conversation. Building a warm and friendly relationship is more important to the therapeutic alliance than a comprehensive record of the session.

Second, in terms of body language scan both the client and yourself. Ensure that your proximity is comfortable to the client, so that if they move their chair forward or backward, do not adjust yours to a distance negating the client's move. Watch for changes in body posture that indicate discomfort or greater assurance. Also be alert for discrepancies between the client's body language and their verbal tone and content. For example, the client who folds her arms while saying that she is quite comfortable with her boss's decision may prompt further questioning from the therapist. Likewise, ensure that your body posture does not communicate impatience (e.g., pen tapping), boredom (e.g., doodling), defensiveness (e.g., arms crossed), discomfort (e.g., breaking eye contact), or excessive earnestness (e.g., sitting too far forward in your seat). Your aim is to convey honest acceptance while supportively affirming the client. If you feel unsure how best to sit, mirroring the client's behaviour can be a good start or leading the client by modelling a relaxed and open manner (e.g., feet firmly on the floor, arms on your legs with palms open).

Third, your voice needs to convey friendly interest. Therefore, watch for signs of emotional tone in your voice and ensure that it matches any emotional content. Likewise, pay attention to the client's emotional tone. In addition to tracking the vocal tone, track the verbal content. Align your conversation with the client's interest and signal any transitions (e.g., "I was wondering if we could switch from the problems you are presently having with your drinking and go back to when it all began, so that I can get a clearer idea of where it all came from. Is this OK with you?"). Transitions signal a change, but it is also useful to include a brief summary of the material covered most recently in the session to indicate that you have been listening to the client. The way that you respond to the client will influence the course of the interview, so track the verbal tone and content of your responses. For instance, consider how the tone of the interview and the content of the client's response would vary if you responded to the client saying, "I've just lost my job" with (a) "that was very careless of you", (b) "how did that happen?" or (c) "how do you feel about losing your job?" Another way to track the client's verbal content is to identify important words. Statements that begin with "I" can often be relevant because they are important to a client and the use of the personal pronoun communicates the personal significance. Clients will also emphasize certain words to highlight key issues. For instance, confusion or ambivalence about impulsive behaviour may be indicated by emphasis in a sentence such as, "*WHY* do I keep drinking too much and getting together with the wrong sort of guys?"

The questions that you ask will help the client to elaborate upon their responses. For example, in an initial interview you could ask open questions to facilitate greater discussion of a topic by asking, "Could you tell me more about that?" or "How did you feel when that happened?" Sometimes you will need to get a client to be more

specific or concrete and at such times you could ask, "Could you give me a specific example?" or "Tell me about a typical drinking session."

The form of a question will also influence the type of answer. *What* questions, often lead to factual answers, therefore they are the easiest to answer. *How* questions initiate a discussion of processes and an account of a sequence of events. *Why* questions bring about a discussion of possible reasons. One problem with why questions is that even though they give you an indication of the client's perceptions of causation, they can put individuals on the defensive and may produce discomfort if they imply blame. Further, Nisbett and Wilson (1977) mount a convincing case that humans do not have introspective access into the causal cognitive processes despite being happy to elaborate on what they believe to be the correct answer. This is perhaps also one reason why a frequent response by clients to a "why" question is "I don't know." "Why" questions are difficult to answer on the spot. Nonetheless, awareness of a client's perception of the cause of their problems (independent of its validity) is useful information when presenting to a client a problem formulation. An alternative to asking direct "why" questions is to indirectly pave the way toward some causal insight by beginning with a "what" question. For example, an answer to the question "Why are you upset with your husband's decision?" requires considerable cognitive processing entailing deliberation and judgement. In contrast, the question "What is it about your husband's decision that upsets you?" prompts the client to simply describe and list all the "things" that come to mind that are upsetting to her. It is far easier for the client to look at a list of concrete exemplars, and then arrive at an overall judgement "why" she was upset, than to ponder that question in the abstract via internal processes. Thus, "what" questions are often better than "why" questions when it comes to eliciting answers about the reasons for a client's behaviours, thoughts or feelings. Finally, *could* questions (e.g., "Could you tell me what your husband does that makes you mad?") tend to be maximally open-ended and therefore useful for generating many options for the client (including a refusal to answer).

However, as you ask questions, remember the goal of therapy is not just to elicit information, but to facilitate a communication. Therefore, track the client's responses to your style of interaction. If your client looks confused, check that you have not been using multiple questions (e.g., "I wonder if you could tell me when the difficulties with your wife began, first her jealousy and then her drinking, but also tell me how you felt about each of them and how each of your children reacted to the whole situation?"). If your client looks uncomfortable, check that you are not asking an excessive number of overly probing or closed questions. In a therapy context, the clinician exerts a degree of influence over the interview that is not present in social contexts, such that clients feel obliged to answer each question. Therefore, reflect on each question and ask yourself if you need to know the information. Although the material elicited in a session is confidential, you do not wish to explore a client's private life any more than you need to. Also, if the client is reticent about answering your questions, consider if you have been using statements framed as questions. For instance, you might say, "Don't you think it would have been more helpful if you had studied harder?" which is really a judgement about the client's effort rather than a helpful therapeutic question. In our experience, one word to watch out for in this respect is "so". Often a question or statement that begins with "so" is one that is about to tell the client what you think. For instance, you might say, "So you've been feeling pretty bad lately." These comments

are much better re-phrased as genuine questions (e.g., "Could you tell me how you've been feeling lately?").

Fourth, non-attention and silence are potentially useful therapist responses. If a client repeatedly brings up the same topic, you may feel the need to shift attention elsewhere. The danger with this strategy is that clients may keep returning to topics when they do not believe you have understood what they are saying or how distressed they are. We will discuss reflective listening in more detail later, but if you are sure that you have heard the message and it is time for a change in topic it is sometimes useful to say, "I hear how distressed you are" while maintaining eye contact with the client. Wait until you get a clear sense that your message has been heard by the client before moving on.

The novice therapist is sometimes worried about silence, believing that the job of the therapist is to fill the therapy hour with words. Notice in our review of the process variables that were related to outcome, the verbal output of the client, but not of the therapist, was consistently related to outcome. Therefore, do not worry about silence. Sometimes saying nothing is the best support you can give. Sometimes you cannot think of what to say because there is nothing to say. Sometimes you need time to think about the best response. Either way, a receptive silence can be a useful therapeutic tool.

Encouraging, Restating and Paraphrasing

So far we have considered the style of questioning and behaving. Although these techniques are important, the goal of a session is to both give and receive information. The information the client is providing will be both verbal and non-verbal. Some information will be explicitly communicated by the client. Other information will be communicated without the client's awareness or will need to be inferred by the therapist. Receiving all the client's messages, decoding them correctly, and conveying to the client that you have accurately heard and understood the rich and complex tapestry of words, emotion and behaviours is at the heart of empathic communication.

Three strategies that assist the therapist to communicate that client messages have been received are encouraging, restating and paraphrasing. Encouraging typically involves behaviours such as head nods, open gestures, positive facial expressions, and verbal utterances (e.g., "U-huh"). Each of these therapist responses seeks to convey an encouragement to continue with a particular line or style of responding. These encouragers need to be used judiciously, since too few leave the therapist looking wooden and too many can be annoying. Remember, the responses are intended to encourage elaboration on particular points, so make sure that you use them when you wish to reinforce a particular utterance. Thus, one trap to avoid is saying "yes" before a client has finished a sentence or idea.

Therapists can also provide encouragement by repeating key words from a client's response. For instance, if a client said, "It happened again. I walked into the office, it went quiet, and I felt that everyone was looking at me. Suddenly I felt that rush of anxiety and started to blush" you might respond, "Everyone was looking at you?" or "you blushed?" Each response encourages the client to elaborate on a particular facet of the experience and the clinician will opt for a particular line of response depending on the overall agenda. The preceding responses would lead the session towards a discussion of the office workers' perceptions on the one hand or the client's physiological response on the other. Later in therapy a clinician might wish to explore recurring patterns and may wish to draw attention to the repetition by responding, "It happened again?"

Other encouragers may be more focused. For instance, you might ask questions to establish the generality of a behaviour (e.g., "How often do you drink each day?"), situational influences (e.g., "Where do you drink?"), onset (e.g., "When did it all begin?"), or course (e.g., "Has it been the same all the time?").

Paraphrasing is a deceptively simple skill. The aim is to distill the client's explicit and implicit messages into a single utterance. The verbal and non-verbal cues, the key ideas that have been spoken and inferred concepts, are concisely summarized. Thus, the key skill in paraphrasing is not speaking, but listening. Begin by paying attention to everything the client is communicating and take time to reflect on the explicit and implicit messages. Consider any themes or important features, evaluate the discrepancies between verbal and nonverbal communications, and formulate a response. Although we will now turn to ways that a summary can be expressed, we cannot emphasize enough the extent to which the key to a successful summary is the thought that occurs before you open your mouth. Providing a good summary can also be facilitated by collecting relevant information. Asking the client how they react to their problems and how others respond can provide you with key elements to include in a summary.

A summary often begins with a stem, such as "It looks to me ..." or "What I'm hearing is ..." or "Putting these ideas together ...". The summary brings together the main points of the issue from a client perspective. To convey clients' perspectives, try to use their language. For instance, if clients have used the terms "sadness" and "grief" to describe their experiences, use their words rather than another such as "depression." Try to clearly express the main elements of the problem. Often clients will be confused and ambivalent so the therapist can assist by highlighting key themes or drawing together seemingly unrelated symptoms into a coherent picture. Finally, after presenting a clear, succinct and meaningful summary, request explicit feedback to check your understanding. You might ask, "Am I hearing you right?" In addition, check that your coverage has been sufficient. We prefer questions such as "What have I missed out?" rather than "Have I missed anything out?" because the former presumes incompleteness and inaccuracies and therefore implicitly encourages correction.

Putting together these three skills of encouraging, restating and paraphrasing, imagine how you would respond to a client who said, "I'm really concerned about my teenage daughter. She used to talk to me and now she has become sullen and withdrawn, so we don't talk. I'm so worried that she's getting into something bad. She's got all these new friends and she won't tell me what they get up to. I don't know what to say, but if she's been using drugs then she can just leave home as far as I'm concerned!"

An encourager might be to respond, "You don't talk?" A restatement might be, "You are terribly concerned about your daughter." Finally, a paraphrase might be, "I'm hearing a few themes emerge in what you say. One theme is that you seem concerned; concerned about the loss of communication with your daughter and concerned about the possibility of harm, so much so that you'd consider asking her to leave. Another theme seems to be one of loss; you describe a sense of loss of communication, closeness and influence. Have I heard you right?" In the paraphrase, some elements are reflections back of what the client said, but others are inferences based on the client's comments. That is, the client did not discuss her feelings about a loss of influence and control over her daughter as she becomes more independent. However, the therapist knows this is a common issue between parents and teenage children, so speculated that this unspoken theme was present, and therefore presented it as a hypothesis. It is wise to check that a

paraphrase is correct, but essential to do so when an inference or speculative interpretation is being presented.

These three communication skills are useful steps in developing an empathic understanding between you and your client; however, empathy goes deeper than communication. Empathy is the ability to see the world from the perspective of another person and communicate this understanding. Behaviourally, it is possible to define verbal and nonverbal actions and attending skills that are associated with empathy, but at its heart empathy is a relational construct. It involves putting yourself into another person's shoes so that you can share a deeper relationship (Egan, 2019). The deep relationship involves positive regard. Positive regard involves selectively attending to the positive aspects of a client's communication. It stems from a humanistic worldview that people are inherently moving forwards and growing in positive way (i.e., self-actualizing). Highlighting these positive aspects identifies positive assets a client can build upon and conveys a sense of warmth and acceptance. Empathic communication also conveys respect and warmth. Clients may not have told others about the issues that they raise in therapy, and thus it is important to convey respect for the client. Show that you know that they are doing their best to deal with their issues. Transmit appreciation for the person's worth as a human being and communicate warmth by smiling or using facial expressions conveying empathic concern when responding to a client's emotions. Clues that the therapist may be failing to empathize and understand the client's worldview may be feelings of confusion, frustration, boredom, irritability or anger. The therapist's job is to notice these emotional reactions, formulate them and respond to them in therapeutic rather than counter-therapeutic ways. We will discuss these process issues more in Chapter 13.

The empathic therapist also needs to demonstrate congruence (having a minimal discrepancy between their perceived and actual self), genuineness and authenticity. Possession of these attributes ensures congruence between verbal and nonverbal behaviours, which ultimately facilitates communication with clients. Clients are the focus of any session and therefore the therapist's issues must not clutter the therapy process. Therapists who are not fully accepting of their clients may exhibit incongruence between their verbal and nonverbal behaviours, which clients may pick up on. If a therapist responds more strongly emotionally to a particular client than others, this might be a clue that counter-transference is occurring (e.g., therapist beliefs, values or relational patterns are being challenged by the client) along the process dimension. It is critical that therapists develop the skills to attend to these reactions, understand and formulate them, and respond to the client in therapeutic ways. Responding emotionally to clients is not at all a reflection of therapist incompetence and in fact it is very normal. However, if countertransference interferes with the therapist's ability to empathize with the client, then ruptures in the relationship may occur. Later in this book (Chapter 13) we will return to how therapists can learn to better understand and formulate their own reactions to clients to prevent ruptures or repair them when they occur. To reiterate, it is normal for therapists to react more strongly emotionally to some clients than others and, rather than being a problem, this can be a very important source of information for the therapist to use when deciding how to respond most therapeutically for a particular client. The therapist needs to determine whether their reaction is likely to be client-induced (i.e., probably typical of how most people respond to the client's behaviour) or therapist-induced (i.e., triggering the therapist's issues). Client-induced reactions provide important information about the impact the client is likely to have on others in their life,

how others are likely to respond and how the therapist can respond in new, more helpful ways. Therapist-induced reactions provide clues about issues the therapist needs to discuss in supervision and/or their own therapy to ensure they do not continue to arise in unhelpful ways during therapy. The therapist's ability to formulate their emotional response to a client will increase the likelihood that they will respond in the session with "client specificity", that is, in the most therapeutic way for that particular client.

Like reflecting the verbal content of a communication, reflecting an emotion begins with a sentence stem followed by a feeling label. The emotional word or phrase aims to use the minimum number of concepts to reflect the affect in the correct tense. For example, match your tense to that used by the client, so that if a client says, "I felt down" it would be better to use the past tense, than to say, "Your mood seems low." Once again, conclude with a check to ensure that your reflection of feeling is accurate.

One facet of a session that is easy to omit is an assessment of the client's skills, strengths and resources. It is a common trap to fall into because clients want to discuss their problems. However, clients are first and foremost people, who also happen to have some problems. Therefore, spend time explicitly considering clients' coping mechanisms and supports. You might ask, "With whom do you talk most often?" and then discuss what they enjoy talking about. Evaluate if they use other people for distraction, dependence, encouragement and motivation, or clarification. You can also ask the client about interests, social activities and religious/spiritual practices.

When coming to the end of a session, summarize the issues covered and draw the themes together. Typically clients will have identified a set of concerns, thus you could say, "Have I got it right, it seems that the main issues for you are ... let us try to rank them into a 'stepladder' of concerns beginning with the least problematic and stepping up to the more concerning." This hierarchy can help set an agenda and identify a tentative treatment plan. Also check that nothing has been omitted by saying, "You have talked about your checking and the intrusive thoughts as well as your depressed mood. Are there any issues we haven't talked about that you'd like to discuss?" or "Is there anything else you would like to tell me?" Finally, at the end of a session, conclude with a clear statement about what is going to happen next. This may involve psychological testing or scheduling a referral or another appointment. The goal is to leave clients with a sense of closure and clarity about the next step.

Troubleshooting

One of the attributes of a strong alliance is flexibility. Therefore, as a clinician it is important to be able to bend with clients. A planned session structure may need to be put on hold or re-organized depending on what clients raise. The uncertainty created may instill a degree of discomfort, which the therapist needs to learn to tolerate in order to be responsive. Having said this, there are common issues clients raise that it is good to have some considered answers.

First, clients often ask, "Do you think you can help me?" Therapists must avoid being overly optimistic, especially if clients raise the issue at the outset of an initial session. If you have not collected sufficient information to answer the question, then indicate that you would prefer to return to it at the end of the session. If you say this, then make sure you do return to the issue (perhaps putting a reminder at the end of your notes). On the other hand, if you have a clear idea about the probable treatment response and a client

asks, "Can you cure me?", then emphasize that you will be working with the client to help them to learn strategies to better manage troubling situations, relationships, behaviours, and emotions. Sometimes describing a stress-diathesis model is helpful in communicating to the client their role in dealing with their problem. For instance, a sunscreen metaphor can be of assistance, where you explain that a person with fair skin will burn more easily in the sun. They might not be able to change their tendency to burn, but they can learn to put sunscreen on to cope better with the potentially damaging rays of the sun.

Second, some clients (especially those with anxiety) may worry that they are going crazy. Silence can be damning at this point, as clients will watch you for signs of hesitation and interpret these as indications of your true beliefs. Therefore, respond quickly and convincingly. For instance, people (with anxiety) may worry that they have a disorder like schizophrenia and comparing and contrasting their symptoms with those of a psychotic disorder can be helpful.

Third, clients will often cry during a session. Ensure that tissues are on hand (and it is wise to routinely check they are within a client's easy reach before the session begins). In addition, use non-verbal cues to convey support and sympathy. Lean forward in your chair (but do not touch the client) and allow silence. Do not rush in and provide reassurance, but allow the client's crying to reach a natural conclusion. Be satisfied with silence until the client uses verbal or non-verbal cues to signal they are seeking a response. Clients often end a period of crying by apologizing or saying "that was silly". Rather than engaging with these sentiments, it is more useful to redirect attention to the trigger and its response by saying something like, "It seems this situation upsets you a great deal."

Fourth, clients can be agitated in the session. When you notice increasing agitation, it is most helpful to break off from the current line of inquiry and focus on it directly by saying, "You seem uncomfortable today, what is going on for you at the moment?"

Fifth, although novice therapists often worry they will not be able to fill the therapy hour (and hence over-prepare), a more common problem is a talkative client. It is particularly a problem for novice therapists because if you have worried that you will not fill the session, or are concerned that you might say the wrong thing, a talkative client is a seeming godsend since you do not have to say another word. However, silence is not always the best response. The client may need your guidance, so start to use more specific closed questions. You also may need to be more intrusive and interrupt the client to impose some order. For instance, you might say, "You have raised many issues, which one is the most important?" Trainee therapists often worry that interrupting the client will upset them and damage the therapeutic alliance, but most clients are quite comfortable with therapists providing explicit cues about how much detail is required in their answers. Clients will usually be responsive and easily shift focus. If a client does react strongly to gentle redirection, this provides the therapist with useful information about their cognitive and interpersonal style.

Sixth, clients can ask you for your advice (e.g., "what do you think I should do?") or invite you to take sides (e.g., "You agree with me don't you? No-one should have to put up with that sort of behaviour.") In each of these situations, it is helpful to draw attention to the collaborative nature of the session. As a therapist you are there to work with the client, but at the end of the day, they are the ones who must live their lives. Therefore, you might respond, "I don't want to talk about what I would do, because we are talking

about the problems you are facing. However, I am going to work with you to see if we can find some solutions to these problems."

Seventh, clients (and therapists) may wander off topic and it becomes necessary to refocus the interview. Sometimes is it useful to say, "I'd like to get back to your main concerns" or "I'm wondering if it might be more productive to focus on your current situation for the time being." Clients may also depart from the therapist's schedule by wanting to move too rapidly into treatment. This is understandable, since clients seek resolution of their problems, but it may be necessary to cover other material in the session first. The clinician might say, "I need to know more about your current problems before we can work out a plan of action." The client may also want to focus on a domain (e.g., childhood relationships) before fully explaining the problem. Thus, the therapist might say, "I would like to know more about your upbringing, but first I need to understand more about your current difficulties. Is this OK with you?"

Finally, clients can ask you for information that you deem to be personal and off limits. The therapeutic relationship is not the same relationship that exists between friends, acquaintances, or even doctor and patient. Rather, it is friendly, in that it is truthful, honest, caring and attentive. Thus, there is empathy, but also appropriate professional separateness and boundaries. Clients come to discuss their problems; you are not there to discuss yours. Clients are there to discuss their lives; you are not there to elaborate on yours. That being said, it can be discourteous and unhelpful to refuse to respond to any requests. Clients may reasonably desire to have some idea of the person they are sharing intimate details with. Therefore, consider before therapy begins, the nature and extent of material you are willing to divulge. For instance, clients can ask if you have had a problem like theirs. Therefore, consider if you have, how you will respond and equally, if you have not, how you will respond. Additionally, clients may ask about your personal life (e.g., "do you have children?") since this may establish your credibility to them. How will you respond comfortably in a genuine and truthful way and what will be most beneficial to the client? Refusing to answer questions point blank can disrupt the relationship, and evasive and disingenuous answers are often annoying to clients. However, if you decide to divulge personal information, ensure that you have considered all the potential effects (therapeutic and counter-therapeutic) and that you are clear about the reasons you are self-disclosing. Some questions you might ask before self-disclosing are: Am I about to self-disclose because I believe it will strengthen the therapeutic relationship in an important way (carefully consider any potential downsides)? Am I disclosing because I feel anxious about setting or enforcing appropriate boundaries (consider seeking supervision or therapy to work on your need to please and under-assertiveness)? Am I disclosing to get my own needs met (seek supervision or your own therapy)? In Chapter 13 we will discuss the differences between self-disclosing and self-involving statements. The former runs the risk of refocusing the session on you rather than the client and may reveal more about yourself that you wish your clients to know. The latter are statements about the therapeutic relationship (the process dimension) and can be helpful ways of strengthening the alliance and moving therapy forward.

In some settings (e.g., rural and remote locations) the issue of therapist confidentiality is a moot point. Since you live in the community in which you work and socialize with the people who are potential clients, the boundaries need to be made explicit with clients (see Chapter 13). Even therapists in urban areas need to reflect on the possibility of meeting a client in a non-therapy setting. For example, the authors have met their

clients in the changing room of a gym, at parties, at airports and even on a remote wilderness track! Therefore, consider how you are going to respond when you meet your clients outside of therapy and if this is likely, then it may be wise to raise it explicitly.

If you have reason to believe it is likely that you will see your client between sessions (e.g., you share acquaintances, live in the same area, engage in the same activities), you might pre-empt the discomfort by letting them know that when you see clients outside of session you do not acknowledge them to protect their confidentiality, so this should not be interpreted as rudeness. If you are working in a small town and will encounter the person in social settings, you might discuss the fact that there will be a clear boundary between what is discussed in therapy and that you will avoid any mention of the client's therapy sessions (including that they even attend your clinic) in the social setting. Although this might seem obvious to the therapist, a frank discussion can be important for easing clients' concerns and ensuring they feel safe to disclose in therapy.

Destroying the Therapeutic Alliance

The novice psychologist can often be daunted by the prospect of building a therapeutic alliance and may worry, "am I doing the right thing?" To this end, it can be helpful to reflect on the therapeutic behaviours that can undermine a good relationship with your client. Being cognizant of these factors can provide a sense of the "boundary conditions" of a good therapeutic alliance.

Norcross and Wampold (2011; Norcross, 2010) in their review identified a series of factors that damage the alliance. The authors warned psychologists to avoid confrontation and criticism of clients. Miller, Wilbourne, and Hettema (2003) demonstrated that confrontation tended to lead to adverse therapy outcomes, whereas rolling with the resistance was associated with positive outcomes (Lundahl & Burke, 2009). Therefore, avoid comments that are pejorative, critical, blaming, invalidating or rejecting. Norcross and Wampold also cautioned against being therapist-centric and assuming an all-knowing approach. The client's perspective predicts outcomes better than the therapist's perspective (Orlinsky et al., 2004) and psychologists are not good judges of poor progress (Lambert, 2010). This raises the question, how can a psychologist know the client's perspective on therapy and be sure of their progress? Subsequent chapters will consider how best to obtain the client's perspective and respond to difficulties that arise in the therapeutic relationship, but at this stage it is sufficient to say that using the listening skills described can provide a good foundation. We will then consider how a measurement system that collects data to supplement clinical impressions can assist this process (see Lambert, 2010; Newnham & Page, 2007, 2010; Nordberg et al., 2014; Scott & Lewis, 2015).

Summary

In conclusion, a science-informed clinical psychologist needs to be cognizant of the empirical literature relevant to the therapeutic relationship. Empirically supported treatments may include specific components that bring about change in the client's behaviour, but the therapeutic relationship is a way of bringing the client into contact with the therapy. Deciding upon a treatment requires careful consideration of many client-related factors and making this decision requires careful assessment of the client as a person and their presenting problems. Assessing clients is the topic to which we now turn.

Chapter

3

Assessing Clients

Picture yourself conducting a clinical interview. A 32-year-old married woman has presented to the service where you are working with difficulties getting to sleep and so you have prepared by reading about insomnia. You open the interview by asking the client to elaborate on her problem. She describes lying in bed, unable to sleep because concerns and worries spin around her mind. In addition to the symptoms you expected, the client tells you that she is overly irritable during the day, has extreme difficulty concentrating, is chronically indecisive and feels immense fatigue. Suddenly, the seemingly simple problem of insomnia has expanded as the client describes other problems that could be part of the sleep difficulties, but could represent another problem altogether. As a clinician you are faced with a number of dilemmas:

- Are the problems related in any way? If so, which problem do you treat first?
- Are the problems manifestations of one underlying cause or multiple causes?
- What treatment is best for which problem or constellation of problems?

Clinical psychologists tackle these dilemmas with every new client. From Figure 3.1 it is apparent that the assessment process involves an objective psychometric assessment, the gathering of relevant background information during an intake interview and an examination of the client's mental state based on observations made during the interview. Together, these data permit a description of the particular profile of symptoms, along with a formulation of the predisposing, precipitating and maintaining factors of symptom presentation.

Diagnostic manuals represent the distillation of clinical experience and research into a format that identifies which problems tend to group into meaningful clusters. These clusters can assist therapists to plan potentially effective treatments because as scientist-practitioners they are then able to refer to and use the psychological literature that bears on the relevant diagnoses. In this chapter we will first consider current diagnostic practices and their limitations, as well as structured ways to conduct diagnostic interviews and a mental state examination. However, before considering diagnostic systems, it is necessary to define "mental disorder".

What is a Mental Disorder?

In its Eleventh Revision of the *International Classification of Diseases and Related Health Problems* (WHO, 2021) the World Health Organization (WHO), defines mental disorders as "clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes that underlie mental and behavioral functioning. These

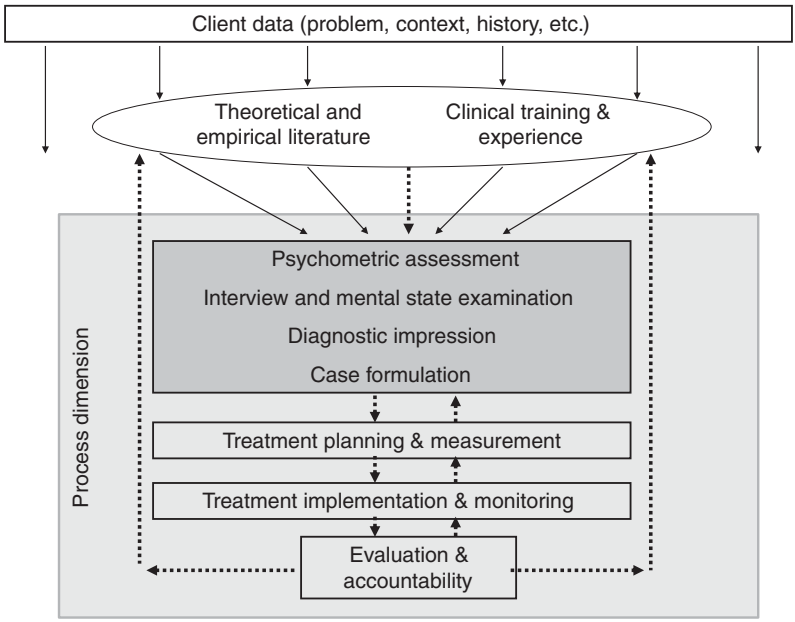

Figure 3.1 The complementary processes of testing, interviewing and examining mental state as precursors to diagnosis, case formulation and treatment planning.

disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational, or other important areas of functioning." The American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (American Pschiatric Association, 2013) defines a mental disorder similarly and adds, "Mental disorders are typically associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response . . . socially deviant behavior and conflicts that are primarily between the individual and the society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual" (p. 20). In addition, the authors note that the definition does not include an expectable and culturally sanctioned response to a particular event (e.g., bereavement). Further, they note that the "behavioral, psychological, or biological dysfunction" must lie within the individual, thereby excluding behaviour that is deviant (e.g., political, religious or sexual) or conflicts with society (see Blashfield, 1998; Rounsaville et al., 2002).

Current Diagnostic Practices

The many different instances of psychopathology present a complex array of phenomena to be organized. Clinicians need to organize the various manifestations of psychopathology for a number of reasons. First, it is necessary to have an agreed nomenclature so that mental health professionals can share a common language. Second, a common language is needed so that information about particular psychopathologies can be retrieved. Third, classification is a fundamental human activity that is necessary to organize the world within which we live. Presently, there are two main diagnostic

systems, the American Psychiatric Association's DSM-5 (APA, 2013) and the World Health Organization's ICD-11 (WHO, 2021). Both of these diagnostic systems classify disorders (rather than clients; Spitzer & Williams, 1987) and thereby assist clinicians as they try to plan treatment in a systematic, rational and scientific way.

Diagnostic Systems: The Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD)

The DSM

The opening section of the DSM-5 (APA, 2013) provides a comprehensive discussion of how to use the manual. Importantly, the manual acknowledges that in addition to a mental disorder diagnosis, it is necessary to construct a clinical case formulation to identify factors that may have contributed to developing the mental disorder. Case formulation will be discussed in a later chapter, but for now we will focus on diagnostic issues and postpone consideration of how to manage the complexity of moving from a description of the presenting problem to a treatment plan using a conceptual formulation of the causes of the client's presentation.

The psychological disorders that may be the reason for treatment that the DSM-5 lists are: (i) Neurodevelopmental Disorders, (ii) Schizophrenia Spectrum and Other Psychotic Disorders, (iii) Bipolar and Related Disorders, (iv) Depressive Disorders, (v) Anxiety Disorders, (vi) Obsessive-Compulsive and Related Disorders, (vii) Trauma- and Stress-Related Disorders, (viii) Dissociative Disorders, (ix) Somatic Symptom and Related Disorders, (x) Feeding and Eating Disorders, (xi) Elimination Disorders, (xii) Sleep-Wake Disorders, (xiii) Sexual Dysfunctions, (xiv) Gender Dysphoria, (xv) Disruptive, Impulse-Control, and Conduct Disorders, (xvi) Substance-Related and Addictive Disorders, (xvii) Neurocognitive Disorders, (xviii) Personality Disorders, (xix) Other Mental Disorders, (xx) Medication-Induced Movement Disorders and Other Adverse Effects of Medication and (xxi) Other Conditions That May Be a Focus of Clinical Attention.

Each section in the DSM-5 follows a similar format. The title of the disorder (accompanied by a DSM code and a corresponding ICD code) is followed by the diagnostic criteria and a verbal description of the diagnostic features. This final section provides clarification of the diagnostic criteria and includes examples. It complements the somewhat stark listing of the diagnostic criteria, in that it provides a rich verbal picture of the disorder, thereby giving the clinical psychologist the context within which the symptoms occur and the manner in which the disorder may present. It develops a sense of the "flavour" of each disorder. In addition to the DSM material, case studies are a useful complementary source of information. Some particularly good examples include Barnhill (2013), First et al. (2017), Meyer and Weaver (2012), Oltmans and Martin (2018), Sattler, Shabatay and Kramer (1998) and Ventura (2016).

Following this section, the DSM-5 provides information on the subtypes of the disorder, associated features, specific cultural, age and gender features, the prevalence, course, familial patterns and differential diagnosis (i.e., distinguishing features from similar or related disorders). By way of illustration, a Major Depressive Disorder is

characterized by a period of at least two weeks with depressed mood and/or a loss of interest in pleasure. To meet diagnostic criteria, a client must also report or exhibit a total of five symptoms, of which three (in addition to depressed mood and anhedonia) or four (in addition to depressed mood or anhedonia) may be of the following: significant weight or appetite change; insomnia/hypersomnia; psychomotor agitation or retardation; fatigue/energy loss; feelings of worthlessness or excessive/inappropriate guilt; decreased thinking ability or concentration, or indecision; recurrent thoughts of death; suicidal ideation without plan; or suicide attempt or plan. Subsequent criteria require the clinician to ensure that the distress or impairment in social, occupational, or other important areas of functioning is "clinically significant" and to rule out other possible diagnoses (e.g., a medical condition or the effects of a substance). The decision about clinical significance relies upon clinical judgement and may use information from friends, family, and other third parties.

The clinician is then asked to specify the severity and other features of the disorder. The severity of a disorder is coded as mild if few, or no, symptoms in excess of those required to make the diagnosis are present (in this case five), and symptoms produce minor impairment in social or occupational functioning. It is coded as severe if many symptoms in excess of those needed to make a diagnosis are present, and severity is moderate if number of symptoms falls between "mild" and "severe" categories. For instance, a client with severe repeated episodes of depression would receive a diagnosis of "Major Depressive Disorder, severe, Recurrent Episode." The DSM diagnostic code would be 296.33 and the corresponding ICD code would be F33.2. The clinician also needs to consider a variety of specifiers that describe the course of the disorder (e.g., chronic), its recurrence and the features that are present. By way of example, one set of features is melancholia, in which the depression involves loss of pleasure in activities and lack of reactivity to usually pleasurable stimuli in the presence of other symptoms such as "empty mood", a depression that is worse in the morning, involves early morning wakening, psychomotor agitation or retardation, significant weight loss and excessive or inappropriate guilt.

The previous edition of the DSM permitted the clinician to code significant psychosocial and environmental problems that have occurred in the preceding year, in part acknowledging that such factors may moderate the treatment and prognosis of mental disorders. Environmental problems included negative life events, environmental difficulties or deficiencies. Psychosocial problems included relationship difficulties and the associated interpersonal stress, as well as insufficient social support or personal resources. Both psychosocial and environmental problems are relevant, as they may be causally related to the onset of problems but can also be a consequence of mental health problems. However, the DSM-5 has decided not to develop its own listing of such problems, and encourages clinicians to use the WHO's taxonomy and ICD 9's V codes (or Z codes in the ICD 11). A listing of the codes can be found in the DSM-5. Consider the example of a woman who plunged into a deep depression following her forced idle state due to a medical condition preventing her from lifting heavy objects. The situation was exacerbated by her also losing her part-time job as a carer working with adults with a disability, where heavy lifting of patients was part of her daily job routine. Thus, noting the concomitant job loss as an "Other problem related to employment" provides insight into the pervasiveness of her recent role transition from active provider for the family to "being a burden" to her family.