THE ROLE OF A CASE CONCEPTUALIZATION MODEL AND CORE TASKS OF INTERVENTION

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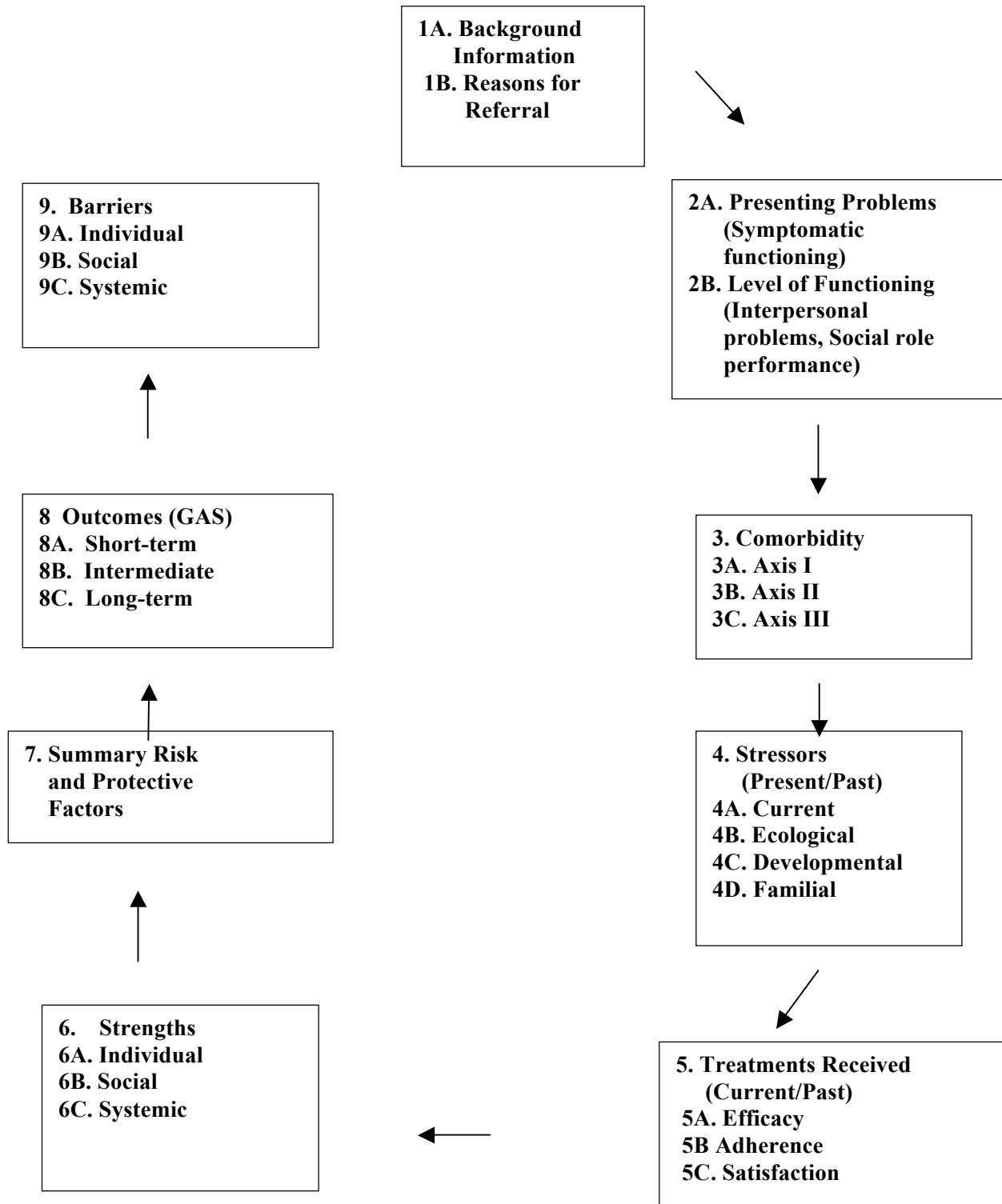**Clearwater, FL 33767**

A CASE CONCEPTUALIZATION MODEL (CCM)

"A clinician without a Case Conceptualization Model is like a Captain of a ship without a rudder, aimlessly floating about with little or no direction"

A well formulated Case Conceptualization Model (CCM) should:

1. give direction to <u>both</u> assessment and treatment decision-making;

2. identify developmental, precipitating and maintaining factors that contribute to maladaptive behaviors and adjustment difficulties and that reduce quality of life;

3. provide information about the developmental, familial, contextual risk and protective factors;

4. highlight cultural, racial and gender-specific risk and protective factors;

5. identify individual, social and cultural strengths and evidence of resilience that can be incorporated into the treatment-decision making;

6. provide a means to collaboratively establish the short-term, intermediate and long-term goals and the means by which they can be achieved;

7. identify, anticipate and address potential individual, social, and systemic barriers that may interfere with and undermine treatment effectiveness;

8. provide a means to assess the client's progress on a regular basis;

9. consider how each of these objectives need to be altered in a developmentally, culturally, ethnically and racially sensitive fashion

10. provide feedback to client and significant others in order to nurture hope in both the client, family members and the treatment team

11. facilitate communication and coordination among staff members

GENERIC CASE CONCEPTUALIZATION MODEL

1A. Background
    Information
1B. Reasons for
    Referral

9. Barriers
9A. Individual
9B. Social
9C. Systemic

2A. Presenting Problems
    (Symptomatic
    functioning)
2B. Level of Functioning
    (Interpersonal
    problems, Social role
    performance)

8 Outcomes (GAS)
8A. Short-term
8B. Intermediate
8C. Long-term

3. Comorbidity
3A. Axis I
3B. Axis II
3C. Axis III

7. Summary Risk
    and Protective
    Factors

4. Stressors
    (Present/Past)
4A. Current
4B. Ecological
4C. Developmental
4D. Familial

6.   Strengths
6A. Individual
6B. Social
6C. Systemic

5. Treatments Received
    (Current/Past)
5A. Efficacy
5B Adherence
5C. Satisfaction

FEEDBACK SHEET ON CASE CONCEPTUALIZATION

Let me see if I understand:
BOXES 1& 2: REFERRAL SOURCES AND
**   PRESENTING PROBLEMS**

"What brings you here is ...? (distress, symptoms,
**   present and in the past)**
"And is it particularly bad when..." "But it tends
**   to improve when you..."**
"And how is it affecting you (in terms of
**   relationship, work, etc)"**

BOX 3: COMORBIDITY

"In addition, you are also experiencing (struggling
**   with)..."**
"And the impact of this in terms of your day-to-day
**   experience is..."**

BOX 4: STRESSORS

"Some of the factors (stresses) that you are currently
**   experiencing that seem to maintain your problems**
**   are...or that seem to exacerbate (make worse)**
**   are... (Current/ecological stressors)**
"And it's not only now, but this has been going on for
**   some time, as evident by..." (Developmental**
**   stressors)**
"And it's not only something you have experienced,
**   but your family members have also been**
**   experiencing (struggling with)..." "And the**
**   impact on you has been..." (Familial stressors**
**   and familial psychopathology)**

BOX 5: TREATMENT RECEIVED

"For these problems the treatments that you have
**   received were-note type, time, by whom"**
"And what was most effective (worked best) was...
**   as evident by...**
"But you had difficulty following through with the
**   treatment as evident by..." (Obtain an**
**   adherence history)**
"And some of the difficulties (barriers) in following
**   the treatment were..."**
"But you were specifically satisfied with...and would
**   recommend or consider..."**

BOX 6: STRENGTHS

"But in spite of...you have been able to..."
"Some of the strengths (signs of resilience) that you
**   have evidenced or that you bring to the present**
**   situation are..."**
"Moreover, some of the people (resources) you can
**   call upon (access)are..." "And they can be**
**   helpful by doing..." (Social supports)**

BOX 7: SUMMARY OF RISK AND
**   PROTECTIVE FACTORS**

"Have I captured what you were saying?"
**   (Summarize risk and protective factors)**
"Of these different areas, where do you think we
**   should begin?" (Collaborate and negotiate with**
**   the patient a treatment plan. Do not become a**
**   "surrogate frontal lobe" for the patient)**

BOX 8: OUTCOMES (GOAL ATTAINMENT
**   SCALING PROCEDURES)**

"Let's consider what are your expectations about the
**   treatment. As a result of our working together,**
**   what would you like to see change (in the short-**
**   term)?**
"How are things now in your life? How would you
**   like them to be? How can we work together to**
**   help you achieve these short-term, intermediate**
**   and long-term goals?"**
"What has worked for you in the past?"
"How can our current efforts be informed by your
**   past experience?"**
"Moreover, if you achieve your goals, what would
**   you see changed?"**
"Who else would notice these changes?"

BOX 9: POSSIBLE BARRIERS

"Let me raise one last question, if I may. Can you
**   envision, can you foresee, anything that might**
** get in the way- any possible obstacles or**
**   barriers to your achieving your treatment**
**   goals?"**
**   (Consider with the patient possible individual, social**
**   and systemic barriers Do not address the**
**   potential barriers until some hope and resources**
**   have been addressed and documented.)**
"Let's consider how we can anticipate, plan for, and
**   address these potential barriers."**
"Let us review once again..." (Go back over the
**   Case Conceptualization and have the patient put**
**   the treatment plan in his/her own words.**
**   Involve significant others in the Case**
**   Conceptualization Model and treatment**
**   plan. Solicit their input and feedback.**
** Reassess with the patient the treatment plan**
**   throughout treatment. Keep track of your**
**   treatment interventions using the coded**
**   activities (2A, 3B, 5B, 4C, 6B, etc) Maintain**
**   progress notes and share these with the patient**
**   and with other members of the treatment team.**
**   "And some of the services you can access are..."**

COMPUTER GENERATED REPORT BASED ON THE CASE CONCEPTUALIZATION MODEL (CCM)

(The numbers and letters in this report refer to the information in the Boxes in the CCM)

1A. <u>Background Information</u>

This patient (note, gender, age, race, and sexual orientation), living circumstances, any specific threats to safety- "red flags". Indicate school and/or employment status and insurance support.

1B. <u>Reasons for Referral</u>

Date and source of referral. Is the patient self referred (sees that he/she has a "problem" or referred by others (school, parents, courts, etc.)? Include the basis of current referral and the patient's perception and motivation for treatment.

2A. <u>Presenting Problem</u> (Symptomatic Functioning)

Include the results of a functional analysis of presenting problems (frequency, intensity, duration, history of presenting problems), as well as "exceptions" of when presenting problems subside and end or are absent. Include developmental history of "externalizing" and "internalizing" problems. Note, source of information.

2B. <u>Level of Functioning</u>

How do these presenting problems (and also co-ordinating disorders [**Box 3**]) impact the patient's Level of Functioning and Quality of Life (contribute to interpersonal problems and ability to fulfill social roles - - student, employment, parent, etc.)?

3. <u>Comorbid and co-occurring problems</u>

In addition, the patient is currently experiencing difficulties with … (note comorbid disorders and impact on level of functioning. Include a <u>developmental history</u> of the sequence of comorbid disorders. Indicate the presence of Axis I (**3A**), Axis II **(3B)** and Axis III **(3C)** co-occurring problems (Axis I - - other psychiatric disorders; Axis II - - personality disorders and developmental learning disabilities; Axis III - - medical issues). Note, source of information.

4. <u>Stressors - - Present/Past</u>

An examination of current and past stressors that precipitate, maintain and exacerbate the patient's difficulties. These include: (give specific examples of four classes of stressors).

   4A. <u>Current Stressors</u> - - include daily hassles, current life experiences of losses, interpersonal conflicts and family dysfunctional behaviors, peer pressures, complicating medical conditions and the like.

4B. <u>Ecological Stressors</u> - - include environmental and cultural stressors such as high crime area, low social cohesion, level of poverty, presence of racism, discrimination, lack of facilities and services.

4C. <u>Developmental Stressors</u> - - include any history of victimization, neglect and familial stressors. (***Note the source of information for developmental stressors***).

4D. <u>Familial Stressors</u> - - include any evidence of familial psychopathology such as clinical depression, antisocial behavior, substance abuse, medical history and intergenerational transmission of stressors and genetic influences.

5. <u>Treatments Received</u> (Current/Past)

5A. Efficacy includes any data on the outcomes of current or past treatments. "What Worked?". Includes the source of information (self-report by patient, significant others behavioral or lab reports, Quality of Life Indicators). Be comprehensive in describing all treatments (medications, psychotherapeutic interventions, hospitalization, 12 Step AA, local faith healers, Chaplains, and the like).

5B. Treatment Adherence - - include compliance data on drop out from treatment, taking medications, active engagement in treatment.

5C. Patient and Familial Satisfaction - - ascertain what treatments the patient and significant others were most satisfied with and would reconsider using, or would recommend to someone else with the same problems and situations.

6. "Strengths and evidence of resilience.

Their "**in spite of protective behaviors**" that are present, even with the influence of "risk factors" and presenting and comorbid disorders fall into <u>three</u> <u>categories</u>. These strengths include **6A**. that reflects the patient's <u>individual strengths</u> (give specific examples); **6B.** that reflects <u>social supports</u> (both material and perceived supports - - "Guardian Angels"),indicators of "bondedness" and stable attachment history; **6C.** that reflects systemic strengths that include various forms of available services and treatment options (material and psychological).

7. Summary of Risk and Protective Factors

Provide the patient and significant others with a summary, using the Box framework of the CCM of the "risk" and "protective" factors. Engage the patient in a discussion of a treatment plan of where to start and how treatment can proceed. Negotiate a treatment approach and check for the patient's theory of his/her presenting problems and what is needed to change or improve his/her situation. Consider how the CCM "fits" the patient's theories of what is needed to be of help.

8. Outcomes - - Goal-attainment Scaling (GAS)

Collaborative goal-setting is used to determine how the patient, significant others and the psychotherapist can determine if the intervention is "working" and leads to the desired behavioral changes. What are the agreed-upon signs of improvement that can be expected **8A**. Short-term; **8B**. Intermediate and **8C**. Long-term? (For each target behavior note what specific change would look like). These behaviorally specific goals should be stated in positive terms as behaviors designed to increase, not stated in negative terms as behaviors designed to be reduced or stopped. Can use Goal Attainment Scaling (GAS) Procedures. Identify up to three Target Behaviors each developed collaboratively with the patient in specifying what Minimal, Moderate and Significant Improvement would look like and how progress is to be evaluated.

Specific Ways Behavior Should Change

	Minimal Improvement		Moderate Improvement		Significant Improvement
	0% change	25% change	50% change	75% change	100% change

Target Behavior 1

Target Behavior 2

Target Behavior 3

Work with patient to indicate what each level of behavioral improvement would look like.

9. Barriers

In order for these behavioral changes to occur, the following barriers need to be anticipated and addressed. These include **9A**. Individual barriers such as level of psychological and neurological impairment, belief systems or reasons for nonparticipation, lack of motivation to change and the like; **9B**. Social barriers such as living in a setting where High Expressed Emotion (Hi EE) barriers of criticism, intrusiveness, co-dependence undermine implementation of the intervention; Systemic barriers that are practical factors such as no transportation, child care, distance, lack of availability of services, insurance issues, long waiting lists, absence of racially and ethnically-sensitive healthcare providers, and the like. Note each barrier and the "game plan" to address each of them. Be specific in describing what should be done and how to be evaluated (outcome-driven patient feedback), follow up assessments and specific ways to build in generalization and maintenance procedures.

QUESTIONS DESIGNED TO ENGAGE THE PATIENT IN A COLLABORATIVE CASE CONCEPTUALIZATION

The psychotherapist can say:

"*Let me explain what I do for a living. I work with folks like yourself and try to determine how things are right now and how you would like them to be.*" (Tap Boxes 2 and 3 on Presenting and Comorbid Problems).

"*What kind of things in the present or past seem to make things worse?*" (Tap Box 4)

"*What have you tried in the past to cope with, handle these problems and your situation?*" "*Did you receive any help from others?*" "*What worked, as evident by?*" "*What did you have difficulty following through with?*" "*What were you satisfied with that you think we can build upon?*" (*Tap Boxes 5 and 6*).

"*If we worked together, and I hope we can, how would we know if you were making progress? What would we see change? What would other people notice?(Tap Box 8*).

"*Let me ask one last question, if I may? Can you foresee or envisage any particular barriers or obstacles that might get in the way of our working together on this treatment plan? How do you think we can increase the likelihood of your maintaining and building upon these changes? (Tap Box 9).*

Notice that all of the Questions are "What" and "How" questions.

CORE COMPETENCIES FOR PSYCHOTHERAPISTS

Donald Meichenbaum, Ph.D

1. **Establish, maintain and routinely monitor the quality of the therapeutic alliance.**

2. **Actively communicate an accepting, supportive, helpful, empathic, validating message. Meet the patients where they are "at" and guide them to what may be more beneficial for them. Follow their lead and take things slowly and be patient.**

3. **Conduct a comprehensive assessment of the reasons for seeking treatment or having been mandated for treatment (e.g., presenting symptoms, current concerns, life problems). Conduct a functional, situational and developmental analyses.**

4. **Assess for the client's and significant other's explanatory models or implicit theories about the nature of the presenting problems and what it will take to change. (Solicit explanations about the treatment and possible barriers and provide a treatment rationale).**

5. **Be culturally sensitive, as well as gender and developmentally sensitive. (Be culturally competent).**

6. **Include assessment of risk to self and to others and risk of revictimization. Ensure client safety.**

7. **Use the "Art of Socratic Questioning" and a discovery-oriented approach. Encourage the client to tell and retell his/her story at his/her "own pace".**

8. **Develop and use a Case Conceptualization Model and provide feedback to the client and significant others.**

9. **Engage the client in collaborative goal-setting that nurtures "hope" and adjust goals collaboratively over the course of treatment. Elicit evidence of "strengths". Use "In spite of" statements and use Time Lines. Encourage positive expectations that psychotherapy can be beneficial in facilitating change.**

10. **Use Motivational Interviewing procedures (Express Empathy, Avoid Argumentation, Develop Discrepancy, Support Self-efficacy) that can impact their willingness and commitment to change.**

11. **Conduct ongoing psycho-education in order to help them become more aware of the determinants of their behavior and the interconnections between their feelings, thoughts, behaviors and reactions of others. Use A "Clock" metaphor of 12 o'clock**

referring to external and internal triggers; 3 o'clock referring to primary and secondary emotions; 6 o'clock referring to thinking process (automatic thought and images, thinking processes and schemas/beliefs, expectations and attribution; 9 o'clock referring to their behaviors and reactions of others and how these contribute to a "vicious cycle". Increase the client's self-awareness of how he/she inadvertently, unwittingly, and unknowingly produce reactions in others that confirm their beliefs.

12. **Routinely solicit feedback about the therapeutic alliance and outcome from the client. Conduct feedback-informed treatment. Monitor change, lack of improvement and deterioration.**

13. **Address therapy-interfering behaviors, therapeutic impasses ("ruptures" to therapeutic alliance) and reasons for treatment nonadherence. Consider the therapist's possible contributions to alliance problems. Attend immediately to any strains or "ruptures" in the alliance that can lead to treatment failure.**

14. **Document, Document, Document. Maintain progress reports using the Case Conceptualization Model.**

15. **Keep the treatment focused and structured. Maintain a sense of direction (use "journey" metaphor). Use language of becoming and sense of possibilities. (Metacognitive and "RE" verbs). Be "principal-driven", not "protocol-driven" - - be clinically flexible.**

16. **Improve credibility of the therapist by fostering client change early in treatment (e.g., symptom reduction, improve relationships).**

17. **Help the client engage in inter-session activities ("Homework" assignments).**

18. **Train intra emotional self-regulation and interpersonal skills. Build in generalization guidelines. (Do not "train and hope" for transfer). Provide integrative treatments for clients with comorbid disorders.**

19. **Where indicated, incorporate spiritually-based interventions.**

20. **Provide corrective experiences within and outside of treatment. Use gradual exposure-based interventions with traumatized/victimized clients, where indicated. But be sensitive to other dominant emotional reactions including, guilt, shame, complicated grief, anger and "moral injuries" and tailor interventions accordingly.**

21. **Encourage and challenge the clients to take a risk in how they behave in the hope of finding results with more positive consequences, or "data" that they will take as "evidence" to unfreeze their beliefs about themselves, others and the future.**

22. **Conduct relapse prevention and self-attribution training ("Taking credit" activities).**

23. Help the client become his/her "own therapist"/"detective". "Restory" one's life.

24. Prepare for termination (Taking stock of changes and planning for the future).

25. Engage in psychotherapist self-care behaviors and experience "vicarious resilience".

26. Work to enhance mastery by means of deliberate practice and self-reflection.

27. Behave in an ethically responsible manner. (Respect boundaries and be aware of psychological treatments that cause harm).

OBSERVATIONS ON CORE PSYCHOTHERAPEUTIC COMPETENCY SKILLS

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1. Establish, maintain and routinely monitor therapeutic alliance (TA).

   The TA is the most robust predictor of therapy outcomes. The amount of change attributable to TA is seven times that of the specific treatment model, or specific treatment techniques. The specific treatment accounts for <u>no</u> <u>more</u> than 15% of variance of treatment outcomes. In comparison, some 36% to 51% of the treatment outcome variance is attributed to the <u>person</u> <u>of the</u> <u>therapist,</u> which is 3 to 4 X that of the specific treatment approach. Moreover, it is not therapist demographic factors (gender, ethnicity, discipline, or experience) that is predictive of treatment outcomes (Bordin, 1979; Horvath et al, 2011; Sperry & Carlson, 2013; Wampold, 2006).

   TA consists of three major elements:

   1. the therapeutic bond and the feeling that there is good communication and the mutual willingness to work together, established between the client and the therapist (mutual liking);

   2. mutually agreed upon treatment goals;

   3. mutual agreement on the methods to achieve the client's treatment goals ("pathways thinking" and being "practically optimistic").

   As Goldfried observed (2013, p. 865) the client should hold the belief: "My therapist really understands and cares about me" and the therapist should hold the belief: "I really enjoy working with this patient." The alliance represents the context in which the change process occurs (Castonguay & Beutler, 2006; Muran & Barber, 2010).

2. Actively communicate an accepting, supportive, helpful, empathetic, validating message.

   The client's trust and confidence in the therapist that he/she is competent and interested in the client's well-being is predictive of outcome. The client must feel safe, hopeful and consider the therapist as trustworthy and nurturing in order to set the stage for the client's self-disclosure of painful emotions and intimate details.
   The client must feel accepted, valued, understood, supported, hopeful and confident that treatment will be helpful.

   > ***"Patience is part of the key to being an effective psychotherapist. Let things happen that happen. Let people find their own comfort. Allow them to learn through struggle. Don't rescue, just support. (Beutler, 2001, p.215).***

   An effective TA may develop as early as the first session, but an effective TA must be firmly in place by the third session if treatment is to be successful. High TA leads to better

treatment and greater likelihood of maintaining change (Skovholt & Jennings, 2004; Sperry & Carlson 2013). Note however, that the improved quality of the therapeutic alliance can follow from behavior change, especially as the treatment sessions progress. Problems in the therapeutic alliance can undermine the efficacy of therapy outcomes. In about 5 % to 10% of cases clients may get worse as a result of psychotherapy (Goldfried , 2013).

The client's evaluation of the quality of the psychotherapeutic relationship is a better predictor of the TA and treatment outcome than is the psychotherapist's evaluation of TA (Castonguay et al., 2010; Horvath et al., 2011).

> ***"It is the therapist and not the treatment that influences the amount of therapeutic change that occurs. Relationship skills or developing a therapeutic alliance is the cornerstone of therapeutic excellence" (Sperry & Carlson, 2013).***

3. Use feedback-assisted treatment. Obtain feedback on a session by session basis.

    Use Rating Scales and Socratic probes and adjust treatment accordingly (see Duncan, 2010; 2012; Duncan et al. 2003; and work by Lambert (2007) and Miller as summarized on www.heartandsoulofchange.com). These are a four item scale that takes two minutes to complete that cover such areas as how well understood and respected the client felt, and whether the therapist worked on what the client wanted, how good is the "fit" and the degree of change in key areas.

    The **PATIENT RATING SCALE (ORS**) which is administered at the beginning of each treatment session assesses the therapeutic progress of psychological functioning and the client's perceived benefits from treatment. The **PATIENT SESSION RATING SCALE** (SRS) which is administered at the end of each session and is discussed with the therapist assesses the client's perception of the relationship and whether the therapist and the client have common therapeutic goals and agreed upon means by which to achieve these goals. These two Scales have been translated into 23 languages and have been administered to 100,000 clients. (See www.psychotherapy.net for an interview with Scott Miller and www.centerforclinicalexcellence.com/site.php?page=measures.php for copies of the measures). Feedback Informed Treatment (FIT) has been listed in SAMHSA Registry of Evidence-based Programs and Practice.

    The client's subjective experience of change early in the treatment process is a good predictor of treatment success (Campbell & Hemsley, 2009;Norcross, 2002; Orlinsky et al. 2004).

4. Provide the client with Corrective Experiences both within and outside of therapy.

    As Alexander and French (1946) had proposed, encourage the client to "reexperience old unsettled conflicts with a new ending." A number of researchers have highlighted that a key feature of behavior change is to help clients increase their awareness ("behavioral pattern

recognition") and then to give themselves permission to take a risk of behaving differently that elicits results ("data") that disconfirms their prior expectations. Use gradual exposure-based treatment, where indicated. Nurture a process of "transformation" (See Castonguay & Hill, 2012; Fraser & Solovey, 2007; Good & Beitman, 2006; Goldfried, 2012; Meichenbaum, 2013; Sperry & Carlson, 2013).

5. Prepare for termination and help the client become his/her "own therapist".

    Provide opportunities for intermittent retrospective "taking stock" throughout treatment. Nurture the client's self-attributions or "taking credit" for behavior change. This naturally transitions into preparing for termination. Tasks to accomplish include:
    Relapse Prevention training - - plan and develop self-control skills to prevent relapse.
    Analyze potential high-risk situations and how to view setbacks and lapses as "learning opportunities".
    Discuss possible future challenges.
    Ask "How different ?", "What learned ?" questions. Have clients fill out checklists and provide examples and reasons.
    Listen for the client's use of "meta-cognitive transitive verbs" ("notice, catch, plan, choose") and use of RE verbs.
    Discuss a self-therapy approach, "Become your own therapist".
    Discuss life-style balance and changes.
    Consider graduation ceremony, if part of a group. Include acknowledgement of accomplishments.
    Consider "unfinished business" and use a journey metaphor.
    Transform into meaning-making and give back activities.
    Bolster self-efficacy by helping the client to embrace negative emotions as signals to examine behavioral patterns and associated expectations. (Use "Clock" metaphor).
    Consider possibility of future treatment.
    Ensure that learning is "fun" - - put the client in a consultative mode to teach others.

    THE ULTIMATE GOAL OF TREATMENT IS TO HELP THE CLIENT TO BECOME HIS OR HER OWN THERAPIST

6. Use the Art of Discovery-Oriented Socratic Questioning Throughout

    A) Examples of Questioning - - Focus on "What" and "How" Questions

    "Let me explain what I do for a living. I work with clients like yourself and try to find out how things are right now in your life. I want to find out how you would like things to change."

    "I would like to find out what you have tried in the past so we can benefit from those experiences. What worked? What did not work, as evident by? What were you satisfied with that you think we can build upon?

"If we worked together, and I hope we can, how would we notice if we were making progress? What would we see changed? What would other folks notice?

"Permit me to ask one last question. Can you foresee, envision anything that might get in the way of our working to achieve your treatment goals?"

B) Questions designed to help clients become their "own therapist".

"Let me ask you a somewhat different question. Do you ever find yourself out there, in your day to day experience, asking yourself the kind of questions that we ask each other right here in therapy?"

The treatment goal is to have the client become his or her own therapist and to take the "psychotherapists voice" with him or her.

C) Embed questions with "So far", "As yet", "In spite of" followed by "How" and "What" questions. Use the language of becoming and nurture a sense of possibility.

D) Questions designed to solicit feedback.

"Are our sessions meeting your needs and doing the kinds of things you would have hoped to accomplish?"

"Is there anything else that you think I can do that might be helpful that I am not doing?"

"As you look back on our work together, what stands out? Are you surprised at all with these changes?"

"On a scale of 1 to 10, where 1 is dissatisfied and 10 is highly satisfied, what number would you rate our working together?"

"As a psychotherapist, I am always trying to learn to become more expert and I wonder if you have any suggestions as to how I might improve the way I work?"
"Would you recommend this type of therapy to a relative or close friend if he/she were in need? What would you say you got out of treatment that they could benefit from?"

"Is there anything I said or did or failed to say or do in today's session that you found particularly helpful or unhelpful?"

"Are you at all surprised with these changes?"

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