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EFFECTS OF SOLUTION-FOCUSED VERSUS PROBLEM-FOCUSED INTAKE QUESTIONS ON PRE-TREATMENT CHANGE

CHRISTOPHER J. RICHMOND
Ferris State University
SARA SMOCK JORDAN
Texas Tech University
GARY H. BISCHOF
ERIC M. SAUER
Western Michigan University

This research tested the hypothesis that changing the language of intake procedures could be beneficial. Two randomized studies compared solution-focused brief therapy (SFBT) intake procedures with traditional intake procedures. In Study 1, clients completed either a standard written intake form with problem-focused questions or an SFBT Short Intake Form. Clients answering the solution-focused questions described significantly more solutions and significantly fewer problems than the comparison group. Study 2 compared an SFBT intake interview with a DSM-based diagnostic intake interview. Clients in the SFBT intake interview improved significantly on the Outcome Questionnaire (OQ) before their first therapy session, whereas those in the diagnostic intake did not. Both studies demonstrated that intake procedures are not neutral information gathering and that strength-based questions have advantages. Using solution-focused language in intake procedures can change the information that clients provide and even lead to pre-treatment change. Both intake procedures are ready for adoption by practitioners.

Study 2 was completed as a dissertation study while the first author was enrolled at Western Michigan University (WMU) in the Counseling Psychology Doctoral Program. The data for Study 2 was collected at WMU and Ferris State University. Special thanks also go to Virginia Tech's Marriage and Family Therapy Clinic, where data for Study 1 were collected.

Note that this article focuses on the relevance of research for practitioners, so many specialized research details were omitted because of space limitations. Any reader who would like to see a more complete research report (or to ask technical questions) is welcome to contact the first or second author.

Address correspondence to Christopher J. Richmond, University Counseling Center, Ferris State University, 1019 Campus Dr., Big Rapids, MI 49307-2280. E-mail: christopherrichmond@ferris.edu or to Sara Smock Jordan, Applied and Professional Studies, Texas Tech University, Broadway and Akron St., Room 260, Human Sciences, Box 1210, Lubbock, TX 79409-1210. E-mail: sara.smock@ttu.edu

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Mental health professionals often assume that a comprehensive psychological intake assessment is essential for determining the client's appropriateness for counseling and planning a successful course of treatment (e.g., Fine & Glasser, 1996). Therefore, mental health agencies have the task of adequately interviewing and assessing clients during the intake (e.g., Shertzer & Linden, 1979). Research indicates that clients may also experience therapeutic benefits as a result of the intake assessment (e.g., Hood & Johnson, 1991). However, little empirical attention has been given to the intake procedure, which includes the intake paperwork and subsequent interview, as a communicative process nor to the language of intake procedures from different therapeutic models. This article describes two studies of solution focused brief therapy (SFBT) intake procedures. Study 1 (conducted by the second author) examined the effect of solution-focused versus problem-focused questions on a written intake form. Study 2 (conducted by the first, third, and fourth authors) compared an SFBT intake interview with a traditional diagnostic intake interview.

Historically, psychotherapy intake procedures have relied on a medical model. This approach focuses on diagnostic information about the client and the presenting problem(s). It also assumes that therapeutic orientation dictates the mechanism for change and the therapeutic and remedial interventions (Wampold, 2001). Because most therapeutic approaches are problem focused, they necessitate diagnostic problem-based questions. The assumption that detailed information about the client's problems must be obtained in order to conduct effective therapy has led to pathologizing, problem-focused intake procedures as the standard in psychotherapy.

SFBT stands in stark contrast to the medical model and problem-focused treatments because it is a strength-oriented model that maintains a positive and future-oriented focus. Specifically, rather than focusing on the diagnosis, etiology, and current nature of the problem, SFBT seeks to initiate and maintain discussions about strengths and resources. When clients are engaged in such conversations, they imagine themselves within their world of possible solutions (e.g., De Jong & Berg, 2002; de Shazer, 1994, Chapter 7).

SFBT has grown considerably in the last two decades, becoming a widely accepted therapeutic approach internationally, with both traditional outcome studies (e.g., Gingrich & Peterson, 2013; Kim, 2008; Kim, Smock, Trepper, McCollum, & Franklin, 2010) and a wide variety of other supporting evidence (e.g., Franklin, Trepper, Gingrich, & McCollum, 2011). Still, little is known about the effectiveness of SFBT language during intake procedures prior to treatment. Recently, the Solution Building Inventory (SBI; Smock, McCollum, & Stevenson, 2010) was developed to measure the construct of solution building and has been validated on a clinical sample (Jordan, in this issue). There are also a growing number of other solution-focused and strength-oriented outcome measures (Smock, 2011). However, studies on solution-building intake procedures are still needed. Such studies fit one of Bavelas's (2011, Table 10.1) four distinct kinds

of evidence, namely, tests of specific techniques or interventions that ask the question "Do key components of [SFBT] work as proposed?" (p. 145).

THE ROLE OF QUESTIONS IN PSYCHOTHERAPY

The traditional purpose of questioning has been to gain information, but questions can also serve as interventions (e.g., Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1980). SFBT treats all questions as interventions rather than as neutral information gathering (O'Hanlon & Weiner-Davis, 2003). McGee (1999; McGee, Del Vento, & Bavelas, 2005) proposed that questions have an interactive impact on conversations in therapy because of their implicit presuppositions. Clark and Schober (1992) defined presuppositions as what a question assumes. These assumptions are usually embedded within the question rather than overtly stated (Tomm, 1988). Questions with different presuppositions may lead to different answers (e.g., McGee et al., 2005). For example, to ask "When was the first time you smoked marijuana?" presupposes that the client has smoked marijuana at least once. To ask "Have you ever smoked marijuana?" presupposes that the client may or may not have ever smoked marijuana.

The presuppositions in questions distinguish problem-solving from solution-building conversations. Questions that are solution focused in nature presuppose hope, strength, and resources. For example, "So what will things look like when you reach your goal?" presupposes that the client has all the resources to reach his or her goal. In contrast, "So what will things look like if you continue to have these problems?" presupposes that the client has several problems that may continue. Because intake procedures consist entirely of questions, analyzing the effects of their presuppositions seems vital.

POSSIBLE EFFECTS OF INTAKE PROCEDURES

Little research exists on the effects of intake procedures. One unpublished study (Steiner, 2006) failed to support the hypothesis that solution-focused language in intake forms would generate more hope, optimism, and confidence than problem-focused forms. In the present article, Study 1 is a more specific test of the effect that a solution-focused versus problem-focused intake form can have on the answers the clients provide.

It is also possible that the questions in an intake procedure could influence pre-treatment change. The concept of pre-treatment change was first discussed by Weiner-Davis, de Shazer, and Gingerich (1987) after they noticed that two thirds of the families they surveyed reported desirable change between their initial phone call and their first session. Lawson (1994) also found that 60% of 86 participants reported

desired change prior to their first session. Pre-treatment change is an important part of SFBT because it highlights client progress prior to the intake interview and is useful for generating further solutions. Study 2 assessed pre-treatment change after a solution-focused versus problem-focused intake interview.

STUDY 1: SFBT VERSUS TRADITIONAL CLINICAL INTAKE FORMS

Written intake forms tend to be regarded as static objects—reified, in Linell's (2005) terms. However, like any other questions, they introduce implicit presuppositions, those presuppositions may elicit different answers. This first study varied the phrasing of questions on written intake forms, comparing typical problem-focused versus solution-focused questions in an SFBT Short Intake Form. It was hypothesized that the different presuppositions in problem-focused versus solution-focused questions would affect the clients' answers. For example, "What problem(s) are you experiencing?" presupposes that the client is experiencing one or even more problems and that these problems are the main focus of treatment. In contrast, "How can we best help you?" presupposes that help is possible and that the client knows how this help could best be provided (i.e., possible solutions).

Method

Participants. The sample was 50 new clients at a university Marriage and Family Therapy (MFT) clinic. They ranged from 14 to 62 years of age; 31 were female, 19 were male. All but five were Caucasian. The participants were randomly assigned one of the two intake forms, with 21 receiving the SFBT Short Intake Form and 29 receiving the problem-focused form.

Instruments. Four items of the short, standard intake form at the MFT Clinic were modified to be solution-focused versions of the original questions (the SFBT Short Intake Form; see Table 1), and a fifth question on pre-intake change was added to both versions. The main dependent variables were the number of problems and the number of solutions listed under Question 1 and the client's rating of any pre-intake change.

Results

Clients who completed the SFBT Short Intake Form listed significantly fewer problems ($M = 1.5$, $SD = .62$; range 0 to 3) than those clients with the problem-focused form ($M = 2.17$, $SD = 1.36$; range 1 to 6), which was a significant difference; $t(48) = -2.3$, $p = .03$, one-tailed. The solution-focused form also elicited significantly more solutions ($M = 1.05$, $SD = .62$; e.g., learning how to cope, sticking

TABLE 1. Problem-Focused and Solution-Focused Intake Form Questions

Problem-Focused Questions	Solution-Focused Questions
(SFBT Short Intake Form)	
1. What problem(s) are you experiencing?	1. How can we best help you?
2. On a scale of 1 (problem is very severe) to 10 (no problem at all) rate the severity of your problem?	2. On a scale of 1 (being farthest away from where you would like to be) to 10 (exactly where you would like to be) where are you now?
3. How long have you had this problem(s)?	3. Where would you like to see yourself one year from now?
4. How have you tried to solve this problem?	4. How will you know you no longer need to come for therapy? (Specifically, what would things look like in your life if you no longer felt the need to attend therapy?)
5. Since you have called the clinic, which of the following has occurred? (circle one please)	5. Since you have called the clinic, which of the following has occurred? (circle one please)
Overall, things have gotten worse	Overall, things have gotten worse
Overall, things have stayed the same	Overall, things have stayed the same
Overall, things have gotten better	Overall, things have gotten better

to goals) than those filling out the problem-focused intake ($M = .07$, $SD = .26$; e.g., relationship issues, anger), which was also a significant difference; $t(48) = 6.50$, $p = .01$, one-tailed. There were no other significant differences.

Discussion

The main finding in this study suggests that the wording of an open-ended question about problems versus solutions can make a difference to the information that the client provides. Asking "What problem(s) are you experiencing?" presupposed not only that a problem existed but that there could be several problems—a presupposition that "How can we best help you?" did not make. Instead, the solution-focused question presupposed that things could get better and that the client knew what would be helpful to him or her.

Limitations and Future Research. The surprising result was that the wording of a single question made a significant difference in clients' responses. There are three limitations, each of which suggests a future study. First, the number of participants in this study was relatively low. The greater power of a larger sample size might have greater potential for identifying additional significant differences between intake forms. Second, racial diversity was limited, making it difficult to

generalize the findings to all ethnic or racial groups. Third, the two intake forms were very short, with only four items that differed. More extensive forms with more variations in the presuppositions might reveal greater differences. Because little research exists on the wording of intake forms, the results of Study 1 provide a rationale for future studies.

STUDY 2: SFBT VERSUS TRADITIONAL DIAGNOSTIC INTAKE INTERVIEW

The purpose of Study 2 was to compare the effectiveness of an SFBT Intake Interview (Richmond, 2007) and a problem-focused diagnostic intake interview. The SFBT Intake Interview was constructed from the stages of solution building (e.g., De Jong & Berg, 2002) and followed de Shazer's (1988) flowchart for the first counseling session (i.e., pre-treatment change question, complimenting, miracle question, exception question or coping question, scaling question, and identification of client strengths and resources). Notice that all of the questions in this interview have positive presuppositions, such as the possibility of change, the existence of current exceptions or coping, and the possibility of the future without the problem. The full SFBT Intake Interview and training procedures can be obtained from the first author.

The problem-focused interview was based on the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I; First, Gibbon, Spitzer, & Williams, 2002), which is a broad, semi-structured instrument that adheres closely to the DSM-IV decision trees for psychiatric diagnosis. The SCID-I was appropriate because it is one of the most widely used diagnostic interviews and is considered a "gold standard" for accurate diagnosis (Shear et al., 2000; Spitzer, Williams, Gibbon, & First, 1992). This study used the overview module, which includes an assessment that leads to a preliminary psychiatric diagnosis, and the screening module, which is an assessment of alcohol and drug use, anxiety symptoms, thought disorder symptoms, and eating disorder symptoms. All of the questions presuppose the possibility of several problems, of a past history of problems, and of exacerbation of the problem.

This study compared the SFBT and the SCID-I intake procedures on counselor ratings, session evaluations, outcome optimism, goal clarity, and reduction of distress. It also examined whether an intake interview could produce pre-treatment change, that is, a statistically significant reduction in symptoms of distress between intake and the first therapy appointment. This study tested the hypothesis that the SFBT intake procedures would be more beneficial, in terms of the above outcome variables, than the SCID-I intake.

Method

Clients and Interviewers. The participants in the intake interviews were 30 clients presenting for counseling at a university counseling center or at one of two

psychology training clinics, all affiliated with universities in the Midwest. Half of the participants had the SFBT Intake Interview and half had the SCID-I intake. The 16 female and 14 male clients were predominantly Caucasian, with a mean age of 26.27 years. Each of the interviewers had completed a master's degree in psychology. There were three male and three female interviewers; all six were Caucasian. Each interviewer was trained on and conducted both the SFBT and SCID-I intake procedures. Three of the interviewers reported their primary theoretical orientation as eclectic, two as cognitive-behavioral, and one as family systems.

Instruments

Counselor Rating Form—Short Version (*CRF-S*). Strong (1968) proposed that clients' perceptions of a counselor's expertness, attractiveness, and trustworthiness affect the counselor's influence. The CRF-S (Corrigan & Schmidt, 1983) uses 12 items with 7-point Likert scales to assess these perceptions. In Corrigan and Schmidt's normative data from clients of community counselors, the mean score for each scale was 25±1, producing a mean total score of 76. Median coefficient alphas for the total score were .91 (range = .82–.94; Corrigan & Schmidt) and .82 (range = .63–.89; Tryon, 1987).

Session Evaluation Questionnaire (*SEQ*). The SEQ Form 5 (Stiles, Gordon, & Lani, 2002) measures session depth (from powerful and valuable to weak and worthless), smoothness (from relaxed and comfortable to tense and distressing), arousal (from still and calm to excited and moving), and positivity (from pleased and confident to angry and afraid). The SEQ uses 21 items with a 7-point bipolar adjective format. Stiles et al. (1994) reported normative data from a large sample of psychotherapy clients; the means were 5 ± 1. Median coefficient alphas for the four dimensions ranged from .93 to .81 (Reynolds et al., 1996).

Immediate Outcome Rating Scale (*IORS*). The IORS (Adams, Piercy, & Jurich, 1991) is an SFBT-oriented measure that assesses goal clarity and outcome optimism. The IORS asks clients to rate 16 statements about goal clarity and outcome optimism on a 7-point rating scale. The authors reported normative data from a small pilot sample of clients receiving family counseling; the means were 21 ± 4. Adams et al. reported coefficient alphas of .86 and .76 for goal clarity and .81 and .83 for outcome optimism at the end of session one and two, respectively.

Outcome Questionnaire 45.2 (*OQ*). The OQ (Lambert et al., 1996) is a 45-item self-report instrument that measures clients' current level of distress and is designed to be administered prior to each therapy session. The internal consistency of OQ total scores was high ($\alpha = .93$), and the 3-week test-retest reliability was $r = .84$ (Vermeersch, Lambert, & Burlingame, 2000). In addition, OQ scores have been shown to be responsive to counseling-related changes over short periods of time

(Vermeersch et al., 2000). Vermeersch et al. (2000) reported normative data from a sample of predominantly university student patients; the mean for the OQ total score at pre-treatment or prior to the intake interview was 70.32 (*SD* = 2.2).

Procedure

Clients were randomly assigned to either the SFBT or the SCID-I intake interview. At the end of the interview, they completed a study packet that included the SEQ, CRF-S, and IORS. They completed the OQ twice, prior to the intake interview and before their first therapy session.

Interviewer Training. The interviewers participated in both SFBT and SCID-I training sessions, which involved both didactic and experiential components. The SFBT interview training addressed (a) basic theoretical formulations of SFBT, (b) goals of therapy, (c) conditions for change, and (d) SFBT techniques. The experiential component involved practice at administering the SFBT interview in client-counselor role-playing dyads. The third author provided feedback to the interviewers based on their performance in these dyadic exercises.

The SCID-I interview training began with a review of the SCID *User's Guide* (First et al., 2002), which explained all of the conventions of the SCID-I and the special instructions for using the various diagnostic modules. As in the SFBT training, the SCID-I training included an experiential component in which the interviewers administered the SCID-I interview in role-playing dyads. The fourth author provided feedback to the interviewers based on their performance in these dyadic exercises.

Interviewer Adherence. All intake interviews conducted for this study were videotaped to determine whether or not the interviewers followed the assigned protocol. The raters were not affiliated with the study and were unaware of its research questions. An interviewer's session was deemed acceptable if the interviewer stayed true to the intake interview protocol by asking each question (or some close variation of it) and then providing sufficient follow-up questions. No interviewers were rated as failing to follow the intake protocol during any stage of the study.

Results

Ratings of the Interviews and Interviewers. The CRF-S, SEQ, and IORS, which clients filled out immediately after their interviews, were compared by *t*-tests, and there were no statistically significant differences between interviews on any of these variables. That is, the clients' ratings of their interviewers, the interviews, and the immediate effects were effectively the same for the two groups and all were within the normative range. Overall, clients did not prefer one form of the interview over the other. (A table depicting these results can be obtained by contacting the first

author. This table also includes the coefficient alphas obtained in this study for the CRF-S, SEQ, and IORS.)

Pre-treatment Change (OQ). Table 2 shows pre- and post-interview means for the two interview groups. Before their interviews, there was no significant difference between the two groups, which confirms the random assignment.

When assessing the effects of the two interviews, there are two different approaches, which reflect two different purposes and questions: The approach in most randomized controlled trials would ignore the individuals' pre-interview scores and apply an independent-samples test to the post-interview scores. This test asks whether there were, on average, significant differences in the samples as a whole (ignoring the effects on individuals). Although the post-interview mean for the SFBT group was lower than that of the SCID-I group, the independent-sample *t*-test was not significant. Even if it had been significant, it would not be informative about how individuals fared in the two conditions.

A researcher who is more interested in practice implications would ask whether individuals tended to improve, given where they started. That is, the test would compare each individual's pre-interview OQ with his or her post-interview score. Was there a significant tendency for individuals to be better than they were before? This is a within-subjects *t*-test, and it showed that the SFBT interview led to a significant post-interview reduction of distress for the individuals in that group; $t(29) = 4.18$, $p < .001$. The same comparison for the SCID-I group showed that these individuals did not show a significant improvement.

A good way to visualize the difference between the two groups is to examine their change scores directly. Lambert et al. (1996) introduced a "reliable change index" for the OQ, in which a change in the total score of 14 points or greater in either direction indicates that the client's improvement or deterioration is statistically significant and reliable (Lambert et al., 1996). The results of the OQ change scores for the SFBT and SCID-I intake groups can be seen in Figure 1. The change scores were calculated by subtracting the post-intake OQ scores from the pre-intake OQ scores. For example, a

TABLE 2. Differences Between SFBT Intake Interview and SCID-I on the Outcome Questionnaire

	SFBT	SCID-I	
	M (*SD*)	*M* (*SD*)	Two-tailed *t*-tests
Pre-interview OQ Scores[a]	73.40 (24.8)	79.30 (21.6)	$t(28) = -.660$
Post-interview OQ Scores[a]	63.70 (20.0)	74.31 (18.9)	$t(28) = .840$
SFBT pre-post comparison[b]			$t(29) = 4.18$*
SCID-I pre-post comparison[b]			$t(29) = .902$

Note. [a]Independent samples *t*-test. [b]Paired samples *t*-test.
* $p < .001$.

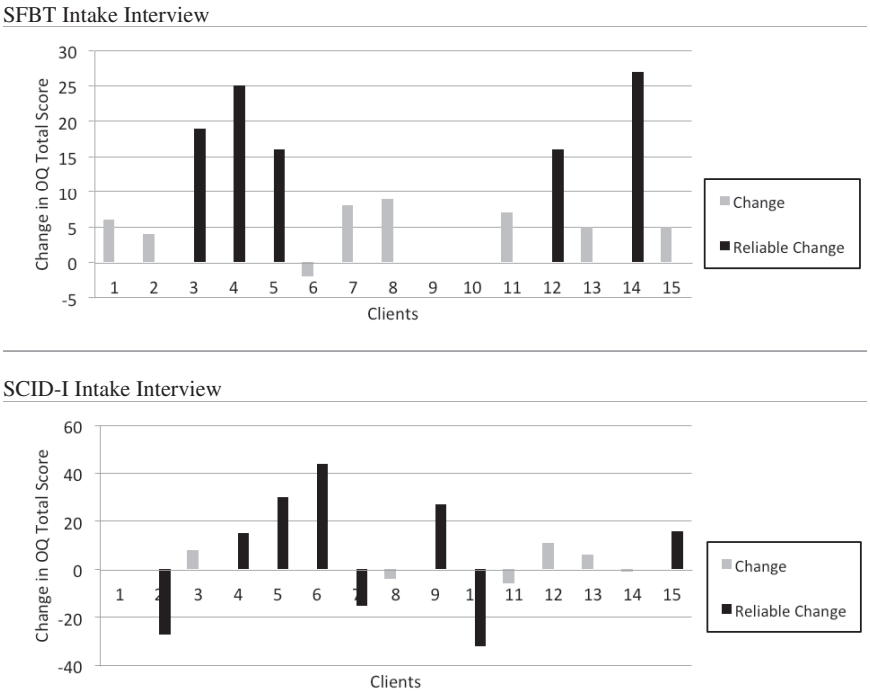

FIGURE 1. Pre-treatment change scores of clients in SFBT and SCID-I intake interview groups. The scores are OQ totals, so positive scores represent a reduction in distress, whereas negative scores represent an increase in distress. *Change* (in grey) means the score changed less than 14 points in either direction. *Reliable change* (in black) means the score changed 14 points or greater in either direction.

pre-intake score of 70 and post-intake score of 60 would result in a change score of 10. Five clients in each group achieved reliable change in the positive direction. However, there were three clients in the SCID-I intake group who showed reliable change in the negative direction; that is, an increase in distress. It is also clear that virtually all individuals in the SFBT group showed positive (or no) change and no deterioration, while those in the SCID-I group ranged from positive change to deterioration. One should not conclude that the SCID-I interview caused the deterioration; the spread of results for this group may simply be typical of what happens between intake and treatment when there is no intervention.

Discussion

The results from the OQ indicated that only the SFBT Intake Interview showed a statistically significant change (reduction) in distress after the interview and before treat-

ment began, thus confirming the hypothesis that changing the language of the intake interview could result in beneficial outcomes. This result is particularly noteworthy because the main focus of this study was on the possibility of pre-treatment change.

The results of this study are consistent with the conclusions of Kim's (2008) meta-analysis of the effectiveness of 22 SFBT treatment outcome studies, which showed that SFBT had positive (albeit small) treatment effects. Furthermore, Kim noted that SFBT appears to be most effective in reducing internalizing behaviors, such as symptoms of depression and anxiety. This result is particularly interesting because, of the several outcome measures employed in Study 2, it was the OQ that provided the most convincing evidence with respect to differences between the two intake interviews. (The OQ measures distress and internalizing behaviors that include symptoms of depression and anxiety; Lambert et al., 1996.) In regard to the internalizing behaviors, the SFBT Intake Interview engages clients in conversations about times when they are less depressed or anxious and times when they are (at least to some degree) happy or relaxed. For example, the client experiencing symptoms of depression might be asked, "Tell me about a time this past week when you did not feel sad or depressed," or "when you felt somewhat or slightly happy." Another example of using strengths-based presuppositions in a question is "So how have you been able to manage your anxiety this week?" Two studies since Kim's review, one comparing SFBT with a traditional problem-focused treatment (Seidel & Hedley, 2008) and the other comparing SFBT with a waitlist control (Smock et al., 2008), also found favorable results on the OQ for those receiving SFBT.

Limitations and Future Research. Surprisingly, this study failed to show that the SFBT Intake Interview was superior to the SCID-I interview on a measure of outcome optimism and goal clarity. Future research may benefit from using measures that more closely assess other constructs consistent with SFBT such as hopefulness, goal setting, self-knowledge of strengths and resources, and personal agency (e.g., Jordan, 2014; Smock et al., 2010).

IMPLICATIONS FOR CLINICAL PRACTICE

Unlike many research studies, the intake procedures introduced here can translate immediately into practice. Study 1 draws attention to the wording of questions in the written forms typically used to gather intake information and shows that changing the wording can change the answers. Study 2 suggests that the SFBT Intake Interview could be equivalent to a first session intervention. That is, some clients who have an SFBT Intake Interview could make significant treatment gains within the limited time between the intake and subsequent therapy session. There are several other possible applications.

Practitioners who are required to submit documentation for insurance purposes can create solution-focused questions that would avoid pathologizing the client

but still gather the requisite diagnostic information. A solution-focused question such as "How can I be helpful to you today?" often elicits from clients a description of their presenting problem(s) before it leads into what the client would find helpful. Similarly, the answer to a question regarding change since calling the clinic is likely to include the reason for calling, but it may also include ways in which things have gotten better. Both of these questions could provide the required diagnostic information but also give the practitioner the opportunity to highlight the client's strengths and resources, as well as the positive steps that he or she has already made prior to the session; e.g., by asking "I see from the intake paperwork that things have been better for you. Tell me what you have done to help facilitate these positive changes."

Another unique contribution of the new intake procedures in this article is to elicit goals that are more specific and positive and that are not simply the absence or reduction of the problem. Both Study 1 and 2 introduce questions that ask clients to consider their desired future. The SFBT Short Intake Form asks clients to scale their current status between "the farthest away from where you would like to be" (= 1) and exactly where they would like to be" (= 10). This question can lead to a description of the client's ultimate goal (= 10) as well as giving the practitioner an opportunity to further assess progress that clients have already made prior to the intake session. For example, if a client rates a 4 on this scale from 1 to 10, the practitioner could ask, "I see that you indicated a 4 on the scaling question; can you tell me the things you have already done that have helped you move from a 1 to a 4."

The miracle question, which is part of the SFBT Intake Interview, also encourages clients to consider their desired future and then discuss it in detail. After clients have discussed their miracle situation, the practitioner could ask, "On a scale from one to ten where ten represents the miracle situation you just described and one is the worst the current problem has ever been, where are you at now?" Once again, using this information, the practitioner can assess progress the client has already made toward their desired future.

The principles behind these two studies also apply to practitioners using other approaches in various settings. The research on continuity of care discusses the importance of consistency in theoretical orientation and treatment techniques throughout the duration of counseling, from the intake to subsequent therapy sessions (Haggerty et al., 2003). Practitioners in various settings could construct intake forms that are congruent with their setting or theoretical orientation. This would ensure consistency between the intake interview and subsequent treatment. At many counseling centers, one therapist administers the intake assessment and then refers the client to another therapist within the same center. Especially in this situation, it may be important to provide the client with a consistent form of therapy from the point of intake through termination.

Finally, both studies highlight the advantage of incorporating strength-based interventions into the treatment process. Because the goal of many mental health practitioners is to formulate an accurate diagnosis, they have used intake forms

and interviews that focus exclusively on the client's problems. However, consider whether clients would be more likely to continue counseling after a detailed exploration of their strengths or after an equally detailed exploration of their weaknesses. The authors would like to encourage mental health practitioners to consider the benefits of adding strength-based questions and interventions to their intake forms and interviews, such as those described in these two studies.

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