tual connection), Perpetual Issues and Solvable Problems Scales, and Sound Marital House scales (Gottman, 1999a; e.g., 20-item scales measuring love maps, fondness and admiration, sentiment override, the Four Horsemen, shared meaning, and so forth). Based on this comprehensive assessment involving both interviews and questionnaires, the couple is given feedback on this information in the third session. Feedback helps to create a more level "playing field" between the therapist and the couple, an experience in which the couple becomes more knowledgeable about their individual as well as relational strengths and growth areas. Furthermore, this information helps to establish a solid foundation of knowledge in both the therapist and client from which to proceed to a marital intervention. Moreover, providing this personal information recognizes the often considerable abilities of the client to help solve their own problems, and is an important positive step away from the expert therapist-dependent patient approach to therapy.

Other Assessment Considerations

All clinicians have values. Moreover, all clinicians have biases that influence the type of therapy they do, the kinds of clients they see, whether they assess or don't assess a client before therapy, and so forth. A study by Boughner, Hayes, Bubenzer, and West (1994) of members of the American Association of Marital and Family Therapy (AAMFT) found that only one-third of respondents reported using any kind of standardized assessment instrument (given sampling bias, this figure is likely inflated when generalized to the population of AAMFT therapists). Surprisingly, the instruments that were commonly employed by these marital and family therapists were individual measures such as the MMPI-2 or the Myers-Briggs Type Indicator.

It is argued that adequately assessing the problems of a client prior to beginning treatment is at heart an ethical issue. Most codes of ethics (e.g., American Association of Marriage and Family Therapy's *AAMFT Code of Ethics*, 1998; American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct*, 1992) emphasize important ethical concepts like risk management, responsibility for client welfare, informed consent, confidentiality, dual relationships, and so forth. The *Canadian Code of Ethics for Psychologists* (2000), however, in addition to these issues, goes an important step further by proposing four hierarchically ranked principles that need to be recognized and considered when there are conflicting priorities in clinical work: Principle I: Respect for the Dignity of Persons (highest ranking); Principle II: Responsible Caring; Principle III: Integrity in Relationships; and Principle IV: Responsibility to Society (lowest ranking). It is the view of this writer that competent assessment, which greatly increases understanding of a client's problem and thus should improve subsequent treatment, is at heart an ethical responsibility. That is, clinical assessment is an essential exercise that shows genuine respect and responsible caring for the client and, ultimately, places the needs of the client ahead of the therapist's idiosyncratic biases.

Lambert (1992) proposes that four therapeutic factors – extratherapeutic, common factors, expectancy or placebo, and techniques – are the principal elements accounting for client improvement in therapy. These factors are believed to account for different proportions of client change during therapy: 1) extratherapeutic (e.g., intrinsic motivation, social support, financial resources; 40% of change); 2) common elements in therapy, especially the quality of the therapist-client relationship (30%); 3) client's positive or negative expectancies about therapy (e.g., placebo effect; 15%); and 4) the particular

therapeutic technique employed (e.g., Cognitive-Behavioral Therapy vs. Interpersonal Therapy vs. Psychodynamic; 15%). Positive change is considered to be primarily the result of client/extratherapeutic factors. Often surprising to researchers and clinicians is that it is not the particular technique employed or the quality of the therapeutic relationship that most accounts for change, but that improvement is primarily determined by qualities of the client that are external to therapy itself (Hubble, Duncan, & Miller, 1999). Given this research-based insight, it seems essential to identify where a client is from the point of view of the process of change, so that therapy will not be attempted with individuals who are not yet ready to alter their lifestyles.

Prochaska (1999) describes six stages in the change process that he argues must be experienced in a linear fashion in order to achieve long-term change: 1) precontemplation (i.e., client is underaware of the need for change), 2) contemplation (i.e., aware one has a problem and is considering change), 3) preparation (i.e., have begun to be committed to change and intend to take action soon), 4) action (i.e., client expends the time and energy to change his/her environment, attitudes, and/or behavior), 5) maintenance (i.e., client works to consolidate changes and prevent relapse), and 6) termination (i.e., therapy is stopped since self-efficacy has been reached). It is noteworthy that the first three stages occur prior to any change or attempts at change. Clearly, if clients are in any of these stages – especially precontemplation and contemplation – they may not be good candidates for therapy at that time.

Determining one's level in the process of change in therapy is clearly beneficial. This information can be acquired by using interview questions, for example. Are you intending to change in the near future?; What changes, if any, are you currently working on? Or they could be included in an initial intake form (Proschaska, Norcross, & Di Clemente, 1994). A formal questionnaire could also be employed to determine a client's stage of change at the beginning of therapy, e.g., the 32-item Stages of Change Scale (SCS; McConnaughy, Prochaska, & Velicer, 1983).

The culmination of the assessment process is the Intake and Assessment Report. This is the communication phase of assessment. Groth-Marnat (1999) suggests that every report should be an integration of old information as well as new information that provides a unique perspective of the client. Old information will include basic demographic data, reason for referral, prior reports and clinical information, and relevant history, whereas new information will include assessment results, clinical observations, summary/conclusions, and treatment recommendations.

Stylistically, the assessment report is a combination of the science (and art) of competent information gathering and the art of persuading the reader that one's assessment of the client's problems are accurate and comprehensive, that the conclusions are practical, and that the recommendations should lead to action during treatment. In communicating one's assessment findings, it is of value to follow several writing guidelines: be clear, concise (yet not overlook important details), coherent and cohesive ("4 Cs of good writing"). Jargon should be avoided. As in all written and spoken communication, remember who your audience is. Write so that an intelligent lay person can understand the report. Avoid gross generalizations by including statements that are specifically relevant to the client. With regard to level of detail, some degree of balance is recommended between presenting general concepts, test results, and examples of behavior.

In sum, the old and new information in an assessment report must be woven together like a tapestry, so that it provides integrated, comprehensive, understandable, and clinically useful data that will guide subsequent therapy.