Instructions for the Short Assessment System

The SAS is more than a diagnostic tool. It is a form of therapeutic assessment, which means that it serves as a useful intervention while also collecting information. While reading the instructions below, understand that these guidelines are intended to help you use the SAS to better understand the needs of the individual client, to monitor the impact created by therapy, and as a form of therapeutic intervention.

General Overview:

The SAS-A is administered before each therapy session. Clients are asked to subjectively rate their distress in certain key areas of functioning (such as sadness, anxiety, etc.). These subjective ratings serve as a means of monitoring progress, increasing introspective awareness, and are displayed in a graph that becomes a means of self-monitoring (something that research has shown to change behavior even without the use of reinforcements). Use an item analysis interview (see handout) to understand the meaning behind the numbers. Mark the client's ongoing progress on the graph in SAS-C.

The SAS-B is administered after each therapy session. Clients are asked to describe their experiences in therapy using a sentence completion technique. This task produces many different benefits. It serves as a means of promoting better understanding between client and therapist. It increases self-awareness for the client. It serves as a means of summarizing what the client experienced during therapy so that new learnings are more accessible. And it helps facilitate positive outcome expectancies by validating the fact that the client did get something out of his therapy session. It is wise to save a few minutes to discuss the results. Address any problem areas that show up on the SAS-B when you receive the form. During the next session, the SAS-B responses can be used to return quickly to important ideas and themes.

The SAS-C is completed as soon as possible. If the client is in crisis, it may not be until the 2nd or 3rd session that it can be completed. The SAS-C allows all of the other measurements to be tied in with the treatment plan and contract. This helps communicate the collaborative nature of the relationship and the boundaries within which the therapy will occur. When clients know what to expect, they are more inclined toward cooperation. When they feel that they have actively contributed to the treatment planning, then they tend to have more ownership in the final results. The SAS-C can be revised whenever necessary but in many cases, only one form will be necessary.

Common Questions:

Q: Is the SAS-A always given to the client at the beginning of the session?

A: It is best to give the SAS-A before meeting with the client, especially on the first visit. This allows you to establish a baseline for the measurement of future progress. The SAS-A can be completed in the waiting room before entering for the session. This helps the client transition into the proper mind set for therapy. There is a sort of "introspective priming" that takes place while answering these questions. Although it is not always necessary, in some instances, the

therapist may want to ask the client if he has experienced a change on any of the scales as a result of therapy, this can also be documented on the form.

Q: The SAS-C, treatment plan, seems to be overloading, too "conscious," too rational for the client to define.

A: The SAS-C can produce some very surprising results. Clients often divulge a great deal about themselves during the first couple of sessions. It is helpful to capture this information in concrete form.

For example, I had a male who recently requested that his wife come into the session with him. She did. Her complaint was that he was verbally abusive, yelled at her often, would say things to hurt her. I aligned myself with her and confronted him sternly for his behavior. He became enraged at me. He insisted that this was his therapy session and that I was not providing him the therapy he had requested. He began to yell and interrupted each of my statements. He challenged me stating that I did not even know what he truly wanted from therapy. At that point, I reminded him that his goals were spelled out in a contract signed by him. He challenged me to state what his actual goals were. I pulled out the SAS-C and read the goal which he had listed as his top priority. It read, "To be less angry toward my wife. To stop screaming at her, to not use any more profanity with her, to stop putting her down." He asked to see the paper for himself, then he just sat in stunned silence. Without that piece of paper, signed by him, I suspect I would have lost control of the session. He later returned for more therapy and according to his wife made satisfactory progress. She then decided to come in for her own therapy.

Q: Is the SAS-C completed after the SAS-A on the same session?

A: The best time to complete the SAS-C is on the first or second session. It is part of the intake assessment. Some clients need more talk time during the first session, forcing me to skip the SAS-C until the second or third session. When possible, it is best to complete it during the second half of the first session. But I am very flexible in how I use these forms.

Q: When is the SAS-B completed?

A: I have my clients complete the SAS-B after the session has ended, while I am writing my notes. This way it does not take away from the therapy time. SAS-A is always at the beginning. SAS-B is always at the end.

Q: The graph on SAS-C has a span of 17 sessions. What if the client does not need that many sessions?

A: You set the span of sessions after asking the client, "How many sessions do you believe is reasonable for you?" This helps you understand what to expect from the client. Some will say, "Three." So I mark a three on the line that states, "Estimated number of sessions: _____" Some have said, "At least a year, or two." For those individuals, I say, "Let us start with 17 sessions. After that we will complete a new treatment plan, if necessary."

Q: What is an Aimline?

This is a dotted line that is drawn on the graph during the first session as a projected estimate of progress in therapy. It is something to compare the actual rate of progress against.

First you help the client pick out one scale on SAS-A for use to measure progress. For example, Scale II: Behavior. If the client rated himself at an "8," then you would place an X on the graph across from the 8. In the box at the bottom, where you see the number 1, you can enter the day's date.

Suppose the client said he would need 10 sessions. You ask him, "In order for you to feel that your therapy has been successful, what number would your distress need to drop down to?" "What would be enough change in order to know you have been successful in therapy?" He might say, "It will need to drop down to 2. That would be great." So you would go over to the column marked by the number 10, and place an X on the row marked by 2. You then draw a dotted line from the first X down to the last X.

At the start of each session, you look on the SAS-A at the scale he picked to measure his progress, in this case scale II, and you place an X on the SAS-C graph that represents his score for that week. Soon a pattern begins to emerge. He will start to show signs of making progress toward his goal, when the new line you graph follows the slope of the dotted line, or he will not show any sign of change, that is if his distress remains just as high as when he began.

This is important information. It allows you to address the client's expectations, perceptions of himself and of the value of the therapy, and whether or not the problem has been defined appropriately and the correct goals established. This sounds very analytical, and it is. But when the conversation is interspersed with indirect suggestions, this activity begins to shape expectations for future success.

Q: How do you talk about the scores on the SAS-A during therapy?

There are many possibilities. If the scores have begun to drop (which means a decrease in distress), then you can ask the client, "What have you been doing differently in order to achieve this progress?" If the score have remained the same, you can ask, "Are you about ready to drop that 8 down to a 7? If so, what will it take? What will you have to do differently during the week? What could we talk about in here right now that would help prepare you to drop that score down to a 7?"

Q: Is the SAS-B done after each session?

A: Yes. Both SAS-A and SAS-B are used with each session. It is the same as a doctor tracking a patient's vital signs at each office visit. I use SAS-B at the end of every single session, unless we are doing something else and run out of time. I look at the SAS-B as a teaching tool for me. It tells me what I am doing right and what mistakes I might have made. It tells me what the client needs from therapy, and exactly where I need to pick up with the next session. In fact, I often pull out the SAS-B from the previous week and read it slowly to the client, this facilitates a connection to the previous week and reestablishes the therapeutic focus.

Q: The SAS-C asks the patient to choose the modality of therapy and then circle which will be most helpful. Isn't it the therapist's responsibility to determine the most helpful therapeutic process?

A: This part of the contract looks more rigid than it is. This is a therapeutic exercise that evokes active participation from the client and respects their right to choice. It gives the client the idea that you want to know what they think. It also gives them a way to warn you away from methodologies they feel are unacceptable. Later, they often give you permission to use something, such as hypnosis, that on the first visit they did not wish to permit. Even medical patients are now used to this degree of respect. Someone diagnosed with cancer is given the option of three or more varieties of treatment by the medical doctor. In regard to psychotherapy, there is a great deal of research showing that patients do better when they receive the treatment "they believe" will be most effective. There are many studies that also show how patient expectancies tend to shape outcomes (see handout). Within the broad categories listed on SAS-C, there is a lot of latitude.

Research Supporting the Use & Design of SAS

Q: Why use a formal system of assessment?

A: There is increasing competition and need for accountability in the health care industry

Therapists who remain unable to systematically evaluate the outcome of treatment have nothing to sell to the purchasers of health care services (Brown, et. al., 1999).

A: Untested assumptions of therapeutic effectiveness are often incorrect

Training and experience do not ensure therapeutic effectiveness (Lambert & Ogles, 2004).

In repeated studies on clinical judgment, experienced clinicians are no more accurate than less experienced clinicians. Mental health professionals who lack a systematic means of acquiring feedback do not learn from their experiences (Garb, 1998).

Ineffective therapists tend to be unaware that they are ineffective (Hiatt & Hargrave, 1995).

There is an inverse relationship between accuracy of clinical judgment and confidence. Therapists who are highly confident tend to overestimate what they think they know. Knowledgeable therapists tend to have only moderate levels of confidence (Garb, 1998).

Q: Why involve the client in treatment planning (SAS-C)?

A: When a treatment is tailored to fit the client's theory of change, the internal resources of the client are more fully engaged.

40 years of outcome research indicate the importance of recognizing the client's central role in the change process (Hubble et al., 1999)

The presentation of a treatment rationale, which the client finds credible, helps generate positive outcome expectancies, which in turn lead to positive outcomes (Frank, 1982; Kazdin & Krouse, 1983; Nau, Caputo, & Borkovec, 1974; Shapiro, 1981)

The therapist's formulations of the problem need only have enough relevance to inspire the client to begin doing the work of change (Rosenzweig, 1936)

Treatment plans are more likely to be met with cooperation when clients identify specific tactics themselves (Bergan & Neumann, 1980). There is more pride and emotional investment in a plan the client helps construct and there is more responsibility for the outcomes. This is achieved by elevating the client to the level of equal participant in the problem-solving process.

"What is needed is the development of a therapeutic situation permitting the patient to use his own thinking, his own understandings, his own emotions in the way that fits him in his scheme of…life" (Erickson, 1980, p. 223)

A: In psychotherapy, expert opinion is not as important as the process of learning and experimentation that occurs during therapy

The use of treatment manuals negatively impacts the quality of the therapeutic relationship, curtails the scope of treatment, and decreases the likelihood of clinical innovation (Addis, Wade, & Hatgis, 1999)

There is no correlation between diagnosis and outcome nor between diagnosis and length of treatment (Brown et al., 1999; Beutler & Clarkin, 1990).

Knowledge of a person's unique circumstances and goals for therapy are better indicators of what approach to apply than a diagnosis (Beutler & Clarkin, 1990).

Client-related factors are the single most significant contributor to outcome in psychotherapy (Miller, Duncan, & Hubble, 1997; Tallman & Bohart, 1999). As much as 40% of improvement during psychotherapy is client-related factors (Asay & Lambert, 1999).

A: Clients benefit from setting goals and having concrete evidence of improvement

When possible, progress monitoring should involve the use of a graph. Using a graph rather than simply recording tabular data has been found to promote progress, in an educational setting, increasing achievement by approximately 0.5 of a standard deviation unit (Fuchs & Fuchs, 1986).

A: Collaborative treatment planning creates a link between client participation and treatment outcomes. This shifts the locus of behavior control from outside forces to the client.

Client's that attribute their improvements to internal factors tend to maintain their progress. Those that attribute their success to the therapist's abilities tend to experience change that is short-lived (Liberman, 1978; Weinberger, 1994, 1995).

Self-efficacy predicts posttreatment behavior better than does the actual end-of-treatment behavior (Bandura 1989).

More than forty years of outcome research show that the quality of the client's participation in therapy stands out as the most important determinant of outcome (Orlinsky, Grawe, & Parks, 1994; Orlinsky, Rønnestad, & Willutzki, 2004).

In therapy there needs to be a clear definition of type of relationship between client and therapist, there needs to be agreement on the goals of therapy, and agreement on the tasks of therapy (Bordin, 1979).

Psychological health is related to a problem solving sequence consisting of the abilities to recognize a problem (both emotionally and intellectually), reflect on problem solutions, make a decision, and take action (Kendall & Braswell, 1982). Clients who are involved in treatment planning learn valuable problem solving skills.

Q: Why collect subjective data about distress (SAS-A)?

A: Therapy is distinguished from coercion when there is clear regard for individual perception of need.

The client is more likely to cooperate with the therapy if he feels that you have a good understanding of the problem. It has been found that the single best predictor of whether or not an intervention plan would be implemented was accurate problem identification. In a study by Bergan and Tombari (1976) over 60% of the variance in plan implementation during work with behavioral consultants was accounted for by clearly identifying the problem to be solved (R=.776).

A: The assessment process can and should be therapeutic

Therapists can ask questions and make statements that presuppose client involvement in the resulting process of change (Berg & Miller, 1992; Walter & Peller, 1992)

Q: Why collect data on client experiences during therapy (SAS-B)?

A: It is important to monitor more than one variable while tracking client progress. Open-ended sentences provide a good means of collecting diverse responses.

All therapies seem to incorporate a number of factors (unrelated to technique) to achieve positive outcomes. These include: 1) therapeutic relationship, 2) expectations for change, 3) defining the problem, 4) experiences of mastery/active participation, 5) attributions of therapeutic outcome (Weinberger, 1995).

A: Outcome expectancies should be monitored and cultivated during therapy

Positive outcome expectancies count for much of the change in therapy (Frank, 1983; Kirsch 1985, 1990) and in some instances therapeutic gains can be attributed entirely to the effects of expectancy (Shapiro, 1981).

The mere promise of treatment can lead to effects (Frank, 1983). A substantial amount of improvement in cognitive therapy occurs after the first session is scheduled but before it has taken place (Beckham, 1989).

Cognitive therapy patients who expect treatment to be effective have superior outcomes (Gaston, Marmar, Gallagher, & Thomson, 1989).

A subjective sense of change must be achieved early in the process. An absence of early improvement in the client's subjective sense of well-being decreases the chances of achieving symptomatic relief by the end of treatment (Howard, Lueger, Maling, & Martinovich, 1993). Clients who worsen by the third visit are twice as likely to drop out as those reporting progress (Brown, et. al., 1999).

A: The therapeutic relationship should be monitored and cultivated during therapy

Therapeutic bond increases in successful psychotherapy, but not when it is unsuccessful (Klee, Abeles, & Muller, 1990).

Therapeutic alliance accounts for more than 35% of outcome variance, even after controlling for original symptomolgy (Gaston, Marmar, Gallagher, & Thompson, 1989). Which accounts for more, of the total variance, than any other commonly measured variable (Lambert, 1992).

A positive alliance is one of the best predictors of therapeutic outcome (Horvath & Symonds, 1991). In therapy, alliance accounts for as much as 54% of the variance (Wampold, 2001).

Client ratings of alliance are far better predictors of outcome than are therapist ratings (Bachelor & Horvath, 1999)

Clients are often reluctant to communicate negative feelings or dissatisfaction with therapy to the therapist (Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996). Clients who express even low levels of disagreement with their therapists report better progress (Hatcher & Barends, 1996)

Therapists who have access to outcome and alliance information are twice as likely to achieve a clinically significant change (Whipple et. al., 2003). Therapist receiving information regarding ongoing the treatment process are better off than 65 percent of those without the benefit of formal assessment.

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