# THE TREATMENT JOURNEY

From First Session to Termination | A clinical companion to The Art of Getting Unstuck

A map, not a mandate. Assessment, diagnosis, goals, interventions, feedback, and endings are connected parts of one evolving clinical process. Follow the client's needs and your modality while keeping the purpose of treatment visible.

## 01 | Begin with the person, build the formulation

An intake can be conversational and still be clinically complete. Follow the client's story while directly addressing required consent, confidentiality, safety, and assessment domains. A provisional understanding may be appropriate when information is still emerging.

| Listen for | Clinical questions to hold |
|---|---|
| Presenting concerns and context | Why now? What is difficult, and what matters to this person? |
| Symptoms and functioning | Onset, frequency, intensity, duration; effects on work, relationships, sleep, self-care, and daily life. |
| History, culture, and strengths | Relevant clinical, medical, relational, developmental, substance-use, and cultural context; supports and protective factors. |
| Safety and diagnostic considerations | Assess indicated risks; consider differential diagnoses and whether diagnostic criteria are supported. |
| Client hopes and preferences | What would they notice if therapy helped? What approaches feel accessible and acceptable? |

## 02 | Translate the story into a direction

Client language: "I say yes to everything, then feel anxious and resentful."

Working formulation: Anticipated rejection and anxiety-driven avoidance contribute to difficulty expressing needs and increased interpersonal strain.

Collaborative goal: Improve psychological flexibility and interpersonal functioning by reducing avoidance of appropriate boundary-setting.

Individualized objective: Recognize early anxiety cues and practice considered responses to requests, with progress evaluated through client report, discussion of real-life situations, and functioning.

Make it measurable without making it arbitrary. Establish a baseline and a review interval. Identify what change would look like in the client's life. Numbers can help, but a made-up "four out of six times" threshold is not inherently more clinically meaningful.

# ASSESS CHANGE, NOT JUST SYMPTOMS

Choose measures that fit the question you are trying to answer. Use more than one lens.

## 03 | Establish a baseline and revisit it

| Lens | What it can tell you | Keep in mind |
|---|---|---|
| Standardized symptom tools (e.g., PHQ-9, GAD-7) | Changes in self-reported symptom severity. | Scores are not diagnoses or complete accounts of functioning. |
| FIDO clinical interview | Frequency, intensity, duration, and onset of a symptom or experience. | A descriptive interview framework, not a validated scale. |
| Function and behavior | Participation, avoidance, work, relationships, self-care, and observable choices. | Anchor change to the client's starting point and context. |
| Individualized goal review / GAS | Progress toward client-specific outcomes; GAS uses defined attainment levels. | Define levels carefully; use consistently and collaboratively. |
| ORS (outcome feedback) | Client-reported well-being and functioning. | Use according to the instrument's instructions and permissions. |
| SRS / alliance feedback | How the client experiences the relationship and session. | Alliance and satisfaction are not identical to clinical improvement. |
| Clinical interview and observation | Meaning, patterns, emotional flexibility, and the client's experience of change. | Document concrete examples and remaining needs. |

## A practical comparison across time

At intake: Client reports agreeing immediately to most requests, frequent anticipatory worry, and avoidance of disagreement. At review: Client notices bodily anxiety cues, pauses before committing, and has initiated two previously avoided conversations. Anxiety persists, but the client reports less interference with decisions. At later review: Client applies the approach in more than one relationship and identifies situations where additional support is needed.

> Ask together: "What feels different outside this room? What remains hard? Are we working on the right things? What would make our next phase of work useful?"

## Documentation thread

Connect presenting condition and functioning → goal → intervention → client response → observed or reported progress → ongoing rationale. Record meaningful clinical details without implying that a favorable session experience alone proves progress.

# WHEN THE ROUTE CHANGES

Review treatment when circumstances change, progress slows, or the original goals no longer fit.

## 04 | Interpret the plateau before changing course

| What you notice | What to explore next |
|---|---|
| Progress is emerging | Name the change, consolidate it, and consider whether goals need refinement. |
| Stabilization is the current need | Clarify safety, functioning, external stressors, and the clinical purpose of maintenance or stabilization. |
| Sessions feel repetitive | Look for the pattern beneath the weekly events; revisit goals and invite feedback on session focus. |
| Little change despite consistent work | Reassess formulation, intervention fit, accessibility, alliance, barriers, and client preferences. |
| New concerns or goals emerge | Assess the new information; revise diagnosis or plan only when clinically supported. |
| Needs exceed the current approach | Consider consultation, supervision, adjunctive services, referral, or a different level of care. |

## A collaborative treatment review can sound like this

“When we started, we focused on the anxiety that made it difficult to express your needs. You’ve begun noticing that pattern sooner, and I’m also hearing that grief has become more central lately. I’d like us to look at what’s changed and decide together whether our goals still fit.”

## Before changing the plan, consider

Is this a predictable phase of the work, a protective response, an alliance concern, a mismatch of approach, a change in external circumstances, or an unmet clinical need? Different explanations call for different responses. Avoid treating every pause as failure or every new topic as a reason to extend care indefinitely.

Insurance and private pay: Private pay does not remove duties of assessment, documentation, competence, or appropriate care. For insurance-based services, verify the specific payer and plan requirements for diagnosis, medical necessity, covered services, authorization, and ongoing documentation. There is no universal rule that every payer requires numerical SMART objectives.

# ENDING WITH INTENTION

Termination is part of treatment, not simply the absence of another appointment.

## 05 | Review the whole journey

Return to the client’s starting point and compare it with their present experience. Review agreed goals, symptom and functional changes, new capacities, unresolved needs, and the client’s own account of what mattered. Acknowledge that progress may involve greater flexibility and self-understanding even when difficult

feelings remain.

## A termination conversation might explore

“When you first came in, you described feeling unable to say no without overwhelming guilt. What do you notice about that now? Which changes feel steady, and where do you still want support? How would you recognize a time to reach out again?”

## 06 | Plan for continuity

Discuss anticipated challenges, strategies for maintaining gains, relevant supports, and how to seek help again if needed. If treatment ends unexpectedly or requires referral, follow applicable clinical, ethical, legal, and documentation obligations. Endings can also carry relational meaning; allow space to process them.

## The journey at a glance

| Phase | Clinical anchor | Question to revisit |
|---|---|---|
| Intake and formulation | Understand person, context, risks, functioning, and working diagnosis. | What brings you here, and what matters? |
| Early treatment | Build alliance, set shared goals, choose approaches, establish baseline. | Are we working toward the same things? |
| Active work | Apply interventions; monitor response and everyday functioning. | What is changing, and what is not? |
| Review and revise | Reassess fit, new information, plateau, and level-of-care needs. | Does our map still match the terrain? |
| Consolidation and ending | Integrate learning, review gains, plan support and closure. | What can you now carry forward? |

The guiding principle: Therapy can be intuitive without being aimless, structured without being mechanical, measurable without reducing people to numbers, and creative without abandoning clinical rigor.

THE NERDIE THERAPIST | Companion resource to The Art of Getting Unstuck: When Therapy Becomes a Weekly Debrief. Educational reference for qualified clinicians; adapt to client needs, scope of competence, modality, law, ethics, and payer requirements.