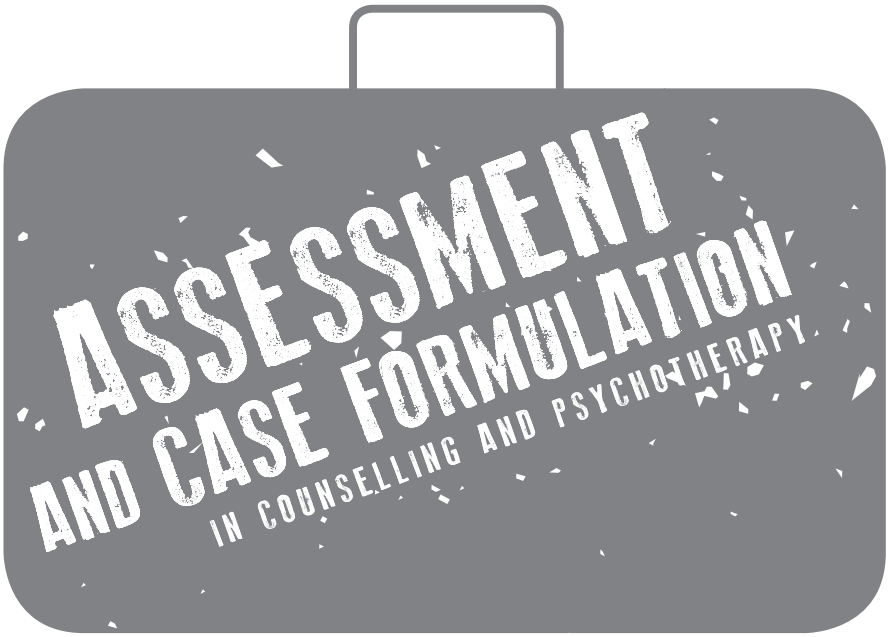

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INTRODUCTION

Chapter outline

This chapter provides an outline of the book and introduces the subject of assessment and case formulation, their applications, assessment contexts and settings and an overview of assessment methods. It provides a general overview about the use of assessment in different health and counselling organisations and in private practice. It presents assessment and case formulation as a flexible, co-created process and highlights the importance of the therapeutic relationship within a relational therapeutic practice. There is a broad discussion about the attitudes related to assessment, diagnosis and case formulation within different theoretical orientations. Finally, the introduction presents the outline of the book and the summary of each chapter.

Assessment normally takes place at the beginning of the therapeutic journey. It can be conducted in a single session or over a period of time. For a client, coming to therapy follows a period of contemplation or crisis and it is usually filled with emotions, some of them conflicting. Meeting a new client can bring up some similar emotions for a therapist and a mix of trepidation, excitement and a sense of responsibility. Assessment is a process and, like psychotherapy, uses multiple skills, which Schön (1983: 130) compares to those of an artist:

> [The psychotherapist] gives an artistic performance … in his selective management of large amounts of information, his ability to spin out long lines of invention and inference, and his capacity to hold several ways of looking at things at once without disrupting the flow of inquiry.

The aim of this book is to present a multifaceted view of assessments and case formulation based on the principles of reflective practice (Bager-Charleson, 2010) and applicable to therapists working in different therapeutic contexts. The debate about differences and similarities between counselling and psychotherapy is current and wide ranging (Reeves, 2013b). In this book I have taken a view that, as ways of working, counselling and psychotherapy are related and intertwined. Assessment is relevant to both and I would like to invite you to consider the issues I have presented in the context of your own training and practice. The terms counselling and psychotherapy are used interchangeably, as are the terms therapist, psychotherapist and counsellor.

ASSESSMENT CONTEXTS

Assessments take place in all counselling and psychotherapy settings, including the health services, educational establishments and independent and voluntary counselling organisations. There is variation in how assessments are conducted in private practice. A role of an assessor can be separate from the role of a therapist, and this is sometimes the case in organisations, such as health services and other counselling agencies. In these contexts assessors make decisions whether to refer clients to therapy or signpost them to other services. Therapists who work independently have more scope to develop their own assessment style and structure. However, independent practice also involves a professional contract with a client and assessment becomes an important part of developing an appropriate and realistic contract with a client.

The most common method of assessment involves face-to-face sessions, although telephone and online assessments are also practised within some counselling organisations (Bager-Charleson & van Rijn, 2011). These can be supplemented by the use of questionnaires prior to assessment or during the session. It can be expected that other modes of communication, such as the use of digital technology, will also develop over time. The way therapists approach assessment depends on their experience and training and their underlying philosophies, which influence how they structure the sessions. Within organisations, assessment methods and procedures also depend on the resources allocated to this process.

For personal reflection

Remember when you last saw a new client.

- What did you feel? What were these feelings were based on: information you had about the client; the nature of your contact (phone, email, a referral service); the context of your work?
- How did your personal circumstances and history play a part in your experience?
- Bearing this in mind, how did you prepare yourself to meet the client?

THEORETICAL ORIENTATIONS

The four main groups of theoretical approaches vary in their approach to assessment and case formulation. The differences are often linked to their attitude to clinical diagnosis and treatment planning. While some approaches use them overtly, others highlight concerns about power imbalance and a potential for labelling. Following the broad overview below, these approaches will be explored at more depth in Chapter 4.

- Current **psychoanalytic approaches** use multiple approaches to case formulation and assessment. Traditionally, psychoanalysts did not use psychiatric diagnosis. They focused on understanding the client's narrative, and the conscious and unconscious patterns that influenced their lives and relationships. A psychoanalyst would use an assessment interview to gauge the client's capacity to develop a working alliance and work psychodynamically.
- **Cognitive behavioural therapies** use psychiatric diagnosis more widely and link it to treatment planning. Research is used to develop therapeutic manuals, which are applied in the treatment of specific disorders. This approach is practised extensively in health settings and is influenced by the medical model of illness and treatment. Research base and transparency of the therapist's approach inform good practice between different settings.
- **Humanistic approaches** have a varied and uneasy relationship to case formulation and assessment. The person-centred approach, developed by Carl Rogers (Rogers, 1951) questioned the benefits of diagnosis.

Person-centred practitioners are concerned about creating labels, which are either potentially damaging or not useful in therapeutic practice. Other, more integrative humanistic approaches, like transactional analysis (TA), founded by Eric Berne (Berne, 1957), use their own theoretical concepts for assessment, diagnosis and case formulation and approach this process as a joint venture between the therapist and the client. Client empowerment and transparency are important principles in all humanistic approaches, even though they might put them into practice in different ways.

- **Integrative approaches** deal with assessment and case formulation in different ways dependent on their models of integration. Their approaches vary from integration of theories to eclecticism and pluralism.

PRINCIPLES UNDERLYING ASSESSMENT AND CASE FORMULATION

This book will primarily focus on assessment and case formulation from the humanistic-relational perspective. In defining the principles of relational psychotherapy, in their case relational TA, Fowlie and Sills (2011a: xxx–xxxiii) list the following:

- The centrality of the therapeutic relationship
- The importance of active engagement by the therapist
- The significance of both conscious and non-conscious patterns of relating
- The importance of embodied and enacted experience
- The importance of subjectivities of both the therapist and the client
- The importance of uncertainty in our search for meaning within the therapeutic process
- The importance of curiosity, criticism and creativity
- The reality of functioning and changing adults, rather than the purely developmental view of the therapeutic relationship

This approach incorporates two-person psychology in looking at how meaning is constructed in the context of the relationship. The client and the therapist bring with them their own experiences, context and individuality and the interaction between them is the product of both. Two-person psychology stems from the psychoanalytic concept of intersubjectivity. Atwood and Stolorow (1984: 64), cited in Orange, Atwood and Stolorow (1997: 3), offer the following definition:

> Psychoanalysis seeks to illuminate phenomena that emerge within a specific psychological field constituted by the intersection of two subjectivities; that of a patient and that of the analyst.

Within the context of humanistic psychotherapy, intersubjectivity is seen as the process of co-creation (Summers & Tudor, 2000). The therapist and the client co-create meaning and experience of the basis of both of their subjective experiences, with all that it entails. Assessment and case formulation in this philosophical framework require the therapist to remain reflective, interested and questioning about their own psychological process and the sociopolitical context and environment. Relational therapists treat the understanding that emerges in the assessment as co-constructed with the client.

APPLYING PRINCIPLES TO PRACTICE

In his writing about reflective practice for professionals, including psychotherapists, Schön (1983) states that reflective practice involves a relationship based on a reflective contract where the practitioner commits him or herself to a degree of openness and a genuine interest in how others perceive reality. Such practice rests on the notion that knowledge is socially constructed, rather than absolute and relates to the philosophies of intersubjectivity and co-creation. More recently, Park (2001) contrasted different types of knowledge, such as representational and relational knowledge.

Representational knowledge is based on correlation and causal relationships, often found in medicine. For example, research shows that there is a high causal relationship between alcohol abuse, liver disease and a correlation with depression and relationship problems. Relational knowledge draws on different sources. It focuses on the role of human relationships in experiencing and knowing the world and requires mutuality. It is directed at, and derives from, each partner in the relationship. For example, the developmental process of attunement (Stern, 1985) describes how a mother and a baby share the emotional experiences through non-verbal processes.

Therapeutic practice, including assessment and case formulation, uses both types of knowledge. For example, a practitioner who knows about the emotional and physical impact of alcohol abuse will bear it in mind in the client assessment. In the session, the interplay of the therapist's focus and personal and professional experiences with the client will often determine the outcome of the session and the potential for developing a working alliance.

Case study 1.1

An assessor in a busy clinic is running late. Punctuality has always been an issue for him and he arrives at his last appointment 15 minutes late, feeling pushed and anxious. The client arrived 10 minutes before the time booked for the session, and she is feeling more and more anxious and uncomfortable as time passes. By the time the assessor arrives, she is quite angry. The assessor apologises, the client apparently accepts the apology and the session begins. However, the client is reluctant to share much personal information about herself. The therapist experiences her as withholding and probes further. This only leads the client to withdraw more. The session is unsatisfactory and eventually grinds to a halt. The client leaves undecided about therapy and the assessor feels useless and unsure what happened.

The same client rings the service again a week later and asks for another assessment. This time the assessment unfolds without difficulty. The client and the assessor share a feeling of warmth and acceptance. Eventually, the client talks about the previous assessment, which reminded her of other experiences with men. She says: 'They always let me down.'

For personal reflection

Have you ever experienced a first session where you and the client did not connect?

- What was going on for you?
- What do you think was going on for the client?

Case study 1.1 shows how the relationship between each assessor and the client impacted the assessment session and highlights the presenting issues in a different way. Both assessments highlight the client's mistrust of men. In the first assessment, the issue was enacted between the therapist and the client. In the second assessment, the client started to reflect on this experience.

If we accept that our knowledge in therapeutic practice is co-constructed with a client and the wider context, we assume that we bring our personal history as well as our prior knowledge, understanding and strategies into the session. Schön (1983) talks about this as tacit

knowledge; about how we approach particular situations. Tacit knowledge consists of theories and strategies learned, practised and applied spontaneously and without much reflection, particularly if everything in the sessions unfolds as expected. For example, assessor 2 might have used her tacit knowledge in the session and possibly reflected on it after the session or in supervision (Schön calls this reflection on practice).

When something unexpected happens during the session we might need to reflect and react differently in the moment. For example, when the client did not respond to the probing by the assessor in the first assessment, the assessor might have paused to change his approach. For example, he might have used his experience of the relationship with the client in the session. He might have said: 'I feel we got off on a wrong foot. I wonder how you are experiencing what is going on.'

This type of approach would be called reflection in action, according to Schön. In order to apply relational principles to assessment and case formulation, and become able to reflect in action, we need to use different approaches to learning in practice. When we adhere to explicit strategies and objectives, Argyris and Schön (1978) call this single-loop learning – we apply our approach to the situation and this application confirms our tacit knowledge. Double-loop learning requires us to correct and reorganise our understanding, assumptions and actions in the moment.

Case study 1.2

The client contacted the therapist by phone a day before the assessment. She was extremely distressed and asked for an emergency appointment, because she did not know how she would manage to wait. She said she was having difficulties with her husband, but could barely speak through distress. The therapist had an image of a young woman in crisis. She prepared for the session thinking that she would start with empathy and soothing, to allow the client to tell what was going on for her, before being able to engage in the full assessment. The following day, she met the client at reception. The client was a well-dressed, middle-aged woman. The therapist thought she seemed formidable and felt a bit anxious. The client introduced herself by saying she was a successful professional, struggling with her husband who has been depressed for a long time. He was a lot younger than her: 'In fact, he is probably no older than you', said the client, looking at the therapist scornfully. The client seemed very different from how the therapist experienced her on the phone, and the therapist was taken aback and felt pushed away.

(Continued)

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If the client had presented similarly in both situations, the therapist could have approached her as she planned, through empathy and gentle enquiry. If this resulted in the beginnings of developing a working alliance and a degree of soothing for the client, the therapist would have confirmed her initial hypothesis (single-loop learning). However, she now needed to find a way of understanding the client and finding a new way of meeting her. She noticed her own discomfort at being dismissed because of her age, and felt curious about what was going on for the client. She noticed the vulnerability and harshness in the way the client made contact and recognised that she needed to pay to attention to both. She considered the client's pattern of attachment and the insecure ambivalent attachment style (Ainsworth, Blehar, Waters & Wall, 1978). She was also aware of the impact of feeling dismissed and realised she would need some support from her supervisor if she were to work with this client. She had experiences of harsh criticism in her past and tended to respond by becoming overly careful.

She decided to test out her reflection by summarising her experience and offering it to the client: 'Last night when we spoke, you were really upset, and now you seem quite cross. It seems that you want support, but it also sounds like you are unsure about what my age might mean for you.'

The client responded, 'I do not know that you are not going to be like my husband. You just seem too young.'

The therapist replied. 'Perhaps we can use this session to explore what is the support you want and whether we can work together, and you can then make a choice.'

In this example the therapist put aside her initial understanding, reflected on her experience and used theory to inform how she was going to engage with the client in the here and now. This therapeutic stance would be described as 'double-loop learning', because the adjustment she made led to a different understanding and a different way of working in the session.

For reflection in supervision

Remember a time when you were overtly or covertly challenged by a client in the first session. In situations like that, it might be difficult to remain open and interested in the process.

- How did you feel and respond to the situation?
- Is there anything you need to discuss with your supervisor that would support you at those times?

The therapeutic stance described in case study 1.2 is well supported by several decades of research into the effectiveness of psychotherapy. In their review of the current research, Norcross and Wampold (2011), highlight the importance of the therapeutic relationship and the therapist's responsiveness in meeting the client. This entails tailoring the therapeutic approach to suit the client, rather than a rigid adherence to a theoretical model.

This book offers an exploration in applying these principles to the process of assessment and case formulation, so that the initial assessment reflects the same values and attitudes as the rest of the therapeutic journey, even though the assessment sessions might be structured differently.

For personal reflection

Reflect on your journey as a therapist.

- How would you describe your identity and your philosophy of practice?
- What tacit knowledge do you hold when you meet your clients?
- What are the theories and approaches underlying your practice and how do they affect your approach to assessment and case formulation?

POSITION OF THE AUTHOR

The relational perspective asks therapists to embrace their subjectivity. This is why you will be asked to reflect on your experiences, views and knowledge throughout this book. As a relational practitioner, it is important that as an author I am also transparent about my views and experience, so that you can understand how they might impact the structure and content of this book.

I grew up in Yugoslavia, before it was broken up by the civil war, and moved to the UK when I qualified as a psychologist. At the time, I was very inspired by the antipsychiatry movement and the works of authors like Laing (1971) and Szasz (1970, 1974). They critiqued the psychiatric system and the use of medication in psychosis, and saw psychotic symptoms in the context of conflicts between the individual, the society and the family. They looked at developing more humane and respectful ways of working with people. Laing set up a therapeutic community in London in order to achieve this aim. The therapeutic community movement was still very active in the 1980s when I came to the UK, and used in the range of approaches and organisations. I

worked in several therapeutic communities as well as other community mental health projects, alongside my TA psychotherapy training.

All of these personal and professional experiences impacted my practice. My experience of civil war, cultural difference and working with people who are treated as marginal by the society has led me to embrace the importance of reflection in developing ethical practice. My experience of people who experienced the acute distress of psychosis has led me away from the antipsychiatry view of psychosis as a flight to freedom within a sick society. However, I still see its importance in developing an ethical approach to diagnosis and treatment.

For a number of years now, I have been a psychotherapist, tutor and supervisor and have worked as Head of Clinical and Research Services at Metanoia Counselling and Psychotherapy Service (MCPS) in London. MCPS is a low-cost community clinic where clients are assessed by a team of assessors and seen by student practitioners.

This book draws on my experiences within the clinic and various other projects I have worked in, as well as my own psychotherapy practice. The case examples are broadly drawn from these experiences and do not represent any individual clients or therapists.

Chapter summary

- Assessment normally takes place at the beginning of the therapeutic journey. It can be conducted in a single session or over a period of time. Assessment and case formulation require complex professional skills and personal awareness.
- Assessments take place in all counselling and psychotherapy settings in the health services, educational establishments, independent and voluntary counselling organisations and private practice.
- Different theoretical orientations vary in their approach to assessment and case formulation. It is important to consider issues of power imbalance and labelling to inform ethical assessment practice in all theoretical approaches.
- The relational therapeutic approach, within the humanistic therapeutic framework (Fowlie & Sills, 2011a), focuses on the centrality of the therapeutic relationship and the co-creation of both the therapist and the client (Summers & Tudor, 2000), each of whom brings their subjective experiences into the consulting room. The relational approach to assessment requires the therapist's awareness of their own subjective process, flexibility and the ability to deal with uncertainty. The application of principles of reflective practice and 'double-loop' learning (Schön, 1983) can facilitate working relationally.

OUTLINE OF THE BOOK

Chapter 2: What is assessment?

This chapter defines assessment using the relevant literature and presents reasons for engaging in it. It introduces issues of access to appropriate treatment, risk assessment, case formulation and treatment planning. The chapter addresses the arguments for and against assessment in counselling and psychotherapy and explores how assessment differs from ongoing therapeutic work. The chapter draws on current research on the therapeutic relationship and the working alliance (Norcross, 2011).

Chapter 3: Assessment structure and skills

This chapter examines how the assessment context impacts the content and the purpose of an assessment session. It suggests how to approach assessment therapeutically and the skills useful in conducting an assessment. The chapter includes a discussion on structuring and keeping assessment notes and includes provisional note format.

Chapter 4: Case formulation

This chapter will present an introduction to the existing approaches to case formulation (Eelis, 2010; Ingram, 2012):

- Single theoretical orientations (such as CBT and psychoanalysis)
- Integration of two or more approaches (Ingram, 2012)
- Personalised, individual integration from a pluralistic stance (Cooper & McLeod, 2011; Eelis, 2010)

The latter will be the primary focus of the book, drawing on a relational, co-creative stance in humanistic psychotherapy (Summers & Tudor, 2000) and intersubjectivity in psychoanalytic traditions (Orange, Atwood & Stolorow, 1997).

Chapter 5: Diagnosis

This chapter presents the challenges and considerations in the use of formal diagnostic systems, such as DSM-5 (American Psychiatric Association

(APA), 2013), in assessment. It discusses the limitations and applications of formal diagnosis within assessment and gives an overview of medication used in mental health treatment. The chapter offers a discussion on the role of assessment in identifying risks in mental health. The chapter gives information about severe mental health problems, such as psychosis, and invites an exploration about its meaning in assessment practice. Finally, it reviews ethical considerations in using clinical diagnosis in relation to safety, therapist competence, appropriateness of therapy and relationship with mental health services.

Chapter 6: Risk assessment

This chapter presents considerations in understanding and assessing risk of suicide and self-harm in counselling and psychotherapy. It builds on the previous chapters on diagnosis and case formulation and addresses:

- Recognising risk and individual protective factors by drawing on current health publications and research, therapeutic dialogue and questionnaires
- Good practice risk assessment in psychotherapy and counselling
- The importance of the therapeutic relationship and therapist's self-awareness, reflection and self-care
- Relationship with mental health services and issues of confidentiality

Risk of violence is not specifically addressed in this chapter. In counselling and psychotherapy practice, assessment for risks of violence would follow the general principles of good practice in risk assessment and diagnosis.

Chapter 7: Impact of culture and issues of difference

This aim of this chapter is to reflect on developing a culturally sensitive, non-oppressive approach to assessment and clinical formulation. It draws on research into the impact of therapists' characteristics on therapeutic outcomes and research into the culture and language within the assessment process. Issues of difference are presented as an integral part of the therapeutic and assessment process. The importance of personal reflection and acknowledgement of prejudice are presented as essential in relational, non-oppressive clinical practice.

Chapter 8: Ethical considerations

This chapter focuses on outcomes of assessment and issues of therapist competence and limitations. Outcomes of assessment require awareness

of different types of counselling agreement (short or long term, trial therapy, etc.) and the therapeutic approaches. You are invited to examine your own fitness to practise in relation to different professional codes of ethics, such as those of the British Association for Counselling and Psychotherapy (BACP) and the United Kingdom Council for Psychotherapy (UKCP) and how this might fluctuate during stressful periods. Therapists' self-care is considered in relation to the prevention of burnout and vicarious traumatisation as well as the importance of continuing professional development and work–life balance.

Chapter 9: Concluding remarks

This chapter draws on the themes emerging from the previous chapters, offers a discussion on issues related to case formulation, diagnosis, risk assessment, diversity and context, and addresses some of the limitations of this book.