PROFESSIONAL SKILLS
FOR COUNSELLORS

Client Assessment

edited by
Stephen Palmer and
Gladeana McMahon

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SERIES EDITOR: COLIN FELTHAM

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The *Professional Skills for Counsellors* series, edited by Colin Feltham, covers the practical, technical and professional skills and knowledge which trainee and practising counsellors need to improve their competence in key areas of therapeutic practice.

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To the future generations: Kate, Tom, Emma, Leonora and Rebecca (SP)

To Mike, Thomas and Tigger (GM)

What Do You Say After You Say 'Er'?

Stephen Palmer

Just imagine for the moment that you are about to meet a new client. It may be easier if you recall the last time you did this.

What went through your mind? Perhaps you were thinking about your previous client; was it a good, a bad or an indifferent session? Maybe you were feeling thirsty as you had left yourself insufficient time to take a tea-break. Of course, it was not your fault that the previous counselling session went a few minutes over. The client just did not want to leave. In fact, perhaps you are feeling depressed and anxious like the client was? It's almost catching!

Are you thinking about the dinner party that you were organising that evening, or the wedding on Saturday? Could you find the new client's referral notes? Did you mislay them? In fact, could you remember the new client's name?

Hopefully this is *not* a familiar story, but seconds later you meet the new client and you show her into the counselling room. You inadvertently direct her to your chair with your assessment forms strewn all over your end of the room. You had placed the papers in front of the fan. 'You idiot! What's wrong with you today?' You can hear these words loudly inside your head. It's too hot to work. The air conditioning is not working. Neither is your brain. It's just not your day and this is a new client. What was her name?

Counsellor: Er. It may be better if you sit here . . . My name is Stephen Palmer. [*At least you have remembered your own name. Yes, you are regaining your composure*!] Before we start, have you any questions you would like to ask me about myself or the Centre?

Jayne: No, not really. I received the details about the therapy you do and a sheet about yourself. I'm glad it's confidential. By the way, what is a psychotherapist? Is it the same as a shrink?

Counsellor: [*Oh no! This is the second time today I've been asked this question. This is a bad start.*] No. Unlike a psychiatrist I have not received training in medicine. In my case I help clients to deal with difficult problems that they are stressed about by using problem-solving strategies and also techniques to help reduce symptoms of stress. This referral letter from your occupational health department at work suggests that you are suffering from panic attacks. It may be a good idea if you give me an overview to the problems as you see them. [*Yes, you are beginning to focus on the job. The assessment starts.*]

Jayne: Well, it started about nine months ago. My boss gave me so much work to do. Even though I complained he paid no attention and after a couple of months I had to work long hours to reach the deadlines. But after six months of long hours I just could not go on. I felt so tired, yet I could not sleep properly. One day, I was in the lift at work and I thought I had a heart attack. I felt so awful, I almost fainted. Later the doctor told me that she thought it was a panic attack and then proceeded to give me beta blockers. They did not work. Now I get panics on the train as well as in confined areas at work. How can you help me?

Counsellor: . . .

Activity

Spend a few moments thinking about the following questions:

- What would you say next?
- Would you ask another question, summarise Jayne's reply in your own words, or stay silent?
- Would you just nod your head or say, 'mmm'?
- What would you be thinking?
- What would you be feeling?
- Would you share your thoughts and/or feelings with your client?
- Would you give Jayne an assessment questionnaire to complete?
- Would you share with Jayne how your approach to counselling would help her with her problem or would you keep this to yourself?

- Would you wish you were somewhere else, with someone else, having an ice-cold drink? Would you share this thought with Jayne? Are you still thinking about the wedding or your previous client? (I hope not!)

The answer to these questions would probably depend upon your approach to counselling and perhaps on your personality too. (I would like to add that the scenario described does not necessarily reflect one of my counselling sessions.) Let us look at this subject further.

It's likely that the behaviour therapist may wish to undertake a behavioural analysis to see exactly what Jayne is avoiding. The cognitive therapist would be very interested in Jayne's cognitions (thoughts) and behaviours. The multimodal therapist would probably systematically examine different aspects of Jayne's personality in terms of seven modalities: behaviours, affects (emotions), sensations, images, cognitions, interpersonal relationships and drugs/biological factors. This is known by the acronym BASIC ID. The psychodynamic counsellor may be particularly interested in exploring earlier experiences and relationships as well as current conflicts. The person-centred counsellor may wish 'to "level" with the client, to show him that he is worthy of absolute attention, that he merits every effort the counsellor can make to understand him, that he is perceived as a fellow human being who, for that reason alone, can be assured of the counsellor's acceptance and honesty' (Mearns and Thorne, 1988: 100). Whatever the approach used by the counsellor, he or she is very likely to be working on building up a good therapeutic alliance with the client.

So How Can This Book Help?

The book is intended for both experienced and inexperienced counsellors, psychotherapists, psychologists and others working in the helping professions. Its intention is to give the reader an overview of the subject, taking a broad brush approach. In eight chapters the authors have covered a wide variety of issues relating to client assessment and later evaluation.

In Chapter 1, a range of general issues are covered including the nature of diagnosis, its benefits and the criticisms against it, and how your approach to counselling affects your assessment of your clients.

Chapter 2 is an introduction to client history taking and associated administration. Essentially, the chapter outlines what a counsellor needs to consider when embarking on client history taking and useful additional items such as client detail forms and information for clients about entering therapy. Chapter 3 focuses on medical and psychiatric assessment. This is one area of counselling and psychotherapy that is so often overlooked on counselling courses, yet may give counsellors a useful insight into psychiatric illness. This chapter covers the subject of suicide in some depth and how counsellors can assess clients for this particularly difficult problem.

The next two chapters focus on what interventions are available for clients. Chapter 4 concentrates on the type of help to give, whether the client being assessed is ready and suitable for counselling, and what may be the best setting for a client, for example individual or group therapy. This chapter looks at the practical issues, whilst Chapter 5, on assessing for optimal therapeutic intervention, covers three linked processes which need to be addressed: exploration, knowledge and planning.

The remaining three chapters show how to set goals, assess modalities, and review and evaluate therapeutic progress. Chapter 6, on assessment and accountability, looks at helping clients to set goals and at the assessment of whether the goals have been attained. Chapter 7 illustrates modality assessment and uses the BASIC ID framework (described earlier) developed by Arnold Lazarus. This comprehensive framework helps the counsellor and client to leave no stone (or modality) unturned. Exploration of each modality may help in establishing new therapeutic goals. It is particularly useful if counsellor and client have reached an impasse in therapy. Chapter 8, on reviewing and evaluating therapeutic progress, focuses on planning, implementing plans, review and evaluation and uses the mnemonic ASPIRE.

Some of the issues covered in the book are coming to prominence as many service purchasers are interested in time-limited therapy and cost-effectiveness. Whether we like it or not, our profession does not exist in a plastic bubble, isolated from the demands of society. We are expected to provide a professional service at all times and client assessment is one crucial area of counselling that is often neglected, especially on basic counselling courses. The aim of this book is to provide readers with new ideas and perspectives on client assessment.

Although the book has been written to a particular structure, the reader does not have to start at Chapter 1 and read through to Chapter 8. Each chapter can stand alone, and counsellors and therapists, experienced and inexperienced, may find a section of interest that they could use in their therapeutic work.

Reference

Mearns, D. and Thorne, B. (1988) *Person-Centred Counselling in Action*. London: Sage.

1 *General Assessment Issues*

Peter Ruddell

Dear Mr Ruddell

I am hoping you can point me in the right direction. My life feels a mess and there seems to be nothing but problems. My moods are up and down. My husband, Rajid, is always irritable with me. I think he may be having an affair, although he denies this and says he loves me. He constantly shouts at the children and I'm scared this may lead to the dreadful sort of upbringing which I've had. I feel I'm walking on eggshells. I think my husband needs help too.

I get so wound up but at least I can concentrate on my housework and can proudly say my house is spotless. This is my only sense of release at the moment.

Please can you help?

Yours sincerely

Jane Khan

What help might be offered to this person? Before deciding, it would be necessary to speak to her further. Even so, a number of hunches or hypotheses about the person and her problems will probably be held in suspension in the mind of an experienced counsellor. A sensitive assessment would precipitate the major problems actually requiring attention, so that both counsellor and client are clear about where help is and is not needed. In this

and the chapters that follow, we hope to help you to develop ways of approaching this rather difficult process.

Assessment is part of the therapeutic process. Consequently, it is important that components of the counsellor/client relationship are not temporarily neglected during assessment. Hence, it will be helpful to apply to the assessment phase all those factors considered in your general practice, such as maintaining an appropriate degree of empathy and trust so as not to compromise the therapeutic relationship. Assessment literally means 'to sit by', and it may be helpful to remember this when faced with the prospect of eliciting information from a client.

Assessment may take place in a number of different ways. It will usually begin, even if only in a tentative form, at the first point of contact which may be at the telephone enquiry stage. I will discuss below how the particular therapeutic framework impacts on the mode and parameters of assessment.

First comes the preliminary assessment, or what the psychodynamic practitioner Malan (1979) terms the 'preliminary enquiry'. Malan suggests the aims of this phase are to discover

1 the exact nature of the fault
2 how it developed
3 other features which may shed light on what has gone wrong
4 what should be done to correct it.

He suggests that the assessment involves a system that is malfunctioning, in which an expert carries out a preliminary enquiry in order to identify what has gone wrong and then prescribes an appropriate intervention in order to try to set it right. Assessment is therefore concerned with the diagnosis of a problem, difficulty, disorder and so on.

Diagnosis involves matching signs and symptoms of your client with a known cluster of symptoms (a syndrome). Chapter 3, on psychiatric assessment, considers such a diagnosis in far greater detail. It is useful to familiarise yourself with the main groups of psychiatric disorder to ensure that the help given to your client is maximally effective.

The purpose of making a diagnosis is to allow the counsellor to intervene in the most effective way possible. Yet this is far more difficult than it first seems as people are complex and are part of wider systems such as family systems, social systems, economic

systems, political systems and cultural systems. Change is only possible within the limitations set by the system or systems of which the person is a part and with the resources at the person's disposal. For this reason, a particular problem might have multiple remedies, or require intervention at many different levels. This is why it is so important to 'sit by' the client to discover why this person is here at this particular time, with this particular problem/dilemma and with these particular resources and coping styles within this framework of functioning. (This concept of functioning within many different systems is considered for the intrapersonal level in Chapter 7.)

The Benefits of Diagnosis

Diagnosis is concerned with classifying a problem. Some counsellors are reluctant to classify problems in this way, and believe that individuals should not have signs and symptoms sectioned off and labelled. They believe this is to reify aspects of the person – to turn the person into a thing, an object of study rather than a complex changing individual.

Yet diagnosis is important if we are not to engage the individual in protracted 'therapy' for a problem which a given approach might never assist. For example, Malan – a psychodynamic therapist – has noted that 'there is no known authenticated case of an obsessional hand-washer being cured by psychoanalytic treatment' (1979: 107).

Diagnosis begins with a consideration of signs and symptoms. Signs are externally observable: sneezing, giggling, inability to make eye contact, loss of weight, protracted silences. Symptoms are subjective: headache, hearing voices not heard by others, or feeling 'low'. In medical diagnosis, it is common to detect the cause of the signs and symptoms (aetiology) as well as considering their development (pathogenesis). In psychiatric diagnosis, aetiology is more usually inferred. For example there is not a known cause of schizophrenia. While certain chemicals or hormones might be in evidence in the body of a person with heightened anxiety, these cannot be said to have caused the anxiety.

A psychiatric diagnosis therefore considers signs and symptoms of a client and matches them against a known category of disorder or dysfunction. For example, a person experiencing low

mood, weight loss, insomnia, lack of energy and feelings of worthlessness might be diagnosed as suffering a major depressive episode. Severity and duration of symptoms and signs are particularly important. For example many people may have experienced most or all of the above symptoms at some time in their lives, but not all at once, or with insufficient severity or too fleetingly to enable the signs and symptoms to be termed a depressive episode.

Symptoms and signs grouped together in the above way as a cluster may be termed a syndrome, a disorder or a disease, and may represent differing levels of severity. But professional thinking over the definition of a disease, a disorder or a syndrome may change over time.

Classification manuals listing such signs and symptoms clusters are regularly updated. The two most commonly used manuals covering mental health problems are the *Diagnostic and Statistical Manual of Mental Disorders* (currently in its fourth edition, DSM IV), published by the American Psychiatric Association (1994), and the fifth section of the *International Classification of Diseases* (currently in its tenth edition, ICD 10), published by the World Health Organisation (1992).

Some people are relieved to receive a diagnosis, but many who have been 'given' a diagnostic label experience it as unhelpful or humiliating. Changed role and status, such as job loss and poverty, may contribute to a person feeling disempowered. Therefore, practitioners need to give much thought to the purpose of diagnosis and consider the usefulness of conveying a diagnosis to an individual in each and every case.

We have considered how psychiatric diagnosis requires a broad and deep knowledge of both signs and symptoms, as well as classification systems to match them against. Some professionals contend that only a practitioner – such as a psychiatrist – who has developed this level of detailed knowledge is likely to be sufficiently well informed to decide upon an accurate diagnosis. Few counsellor training courses devote much time to such study, and consequently many counsellors are ill equipped to make an informed diagnosis. In view of the problem of labelling discussed below, it is particularly important when a diagnosis is given that it is accurate and the person providing it is acting within his field of competence. This may be an important factor in ensuring that the most appropriate help is offered. Yet many professionals other

than counsellors, such as those general practitioners (GPs) who have not taken psychiatry as one of the core components of their general practitioner training, may find it necessary to provide a diagnosis without consultation with a psychiatrist. There are many instances where a common problem, such as depression or anxiety, can be easily diagnosed, and where a person with advanced training in psychiatry need not be involved. The main difficulty here is that signs and symptoms may suggest a common problem to the inexpert eye instead of recognition of a rare (or less common) problem. Yet this can happen to psychiatrists inexpert in other fields. For example, I know of a case where the individual was simply treated for depression for several years: it subsequently transpired that she was suffering from a medical condition known as lupus which went untreated. (See Chapter 3, in which psychiatric problems resulting from other illnesses and as iatrogenic consequences of certain drug treatments are discussed.)

The public desire for greater knowledge about a range of issues has led to a welcome growth in self-help books in recent years. Many of these books have an element of self-assessment within them. For example, *The Feeling Good Handbook* (Burns, 1989: 49–60) has a short chapter entitled 'How To Diagnose Your Moods'. Other books are more exclusively focused on diagnosis, such as Bartlett (1987). The extent to which well written and well researched books on self-diagnosis are helpful or harmful depends partly on the person using them being able to absorb the information and match it against their own problems or symptoms. The efficacy of self-diagnosis is a complex issue worthy of future research.

Purposes of Diagnosis

There are three main purposes for making a diagnosis. The first is to identify what the problem is, so that appropriate intervention(s) can be made. Whereas diagnosis is concerned with finding commonalities between the symptoms and signs of the person before you, to compare with a classification, treatment is very much concerned with a biopsychosocial assessment (see later). This is an assessment of all sources of help available to this particular person at this particular time. Diagnosis is therefore concerned with similarities whereas treatment is very much concerned with individual differences.

The second reason for diagnosis is for research, with a view to improving interventions for future sufferers. Psychiatry is a very young science, and only in the last four decades has specific treatment for particular psychiatric problems been attempted. Unsurprisingly, psychopharmacology is primitive in comparison with general medicine, and is generally ameliorative rather than curative. Similarly it is only in more recent years that psychotherapy and counselling have begun to be subjected to scrutiny through various outcome studies (see Smith et al., 1980).

A third reason for diagnosis centres around knowledge, communication and memory. This includes communicating with other professionals as well as representing (and remembering) the outside world through specialised language. For example, a carpenter has a specialised language to represent the tools and materials with which he or she works. Some wood is called oak, other ash, maple or mahogany. These terms are probably known by people generally. Yet if a furniture-maker wishes to build a billiard table, he may specify 'Andaman padouk' for its colour and physical qualities. Similarly, a practitioner in the mental health field might use a label to indicate a particular type of problem, such as panic disorder without agoraphobia. Such terms can enable the practitioner to build up a body of knowledge around various diagnostic categories to guide their practice. In this way, it is hoped that the counsellor is less likely to employ interventions which have no chance of aiding the client, just as the furniture-maker will not use wood for a billiard table which will twist and warp!

It is important that this means of classification is not allowed to deteriorate into the process of reification noted above. The person seeking help may be suffering with signs and symptoms which can be given a certain name, such as schizophrenia, manic depression or post-traumatic stress disorder. The person, however, is not a schizophrenic or a manic depressive any more than a person suffering from influenza is a 'flu'! Associated with the process of reification is stigmatisation, which has been described by Goffman both in its general sense (Goffman, 1963) and as it applies to people in 'total institutions' (Goffman, 1974).

An allied criticism of psychiatric diagnosis comes from the anti-psychiatry school of thought. Thomas Szasz (1991) suggests that because most mental 'disorders' do not have a demonstrable physical pathology, they are not illnesses and hence should not,

in his view, be the province of doctors. Szasz also makes the point that 'if mental illnesses are diseases of the central nervous system, they are diseases of the brain, not the mind' (1991: 1574). In noting that psychiatric diagnoses allude only to human behaviours, Szasz suggests that such diagnoses do not deprive the person of free will. However, a number of physical diseases do not have (known) gross pathology, while there are both genetic and biochemical grounds pointing, for example, to a physical basis for schizophrenia and depressive disorders.

The second main aspect of assessment, the biopsychosocial formulation, considers the unique characteristics of the individual with a view to aiding recovery or change. In this process the person is regarded holistically, in their entirety, which includes their individual strengths and weaknesses and their total resources such as family support, social networks, work and professional structures, interests and so forth. A clear guide to assessment written from a social work perspective, which recognises the importance of a holistic approach, can be found in Lukas (1993).

One attempt to explain the concept of the whole person – and indeed going beyond the individual – is the idea of systems. Much has been written about systems theory, and certain therapeutic models are largely based upon such a theory, for example, family therapy (see Minuchin et al., 1978).

From the perspective of assessment, the main point to grasp is that individuals function as wholes, although many different parts may be operating at any one time. A change to any part of the system is likely to have consequences, and lead to changes within other parts of the system. For example, an intervention focused upon a person's cognitive processes (thinking) is likely to be accompanied by an alteration in their affective (emotional) and behavioural systems – the process being interactive. This interaction of subsystems underlies the cognitive therapies. Chapter 7, on the assessment of specific modalities, also gives examples of the ways in which different subsystems operate together in particular ways.

While the person has a number of subsystems operating within her, she is also part of other systems: social, cultural, family and employment. The person is a subsystem too, and a change to the person (now the subsystem) is likely to bring about changes to those other, wider systems. Equally, changes in those wider systems are likely to affect the person. If this whole process can

be kept in mind while assessing the person's potential for positive change, this will be very useful.

The biopsychosocial assessment is an attempt to view the individual from this wider perspective. This rather clumsy word is a collection of three other words: 'biological', 'psychological' and 'social'. Such an assessment acknowledges that a change in any part of the overall system will affect the person as a whole; for example a change in a person's cell formation, such as in cancer, is likely to lead to changes in their psychological systems too. While a particular subsystem (in this case biological) might initiate change in the individual, such change may nevertheless be mediated through other subsystems, such as psychological and social. For this reason, it is often futile to think of a particular problem as being biological *or* social *or* psychological. These different systems interact, and while a particular problem might be prompted by a particular subsystem (such as the biological), change may be effected through other subsystems or a combination of them.

Practice Points

Assessment is *part* of counselling: avoid temporarily neglecting good counselling practice during assessment.

The purpose of assessment is to identify problems and to identify possible solutions, which may be multiple.

Diagnosis matches the client's signs and symptoms against known clusters of signs and symptoms to discover if a match can be found. Severity and duration are important. The known clusters are given in classification manuals.

Be aware of the problems of labelling and stigmatisation.

The biopsychosocial formulation views the individual holistically and is particularly sensitive to the individual differences of each person. It recognises that individuals are part of multiple systems and therefore function at many different levels. Individuals also have many different parts operating within them. Interventions can therefore be focused at many different points.

The Manner of the Assessment: Theories of Mind

A challenge faced me in writing this chapter: assessment covers the total range of counselling approaches. It is important to

appreciate that your particular model of counselling (that is the theoretical framework in which you trained) will make assumptions about the nature of the human condition – about what it means to be human. These assumptions will fundamentally colour the counsellor's beliefs about the nature of the problems for which people seek help, the type of intervention which should be offered and the significance and meaning of the relationship between you and the person you hope to assist.

The range of different psychological therapies is extensive and continues to proliferate (Karasu, 1986). It is important to understand where your particular therapy fits into the overall pattern of therapies: what are the fundamental beliefs it is based upon, and what distinguishes it from similar therapies? It can also be useful to understand the major points of concurrence and disagreement with other therapies. The acquisition of this type of knowledge is important because it will help you to develop a broad framework within which to understand counselling more fully and to help you recognise where different approaches may be largely incompatible. A full discussion of these issues is beyond the scope of this book, but we will consider some aspects of three major therapeutic systems to understand how they might affect the process of assessment.

In the psychoanalytic framework (after Freud, 1916) the client (analysand) expresses their fears and wishes to the analyst through free association: 'he should report his thoughts without reservation and . . . he should make no attempt to concentrate while doing so' (Rycroft, 1968: 54). In a transference relationship with the therapist, the client displaces feelings, attitudes and impulses of earlier relationships onto the therapist. This is aided by the therapist being relatively neutral and anonymous. Through interpretations of this transference by the analyst, the client comes to recognise earlier conflicts and thus adopts a more appropriate (that is, non-transferential) relationship with others. Symptoms are usually seen as expressions of such intrapsychic conflict, that is conflict between two parts of the same mind, in contrast to conflict between two persons (1968: 77). A clear guide to psychodynamic counselling which does not assume an implicit knowledge of the field can be found in Jacobs (1988).

The person-centred framework (after Rogers, 1951) finds the therapist relating to the individual before her as unique and worthwhile (unconditional positive regard). She is empathic: she