

THE ASSESSMENT PROCESS

Some of the aims of assessment are:

- 1) To ascertain whether the patient is suitable for and likely to obtain optimal benefit from the service.
- 2) To ascertain what the problem is.
- 3) To obtain a coherent understanding of the problem. To obtain an understanding of how the patient got “stuck” in the process of adjusting.
- 4) To make a judgement as to whether the patient and the presenting problem fit the skills and abilities of the therapist.
- 5) To judge whether the presenting problem is amendable to intervention. – What are the variables that appear to affect the problem? What variables seem to make the problem worse? What variables seem to make it better? Who says it’s a problem? What is their stake in having the problem? What is the motivation and capacity for change?
- 6) To assess the function of “the problem” for the patient and/or the wider system.
- 7) To contract with the patient on what “the problem is”.
- 8) To positively reframe “the problem”.
- 9) To ascertain whether the therapist’s world view sufficiently coincides with the patient’s world view.
- 10) To gather information and build a working relationship.

What sorts of questions are found to be useful in assessments?

- 1) Questions which help to clarify and gain understanding of the problem.
- 2) Questions that assess the risk that the patient presents to him/herself and to others.
- 3) Other questions like:
 - a) “What have you done already to help solve the problem?”
 - b) “What help are you looking for?”
 - c) “How far back do we have to go to find you well?”

- d) “How will we know when you are better?”
- e) “What makes the problem worse?”
- f) “What makes the problem better?”
- g) “What will happen if it doesn’t get better?”
- h) “Why is it bad *now*?”
- i) “What has changed (if anything) since last week?”

“Why has it changed?”

“Why has it not changed?”

“What thoughts and feelings bring on the symptoms?”

- 4) To ourselves we need to ask:

Who else is involved in the patient’s problem?

What does the problem mean to the others in the patient’s system?

How psychologically minded is this patient?

How motivated is this patient to change?

What stops this patient from changing? What are this patient’s defence mechanisms?

What are this patient’s resources, strengths and assets?

What are the variables that I can influence to bring about change in the symptom or presenting problem? How can I influence these variables?

- 5) Be wise enough to understand that, in groups, teams, organisations, and families, there are multiple truths, not one alone. Even when there seems to be a dominant or consensus view there are likely to be other, perhaps diametrically opposite views in the group that may have equal legitimacy. Be aware of the forces that may distort or hide group realities: projective processes, power issues, scapegoating processes, and personal needs of the actors involved, such as a need to dominate, self-display, take up a safe position, fear of ridicule, etc., etc. Be aware that there will be personal motivations, conflicts and defences that operate as underlying motivators of individual and group behaviour. Be aware that the voice of the powerful (parents, managers, etc.), the articulate, or the apparent consensus view may be the problem or a symptom of the problem. The views of the voiceless of the scapegoated may help to reveal underlying issues. Scapegoats may know more about the system dynamics than others in the system or they may reveal a problem, by illustrating the group symptom,

without knowing what it is. Patterns of alliance and patterns of relating are important to assess. Who has the power and how is this used or avoided? What cannot be voiced, experienced? What do relationships and viewpoints mean in term of internal models of relationships? What is the relationship to the context, the world outside the system boundaries?

- 6) Finally, read nineteenth century fiction as well as, or rather than, psychology – this will give you a complex view of relationships, motivations, group dynamics, psychopathological patterns. Good starting points: George Eliot, *Middlemarch* and Dostoyevsky's *The Brothers Karamazov*.

“If you want to learn about people’s personalities and intentions, you would probably do better reading novels than reading psychology books. Maybe that’s the best way to come to an understanding of human beings and the way they act and feel, but that’s not science. Science isn’t the only thing in the world, it is what it is...science is not the only way to come to an understanding of things.” “If I am interested in learning about people, I’ll read novels rather than psychology.” “I think the Victorian novel tells us more about people than science ever will...and we will always learn more about human life and human personality from novels than from scientific psychology.” “We learn from literature as we learn from life; no one knows how, but it surely happens. In fact, most of what we know about things that matter comes from such sources, surely not from considered rational inquiry (science), which sometimes reaches unparalleled depths of profundity, but has a rather narrow scope.” “It is almost certain that literature will forever give far deeper insight into what is sometimes called ‘the full human person’ than any modes of scientific inquiry may hope to do”. *Noam Chomsky, The Chomsky Reader*.