This chapter examines the principles of psychological assessment applied to clinical and counselling settings where clients typically seek help because they are in emotional distress, experiencing, for example, anxiety, depressed mood or chronic anger. Such problems may be related to a range of other problems such as experiences of trauma, relationship conflicts, social or work difficulties, or excessive attempts at self-control (as in some eating disorders or obsessive-compulsive problems), or to poor impulse control (for example, with respect to aggression, gambling, substance use). The main focus of this chapter is the initial gathering of information in these contexts. This is called an intake assessment.

**Figure 23.1** The phases in the process of intake and ongoing assessment

- **Initial assessment** (semi-structured interviews supplemented by other methods of data gathering) as described in this chapter
- **Information gathered**
- **Case formulation**
- **Treatment plan**
- **Treatment implementation**
- **New information** (about client’s history, life situation, and client’s response within and between sessions)
An intake assessment is the first step in a process whose aim is to deliver meaningful help to clients in distress. The second step is to use the information gathered during the assessment to make a case formulation. This incorporates a psychological understanding of clients’ problems that can serve as the basis for the third step, the making of a treatment plan. Since the implementation of a treatment plan usually requires at least a few further sessions (and sometimes a large number), it is only worth embarking on the assessment process where it can be expected that a client seeking help can attend a series of sessions on a regular basis. A clinical assessment of this sort does not end once the intake is completed. Once treatment is implemented, new information is gained and the clinician engages in an ongoing assessment process that may lead to modifying the case formulation, and, in turn, the treatment plan, as illustrated in Figure 23.1.

A flexible and pragmatic qualitative investigation

The general principles of assessment, case formulation and treatment planning have a long history within clinical and counselling psychology in Europe and North America (for example, Freeman, Pretzer, Fleming & Simon, 2004; Kuyken, Padesky & Dudley, 2008; Mace, 1995), and have been regularly applied in South Africa since clinical and counselling psychologists began to develop a professional identity here in the 1970s and even before then (for example, Rachman, 1958). This chapter examines the application of clinical assessment under South African conditions based on case examples and published case studies, and discusses the problems and challenges that practitioners face due to time constraints, shortage of resources or cultural and contextual factors.

Unlike most other chapters in this volume, this one does not describe a rigidly structured assessment technique with quantified results and normative data. This is because a clinical assessment is a pragmatic investigation that is largely a process of qualitative evaluation based on the same principles as phenomenological-hermeneutic research (see Kvale, 1996). The phenomenological aspect is that the main interest is the lived experience of clients – their everyday thoughts, beliefs and attitudes (conscious or unconscious), emotions, body sensations and behaviour within the contexts of their everyday lives. The hermeneutic aspect is that clinicians draw on existing clinical knowledge and theory to guide their questioning and to interpret the information obtained. In formulating the case, clinicians need to ensure that they do not arbitrarily impose an interpretation from theory that is not supported by the information obtained from the client. The problems of many clients can be satisfactorily understood in terms of existing clinical theory, but, where they cannot, the case could be written up and published as a means of extending and refining existing theory (Dattilio, Edwards & Fishman, 2010; Edwards, Dattilio & Bromley, 2004).

A semi-structured interview is the main method of gathering information. Clinicians need to facilitate a balance between encouraging clients to express themselves in their own words and obtaining the specific kinds of information that will enable them to provide meaningful help. They also need to be responsive
to the personal characteristics of the clients being assessed, the particular details of their lives, and the socio-economic and cultural contexts in which they live. Some of the information that clinicians ask about will be sensitive and likely to evoke distressing emotions in the client. For this reason, clinicians will not only be covering a list of important questions, but will be putting their client at ease, offering hope, building trust, and laying a relational foundation for any future work together if a course of treatment is indicated (Tantam, 1995).

In order to obtain the information that will be needed for a meaningful formulation of the case, other individuals may need to be interviewed. In assessing children, parents or caregivers are interviewed to provide background information. Such interviews also enable the clinician to assess the degree of support within the family, which may be essential if treatment is to be effective (Leibowitz-Levy, 2005; McDermott, 2005). Interviews with parents/caregivers and teachers are often central in the assessment of children’s scholastic problems (see, for example, Whitefield-Alexander & Edwards, 2009). In assessing Tumeleng, a boy with severe conduct problems, Smith (2006) also interviewed the boy’s father and sister, as well as two members of the school staff who knew him well. In addition to the interview, clinicians may draw on several other methods of gathering information that will contribute to an understanding of clients’ problems.

Another method of data collection is to ask clients to observe their own behaviour and report back to the clinician at the next session. The clinician or an assistant may even observe the client’s behaviour in a natural setting: observations of children’s behaviour in the classroom may be valuable in the assessment of scholastic or behavioural problems. In assessing children, clinicians can obtain valuable information about factors related to their problems by observing the mother playing with her child in a clinic playroom, or by observing the child’s spontaneous play or drawings. Self-report scales may be used to measure a range of responses, including those associated with depression, anxiety and post-traumatic stress (this aspect is elaborated by Young and Edwards in chapter 22 of this volume). For children, parents may complete a parenting scale that taps their style of parenting and administering discipline (Smith, 2006), and parents or teachers may complete behaviour checklists (Mashalaba & Edwards, 2005; Whitefield-Alexander & Edwards, 2009).

Much useful information is also available from clients’ nonverbal behaviour: the volume, speed and intensity of their speech; their posture and gestures; their clothing; and their punctuality. As important as what clients say may be ‘what they’re not saying’, and clinicians may use this to probe for ‘information that might be out of their current awareness’ (Padesky, 1996). Projective tests can also help to access aspects that clients cannot verbalise. Although these can be formally scored if appropriate norms are available, they can also be interpreted using standard methods of qualitative research and linking themes with other material obtained during the assessment. This is illustrated by McDermott’s (2005) case study of 11-year-old Nosipho, where the Draw-A-Person Test provided valuable information about her identity as a black child, and the game of making a ‘life road’ became an instrument not only for ongoing assessment but also for treatment. Killian, Van der Riet, O’Neill, Hough and Zondi (2008)
also provide evidence for the value of these methods in providing information about children’s experience. Their study of children’s agency under conditions of extreme adversity used focus groups in which a range of methods drawn from clinical practice were used, including making a ‘life road’ and other projective techniques. Material obtained in this way can largely be interpreted qualitatively, in conjunction with other information and further questioning of the client. Quantitative analysis of projective drawings can be misleading, though: in an earlier study of preschool children exposed to township violence, Magwaza, Killian, Petersen and Pillay (1993) found that the most severely traumatised children showed less trauma content in their drawings.

Areas to be covered in a clinical assessment

The aim of the assessment is to obtain enough information to form the basis for a case formulation, management recommendation and treatment. This means that clinicians are not just going through a checklist of information to be obtained, but are asking questions with specific goals in mind. The kinds of information that need to be gathered during a psychological assessment in order to inform such a final recommendation are summarised in Table 23.1 (note that not all of the items in the table are elaborated below).

Table 23.1 Kinds of information to be gathered in a clinical assessment

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenting problems</td>
<td>The specific concerns that led the client to seek treatment: behavioural (relationship conflict or abuse, substance misuse, eating disorders, compulsive behaviours, sexual difficulties); emotions and mood (anxiety, depression, anger). Other prominent current psychological problems that emerge from the assessment interviews.</td>
</tr>
<tr>
<td>History, time course and impact of presenting problems</td>
<td>Onset, time course and severity of each problem or symptom. Impact on the client’s everyday life (social and occupational functioning).</td>
</tr>
<tr>
<td>Case history</td>
<td>A summary of the main events of the client’s life from birth to the present. Needs to include information about family, peer relationships, education and occupation, major life changes or traumatic events, medical problems, sexual orientation and history.</td>
</tr>
<tr>
<td>Screening</td>
<td>Check for problems that client may avoid disclosing such as substance use or abusive behaviour. Be alert for problems related to factors which cannot be addressed by psychological treatment: for example, headaches may be caused by a brain tumour, memory difficulties may be the result of brain injury following a motor vehicle accident, dizzy spells may be due to epilepsy.</td>
</tr>
<tr>
<td>Risk assessment</td>
<td>An assessment of whether the client is at risk of harming self (suicide, self-mutilation) or others (assault, murder, drunken driving).</td>
</tr>
</tbody>
</table>
### Contextual factors
Factors likely to have a bearing on delivery of an intervention. These include social support (family, community), neighbourhood (safety, resources, services), cultural aspects (religious or cultural beliefs of client and family), current employment and financial stability.

### Vulnerabilities
Developmental vulnerabilities (see predisposing factors in Table 23.2). Current vulnerabilities (lack of social support, unsafe or abusive environment, financial problems, etc.).

### Strengths
Factors that may help clients to address their problems (motivation, social support, personality strengths).

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**Presenting problems, course and severity**

Initially, the most important focus is the presenting problem or problems that led the client to seek help. While the clinician may begin with open-ended questions to facilitate clients’ sharing their problems in their own words, this is followed up by more focused questions based on the clinician’s knowledge of the kind of problem the client is presenting, and the kinds of psychological and behavioural processes that might be associated with it. For example, where a client is presenting with low mood, lack of motivation and fatigue, clinicians will ask questions to establish whether this fits the picture of a clinical depression, and, if so, what particular symptoms are present. It is also important to establish how severe the client’s symptoms are, and the degree of their negative impact on the client’s everyday life (Gilbert, Allan, Nicholls & Olsen, 2005). Information about the time course of the problem is also important. For example, is this the first experience of depressed mood or has the client been depressed like this for years? Does the client regularly experience episodes of depressed mood following events such as disappointments or relationship conflicts? The therapist should pay attention to any events that might have precipitated the current problem. For example, a client who has coped with a sense of failure by putting great effort into his work finds himself depressed after being retrenched from his job (see discussion of precipitating factors below). Where there are several problems, it is important to establish the time course of each: for example, a client may have a history of social anxiety going back to early high school days, but may only have experienced significant depression at the age of 25.

**Case history**

Taking a case history means surveying the course of a client’s whole life, including the circumstances of his or her birth, his or her family relationships, relocations (moving house, moving towns), his or her progress at school, his or her peer relationships at different phases, traumatic events (family deaths, experiences of abuse, crime and violence), his or her intimate (including sexual) relationships, birth of children and work history. It is particularly important to gather information about life events that might render an individual vulnerable to psychological difficulties. Stressful conditions that increase vulnerability to psychological problems include many events that have the potential to disrupt family stability and the security of the child’s attachment to caretakers. An example
Assessment in routine clinical and counselling settings

would be living in a family where parents are neglectful, emotionally unstable or unpredictable, verbally or physically abusive, in chronic conflict, abusing alcohol or drugs, or suffering from other serious mental health problems such as depression or psychotic disorders. Clinicians should also be alert for information about such events as chronic disabling illness of a parent, the death of a parent or sibling, a sudden shift in caretaking arrangements (for example, a child who has been cared for by the mother is suddenly left with a grandmother), or breakdown in the relationship between parents (including separation and divorce). The relationship between these kinds of events and psychological problems is well established by research both internationally (Agrawal, Gunderson, Holmes & Lyons-Ruth, 2004; Chapman, Dube & Anda, 2007; Edwards, Holden, Anda & Felitti, 2003) and locally (Seedat, Stein, Jackson, Heeringa, Williams & Myer, 2009).

Screening and risk assessment

Questions should not be confined to what clients talk about spontaneously. Clients and those concerned about them are often unaware of what causes their problems, or of the connection between different problems. Tumeleng’s violent behaviour at school followed on his being sent away to boarding school in another country and being severely bullied (Smith, 2006). A student who became so depressed that she could not study did not realise that the main factor behind this was an abortion she had had a few months earlier (Boulind & Edwards, 2008). Alcohol abuse and dependence often lead to depressed mood and severe anxiety states, but clients may report the depression and anxiety without reporting the substance problem and without understanding that they are connected. For this reason, investigation of the presenting problems should include the use of screening questions that probe substance abuse, self-harm and other impulse-control symptoms that clients might not readily admit. Symptom checklists or checklists based on DSM or International Classification of Mental and Behavioural Disorders (ICD) diagnostic criteria can be a valuable means of ensuring that important information is not missed (Young & Edwards, chapter 22, this volume).

A risk assessment needs to be carried out early in the assessment to ascertain whether clients are a danger either to themselves (for example, by attempting suicide) or to others (for example, by assaulting or even killing someone). Research shows that suicidal ideation is associated most strongly with affective disorders, followed by substance abuse (especially alcohol) and schizophrenia, and, while suicidal thoughts are common, actual suicide is rare, so suicidal ideation is not necessarily indicative of high suicide risk (Davies, Naik & Lee, 2001). The sensitivity and specificity of the known risk factors is low, which means that there is no sure way of predicting whether clients will attempt suicide (Powell, Geddes, Deeks, Goldacre & Hawton, 2000). However, there is significant risk associated with having made previous suicide attempts, as well as with hopelessness. Client impulsiveness and aggressiveness are also causes for concern. In these kinds of cases, clinicians should use direct questioning about the nature of suicidal thoughts, the strength of the client’s intent and whether the client has firm plans using a specific method. Where there is clear intent, clinicians should ask about access to lethal methods (for example, whether
clients have been collecting medications on which to overdose, or own a gun) since there is a greater risk when means are available (Hawton & Van Heeringen, 2009). The same general approach would hold in cases where clients actively threaten to assault or kill someone. Clinicians must also be alert for clients who may be at risk of being harmed by others (for example, a child who is being sexually or physically assaulted by a family member).

Where clinicians establish that there is significant risk, they are ethically required to take action. Where a child is being abused, this may need to be reported to authorities. In the case of suicidal ideation, for less severe cases clinicians can consider using anti-suicide contracts, but their effectiveness has not been clearly established (Lee & Bartlett, 2005). Where there is more severe intent, it may be important to alert family members, and interventions might include the removal of firearms and/or lethal medication and voluntary or, in extreme cases, involuntary hospital admission. The appropriate course of action will depend on local mental health resources and should preferably be discussed with a supervisor or colleague (Allan, 2008). In the long term, the only sure way of decreasing suicide risk is to treat the client's mental disorder (Cavanagh, Carson, Sharpe & Lawrie, 2003), and therefore suicide management strategies that risk alienating clients from mental health services should be used sparingly. Bantjes and Van Ommen (2008) have developed a Suicide Risk Assessment Interview Schedule which provides a detailed checklist of risk factors to be probed in the course of a semi-structured interview. They illustrate its application using two case examples of students who sought assistance at a South African university counselling service, and discuss principles for making appropriate management decisions that are no more intensive than necessary, and most likely to preserve the therapeutic relationship.

A final aspect of screening is to be attentive to problems or symptoms that are not caused by psychological factors. For example, a client suffering from infectious mononucleosis (glandular fever) may experience loss of energy and motivation (Candy, Chalder, Cleare, Wessely & Hotopf, 2004); a client who has suffered a recent concussion may experience headaches, dizziness or concentration difficulties related to bruising of the brain (Lovell et al., 2006; Shuttleworth-Edwards, Whitefield-Alexander & Radloff, chapter 30, this volume); and a client in the early stages of AIDS may develop a number of cognitive impairments (Joska, Fincham, Stein, Paul & Seedat, 2010).

**Contextual factors, vulnerabilities and strengths**

Clients' psychological difficulties are embedded in their everyday lives, so they cannot be understood without information about their families, friendships and intimate relationships, work setting, financial means, access to medical care, and the kind of home and neighbourhood they live in (with respect to such factors as overcrowding and exposure to crime). For example, at a South African university counselling centre, black students seeking counselling were more distressed than their white counterparts, possibly because of issues such as racism, financial strain, trauma, poor academic preparation and a lack of social support (Young, 2009). Trauma, too, is a common feature of South African society (Edwards,
Assessment in routine clinical and counselling settings

2005), and individual treatment of members of communities affected by chronic violence may have limited impact unless support structures are also built within the affected community (Higson-Smith & Killian, 2000). In addition, poverty – with its associated poor living conditions and poor nutrition – makes a significant contribution to poor mental health. Failure to take into account such contextual factors that might cause, shape or aggravate psychological disorders will in all likelihood result in a poor response to treatment.

An evaluation of clients’ strengths provides an important counterpoint to the identification of factors in the case history that might confer vulnerability (as discussed above). Some individuals show remarkable resilience in the face of adversity, and remain optimistic in the face of very difficult life circumstances. The inclusion of the client’s strengths may result in a case conceptualisation that is more acceptable to the client, which can promote therapist/client collaboration (Kuyken et al., 2008). In such cases, therapy can focus on enhancing strengths as well as alleviating problems, which can enhance the prevention of relapse (Brewin, 2006).

Assessment and intervention: managing priorities

Clinicians must exercise judgement with respect to how they manage the gathering of all this information. To cover all the areas in Table 23.1 comprehensively could take several hours. Meanwhile, the client may have urgent concerns that are not being addressed. One way to overcome this is to schedule two to three hours at a time. Breaks can be included for the client to rest, and for the clinician to reflect on the information obtained and plan the focus for the next part of the interview. Where clients are in crisis, the clinician may need to intervene immediately to calm intense emotions or reduce suicide risk. In such cases the clinician may have to move between conducting the assessment and a crisis-intervention approach (Dattilio & Freeman, 2007).

Because of time constraints the clinician may choose to obtain only a limited history, and build up a fuller history as details emerge in the course of treatment. This allows for problems that might respond to brief structured interventions to be addressed more rapidly. Where clinicians elect to do this, it is particularly important to view the process of assessment as ongoing so that, as they build up a fuller picture over the course of a few sessions, they can reformulate the case and renegotiate with the client about what is likely to be involved in treatment (see Figure 23.1).

The disadvantage of skipping aspects of the assessment process is that information vital for case formulation may be missed, resulting in inappropriate interventions being offered. This could waste time and undermine the clinician's credibility. Another reason for not plunging into treatment prematurely is that psychotherapy or counselling may not be appropriate for all clients who are assessed, and it is one aim of the assessment to determine whether a psychological intervention is appropriate at all. Furthermore, a systematic assessment means that the clinician may open up areas of experience that the client might otherwise avoid, and this can benefit the client. If very traumatic experiences are touched on that clients are too distressed to go into detail about
(such as childhood sexual abuse), the clinician can at least note their significance and consider their possible contribution to current problems. For some clients the assessment process itself can result in some improvement, as measured by the sorts of measures used to evaluate therapy outcomes (Young, 2006a). This is because having had the opportunity to discuss their problems with a sympathetic therapist, and having felt understood, they may subsequently put insights gained from this process into action to improve their lives (Young, 2006b).

Case formulation

Throughout the assessment process, information is gathered in such a way as to serve as a basis for the steps set out in Table 23.2: making a diagnosis, developing a case formulation, making recommendations for management and devising a treatment plan.

A provisional diagnosis is made by using the diagnostic criteria in, for example, the ICD-10 (World Health Organization, 1992) or DSM-IV (APA, 2000), and systematically checking to see if the client meets them.

Table 23.2 Case formulation, management recommendation and treatment plan

<table>
<thead>
<tr>
<th>Diagnosis (ICD-10; DSM-IV)</th>
<th>A formal diagnosis based on the criteria set out in the ICD-10 and/or DSM-IV.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case formulation</td>
<td>Predisposing factors</td>
</tr>
<tr>
<td></td>
<td>Precipitating factors</td>
</tr>
<tr>
<td></td>
<td>Maintaining factors</td>
</tr>
<tr>
<td>Management recommendations</td>
<td>Should the client be referred for further specialist assessment (for example, by a psychiatrist or neurologist)? Does the client need crisis intervention? Does the client need to be hospitalised? Can the client be helped with a course of psychotherapy or counselling?</td>
</tr>
<tr>
<td>Treatment plan</td>
<td>This should address the presenting problems based on the factors that are currently maintaining them. Interventions need to be selected according to the evidence base in the clinical research literature and adapted to suit the contextual features of clients’ lives, and taking into account their vulnerabilities and strengths.</td>
</tr>
</tbody>
</table>
A case formulation, also called a case conceptualisation, describes and explains the client’s distress. It incorporates clinical hypotheses about the factors underlying the development and the maintenance of the problem (Kuyken et al., 2008; Persons, 2006). Although there may be differences in how this is done within different approaches to psychotherapy, case formulation is central to most approaches to psychotherapy (Eells, 2007; Mace, 1995) and formulations from different approaches can be remarkably similar (Persons, Curtis & Silberschatz, 1991). This chapter summarises the basic principles, based on an analysis of predisposing, precipitating and maintaining factors, using examples set out in Table 23.3. However, case formulation is a complex process to which many clinicians pay inadequate attention (Eells, Lombart, Kendjelic, Turner & Lucas, 2005), and a full treatment is beyond the scope of this chapter.

Table 23.3 Contrasting treatment plans for three cases of women with major depressive disorder

<table>
<thead>
<tr>
<th>Client</th>
<th>Context and formulation</th>
<th>Treatment focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sindi</td>
<td>Ongoing marital discord. Husband regularly criticises and belittles her and sometimes physically assaults her. She is feeling chronically helpless and hopeless. She was raised in a home where such abuse was routine and watched her mother being treated in the same way.</td>
<td>Educate her about the relationship between abuse and depression, and about women’s rights. Help her stand up to and confront her husband or take steps to leave him. Increase her social support. Discuss possible legal action.</td>
</tr>
<tr>
<td>Bulelwa</td>
<td>Unresolved bereavement – started when her 6-month-old baby died of a severe infection a few months ago. She is unable to talk about this without bursting into tears.</td>
<td>Help her accept the loss using bereavement therapy.</td>
</tr>
<tr>
<td>Nomvuyo</td>
<td>As a child her father expected her to perform at a high level, and often implied that she was incompetent. She was recently promoted but has been having panic attacks related to the extra responsibilities she has to undertake. The panic attacks are interfering with her work performance, and she fears that her superiors can see how poorly she is doing and will fire her. She feels increasingly out of control and helpless about solving the problem.</td>
<td>Address her anxiety about being evaluated. Train her in anxiety management techniques and panic control. Help her get an accurate appraisal of her ability to meet her responsibilities, and use a problem-solving approach to mastering the new challenges in her work.</td>
</tr>
</tbody>
</table>

**Predisposing factors** are those that have rendered clients vulnerable to their current problems. For example, a client’s depression may be directly related to an unstable family situation in the first few months or years of life, the death of a parent, or a sexual molestation that occurred in early childhood. A client whose mother died when she was an infant and who was sent from one caretaker to another over the following ten years would be vulnerable to intense feelings of abandonment, and the resulting insecurity could predispose her to intense anxiety and difficulties in current intimate relationships. The meaning such events had for the client will
Section Two: Personality and Projective Tests

need to be explored to provide a basis for understanding how these may have conferred vulnerability. The experience of emotional and physical abuse as routine while growing up may result in learned helplessness (as with Sindi in Table 23.3). Parental criticism may impart beliefs about the self such as ‘I’m incompetent’ (as with Nomvuyo in Table 23.3). Many clients are unaware of the link between past distressing events and current psychological functioning, and it is the task of the clinician, in developing the case formulation, to put forward credible hypotheses about this. In developing contexts such as South Africa, where poverty, crime and illness are not uncommon, it is particularly important to consider the impact of the accumulation of stressful life events and adversity both in conferring vulnerability and in the development of resilience (Turner & Butler, 2003).

Precipitating factors are those that set off a particular problem. In the examples in Table 23.3, the death of Bulelwa’s baby and Nomvuyo’s promotion are precipitating factors, as they are associated with the onset of symptoms. In the case of Sindi there may be no precipitating factor. Having been raised in an abusive family from which she progressed into an abusive marriage, she may have been depressed for so long that no clear onset can be identified.

Maintaining factors are those that keep the problem going. It is important to recognise that what may have caused a problem might be very different from what maintains it, and that both may need to be addressed in therapy. A depressed person withdraws socially and feels lonely, which exacerbates the depression. A woman in an abusive relationship (like Sindi in Table 23.3) may believe that if she perseveres, her partner will change, or may simply believe that this is what happens to women. A bereaved person who is too distressed to talk about the loss (like Bulelwa in Table 23.3) is unable to grieve and let go. Individuals experiencing panic attacks (like Nomvuyo in Table 23.3) may feel less and less able to cope, and even believe that they have a chronic incurable illness, and this demotivates them from trying to address their problems.

The management recommendation and treatment plan

The case formulation is the basis for a management recommendation. Since not all symptoms have a psychological basis, some clients may need to be referred to a medical practitioner or specialist to rule out any serious undiagnosed medical condition. Persistent headaches, for example, could be related to chronic anxiety or suppressed anger, but they can also be caused by a brain tumour or another underlying neurological disorder. Similarly, where clients report episodes of loss of consciousness, a referral for investigation of a possible diagnosis of epilepsy should be made. Some clients’ problems may be too severe for outpatient psychotherapy or counselling, and the outcome of the assessment may be a referral to a psychiatrist or a recommendation for hospitalisation or referral to a specialised substance abuse unit.

For many cases, however, the outcome of the assessment is a recommendation for a course of psychotherapy or counselling, and the case formulation will provide
the basis for the treatment plan. This step is illustrated by the three cases described in Table 23.3 of women suffering from major depressive disorder. Presenting the formulation and treatment plan is an important step which, if done well, can motivate the client and give them hope. If you imagine yourself presenting the treatment plan to each of these three women, you will be able to understand why Ahmed and Westra (2009) found that where clinicians can provide clients with a clear understanding of the cause of their distress and a rationale for the treatment plan, clients are more likely to be motivated to engage with treatment.

Currently there is a debate about the extent to which psychological treatments can be defined and manualised. A closely manualised treatment would be one that follows the same fixed protocol across a set number of sessions for any client. While such manuals work for less complicated procedures such as systematic desensitisation, most treatments are more complex, and treatment manuals emphasise general principles for planning treatment based on theory rather than prescribing the details session by session. This kind of flexible manualisation is widely recommended in cognitive behaviour therapy approaches stemming from the work of Beck (Westbrook, Kennerley & Kirk, 2007), and found in the treatment of post-traumatic stress disorder (PTSD) (Ehlers & Clark, 2000) and borderline personality disorder (Giesen-Bloo et al., 2006). It is also an increasing characteristic of psychodynamic approaches (Cabaniss, Cherry, Douglas & Schwartz, 2010; Leichsenring et al., 2009).

In these approaches, clinicians do an initial assessment of the kind described in this chapter, followed by an ongoing assessment based on new information that emerges from treatment sessions, clients’ response to treatment, and clients’ behaviour and experience between sessions. On this basis the case formulation is regularly refined and updated (see Figure 23.1). Such ongoing assessment is a feature of Edwards’s (2009) model for working with South African clients with PTSD or complex trauma, which allows clinicians to be responsive to the needs of each client on a session-by-session basis.

Assessment for psychotherapy in practice in South Africa

In multicultural societies the principles of assessment need to be flexibly adapted to working with clients from different backgrounds and in different settings. Since a clinical assessment is a form of qualitative investigation that is responsive to the individual characteristics of each client, sensitivity to culture and context is an essential feature of the process. Even where clinicians are from a similar cultural background to their clients, there may be differences in perspective related to such factors as family traditions, school experience, political loyalties and religious affiliation. The more clinicians understand these kinds of contextual factors, the more they can draw on resources within the client’s environment. Donald and Hlongwane (1989) show how clinicians working with black African children intervened with psychotherapy to address some aspects of their problems, but addressed other aspects by encouraging families to work with African healers.
Eagle (2004) describes cases of African clients with PTSD where, in order to plan treatment, the clinician needed to understand how traditional African beliefs impacted on the way trauma was experienced. Religious syncretism, whereby people follow Christian belief systems and simultaneously hold traditional cultural beliefs and practise cultural rituals that are often in contradiction to their Christian belief system, is not uncommon (Leclerc-Madlala, Simbayi & Cloete, 2009). The clinician, therefore, should explore how clients understand their problems and the cultural context in which these problems have developed. A woman who believes that a particular religious practice offers her protection from witchcraft might present with anxiety if something happens to prevent her from carrying out her practice, or if her faith in the practice is undermined.

The process of assessment described here has not been the focus of much formal research (Tantam, 1995). Despite this, it forms the basis of treatment planning in the majority of scientific evaluations of psychological interventions – for example, in randomised controlled trials. It is also fundamental to conducting systematic case studies (Dattilio et al., 2010). The applicability to South African contexts of the kind of assessment described in this chapter has been documented in several case studies which describe the treatment of a range of clinical problems. These include several cases of PTSD: in a male student who had had to identify his brother who had been killed in a road accident and badly burned (Karpelowsky & Edwards, 2005); in a schoolgirl whose policeman father had treated her and her mother abusively and whose mother had died of AIDS (McDermott, 2005); in a schoolgirl who had twice been raped near her township home (Payne & Edwards, 2009); and in a female student who developed depression and PTSD following an abortion (Boulind & Edwards, 2008). Other clinical problems addressed in published case studies include childhood Attention Deficit/Hyperactivity Disorder (Whitefield-Alexander & Edwards, 2009), childhood conduct disorder (Mashalaba & Edwards, 2005; Smith, 2006) and social anxiety disorder (Edwards, Henwood & Kannan, 2003; Edwards & Kannan, 2006). There is thus a clear body of evidence that the principles set out in this chapter are appropriate for a diverse range of clinical contexts in South Africa.

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