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Reflections on assessment, diagnosis and formulation

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Editorial CCPP

Rudi Dallos

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This editorial introduces the first of two special sections devoted to the exploration of different types of assessment and their applications in a variety of clinical contexts. Assessment has a long history in clinical child psychology and psychiatry and continues to be at the basis of clinical practice. It makes obvious sense to assume that our practice should be based on thorough assessment but a question that follows is – assessment of what? Traditionally assessment has focussed on the ‘presenting’ problem of the child that has come to be referred to a service. This of course occurs through a variety of routes and for a variety of reasons. To take two examples from the papers included in this issue a child may be referred for an assessment of *disruptive mood dysregulation disorder* or of *developmental trauma*. Both of these requests for assessment, however can already be seen to contain some assumptions about what the problems are in what ways the findings might be framed. In effect assessment is not neutral of underlying theory or assumptions. In both these example the request is in relation to exploring whether the child’s conditions meets the criteria for a diagnosis, e.g, DSM(v) criteria and in turn makes an assumption that there are real conditions, similar to form of illness that comprise the condition. Consideration of the pathways to assessment therefore invites us to think about clinical formulation (Johnstone and Dallos, 2016) which has come to be regarded as one of the central features of clinical work. Formulation is seen to offer a broader framework than diagnosis and employs assessment to develop psychological explanations of problems. Diagnosis and formulation are not simply distinct activities. Frequently in a request to initiate an assessment of a possible diagnosis there is already a formulation that the presenting symptoms can and should be considered as a cluster that make up a diagnostic category. So, assessment is not a neutral process from which diagnoses or formulations result but is actively shaped by our preconceptions about what we are looking for and what is relevant to assess.

There are a range of further pre-conceptions that shape assessment: A primary question is what type of data or information the assessment aims to gather. We can see in the papers in this special section that they cover assessment using standardised inventories, qualitative interviews and structured interviews. These various methods are based in different research epistemologies, for example inventories usually claim to produce objective, generalisable and quantitatively measurable data (Emily A McTate and Jarrod M Leffler, this issue). Assessment oriented towards diagnosis assumes that the findings should be reliable (open to repetition across time) and validly measure a real entity. In contrast, qualitative methods shy away from the term assessment and prefer to discuss exploration, subjective experience and mapping of unique rather than generalisable evidence (Miranda Wolpert, et al). The ways that these are presented also tend to be different with assessments using ‘objective’ inventories are usually in the form of tables of statistics and qualitative explorations in terms of quotes from participants. These approaches are normally contrasted but in fact we can see overlaps: Most inventories use self- report questions which invite people to think about and then quantify their experiences in terms of ratings or rankings. But in qualitative interviews people may also quantify their experiences, for example with phrases, such as ‘I was extremely upset’ or ‘I was a bit annoyed’. We also see examples in this issue of assessments from

attachment theory which can be seen as a sort of hybrid (Kasia Kozłowska and Bronwen Elliott, this issue). The assessment of patterns of attachment employ structured interviews but then focus on specific features of the defensive processes exhibit in how people talk about their experiences rather than an analysis of the content.

Attachment based assessments also exemplify the issue of whether assessment is a collaborative process, in which the person being assessed is an active and informed partner or whether the assessment is largely done to them. This contains the question of what happens during the assessment, for example in an interview a person is actively being asked to consciously reflect on their experiences. It also relates to what feedback results from the assessment. In attachment measures the person is usually not made aware of why the questions are being asked or that the focus will be on their defensive processes and they would not be expected to be consciously aware of these. This in turn embodies different power dynamics, for example regarding how feedback can be given. These issues become more vital when questions of risk and safety become involved (Ben Grey and Steve Farnfield, this issue) where the cost of not getting the assessment 'right' are significant and sharing findings of an assessment, for example with parents may be very difficult: To not fully share the assessments of 'dangerousness' may imply condoning or minimising and sharing as promotion blame, withdrawal and defensiveness.

A final question which is whether and how assessment can become a vital and dynamic part of clinical work. George Kelly (1955) suggested that exploration and intervention were two sides of the same coin. He described therapy and the relationship between client and therapists as analogous to the relationship between a researcher and their supervisor. The researcher explores their life with the guidance of the supervisor. Kelly's best known method, the repertory grid embodies this concept in that as the person generates their grid they actively and consciously explore their life and relationship which inevitable produces new insights, connections, understandings and reflection. Systemic therapies also emphasise that exploration/assessment and intervention are inter-linked and many of the 'techniques' of family therapy involve asking questions. Evidence is accumulating that, when therapists include regular reflective assessment from clients and families, their effectiveness in promoting positive change increases (Latchford and Green, 2012). Systemic therapies have similarly developed the idea of 'progressive hypothesising' to capture the idea that feedback from families is continually employed to develop and refine our hypotheses or formulations about the family. As an example, in a family a mother described that her daughter was suffering from a high degree of anxiety and clinginess. We started with an assessment in the form of a hierarchy of her fears but as our work progressed the assessment moved to an exploration of the hostility and tension the mother was experiencing from her neighbours and which was impacting on her daughter.

We hope these series of papers will stimulate your renewed interest in this important area.

Green, D. and Latchford, G (2012) *Maximising the Benefits of Psychotherapy: A Practice – Based Evidence Approach*. London: Wiley

Johnstone, L. and Dallos, R. (2016 2nd Edn) *Formulation in Psychology and Psychotherapy: Making sense of people's problems* UK: Routledge