This chapter is organized into four sections. In the first part, the concept of assessment is discussed and several definitions are proposed. Four phases of clinical assessment are described. The second section looks at the question, "What to assess?," and suggests that the bio-psycho-social-cultural model of human nature is necessary to adequately answer it. It is argued that all of these influences on human behavior need to be addressed directly in assessment or, at a minimum, require sensitive recognition of their presence. The third part considers the question, "How to assess?" The four pillars of assessment are presented, and norm-referenced tests, interviews, observations, and informal assessment are discussed as techniques for learning more about the client's problem. Attention is then turned towards assessment in marriage, and two models are presented. The final section discusses assessment as a fundamentally ethical issue, stages of change, writing assessment reports, and giving feedback to the client.

Defining Assessment

The field of mental health has long been dominated by the medical model. Medicine has traditionally espoused the need for the classification of medical problems – namely, diagnosis – prior to treating. An initial interview by a psychiatrist typically will end with a psychiatric diagnosis – a label that defines a patient according to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; 2000) in North America or the *International Classification of Diseases*, Clinical Modification (ICD-9-CM; 1992) in Europe and other parts of the world. Although it is acknowledged that accurately identifying a disorder before beginning treatment is valuable in providing health services, this simple categorization of disorders fails to recognize the complexity of human nature that is necessary to adequately understand a client's presenting issues and, furthermore risks giving an individual a psychiatric label with potentially harmful effects to his/her self concept. For example, a psychiatric diagnosis misses the less obvious and often important differences among individuals who have been classified into a particular category, e.g., broader macro influences such as culture and gender, the less obvious situational determinants and correlates of a problem, the specific strengths an individual may bring to therapy, and so forth.

In contrast, the *assessment* of mental health problems is much broader in scope, an approach that recognizes the complex nature of issues that a client (considered in this chapter to be an individual, couple, or family) can bring to the clinic. Assessment has been defined in different ways, but the various definitions reflect the attempt to gain a more comprehensive understanding of the client's world. Brock and Barnard (1999) stated that assessment is "the taking in of information to make informed decisions" (p. 18). Assessment has also been described as "a process of solving problems (answering questions)" (Maloney & Ward, 1976, p. 5). Groth-Marnat (1999) makes the following important points about assessment:

> The central role of clinicians conducting assessments should be to answer specific questions and aid in making relevant decisions. To fulfill this role, clinicians must integrate a wide range of data and bring into focus diverse areas of knowledge. Thus, they are not merely administering and scoring tests. ... assessment attempts to evaluate an individual in a problem situation so that the information derived from the assessment can somehow help with the problem. Tests are only one method of gathering data, and the test scores are not end products, but merely means of generating hypotheses. ... assessment, then, places data in a wide perspective, with its main focus being problem solving and decision making. (pp. 3-4)

One view of assessment is that it is an ongoing procedure throughout therapy, and it is only when therapy stops that assessment ceases as well. This view is often held by therapists who favor an informal interview approach to gathering information about a client, and who are less inclined to use formal instruments. Although some authors suggest that assessment is both an initial as well as ongoing activity (e.g., Peterson & Sobell, 1994), it is argued here that this view, although promising in theory, with the many demands of clinical work, in practice can easily become a convenient rationalization for not making the time to carry out a systematic initial assessment. This not uncommon omission can then result in poorly focused therapy and ultimately a disservice to the client.

On the other hand, assessment is more commonly recognized as "the group of procedures used at the outset of therapy to design an initial treatment plan" (Brock & Barnard, 1999, p. 18). This is the approach favored by this writer and reflects Kettering's crucial insight that "a problem well stated is a problem half solved." This perspective is relevant not only for more established problems that are being addressed in a clinical setting, but also in attempting to resolve smaller issues that arise in everyday life. If individuals were less inclined to deny and rationalize the problems they experience in their own lives, then they would likely be more inclined to accept the existence of personal problems and thus a solution could be attempted. In short, problems in life rarely get resolved unless people initially recognize that they exist.

Groth-Marnat (1999) suggests that there are four general phases in clinical assessment: 1) evaluating the referral question, 2) acquiring knowledge relating to the content of the problem, 3) data collection, and 4) interpreting the data. Although these steps are defined as distinct sequential components, they can often take place at the same time and interact with each other. Groth-Marnat emphasizes that during these assessment phases "the clinician should integrate data and serve as an expert on human behavior, rather than merely as an interpreter of test scores" (pp. 30-31).

The first phase, evaluating the referral question, refers to clarifying the initial presenting problem, whether this is a formal request for assessment from a referral agency or a couple requesting help with their marriage. Competent assessment of clinical problems can be limited if the issue is not properly understood, so this initial stage is of critical importance. The second phase of assessment is acquiring knowledge related to the content of the problem. This involves being knowledgeable about the specific type of disorder being presented as well as carefully selecting the tests that will be used to collect information about the problem (e.g., being knowledgeable about a test's reliability and validity). In addition, it is important to be sensitive to whether a test is appropriate or not as a function of differences in clients' ethnicity, age, education level, and so forth.

The third phase, data collection, refers to obtaining information from four general areas: test scores, personal history, behavior observations, and interview data. Whereas tests are a key tool for acquiring information about a problem, a client's case history is of equal importance since it provides a context for both understanding and giving meaning to the test results. Observing the behavior of a client (e.g., negative interactions in a dysfunctional family, a disruptive child in the classroom) and interviewing the parents and/or teachers about the client can also be valuable sources of information. It is impor-