Moving beyond the single story:

using a double-storied assessment tool in narrative practice

by Jake Peterson

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Abstract

This paper explores the danger of a single story in traditional mental health assessments, and presents an alternative assessment tool that seeks to contribute to rich story development while satisfying organisational requirements. This double-storied assessment tool elicits stories of strength and hope alongside stories of difficulty. The paper draws on the maps of narrative practice and discusses six aspects of the assessment tool: structuring safety, externalising conversations, re-membering conversations, unique outcomes, deconstruction and documentation. Transcripts from case examples are used to demonstrate the use of the assessment tool. The tool can be used by narrative practitioners and other mental health professionals who are required to administer assessments and wish to resist pathologising approaches and to invite practices of accountability into their work.

Key words: assessment; formulation; risk; suicide; externalising; double-story; rich story development; narrative practice

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Many people work in contexts in which there is a mandate to conduct an assessment or clinical formulation of some kind. I have become increasingly uncomfortable administering assessments that include observation, normalising judgement and examination (see Keenan, 2001), and which might contribute to the dominance of problem stories in people's lives. I wondered if an alternative process could satisfy my organisation's requirement to gather enough information for risk assessment and allocation to a counsellor, *and also* provide a double-storied account that could contribute to a richer understanding of people's preferred stories of resistance, survival and responding to the problems in their lives.

Many practitioners and researchers have contributed ideas on poststructuralist case formulation and assessment in narrative therapy (Begum, 2007; Carrey, 2007; Dalyell et al., 2008; Forster & Taub, 2016; Harper & Spellman, 2013; Madsen, 2007; Meehan & Guilfoyle, 2015; Timm, 2015; Weber, 2007). What remains absent is an integrated and practical approach in a mental health context. This paper presents an alternative assessment questionnaire that seeks to be collaborative and affirming of the person and their expertise about their lives (Weber, 2007), to honour people's alternative claims about identity (Begum, 2007), to provide space for people to share the wisdom they have in dealing with problems (Dalyell et al., 2008), and to be life-sustaining (Forster & Taub, 2016) for people. This alternative assessment tool can be used in mental health or counselling contexts to draw out double-storied narratives of peoples' lives. It elicits stories of strength and hope alongside stories of difficulty and despair and could be considered one possibility for making assessments in a way that is more congruent with narrative practice in resisting pathologising practices.

Effects of assessments on people being assessed

Mental health assessments are mostly single-storied, problem-saturated and focus primarily on assessing risk. They often start with the problem and remain focused on problem (Madsen, 2007). This risks the introduction or entrenchment of problem-saturated identity categories such as 'schizophrenic', 'worthless' or 'failure'. If we privilege the single story of the problem, other stories steeped in hopes, dreams, commitments, skills and survival can become lost.

There is also a risk of bringing shame or stigma into the room when asking about sensitive issues like alcohol and drug use, unsafe sex or suicidal thoughts.

Asking about potentially traumatic experiences may have effects for the person. We can't measure how often people leave an assessment session and don't come back, or leave and get high to cope with talking about difficult issues. There is a risk that assessment processes may elicit and document trauma without providing support for the person. Where demand for a service eclipses its capacity, people may have a significant wait between assessment and being allocated a counsellor.

Effects on people administering the assessments

Formulations and assessments can position the therapist, rather than the client, as the expert. In medically oriented practices like 'interviewing', 'diagnosing' and 'treating', the expert determines the objective truth about the person. Claims to 'know' persons can contribute to what Meehan and Guilfoyle (2015, p. 25) have called the 'narrowing down of human multiplicity to a single-voiced vision of life'. It is crucial to resist reducing people's complexity to simplicity (Reynolds, 2020), and to avoid categorising people's stories and acts of resistance as trauma symptomology.

Administering assessments can position therapists as gatekeepers determining who is allowed to access services and who is not. This is particularly noticeable in relation to risk assessment: in some settings clients who are deemed to be too 'high risk' must be referred elsewhere. Such a gatekeeping position might contribute to the therapist forming negative identity conclusions about people who have been assessed as too high risk.

A conversation about doing no harm

Since the start of the COVID-19 pandemic, demand for counselling has eclipsed capacity in my organisation. My colleague Guy Campbell raised concerns about the effects of asking specific questions during an assessment. He reflected that asking questions about trauma history and then having clients placed on a waitlist for months did not sit right with him.

I wondered about the effects of our questions on workers, and whether there was a risk that the

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assessment process would take workers away from what they valued. After hearing Guy speak about the discomfort of administering an assessment before placing a client on a long waitlist, I asked him more about his experiences:

Jake: I'd like to explore a little bit about what you said today about asking questions about a person's family of origin or experiences of trauma and then leaving them to sit on a waitlist for months. That didn't sit right with you. I think the word you used was that it didn't feel 'ethical'. Could you say a little bit more about that?

Guy: Well, I guess that didn't feel ethical because we were potentially opening stuff up around traumatic experiences and asking people to be less contained, and then asking them to re-contain themselves for a long period of time on the waitlist. And for little client benefit because the person who would ultimately work with that client may well not even look at the family of origin assessment. They would do their own questioning. So it was ethical in terms of more risk of client harm than client benefit.

When I asked Guy if this implied something about what he held to be important in his work, he shared the importance of client-centeredness. Guy noted, 'There's a risk in the assessment process that [workers] feel like it's their job to dive in, capture the trauma, document it and then send the clients on their way'. I was intrigued by Guy's decision not to ask about trauma history during assessments. When I asked about this action, he said, 'I'm not going to do a trauma history. I guess I'm switching the goal from gathering a certain amount of information for us, to gathering just enough information, but ultimately having the client feel positive leaving assessment: feeling okay and walking out feeling more contained than they did walking in'.

I was curious about whether Guy thought this action took him closer to or further from the ethical ways of working that were important to him:

> Closer. Well, I guess, 'do no harm'. It is navigating an assessment process in a way that's less likely to cause harm, and adapting to the context of the services. This assessment tool was created in a very different time and place. I don't know if it's an ethical thing, but I guess the ethics of using tools in a way that matches them to the human interaction and not letting the tools dictate the exchange.

The role of assessment in narrative practice

If assessments are less than helpful and potentially harmful, why would we consider conducting them? Many people work in contexts in which there is a requirement to administer an assessment of some kind. Some might not be in a position to decline to administer an assessment. Others work in contexts in which they offer multiple services, and an assessment might ensure that a client can access the most appropriate or responsive service. This invites considerations about who decides which service is most appropriate – the client or the therapist?

Meehan and Guilfoyle (2015) argued that it is possible and desirable from a clinical perspective to formulate – to make some kind of sense of our clients and their contexts in a theoretically disciplined way. Harper and Spellman (2013) suggested that formulation is a structured story for therapists and clients, which gives one account of why things are the way they are and what might need to happen for things to change. Such an approach can orient therapist and client towards ways forward. Madsen (2007) has reminded us that our formulation is not 'objective truth' but one of many possible stories. However, our formulations have strong effects on our view of clients, on clients' views of us and on our developing relationships.

Constructing a new double-storied assessment tool

The process of constructing a new double-storied assessment tool included:

- reviewing the current assessment document and process in my organisation for areas that might keep people ensnared in problems
- constructing a new double-storied assessment tool using maps of narrative practice (M. White, 2007)
- putting the double-storied assessment tool into practice, with the hope of piloting it throughout the broader counselling team.

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The double-storied assessment tool I constructed draws on externalising conversations, re-membering conversations and conversations to highlight unique outcomes and possible subordinate storylines of people's lives. Reynolds' (2010) work on structuring safety, White's (1991) engagement with deconstruction in therapy, therapeutic documents (Epston & M. White, 1992; Fox, 2003; Newman, 2008), checklists of social and psychological resistance (Denborough, 2008) and an alternative suicide risk screening tool (Forster & Taub, 2016) were all instrumental in developing the double-storied assessment tool.

See Table 1 for a comparison of a traditional mental health assessment and the double-storied assessment tool.

	Traditional assessment	Double-storied assessment
Positioning	Single-storied, emphasis on problems	Double-storied, emphasis on skills and resistance
Therapeutic posture	Centred and influential	Decentred and influential
Notion of expert	Therapist as expert	Client as expert
Practices	Medically oriented practices	Accountability practices
Risk assessment	Focus primarily on assessing risk	Focus on discussing and managing risk together
Instruments	Clinical screening tools	Checklists of social and psychological resistance

Table 1. Comparison of traditional mental health assessment and the double-storied assessment tool

Structuring safety

The last thing I want to do is to replicate oppression or dominant discourses, to locate problems within individuals or to retraumatise people. Vikki Reynolds' work on structuring safety with refugees and survivors of torture and several practices from Denborough's (2005) framework for receiving and documenting testimonies of trauma were influential in the development of the double-storied assessment tool.

Slowing down is a practice described by Reynolds (2010) to make room for safe-enough conversations and to give people a new map out of trauma. We can slow down to ensure that the conversation is useful and to avoid replicating oppression or re-traumatising people. For example, we might ask: 'How will the telling be different for you after this session?'

Richardson/Kianewesquao and Reynolds (2014) wrote about creating space for people to 'speak their no' and negotiating permission as one way for people to have an informed 'no'. I might say something like, 'You can share as little or as much as you'd like' or this question from Reynolds (2002, p. 91): 'If I ask anything that's not OK, you don't have to answer. A good response would be to ask me why I asked that question. That would help catch me about asking questions that I shouldn't'.

Jake: What ways of knowing yourself have you trusting that you will be able to say 'no' to me if I ask something that is not okay?

Maggie[1]: I would probably answer any question.

Jake: What would it take for you to be able to say 'no' to me if you weren't okay with a question? Is there a history of you being able to say 'no'?

Maggie: My mum was very controlling, so if I hadn't learnt to say no, it would have been difficult. I feel I would be able to say no upfront, or 'not sure I want to answer this now'.

Jake: What would I be seeing or noticing if I asked a question you weren't okay with, or a conversation became too unsafe for you?

Maggie: Hmm, you are the first person to ask me that. Fidgeting in general and with my hands if you were able to see me. I might look down or shut down.

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From here, it was important to continue making room for a safe-enough conversation with Maggie. I continued structuring safety during this assessment by checking in with Maggie throughout the conversation: 'Can I just check in with you at this point and make sure the conversation is going okay with you?' If I were to notice Maggie fidgeting, looking down or shutting down, I might ask, 'Is this fidgeting anxiety, or is this the conversation being too unsafe for you, or something else?'

Externalising conversations

When people come to us for a consultation, they often come with internalised negative identity conclusions about themselves, such as 'I'm depressed, worthless, a failure'. They might speak of the problem as if it were part of them or within them (Morgan, 2000). Externalising conversations enable people to separate their identity from the problem. This separation might lead to someone having a sense of being able to act in relation to the problem or even joining together with others against the problem rather than seeing themselves as the problem. My hope for this assessment tool was to locate a more particular or 'experience-near' (M. White, 2007) name for their concern which could be used in externalising conversations.

The double-storied assessment tool engages with Michael White's (2007) statement of position map and uses the four categories of inquiry throughout:

- negotiating a particular, experience-near definition of the problem *(What would you call this kind of problem?)*
- mapping the effects of the problem *(What do you know about the problem?)*
- evaluating the effects of the problem's *activities (What do you think about the problem?)*
- justifying the evaluation *(What relationship would you like with the problem?)*

Jake: What would you name this kind of problem?

Mary: Depression, anxiety, C-PTSD.

Jake: How has the experience of these diagnostic labels changed how you view yourself? Did you find the diagnosis helpful, unhelpful or somewhere in-between?

Mary: I guess helpful. It confirmed things for me. It was validating because before, I was just called 'sad' or 'lazy', and there are terms for why I can't do shit.

Jake: I know from other people what it's been like to share their lives with depression and anxiety, and I'm wondering what it's been like for you.

Mary: It's like always fight or flight, gasping for air and can't do anything.

Jake: So it's a fight or flight anxiety or a gasping for air anxiety? Is there a story you could share about what the 'fight or flight anxiety' has been up to?

We can see how this description is becoming more experience-near for Mary or closer to how they have come to understand this problem. It's not using my words or professional language or diagnoses to understand the problem. We can continue to check in about whether this is how they would like to refer to the problem, or if the diagnosis is a better fit or both. Later in the conversation, I began exploring other categories of inquiry from the statement of position map:

Jake: What effects has this 'fight or flight anxiety' had on your life or on other people's lives?

Mary: I don't leave the apartment anymore. Even getting out of bed can be difficult. I have increased panic attacks and sensory stuff.

Jake: Can you say more about the panic attacks and sensory stuff? What's that been like for you?

Mary: Feeling tense and can't do anything. Sometimes I have to take Valium to get through. The sensory stuff is overwhelming: sensitive to light, sound.

Jake: And what about what 'fight or flight anxiety' has been up to in other people's lives or in your relationships? Has it tried to take over those too?

Mary: Yeah, it definitely impacts others because I self-isolate and avoid people. The experience of the [COVID-19] pandemic has made isolation worse.

Jake: This might be a strange question, but I'm wondering what it's been like to share your

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life with this problem? Are you happy with what this 'fight or flight anxiety' has been up to, or would you like it to be different?

Mary: Different.

Jake: Different, yeah. Why is that? How have you become so clear about that?

Mary: I guess I've had moments of happiness here and there: art and friends, connection. Maybe not joy, but knowing everything is connected through art and sharing that with friends.

Deconstruction

Morgan (2000) suggested that problems only survive and thrive when supported and backed up by particular ideas, beliefs and principles.

Deconstruction is a method of inviting people to consider how their experience is shaped by taken-for-granted discourses and making them available for exploration. These discourses can have people feeling they are failing when compared to an idealised norm or standard. In the double-storied assessment, deconstruction is one way to question the social and cultural narratives of domination and oppression.

Jake: What toll do you think living in a homophobic society, or growing up in a family who has had negative views about gay people, has had on your sense of self, or on being a gay man in a relationship with another man?

D: It's made me question myself, my relationship. It was a burden growing up being told gay men are immoral or going to hell or not able to be happy.

Jake: So what is the impact of living in a society that discourages you from freely and openly expressing your commitment to the person you love?

D: I can't hold hands with him in public. I tell my parents he's my housemate. I hide our photos when my family comes over. I can't tell them I love this person, and that I'm happy, and that I want to spend the rest of my life with him.

You can see some dominant narratives being uncovered: heterosexuality is the norm, homosexuality is immoral and sinful, and gay men cannot have happy lives. Many gay men come to therapy feeling ashamed and inferior because of socially constructed messages about homosexuality. Over time people may come to accept these discourses, leading to a deeply embedded negative view of themselves. Deconstruction questions can shine a light on taken-for-granted cultural ideas and beliefs, connecting private stories to a political landscape.

Unique outcomes

If we assume that problems are never 100% successful in taking over a person's life, then times when the problem has had less influence (or no influence at all) could be considered unique outcomes. These unique outcomes can lead to an alternative story, an exception to the problem, that can be further developed through re-authoring conversations. Problems can sometimes be so internalised that they might make it difficult for people to remember exceptions to them. If no instances come to mind, I have found this question helpful: 'How have you managed to stop the problem from getting even worse?' (Harper & Spellman, 2013; Morgan, 2000).

Jake: Have you noticed when these suicidal thoughts have the upper hand in your life? Are there occasions where you have the upper hand?

Lee: I feel hopeless and want to give up, but then I think 'I'm so glad that didn't happen' and something tells me it's a good thing it didn't happen.

Jake: If you had to guess what that something is that tells you it's a good thing, what might that be?

Lee: I don't know. Sometimes I think maybe I could go to heaven and be with Mum again.

Jake: Sometimes we can't find the words, and I'm wondering, is there an image that comes to mind for you when you think about this?

Lee: I imagine if my mum was here and she would say to me, 'Don't give up. You are a fighter, just like me'.

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Now we have a very moving image of Lee's mum standing by his side and speaking words of encouragement. We can then ask if there is a story of Lee being a 'fighter'.

Re-membering conversations

Problems can isolate or disconnect people from those they care about, and re-membering conversations are one way to reconnect people with these significant relationships. These relationships can be with people living or dead (e.g. family, friends, significant people in the community), real or imaginary (e.g. favourite characters), or pets, places or symbols. Re-membering can help uncover or develop a newly emerging alternative story.

Re-membering uses a 'club of life' metaphor to describe identity (Myerhoff, 1982). Michael White described this in a therapeutic context as contributing 'to the development of a multi-voiced sense of identity, rather than the single-voiced sense of identity that is a feature of the encapsulated self … This is a sense of identity that features positive but non-heroic conclusions about one's actions in life and about who one is' (M. White, 2007, pp. 136–138).

Let's return to Lee's story. I continued to structure safety with him by checking in: 'would you mind if I asked more questions about this?' Lee said this would be okay.

Jake: How did your mum know these things about you, about you being a fighter?

Lee: I don't know. I guess she knows I don't give up, like when I was bullied at school – sort of not backing down.

Jake: Not backing down, yeah. What is it about you that told her about this?

Lee: I stood up for myself a lot and stood my ground. When it got really bad, I told my mum, and she met with my teacher and the school.

Jake: What can you now see in yourself about being a fighter or standing your ground?

Lee: I can see that maybe I don't give up easily.

Documentation

Epston (1994, p. 31) wrote that 'the words in a letter don't fade and disappear the way conversation does; they endure through time and space, bearing witness to the work of therapy and immortalizing it'. I wondered whether rich story development had to end when the assessment appointment ended. The therapist could write a therapeutic letter to the client after the appointment to summarise the alternative stories uncovered and offer reflective questions to consider. This might act as a 'counter-document' to more pathologising and problem-saturated descriptions that could be encountered in an assessment. The therapeutic letter could draw on the client's words, phrases and images to 'rescue the said from the saying of it' (Newman, 2008). People could continue to refer to this letter while on a waitlist for counselling.

> Dear Lee,
>
> Thank you for meeting with me the other day. You shared with me how depression and the suicidal thoughts have influenced your life recently, and it sounds like they have been in your life for a long time. Depression and its powerful allies have used many tricks to lure you into feeling hopeless about the future and 'wanting to give up'.
>
> Yet despite the power of depression, you never completely gave up. You mentioned that these thoughts have at times convinced you to try to take your life, but then you thought, 'I'm so glad that didn't happen' and 'something tells me it's a good thing it didn't happen'. In looking back, can you remember times in your life when you said 'no' to suicide or took a stand against suicide? You shared a touching thought of your mum and imagined her by your side, saying, 'Don't give up. You are a fighter, just like me'. Is there a story that comes to mind of you being a fighter, just like your mum? When you remember this story, what image comes to mind for you? Does this image help give you the upper hand over depression and the suicidal thoughts?
>
> Lee, who else in your life would appreciate or know you are taking this stand against suicide? You shared how significant John and Jordan have been to you and the relief of finally having 'gay connections' in your life. If I were to ask them what they appreciate most about this stand you are taking, what might they say to me? How

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might thinking more about theses connections to your friends and the gay community help take you closer to where you want to be?

With warmth and care,

Jake

Another kind of documentation: Checklists and screening tools

The Kessler Psychological Distress Scale (K10) and AUDIT (Alcohol Use Disorders Identification Test) are examples of screening tools used in assessing risk. They are not 'therapeutic' and do not contribute to rich story development. They tend to focus on what experts might rate as a depressive disorder, unhealthy alcohol use or high risk of suicide, rather than what's absent but implicit (Freedman, 2012) in despair, or alcohol use as a way of surviving trauma or suicidal thoughts as a protest against what's been unjust in a person's life.

Alternative screening tools might provide a counter to these more traditional instruments. The first screening tool in the double-storied assessment was adapted from the checklist of social and psychological resistance (Denborough, 2008) and is an adjunct to the K10 scale. It is also a 10-item checklist, but any score can locate possibilities for unique outcomes.

The second tool is adapted from an alternative suicide risk screening tool (Forster & Taub, 2016) and suicide prevention practices from a narrative therapy and critical suicide studies framework (J. White & Morris, 2019). Most standard suicide risk assessments gather information only to assess risk, such as a person's plan to kill themselves, the likelihood of that plan resulting in death, availability of means to enact the plan and so on. The alternative questionnaire presents more generative questions leading to openings to preferred stories.

I asked Lee if it would be okay if I asked him different kinds of questions. I further introduced this by telling him that 'some of these questions might seem strange, but I'd like to ask you questions about other experiences you might have had'. Lee seemed surprised and eager to continue. When I asked him about *displaying acts of caring, concern or comfort for others,* Lee spoke about friends who he met before the pandemic. These were his first gay friends, which was significant for Lee because they were his connection to the LGBTQIA+ community. Lee had become close to these friends, and he said he displayed acts of caring 'most of the time'. Without further prompting, he smiled and shared stories of these qualities in action: noticing when they are tired or down and asking them if they are okay or if they need anything. When I asked Lee about finding ways to hold on to hope, he shared a moving image of 'thinking about a future partner and imagining what life could be like for him. I imagine bumping into him, and this gives me hope'.

Practices of accountability

Many of us work with people who have experienced harm from assessments and the mental health system. Accountability is required in this work so that we do not replicate practices of oppression or create further harm. Accountability practices include:

- Resisting medically oriented or pathologising practices such as 'interviewing', 'diagnosing' and 'treating'. Making room for people to be in relation to the problem in ways that are honouring of their experience. One practice is to make past mental health diagnoses or medical labels explicit by asking if the experience of receiving this label changed how they viewed themselves and whether there is anything they would like to change or add to the diagnostic label they were given.
- Locating everyone culturally, including oneself and people from the dominant culture. This resists replicating oppression, colonisation and heteronormativity, making room for people to determine how they would like to be culturally located (Hoff, 2016; Reynolds, 2014).
- Giving people an outline of the categories/questions and explaining their inclusion. Providing the questions demystifies the experience and provides some scaffolding before the assessment appointment.
- Inviting people to ask you questions or 'interview' you. I might ask, 'Do you have any questions you would like to ask me?' A 'reverse assessment' provided to the client might include questions they can ask the therapist, such as 'If I have a concern or need to share feedback, how can I do that?' 'What ways of working might have me trusting that this can be a safe place for me?'
- Inviting clients into an active role by asking, 'Is there anything you wish I had asked but didn't?'

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Or 'Is there anything you were hoping we could talk about today but didn't?'

- Asking people what they would like to have written in the assessment document. The assessment itself could be considered documentation of a client's life experiences and could be given to them (Madsen, 2007).

Final thoughts

People are always telling stories and making meaning from these stories. If someone comes to us despairing because of oppression, we must not contribute to a single story of oppression. People are never passive recipients of trauma (Denborough, 2015) and are always resisting, responding and moving towards safety. A double-storied assessment is one way to contribute to rich story development by uncovering subordinate storylines. A subordinate storyline might be hanging by a thread, but there is always a thread. Our task is to pick up the threads that might be woven into an alternative story. The more richly these threads are described, the stronger the tapestry. People become more aware of actions they could take that would be more in harmony with what's important to them, what they give value to and what they intend for their lives. Assessments can be more useful to people and be administered in ways that do not lead to oppressive practices of interrogation, pathology or normalising judgement. The double-storied assessment tool presented here might be considered one of many possibilities for administering assessments collaboratively *alongside* people.

Double-storied assessment tool

Introducing the assessment

I am going to ask you some questions to help me understand what's going on for you, your hopes are for counselling and any concerns you might have. There are no right or wrong answers. Take as much time as you need. Some of what we will discuss may be difficult for you to talk about, so you can share as little or as much as you would like. If any questions are irrelevant or uncomfortable for you, we can skip them. I would also like to know if you just don't like any of the questions. Today's session is also a chance for you to assess me, so I invite you to ask any questions you might have.

Part 1: Discovering and externalising the problem story

- What would you name this kind of problem?
- Is there an image that comes to mind when you think about your relationship with [identified problem]?
- Tell me a little about your history with this problem. When did you first notice the influence of the problem?
- What effects has the problem had on your life or on other people's lives?
- How has the problem had your acting/talking/thinking/feeling?
- What has it been like to share your life with [identified problem]? Are you happy with how it is, or would you like to change it?
- What does this position you are taking say about the things that are important to you? How have you become so clear about this?
- Has the problem, or another problem, ever been given a label by a medical or mental health professional? How has this experience changed how you view yourself?
- Is there anything you would like to change or add to the diagnostic label you were given?

Part 2: Discovering subordinate storylines

Unique outcomes and coping

- Tell me about times where you've been victorious, or worked towards being victorious, over [the identified problem] (Timm, 2015)
- How have you managed to stop the problem from getting even worse? (Harper & Spellman, 2013)
- What have you already done to address the problem?
- In what ways have you resisted the power of [the identified problem]?

Tracing the history and meaning of unique outcomes

- How did you manage to resist this? When did it happen? Who else was there? How long did it last? What happened just before or after? How did you prepare yourself? (Harper & Spellman, 2013)

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- Has this survival or resistance led you to revise your opinion of yourself as a 'failure'? (Harper & Spellman, 2013)
- What would you name this story?

Exploration of significant people

- Who in your life do you think would support your decision to come here and work on overcoming [the identified problem]? (Timm, 2015)
- Who are the significant persons in your life?
- If I were to ask them what you are like outside the influence of [identified problem] what might they say to me?

Experience with counselling and goals

- What services, if any, are you currently involved with?
- What have been your experiences with counselling, if any? What did you find helpful or unhelpful?
- What would you like to get out of counselling?
- How will you know when you are ready to finish? What would you be noticing?

Part 3: 'Risk assessment'

Medical information and risk factors

- What effects has the problem had on your physical health? Has it exacerbated existing medical concerns for you or others?
- What, if any, interactions have the problem(s) had with suicidal ideation, violence, substance misuse, sexual abuse or neglect in your life?

Exploration of suicide and life-promoting questions

- What do these suicidal thoughts say about what you treasure? What might these suicidal thoughts be a protest against? (J. White & Morris, 2019)
- Do these suicidal thoughts take you closer to or further away from the values you hold closest? (J. White & Morris, 2019)
- Have you noticed when these suicidal thoughts have the upper hand? Are there occasions where you have the upper hand? (J. White & Morris, 2019)
- Has [identified problem] recruited you into making a concrete plan to end your life and if so, what is the image of how this would be done? (Forster & Taub, 2016)
- Tell me about anyone else you know who has been vulnerable to listening to [identified problem] and acted on thoughts of ending their life (Forster & Taub, 2016).

Alternative to K10 questionnaire

This 'Alternative to K10 questionnaire' has been shaped by the Checklist of Social and Psychological Resistance (Denborough, 2008)

Each item is scored from one 'none of the time' to five 'all of the time'. Scores for the 10 items are summed, yielding a minimum score of 10 and a maximum score of 50. Any score can locate possibilities for unique outcomes.

In the past four weeks, how often have you:

- displayed acts of caring, concern or comfort for others (this may include caring for children, other adults or pets)?
- received care or comfort from others (and were able to take this in)?
- displayed acts of caring for yourself?
- displayed acts of dignity or pride?
- found ways to hold on to hope (this may include spiritual or religious practices)?
- displayed acts of bravery?
- tried to stay connected to others (in person, by phone, video, etc.)?
- found ways to stay in touch with what is precious to you?
- been able to find joy in small moments?
- been able to connect with humour or irony?

Are there any questions you wish I had asked you but didn't?

Are there any questions you want to ask me?

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Note

[1] All client names have been changed to ensure confidentiality.

References

Begum, M. (2007). Conversations with children with disabilities and their mothers. *International Journal of Narrative Therapy and Community Work*, (3), 11–16.

Carrey, N. (2007). Practicing psychiatry through a narrative lens. In C. Brown & T. Augusta-Scott (Eds.), *Narrative therapy: Making meaning, making lives* (pp. 77–104). New York, NY: Sage.

Dalyell, L., MaryRose, Cathie, Natalie, Katherine, Theresa, Gail, & Ann. (2008). Narrative approaches in Centrelink: 'It's those turning questions...'. *International Journal of Narrative Therapy and Community Work*, (4), 38–59.

Denborough, D. (2005). A framework for receiving and documenting testimonies of trauma. *International Journal of Narrative Therapy and Community Work*, (3/4), 34–42.

Denborough, D. (2008). *Collective narrative practice: Responding to individuals, groups, and communities who have experienced trauma*. Adelaide, Australia: Dulwich Centre Publications.

Denborough, D. (2015). *Narrative therapy charter of story-telling rights by David Denborough*. Retrieved from www.dulwichcentre.com.au/narrative-therapy-charter-of-story-telling-rights-by-david-denborough/

Denborough, D. (2019). *Political dictionary for the field of narrative practice*. Adelaide, Australia: Dulwich Centre Publications.

Epston, D. (1994). Extending the conversation. *Family Therapy Networker*, *18*(6), 31–37, 62–63.

Epston, D., & White, M. (1992). Consulting your consultants: The documentation of alternative knowledges. In *Experience, contradiction, narrative and imagination: Selected papers of David Epston & Michael White, 1989–1991* (pp. 11–26). Adelaide, Australia: Dulwich Centre Publications.

Forster, C., & Taub, R. (2016). First steps towards an alternative suicide risk screening tools: Navigating risk assessment and encouraging life-sustaining conversations. *International Journal of Narrative Therapy and Community Work*, (4), 67–76.

Fox, H. (2003). Using therapeutic documents: A review. *International Journal of Narrative Therapy and Community Work*, (4), 26–36.

Freedman, J. (2012). Explorations of the absent but implicit. *International Journal of Narrative Therapy and Community Work*, (4), 1–10.

Harper, D., & Spellman, D. (2013). Formulation and narrative therapy: Telling a different story. In L. Johnstone & R. Dallos (Eds.), *Formulation in psychology and psychotherapy* (pp. 116–140). London, England: Routledge.

Hoff, C. (Producer). (2016, February 14). *Activism in therapy: An ethic of witnessing w/ Vikki Reynolds, PhD* [Audio podcast]. Retrieved from www.chrishoffmft.podbean.com/e/the-radical-therapist-015-%e2%80%93-activism-in-therapy-an-ethic-of-witnessing-w-vikki-reynolds-phd/

Keenan, E. K. (2001). Using Foucault's "disciplinary power" and "resistance" in cross-cultural psychotherapy. *Clinical Social Work Journal*, *29*(3), 211–227. doi:10.1023/A:1010403627706

Madsen, W. C. (2007). What we see is what we get: Reexamining our assessment process. In W. C. Madsen (Ed.), *Collaborative therapy with multi-stressed families* (pp. 45–84). New York, NY: Guilford.

Meehan, T., & Guilfoyle, M. (2015). Case formulation in poststructural narrative therapy. *Journal of Constructivist Psychology*, *28*(1), 24–39.

Morgan, A. (2000). *What is narrative therapy?* Adelaide, Australia: Dulwich Centre Publications.

Myerhoff, B. (1982). Life history among the elderly: Performance, visibility and re- membering. In J. Ruby (Ed.), *A crack in the mirror: Reflexive perspectives in anthropology* (pp. 99–117). Philadelphia: University of Pennsylvania Press.

Newman, D. (2008). Rescuing the said from the saying of it: Living documentation in narrative therapy. *International Journal of Narrative Therapy and Community Work*, (3), 24–34.

Reynolds, V. (2002). Weaving threads of belonging: Cultural witnessing groups. *Journal of Child and Youth Care, 15*(3), 89–105.

Reynolds, V. (2014). Centering ethics in group supervision: Fostering cultures of critique and structuring safety. International *Journal of Narrative Therapy and Community Work*, (1), 1–13.

Reynolds, V. (2010). A supervision of solidarity. *Canadian Journal of Counselling*, *44*(3), 246–257.

Reynolds, V. (2020). Trauma and resistance: 'Hang time' and other innovative responses to oppression, violence and suffering. *Journal of Family Therapy*, *43*(3), 347–364. doi:10.1111/1467-6427.12293

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Richardson/Kianewesquao, C., & Reynolds, V. (2014). Structuring safety in therapeutic work alongside Indigenous survivors of residential schools. *Canadian Journal of Native Studies*, *34*(2), 147–164.

Timm, M. (2015). Deconstructing pathology: A narrative view of the intake process. *Journal of Constructivist Psychology*, *28*(4), 316–328.

Weber, M. (2007). Narrative therapy, “eating disorders”, and assessment: Exploring constraints, dilemmas, and opportunities. *International Journal of Narrative Therapy and Community Work*, (2), 63–70.

White, J., & Morris, J. (2019). Re-thinking ethics and politics in suicide prevention: Bringing narrative ideas into dialogue with critical suicide studies. *International Journal of Environmental Research and Public Health*, *16*(18), 1–13. doi:10.3390/ijerph16183236

White, M. (1991). Deconstruction and therapy. *Dulwich Centre Newsletter*, (3), 1–21.

White, M. (2007). *Maps of narrative practice*. New York, NY: Norton.

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