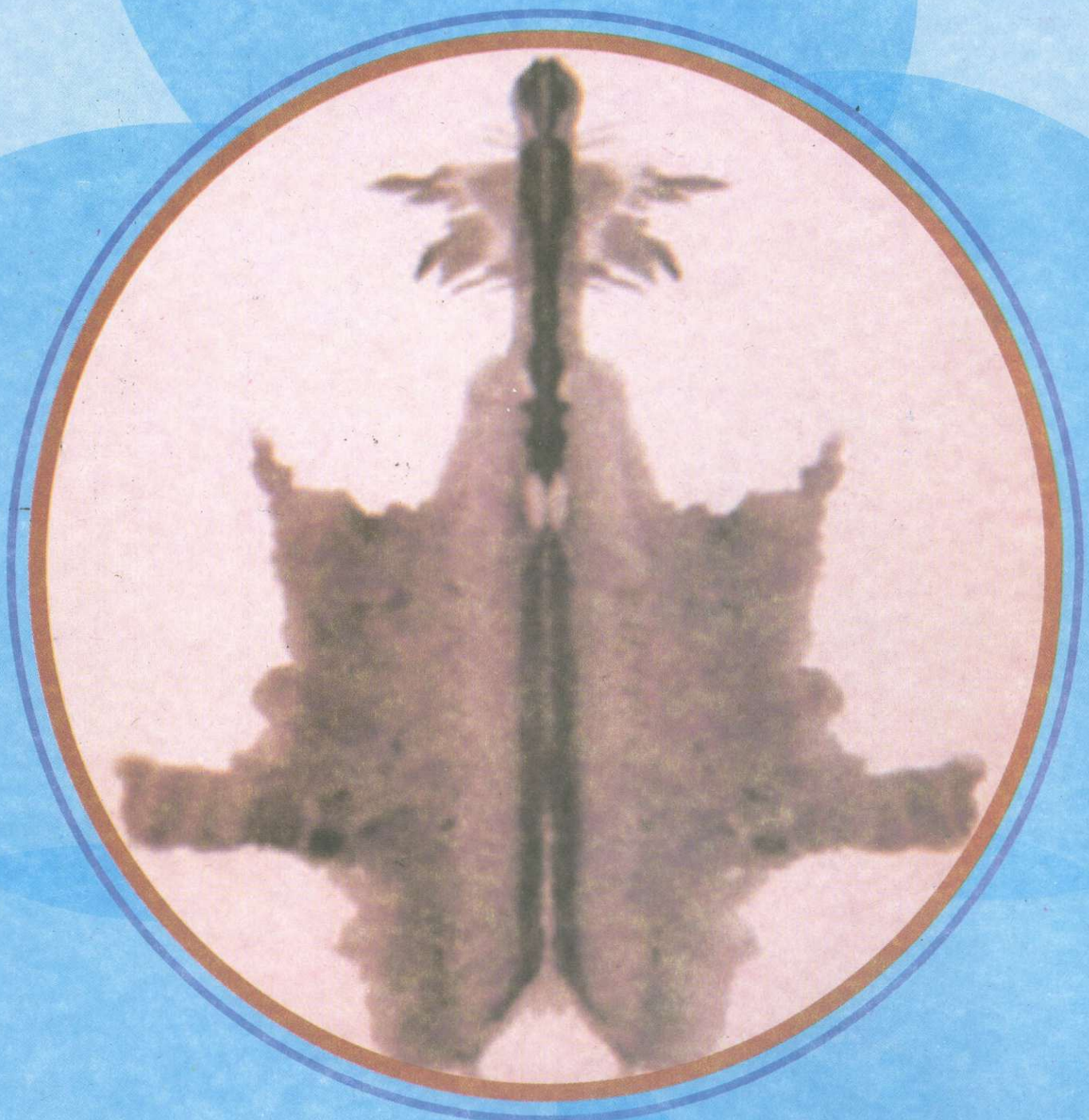
ignou
THE PEOPLE'S UNIVERSITY
Indira Gandhi National Open University
School of Social Sciences

GROUP A
MPCE-012
PSYCHODIAGNOSTICS



"शिक्षा मानव को बन्धनों से मुक्त करती है और आज के युग में तो यह लोकतंत्र की भावना का आधार भी है। जन्म तथा अन्य कारणों से उत्पन्न जाति एवं वर्तमान विषमताओं को दूर करते हुए मनुष्य को इन सबसे ऊपर उठाती है।"

– इन्दिरा गांधी

"Education is a liberating force, c
in our age it is also a democratis
force, cutting across the barriers
caste and class, smoothing
inequalities imposed by birth a
other circumstances."

– Indira Gan

ignou
THE PEOPLE'S
UNIVERSITY

Indira Gandhi
National Open University
School of Social Sciences

GROUP A

MPCE-012

Psychodiagnostics

Block

1

INTRODUCTION TO PSYCHODIAGNOSTICS

UNIT 1

Introduction to Psychodiagnostics, Definition, Concept and Description 5

UNIT 2

Methods of Behavioural Assessment 20

UNIT 3

Assessment in Clinical Psychology 36

UNIT 4

Ethical Issues in Assessment 54

Expert Committee

Prof. A. V. S. Madnawat
Professor & HOD Department of Psychology, University of Rajasthan. Jaipur

Dr. Usha Kulshreshtha
Associate Professor, Psychology University of Rajasthan, Jaipur

Dr. Swaha Bhattacharya
Associate Professor
Department of Applied Psychology Calcutta University, Kolkata

Prof. P. H. Lodhi
Professor and Head of the Department of Psychology University of Pune, Pune

Prof. Amulya Khurana
Professor & Head Psychology Humanities and Social Sciences Indian Institute of Technology New Delhi

Prof. Waheeda Khan
Professor and Head Department of Psychology
Jamia Millia University
Jamia Nagar, New Delhi

Prof. Usha Nayar
Professor, Tata Institute of Social Sciences, Deonar, Mumbai

Prof. A.K. Mohanty
Professor, Psychology
Zakir Hussain Center for Education Studies, Jawaharlal Nehru University, New Delhi

Dr. Madhu Jain
Reader, Psychology
Department of Psychology
University of Rajasthan, Jaipur

Dr. Shailender Singh Bhati
Lecturer, G. D. Government Girls College, Alwar, Rajasthan

Prof. Vandana Sharma
Professor and Head of Department
of Psychology
Punjabi University, Patiala

Prof. Varsha Sane Godbole
Professor and Head of Department of Psychology
Osmania University, Hyderabad

Dr. S. P. K. Jena
Associate Professor and Incharge Department of Applied Psychology University of Delhi South Campus Benito Juarez Road. New Delhi

Prof. Manas K. Mandal
Director
Defense Institute of Psychological Research
DRDO, Timarpur, Delhi

Ms. Rosley Jacob
Lecturer, Department of Psychology, The Global Open University Nagaland, Paryavaran Complex, New Delhi

Dr. Vijay Kumar Bharadwas
Director
Academie Psychologie, Jaipur

Prof. Dipesh Chandra Nath
Head of Dept. of Applied Psychology, Calcutta University Kolkata

Dr. Mamta Sharma
Assistant Professor
Department of Psychology
Punjabi University, Patiala

Dr. Vivek Belhekar
Senior Lecturer
Bombay University, Mumbai

Dr. Arvind Mishra
Assistant Professor
Zakir Hussain Center for Educational Studics. Jawaharlal Nehru University, New Delhi

Dr. Kanika Khandelwal Associate Professor and Head of Department of Psychology
Lady Sri Ram College,
Kailash Colony, New Delhi

Prof. G. P. Thakur
Professor and Head of Department of Psychology (Rtd.)
M.G. Kashi Vidhyapeeth
Varanasi

Content Editor

Prof. Vimala Veeraraghavan
Emeritus Professor, Psychology
Department of Psychology
SOSS, IGNOU, New Delhi

Format Editor : Prof. Vimala Veeraraghavan & Dr. Shobha Saxena *(Academic Consultant)*, IGNOU, New Delhi

Programme Coordinator : Prof. Vimala Veeraraghavan, IGNOU, New Delhi

Block Preparation Team

Units 1-4 Course Writer
Ms. Kiran Rathore
Assistant Professor
Department of Psychology
Osmania University, Hyderabad

PRINT PRODUCTION

Shri Rajiv Girdhar
A.R. (Publication)
MPDD, IGNOU, New Delhi

Shri Hemant Kumar
S.O. (Publication)
MPDD, IGNOU, New Delhi

November, 2020 (Reprint)
© *Indira Gandhi National Open University, 2010*
ISBN-978-81-266-5533-5

All right reserved. No part of this work may be reproduced in any form, by mimeograph or any other means, without permission in writing from the Indira Gandhi National Open University.

Further information on Indra Gandhi National Open University courses may be obtained from the University's office at Maidan Garhi, New Delhi-110 068.

Printed and published on behalf of the Indira Gandhi National Open University, New Delhi by Registrar, MPDD.
Printed at M/s Saraswati Offset Printer Pvt. Ltd., Saraswati House, A-5, Naraina Industrial Area, Phase-II, New Delhi-110028

BLOCK 1 INTRODUCTION

Over the last century the scope of activity of clinical psychologists has increased exponentially. In earlier times psychologists had a much more restricted range of responsibilities. Today psychologists not only provide assessments but treat wide variety of disorders in an equally wide variety of settings, consult, teach, conduct research, help to establish ethical policies, deal with human engineering factors, have a strong media presence, work with law enforcement in profiling criminals, and have had increasing influence in the business world and in the realm of advertising, to identify just a few of the major activities in which they are engaged. Nonetheless, the hallmark of psychologists has always been assessment and it continues to be a mainstay of their practices in the twenty-first century. Indeed, in each of the activities just described, psychologists and their assistants are performing assessments of some sort.

Unit 1 deals with the definition and concept of psycho diagnostics. In this unit the variable-domains, data sources and practical applications of psychological assessment have been covered in depth.

Unit 2 covers methods of behavioural assessment. In this unit attempt has been made to explain what behavioural assessment is, the various methods or techniques of behavioural assessment have been discussed along with their advantages and limitations. The last part of the unit deals with the future perspectives of behavioural assessment.

In **Unit 3**, the first half deals with the definition and purpose of clinical assessment and last half is concerned with the application of assessment in the field of clinical psychology. **Unit 4** covers the main ethical considerations involved in psychological assessment. It covers the specific standards and principles that a psychologist must adhere while testing and this unit also covers the important ethical issues such as confidentiality, informed consent and privacy in assessment.

UNIT 1 INTRODUCTION TO PSYCHODIAGNOSTICS, DEFINITION, CONCEPT AND DESCRIPTION

Structure

1.0 Introduction

1.1 Objectives

1.2 Psychodiagnostics

1.3 Testing, Assessment and Clinical Practice

1.4 Variables Domains of Psychological Assessment

- 1.4.1 Performance Variables
- 1.4.2 Personality Variables

1.5 Data Sources for Psychological Assessment

- 1.5.1 Actuarial and Biographical Data
- 1.5.2 Behavioural Trace
- 1.5.3 Behavioural Observation
- 1.5.4 Behaviour Ratings
- 1.5.5 Expressive Behaviour
- 1.5.6 Projective Technique
- 1.5.7 Questionnaires
- 1.5.8 Objective Test
- 1.5.9 Psycho Physiological Data

1.6 Practical Applications

- 1.6.1 Assessment of Intelligence and Other Aptitude Functions
- 1.6.2 Psychological Assessment in Clinical Context
- 1.6.3 Assessment in Vocational Guidance Testing and Job Selection / Placement

1.7 Let Us Sum Up

1.8 Unit End Questions

1.9 Suggested Readings

1.0 INTRODUCTION

Intelligence tests, personality tests, behavioural assessments, and clinical interviews all yield potentially important information about the person being tested, but none of these techniques provides an overall assessment of the examinee's level of functioning. In other words, no individual test provides a complete picture of the individual; it provides only a specific piece of information about that person. One major task of psychologists involved in assessment is to evaluate information provided by many tests, interviews, and observations, and to combine this

information to make complex and important judgments about individuals. For example, when an individual shows evidence of difficulty in adjusting to the demands of daily life, a clinician must decide whether therapy would be helpful and, if so, what type of therapy would be most appropriate.

Psychologists also are called on to assess individuals in a variety of non clinical settings. For example, school psychologists might consider information about a child's intellectual performance, social, skills, and home environment in recommending placement in special education program Industrial psychologists might be asked to evaluate management trainees who participate in a series of assessment exercises. In each case, it is assumed that the assessment is more than a simple combination of test scores — it is a judgment on the part of a trained professional.

Although expert judgment plays a part in each form of psychological measurement, the practice of clinical assessment and the implementation of structured assessment programs both broadly defined as the integration of multiple pieces of information into an overall evaluation of the present state of the individual being assessed, is somewhat unique in that human judgment is an integral component of the process. In this unit we are studying all about assessment in psycho diagnostics. We start with introducing what is psycho diagnostics and follow up by testing, assessment and clinical practice. Then we deal with variable domains of psychological assessment within which we discuss performance and personality variables. Then we present the data sources for psychological assessment and then deal with practical application of assessment.

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Explain the definition and concept of Psychodiagnostics;
- Discuss the various domains of psychological assessment;
- Explain the ten data sources for psychological assessment; and
- Describe the practical applications of psycho diagnostic assessment.

1.2 PSYCHODIAGNOSTICS

Korchin and Schuldberg (1981) define psychodiagnosis as a process that

a) uses a number of procedures,

b) intended to tap various areas of psychological functions,

c) both at a conscious and unconscious level,

d) using projective techniques as well as more objective and standardized tests,

e) in both cases, interpretation may rest on symbolic signs as well as scoreable responses,

f) with the goal of describing individuals in personological rather than normative terms. (p. 1147)

The term psychodiagnosis might be applied more aptly to the neutral term clinical assessment. The central difference between clinical assessment and other testing applications is that the clinician, rather than the test, is at the center of the assessment process. The clinician has two distinct functions, both of which are essential to the assessment process. First, the clinician must gather data. Although standardized tests are used in clinical assessment, projective tests, interviews, and behavioural observations represent the clinician's most important measurement tools. Second, the clinician must integrate data from various tests, interviews, and observations to form an overall assessment of the individual.

The data gathering function has clear implications for the quality of psychological measurement. A clinician who makes inaccurate observations, conducts poorly structured interviews, or misinterprets or misrecords responses to open ended questions or ambiguous stimuli (e.g., responses to Rorschach cards) is not likely to produce valid assessments. The clinician often functions as a measurement instrument, and it is important to assess the reliability and validity of the clinical data he or she gathers. Although it may not be immediately obvious, the clinician's second function the integration of clinical data-also affects the quality of psychological measurement in clinical settings. Assessment represents an attempt to arrive at a valid classification of each individual patient or client. In some cases, clinicians may be called on to diagnose or assist in the diagnosis of mental or behavioural disorders. In others, the clinician must make recommendations regarding the placement of children or adults in remedial education or in therapeutic programs. In any case, the classification of individuals represents a fundamental type of measurement, and the clinician's skill in integrating diverse sources of data may be a critical factor in determining the validity of his or her classifications and assessments of individuals.

1.3 TESTING, ASSESSMENT AND CLINICAL PRACTICE

At one time, psychological testing represented one of the most important activities of clinical psychologists (Korchin & Schuldberg, 1981; McReynolds, 1968; Rabin, 1981). Since the early 1980s, the practice of clinical psychologists has shifted steadily from an emphasis on assessment and diagnosis to an emphasis on psychotherapy and adjustment. Several reviews of research and practice, however, suggest that testing will remain an important activity and that many of the tests now widely used (e.g., standardized measures of intelligence, theMMPI-2) will remain popular even if they are partially supplemented by new testing technologies.

Although clinicians do not appear to devote as much of their time to testing as in the past, psychological testing still represents an important activity for practicing clinicians. Wade and Baker's (1977) survey suggested that over 85% of practicing clinical psychologists used tests and that over one third of their therapy time was devoted to test administration and evaluation. Patterns of test use have been quite stable since the1970s and probably will remain so for the foreseeable future. Psychological testing appears to be a common activity, regardless of the psychologist's therapeutic orientation (e.g., behavioural, cognitive).

The most widely used clinical tests can be divided into three types:

1) Individual tests of general mental ability,

2) Personality tests, and

3) Neurological tests.

The Wechsler Intelligence Scales (WISC-III and WAIS-III) and the Stanford-Binet represent the most popular tests of general mental ability. These tests serve a dual function in forming assessments of individuals. First, an evaluation of general mental ability often is crucial for understanding an individual's behaviour, since many behavioural problems are linked to intellectual deficits. Second, individual intelligence tests present an opportunity to observe the examinee's behaviour in response to several intellectually demanding tasks, and thus they provide data regarding the subject's persistence, maturity, problem-solving styles, and other characteristics.

The Rorschach, the Thematic Apperception Test (TAT), and the Minnesota Multiphasic Personality Inventory (MMPI) represent three of the most popular personality tests. Of the three, the MMPI is most closely associated with the diagnosis of psychopathology, whereas the TAT is most closely associated with the assessment of motives and drives. The Rorschach may be used for a variety of purposes, ranging from the assessment of specific personality traits to the diagnosis of perceptual disorders, depending on the scoring system used.

The Bender-Gestalt and the Luria-Nebraska Neuropsychological Test Battery are widely used in the diagnosis of neurological disorders. The Bender-Gestalt is used in the assessment of perceptual disorders and organic dysfunctions, although it may be used for a wide range of diagnostic purposes, whereas the Luria Nebraska Battery provides a wide ranging assessment of perceptual, motor, and intellectual functions that might be affected by damage to specific portions of the brain.

1.4 VARIABLE DOMAINS OF PSYCHOLOGICAL ASSESSMENT

Psycho diagnostic assessment methods have been developed for a wide spectrum of trait and state variables affecting human behaviour. Following a proposal by Cronbach (1949), one distinguishes between performance and personality measures, the former referring to measures of *maximum* behaviour a person can maintain the latter to measures of *typical* style of behaviour. Intelligence tests are examples of performance measures, a test of extraversion introversion or of trait anxiety examples of personality measures. While handy for descriptive purposes, this distinction must not be mistaken for a theoretical one, as trait measures of performance may in fact correlate with trait measures of personality (for example, speed of learning with level of trait anxiety).

Within the limits of this distinction, the following summary list help to illustrate the scope of behavioural variables for which assessment procedures have been developed.

1.4.1 Performance Variables

These include measures of sensory processes (for example: tactile sensitivity, visual acuity, color vision proficiency, auditory intensity threshold); perceptual aptitudes (tactile texture differentiation, visual closure, visual or auditory pattern recognition, memory for faces, visuo spatial tasks, etc.). Measures of attention

and concentration (tonic and phasic alertness; span of attention, distractibility, double performance tasks, vigilance performance over time), psychomotor aptitudes (including a wide variety of speed of reaction task designs), measures of learning and memory (short term vs. long term memory, memory span, intentional vs. incidental memory, visual / auditory / kinesthetic memory), assessment of cognitive performance and intelligence (next to general intelligence a wide range of primary mental abilities like verbal comprehension, word fluency, numerical ability, reasoning abilities, measures of different aspects of creativity, of social or emotional intelligence; assessment of language proficiency (developmental linguistic performance, aphasia test systems, etc.); measures of social competence.

1.4.2 Personality Variables

These include the assessment of primary factors of personality (especially of the so called Big Five and numerous more specific personality measurement scales); special clinical schedules and symptom checklists (to assess anxiety, symptoms of depression, schizotypic tendency, personality disorders, etc.); motivation structures and interests; styles of daily living; pastime and life goals; assessment of incisive life events; assessment of stress tolerance and stress coping (including coping with serious illnesses and ailments); plus a wide range of still more specific assessment variables, like measures for the assessment of specific motives or specific styles of coping with illness or stressful life events.

By now even the number of Psycho diagnostic assessment methods meeting high psychometric standards must have already reached many tens of thousands, rendering it totally impossible to give more than an informative overview within the limitations of this unit. Rather than enumerating hundreds of assessment procedures we shall here take a systematic look at major data sources for psychological assessment and then briefly examine a few selected psycho diagnostic assessment problems and how they would be typically approached.

Self Assessment Questions

1) Define psycho diagnostics and describe its features.

.....

.....

.....

2) Elucidate testing, assessment and clinical practice.

.....

.....

.....

3) What are the two variable domains of psychological assessment?

.....

.....

.....

1.5 DATA SOURCES FOR PSYCHOLOGICAL ASSESSMENT

By a rough estimte, more than 80% of all published assessment methods will be questionnaires or objective tests. As we shall see in this section, the range of possible assessment data sources extends considerably farther though. And in practical assessment work too psychologists tend to complement (cross-check or simply expand) their assessment by some or several non-questionnaire and non-test methods. For example, in clinical assessments behaviour observation and interview data, often also psycho physiological data are considered essential additional information, as is interview and actuarial/biographical data in industrial/organisational assessments. You can refer to Pawlik (1996, 1998) for details of this classification of data sources.

1.5.1 Actuarial and Biographical Data

This category refers to descriptive data about a person's life history, educational, professional and medical record, possibly also criminal record. Age, type and years of schooling, nature of completed professional education/vocational training, marital status, current employment and positions held in the past, leisure activities, and past illnesses and hospitalisations are examples of actuarial and biographical data. As a rule, such data is available with optimum reliability and often represents indispensable information, for example, in clinical and industrial/organisational assessments. Special biographical check list-item assessment instruments may be available in a given language and culture for special applications.

1.5.2 Behaviour Trace

This refers to physical traces of human behaviour like handwriting specimen, products of art and expression (drawings, compositions, poems or other kinds of literary products), left-overs after play in a children's playground, style (tidy or untidy, organised or 'chaotic') of self-devised living environment at home, but also attributes of a person's appearance (e.g., bitten finger nails!) and attire. While at times perhaps intriguing, also within a wider humanistic perspective, the validity of personality assessments based on behaviour traces can be rather limited. For example, graphology (handwriting analysis) has been known for a long time to fall short of acceptable validity criteria in carefully conducted validation studies (Guilford, 1959; Rohracher, 1969). On the other hand, behaviour trace variables may provide valuable information in clinical contexts and at the process stage of developing assessment hypotheses.

1.5.3 Behaviour Observation

In some sense, behaviour observation will form part of each and every assessment. In the present context the word observation is used in a more restricted sense, though, referring to direct recording/ monitoring, describing, and operational classification of human behaviour, over and above what may be already incorporated in the scoring rationale of a questionnaire, an interview schedule, or an objective test. Examples of behavior observation could be: studying the behaviour of an autistic child in a playground setting; monitoring the behaviour of a catatonic patient on a 24-hour basis; observing a trainee's performance in a newly designed work place; or self monitoring of mood swings by a psychotherapy patient in between therapy sessions. In a way, it is regrettable that the development of self

administering questionnaires and objective tests, starting in the 1920s and 1930s,has pushed careful, systematic behaviour observation to the side of the assessment process. Only in recent years, especially within clinical assessment and treatment contexts following behavior therapeutic approaches, is the potential value of behaviour ratings for the assessment process being re discovered.

1.5.4 Behaviour Ratings

In behaviour rating assessments a person is asked to evaluate her / his own behaviour or the behaviour of another person with respect to given characteristics, judgmental scales, or checklist items. The method can be applied to concurrent behaviour under direct observation (as in modern assessment center applications) or, and more typically, to the rater's explicit or anecdotal memory of the ratee's behaviour at previous occasions, in (pastor imagined) concrete situations, or in a general sense. Behaviour rating methods may tell more about the mental representations that raters hold (developed, believe in) regarding the assessed person's behaviour than about that behaviour itself.

Behaviour ratings constitute an essential methodology in clinical and industrial / organisational psychology, in psychotherapy research and, last but not the least, in basic personality research. Modern text books of personality research usually give detailed accounts of how to devise behaviour rating scales and how to compensate for common sources of error variance in ratings.

1.5.5 Expressive Behaviour

As a technical term, expressive behaviour refers to variations in the way in which a person may look, move, talk, express her / his current state of emotion, feelings or motives. Making a grim-looking face, trembling, getting a red face, sweating on the forehead, walking in a hesitant way, speaking loudly or with an anxiously soft voice, would be examples of variations in expression behaviour.

Thereby expression refers to stylistic attributes in a person's behaviour which will induce an observer to draw explicitly or implicitly inferences about that person's state of mind, emotional tension, feeling state, or the like. Assessing another person from her / his expressive behaviour has a long tradition which goes back to pre scientific days. More recently this approach has been extended to the study of gross bodily movement expression (Feldman & Rim´e, 1991). This research is relevant also for developing teaching aids in psychological assessment and observer training.

1.5.6 Projective Technique

In the 1930s and 1940s many clinical psychologists, often influenced by psychoanalysis and other forms of depth psychology, placed high expectations in projective techniques, believing that they would induce a person to express her/ his perception of the ambiguous stimulus material, thus willingly or even unwillingly 'uncovering' her/his personal individuality, including motives and emotions that the person may not even be aware of. Later, in the1950s and 1960s, research has clearly shown that such assessment methods not only tend to lack in scoring objectivity and psychometric reliability, but, and still more important, also turned out to be of very limited validity, if any.

Nevertheless projective tests still keep some of their appeal today, and research in the1960s and thereafter succeeded in improving techniques like the Rorschach

test at least as far as scoring objectivity and reliability are concerned. Further more thematic association techniques like the TAT maintain their status as assessment methods potentially useful for deducing assessment hypotheses. In addition, special TAT forms have been devised for assessing specific motivation variables such as achievement motivation(McClelland, 1971). In the clinical context, once their prime field of application, projective techniques are no longer considered a tenable basis for hypothesis testing and theory development, let alone therapy planning and evaluation.

Most psychodiagnostic assessments will include an interview at least as an ancillary component and be it only for establishing personal contact and an atmosphere of trust. Extensive research on interview structure, interviewer influences, and interviewee response biases has given rise to a spectrum of interview techniques for different purposes and assessment contexts. As a rule, clinical assessments will start out with an exploratory interview in which the psychologist will seek to focus the problem at hand and collect information for deriving assessment hypotheses. An interview is called unstructured if questions asked by the psychologist do not follow a predetermined course and, largely if not exclusively, depends on the person's responses and own interjections. Today most assessment interviews are semi structured or fully structured. In the first case, the interviewer is guided by a schedule of questions or topics, with varying degrees of freedom as to how the psychologist may choose to follow up on the person's responses. Fully structured interviews follow an interview schedule containing all questions to be asked, often with detailed rules about which question(s)to ask next depending on a person's response to previous questions. An example of such a structured clinical interview schedule is the Structured Clinical Interview (SCID; Spitzer, Williams, & Gibbon, 1987) for clinical assessments according to the Diagnostic and Statistical Manual (DSM).

1.5.7 Questionnaires

Originally, personality inventories, interest surveys, and attitude or opinion schedules were devised as structured interviews in written, following a multiple choice response format (rather than presenting questions open ended as in an interview proper). In a typical questionnaire each item (question or statement) will be followed by two or three response alternatives such as 'Yes, do not know, No' or 'True, Cannot Say, Untrue'.

Early clinical personality questionnaires like the Minnesota Multiphasic Personality Inventory (MMPI) drew much of their item content from confirmed clinical symptoms and syndromes. By contrast, personality questionnaires designed to measure extraversion, introversion, neuroticism, and other personality factors in healthy normal persons rely on item contents from empirical (mostly factor analytic) studies of these primary factors of personality. As in behaviour ratings, research identified a number of typical response sets also in questionnaire data, including acquiescence (readiness to choose the affirmative response alternative, regardless of content) and social desirability (preference for the socially more acceptable response alternative). One way to cope with these sources of deficient response objectivity was to introduce special validity scales (as early as the MMPI) to control for response sets in a person's protocol. Yet individual differences in response sets may and in fact do relate also to valid personality variance themselves.

There is common agreement today that a person's responses to a questionnaire must not be interpreted as behaviourally veridical, but only within empirically established scale validities. For example, a person's response to the questionnaire item 'I frequently feel fatigued without being able to give a reason' must not be interpreted, for example, as being behaviourally indicative of the so called fatigue syndrome. Rather subjects may differ in what they mean by 'frequently', by 'fatigued', by 'without reason' and on how broad a time and situation sample they base their response. After all, questionnaire data is assessment data about mental representations (perception, memory, evaluation) of behaviour variations in a person's self perception and self cognition. They tell us a lot about the awareness persons develop of their own behavior which may, but need not, turn out veridical in objective behavioural terms. So the aforementioned item will carry its diagnostic value *only* as contributing to the validity of a psychometrically reliable questionnaire scale, in this case the scale 'neuroticism', with proven high clinical validity.

1.5.8 Objective Test

Tests constitute the core of psychological assessment instruments; it is through them that psychological assessment has reached its level of scientific credibility and wide range of applications. A test is a sample of items, questions, problems etc. chosen so as to sample, in a representative manner, the universe of items, questions or problems indicative of the trait or state to be assessed, for example, an aptitude or personality trait or a mood state like alertness. The adjective 'objective' refers to administration, scoring, and response objectivity in test development. Objective tests have been developed for the full spectrum of behaviour variables mentioned above. Their number goes into tens of thousands.

A test is called an individual test, if it needs an examiner to administer it individually to the person assessed. Psychomotor and other performance tests are typical examples of tests still given individually. Still the most widely used intelligence test system, the Wechsler Adult Intelligent Scale (WAIS; Wechsler, 1958; and later editions) and its derivatives are administered individually throughout. The other test design, group tests, are devised so that one examiner can administer them to a number of persons (typically 20 to 30) at the same time in the same setting. Traditionally group tests were developed in so-called paper-and-pencil form, with the test items printed in a booklet and the person answering on a special answer sheet.

While the development of objective behaviour tests of performance has been brought to a high level of proficiency and psychometric quality, objective behaviour tests of personality still linger in a far from final phase of development that is despite massive, continuing efforts by Eysenck, Cattell and many others (Cattell & Warburton, 1965; Hundleby, Pawlik, & Cattell, 1963). There is confirmed empirical evidence to the fact that personality variables, i.e., measures of mode and style of typical behaviour (rather than of optimum performance), are more difficult to assess through objective tests than through conventional questionnaire scales, behaviour observations, or behaviour ratings.

1.5.9 Psycho Physiological Data

All variations in behaviour and conscious experience are nervous system based, with ancillary input from the hormone and the immune system, respectively, and from peripheral organic processes. This should lead us to expect that individual differences as revealed in psychological assessment should be accessible also,

and perhaps even more directly so, through monitoring psycho physiological system parameters that relate to the kind of behaviour variations that an assessment is targeted at. These psycho physiological variables include measures of brain activity and brain function plasticity (electroencephalogram, EEG; functional magnetic resonance imaging, fMRI; magnetoencephalogram, MEG), of hormone and immune system parameters and response pattern, and of peripheral psycho physiological responses mediated through the autonomic nervous system (cardiovascular system response patterns: electrocardiogram, ECG; breathing parameters: pneumogram; variations in sweat gland activity: electro dermal activity, EDA; in muscle tonus: electro myogram, EMG; or in eye movements and in pupil diameter: pupillometry). Standard psychophysiology textbooks (Caccioppo & Tassinary, 1990) introduce basic concepts and measurement operations. Modern computer assisted recording and analysis of psycho physiological data facilitate on line monitoring, often concurrent with presentation of objective tests, in an interview situation or even, by means of portable recording equipment, in a person's habitual daily life course (ambulatory psychophysiology).

Self Assessment Questions

1) In the data sources of psychological assessment, describe actuarial and biographical data.

.....

.....

.....

2) Explain behavioural trace and behavioural observation.

.....

.....

.....

3) Describe behaviour ratings.

.....

.....

.....

4) What is expressive behaviour?

.....

.....

.....

5) Describe projective techniques.

.....

.....

.....

6) Elucidate objective tests and questionnaires.

.....

.....

.....

7) What is involved in psycho physiological data?

.....

.....

.....

1.6 PRACTICAL APPLICATIONS

In this section, you will be introduced to some frequently used methods of psychological assessment for three frequently encountered assessment problems: testing of intellective and other aptitude functions; psychological assessment in clinical contexts; and vocational guidance testing.

1.6.1 Assessment of Intelligence and Other Aptitude Functions

Clearly this is the primary domain of objective behaviour tests. The tests of cognitive and other aptitudes were among the first methods of assessment ever to be developed. Following up on the scaling proposal of mental age (age equivalence, in months, of the number of test items solved correctly) as suggested by Binet and Henri (1896) in their prototype scale of intellectual development in early childhood, the German psychologist William Stern suggested an intelligence quotient (IQ), defined as the ratio of mental age over biological age, as a measurement concept for assessing a gross function like intelligence in a score that would be independent of the age of the person tested. When subsequent research revealed psychometric inadequacies with this formula, the US psychologist David Wechsler proposed in his test (Wechsler, 1958) an IQ computed as age standardized normalized standard score (with mean of 100 and standard deviation of 15). Now available in re designed and re standardized form as Wechsler Adult Intelligence Scale (WAIS), Wechsler Intelligence Scale for Children (WISC) and Wechsler Pre-School Test of Intelligence, this test package has become the trend setting intelligence test system of widest application, also internationally through numerous foreign language adaptations. So a closer look at its assessment structure seems in order.

The WAIS, for example, contains ten individually administered tests of two kinds:

i) verbaltests (general information, general comprehension, digit memory span, arithmetic reasoning, finding similarities of concepts) and

ii) five performance tests (digit symbol substitution, arranging pictures according to the sequence of a story, completing pictures, mosaic test block design, object assembly of two dimensional puzzle pictures). A person's test performance is assessed in three IQ scores, viz.,

a) Verbal IQ,

b) Performance IQ, and

c) Total IQ.

Surprisingly enough, this kind of over all test of cognitive functioning is still maintained in practical assessment work, despite undisputable and overwhelming empirical evidence that general intelligence as a trait will only account for part, at most perhaps about 30% of individual difference variation in cognitive tests (Carroll, 1993). More recent examples of general intelligence type tests are the Kaufman Assessment Battery (Kaufman & Kaufman,1983, 1993).

An alternative, theoretically more developed approach is called differential aptitude assessment. Tests in this tradition are usually based on the results of factor analytic multi trait studies of intelligence, originating in the work of Thurstone, Guilford and their students. Thurstone's Primary Mental Abilities Test (PMA, Thurstone & Thurstone, 1943), the Differential Aptitude Tests Battery (DAT; Bennett et al.,1981), the Kit of Reference Tests for Cognitive Factors (French, Ekstrom, & Price, 1963) are typical examples of this assessment approach that provides separate standardized scales for each selected primary intelligence factor.

In addition to these tests of intellective functions, numerous more specialised aptitude tests have been developed such as the Wechsler Memory Scale (Wechsler & Stone, 1974), special performance tests for neuropsychological assessment, e.g., of brain damaged patients (Lezak,1995), for assessing mentally handicapped persons and the diagnosis of dementia, as well as for special sensory and psychomotor functions.

1.6.2 Psychological Assessment in Clinical Context

In addition to some assessment questions mentioned in the preceding paragraph, in clinical psycho diagnostics one faces questions of testing for personality variables, for behaviour disorders and / or specific symptomatologies (as in the hyperactivity attention deficit disorder or posttraumatic stress disorder syndrome, for example). The MMPI was a classical prototype clinical personality test, which like the Wechsler tests of intelligence, has frequently been adapted and translated into other languages. In addition, the large item stock of the MMPI (more than 550 items) has been utilised as a base from which a great number of special questionnaire scales were developed, perhaps best known among them the Taylor Manifest Anxiety Scale (MAS by Taylor, 1953). More recent personality questionnaires used in clinical psycho diagnostics would include, for example, the 16 Personality Factors Questionnaire (16 PF; Cattell, Cattell, & Cattell, 1994; also adapted and translated into many other languages).

Besides these broad-band multi-scale questionnaires numerous assessment instruments of narrower focus have been developed. Examples are the Beck Depression Inventory, assessment instruments for studying phobic or obsessive symptoms or, more recently, interview and diagnostic inference schedules implementing the DSM and ICD approaches of descriptive disease classification. Often introduced as *the* master methodology of clinical psycho diagnostics, DSM IV- and ICD 10-based assessment strategies, have recently received increasing criticism because of their purely descriptive, at theoretical nature, without recourse to etiology of behaviour disorders and their development. It yet remains to be seen if this criticism will give rise to novel, more etiologically oriented clinical assessment philosophies.

1.6.3 Assessment in Vocational Guidance Testing and Job Selection/Placement

Ever since the1920s a multitude of tests of varying conceptual band width have been developed to assess specific aptitudes and interest variables related to different vocational training curricula and on the job work demands. In vocational guidance testing, integrated multi dimensional systems like one inaugurated by Paul Host in the 1950s for the US State of Washington have since become a model of approach in many countries. For example, the German *Bundesanstalt f'urArbeit* (Federal Office of Labor) developed its own multi dimensional testing and prognosis system for vocational guidance counseling at senior high school level. A similar, CAT formatted multi dimensional test system has been developed by the German Armed Forces Psychological Service Unit. Comparable assessment systems for guidance and placement have been devised, for example, in the UK and the US. Compared to these broad band assessment systems, job selection / placement testing in industrial and organizational psychology typically is narrower in scope, though more demanding in specific functions and job related qualifications.

Before implementing such an assessment system, a careful analysis of the job structure, the nature of professional demands and of contextual situational factors is absolutely compulsory. The literature offers a developed instrumentalism for carrying out such analyses (Kleinbeck & Rutenfranz, 1987). Since the1970s / 1980s a new methodology called 'assessment center' has been introduced to provide for behaviour observation, behaviour rating, and interview assessment data in selected social situations devised to mirror salient demand situations in future on the job performance (Lattmann,1989). In continental Europe the assessment center approach has even become something like *the* method of choice, in selecting, for example, persons for higher level managerial positions. Moreover, single stage assessment and testing is now being replaced by on the job personnel development programs and special trainings offered to devise a more intervention oriented, multi stage approach to assessment in organisational development. In CAT formatted assessment programs for industrial / organisational selection and placement applications, also special simulation techniques (for example, in testing for interpersonal cooperation under stress conditions) are currently under development.

Self Assessment Questions

1) Discuss practical application of psychological assessment.

.....

.....

.....

2) Describe assessment of intelligence and other aptitude functions.

.....

.....

.....

3) Elucidate psychological assessment in clinical context.

.....

.....

.....

4) Discuss assessment in vocational guidance testing and job selection and placement.

.....

.....

.....

1.7 LET US SUM UP

As a technical term, 'psycho diagnosis' refers to methods developed to describe, record, and interpret a person's behaviour, be it with respect to underlying basic dispositions (traits),to characteristics of state or change, or to such external criteria as expected success in a given training curriculum or in psychotherapeutic treatment. Methods of psychological assessment and testing constitute a major technology that grew out of psychological research, with widespread impact in educational, clinical, and industrial/organisational psychology, in counseling and, last but not least, in research itself.

In the most general sense, all assessment methods share one common feature: they are designed so as to capture the enormous variability (between persons, or within a single person) in kind and properties of behaviour and to relate these observed variations to explanatory dimensions or to external criteria of psychological intervention and prediction. As a distinct field of psychology, psychological assessment comprises (1) a wide range of instruments for observing, recording, and analysing behavioural variations; (2) formalised theories of psychological measurement underlying the design of these methods; and, finally, (3) systematic methods of psycho diagnostic inference in interpreting assessment results. In this unit all three branches of psychological assessment have been covered and major methods of assessment have been reviewed.

Assessment methods differ in the approach taken to study behavioral variations: through direct observation, by employing self ratings or ratings supplied from contact persons, by applying systematic behaviour sampling techniques (so called 'tests') or through studying psycho physiological correlates of behaviour. In this unit these alternative approaches are dealt with as different *data sources* for assessment.

1.8 UNIT END QUESTIONS

1) Discuss the concept and definition of psychodiagnostics?

2) Mention some of the most widely used tests in clinical practice?

3) Describe the variable-domains of psychological assessment?

4) Discuss in depth the ten data sources for psychological assessment?

5) Write about the practical applications of psychological assessment?

1.9 SUGGESTED READINGS

Plante, T. G. (2005). *Contemporary Clinical Psychology (2nd Ed.).* New Jersey: John Wiley & Sons, Inc.

Trull, T.J. (2005). *Clinical Psychology (7th Ed.).* USA: Thomson Learning, Inc.

UNIT 2 METHODS OF BEHAVIOURAL ASSESSMENT

Structure

2.0 Introduction

2.1 Objectives

2.2 Behavioural Assessment

- 2.2.1 Goals of Assessment
- 2.2.2 Behavioural Assessment and Traditional Assessment
- 2.2.3 Focus of Behavioural Assessment
- 2.2.4 Assumptions and Perspectives of Behavioural Assessment

2.3 Assessing Target Behaviours

- 2.3.1 Selection of Target Behaviour

2.4 Self-Report Methods

- 2.4.1 Examples of Self-Report Inventories
- 2.4.2 Strengths and Weaknesses of Self-Report Inventories
- 2.4.3 Formats of Self-Report Inventories

2.5 Direct Observation and Self-Monitoring

- 2.5.1 Disadvantages of Direct Observation
- 2.5.2 Types of Direct Observation
- 2.5.3 Unobtrusive Observation
- 2.5.4 Analogue Observation
- 2.5.5 Self-Monitoring

2.6 Psychophysiological Assessment

2.7 Future Perspectives

2.8 Let Us Sum Up

2.9 Unit End Questions

2.10 Suggested Readings

2.0 INTRODUCTION

In this unit we will be dealing with behavioural assessment. We start with introduction to behavioural assessment within which we also discuss goals of assessment, work out the differences between traditional and behavioural assessments, indicate the typical focus of behavioural assessment and state the various assumptions underlying behavioural assessment.

Then we point out the importance of target behaviours andhow the target behaviours should be selected. This is followed by Methods of assessment which includes self report methods including self report inventories. We point out the strengths and weaknesses of these self report inventories and present the format of self report inventories such as the interview, questionnaires etc. This is followed by direct observation as a method of assessment, within which we

discuss the disadvantages of direct observations and present the types of observations which includes unobtrusive observation, analogue observation etc. Then we take up the psychophysiolofical assessemtn and discuss the future perspectives of behavioural assessment.

2.1 OBJECTIVES

After completing this unit you will be able to:

- Explain what behavioural assessment means;
- Describe the various methods of behavioural assessment;
- Discuss the advantages and limitations of the methods of behavioural assessment; and
- Discuss the future perspectives of behavioural assessment.

2.2 BEHAVIOURAL ASSESSMENT

A major impetus for behaviour therapy was disenchantment with the medical model of psychopathology that views problem behaviours as the result of an underlying illness or pathology. Behaviourists assert that both 'disordered' and 'non-disordered' behaviour can be explained using a common set of principles describing classical and operant conditioning.

Behaviourists believe that behaviours are best understood in terms of their function. Two 'symptoms' may differ in form, while being similar in function. For example, Jacobson (1992) describes topographically diverse behaviours such as walking away or keeping busy that all function to create distance between a client and his partner. Conversely, topographically similar behaviours may serve different functions. For example, tantrums may serve to elicit attention from adults or may be an indication that the present task is too demanding. Behaviour therapists try to understand not only the form but also the function of problem behaviours within the client's environment.

2.2.1 Goals of Assessment

The initial goals of assessment are to identify and construct a case formulation of the client's difficulties that will guide the clinician and patient towards potentially effective interventions. For the behaviour therapist, this involves identifying problem behaviours, stimuli that are present when the target behaviours occur, along with associated consequences, and organism variables including learning history and physiological variables. The results of this functional analysis are used to design a behavioural intervention that is tailored to the individual client and conceptually linked to basic learning principles.

2.2.2 Behavioural Assessment and Traditional Assessment

Behavioural assessment is one of a variety of assessment traditions such as projective testing, neuropsychological assessment, and objective testing. Behavioural assessment distinguishes itself by being a set of specific techniques as well as a way of thinking about behaviour disorders and how these disorders can be changed. One of its core assumptions is that behaviour can be most effectively understood by focusing on preceding events and resulting consequences. Out of this core

assumption has come a surprisingly diverse number of assessment methods, including behavioural interviewing, several strategies of behavioural observation, measurement of relevant cognitions, psycho physiological assessment, and a variety of selfreport inventories.

Behavioural assessment can be most clearly defined by contrasting it with traditional assessment. One of the most important comparisons is the emphasis that behavioural assessment places on situational determinants of behaviour. This emphasis means that behavioural assessment is concerned with a full understanding of the relevant antecedents and consequences of behaviour. In contrast, traditional assessment is often perceived as more likely to view behaviour as the result of enduring, underlying traits. It is this underlying difference in conceptions of causation that explains most of the other contrasts between the two traditions. An extension of this conceptual difference is that behavioural assessment goes beyond the attempt to understand the contextual or situational features of behaviour and, more importantly, concerns itself with ways to change these behaviours. There is a close connection between assessment itself and its implications for treatment. Thus, behavioural assessment is more direct, utilitarian, and functional.

The perceived limitations of traditional assessment were a major factor in stimulating the development of behavioural assessment. Specifically, traditional assessment was considered to focus too extensively on abstract, unobservable phenomena that were distant from the actual world of the client. In addition, behaviourists felt that traditional clinical psychology had stagnated because its interventions were not sufficiently powerful and too much emphasis was placed on verbal therapy.

A further contrast between behavioural and traditional assessment is that behavioural assessment is concerned with clearly observable aspects in the way a person interacts with his or her environment. A typical behavioural assessment might include specific measures of behaviour (overt and covert), antecedents (internal and external), conditions surrounding behaviours, and consequences. This knowledge can then be used to specify methods for changing relevant behaviours. Although some behavioural assessors might take selected personality traits into account, these traits would be considered relevant only if they had direct implications for therapy. For example, certain personality styles interact with the extent and type of depressive cognitions, and the existence of a personality disorder typically predicts therapeutic outcome. This focus on the person and his or her unique situation is quite different from psychodynamic, biochemical, genetic or normative trait models.

2.2.3 Focus of Behavioural Assessment

The behavioural approach stresses that different behaviour disorders are typically expressed in a variety of modes. These might include overt behaviours, cognitions, changes in physiological states, and patterns of verbal expressions. This implies that different assessment strategies should be used for each of these modes.

An inference based on one mode does not necessarily generalise to another. For example, anxiety for one person may be caused and maintained primarily by the person's cognitions and only minimally by poor social skills. Another person might have few cognitions relating to anxiety but be anxious largely because of inadequate social skills. The person with inadequate social skills might be most effectively treated through social skills training and only minimally helped through approaches that alter irrational thoughts.

It should also be noted that altering a person's behaviour in one mode is likely to affect other modes, and these effects might have to be considered. Whereas the preceding information presents a relatively rigid and stereotyped distinction between traditional and behavioural assessment, most practicing clinicians, including those who identify themselves as behaviour therapists, typically combine and adopt techniques from both traditions.

2.2.4 Assumptions and Perspectives of Behavioural Assessment

The assumptions and perspectives of behavioural assessment have resulted in an extremely diverse number of approaches and an even wider variety of specific techniques. These approaches and their corresponding techniques can be organised into the areas of behavioural interviewing, behavioural observation, cognitive behavioural assessment, psychophysiological assessment, and self report inventories.

Self Assessment Questions

1) Define and describe behavioural assessment.

.....

.....

.....

2) What are the goals of behavioural assessment?

.....

.....

.....

3) Differentiate between behavioural assessment and traditional assessment.

.....

.....

.....

4) Describe the assumptions underlying behavioural assessment.

.....

.....

.....

2.3 ASSESSING TARGET BEHAVIOURS

The process of defining and measuring target behaviours is essential to behavioural assessment. Vague complaints must be expressed as specific quantifiable behaviours. For instance, anger might include responses such as hitting walls, refusing to talk or other specific behaviours. The client's goals must be defined in terms of those specific behavioural changes that would occur if treatment were effective.

2.3.1 Selection of Target Behaviour

Target behaviour selection can be complicated by the complexity with which many responses are expressed. Behaviourists have long recognised that many clinical problems involve responses that cannot be readily observed. Some responses such as intrusive thoughts or aversive mood states are private by nature. Others, such as sexual responses, may be private and unobservable due to social convention. Many clinical complaints may include both observable and private responses. For example, depressed mood and suicidal ideation might be accompanied by crying, or other overt behaviours. Public and private responses may not always appear consistent. For example, an agoraphobic client may enter a shopping mall during an assessment but may do so only with extreme subjective distress.

Cone (1978) suggested that the bio informational theory of emotion developed by Lang(1971) is useful for conceptualising clinical problems. Lang (1971) asserted that emotional responses occur in three separate but loosely coupled response systems. These are the cognitive/linguistic, overt behavioural, and psycho physiological systems. A given response such as a panic attack may be divided into physiological responses such as increased heart rate and respiration, cognitive responses such as thoughts about dying or passing out, and overt behavioural responses such as escape from the situation, sitting down, or leaning against a wall for support. Ideally, each response mode should be assessed, there being no a priori reason to value one modality over another. Discrepancies are best considered with regard to the particular client, the goals of therapy, and ethical considerations. For example, it may be wise to take verbal reports of pain seriously even if they do not match evidence of tissue damage or physiological arousal.

The triple response conceptualisation of clinical problems has encouraged the development and utilisation of methods that more or less directly assess each response mode. Overt behaviours have been assessed by direct observation, with psycho physiological assessment used to assess bodily responses, and self-report measures developed to quantify subjective experiences. The apparent link between assessment methods and particular response modes is not absolute. For example, a client might verbally report sensations such as heart pounding, muscle tension, or other noticeable physical changes. However, in some cases, the method of assessment is more closely bound to a particular response mode. This is true of physiological processes such as blood pressure that are outside of the client's awareness and in the case of thoughts or subjective states that can only be assessed by verbal report. In the following sections self-report measures, direct observation, and psycho physiological measurements are described in more detail.

2.4 SELF REPORT METHODS

A self report inventory is a personality inventory in which a person is asked which of a list of traits and characteristics describe her or him or to indicate which behaviours and hypothetical choices he or she would make. This type of test is often presented in a paper-and-pencil format or may even be administered on a computer. A typical self report inventory presents a number of questions or statements that may or may not describe certain qualities or characteristics of the test subject.

Self-report measures have been used by many researchers to assess the behavioural, cognitive, and affective aspects of task engagement. Items relating to the cognitive aspects of engagement often ask the subjects to report on factors such as their attention versus distraction during a task, the mental effort they expend on these tasks (e.g., to integrate new concepts with previous knowledge), and task persistence (e.g., reactions to perceived failures to comprehend the concerned material). Subjects can also be asked to report on their response levels during class time (e.g., making verbal responses within group discussions, looking for distractions and engaging in non-academic social interaction) as an index of behavioural task engagement. Affective engagement questions typically ask the subjects to rate their interest in and emotional reactions to learning tasks on indices such as choice of activities (e.g., selection of more versus less challenging tasks), the desire to know more about particular topics, and feelings of stimulation or excitement in beginning new projects.

A variety of self-report questionnaires have been used in research on subjects' engagement, reflecting the multi faceted nature of the construct. Wigfield (1997) suggested that high levels of task engagement were often reflected in factors such as the subjects' learning beliefs and expectations (e.g., Miller, et al, 1996), self-efficacy (Pintrich & Schrauben, 1992), task interest levels (Schiefele, 1995), and use of effective and/or deep, rather than "shallow" or "surface" learning strategies. Researchers have used different combinations of these indicators in empirical evaluations. Thus, typical assessment protocols comprise a number of separate indices for assessing the cognitive, affective or behavioural manifestations of task related engagement. This reflects the fact that no one instrument is likely to be able to comprehensively assess the subject's engagement on all of the construct dimensions listed. Using separate indices also allows educators to adapt the focus of their protocols more towards their own instructional goals.

Attitudes towards, and interests in, learning tasks are highly interrelated constructs and thus often assessed within the same scale

2.4.1 Examples of Self-Report Inventories

The MMPI-2

Perhaps the most famous self-report inventory is the Minnesota Multiphasic Personality Inventory (MMPI). This personality test was first published in the 1940s, later revised in the 1980s and is today known as the MMPI-2. The test contains more than 500 statements that assess a wide variety of topics including interpersonal relationships, abnormal behaviours and psychological health as well as political, social, religious and sexual attitudes.

The 16 Personality Factor Questionnaire

Another well known example of a self-report inventory is the questionnaire developed by Raymond Cattell to assess individuals based on his trait theory of personality. This test is used to generate personality profile of the individual and is often used to evaluate employees and to help people select a career.

California Personality Inventory

California personality inventory is based on the MMPI, from which nearly half questions are drawn. The test is designed to measure such characteristic as self control, empathy and independence.

2.4.2 Strengths and Weaknesses of Self-Report Inventories

Self-report inventories are often a good solution when researchers need to administer a large number of tests in relatively short space of time. Many self report inventories can be completed very quickly, often in as little as 15 minutes. This type of questionnaire is an affordable option for researchers faced with tight budgets.

Another strength is that the results of self report inventories are generally much more reliable and valid than projective tests. Scoring of the tests a standardized and based on norms that have been previously established.

However, self report inventories do have their weaknesses. For example, while many tests implement strategies to prevent "faking good" or "faking bad," research has shown that people are able to exercise deception while taking self report tests (Anastasi & Urbina, 1997).

Another weakness is that some tests are very long and tedious. For example, the MMPI takes approximately 3 hours to complete. In some cases, test respondents may simply lose interest and not answer questions accurately. Additionally, people are sometimes not the best judges of their own behaviour. Some individuals may try to hide their own feelings, thoughts and attitudes.

There are several formats for collecting self report data. These include interviews, questionnaires and inventories, rating scales, think aloud, and thought sampling procedures. It is most often the case that an assessment would include several of these methods.

2.4.3 Formats of Self-Report Inventories

Interviews

The clinical interview is the most widely used method of clinical assessment, and is particularly advantageous in the early stages of assessment. The most salient of its advantages is flexibility. The typical interview begins with broad-based inquiry regarding the client's functioning. As the interview progresses, it becomes more focused on specific problems and potential controlling variables. Interviewing also provides an opportunity to directly observe the client's behaviour, and to begin developing a therapeutic relationship.

The clinical interview also has important disadvantages. Interviews elicit information from memory that can be subject to errors, omissions, or distortions. Additionally, the interview often relies heavily on the clinician to make subjective judgements in selecting those issues that warrant further assessment or inquiry. One could reasonably expect that different clinicians could emerge from a clinical interview with very different conceptualisations of the client.

Structured and semi structured interviews were developed in order to facilitate consistency across interviewers. Structured interviews are designed for administration by non clinicians such as research assistants in large scale studies. A structured interview follows a strict format that specifies the order and exact wording of questions. Semi-structured interviews are more frequently used by trained clinicians. They provide a more flexible framework for the course of the interview while providing enough structure to promote consistency across administrations. While specific questions may be provided, the interviewer is free to pursue additional information when this seems appropriate. In general, the goal

of enhanced reliability has been attained with the use of structured and semi structured interviews. However, the majority of these interviews are designed for purposes of diagnosis rather than more particular target behaviours or functional assessment.

Just as the clinical interview proceeds from a general inquiry to more focused assessment of behavioural targets, other self-report measures vary in the degree to which they assess general areas of functioning versus particular problem behaviours. In general, those measures that assess general constructs such as depression or general domains of functioning are developed using group data and are meant to be applicable to a wide range of clients. Examples of these nomothetic measures include personality inventories and standardized questionnaires. Other self report methods can be tailored more toward individual clients and particular problem responses. These include rating scales and think aloud procedures.

Table 1: Steps in Behavioural Interviewing

- Identify the problem and specify target behaviours.
- Identify and analyse relevant environmental factors.
- Develop a plan for intervention.
- Implement this plan.
- Evaluate the outcomes of treatment.
- Modify treatment as needed and re evaluate outcomes.

Questionnaires

Questionnaires are probably the next most common assessment tool after interviews. Questionnaires can be easily and economically administered. They are easily quantified and the scores can be compared across time to evaluate treatment effects. Finally, normative data is available for many questionnaires so that a given client's score can be referenced to a general population.

There has been a rapid proliferation of questionnaires over the last few decades. Some questionnaires focus on stimulus situations provoking the problem behaviour, such as anxiety provoking situations. Other questionnaires focus on particular responses or on positive or negative consequences. The process of choosing questionnaires from those that are available can be daunting. Fischer and Corcoran (1994) have compiled a collection of published questionnaires accompanied by summaries of their psychometric properties.

Many behaviourists have expressed concern with the apparent reliance on questionnaires both in clinical and in research settings. These criticisms stem in part from repeated observations that individuals evidence very limited ability to identify those variables that influence their behaviour. Additionally, behaviourists point out that we tend to reify the constructs that we measure. This may lead to a focus on underlying dispositions or traits in explaining behaviour rather than a thorough investigation of environmental factors and the individual's learning history. Behaviourists do make use of questionnaires but tend to regard them as measures of behavioural responses that tend to correlate rather than as underlying traits or dispositions.

Rating Scales and Self-Ratings

Rating scales can be constructed to measure a wide range of responses. They are often incorporated into questionnaires or interviews. For example, a client may be asked to rate feelings of hopelessness over the past week on a scale of 0–8. Clinicians might also make ratings of the client's noticeable behaviour during the interview or the client's apparent level of functioning.

The main advantage of rating scales is their flexibility. They can be used to assess problem behaviours for which questionnaires are not available. Additionally, rating scales can be administered repeatedly with greater ease than questionnaires. For example, rather than pausing to complete an anxiety questionnaire, a client might provide periodic self-ratings of discomfort during an anxiety provoking situation. The main disadvantage of rating scales is the lack of normative data.

Thought Listing and Think A loud Procedures

Clinicians are sometimes interested in the particular thoughts that are experienced by a client in a situation such as a phobic exposure or role play. The use of questionnaires may interfere with the situation and may not capture the more idiosyncratic thoughts of a particular client. Think aloud and thought sampling procedures may be used under these circumstances.

These procedures require the client to verbalize thoughts as they occur in the assessment situation. Thoughts can be reported continually in a think-aloud format or the client may periodically be prompted to report the most recently occurring thoughts in a thought sampling procedure. When the requirements of think aloud procedures may interfere with the client's ability to remain engaged in the assessment situation, the client may be asked to list those thoughts that are recalled at the end of the task. These procedures carry the advantage of being highly flexible. Like other highly individualised methods, they also carry the disadvantage of lacking norms.

Self Assessment Questions

1) What are self report methods?

.....

.....

.....

2) State examples of a few major self report inventories.

.....

.....

.....

3) Discuss the strengths and weaknesses of self report inventories.

.....

.....

.....

4) Discuss the different formats of self report inventories as for example interviews etc.

.....

.....

.....

2.5 DIRECT OBSERVATION AND SELF MONITORING

One of the most direct forms of assessment is observation by trained observers. Direct observation can be conducted by clinicians, professional staff, or by participant observers who already have contact with the client. Rather than reporting in retrospect, observers can record all instances of the target behaviour that they witness, thereby producing a frequency count. Depending on the type of target response, this task could be arduous. Recording all instances of highly frequent and repetitive behaviours can place undue demands on observers. There are several ways to decrease the demands on the observer and thereby facilitate more faithful data collection. One option is the use of brief observation periods. For example, a parent might be asked to record the frequency of the target behaviour at intervals during those specific situations when the behaviour is probable. When the target behaviour is an ongoing response, the observer might employ momentary sampling procedures and periodically check to see if the behaviour is occurring. The features of direct observation are listed in the box given below.

Key Characteristics of Direct Observation and Recording of Behaviour

- Behaviour is observed in a natural setting.
- Behaviour is recorded or coded as it occurs.
- Impartial, objective observers record behaviour.
- Behaviour is described in clear, crisp terms, requiring little or no inference by the observer.

2.5.1 Disadvantages of Direct Observation

Direct observation carries some disadvantages. It can be costly and time-consuming. In the strictest sense it would be favourable to utilise multiple observers so that the concordance of their recording could be checked. It has been shown that the reliability of observations is enhanced when observers know that the data will be checked. However, this may not be practical, particularly in clinical settings. The use of participant observers may be a less costly alternative in many cases. Direct observation can also result in reactive effects. Reactivity refers to changes in behaviour that result from the assessment procedure. Making clients aware that they are being observed can alter the frequency or form of the target response. This can occur even with the use of participant observers. The variables that influence observee reactivity are not well understood. For ethical reasons, it may be unwise to conduct observations without the client's awareness.

Also in direct observations, people know that you are watching them. The only danger is that they are *reacting* to you. As stated earlier, there is a concern that individuals will change their actions rather than showing you what they're REALLY like. This is not necessarily bad, however. For example, the contrived behaviour may reveal aspects of social desirability, how they feel about sharing their feelings in front of others, or privacy in a relationship. Even the most contrived behaviour is difficult to maintain over time. A long term observational study will often catch a glimpse of the natural behaviour. Other problems concern the generalisability of findings. The sample of individuals may not be representative of the population or the behaviours observed are not representative of the individual (you caught the person on a bad day). Again, long-term observational studies will often overcome the problem of external validity. What about ethical problems you say? Ethically, people see you, they know you are watching them (sounds spooky, I know) and they can ask you to stop.

2.5.2 Types of Direct Observation

There are two commonly used types of direct observations:

Continuous Monitoring: This involves observing a subject or subjects and recording (either manually, electronically, or both) as much of their behaviour as possible. Continuos Monitoring is often used in organisational settings, such as evaluating performance. Yet this may be problematic due to the Hawthorne Effect. The Hawthorne Effect states that workers react to the attention they are getting from the researchers and in turn, productivity increases. Observers should be aware of this reaction. Other CM research is used in education, such as watching teacher-student interactions. Also in nutrition where researchers record how much an individual eats. CM is relatively easy but a time consuming endeavor. You will be sure to acquire a lot of data.

Time Allocation: This involves a researcher randomly selecting a place and time and then recording what people are doing when they are first seen and before they see you. This may sound rather bizarre but it is a useful tool when you want to find out the percent of time people are doing things (i.e. playing with their kids, working, eating, etc.). Thereare several sampling problems with this approach. First, in order to make generalisations about how people are spending their time the researcher needs a large representative sample. Sneaking up on people all over town is tough way to spend your days. In addition, questions such as when, how often, and where should you observe are often a concern. Many researchers have overcome these problems by using nonrandom locations but randomly visiting them at different times.

2.5.3 Unobtrusive Observation

Unobtrusive measures involves any method for studying behaviour where individuals do not know they are being observed (don't you hate to think that this could have happened to you!). Here, there is not the concern that the observer may change the subject's behaviour. When conducting unobtrusive observations, issues of validity need to be considered. Numerous observations of a representative sample need to take place in order to generalise the findings. This is especially difficult when looking at a particular group. Many groups posses unique characteristics which make them interesting studies. Hence, often such findings are not strong in external validity. Also, replication is difficult when using non-conventional measures (non-conventional meaning unobtrusive observation). Observations of a very

specific behaviours are difficult to replicate in studies especially if the researcher is a group participant (we'll talk more about this later). The main problem with unobtrusive measures, however, is ethical. Issues involving informed consent and invasion of privacy are paramount here. An institutional review board may frown upon your study if it is not really necessary for you not to inform your subjects.

There are two types of unobtrusive research measures you may decide to undertake in the field and these are given below. (i) behaviour trace studies (ii) disguidsed field observation. Let us deal with these in some detail.

Behaviour Trace Studies: Behaviour trace studies involve findings things people leave behind and interpreting what they mean. This can be anything to vandalism to garbage. The University of Arizona Garbage Project one of the most well known trace studies. Anthropologists and students dug through household garbage to find out about such things as food preferences, waste behaviour, and alcohol consumption. Again, remember, that in unobtrusive research individuals do not know they are being studied. How would you feel about someone going through your garbage? Surprisingly Tucson residents supported the research as long as their identities were kept confidential. As you might imagine, trace studies may yield enormous data.

Disguised Field Observations: In Disguised field analysis the researcher pretends to join or actually is a member of a group and records data about that group. The group does not know they are being observed for research purposes. Here, the observer may take on a number of roles. First, the observer may decide to become a complete participant in which they are studying something they are already a member of. For instance, if you are a member of a sorority and study female conflict within sororities you would be considered a complete participant observer.

On the other hand you may decide to only participate casually in the group while collecting observations. In this case, any contact with group members is by acquaintance only. Here you would be considered an observer participant.

Finally, if you develop an identity with the group members but do not engage in important group activities consider yourself a participant observer. An example would be joining a cult but not participating in any of their important rituals (such as sacrificing animals). You are however, considered a member of the cult and trusted by all of the members. Ethically, participant observers have the most problems. Certainly there are degrees of deception at work. The sensitivity of the topic and the degree of confidentiality are important issues to consider.

2.5.4 Analogue Observation

Analogue observation is a method of direct observation, but it occurs in a contrived, carefully structured setting, designed specifically for the assessment. By contrast, direct observation occurs in a naturalistic setting. In analogue assessment or observation, after the setting has been structured, direct observation of behaviour follows, using many of the principles of observation previously described.

2.5.5 Self-Monitoring

In self-monitoring procedures, the client is asked to act as his or her own observer and to record information regarding target behaviours as they occur. Self monitoring can be regarded as a self report procedure with some benefits similar to direct

observation. Because target behaviours are recorded as they occur, self-monitored data maybe less susceptible to memory related errors. Like other self report methods, self monitoring can be used to assess private responses that are not amenable to observation. Self-monitored data also have the potential to be more complete than that obtained from observers, because the self monitor can potentially observe all occurrences of target behaviours.

There are several formats for self monitoring. Early in assessment, a diary format is common. This allows the client to record any potentially important behaviours and their environmental context in the form of a narrative. As particular target behaviours are identified, the client may utilise data collection sheets for recording more specific behavioural targets and situational variables. When behaviours are highly frequent or occur with prolonged duration, the client may be asked to estimate the number of occurrences at particular intervals or the amount of time engaged in the target response.

It is often desirable to check the integrity of self monitored data. Making the client aware that their self-monitored data will be checked is known to enhance the accuracy of data collection. Self-monitored data can be checked against data obtained from external observers or can be compared to measured byproducts of the target response. For example, self monitored alcohol consumption can be compared to randomly tested blood alcohol levels.

Among the disadvantages of self monitoring are its demands on the client for data collection and the lack of available norms. Like direct observation, self monitoring also produces reactive effects. However, this disadvantage in terms of measurement can be advantageous in terms of treatment. This is because reactive effects tend to occur in the therapeutic direction, with desirable behaviours becoming more frequent and undesired behaviours tending to decrease.

This temporary effect of the procedure can produce some relief for the client and help to maintain an investment in treatment.

Self Assessment Questions

1) Define and describe direct observation.

.....

.....

.....

2) Describe self monitoring.

.....

.....

.....

3) What are the disadvantages of direct observation?

.....

.....

.....

4) Delineate the different types of direct observation.

.....

.....

.....

5) What is meant by unobtrusive observation?

.....

.....

.....

6) Describe analogue observation.

.....

.....

.....

7) Elucidate self monitoring.

.....

.....

.....

2.6 PSYCHOPHYSIOLOGICAL ASSESSMENT

Psychophysiological assessment is a highly direct form of measurement that involves assessing the byproducts of physiological processes that are associated with behavioural responses. For instance, a cardio tacho meter can be used to measure electrical changes associated with activity of the heart. While clients can verbally report many physiological changes, a direct measurement via instrumentation carries several advantages. Physiological measures can be sensitive to subtle changes and to physiological processes that occur without the client's awareness. They can also provide both discrete and continuous data with regard to physiological processes while requiring only passive participation from the client. Additionally, most clients lack familiarity with psycho physiological measurement, making deliberate distortion of responses improbable.

The main disadvantage of psychophysiological measurement is the cost of equipment and training. This problem is compounded by the observation that it is often desirable to include measures of multiple physiological channels. For example, there can be substantial variance across individuals in the degree of response exhibited on a given physiological index. Those measures that are most sensitive for a given individual may not be included in a limited psycho physiological assessment. With technological advances in this area, less costly instrumentation will likely become more available.

2.7 FUTURE PERSPECTIVES

Over the past two decades, research devoted to direct observation and self-monitoring procedures has declined dramatically. This trend has been mirrored by

a rapid proliferation of questionnaires and research examining their psychometric properties. One likely reason for this shift is the current climate of managed healthcare. The goal of more efficient and less costly healthcare has created pressure for more rapid and inexpensive forms of assessment and treatment. Psycho physiological recording equipment is simply too expensive for most clinicians to afford and maintain. The task of training and paying trained observers can also be costly.

Even when participant observers are used, the procedure can place inordinate demands on these individuals. While self-monitoring is less costly, it does place more demands on the client and more time is required to obtain useful information beyond an initial interview. In general, the more direct methods of behavioural assessment have the disadvantage of also being more costly and time consuming. The trend toward more rapid assessment seems to select for brief, easily administered, and relatively inexpensive questionnaires and rating scales. There have been calls for more research devoted to behavioural assessment methods. This research might lead to more efficient methods for implementing these assessment procedures. There is also a need to determine if the data from these assessments facilitates more efficient and/or effective treatment. If empirical support for the utility of behavioural assessment techniques is generated, this may help to increase the receptiveness of third party payers to the use of these procedures.

To conclude what wehave discussed so far, we could state that the goals and conduct of behavioural assessment are directly linked to learning theory and to the goal of altering behaviour through the use of behavioural principles. The hallmark of behavioural assessment is an emphasis on the function rather than the form of problem behaviours, and on the specification of problem behaviours, as well as their environmental and organismic controlling variables in more detail than is typical of diagnostic classification. While diagnostic assessment tools might be included, behavioural assessment demands further molecular analysis of specific target behaviours and controlling variables.

Behaviour therapists have long recognised that clinical problems are often part of the client's private experience, and that many are a combination of verbal, physiological, and overt behavioural responses. A comprehensive assessment considers each of these modalities. While these ideas are still fundamental in behavioural assessment, the more costly and time-demanding methods of behavioural assessment are becoming more difficult to include in clinical assessment and are less apt to be the focus of research.

2.8 LET US SUM UP

Behavioural assessment differs from traditional assessment in several fundamental ways. Behavioural assessment emphasises direct assessments (naturalistic observations) of problematic behaviour, antecedent (situational) conditions, and consequences (reinforcement). By conducting such a functional analysis, clinicians can obtain a more precise understanding of the context and causes of behaviour. It is also important to note that behavioural assessment is an ongoing process, occurring at all points throughout treatment.

We have surveyed some of the more common behavioural assessment methods. Behavioural interviews are used to obtain a general picture of the presenting problem and of the variables that seem to be maintaining the problematic behaviour. Observation methods provide the clinician with an actual sample (rather than a

self-report) of the problematic behaviour. Observations can be made in naturalistic conditions (as behaviour typically and spontaneously occurs) or under more controlled conditions (in simulated or contrived situations or conditions). Behavioural assessors may also have clients self-monitor ("self-observe") their own behaviours, thoughts, and emotions.

Variety of factors can affect both the reliability and validity of observations, including the complexity of the behaviour to be observed, how observers are trained and monitored, the unit of analysis chosen, the behavioural coding system that is used, reactivity to being observed, and the representativeness of the observations.

2.9 UNIT END QUESTIONS

1) What is behavioural assessment?

2) Describe the various methods of behavioural assessment? Discuss their advantages and limitations?

3) What are self report methods?

4) Discuss the observational methods and bring out the features of the same

5) What are psychophysiological assessments? Describe

6) What are the future perspectives of behavioural assessment?

2.10 SUGGESTED READINGS

Groth-Marnat, G (2003)` . *Handbook of Psychological Assessment (4th ed.).* New Jersey: John Wiley & Sons, Inc.

Ramsay, M.C., Reynolds, C.R., Kamphaus, R.W (2002). *Essentials of Behavioural Assessment.* New York:John Wiley & Sons, Inc.

UNIT 3 ASSESSMENT IN CLINICAL PSYCHOLOGY

Structure

3.0 Introduction

3.1 Objectives

3.2 Definition and Purpose of Clinical Assessment

- 3.2.1 Definition of Psychological Assessment
- 3.2.2 Psychological Assessments
- 3.2.3 Psychologists as Detectives
- 3.2.4 Comprehensive Assessments
- 3.2.5 Psychological Assessment as Important Tools
- 3.2.6 Reliability and Validity

3.3 Types of Psychological Assessment

- 3.3.1 Addiction Assessments
- 3.3.2 Description of FAMHA
- 3.3.3 MISU Characteristics
- 3.3.4 SUMI Characteristics
- 3.3.5 MCSU Characteristics
- 3.3.6 Development of the Scale
- 3.3.7 Validity and Reliability

3.4 The Referral

- 3.4.1 Factors that Influence Clinicians Response to Referral Questions

3.5 Assessment in Clinical Psychology

- 3.5.1 Deciding on Therapy
- 3.5.2 Planning Therapy
- 3.5.3 Conducting Therapy
- 3.5.4 Evaluating Therapy

3.6 Instruments

3.7 Let Us Sum Up

3.8 Unit End Questions

3.9 Suggested Readings

3.0 INTRODUCTION

In this unit we will be discussing about assessment in clinical psychology. We start with definition and purpose of clinical assessment followed by psychological assessment as done by clinical psychologists. Then we take up the detection of certain disorders by clinical psychologists almost like that of degtectives. Then we deal with the comprehensive psychological assessments that clinical

psychologists make. Then we deal with types of psychological assessment which includes under it addiction assessments, description of the addiction and mental illness test called FAMHA (Functional Assessment of Mental Health and Addiction Scale). Then we deal with typical characteristics of MISU (Mentally Il substance users), SUMI (Substance Using Mentally Ill) and MCSU (Medically compromised substance using patents) characteristics. Then we present how then scale FAMHA was developed and its reliability and validity. The next section deals with the referral and how clinical psychologists deal with the same in terms of assessment. This is followed by assessment in clinical psychology within which we dealm with how assessment helps in deciding on therapy, planning therapy, conducting therapy and evaluating therapy.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Define and describe the psychological assessment in clinical setting;
- Explain the different types of psychological assessment;
- Explain the purpose of clinical assessment;
- Explain the referral and assessment;
- Describe assessment in clinical psychology; and
- Describe the applications of psychological assessment in the field of clinical psychology.

3.2 DEFINITION AND PURPOSE OF CLINICAL ASSESSMENT

Psychological assessment as an area of emphasis has seen its ups and downs. Abeles (1990) commented on the recent "rediscovery" of assessment. He observed that during the 1960s and 1970s, there seemed to be a decline in interest in psychological assessment. Therapy was the more glamorous enterprise, and assessment almost seemed somehow "unfair" to clients. It appeared that clinical psychology's historical commitment to assessment was waning. The prevailing attitude about assessment was "Let the technicians do it!" But in the 1980s, something else began to happen. Students began to show an interest in specialisation. They discovered forensic psychology (the application of psychology to legal issues), or they became intrigued by pediatric psychology, geriatrics, or even neuropsychology.

But to become a specialist in such areas, one needs to know a great deal about assessment. You cannot answer a lawyer's questions about the competence of a defendant unless you have thoroughly assessed that individual through tests, interviews, or observations. You cannot decide on issues of neurological insult versus mental disorder until you have assessed that client. As Abeles (1990) stated:

"It is my contention that one of the unique contributions of the clinical psychologist is the ability to provide assessment data. Providing assessments is again becoming a highly valued and respected part of clinical psychology and in my opinion is

coequal with intervention and psychotherapy as a vital activity of clinical psychology. Let us continue to rediscover assessment! (p. 4).

3.2.1 Definition of Psychological Assessment

Psychological assessment can be formally defined in many ways. Clinical assessment involves an evaluation of an individual's strengths and weaknesses, a conceptualisation of the problem at hand (as well as possible etiological factors), and some prescription for alleviating the problem; all of these lead us to a better understanding of the client. Assessment is not something that is done once and then is forever finished. In many cases, it is an ongoing process—even an everyday process, as in psychotherapy. Whether the clinician is making decisions or solving problems, clinical assessment is the means to the end.

Intuitively, we all understand the purpose of diagnosis or assessment. Before physicians can prescribe a treatment, they must first understand the nature of the illness. Before plumbers can begin soldering pipes, they must first determine the character and location of the difficulty. What is true in medicine and plumbing is equally true in clinical psychology. Aside from a few cases involving pure luck, our capacity to solve clinical problems is directly related to our skill in defining them. Most of us can remember our parents' stern admonition: "Think before you act!" In a sense, this is the essence of the assessment or diagnostic process.

3.2.2 Psychological Assessments

Physicians run "tests" to identify illnesses of diseases. Sometimes one test identifies the source of problems such as an x-ray revealing a tumor, or a blood test showing low iron levels or anemia. However, some illnesses aren't so clear-cut, requiring a battery of tests and medical procedures to accurately diagnose complex conditions.

Clinical psychologist's tools also are used to diagnose learning disabilities, determine competency to stand trial for a crime, and guide individuals into a deeper understanding of their vocational and avocational likes and dislikes.

Clinical psychologists similarly use various tools, called psychological tests to help diagnose mental illness and disease. But like complex medical conditions, tests often don't provide all the answers, so psychologists rely on a broader educational tool called an "assessment" to more accurately diagnose psychological conditions. Based on assessments, psychologists develop and apply effective therapeutic treatment plans and interventions

3.2.3 Psychologists as Detectives

Psychologists conducting assessments are likes detectives trying to solve a case. The assessment requires a gathering of information from multiple sources, from written tests, personal interviews, job history records, and reports and records from other physicians, therapists, and counselors. The clinical psychologist compiles an entire "case history" or in-depth story of a person's inner and outer life, a sort of journey into the intricacies of psyche and behaviours. Past and present life situations are also considered.

According to Wikipedia, 91% of clinical psychologists perform some type of assessment. But the complexity of the assessment depends on several factors, such as the clinical setting, the severity of the condition, and the age and ability

of the particular client. For example, an assessment done on a child struggling in school will be quite different from an assessment conducted with a suspected criminal. And an assessment given to a soldier in Afghanistan experiencing symptoms of trauma will differ dramatically from an individual seeking treatment for depression from a psychotherapist who uses a form of "talk therapy" to diagnose and treat clients.

A "full" assessment of the soldier probably isn't likely given the conditions of war and fighting, yet military psychologists are trained to assess soldiers using other methods, such as observational or interview-type approaches, to determine an effective immediate intervention, or to determine if the soldier needs to be removed from the situation and admitted to a military facility for a more thorough assessment, and longer term therapy. Likewise, psychotherapists in private settings have more flexibility in the type of assessment given to clients than psychotherapists working in a mental health facility or hospital, which often recommends standard, commonly used tools for tests and assessments.

3.2.4 Comprehensive Assessments

The strength of the psychological assessment process stems from its comprehensive, scientific methodology. Testing implies something like a blood test, where you just give a test and get a number," explained Smith, also in private practice and a faculty member at the University of California, Berkeley. "Assessment is a much more complex enterprise where you integrate data points from various places to get a more comprehensive understanding. Psychologists must be able to select the best assessment tools available for certain client populations, and to become, in a sense, wise consumers of psychological research. Also, a post-assessment must occur after a psychological intervention has been applied, assessing the impact on the client's behaviour and progress toward healing.

3.2.5 Psychological Assessment as Important Tools

Scientific research in clinical psychotherapy has evolved since its beginnings after World War II, as psychologists attempted to understand and treat soldiers with shell shock – what today is called post traumatic stress disorder. Over the years, many in the scientific community have questioned the reliability and validity of psychological testing as compared to medical testing. studies conducted over the past few decades have proven the efficacy of psychological tests, according to professionals working in the field. In the American Psychological Association's journal "Monitor," an article by Jennifer Draw explored the results from a study conducted by the American Psychological Association's Psychological Assessment Work Group. The PAWG researchers found that many psychological tests produce results of comparable validity to medical tests such as Pap smears, mammography, magnetic resonance imaging (MRI) and electrocardiograms. As an example, the researchers cited test scores from the Minnesota Multiphasic Personality Inventory (MMPI) that had an average ability to detect depressive or psychotic disorders with the same reliability that Pap tests detect cervical abnormalities.

The researchers also went a step further to conclude that some psychological tests work as well as medical tests in detecting the same illnesses. They point to neuropsychological testing for dementia producing results with the same level of effectiveness as an MRI.

3.2.6 Reliability and Validity

Reliability means that an experiment or test reports the same results after a repeated number of trials. Independent researchers must be able to replicate experiments using the same controls as the original researchers, making the research generalisable. Validity determines if the experiment measures exactly what the researchers attempted to measure – or the specific concept under study. External validity means that the study results are generalisable; internal validity concerns the rigor of the study's design and procedures.

Self Assessment Questions

1) Define clinical assessment.

.....

.....

.....

2) Describe the purpose of assessment.

.....

.....

.....

3) What are psychological assessments?

.....

.....

.....

4) Describe psychologists as detectives.

.....

.....

.....

5) Discuss psychological instruments as important tools.

.....

.....

.....

3.3 TYPES OF PSYCHOLOGICAL ASSESSMENT

Thousands of psychological tests exist all falling in one of the following categories:

i) intelligence or IQ tests, such as WAIS IV , WICS IV, Stanford Binet,

ii) Cattell Culture Fair III,

iii) Woodcock Johnson Tests of Cognitive Abilities III.

iv) Attitude scales such as Thurstone scale or Liket scale and

v) Personality tests such as the MMPI, MCMI III,

vi) Beck Depression Inventory and

vii) Child Behaviour Check List.

viii) The Rorschach Test used less frequently is also a personality test.

ix) Direct Observation tests, such as the Parent-Child Interaction Assessment-II, the MacArthur Story Stem Battery and the Dyadic Parent-child Interaction Coding System.

3.3.1 Addiction Assessments

The assessment of client functioning is a critical component of both treatment outcome evaluation and assessment of individual level of need for individual treatment planning and service delivery selection. This is especially true for the dually diagnosed client with multiple concomitant needs, on a variety of levels.. The Functional Assessment of Mental Health and Addiction scale (FAMHA) was specifically designed to meet both criteria.

While it is beneficial to note the positive client changes that occur due to the effects of treatment, it is perhaps more important to have a functional baseline or clinical yardstick with which to plan an effective strategies of biopsychosocial interventions. This is of utmost importance for dually diagnosed clients, with multiple service needs in mental health, addiction treatment, and medical interventions.

A basic, core goal of all treatment is to produce substantial and enduring changes in client behaviours, cognitions and moods and more useful strategies for managing their day-to-day lives. The only other goal of treatment is then to reduce a client's distress to the greatest degree possible. By determining a client's specific level of functioning across all major biopsychosocial domains and an overall level of functioning, specific symptom and functional deficit profiles emerge that can then be used for more effective treatment planning. Such assessments are client centered by their very nature and specifically relate to the distress and difficulties that each patient must endure in their daily lives. Thus, functional assessments like the FAMHA are the key to not only measuring the outcomes of treatments on a broad scale, but crucial to the clinician's full understanding of patient's individual needs.

3.3.2 Description of the FAMHA

The Functional Assessment of Mental Health and Addiction (FAMHA; Anderson & Bellfield, 1999) is a clinician rating scale, specifically designed to accurately assess dually diagnosed, across a broad range of symptom and functional domains. It was developed in response to clinical and outcome research goals identified by the Department of Health (1996) which emphasised the need for extending research on the outcome of treatment for substance misuse problems. It is meant for three different types of addicts.

i) mentally ill substance users (MISU),

ii) substance using mentally ill (SUMI), and

iii) medically compromised substance using patients (MCSU)

The assessment scale is specifically tailored to assess the multifaceted needs of severely distressed patients and to identify specific areas for effective therapeutic interventions. The 46 items of the scale document functional deficits across all biopsychosocial functional domains in such a way as to capture the current state of overall functioning, whilst demonstrating specific areas of need.

Thus, it can be used as both an indicator of current functioning for diagnostic assessment and as a repeated measure to demonstrate the changes that occur to patients throughout the clinical cycle.

Sciacca (1991) noted significant differences between various subpopulations of dually diagnosed patients (in both mental health and addiction treatment settings) that have an impact on treatment planning and service delivery for each patient population. The term dual diagnosis is somewhat broad and misleading (for example; mental illness and learning disabilities are dual diagnoses).

The distinction between MISU, SUMI, and MCMU patients has a significant impact on the selection and use of a variety of intervention techniques and strategies.

MISU patients generally present with symptoms of severe and enduring mental illness that has been complicated by the use of psychotopic substances.

SUMI patients are characterised by their excessive use of psychotropic agents with the subsequent development of a concomitant severe and persistent mental illness.

MCSU patients characteristically use large amounts of psychotropic agents in the presence of a long term or severe physical injury, illiness or ongoing medical condition.

Traditionally, MISU patients have gravitated toward mental health treatment systems, SUMI patients have generally sought treatment in addiction treatment settings; while MCSU patients have relied on medical treatment facilities to seek therapeutic relief.

Mental illness, substance use/misuse and medical conditions must be approached differently for each group to achieve effective therapeutic outcomes (Sciacca, 1991). The severe and persistent mental illness of MISU patients make it difficult for them to engage in the motivational interviewing or more restrictive treatments often used in addiction treatment settings (Bachrach, 1984).

On the other hand, SUMI and MCSU patients often require relief from the effects of addiction and withdrawal before they can fully focus on their treatment for the medical, psychological and social issues that have emerged or intensified as a result of their substance use.

For this reason, the FAMHA was designed to assess individual differences in symptomatology, whilst differentiating these two populations on a functional level.

Effective treatment of MISU, SUMI and MCSU patients requires diagnostic clarification as the initial step in successful care planning. To address the problem of multiple diagnoses of mental illness, medical conditions and substance abuse, clinicians from addiction, medical, and psychiatric backgrounds must learn to make the clinical formulations for each of the concomitant disorders, using clear diagnostic standards and evidence based assessments.

One of the principal goals of the FAMHA is to quantitatively measure the degree and intensity of mental illness and substance misuse. It also profiles the interactive effects of multiple disorders that must be explored on an individual basis.

The consideration of which disorder came first, while perhaps etiologically important, should not interfere with the diagnosis and treatment of persistent conditions that exist and simultaneously interact on a functional level (Breakey, 1987; Miller, 1994).

A major advantage of using the FAMHA is that it can be quickly and effectively administered to provide diagnostic indicators and monitor the effects of treatment over time.

The following list identifies many of the characteristics that distinguish MISU, SUMI and MCSU patients which can be quantitatively assessed on the FAMHA:

3.3.3 MISU Characteristics

1) Severe mental illness exists independently of substance abuse; persons would meet the diagnostic criteria of a major mental illness even if there were not a substance abuse problem present.

2) MISU persons have a DSM-IV-R, Axis I (American Psychiatric Association, 1987) diagnosis of a major psychiatric disorder, such as schizophrenia or major affective disorder.

3) MISU persons usually require medication to control their psychiatric illness; if medication is stopped, specific symptoms are likely to emerge or worsen.

4) Substance abuse may exacerbate acute psychiatric symptoms, but these symptoms generally persist beyond the withdrawal of the precipitating substance.

5) MISU persons, even when in remission, frequently display the residual effects of major psychiatric disorders (for example, schizophrenia), such as marked social isolation or withdrawal, blunted or inappropriate affect, and marked lack of initiative, interest, or energy.

Evidence of these residual effects often differentiates MISU from populations of substance abusers who are not severely mentally ill.

3.3.4 SUMI Characteristics

1) SUMI patients have severe substance dependence (alcoholism; heroin, cocaine,amphetamine, or other addictions), and frequently have multiple substance abuse and/or polysubstance abuse or addiction.

2) SUMI persons usually require treatment in alcohol or drug treatment programs. SUMI persons often have coexistent personality or character disorders.

3) SUMI patients may appear in the mental health system due to "toxic" or "substance-induced" acute psychotic symptoms that resemble the acute symptoms of a major psychiatric disorder. In this instance, the acute symptoms are always precipitated by substance abuse, and the patient does not have a primary Axis I major psychiatric disorder.

4) SUMI patients' acute symptoms remit completely after a period of abstinence or detoxification. This period is usually a few days or weeks, but occasionally may require months.

5) SUMI patients do not exhibit the residual effects of a major mental illness when acute symptoms are in remission.

3.3.5 MCSU Characteristics

1) MCSU patients continued to use large amounts of substances even after their medical conditions have gone into remission or have been successfully treated.

2) These patients begin using psychotropic agents in an effort to seek relief from physical pain due a medical condition.

3) MCSU patients often have long term medical conditions (i.e. HIV, Heart Conditions, Autoimmune deficiencies, etc.) that reduces their level of physical functioning and makes them vulnerable to substance use disorder.

4) The hopeless and helpless feelings associated with long term or severe medical conditions produce depressive states that are reduced by the use of intoxicating or pain relieving substances.

5) The loss of physical function and range of motion often produces a reduction in psychological functioning and increases the reliance on pharmacological agents.

3.3.6 Development of the Scale

The FAMHA was developed with a variety of criteria in mind. To adequately assess MISU, SUMI, and MCSU patients in naturalistic settings, specific criteria developed by Green and Greely (1987) were applied to the scale as it was modified in development phases and pilot trials. It was felt that the FAMHA should not only assess the obvious symptom categories of major mental illness and addiction, but should also:

- include functional domains that are deemed important for community based treatment clinics;
- demonstrate reliability and validity;
- possess sensitivity to treatment-related change;
- be appropriate and relevant to the dually diagnosed population that it functionally assesses;
- be a useful tool for treatment planning and clinical governance;
- have low administration costs;
- be relatively easy to use by all levels of clinical staff.

The current version of the FAMHA meets all of these criteria and can be administered in as little as 8 minutes by a trained, experienced rater.

The FAMHA builds on the strengths of the Specific Level of Functioning scale (SLOF) (Schnieder & Struening - 1983), Symptom Checklist 90 (SCL-90R)(Derogatis, 1975), the Bellevue Psychiatric Audit (BPA)(Hardesty & Burdock, 1962) and the Addiction Severity Index, 5th Edition (ASI)(McLellan et al, 1997). It combines a variety of clinical and functional dimensions into a 46 item clinician rating scale that is subdivided into 6 biopsychosocial dimensions:

1) Socio-legal

2) Social – Community Living

3) Social – Interpersonal Skills

4) Mood

5) Psychological Functioning

6) Physical Functioning.

In addition to the dimensional scales, data as to the patient's primary and secondary drug of choice, alcohol consumption, prior mental health and addiction treatment episodes, demographics, and current medical, mental health and addiction diagnoses are also collected to add to the clarity of the diagnostic profile. It is expected that continued statistical analysis, including factor analyses of further trials, will yield more refined, discrete scale dimensions and add to the overall utility of the instrument.

Similar to the SLOF in appearance, the FAMHA uses a seven point, three way anchored Likert like scale, ranging from extremely dysfunctional symptoms or behaviours (Score 1) to normative levels of these behaviours and symptoms (Score 7).

The low end, mid-point and high points of functioning are anchored by descriptors for each item. This allows for enhanced inter rater reliability and validity of patient/ clinic-wide functional assessments.

Like the SLOF and SCL-90R, each of the 46 items of the FAMHA is evaluated on the Likert-like scale. Due to the specific nature of each of these 46 functional items, the FAMHA assumes a high degree of assessor familiarity with the patient.

The scale was designed to quantify patient functional levels more systematically than the Global Assessment of Functioning (GAF)(APA, 1994) and provides for the systematic rating of functional deficits in critical areas of that could not otherwise be assessed in this population. In addition, FAMHA overall scores are designed with a coefficient that readily converts the total score to overall GAF scores. Thus, it refines the diagnostic profile for individual patients that is necessary for appropriate diagnosis within both ICD-10 (WHO-1996) and DSM-IV (APA 1994) diagnostic systems.

3.3.7 Validity and Reliability

The concordance rates between the FAMHA total scores, sub-scores and GAF scores are currently in clinical trials and cannot yet be reported on. However, due to the high degree of similarity between the SLOF and the FAMHA, it is assumed that patient scores on each FAMHA dimension will significantly correlate with overall GAF scores and subscores.

The SLOF concordance rates for the various components were reported to be r =.67 for the social component, .60 for the psychological, and .50 for the physical component. Moderate associations were found between the SLOF substance abuse scale and the Drake et al. (1990) substance abuse scale (r =.73) (Uehara et al. 1994).

This concordance rate should be mirrored in the FAMHA, since most of these specific SLOF items are embedded in the FAMHA as well.

Further clinical trials should conclusively demonstrate the usefulness of combining level of functioning information across mental health and addiction dimensions and ultimately, validate the FAMHA as an ideal instrument for assessing dually diagnosed patients in mental health and addiction treatment settings.

To sum up this section, the FAMHA documents the outcomes of treatment by quantifying the substantial and enduring changes in client behaviours, cognitions, moods and day-to-day client functioning It also notes reductions in distress due to the effects of treatment. By determining a client's specific level of functioning across a number of domains and an overall level of functioning. specific profile emerge that can then be used for more effective treatment planning.

FAMHA assessments are client centered by their very nature and specifically relate to the distress and difficulties that each patient must endure in their daily lives. Thus, such assessments are crucial to a clients mental health, substance use, and medical recovery.

The FAMHA was designed to meet the specific clinical and research needs of practitioners/researchers in a wide variety of treatment settings. From the data currently available, it is clear that the FAMHA is a sensitive diagnostic tool for use with MISU, SUMI and MCSU patients. It's ability to document functional changes that occur throughout the treatment cycle and utility as a basic research tool to obtain specific epidemiological and diagnostic information make it an ideal instrument for use with on this severely dysfunctional and distressed population.

Self Assessment Questions

1) What are the various types of psychological assessments?

.....

.....

.....

2) Describe FAMHA.

.....

.....

.....

3) Describe the characteristics of MISU, SUMI and MCSU.

.....

.....

.....

4) How was the FAMHA scale developed?

.....

.....

.....

5) Discuss the reliability and validity of the scale.

.....

.....

.....

3.4 THE REFERRAL

The assessment process begins with a referral. Someone—a parent, a teacher, a psychiatrist, a judge, or perhaps a psychologist—poses a question about the patient. "Why is John disobedient?"

"Why can't Anita learn to read like the other children?" "Is the patient's impoverished behavioural repertoire a function of poor learning opportunities, or does this constriction represent an effort to avoid close relationships with other people who might be threatening?"

Clinicians thus begin with the referral question. It is important that they take pains to understand precisely what the question is or what the referral source is seeking. In some instances, the question may be impossible to answer; in others, the clinician may decide that a direct answer is inappropriate or that the question needs rephrasing. For example, the clinician may decide that the question "Is this patient capable of murder?" is unanswerable unless there is more information about the situation. Thus, the question might be rephrased to include probabilities with respect to certain kinds of situations. If parents want their child tested for the sole, often narcissistic, purpose of determining the child's IQ, the clinician might decide that providing such information would eventually do the child more harm than good. Most parents do not have the psychometric background to understand what an IQ estimate means and are quite likely to misinterpret it. Thus, before accepting the referral in an instance of this kind, the clinical psychologist would be well advised to discuss matters with the parents.

3.4.1 Factors that Influence Clinician Response to Referral Question

The kinds of information sought are often heavily influenced by the clinician's theoretical commitments. For example, a psychodynamic clinician may be more likely to ask about early childhood experiences than a behavioural clinician. In other cases, the information obtained may be similar, but clinicians will make different inferences from it. For example, frequent headaches may suggest the presence of underlying hostility to a psychodynamic clinician but merely evidence of job stress to a behavioural clinician. For some clinicians, case-history data are important because they aid in helping the client develop an anxiety hierarchy; for

others, they are a way of confirming hypotheses about the client's needs and expectations.

Assessment, then, is not a completely standardised set of procedures. All clients are not given the same tests or asked the same questions. The purpose of assessment is not to discover the "true psychic essence" of the client but to describe that client in a way that is useful to the referral source—a way that will lead to the solution of a problem. Of course, this does not mean that one description is as good as another for a particular case. One clinician's cognitive-behavioural formulation of a case may involve a poor understanding of cognitive-behavioural theory. There are even instances in which certain cases seem to lend themselves more to a psychodynamic description than to a behavioural description. Because of the complexity of our subject matter and incomplete state of our knowledge, there is sometimes more than one good road to Rome.

3.5 ASSESSMENT IN CLINICAL PSYCHOLOGY

Psychological assessment is utilised in clinical psychology primarily for purposes of differential diagnosis, treatment planning, and outcome evaluation.

Differential diagnosis involves drawing on assessment information to describe an individual's psychological characteristics and adaptive strengths and weaknesses. These descriptions provide a basis for determining

What type of disorder an individual may have,

The severity and chronicity of this disorder and the circumstances in which it is likely to be manifest, and

The kinds of treatment that are likely to provide the individual relief from this disorder.

With respect to further treatment planning, adequate assessment information helps to guide treatment strategies and anticipate possible obstacles to progress in therapy. As for outcome evaluation, pre-treatment assessments establish an objective baseline against which treatment progress can be monitored in subsequent evaluations, and by which the eventual benefits of the treatment can be judged at its conclusion. These clinical contributions of psychological assessment can be implemented during each of four sequential phases in delivering psychological treatment: deciding on therapy, planning therapy, conducting therapy, and evaluating therapy.

3.5.1 Deciding On Therapy

The first step in the clinical utilisation of assessment information consists of deciding whether a patient needs treatment and is likely to benefit from it. Accurate differential diagnosis identifies pathological conditions (e.g. depression, paranoia) and maladaptive characteristics (e.g. passivity, low self-esteem) for which treatment is usually indicated, and adequate psychological evaluation helps to distinguish such conditions and characteristics from normal range functioning that does not call for professional mental health intervention. Assessment methods also provide valuable information concerning two factors known to predict whether people are likely to become involved in and profit from psychotherapy: their motivation for treatment and their accessibility to being treated.

Motivation for treatment usually corresponds to the amount of subjectively felt distress that people are experiencing. Accessibility to psychological treatment typically depends on how willing people are to examine themselves, to express their thoughts and feelings openly, and to make changes in their customary beliefs and preferred ways of conducting their lives. Information derived from appropriate assessment procedures can provide clinicians with objective indices of each of these variables, and these assessment data can in turn be used as a basis for determining whether to recommend and proceed with some form of treatment.

3.5.2 Planning Therapy

- Planning therapy for patients who need and want to receive psychological treatment involves .
- Deciding on the appropriate setting in which to deliver the treatment,
- Estimating the duration of the treatment, and
- Selecting the particular type of treatment to be given.

With respect to deciding on the treatment setting, assessment data provide reliable information concerning the severity of a patient's disturbance, the patient's ability to distinguish reality from fantasy, and his or her likelihood of becoming suicidal or dangerous to others, all of which bear on whether the person requires residential care or can be treated safely and adequately as an outpatient. The more severely disturbed people are, the farther out of touch with reality they are, and the greater their risk potential for violence, the more advisable it becomes to care for them in a protected environment.

Regarding treatment duration, clinical experience and research findings consistently indicate that mild and acute problems of recent onset can usually be treated successfully in a shorter period of time than severe and chronic problems of long-standing duration. A variety of psychodiagnostic measures provide clues to the chronicity as well as the severity of symptomatic and characterological mental and emotional problems, and pretreatment data obtained with these measures can accordingly help clinicians formulate some expectation of how long a treatment is likely to last. Having available such assessment-based information on expected duration in turn assists clinicians in presenting treatment recommendations to prospective patients (Hurt, Reznikoff & Clarkin, 1991).

As for treatment selection, people who are relatively psychologically minded, self-aware, and interested in gaining fuller self-understanding are relatively likely to respond positively to an uncovering, insight-oriented, and conflict focused treatment approach. Patients whose preference is to feel better without having to examine themselves closely, on the other hand, are more likely to become actively engaged in supportive and symptom-focused approaches to treatment than in exploratory psychotherapy.

Psychologically minded people are inclined to feel dissatisfied with supportive treatment, because it does not get at the root of their problems, whereas relief-minded people tend to feel uncomfortable in uncovering treatment, because it makes unwelcome demands on them.

Additionally, there is reason to believe that some kinds of conditions and difficulties, especially in people who are problem-oriented, respond relatively well to cognitive-behavioural forms of treatment, whereas other kinds of disorders and maladaptive

tendencies, especially in people who are interpersonally oriented, respond better to psychodynamic-interpersonal than cognitive behavioural therapy (Beutler& Harwood, 1995; Hayes, Nelson & Jarrett, 1987).

Psychological mindedness and preferences for problem-oriented or interpersonally oriented approaches to life situations are among a vast array of personality characteristics that can be measured with assessment methods. Accordingly, adequately conceived pre-therapy psychological assessment can facilitate treatment planning by differentiating among psychological states and orientations of the individual that have known implications for successful response to particular treatment approaches.

3.5.3 Conducting Therapy

Psychological assessment can play a key role in conducting therapy by helping to identify in advance:

- Treatment targets on which the therapy should be focused and
- Possible obstacles to progress towards these treatment goals.

Appropriately collected assessment data, and particularly the results of a multimethod test battery, typically contain many normal range findings and often some indications as well of notably good personality strengths and especially admirable personal qualities. At the same time, especially in people who are being evaluated for symptoms or difficulties that have led them to seek professional help, test data are likely to reveal specific adaptive shortcomings and coping limitations. One person may show a penchant for circumstantial reasoning and poor judgement; another person may give evidence of poor social skills and interpersonal withdrawal; a third may exhibit considerable emotional inhibition with restricted capacity to express feelings and feel comfortable in emotionally charged situations.

In short, any assessment findings that fall outside of an established normal range and are known to indicate specific types of cognitive dysfunction, affective distress, coping deficit, personal dissatisfaction, or interpersonal inadequacy in turn assist therapists and their patients in deciding on the objectives of their work together and directing their efforts accordingly.

Some psychological characteristics of patients that constitute targets in their treatment may also pose obstacles to their becoming effectively engaged in therapy and making progress toward their goals. For example, people who are set in their ways and characteristically rigid and inflexible in their views often have difficulty reframing their perspectives or modifying their behaviour in response even to well-conceived and appropriately implemented treatment interventions. People who are interpersonally aversive or withdrawn may be slow or reluctant to form the kind of working alliance with their therapist that facilitates progress in most forms of therapy.

People who are relatively satisfied with themselves and not experiencing much subjectively felt distress may have little tolerance for the demands of becoming seriously engaged in a course of psychological treatment. Characteristics of these kinds do not preclude effective psychotherapy, but they can result in slow progress, and they may cause patients and therapists to become discouraged and terminate prematurely a treatment that does not appear to be going well.

Pretreatment assessment data serve to alert therapists in advance to possible treatment obstacles, which can help them understand and be patient with initially slow progress and also guide them in dealing directly with these obstacles, as by concentrating in the early phases of therapy on encouraging flexibility and open-mindedness, building a comfortable and trusting treatment relationship, or generating some motivation for the patient's involvement in the therapy.

3.5.4 Evaluating Therapy

Psychological assessment provides valuable data for monitoring the progress of therapy and measuring its eventual benefit. For this potential benefit of assessment to be realised, it is vital for assessment data to be collected from patients prior to their beginning treatment. In addition to helping to identify treatment targets and the long term objectives of therapy, pre-treatment data provide an objective baseline for comparison with the results of subsequent assessments.

Periodic reevaluations can then shed light on whether the treatment is making a difference, how close it has come to meeting its aims, in what way the focus of continued treatment should be adjusted, and whether a termination point has been reached. For example, if a reliable test index shows abnormally high anxiety, low self-esteem, poor self-control, or excessive anger, and a retest during treatment shows the same or a worse result for any of these treatment targets, there is objective evidence that no progress has been made on this front. Such results can then lead to an informed decision to alter the type or focus of the treatment, change the therapist, or await the next re-assessment before making any change.

On the other hand, should retesting show an index closer to an adaptive range than initially, there is reason to conclude that progress is being made on the treatment target related to that index but that further improvement remains to be made in that area. When an initially abnormal test result is found on retesting to be in an adaptive range, then therapists and their patients can conclude with confidence that they have achieved the objective to which this result relates and do not need to address it further. At the point when retesting indicates that most or all of the treatment targets have reached or are approaching as much resolution as could realistically be expected, then the assessment process helps to indicate that an appropriate termination point has been reached.

Assessments conducted at the conclusion of psychotherapy, when compared with initial baseline evaluations, provide an objective basis for evaluating the overall benefit of the treatment that has been provided. Evaluations of treatment benefit made possible by pre-therapy and post-therapy assessments serve important research and practical purposes in clinical psychology. With respect to research issues, assessment data bearing on treatment benefit facilitates comparison studies of the relative effectiveness of different types and modalities of therapy. For practical purposes, retest findings demonstrating treatment benefit bear witness to the value of psychological interventions, particularly as weighed against the financial cost of these services (Kubiszyn et al., 2000).

3.6 INSTRUMENTS

Surveys of clinical psychologists and the contents of standard handbooks concerning psychological assessment identify several instruments as being among those most widely used by clinicians in the United States for purposes of differential diagnosis,

treatment planning, and outcome evaluation. Four of these measures are relatively structured self-report inventories on which conclusions are derived from what respondents are able and willing to say about themselves: the Minnesota Multiphasic Personality Inventory, the Millon Clinical Multiaxial Inventory, the Sixteen Personality Factors Questionnaire, and the Personality Assessment Inventory.

Four of them are relatively unstructured performance based measures in which the key data consist not of what respondents say about themselves but how they deal with various kinds of somewhat ambiguous tasks that are assigned to them: the Rorschach Inkblot Method, the Thematic Apperception Test, several types of figure drawing tasks, and some alternative sentence completion methods.

Self Assessment Questions

1) What is Referral and what does it involve?

.....

.....

.....

2) Discuss the assessment in clinical psychology.

.....

.....

.....

3) How is psychological assessment used in deciding therapy?

.....

.....

.....

4) How is psychological assessment used in planning therapy?

.....

.....

.....

5) Discuss psychological assessment for conducting and evaluating therapy.

.....

.....

.....

6) State some of the instruments of clinical psychology.

.....

.....

.....

3.7 LET US SUM UP

Psychological assessment has been an integral part of clinical psychology since its inception and continues to the present day to provide practitioners with valuable information to guide their evaluation and treatment of persons who seek their help. At times, failure to appreciate the benefits of preceding treatment with thorough assessment has led to insufficient teaching and learning of psychodiagnostic methods by clinical psychologists, as has the regrettable and shortsighted devaluing of diagnostic procedures by health insurance providers. However, the future application of psychodiagnostic methods in clinical psychology appears to rest safely in the hands of practitioners and researchers who know from their experience and data how useful assessment can be in facilitating good clinical decisions.

3.8 UNIT END QUESTIONS

1) What is the definition and purpose of clinical assessment?

2) Discuss in detail the application of psychological assessment in clinical psychology?

3) Write about some of the most widely used instruments in clinical assessment?

4) Describe the FAMHA, its devising, its use, and reliability and validity.

5) How is psychological assessment used in clinical settings?

3.9 SUGGESTED READINGS

Plante, T. G. (2005). *Contemporary Clinical Psychology (2nd Ed.)*.New Jersey: John Wiley & Sons, Inc.

Trull, T.J. (2005).*Clinical Psychology (7th Ed.)*.USA: Thomson Learning, Inc.

UNIT 4 ETHICAL ISSUES IN ASSESSMENT

Structure

4.0 Introduction

4.1 Objectives

4.2 Ethics in Assessment

- 4.2.1 Mismatched Validity
- 4.2.2 Confirmation Bias
- 4.2.3 Confusing Retrospective and Predictive Accuracy
- 4.2.4 Unstandardising Standardised Tests
- 4.2.5 Ignoring the Effects of Low Base Rates
- 4.2.6 Misinterpreting Dual High Base Rates
- 4.2.7 Perfect Conditions Fallacy
- 4.2.8 Financial Bias
- 4.2.9 Ignoring Effects of Audio Recording Video Recording or the Presence of Third Party Observers
- 4.2.10 Uncertain Gate Keeping

4.3 APA Ethics Code

- 4.3.1 Ethical Principles
- 4.3.2 Ethical Standards
- 4.3.3 Standards for Educational and Psychological Tests

4.4 Ethical Issues in Assessment

- 4.4.1 Informed Consent
- 4.4.2 Confidentiality
- 4.4.3 Invasion of Privacy

4.5 Let Us Sum Up

4.6 Unit End Questions

4.7 Suggested Readings

4.0 INTRODUCTION

Wherever people live and work together, they evaluate their own actions and those of others as good or bad, justified or unjustified, fair or unfair, and they ascribe to others and to themselves in particular situations the responsibility for doing what should be done and not doing what should not be done. The entirety of the rules that these evaluations follow in everyday life is characterised as morality. Any one publicly violating them incurs the disdain of the others. Insofar as people acknowledge the existence of moral rules, they also judge themselves before their own conscience. Moral rules therefore have a high status in subjective experiencing, thinking, and acting. Morality, however, can also be misused in order to give others a bad conscience. It can likewise be employed as a weapon

to question the privileges of others or to defend one's own privileges. Finally, it can be used to create solidarity with others.

Moral rules can also find their way into national laws. But not all national laws have amoral basis. Whoever can be shown to have violated national laws must usually reckon with sanctions of the state, such as fines or prison terms. Finally, in addition to the rules of morality and the laws of the state, there are standards or norms, such as those of associations or professional organisations (American Educational Research Association, American Psychological Association). These prescribe how the members of these organisations are to conduct themselves during the performance of their professional activities. Anyone who can be demonstrated to have violated these rules is threatened in the worst instance with expulsion from the professional organisation, which in some countries can have legal consequences, namely, one can be prohibited from carrying out one's professional activities.

Assessment may be defined as "a conceptual, problem solving process of gathering dependable, relevant information about an individual, group, or institution to make informed decisions" (Turner, DeMers, Fox, &Reed, 2001, p. 1100). The importance of assessment to psychology cannot be overstated, as psychological testing may be considered "a defining practice of professional psychology since the field's inception" (Camera, Nathan, & Puente, 2000, p. 141). The outcomes of psychological assessment may be life altering, such as placing a child in special education classes, denying an applicant a job, or altering treatment of a patient.

Given the importance of assessment, it is not surprising that there are numerous ethical pitfalls for the assessor. This unit reviews the main ethical issues inherent in assessment, including competence, informed consent, and confidentiality.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Describe ethics in assessment;
- Elucidate the common fallacies in psychological assessment;
- Explain the main ethical considerations involved in psychological testing;
- Discuss the specific norms and principles that a tester is expected to adhere while testing;
- Explain confidentiality issues;
- Elucidate the APA Ethics code; and
- Describe the ethical issues in assessment.

4.2 ETHICS IN ASSESSMENT

Tests are tools used by professionals to make what may possibly be some serious decisions about a client; thus both tests and the decision process involve a variety of ethical considerations to make sure that the decisions made are in the best interest of all concerned and that the process is carried out in a professional manner. There are serious concerns, on the part of both psychologists and lay people, about the nature of psychological testing and its potential misuse, as well as demands for increased use of tests.

It must be remembered that there are certain important fallacies in psychological assessment. These have to be kept in mind while doing assessment. In addition we have many ethical considerations that have to be considered which are given in the sections below.

There are 10 common fallacies and pitfalls that plague psychological testing and assessment.

They are:

1) mismatched validity;
2) confirmation bias;
3) confusing retrospective and prospective accuracy (switching conditional probabilities)
4) unstandardising standardised tests;
5) ignoring the effects of low base rates;
6) misinterpreting dual high base rates;
7) perfect conditions fallacy;
8) financial bias;
9) ignoring the effects of audio-recording, video-recording, or the presence of third-party observers; and
10) uncertain gate keeping.

These assessment fallacies and pitfalls are discussed in more detail below.

4.2.1 Mismatched Validity

Some tests are useful in diverse situations, but no test works well for all tasks with all people in all situations. Hence selecting assessment instruments involves complex questions, such as for instance, "Has research established sufficient reliability and validity (as well as sensitivity, specificity, and other relevant features) for this test, with an individual from this population, for this task (i.e., the purpose of the assessment), in this set of circumstances?" It is important to note that as the population, task, or circumstances change, the measures of validity, reliability, sensitivity, etc., will also tend to change.

To determine whether tests are well-matched to the task, individual, and situation at hand, it is crucial that the psychologist ask a basic question at the outset: Why exactly am I conducting this assessment?

4.2.2 Confirmation Bias

Often we tend to seek, recognise, and value information that is consistent with our attitudes, beliefs, and expectations. If we form an initial impression, we may favour findings that support that impression, and discount, ignore, or misconstrue data that do not fit.

This premature cognitive commitment to an initial impression which can form a strong cognitive set through which we sift all subsequent findings is similar to the logical fallacy of hasty generalisation.

To help protect ourselves against confirmation bias (in which we give preference to information that confirms our expectations), it is useful to search actively for data that disconfirm our expectations, and to try out alternate interpretations of the available data.

4.2.3 Confusing Retrospective and Predictive Accuracy

Predictive accuracy begins with the individual's test results and asks: What is the likelihood, expressed as a conditional probability, that a person with these results has condition (or ability, aptitude, quality, etc.) X?

Retrospective accuracy begins with the condition (or ability, aptitude, quality) X and asks: What is the likelihood, expressed as a conditional probability, that a person who has X will show these test results?

Confusing the "directionality" of the inference (e.g., the likelihood that those who score positive on a hypothetical predictor variable will fall into a specific group versus the likelihood that those in a specific group will score positive on the predictor variable) causes many errors.

This mistake of confusing retrospective with predictive accuracy often resembles the affirming the consequent logical fallacy:

4.2.4 Unstandardising Standardised Tests

Standardised tests gain their power from their standardisation. Norms, validity, reliability, specificity, sensitivity, and similar measures emerge from an actuarial base, that is a well selected sample of people providing data (through answering questions, performing tasks, etc.) in response to a uniform procedure in (reasonably) uniform conditions. When we change the instructions, or the test items themselves, or the way items are administered or scored, we depart from that standardisation and our attempts to draw on the actuarial base become questionable.

There are other ways in which standardisation can be defeated. People may show up for an assessment session without adequate reading glasses, or having taken cold medication that affects their alertness, or having experienced a family emergency or loss that leaves them unable to concentrate, or having stayed up all night with a loved one and now can barely keep their eyes open. The professional conducting the assessment must be alert to these situational factors, how they can threaten the assessment's validity, and how to address them effectively.

It is our responsibility to recognise the limits of competence and to make sure that any assessment is based on adequate competence in the relevant areas of practice, the relevant issues, and the relevant instruments.

4.2.5 Ignoring the Effects of Low Base Rates

Ignoring base rates can play a role in many testing problems but very low base rates seem particularly troublesome. Imagine a psychologist has been commissioned to develop an assessment procedure that will identify crooked judges so that candidates for judicial appointment can be screened. It's a difficult challenge, in part because only 1 out of 500 judges is (hypothetically speaking) dishonest.

Let us say that the psychologist pulls together all the actuarial data that he can locate and finds that he is able to develop a screening test for crookedness based on a variety of characteristics, personal history, and test results. Let us say that his method is 90% accurate.

When this method is used to screen the next 5,000 judicial candidates, there might be 10 candidates who are crooked (because about 1 out of 500 is crooked). A 90% accurate screening method will identify 9 of these 10 crooked candidates as crooked and one as honest.

The problem is the 4,990 honest candidates. Because the screening is wrong 10% of the time, and the only way for the screening to be wrong about honest candidates is to identify them as crooked, it will falsely classify 10% of the honest candidates as crooked. Therefore, this screening method will incorrectly classify 499 of these 4,990 honest candidates as crooked.

So out of the 5,000 candidates who were screened, the 90% accurate test has classified 508 of them as crooked (i.e., 9 who actually were crooked and 499 who were honest). Every 508 times the screening method indicates crookedness, it tends to be right only 9 times. And it has falsely branded 499 honest people as crooked.

4.2.6 Misinterpreting Dual High Base Rates

As part of a disaster response team, let us say a psychologist is flown in to work at a community mental health center in a city devastated by a severe earthquake. Taking a quick look at the records the center has compiled, he notes that of the 200 people who have come for services since the earthquake, there are 162 who are of a particular religious faith and are diagnosed with PTSD related to the earthquake, and 18 of that faith who came for services unrelated to the earthquake. Of those who are not of that faith, 18 have been diagnosed with PTSD related to the earthquake, and 2 have come for services unrelated to the earthquake.

It seems almost self-evident that there is a strong association between that particular religious faith and developing PTSD related to the earthquake. That is, 81% of the people who came for services were of that religious faith and had developed PTSD. Perhaps this faith makes people vulnerable to PTSD. Or perhaps it is a more subtle association, in that this faith might make it easier for people with PTSD to seek mental health services.

But the inference of an association is a fallacy, because ninety percent of all people who seek services at this center happen to be of that specific religious faith (i.e., 90% of those who had developed PTSD and 90% who had come for other reasons) and 90% of all people who seek services after the earthquake (i.e., 90% of those with that particular religious faith and 90% of those who are not of that faith) have developed PTSD. The 2 factors appear to be associated because both have high base rates, but they are statistically unrelated.

4.2.7 Perfect Conditions Fallacy

When we are in haste, we like to assume that "all is well," that in fact "conditions are perfect." If we do not check, we may not discover that the person we are assessing for a job, a custody hearing, a disability claim, a criminal case, asylum status, or a competency hearing took standardised psychological tests and completed other phases of formal assessment under conditions that significantly distorted the results. For example, the person may have forgotten the glasses they need for reading, be suffering from a severe headache or illness, be using a hearing aid that is not functioning well, be taking medication that impairs cognition or perception, have forgotten to take needed psychotropic medication, have

experienced a crisis that makes it difficult to concentrate, be in physical pain, or have trouble understanding the language in which the assessment is conducted.

4.2.8 Financial Bias

It is a very human error to assume that we are immune to the effects of financial bias. But a financial conflict of interest can subtly affect the ways in which we gather, interpret, and present even the most routine data. This principle is reflected in well established forensic texts and formal guidelines prohibiting liens and any other form of fee that is contingent on the outcome of a case. *The Specialty Guidelines for Forensic Psychologists*, for example, state: "Forensic psychologists do not provide professional services to parties to a legal proceeding on the basis of 'contingent fees,' when those services involve the offering of expert testimony to a court or administrative body, or when they call upon the psychologist to make affirmations or representations intended to be relied upon by third parties."

4.2.9 Ignoring Effects of Audio Recording, Video Recording or the Presence of Third Party Observers

Empirical research has identified ways in which audio recording, video recording, or the presence of third parties can affect the responses (e.g., various aspects of cognitive performance) of people during psychological and neuropsychological assessment. Ignoring these potential effects can create an extremely misleading assessment. Part of adequate preparation for an assessment that will involve recording or the presence of third parties is reviewing the relevant research and professional guidelines.

4.2.10 Uncertain Gate Keeping

Psychologists who conduct assessments are gatekeepers of sensitive information that may have profound and lasting effects on the life of the person who was assessed. The gatekeeping responsibilities exist within a complex framework of federal (e.g., HIPAA) and state legislation and case law as well as other relevant regulations, codes, and contexts.

The following scenario illustrates some gate keeping decisions psychologists may be called upon to make.

Clarifying issues to the client regarding to whom the information will be conveyed when asked for, while planning an assessment is important because if the psychologist does not clearly understand them, it is impossible to communicate the information effectively as part of the process of informed consent and informed refusal. Information about who will or will not have access to an assessment report may be the key to an individual's decision to give or withhold informed consent for an assessment. It is the psychologist's responsibility to remain aware of the evolving legal, ethical, and practical frameworks that inform gatekeeping decisions.

Self Assessment Questions

1) Define and describe ethics in assessment.

.....

.....

.....

2) What are the 10 fallacies in psychological assessment?

.....

.....

.....

3) Describe what is mismatched validity and confirmation bias?

.....

.....

.....

4) Describe unstandardising standardised tests.

.....

.....

.....

5) What is ignoring effects of audio and video recording?

.....

.....

.....

6) Describe uncertain gate keeping.

.....

.....

.....

4.3 APA ETHICS CODE

The American Psychological Association has since 1953 published and revised ethical standards, with the most recent publication of *Ethical Principles of Psychologists and Code of Conduct* in 2002. This code of ethics also governs, both implicitly and explicitly, a psychologist's use of psychological tests.

4.3.1 Ethical Principles

The Ethics Code contains six general principles:

i) **Competence:** Psychologists maintain high standards of competence, including knowing their own limits of expertise. Applied to testing, this might suggest that it is unethical for the psychologist to use a test with which he or she is not familiar to make decisions about clients.

ii) **Integrity:** Psychologists seek to act with integrity in all aspects of their professional roles. As a test author for example, a psychologist should not make unwarranted claims about a particular test.

iii) **Professional and scientific responsibility:** Psychologists uphold professional standards of conduct. In psychological testing this might require knowing

when test data can be useful and when it cannot. This means, in effect, that a practitioner using a test needs to be familiar with the research literature on that test.

iv) **Respect for people's rights and dignity:** Psychologists respect the privacy and confidentiality of clients and have an awareness of cultural, religious, and other sources of individual differences. In psychological testing, this might include an awareness of when a test is appropriate for use with individuals who are from different cultures.

v) **Concern for others' welfare:** Psychologists are aware of situations where specific tests (for example, ordered by the courts) may be detrimental to a particular client. How can these situations be resolved so that both the needs of society and the welfare of the individual are protected?

vi) **Social responsibility:** Psychologists have professional and scientific responsibilities to community and society. With regard to psychological testing, this might cover counseling against the misuse of tests by the local school.

4.3.2 Ethical Standards

In addition to these six principles, there are specific ethical standards that cover eight categories, ranging from "General standards" to "Resolving ethical issues." The second category is titled, "Evaluation, assessment, or intervention" and is thus the area most explicitly related to testing; this category covers 10 specific standards:

1) Psychological procedures such as testing, evaluation, diagnosis, etc., should occur only within the context of a defined professional relationship.

2) Psychologists only use tests in appropriate ways.

3) Tests are to be developed using acceptable scientific procedures.

4) When tests are used, there should be familiarity with and awareness of the limitations imposed by psychometric issues, such as those discussed in this course.

5) Assessment results are to be interpreted in light of the limitations inherent in such procedures.

6) Unqualified persons should not use psychological assessment techniques.

7) Tests that are obsolete and outdated should not be used.

8) The purpose, norms, and other aspects of a test should be described accurately.

9) Appropriate explanations of test results should be given.

10) The integrity and security of tests should be maintained.

4.3.3 Standards for Educational and Psychological Tests

In addition to the more general ethical standards discussed above, there are also specific standards for educational and psychological tests (American Educational Research Association,1999), first published in 1954, and subsequently revised a number of times.

These standards are quite comprehensive and cover

- Technical issues of validity, reliability, norms, etc.
- Professional standards for test use, such as in clinical and educational settings;
- Standards for particular applications such as testing linguistic minorities; and
- Standards that cover aspects of test administration, the rights of the test taker and so on.

Self Assessment Questions

1) Describe the importance of APA ethics code.

.....

.....

.....

2) What are ethical principles?

.....

.....

.....

3) What do you understand by ethical standards?

.....

.....

.....

4) Describe standards for educational and psychological tests.

.....

.....

.....

4.4 ETHICAL ISSUES IN ASSESSMENT

In considering the ethical issues involved in psychological testing, three areas seem to be of paramount importance: informed consent, confidentiality, and privacy.

4.4.1 Informed Consent

The term informed consent is commonly used throughout the field of psychology; for example, consent to treatment, consent to participate in research, and consent to release information are but a few of the contexts in which consent is given and sought. Consent, however, is a legal term, and care should be given to its application within the realm of psychological assessment. While the intent here is to provide a general understanding of informed consent, the information presented should not be used in substitution for state law or ethical guidelines.

Informed consent in assessment implies that the test taker (or his or her legal guardian) has agreed to be evaluated prior to testing and after being informed of reasons for testing, intended uses of data, possible consequences (including risks and benefits), what information will be released (if any), and to whom the information will be released (APA, 1996). The APA Committee on Psychological Tests and Assessment (1996) indicated that informed consent may be desirable to obtain even when not required (e.g., court-ordered assessment). Further, even when informed consent is not required, it is advisable to inform test takers of the testing process, including who may have access to the report, unless such information will threaten the psychometric properties of the instrument or test (APA, 1996).

Typically, consent consists of three separate aspects: voluntariness, competence, and information. First, voluntariness implies that the examiner must obtain the test taker's consent "without exercising coercion or causing duress, pressure, or undue excitement or influence" (Koocher & Keith-Spiegel, 1998, p. 417).

Second, the test taker must be considered legally competent to grant consent. Unless legally deemed incompetent, all adults are assumed competent to give consent. Children, however, generally are not presumed to be competent, although the legal age to give consent varies by state. In assessing children or adults deemed legally incompetent, substitute consent should be obtained from parents, legal guardians, or from the court as applicable. Everstine and colleagues (1980) recommended obtaining consent from both the required substitute and from the incompetent person whenever possible. At the very least, information about testing in developmentally-appropriate language should be given to the legally incompetent person, and assent, or agreement, should be obtained.

Finally, the test taker must have the requisite information to consent. Sufficient information must be provided to the test taker to allow the individual the opportunity to make an informed decision regarding his or her participation in assessment. While it is unnecessary (and perhaps impossible) to review all possible outcome scenarios with the client, it is necessary to provide facts a reasonable person would need in arriving at an informed decision. Whether test results will be used in decision making, if copies of test reports will be kept in the client's file and the right to refuse testing or to withdraw at any time are examples of information that should be given to each potential test taker.

Information on feedback policies is particularly important, as it appears that psychologists do not routinely provide feedback to test takers. As recently as 1983, Berndt's survey of psychologists found that a majority favored only limited feedback to test takers, suggesting that most examiners viewed full disclosure on a regular basis as an unrealistic goal. However, APA (1996) clearly has stated that test takers have the right to feedback about testing results, unless this right is waived by the test taker prior to testing or prevented by law (e.g., when courts mandate testing for competency to stand trial). A feedback session is recommended to serve two main purposes (Welfel, 1998). First, a feedback session allows the test taker an opportunity to respond to incorrect or misleading conclusions. Second, feedback may be therapeutic for the client, promoting symptom reduction and improved client-therapist rapport.

However, special care should be given in how information is presented to the individual client. Many psychological assessment instruments are complex, even for the professional trained in its usage, psychometric properties, and interpretation. Therefore, summary reports may be more beneficial to clients than raw test data.

Reports should be written in a manner that is clear and simple and free from technical language in order to avoid misinterpretation and misunderstanding. Examiners should be available to answer specific questions about assessment results and to clarify questions raised by the client.

In summary, a good rule of thumb is "to provide as full a description as time, interest, and test security allow, [only] omitting or postponing review of results that the counselor judges would be harmful to the client's current wellbeing" (Welfel, 1998, p. 230). Regardless of the method of feedback utilised, a description of the examiner's feedback policy should be reviewed during informed consent procedures.

Information on obsolete data policies should also be reviewed with each test taker. APA (2002) requires that examiners refrain from basing recommendations or decisions on obsolete or outdated testing data. How long a psychologist may rely on certain test results depends primarily on the construct being measured (Welfel, 1998). Tests that measure rapidly changing constructs, such as depressed or anxious moods (e.g., Beck Depression Inventory, Beck Anxiety Inventory) may be valid only for several days or weeks. Other tests that measure more stable personality constructs (e.g., Minnesota Multi phasic Personality Inventory) may be valid for several months. Regardless of the tests employed, examiners should inform potential test takers of their policies on removal of such data.

Clearly, much information should be provided to test takers prior to examination. Following the presentation of this information, common practice entails asking the client to state the concept in his own words. This practice gives the examiner some degree of certainty regarding the client's understanding of consent.

Use of written documents to record the terms of consent is standard. Both client and clinician can benefit from a written contract specifying client rights and responsibilities, limitations of confidentiality, and fees for services. Documentation of informed consent should be reviewed verbally with the client in language appropriate to the client's level of understanding and free from technical jargon or colloquial terminology. As a rule of thumb, consent forms should be written at no higher than a 7th grade reading level. Additionally, the client should be given an opportunity to look over such documentation and ask questions before signing, in order to ensure understanding. Research conducted on the effects of written informed consent forms generally has found positive effects. For example, Handelsman (1990) found that the use of written consent forms increased clients' positive judgments of therapists' experience, likeability, and trustworthiness.

4.4.2 Confidentiality

There are many issues of concern when it comes to ethics, one such issue being the right to privacy. The concepts of individual rights and privacy are an essential part of our society and must be taken seriously when students are involved. The Ethical Principles assert individual rights to privacy and confidentiality as well as self-determination. The term confidentiality indicates that individuals are guaranteed privacy in terms of all personal information that is disclosed and that no information will then be disclosed without the individual's direct permission. There are times however, that confidentiality is breached because managers, for example, will seek out psychological information about their employees. Another example is that teachers may seek test scores for students, however, with the good intention of understanding issues of performance (McIntire & Miller, 2007).

Another ethical concern is the right to informed consent. Self-determination is a right to every individual which means that individuals are entitled to receive complete explanations in regards to why exactly they are being tested as well as how the results of the test will be used and what their results mean. These complete explanations are commonly known as informed consent and should be conveyed in such a way that is straight-forward and easy for students to understand. In situations involving minors or those with limited cognitive abilities, informed consent needs to come from both the student themselves as well as their parent or guardian. However, parental permission should not be confused with informed consent. Educators have a responsibility to ensure that the student as well as their parent or guardian understand all implications and requirements that will be involved in any test before it is even administered (McIntire & Miller, 2007).

Koocher and Keith-Spiegel defined confidentiality as "a general standard of professional conduct that obliges a professional not to discuss information about a client with anyone" (1998, p. 116). Confidentiality between clinician and client cannot be overstated as a critical ingredient for candid and cooperative participation. It can be argued that confidentiality is what allows psychological services to be effective, since without candid client participation assessment results can be invalid, diagnoses inaccurate, and therapy ineffective. The basis for most clients agreeing to receive psychological services is an understood agreement of confidentiality, and is among the primary reasons why informed consent is requested and documented.

It is important to ensure that clients have an understanding of the limits of confidentiality. For example, in USA, all 50 states have legal statutes which mandate disclosure of various information, including child abuse, elder abuse, suicide, and/or imminent harm to others. In addition, assessment and testing are frequently conducted for third parties that have a vested interest in the outcome of test data. For example, insurance companies and health maintenance organisations (HMOs) can and do request assessment information in order to determine eligibility for coverage or reimbursement for services rendered. Furthermore, employers, legal representatives, and schools often request testing results to aid in decision-making. The amount of information requested can vary widely from complete and full disclosure of all test data in legal proceedings to summary reports prepared for prospective employers.

Releasing information to individuals or entities other than the client presents a myriad of ethical and legal obstacles. Psychologists should refer to the APA Ethics Code (2002) for guidance. To comply with the Ethics Code, psychologists should inform test takers, prior to assessment, of any mandatory, as well as any likely, releases of information. In addition, when requests from third parties are received, psychologists should have test takers sign their consent to release specific testing information. Finally, psychologists, once granted consent, should exercise extreme caution in releasing only the necessary information to satisfy the inquiry of the third party rather than releasing the entire contents of the client's chart. As stated previously, examiners should not release secure test materials (e.g., protocols, test items) unless permission is granted from the testing publisher.

Child test takers pose special dilemmas for examiners. As previously discussed, unless granted by law, children are not considered capable of consenting to assessment. Therefore, testing results may be shared with the legal guardian who consented to the child's participation in assessment. However, a good rule of

thumb is to follow the same procedures utilised for release of information to third parties. In other words, examiners must clarify limits of confidentiality with the child and legal guardian at the outset of testing and should only release relevant information to the legal guardian.

4.4.3 Invasion of Privacy

One of the main difficulties examinees can encounter in relation to psychological tests is that the examiner might discover aspects of the client that he or she would rather keep secret. Also of concern is that this information may be used in ways that are not in the best interest of the client. The Office of Science and Technology (1967), in a report entitled *Privacy and Behavioral Research,* has defined *privacy* as " the right of the individual to decide for him/herself how much he will share with others his thoughts, feelings, and facts of his personal life" (p. 2). This right is considered to be "essential to insure dignity and freedom of self-determination" (p. 2). The invasion of privacy issue usually becomes most controversial with personality tests because items relating to motivational, emotional, and attitudinal traits are sometimes disguised. Thus, persons may unknowingly reveal characteristics about themselves that they would rather keep private. Similarly, many persons consider their IQ scores to be highly personal.

The ethical code of the American Psychological Association (1992) specifically states that information derived by a psychologist from any source can be released only with the permission of the client. Although there may be exceptions regarding the rights of minors, or when clients are a danger to themselves or others, the ability to control the information is usually clearly defined as being held by the client. Thus, the public is often uneducated regarding its rights and typically underestimates the power it has in determining how the test data will be used.

Despite ethical guidelines relating to invasion of privacy, dilemmas sometimes arise. For example, during personnel selection, applicants may feel pressured into revealing personal information on tests because they aspire to a certain position. Also, applicants may unknowingly reveal information because of subtle, non obvious test questions, and, perhaps more important, they have no control over the inferences that examiners make about the test data. However, if a position requires careful screening and if serious negative consequences may result from poor selection, it is necessary to evaluate an individual as closely as possible. Thus, the use of testing for personnel in the police, delicate military positions, or important public duty overseas may warrant careful testing. In a clinical setting, obtaining personal information regarding clients usually does not present problems. The agreement that the information be used to help clients develop new insights and change their behaviour is generally clear and straightforward. However, should legal difficulties arise relating to areas such as child abuse, involuntary confinement, or situations in which clients may be a danger to themselves or others, ethical questions often arise. Usually, there are general guidelines regarding the manner and extent to which information should be disclosed. These are included in the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* (1992), and test users are encouraged to familiarise themselves with these guidelines. Adequate handling of the issue of an individual's right to privacy involves both a clear explanation of the relevance of the testing and obtaining informed consent. Examiners should always have a clear conception of the specific reasons for giving a test.

Thus, if personnel are being selected based on their mechanical abilities, tests measuring areas such as general maladjustment should not ordinarily be administered. Examiners must continually evaluate whether a test, or series of tests, is valid for a particular purpose, and whether each set of scores has been properly interpreted in relation to a particular context. Furthermore, the general rationale for test selection should be provided in clear, straightforward language that can be understood by the client. Informed consent involves communicating not only the rationale for testing, but also the kinds of data obtained and the possible uses of the data. This does not mean the client should be shown the specific test subscales beforehand, but rather that the nature and intent of the test should be described in a general way. For example, if a client is told that a scale measures "sociability," this foreknowledge might alter the test's validity in that the client may answer questions based on popular, but quite possibly erroneous, stereotypes. Introducing the test format and intent in a simple, respectful, and forthright manner significantly reduces the chance that the client will perceive the testing situation as an invasion of privacy.

Self Assessment Questions

1) What is meant by informed consent?

.....

.....

.....

2) Describe the various issues involved in confidentiality.

.....

.....

.....

3) What is meant by invasion of privacy?

.....

.....

.....

4.5 LET US SUM UP

For psychologists conducting assessments, both ethical and legal issues must be considered. Psychologists should be familiar with the main ethical issues of competence, informed consent, and confidentiality as they relate to assessment. Remaining competent as an assessor implies psychologists should regularly seek consultation and education opportunities, as the field of assessment continues to expand and develop. Those conducting psychological assessments are encouraged to vigilantly revisit the components of informed consent and continue exploring techniques to effectively communicate the aspects of consent to their clients. Psychologists should also be aware of state and federal laws that pertain to assessment and seek clarification and consultation for legal questions as needed.

4.6 UNIT END QUESTIONS

1) Describe the various common fallacies involved in psychological assessment.

2) Describe in detail the principles and standards for assessment in APA code of ethics?

3) Elucidate the ethical issues in assessment.

4.7 SUGGESTED READINGS

Groth-Marnat, G (2003). *Handbook of Psychological Assessment (4th ed.).* New Jersey: John Wiley & Sons, Inc.

Trull, T.J. (2005). *Clinical Psychology (7th Ed.).*USA: Thomson Learning, Inc.

REFERENCES

Abeles, N. (1990). Rediscovering psychological assessment. *Clinical Psychologist,* 10, 3–4.

American Educational Research Association. (1999). *Standards for Educational and Psychological Testing*. Washington, DC: Author.

American Psychological Association Committee on Psychological Tests and Assessment. (1996). Statement on the disclosure of test data. *American Psychologist, 51*(6), 644–648.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47,* 1597–1611.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57*(12), 1060–1073.

Bennett, G. K., Seashore, H. G., &Wesman, A. G. (1981). *Differential Aptitude Tests (DAT)* (5th ed.). New York: Psychological Corporation

Beutler, L.E. & Harwood, T.M. (1995). How to assess clients in pre-treatment planning. In Butcher, J.N. (Ed.), *Clinical Personality Assessment* (pp. 59–77). New York: Oxford.

Binet, A., & Henri, V. (1896). Psychologieindividuelle. *Ann´eePsychologique*, 2, 411–465.

Caccioppo, J. T., &Tassinary, L. G. (Eds.). (1990). *Principles of Psychophysiology – Physical Social and Intervential Elements*. New York: Cambridge University Press.

Camera, W. J., Nathan, J. S., & Puente, A. E. (2000). Psychological test usage: Implications in professional psychology. *Professional Psychology: Research and Practice, 31*(2) 141–154.

Cattell, R. B., & Warburton, F. W. (1965). *Principles of Personality Measurement and A Compendium of Objective Tests*. Champaign, IL: University of Illinois Press.

Cattell, R. B., Cattell, A. K., & Cattell, H. E. P. (1994). *16 PF-Test* (5th ed.). Champaign, IL:

Cone, J.D. (1978). The behavioural assessment grid (BAG): a conceptual framework and a taxonomy. *Behaviour Therapy*, 9, 882–888.

Cronbach, L. J. (1949). *Essential of Psychological Testing* (3rd ed.). New York: Harper & Row.

Everstine, L., Everstine, D. S., Heymann, G. M., True, R. H., Frey, D. H., Johnson, H. G., et al. (1980). Privacy and confidentiality in psychotherapy. *American Psychologist, 35,* 828–840.

Feldman, R. S., &Rim´e, B. (Eds.). (1991). *Fundamentals of Nonverbal Behavior*. Cambridge: Cambridge University Press.

Fischer, J. & Corcoran, K. (1994). *Measures for Clinical Practice: A Sourcebook* (2 vols., 2nd ed.). New York: Macmillan.

French, J. W., Ekstrom, R. B. & Price, L. A. (1963). *Manual and Kit of Reference Tests for Cognitive Factors*. Princeton, NJ: Educational Testing Service.

Guilford, J. P. (1959). *Personality*. New York: McGraw-Hill.

Handelsman, M. M. (1990). Do written consent forms influence clients' first impressions of therapists? *Professional Psychology: Research and Practice*, 21(6), 451–454.

Hayes, S.C., Nelson, R.O. & Jarrett, R.B. (1987). The treatment utility of assessment. *American Psychologist*, 42, 963–974.

Hundleby, J. D., Pawlik, K., &Cattell, R. B. (1963). *Personality Factors in Objective Test Derives*. San Diego, CA: Knapp.

Hurt, S.W., Reznikoff, M. &Clarkin, J.F. (1991). *Psychological Assessment, Psychiatric Diagnosis, & Treatment Planning*. New York: Brunner/ Mazel.

Institute for Personality and Ability Testing Inc. (IPAT).

Jacobson, N.S. (1992). Behavioural couple therapy: a new beginning. *Behaviour Therapy*, 23, 493–506.

Kaufman, A. S., & Kaufman, N. L. (1983). *Kaufmann Assessment Battery for Children*. Circle Pines, MN: American Guidance Service.

Kaufman, A. S., & Kaufman, N. L. (1993). *Kaufman Adolescent and Adult Intelligence Test*. Circle Pines, MN: American Guidance Service.

Kleinbeck, O., & Rutenfranz, J. (Ed.). (1987). Arbeitspsychologie [Psychology of work]. In *Enzyklop ¨adie der Psychologie*(vol. D/III/1). G¨ottingen: Hogrefe.

Koocher, G. P., & Keith-Spiegel, P. (1998). *Ethics in psychology: Professional Standards and Cases* (2nd ed.). New York: Oxford University Press.

Korchin, S. J., &Schuldberg, D. (1981). The future of clinical assessment. *American Psychologist,* 36, 1147-1158.

Kubiszyn, T.W., Meyer, G.J., Finn, S.E., Eyde, L.D., Kay, G.G., Moreland, K.L., Dies, R.R. &Eisman, E.J. (2000). Empirical support for psychological assessment in clinical health care settings. *Professional Psychology*, 31, 119–130.

Lang, P.J. (1971). The application of psychophysiological methods to the study of psychotherapy and behaviour modification. In Bergin, A.E. & Garfield, S.L. (Eds.), *Handbook of Psychotherapy and Behaviour Change*. New York: Wiley.

Lattmann, C. (Ed.). (1989). *Das Assessment-Center-Verfahren der Eignungsbeurteilung. SeinAufbau, seine Anwendung und seinAussagegehalt* [The assessment-center procedure of aptitude assessment. Its design, application and validity]. Heidelberg: Physica Verlag.

Lezak, M. D. (1995). *Neuropsychological Assessment* (3rd ed.). New York: Oxford University Press.

McClelland, D. C. (1971). *Assessing Human Motivation*. New York: General Learning Press.

McReynolds, P. (1968). An introduction to psychological assessment. In P. McReynolds (Ed.), *Advances in Psychological Assessment* (Vol. 1). Palo Alto, CA: Science and Behavior Books.

Office of Science and Technology. (1967). *Privacy and Behavioral Research.* Washington, DC: U.S. Government Printing Office.

Pawlik, K. (1998). The psychology of individual differences: The personality puzzle. In J. G. Adair, D. B´elanger, & K. L. Dion, (Eds.), *Advances in Psychological Science* (vol. 1, pp. 1–30). Hove, UK: Psychology Press.

Pawlik, K. (Ed.) (1996). *Grundlagen und Methoden der DifferentiellenPsychologie* [Foundations and methods of differential psychology]. In *Enzyklop ¨adie der Psychologie*(vol. C/VIII/I). G¨ottingen: Hogrefe.

Rabin, A. I. (1981). Projective methods: A historical introduction . In A. Rabin (Ed.), *Assessment with Projective Techniques: A Concise Introduction* . New York: Springer.

Rohracher, H. (1969). *Kleine Characterkunde*[Brief characterology] (12th ed.). Vienna: Urban &Schwarzenberg.

Spitzer, R. L., Williams, J. B. W., & Gibbon, M. (1987). *Instruction Manual for the Structural Clinical Interview for DSM-III-R.* New York: State Psychiatric Institute.

Taylor, J. A. (1953). A personality scale of manifest anxiety. *Journal of Abnormal and Social Psychology*, *48*, 285–290.

Thurstone, L. L., &Thurstone, T. G. (1943). *The Chicago Tests of Primary Mental Abilities*. Chicago: University of Chicago Press.

Turner, S. M., DeMers, S. T., Fox, H. R., & Reed, G. M. (2001). APA's guidelines for test user qualifications. *American Psychologist*, *56*(12), 1099–1113.

Wade, T. C., & Baker, T. B. (1977). Opinions and use of psychological tests. *American Psychologist*, 32, 874-882.

Wechsler, D. (1958). *The Measurement and Appraisal of Adult Intelligence.* Baltimore, MD: Williams &Wilkens.

Wechsler, D., & Stone, C. P. (1974). *Wechsler Memory Scale II Manual.* New York: Psychological Corporation.

Welfel, E. R. (1998). *Ethics in Counseling and Psychotherapy*. Pacific Grove, CA: Brooks/Cole Publishing.

NOTES