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Psychodiagnostics

Block

2

PSYCHODIAGNOSTICS IN PSYCHOLOGY

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BLOCK 2 INTRODUCTION

Unit 1 begins the focus on assessment in all aspects of clinical psychology. Different types of assessment have different goals, and these purposes are articulated. Consideration is given to differences when assessments are geared toward direct service to patients, in consultation to other professionals, and to answer specific clinical questions or monitor clinical progress. This unit starts with the objectives of assessment, followed by presenting distinction between psycho diagnostic assessment and psychiatric consultation. Then we deal in detail the DSM IV TR diagniostic criteria. This is followed by the specific types of assessments such as the cognitive assessment, behavioural and personality assessment.

Unit 2 presents the different stages in psycho diagnostics. The practice of psychological assessment involves *considerably* and *qualitatively* more than merely administering tests, questionnaires, or behaviour ratings in a uniform way. Failure to adequately conceptualise the psycho diagnostic process, from the statement of a problem to the final interpretation of results, has created considerable confusion and contributed to psychometric inadequacies of the professional practice years back. This unit shows a condensed summary process of psychological assessment according to present day conceptualisation. In this unit successive stages of an assessment procedure are described in detail.

Procedures used in the assessment of a particular patient should, ideally, be those best suited to answer specifically the referral questions, as these emerge from earlier assessment and are clarified by the referring and testing clinicians. For such questions may be answered either through a single standardized test or a group of tests. The first half of this unit covers the definition and uses of test batteries.

Probably the single most important means of data collection during psychological evaluation is the assessment interview. **Unit 3** deals with this aspect in detail. Without interview data, most psychological tests are meaningless. The interview also provides potentially valuable information that may be otherwise unobtainable, such as behavioural observations, idiosyncratic features of the client, and the person's reaction to his or her current life situation. In addition, interviews are the primary means for developing rapport and can serve as a check against the meaning and validity of test results. The second half of this unit is concerned with the assessment interview. The skills and techniques, formats and types of interviews are discussed in detail. We start the unit with defining and describing test batteries, followed by the use of test batteries. Then we take up Assessment interview followed by skills and techniques of interview. Under this we discuss rapport, listening skills, communication, observation of behaviour etc. This is followed by presenting the various formats of interviews which includes structured, semi structured and unstructured formats of interview. Then we take up types of interviews under which we discuss the intake interviews, mental status assessment interview, crisis interviews, diagnostic interview and computer assisted interviews.

Unit 4 deals with the psychological report which is the end product of assessment. It represents the clinician's efforts to integrate the assessment data into a functional whole so that the information can help the client solve problems and make decisions. Even the best tests are useless unless the data from them is explained in a manner

that is relevant and clear, and meets the needs of the client and referral source. This requires clinicians to give not merely test results, but also interact with their data in a way that makes their conclusions useful in answering the referral question, making decisions, and helping to solve problems.

An evaluation can be written in several possible ways. The manner of presentation used depends on the purpose for which the report is intended as well as on the individual style and orientation of the practitioner. The format provided in this unit is merely a suggested outline that follows common and traditional guidelines. It includes methods for elaborating on essential areas such as the referral question, behavioural observations, relevant history, impressions (interpretations), and recommendations. In this unit we start with a definition and description of what a psychological report is and how to communicate assessment results etc. Then we present the general guidelines of writing a psychological report which includes the length of the report, degree of emphasis, domains etc. Then we discuss the models of psychological report and the levels of report which includes three levels. This is followed by a section on format of psychological report.

UNIT 1 OBJECTIVES OF PSYCHODIAGNOSTICS

Structure

1.0 INTRODUCTION

This unit begins the focus on assessment in all aspects of clinical psychology. Different types of assessment have different goals, and these purposes are articulated. Consideration is given to differences when assessments are geared toward direct service to patients, in consultation to other professionals, and to answer specific clinical questions or monitor clinical progress. This unit starts with the objectives of assessment, followed by presenting distinction between psycho diagnostic assessment and psychiatric consultation. Then we deal in detail the DSM IV TR diagniostic criteria. This is followed by the specific types of assessments such as the cognitive assessment, behavioural and personality assessment.

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Elucidate the objectives for clinical assessment;
- Describe the purpose for conducting at least three types of assessment (cognitive assessment, personality assessment, and behavioural assessment);
- Explain the purpose of psycho diagnostic assessment;
- Differentiate between psychiatric interview and psycho diagnostic testing;
- Elucidate the various types of testing;
- Analyse the logistics and details; and
- Delineate the specific types of assessment.

1.2 OBJECTIVES OF PSYCHODIAGNOSTICS

Before taking up the objectives of psycho diagnostics, let us see how psychodiagnostic testing differs from psychiatric consultation

1.2.1 Differences between Psychodiagnostic Assessment and Psychiatric Consultation

A psychiatric consultation consists of a thorough clinical interview, review of records, and observation of the patient's behaviour by a psychiatrist or psychologist. For many psychiatric concerns, this is the most appropriate referral and connects the patient with a mental health provider.

Psychodiagnostic testing is a specialised diagnostic procedure that identifies and quantifies degrees of psychopathology. In contrast to a psychiatric consultation, it uses written, oral and projective instruments to evaluate a patient's mental processes and to assess how their thinking and emotions are likely to impact their behaviour. Therefore, psycho diagnostic testing provides objective data on a patient's psychological functioning and is a useful tool for clarifying confusing clinical presentations.

Psychodiagnostic testing enhances diagnostic accuracy by controlling for subjective opinion because it uses highly reliable, standardized tests that have been validated in clinical trials. Because it is able to provide both accurate diagnostics and grade the severity of impairment, psycho diagnostic testing helps the physician or psychiatrist to make pharmacological or psychotherapeutic treatment recommendations that have the highest likelihood of success.

Psychodiagnostic testing, because of its standardized and objective qualities, aids the practitioner in developing differential treatment recommendations.

1.2.2 Referral for Psychodiagnostic Testing

Patients sometimes present confusing clinical pictures. They require sophisticated and extensive work ups to distinguish the psychological contributions that confound accurate diagnoses. Referral for psycho diagnostic testing is a valuable tool in arriving at a diagnostic decision.

Examples of appropriate referrals for psychological testing include the following:

- Patients having substance abuse problems
- Patients with possible learning disabilities
- Patients with suspected mental retardation or poor intellectual functioning
- Patients with mood disorders
- Patients with anxiety and panic disorders
- Patients who have experienced trauma
- Children and adolescents who are "acting-out"
- Patients with suspected personality disorders.

1.2.3 The Psychodiagnostic Report

The psychodiagnostic report is designed to answer specific referral questions. These may include questions regarding diagnostic clarification, differentiation between transient "state" disorders and long-standing "trait" disorders (DSM Axis I versus Axis II disorders), intellectual functioning, learning style, current psychosocial stressors, and adaptive ability.

Reports also include treatment recommendations that are based on the synthesized results of the clinical interview, mental status examination, patient's personal, family and cultural history, and findings from the standardized tests. Clinicians can use these objective recommendations to develop interventions with the highest likelihood of success.

1.2.4 Application of Psychodiagnostic Testing

Psycho diagnostic testing is a widely recognised diagnostic procedure that is used in a variety of non-medical settings. Examples include:

1) **Forensics:** In this context, 80% of psychological testing is ordered when the defendant's psychiatric condition is seen important in a criminal case. Other legal uses of psycho diagnostic testing include child custody evaluations, contested estates, wrongful termination and harassment cases, etc.

2) **Insurance Settlements:** Insurance companies rely on psycho diagnostic testing for a variety of disability and Workman's Compensation cases. Similarly, the Department of Social Services routinely uses psycho diagnostic tests to make Social Security determinations. Psycho diagnostic testing is particularly useful in ruling out malingering.

3) **Employment Environments:** Psychodiagnostic testing was originally developed during World War II a screening device to increase the efficacy in deploying military personnel in stressful situations. It is still used extensively by police departments, the military, and other employers to ensure that recruits are psychologically suited to the required tasks.

4) **School Settings:** Psychodiagnostic testing is used by counselors in schools and universities to help students make career choices based on their aptitudes and abilities. It is also the mainstay of assessments for special education placement, admission to gifted programs, and learning disability assessment.

The function of assessment in clinical practice varies greatly and can include any and all of the following objectives:

- Diagnosis and/or evaluation of clients' reason for seeking treatment
- Case conceptualisation
- Treatment planning
- Monitoring of client response to treatment
- Change clients' behaviour or cognitions through increased self-awareness (e.g., self-monitoring, behavioural experiments)
- Program evaluation or individual clinician evaluation of effectiveness.

1.2.5 Reasons for Psychodiagnostic Testing

There are many reasons for conducting a psychological assessment, and each reason requires the assessor to initiate different tasks. Likewise, selecting methods and techniques for acquiring clinical information depends on the nature and function of the assessment. Therefore, before learning how to conduct an assessment, practitioners of clinical psychology must understand why or for what purpose assessments are conducted.

In general, the major aims of assessments are to gather information about persons, systems, environments, or phenomenon (or some combination of these), and to enable *classification, description,* and *comprehension or evaluation* of current circumstances. Assessments also may be directed to *predict* future behaviours (dangerousness, suicide) or circumstances (maintaining employment). Commonly, assessments seek to respond to more than one of these goals at a time and can be tailored to address several clinical or research questions. Therefore, there will be overlap among the strategies and techniques used for collecting information for each purpose.

1.2.6 The Purpose of Diagnostic Assessment

The purpose of diagnostic assessment is to differentiate between "normal" and "abnormal" behaviour, to differentiate among various "abnormal" constellations of symptoms, and to classify individuals based on identified abnormalities or "presentation of disease" (Chaplin, 1985).

The purpose of the diagnostic interview is to arrive at an understanding of a client's presenting problem through an assessment of current life situations, developmental processes, family and developmental background, enduring personality trends, assets, and vulnerabilities, as well as manifest behaviour and responsiveness in the interview situation.

In order to conduct such psycho diagnostics, the clinician must have the following steps:

1) Signed consent form(s).
2) Audio/Video tape of interview session.
3) Verbatim transcript of audio/video tape.
4) Case report.

Conducting the Interview: The clinical psychologist is expected to explore the presenting problem and its precipitating factors in some depth. How he chooses to do so should be based on his clinical judgment, and procedures used.

1.2.7 Areas to be Covered in Diagnostic Interview

1) **Identifying Information:** Description of interview setting and role of interviewer in establishing an intake process.

   Include client's sex, age, social class, race, religion, marital status, occupation, education, and current living situation of client (with a description of the family constellation at time of interview). Also include a current level and effectiveness of functioning when you describe current living situation.

2) **Presenting Complaints:** Current symptoms, anxieties, moods, difficulties in personal and / or occupational relationships and activities. Overt reason(s) for seeking help and referral route to interviewer.

3) **Presenting Appearance:** Description of salient aspects of physical appearance and mannerisms, as well as observations of significant interactions with interviewer. Specify significant behavioural, affective, interactional observations that helped in assessing the client's problems and strengths.

4) **Precipitating Factors and History of the Problem:** Events and / or life changes that accompanied appearance of psychological distress, or appear associated with such distress. Development and course of problems since client first noticed their appearance. Previous efforts at resolution and apparent consequences.

5) **History of the Person/Social Context:** Areas of information developed will depend on the type of problem and interviewer's orientation and rationale for the interview.

   Integrate, as applicable, issues of diversity, including, but not limited to gender, sexual orientation, race, age, cultural background, socio economic status, religious or spiritual identifications, and ability or disability when addressing the following sub sections.

6) **Developmental History:** Developmental milestones and attendant stresses (e.g. early separations from family, adolescent stresses, young adult crises, etc.). The "Developmental History" and "Family History" sections can be integrated.

7) **Family History:** Family of origin, constellation, ages, ethnic racial and religious backgrounds, description of parents, siblings, and quality of relationships with such figures at critical times in childhood and adolescence, major losses, changes, and traumas within family history as evidence. Whether there has been any severe or mild psychological disturbance in family members. Such problems should be mentioned here if not included fully in earlier sections. Include the inter factional consequences of behaviour within family.

8) **School History:** Achievements, problems, aspirations significant relationship with authority figures.

9) **Peer Relations:** Significant relationships, difficulties, conflicts through life.

10) **Sexual History:** Early childhood memories, traumas / abuse, parental attitudes, reactions to physical changes at puberty, dating, sexual intercourse, masturbation, sexual orientation and/or conflicts in that area. Current attitudes toward sexuality, current sexual activity.

11) **Work History:** Relations to work roles, work, mates, authorities, job changes, central work assets and liabilities.

12) **Medical History:** Past history of significant illness, injuries, disabilities, reactions to such physical problems, family reactions to illness. Include the presence of substance abuse, use of prescription medications, cigarettes, alcohol, etc.

13) **Analysis / Formulations:** The clinical psychologist integrates material presented in the report to develop an understanding of client's major manifest and latent presenting complaints. He then uses those concepts most consistent with his orientation and most relevant to his treatment recommendation.

Regardless of theoretical orientation, appropriate integration of issues of diversity is a requirement of the professional and competent psychologist.

Self Assessment Questions

1) State the objectives of psychodiagnostic testing.

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2) Differentiate between psychodiagnostic assessment and psychiatric consultation.

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3) What should be the format and contents in psycho diagnostic report?

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4) Discuss the applications of psychodiagnotic testing.

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5) What are the purposes of diagnostic assessment?

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6) What areas should be covered in diagnostic interview?

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1.3 DSM IV (TR) DIAGNOSIS

The report must include a DSM diagnosis that addresses all five Axes with diagnostic modifiers, if or when applicable.

Recommendations

The nature of recommendations should flow from the needs of the client and the orientation of the interviewer. If interviewer's orientation emphasises treatment goals and specific modalities of therapy, recommendations along these lines should be included. If the orientation of interviewer is along a more expressive / exploratory modality, recommendations will be far less structured or definite. Rather, the interviewer might note possible areas deserving some focus in the therapy.

The interview is to last no more than 50 minutes, and no less then 45 minutes. A 60 minute interview will be allowed.

Questions that diagnostic assessments can answer include the following examples.

- A 6-year-old child is having trouble in school, and not staying in his seat during lessons: Does the child have an attention deficit disorder, an anxiety disorder, or conduct disorder?
- A 68-year-old female has been increasingly forgetful, less energetic, and confused: Is she depressed or suffering from the onset of dementia?
- Why is the 35-year-old male having chest pains and rapid heart rates without any biological explanation for these symptoms?

Answering such questions through diagnostic assessments may lead to recommendations for treatment, establishment of the clients' eligibility (or ineligibility) for disability services (e.g., disability accommodations, reimbursement from insurance companies), or simply increased understanding of patients' symptoms, which will enable other health care practitioners to work more effectively with them.

Diagnostic assessments in a psychological setting are similar in concept to physicians' medical examinations. Medical patients arrive in physicians' offices for many reasons. Depending on the motivation for the visit, physicians either focus on a specific complaint presented by the patient, or may evaluate the entire person in the search for "what's wrong?"

There is a clear mission to search for abnormality or pathology, identify the malady, and report the findings. Typically, such an examination would lead to treatment if a disease or abnormality were found. Seldom does a physician examine a patient only to identify optimal functioning; information is typically a by product of the diagnostic or physical examination. Similarly, diagnostic psychological assessments tend to be "disease" focused and are criticized for following a deficit model, rather than a balanced model of strengths and deficits.

Furthermore, behavioural and cognitive behavioural psychologists criticize diagnostic assessments for excluding contextual information about antecedents, consequences, and social, physical, and cultural environmental factors from the evaluation of persons' reported problems and symptoms. Partially, this phenomenon is a function of the classification systems that guide diagnostic evaluations.

1.3.1 Classification Systems

The *Diagnostic and Statistical Manual of Mental Disorders* (4th Edition; *DSM-IV-TR;* American Psychiatric Association, 2000) is the guide most commonly used by mental health professionals in the United States for diagnosing psychological, psychosocial, interpersonal and environmental problems in children, adolescents, and adults. The *International Classification of Disorders-10* (*ICD-10;* WHO, 1992) is also used worldwide, and is the preferred classification system by physicians.

Classification systems, as the basis for diagnostic assessments, are derived from enormous amounts of research on very large samples of the population. Their purpose is to provide nomothetic information. Nomothetic information is information that establishes general principles, norms, or laws.

With regard to the *DSM-IV-TR* (American Psychiatric Association, 2000) or *ICD-10* (WHO,1992), nomothetic information informs us how many people with certain characteristics, features, or symptoms may behave, interact with others, or reportedly feel about themselves, others, and the world around them. The information differentiates persons with such characteristics, features, or symptoms from data collected on large volumes of "normal" people, or individuals who do not have difficulty in personal, social, occupational, or academic functioning.

For example, we know that many adults with major depressive disorders often have persistent feelings of extreme hopelessness about their future, and they have felt this way for an extended period (2 weeks or more; American Psychiatric Association, 2000). Non depressed, normal persons, while in a temporary negative mood state, may endorse intermittent feelings of hopelessness about specific situations or momentary feelings of hopelessness about their futures, but they do not typically report enduring feelings of hopelessness under ordinary circumstances. It is important to remember, however, that information in the *DSM-IV-TR* and *ICD-10* is based on average scores and commonalities in self reports or evaluations, and that there are variations within the group and exceptions to the rules and criteria established. Therefore, not all persons who meet criteria for a Major Depressive Disorder will endorse having persistent feelings of hopelessness, but they will likely overlap with the majority group in other symptomatology.

The classification systems continue to evolve in accordance with the development in the fields of clinical and social psychology, anthropology, and epidemiology. The *DSM-IV-TR* is revised periodically to include information about populations and variables that had been under represented in the past. In the most recent revision, the task forces in charge of improving on the *DSM-IV-TR* have increased attention to diversity and cultural factors and strive to increase understanding and classification of patterns of symptoms that may warrant a diagnosis or specific nomenclature in future additions.

Diagnostic manuals have significant merits and have allowed for a certain degree of standardization in the field of clinical psychology. They provide a means for

professionals to communicate about clients or patients, and disseminate synthesized conclusions from volumes of research. Psychologists gear diagnostic assessments, in part, to seek confirmation or disconfirmation of persons' fit with nomothetic information.

The *DSM-IV-TR* provides a starting point for understanding clients' clinical presentations and for determining general directions for treatment planning. However, to solely rely on nomothetic information would be equivalent to taking a cookbook approach to identifying persons' problems and solutions to their problems. As you know from your own experience with others, people are much more complex. Relying on group norms and typical or common presentations would be misleading in diagnosis and treatment. Psychologists also have an ethical obligation to consider personal characteristics of individuals assessed to ensure tests are valid for the person tested, interpretation of data is appropriate, and recommendations based on test data are culturally and individually relevant (APA, 2003, 9.0). As such, nomothetic information is balanced and integrated with *ideographic* (individual) information. Ideographic assessments are characteristic of behavioural assessments, and are defined and discussed in more detail in block1.

1.3.2 Logistics and Details of Diagnostic Assessments

Mental health professionals who have training and experience using the *DSMIV-TR* or *ICD-10,* and specialised measures, inventories, or structured interviews use these tools to conduct diagnostic assessments for a variety of purposes. The APA Ethical Principles and Code of Conduct (APA, 2003) specifies that only trained qualified individuals should use psychological tests, and outlines the cautions to be taken. Clients or family members of clients might request a diagnostic assessment. Clinicians routinely incorporate diagnostic assessments into their standard practices for evaluating new clients for treatment planning.

Non mental health professional colleagues (medical professionals, school administrators, teachers), or mental health professionals who desire more precise understanding of their patients' presentations of symptoms may request consultation with professionals trained to conduct diagnostic assessments. Diagnostic assessments may also be conducted to screen, classify, or assign individuals for clinical research studies according to the information obtained. Likewise, forensic psychologists may conduct diagnostic assessments to determine clients' mental competencies to stand trial or mental states related to committed crimes.

Depending on the complexity of the client's presentation of symptoms, a diagnostic assessment may be accomplished through interviewing alone, or may require interviewing in combination with other tests and measurements. A diagnostic assessment may be one component of a comprehensive evaluation of an individual, or it may be the sole purpose of an assessment. Although diagnostic assessments may be repeated over time to determine whether temporal symptoms have been alleviated, certain diagnoses are considered unremitting, lifelong conditions (antisocial personality disorder, borderline personality disorder, narcissistic personality disorders; A. T. Beck, Freeman, Davis, & Associates,2004), and therefore, reevaluation may not occur. Unlike some forms of behavioural assessment, practitioners may conduct diagnostic assessments in almost any setting in which they work. These evaluations are not dependent on viewing clients in their naturalistic environments.

1.3.3 Clinical Examples

Example 1: For a client who is self referred to a psychologist specialising in sleep disorders, a diagnostic assessment is necessary to determine if the client indeed has a sleep disorder, and if so, what kind; or to determine if the sleep difficulties are secondary to other medical or psychological problems. Once the psychologist determines the nature of the client's difficulty, treatment interventions may be offered, or an appropriate referral made if the sleep difficulties are determined to be secondary to another psychological or medical problem.

Example 2: In psychiatric emergency rooms, psychologists may conduct diagnostic assessments to determine patients' needed level of care, and to communicate this information to triage facilities (inpatient unit, partial program, or out patient clinic) before discharging or admitting patients to other units for follow up care.

Example 3: If someone you know told you that her child has a reading disability, would you know how to help your friend assess the services that her child needs? Most professionals would need more specific information to develop recommendations or a treatment plan. For starters, what are the child's current learning strengths and difficulties, environmental supports, learning strategies used individual and family expectations, and self efficacy beliefs? Note that you can ethically help a friend consider services that might be appropriate for a particular disorder, but you cannot ethically give recommendations or treatment plans on a casual basis to personal friends and acquaintances. Assessments, just like therapy, must always be conducted within the boundaries of aformal professional relationship (APA, 2002).

1.3.4 Descriptive Assessments

Descriptive assessments, broadly described, are conducted to learn more about clients' cognitive functioning, psychosocial functioning, academic achievement, personality, behaviour, or specific needs within an identified area of interest (e.g., caregivers' needs). Assessment questions may focus on individuals, families, groups of people (e.g., group home setting; hospital unit), or person environment interactions (e.g., goodness of fit between a developmentally disabled adult and her social rehabilitation program setting).

Mental health professionals conduct these assessments to obtain background and general information necessary for better understanding of clients' problems and factors contributing to those problems. Such assessments aid professionals in planning treatment, providing academic or occupational counseling, and designing group or individual behaviour modification interventions. Researchers or program evaluators may use descriptive assessments to provide end users of their work with information about populations or programs under study.

Descriptive assessments are often combined with diagnostic assessments, and some methods of evaluation will accomplish data collection for both purposes. Data collection techniques for descriptive assessments include a combination of interviews, observation, self report inventories and questionnaires, reports by others, computerized assessment, and physiological assessment. Clinical psychologists with proper training can conduct most types of descriptive assessments. Psychologists also commonly specialise in assessments for specific aged populations (e.g., children/adolescents, adults, senior adults), disorders (e.g.,

learning disabilities, traumatic brain injury, Huntington's chorea)or psychosocial problems (e.g., court adjudicated offenders).

1.3.5 Prediction Assessments

While evaluation of current functioning is critical to most types of assessment, under certain circumstances, psychologists are also asked or required to predict clients' future behaviours or the effect or impact that situations or life events will have on individuals' thoughts, feelings, behaviours, or overall functioning.

Predictive assessments are often necessary in or for medical, forensic, and occupational settings, and traditional mental health in and outpatient settings. Given the uniqueness of individuals, and the inconsistency of behaviours characteristic of persons with certain personality disorders or other problems, most predictive assessments remain tentative and qualified as "best estimations.

The accuracy of any assessment, but especially of predictive assessments, relies on the availability, accuracy, and reliability of data about the *predictor* and *predicted* variables. Predictor variables are those factors that are presumed to proceed or co occurs with the behaviour to be predicted, and to be causally related in some way.

Some behaviours are more easily predictable than others. Assuming we have comprehensive information leading to the diagnosis, it is likely that a young adult with social anxiety, without treatment, will have difficulty delivering his 30-minute presentation to the 75 students in his college course; an older adult who had little social support other than her recently deceased spouse, who also has a history of poor coping skills, may be likely to have difficulty adjusting to widowhood, and may suffer from complicated bereavement. Such predictions are fairly easy to make, given a thorough assessment of past behaviour, current functioning, and other psychosocial variables, and the predictable nature of the behaviours in question.

When more difficult predictions of future behaviour are requested or necessary, significant consequences may be associated with the outcome of the evaluation. For example, predictions of suicide risk, dangerousness, psychological suitability for specific medical treatments, or prediction of psychological preparedness for parenthood (adoption) require psychologists to gain as much certainty as possible, since the consequences related to poor or inadequate assessment can obviously be grave.

The APA Code of Ethics cautions that predictions or recommendations made based on assessments should specify the sources of data collected and that for mandated individuals specifically (and all others, generally), appropriate informed consent must be obtained. Some examples of prediction assessments will illustrate the complexities of this work.

Psychologists working in almost any clinical setting will be faced with the need to conduct suicide and dangerousness risk assessments. Current suicide symptoms and homicidal ideation are standard components of most psychologists' intake assessment and mental status examination. When clients endorse suicidal or homicidal ideation (thoughts), further evaluation is necessary to determine the severity of these thoughts, the clients' likelihood of acting on these thoughts and plans to do so, and their ability or access to the means by which they could execute their plans.

Based on thorough assessments, clinical psychologists are expected to make predictions about a client's safety and the safety of others, before they can release the client from their presence. However, Rudd and Joiner (1998) emphasise that although the court system seems to imply that clinicians should be able to predict suicide, empirical data show that "prediction" models of suicide consistently fail; therefore, the complexity of this task cannot be overstated.

Based on research reviewed by Rudd and Joiner, clinicians' "risk" assessments (focusing on patients' current state) are more accurate and reliable than actual predictions (implying future behaviour) of suicide attempts or completion. Risk assessment for suicide consists of evaluation of predisposing factors (e.g., age, sex, previous psychiatric diagnosis, history of suicidality), acute and chronic risk factors and precipitating factors (current stressors or losses, such as job, loved ones, physical or cognitive ability, chronic pain, affective disorders, poor problem solving skills, social isolation, poor impulse control), and protective factors (active involvement in treatment, good physical health, good problem solving ability, social support, hopefulness).

In medical settings, physicians constantly make decisions and predictions about patients' likely physical response to medications, medical interventions (e.g., surgery, radiation, organ transplantation), and treatments (e.g., light therapy). However, many physicians recognise that biological responses are not the only concern. Patients' compliance with medical regimens and ability to cope with necessary lifestyle and behavioural changes can be equally important. Clinical (or clinical health) psychologists aid physicians' decision making and treatment planning for patients by conducting predictive assessments relating to these issues.

For example, organ transplant recipients must comply with medication and behavioural (bone marrow transplant recipients must stay away from crowds for 6 months to 1 year, due to low immune functioning) regimens following transplants. Many recipients take as many as 5 to 10 medications following the transplant, including anti rejection medications to prevent their bodies from rejecting the new organ. If patients do not comply with this requirement, fatal consequences could result.

Physicians, therefore, want to be as certain as possible that treatment is truly in an individual's best interest. Likewise, individuals with histories of drug or alcohol abuse may be questionable candidates for some medical treatments because of the potential for them to cope poorly with the short or long term effects of treatment, and the lethality of mixing alcohol or drugs with the prescribed regimen they may be given. Psychologists must assess patients' past behaviours, current functioning (emotional state, desire or motivation for treatment, coping skills), psycho social resources (strength in faith or spirituality, social support), and other factors, to evaluate the strengths and potential threats or weaknesses that can impact future behaviour.

Psychologists working in forensic settings are likely to conduct predictive assessments for various reasons. For offender populations, prediction of recidivism is likely required as part of court system procedures relating to sentencing and parole, and defendant and plaintiff initiated evaluations. Family/marital lawyers also frequently hire clinical and forensic psychologists to evaluate clients' current functioning (descriptive assessment or diagnostic assessment), and predict future behaviours. Behaviours of interest in family/marital law might include clients' likelihood of future abusive behaviours; clients' future abilities to manage anger

and aggression if rehabilitation is sought; clients' likelihood of complying with child custody mandates and abilities to maintain effective parenting skills, and children's predicted responses to custody arrangements. Numerous other examples exist.

Occupational settings provide rich opportunities for psychological assessment. Questions to be answered in occupational settings may relate to the workforce in a company as a whole, or individuals within a work force. Prediction assessments might be sought to answer questions such as the following ones:

1) What is the likelihood of this employee's occupational success, given the specific accommodations and training available?

2) What variables are predictive of burnout in persons with a particular job or position?

3) What is the likely psychological impact of a specified corporate change on upper level management?

Psychologists working in employee assistance programs may conduct more traditional clinical prediction assessments.

Thus far, descriptions and examples of the goals and types of assessments clinical psychologists conduct have remained general. The following section describes several specific types of assessment that are conducted to answer specific questions.

Self Assessment Questions

1) What are the criteria given in DSM IV TR diagnosis?

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2) Discuss in detail the classification system of DSM IV TR.

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3) What are the logistics and details of diagnostic assessments?

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4) What is a descriptive assessment?

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5) Discuss in detail the predictive assessments.

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1.4 SPECIFIC TYPES OF ASSESSMENT

To differentiate among the different types of assessment, several key questions are answered within each of the following subsections to address the elements of what, when, who, where, why, and how.

1) What are the goals of assessment?

2) When, relative to other life events, will the assessment take place?

3) Who requests the evaluation or who refers clients for specific assessments?

4) Who is (are) the person(s) to be evaluated?

5) Where will the assessment be conducted?

6) Why is the assessment necessary?

7) How will the information be used?

The answers to these questions vary depending on the assessment prescribed. Some overlap can also be noted as the different applications of assessment are illustrated.

Although classifying an individual as mentally retarded may be useful for communicating a person's general functioning level among professionals, describing the person's strengths, weaknesses, likes and dislikes, will be equally or more important in the development of a behaviour modification plan.

1.4.1 Cognitive Assessment

Cognitive assessment focuses on understanding brain behaviour relationships, information processing, and thinking skills. The following critical aspects of cognition may be targeted for assessment: attention, perception, memory, schemas, learning (intelligence; achievement; aptitude), cognitive development, creativity, language, problem solving, decision making, and judgment. Neuropsychological tests, intelligence tests, achievement and aptitude tests, and development tests are specific types of cognitive assessments for evaluating these areas.

Clinicians who conduct or request cognitive assessments are interested in understanding individuals' skills (strengths and deficits), abilities, and limits, and comparing these skills and abilities with clients' own displayed affect and behaviours. Individuals' functioning is usually compared with their own previous or prospective functioning, to normative standards predetermined by research, or both. Some high schools require youth football players (and other sports participants) to have cognitive assessments prior to beginning the football season. These baseline assessments provide individual norms that are later used for comparison with post injury (concussions) cognitive assessments if football players are hurt during the season. Cognitive assessments may be conducted periodically to evaluate positive

or negative change overtime, such as yearly achievement testing in language development or mathematics skills.

Intelligence testing exemplifies an assessment done to evaluate individuals' functioning compared with normative standards: parents may request IQ (intelligence quotient) testing to determine children's scholastic needs and readiness to begin elementary school, or later in life for psycho educational planning.

Other reasons cognitive assessments may be indicated are numerous. Cognitive assessments may be required when persons are not reaching expected developmental milestones, such as language skills. Self recognition or by others of non normative (non average) behaviour, either positive (superior intellectual abilities, creativity), or negative (attention problems, extreme emotional lability), often generates referrals for cognitive assessment. Significant changes in cognitive functioning are usually noticed by individuals, family, and friends, and often lead to visits to primary care physicians or emergency rooms; these health professionals may require psychologists' assistance in diagnosing or understanding the cause for the behaviour change (Rozensky, Sweet, & Tovian, 1997).

Such sudden or gradual behaviour changes may have resulted from a known external event (accident), or a known or initially unknown biological change (tumor, medication side effects, aging process). Thus, cognitive assessments are useful for individuals across the life span, for purposes of diagnosis, understanding, and treatment or future planning.

1.4.2 Personality Assessment

Definition of Personality

Various theorists have defined *personality* in many ways, over the many years that the discipline of psychology has evolved. Most definitions and theorists have agreed that personality refers to stable, enduring characteristics that uniquely define individuals' ways of being or of viewing life situations, theworld, and others in it (see Chaplin, 1985, for various definitions). Furthermore, personality may be defined using the terminology of individuals' temperament and traits.

Temperament

This refers to a person's disposition and is often assumed to be largely biologically predetermined. Much research on temperament has been conducted on infants and children. Equating temperament with personality may be appropriate according to some psychological theories, especially those rooted in the psychodynamic traditions or medical models; other theories might suggest that persons are born with a particular temperament, and stable characteristics develop in addition to this biologically predetermined disposition to result in personality.

Traits

These refer to individuals' relatively stable ways of thinking or behaving, or their disposition that may develop over time. The term trait implies that the environment and one's interaction with it or others may formatively develop one's personality. Traits differ from persons' behaviours, that is, traits refer to how people *are;* behaviours describe what people *do.* If you had to describe your best friend in three sentences, what would you say? Perhaps, you might say thatyour friend is "fun or funny," "loyal," "kind and compassionate," "trustworthy,""sociable," "outgoing," or other similar descriptors.

Most people define others in global terms, describing the most characteristic style of the individuals. They attach these global terms based on behaviours they have observed. Your friend may be described as "funny" because she tells jokes and elicits laughter. Some people are described as having "different personalities" depending on the social context (e.g., social versus business). Descriptors, such asthose of your friend, are typically representative of the combination of temperament and traits, or his or her "personality."

How did you arrive at the description of your friend? If you are like most people, you have observed your friend in various situations or in interactions with you. You observed her behaviour and the emotions she expressed. You also noticed her consistent ways of viewing herself and relating to others and her environment, and made inferences based on these observations. In essence, you have conducted a personality assessment, because formal assessment relies on similar processes!

Possible goals and objectives of formal personality assessment are diagnosis and understanding of persons' ways of relating to others and the environment for the purpose of description, prediction, and treatment in clinical or counseling (career vocational) settings, employment settings, or forensic settings, among others. In your assessment of your friend, you have diagnosed (classified your friend) and attempted to understand him or her. (Don't worry; if you have chosen to pursue a career in clinical psychology, you will often be accused of or asked if you are analyzing your friends anyway!)

Substantial training in psychometrics, test theory, test development, diversity variables (ethnicity, race, culture, gender, age, language, disabilities), and supervised experience are required for use of most psychological tests, including personality tests (S. M. Turner, DeMers, Fox, & Reed, 2001).

1.4.3 Behavioural Assessment

Behavioural assessment aims to identify the frequency, context, and most importantly, the function of a person's behaviour. The focus of behavioural assessment is on *individual, specific* behaviours and comparison of the person's behaviour across situations and in different environments (home, school, work, social situations).

Behavioural assessment developed from the principles of behavioural therapy, and therefore, emphasises the importance of behavioural chains, or the relationships between stimuli and responses, and behaviours and consequences. In the truest sense, behavioural assessments focus only on operationally defined, overt, observable behaviour that can be objectively measured.

Behaviour has been more broadly defined over time with the merging of the cognitive and behavioural theoretical orientations and principles. Behaviours sometimes may refer to cognitive processes such as *coping,* which has overt and covert components. Behaviourists may accept this leniency in the definition with the caveat that covert processes may be considered internal behaviours. For the purpose of this discussion, however, behavioural assessment will be reviewed in its truest form.

In general, psychologists might adopt a behavioural assessment paradigm as a means for evaluating clients and conceptualising their problems (Haynes & O'Brien, 2000; A. M. Nezu et al., 1997). As a paradigm, clinicians who base all assessments on this model do so because it is usually largely consistent with their theoretical

orientation to understanding human behaviour, and their approach to assessment and treatment of patients.

Self Assessment Questions

1) Discuss in detail the cognitive assessment.

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2) Describe how personality is assessed?

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3) What is involved in behavioural assessment?

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1.5 LET US SUM UP

Psychological assessments generally seek to classify, describe, or predict clients' psychological functioning and behaviours. Many referral or assessment questions require evaluations structured to accomplish more than one of these goals. Clinical psychologists conduct assessments in various settings, assuming various roles (e.g., consultant, health care team, independent practitioner).

1.6 UNIT END QUESTIONS

1) A psychologist who claims that Test X can predict a behaviour with 100% accuracy, most likely is breaking the ethical principle of integrity. True or False?

2) The purpose of diagnostic assessment is to classify individuals based on identified abnormalities or "presentation of disease" True or False?

3) Mental health professionals conduct diagnostic assessments to obtain background and general information necessary for better understanding of clients' problems and factors contributing to those problems. True or False?

4) Predictor variables are those factors that are presumed to precede or co-occur with the behaviour to be predicted, and to be causally related in some way. True or False?

5) Clinicians who conduct or request cognitive assessments are interested in understanding individuals' skills (strengths and deficits), abilities, and limits. True or False?

6) Trait refers to stable, enduring characteristics that uniquely define individuals' ways of being or of viewing life situations, the world, and others in it. True or False?

7) Temperament refers to a person's disposition and is often assumed to be largely biologically predetermined. True or False?

8) The term trait implies that the environment and one's interaction with it or others may formatively develop one's personality. True or False?

9) Behavioural assessment developed from the principles of psychoanalytic therapy. True or False?

10) Data collection techniques for descriptive assessments include a combination of interviews, observation, self-report inventories and questionnaires, reports by others, computerized assessment, and physiological assessment. True or False?

11) Discuss in depth the objectives of psychodiagnostics with relevant examples?

12) Describe the several specific types of assessment that are conducted to answer specific questions in psychological assessment with examples?

1.7 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.

UNIT 2 DIFFERENT STAGES IN PSYCHODIAGNOSTICS

Structure

2.0 INTRODUCTION

The practice of psychological assessment involves *considerably* and *qualitatively* more than merely administering tests, questionnaires, or behaviour ratings in a uniform way. Failure to adequately conceptualise the psychodiagnostic process, from the statement of a problem to the final interpretation of results, has created considerable confusion and contributed to psychometric inadequacies of the professional practice years back. This unit shows a condensed summary process of psychological assessment according to present day conceptualisation. In this unit successive stages of an assessment procedure are described in detail.

2.1 OBJECTIVES

After reading this unit, you should be able to:

- Understand that there are different stages in the assessment process; and
- Discuss in detail the stages in psychological assessment.

2.2 PSYCHODIAGNOSTICS

This is a branch of psychology concerned with the use of tests in the evaluation of personality and the determination of factors underlying human behaviour.

1) Any of various methods used to discover the factors that underlie behaviour, especially maladjusted or abnormal behaviour.

2) The branch of clinical psychology that emphasises the use of psychological tests and techniques for assessing mental illness.

   - the science or art of making a personality evaluation.
   - the diagnosis of a mental disorder.

Psychodiagnostic Assessment of Children: Dimensional and Categorical Approaches provides comprehensive guidelines for assessing and diagnosing a

broad spectrum of childhood disorders. In this groundbreaking new text, Randy Kamphaus (coauthor of the BASC and BASC-II) and Jonathan Campbell discuss both theoretical and practical aspects of the field. Their detailed coverage provides students and professionals with important research findings and practical tools for accurate assessment and informed diagnosis.

This monumental new work begins by explaining dimensional (e.g., classification methods that emphasise quantitative assessment measures such as behaviour rating scales) and categorical (e.g., classification methods that emphasise qualitative assessment measures such as clinical observation and history-taking) methods of assessment and diagnosis. It then highlights assessment interpretation issues related to psychological assessment and diagnosis. The remainder of the text covers constructs and core symptoms of interest, diagnostic standards, assessment methods, interpretations of findings, and case studies for all of the major childhood disorders.

The disorders include:

- Mental retardation
- Learning disability
- Autism spectrum disorders
- Depression
- Anxiety disorders
- Traumatic brain injuries
- Eating disorders
- Attention deficit hyperactivity disorder
- Conduct disorder
- Oppositional defiant disorder
- Substance abuse and dependence
- Sub syndromal and hyper syndromal impairments

Psychodiagnostics is understood in two ways:

1) In the broadest sense it refers to moving closer to the psychological measurement in general and may refer to any object, verifiable psychodiagnostic analysis, speaking as the identification and measurement of its properties;

2) In a narrow sense, a more widespread measuring of the individual — psychodiagnostic personality traits.

In psychodiagnostic the data or information gathering can be divided into three main phases:

1) Collection of data.

2) Processing and interpretation of data.

3) Decision making that is psychodiagnosis and prognosis.

Psychodiagnostics develops methods for detecting and measuring individual psychological characteristics of personality.

As a theoretical discipline, psychodiagnostics deals with variables and constants that characterise the inner world of man.

Psychodiagnostics is a way to verify the theoretical constructions . It is a way of moving from abstract theory, generalised to the particular facts.

Theoretical psychodiagnostic relies on the basic principles of psychology:

i) Principle of reflection — an adequate reflection of the world provides a person an effective regulation of its activities;

ii) Principle of development — orienting study of the conditions of psychic phenomena, their trends, qualitative and quantitative characteristics of these changes;

iii) Principle of the dialectical relation of essence and phenomenon — allows you to see the mutual conditioning of the philosophical categories of the material of psychic reality as long as they non identical;

iv) principle of the unity of consciousness and activity — consciousness and mind are formed in human activity, the activity is regulated by both consciousness and psyche;

v) Personal principle — requires psychological analysis of individual to individual, taking into account its specific situation in life, its ontogeny.

These principles underpin the development of psychodiagnostic methods —ways of obtaining reliable data on the content of the variables of mental reality.

The emergence of psycho-diagnostics, as a science and basic stages of its development.

psychodiagnosis modern history begins with the first quarter of the nineteenth century, that is the beginning of a period of clinical development psychodiagnostic knowledge. Doctor psychiatrists have begun to conduct clinics systematic monitoring of patients, recording and analysing the results of their observations.

At this time there are psychodiagnostic methods such as observation, interviews, analysis of documents. But these methods were qualitative, and therefore on the same data different doctors often have different conclusions.

Modern methods of psycho diagnostics on the main psychodiagnostic processes, properties and states rights have appear in the late nineteenth and early twentieth century. At this time actively developing the theory probability and mathematical statistics, which later became build scientific methods of quantitative psychodiagnosis.

Psychological Assessment versus Psychological Testing

It is important to note the difference between psychological assessment and psychological testing. Testing is a relatively straight forward process wherein a particular test is administered to obtain a specific score. Subsequently, a descriptive meaning can be applied to the score based on normative, nomothetic findings. For example, when conducting psychological testing, an IQ of 100 indicates a person possesses average intelligence.

Psychological assessment, however, is a quite different enterprise. The focus here is not on obtaining a single score, or even a series of test scores. Rather, the focus is on taking a variety of test derived pieces of information obtained from multiple methods of assessment, and placing these data in the context of historical information, referral information, and behavioural observations in order to generate a cohesive and comprehensive understanding of the person being evaluated.

These activities are far from simple. They require a high degree of skill and sophistication to be implemented properly.

Thus, personality assessment is a complex clinical enterprise where the tools of assessment are used in concert with data from referring providers, clients, families, schools, courts, and other influential sources.

Although tests form the cornerstone of the work, personality assessment is the comprehensive interpretation of a person given all relevant data. This is not an easy enterprise and relies on substantial clinical skill, knowledge, and experience. However, if done well, the results can be very fulfilling for both clinicians and clients alike.

Monitoring of Treatment

Personality assessment tests have shown to be sensitive to the changes that clients experience in psychotherapy. Some measures, such as the Beck Depression Inventory were specifically designed to be used as adjuncts to treatment by measuring change.

Personality assessment results can be used as baseline measures, with changes reflected in periodic retesting. Clinicians can use this information to modify or enhance their interventions based on test results.

Use of Personality Assessment as treatment

The Therapeutic Assessment model was developed to increase the utility of personality assessment and feedback by making assessment and feedback a therapeutic endeavor. Based on the principles of self and humanistic psychology, the therapeutic Assessment model views assessment as a collaborative endeavour in which both the client and the assessor work together to arrive at a deeper understanding of the client's personality, interpersonal dynamics, and present difficulties.

The client becomes an active collaborator in a mutual process to better understand the nature of his or her concerns and the assessor discusses (rather than delivers) test results in a manner that is comfortable and understandable to the client. This approach stands in contrast to the more typical information gathering approach to assessment often used in neuropsychological and/or forensic psychology practice, where clients are less engaged in the process of assessment, and feedback may be provided in only a brief summary or written format.

2.3 PSYCHODIAGNOSTIC ASSESSMENT

Assessment consists of evaluating the relative factors in a client's life to identify themes for further exploration.

Diagnosis which is sometime a part of the assessment process consists of identifying a specific mental disorder based on a pattern of symptoms that leads to a specific

diagnosis found in the DSM IV TR. Both assessment and diagnosis are intended to provide direction from the treatment process.

Psychodiagnostics (psychological diagnosis) is a general term covering the process of identifying and emotional or behavioural problem and making a statement about the current status of a client. Psychodiagnostics may also include identifying a syndrome that conforms to a diagnostic system such as the DSM IV TR. This process involves identifying possible causes of the person's emotional, cognitive, physiological and behavioural difficulties leading to some kind of treatment plan designed to ameliorate the identified problem.

The clinician must carefully assess the client's presenting symptoms and think critically about how this particular conglomeration of symptoms impair the client's ability to function in his daily life. Practitioners often use multiple tools to assist them in this process, including clinical interviewing, observation, psychometric tests and rating scales.

Differential diagnosis is the process of distinguishing one form of mental disorder from another by determining which of two (or more) disorders with similar symptoms the person is suffering from. The DSM IV TR is the standard reference for distinguishing one form of mental disorder from another. It provides specific criteria for classifying emotional and behavioural disorders and shows the differences among various disorders. In addition to describing cognitive, affective, personality disorders this also deals with a variety of disorders pertaining to developmental stages, substance abuse, moods, sexual and gender identity, eating, sleep, impulse control and adjustment.

Unless a thorough picture of the client's past and present functioning is formed, specific counseling goals cannot be formulated. Furthermore, evaluation of progress, change, improvement or success may be difficult without an initial assessment.

Assessment, Diagnosis and Contemporary Theories of Counselling

Psychoanalytic theory: Some psychoanalytically oriented therapists favour psychodiagnostics. This is partly due to the fact that for a long time in the United States psychoanalytic practice was largely limited to practitioners of medicine. Some of these psychodynamically oriented therapies note that in its effort to be theory neutral the DSMIV TR eliminated terminology linked to psychoanalytical perspective.

Adlerian theory: Assessment is basic part of Adlerian therapy. The initial sessions focus on developing a relationship based on a deeper understanding of the individual's presenting problem. A comprehensive assessment involves examining the client's life style. The therapist seeks to ascertain the faulty, self defeating beliefs and assumptions about self, others and life that maintains the problematic behavioural patterns the client brings to therapy.

Existential theory: The main purpose of existent clinical assessment is to understand the personal meanings and assumptions clients use in structuring their existence. This approach is different from the traditional diagnostic framework because it focuses on understanding the client's inner world and not on understanding individual from an external perspective.

Person centered theory: The best vantage point to understand another person is through his subjective world. They believe that the traditional assessment and diagnosis are detrimental because they are external ways of understanding client.

Gestalt theory: Gestalt theory gathers certain types of information about their client's perceptions to supplement the assessment and diagnostic work done in the present moment. Gestalt therapists attend to interruptions in the client's contacting functions and the result is a functional diagnosis of how individuals experience satisfaction or blocks in their relationship with the environment.

Behaviour theory: This begins with a comprehensive assessment of the client's present functioning with questions directed to past learning that is related to current behaviour. Practitioners with a behavioural orientation generally favour a diagnostic stance valuing observation and other objective means of appraising both a client's specific symptoms and the factors that have led up to the client's malfunctioning.

Thus every theory requires that there is a thorough psychodiagnostic assessment before one could plan any kind of intervention.

2.4 STAGES IN PSYCHODIAGNOSTICS

Sundberg and Tyler (1962) described the course of clinical assessment as a flow through four major stages:

1) **Preparation:** In which the clinician learns of the patient's problem, 'negotiates' the referral questions, and plans further steps in assessment;

2) **Input:** during which data about the patient and his situation are collected;

3) **Processing:** during which the material collected is organised, analysed and interpreted; and

4) **Output:** during which the resulting study of the person is communicated and decisions as to further clinical actions made.

Depending on whether the clinician favours a psychometric or clinical orientation there will be greater or lesser use of statistical prediction or of clinical interpretation.

Below is the general outline of the stages or phases of clinical assessment found in books of psychological testing and which can provide both a conceptual framework for approaching an evaluation and a summary of some of the points already discussed in blocks. Although the steps in assessment are isolated for conceptual convenience, in actuality, they often occur simultaneously and interact with one another. Through out these phases, the clinician should integrate data and serve as an expert on human behaviour rather than merely an interpreter of test scores. This is consistent with the belief that a psychological assessment can be most useful when it addresses specific individual problems and provides guidelines for decision making regarding these problems. The stages are as follows:

Application of Psychodiagnotic Evaluations

This includes the following areas in which psychodiagnostic assessment is applied.

- psychological and emotional injury
- psychosomatic disorders

- Workers compensation
- Industrial injury
- Occupational stress
- Sexual harassment and discrimination suits
- Disability determinations
- Maritime stress claims
- Workplace violence
- Fitness for duty
- Competence to stand trial
- Criminal responsibility

Evaluating the Referral Question

Many of the practical limitations of psychological evaluations result from an inadequate clarification of the problem. Because clinicians are aware of the assets and limitations of psychological tests, and because clinicians are responsible for providing useful information, it is their duty to clarify the requests they receive. Furthermore, they cannot assume that initial requests for an evaluation are adequately stated. Clinicians may need to uncover hidden agendas, unspoken expectations, and complex interpersonal relationships, as well as explain the specific limitations of psychological tests. One of the most important general requirements is that clinicians understand the vocabulary, conceptual model, dynamics, and expectations of the referral setting in which they will be working (Turner et al., 2001).

Clinicians rarely are asked to give a general or global assessment, but instead are asked to answer specific questions. To address these questions, it is sometimes helpful to contact the referral source at different stages in the assessment process. For example, it is often important in an educational evaluation to observe the student in the classroom environment. The information derived from such an observation might be relayed back to the referral source for further clarification or modification of the referral question. Likewise, an attorney may wish to somewhat alter his or her referral question based on preliminary information derived from the clinician's initial interview with the client.

Psychodiagnostic testing enhances diagnostic accuracy by controlling for subjective opinion because it uses highly reliable, standardized tests that have been validated in clinical trials. For example: the reliability of the Wechsler Adult Intelligence Scale, which measures cognitive abilities and determines intelligence quotients, ranges from impressive .93 to .97. Because it is able to provide both accurate diagnostics and to grade the severity of impairment, psychodiagnostic testing helps the physician or psychiatrist to make pharmacological or psychotherapeutic treatment recommendations that have the highest likelihood of success. "Differential therapeutics", the prescription of effective treatments and proscription of ineffective ones, is the standard of care in contemporary medicine. Psychodiagnostic testing, because of its standardized and objective qualities, aids the practitioner in developing differential treatment recommendations.

Patients sometimes present confusing clinical pictures. They require sophisticated and extensive work-ups to distinguish the psychological contributions that confound accurate diagnoses and/or treatment of their conditions. Referral for psychodiagnostic testing is a cost-effective and valuable tool in the diagnostic decision-tree.

Examples of appropriate referrals for psychological testing include:

- Patients whom you suspect have substance abuse problems
- Patients with possible learning disabilities
- Patients with suspected mental retardation or poor intellectual functioning
- Patients with mood disorders
- Patients with anxiety and panic disorders
- Patients who have experienced trauma
- Children and adolescents who are "acting-out"
- Patients with suspected personality disorders

The psychodiagnostic report is designed to answer specific referral questions. These may include questions regarding diagnostic clarification, differentiation between transient "state" disorders and long-standing "trait" disorders (DSM Axis I versus Axis II disorders), intellectual functioning, learning style, current psychosocial stressors, and adaptive ability. Reports also include treatment recommendations that are based on the synthesized results of the clinical interview, mental status exam, patient's personal, family and cultural history, and findings from the standardized tests. Clinicians can use these objective recommendations to develop interventions with the highest likelihood of success

The information to be gathered in psychodiagnostics step by step are given below.

Step by step procedure in psychodiagnostics

1) State the client's name, age, date of evaluation and examiner. Document the reason for referral. This section captures why a professional psychological assessment was requested and the expected outcome recommendation type such as special education placement, diagnosis, need for therapeutic intervention and competence.

2) Summarize background information on the client. This report section should be broken up into categories of related information such as medical conditions, test, and medications; clinical history, developmental milestones, education, behaviour, social situation and family. Each subsection should be presented in chronological order.

3) Provide client information details extracted from interviews with parents or family members that were part of the evaluation procedure. Include facts and professional impressions.

4) Report on your observations of the client during testing and interviewing. If evaluating a young child, include data on free-play behaviour and interactions with parents or siblings.

5) List tests used. Because your report may be read by non-professionals, it is helpful to provide a brief description of what each test measures. Report test results. List test and scoring by section, subtest or total score.

6) Interpret the test results. This critical section of the report can be approached in several ways: you can report the meaning of the results of each test, tie the results to the initial reasons for evaluation, or integrate the results by category such as intellectual ability, competence, interpersonal skills, neuropsychological factors and mental status.

7) Write a summary and recommendations. For this section, integrate information from all sections of the report into a capsule of your diagnosis using the DSM IV, your conclusions relative to the reason for evaluation, key findings about the client and recommendations.

8) Acknowledge the confidentiality of the report information on each page. Print the report on letterhead stationery, sign your name and provide your professional credentials including license number and licensing authority.

Mental Status Examination

The history and Mental Status Examination (MSE) are the most important diagnostic tools a a clinical psychologist or a psychiatrist has to obtain information to make an accurate diagnosis. Although these important tools have been standardized in their own right, they remain primarily subjective measures that begin the moment the patient enters the office. The clinician must pay close attention to the patient's presentation, including personal appearance, social interaction with office staff and others in the waiting area, and whether the patient is accompanied by someone (i.e., to help determine if the patient has social support). These first few observations can provide important information about the patient that may not otherwise be revealed through interviewing or one-on-one conversation.

When patients enter the office, pay close attention to their personal grooming. One should always note things as obvious as hygiene, but, on a deeper level, also note things such as whether the patient is dressed appropriately according to the season. Other behaviours to note may include patients talking to themselves in the waiting area or perhaps pacing outside the office door. Record all observations.

The next step for the interviewer is to establish adequate rapport with the patient by introducing himself or herself. Speak directly to the patient during this introduction, and pay attention to whether the patient is maintaining eye contact. Mental notes such as these may aid in guiding the interview later. If patients appear uneasy as they enter the office, attempt to ease the situation by offering small talk or even a cup of water. Many people feel more at ease if they can have something in their hands. This reflects an image of genuine concern to patients and may make the interview process much more relaxing for them.

Beginning with open ended questions is desirable in order to put the patient further at ease and to observe the patient's stream of thought (content) and thought process. Begin with questions such as "What brings you here today?" or "Tell me about yourself." These types of questions elicit responses that provide the basis of the interview. Keep in mind throughout the interview to look for nonverbal cues from patients. As they speak, for example, note if they are avoiding eye contact, acting nervous, playing with their hair, or tapping their foot repeatedly. In addition to the patient's responses to questions, all of these observations should be noted during the interview process.

As the interview progresses, more specific or close ended questions can be asked in order to obtain specific information needed to complete the interview.

At some point during the initial interview, a detailed patient history should be taken. Every component of the patient history is crucial to the treatment and care of the patient it identifies. The patient history should begin with identifying patient data and the patient's chief complaint or reason for coming to the clinic. The patient's chief complaint should be a quote recorded just as it was spoken, in quotation marks, in the patient's record. This also is where all history of illness is recorded, including psychiatric history, medical history, surgical history, and medications and allergies. Of interest, it is important to make direct inquiry to items such a family history of members being murdered etc.

Obtain a complete social history. This addition to the patient history can be most crucial when discharge planning begins. Inquire if the patient has a home. Also ask if the patient has a family, and, if so, if the patient maintains contact with them. This also is the area in which any history of drug and alcohol abuse, legal problems, and history of abuse should be recorded.

Following completion of the patient's history, perform the MSE in order to test specific areas of the patient's spheres of consciousness. To begin the MSE, once again evaluate the patient's appearance. Document if eye contact has been maintained throughout the interview and how the patient's attitude has been toward the interviewer. Next, in order to describe the mood aspect of the examination, ask patients how they feel. Normally, this is a one-word response, such as "good" or "sad."

Next, the interviewer's task is to define the patient's affect, which will range from expansive (fully animated) to flat (no variation). The patient's speech then is evaluated. Note if the patient is speaking at a fast pace or is talking very quietly, almost in a whisper. Thought process and content are evaluated next, including any hallucinations or delusions, obsessions or compulsions, phobias, and suicidal or homicidal ideation or intent.

Then, the patient's sensorium and cognition are examined, most commonly using the Mini-Mental State Examination. The interviewer should ask patients if they know the current date and their current location to determine their level of orientation. Patients' concentration is tested by spelling the word "world" forward and backward. Reading and writing are evaluated, as is visuospatial ability. To examine patients' abstract thought process, have them identify similarities between 2 objects and give the meaning of proverbs, such as "Don't cry over spilled milk." Once this is completed, perform the physical examination and needed laboratory tests to help exclude medical causes of presenting symptoms.

A compilation of all information gathered throughout the interview and MSE leads to the differential diagnosis of the patient. Once this diagnosis is established, a treatment plan is formulated. At this point, involving the treatment team (e.g., social workers, nurses, others) is important to help carefully explain to patients what their treatment will entail.

Once the history and MSE are complete, documenting this event accurately and efficiently is important.

Specifically the Mental Status Examination should cover the following:

Appearance, attitude and motor activity – dress, grooming, signs of illness and behaviour

Mood and affect – range, lability appropriateness

Speech – quality

Thought – Content (Delusion, suicidal & homicidal ideations, obsessions)

Thought – Form (Circumstantiality, tangentiality, loosening of associations, flight of ideas, derealisation, depersonalisation, dissociative events, concreteness, grandiosity)

Perception - Hallucinations and illusions

- Alertness
- Orientation to time, place, and person
- Concentration
- Recent and remote memory
- Language (e.g., naming objects, repeating phrases, performance of commands)
- Calculations
- Construction
- Insight and judgment

Hallucinations and illusions

Onset of illness

Symptoms of Depression

Sleep (hypersomnia or insomnia)

Interest (loss of interest in activities once enjoyed)

Guilt (inappropriate guilt, feelings of worthlessness)

Energy (decreased)

Concentration (decreased)

Appetite (increased or decreased)

Psychomotor agitation/retardation

Suicidal ideation

Acquiring Knowledge Relating to the Content of the Problem

Before beginning the actual testing procedure, examiners should carefully consider the problem, the adequacy of the tests they will use, and the specific applicability of that test to an individual's unique situation. This preparation may require referring both to the test manual and to additional outside sources. Clinicians should be familiar with operational definitions for problems such as anxiety disorders, psychoses, personality disorders, or organic impairment so that they can be alert

to their possible expression during the assessment procedure. Competence in merely administering and scoring tests is insufficient to conduct effective assessment. For example, the development of an IQ score does not necessarily indicate that an examiner is aware of differing cultural expressions of intelligence or of the limitations of the assessment device. It is essential that clinicians have in depth knowledge about the variables they are measuring or their evaluations are likely to be extremely limited.

Related to this is the relative adequacy of the test in measuring the variable being considered. This includes evaluating certain practical considerations, the standardization sample, and reliability and validity. It is important that the examiner also consider the problem in relation to the adequacy of the test and decide whether a specific test or tests can be appropriately used on an individual or group. This demands knowledge in such areas as the client's age, sex, ethnicity, race, and educational background, motivation for testing, anticipated level of resistance, social environment, and interpersonal relationships. Finally, clinicians need to assess the effectiveness or utility of the test in aiding the treatment process.

Data Collection

After clarifying the referral question and obtaining knowledge relating to the problem, clinicians can then proceed with the actual collection of information. This may come from a wide variety of sources, the most frequent of which are test scores, personal history, behavioural observations, and interview data. Clinicians may also find it useful to obtain school records, previous psychological observations, medical records, police reports, or discuss the client with parents or teachers. It is important to realise that the tests themselves are merely a single tool, or source, for obtaining data.

The case history is of equal importance because it provides a context for understanding the client's current problems and, through this understanding, renders the test scores meaningful. In many cases, a client's history is of even more significance in making predictions and in assessing the seriousness of his or her condition than his or her test scores. For example, a high score on depression on the MMPI-2 is not as helpful in assessing suicide risk as are historical factors such as the number of previous attempts, age, sex, details regarding any previous attempts, and length of time the client has been depressed. Of equal importance is that the test scores themselves are usually not sufficient to answer the referral question.

For specific problem solving and decision making, clinicians must rely on multiple sources and, using these sources, check to assess the consistency of the observations they make.

Interpreting the Data

The end product of assessment should be a description of the client's present level of functioning, considerations relating to etiology, prognosis, and treatment recommendations. Etiologic descriptions should avoid simplistic formulas and should instead focus on the influence exerted by several interacting factors. These factors can be divided into primary, predisposing, precipitating, and reinforcing causes, and a complete description of etiology should take all of these into account. Further elaborations may also attempt to assess the person from a systems

perspective in which the clinician evaluates patterns of interaction, mutual two way influences, and the specifics of circular information feedback. An additional crucial area is to use the data to develop an effective plan for intervention.

Clinicians should also pay careful attention to research on, and the implications of, incremental validity and continually be aware of the limitations and possible inaccuracies involved in clinical judgment. If actuarial formulas are available, they should be used when possible. These considerations indicate that the description of a client should not be a mere labeling or classification, but should rather provide a deeper and more accurate understanding of the person. This understanding should allow the examiner to perceive new facets of the person in terms of both his or her internal experience and his or her relationships with others.

To develop these descriptions, clinicians must make inferences from their test data. Although such data is objective and empirical, the process of developing hypotheses, obtaining support for these hypotheses, and integrating the conclusions is dependent on the experience and training of the clinician. This process generally follows a sequence of developing impressions, identifying relevant facts, making inferences, and supporting these inferences with relevant and consistent data. Maloney and Ward (1976) have conceptualised a seven phase approach to evaluating data.

They note that, in actual practice, these phases are not as clearly defined but often occur simultaneously. For example, when a clinician reads a referral question or initially observes a client, he or she is already developing hypotheses about that person and checking to assess the validity of these observations.

Phase 1

The first phase involves collecting data about the client. It begins with the referral question and is followed by a review of the client's previous history and records. At this point, the clinician is already beginning to develop tentative hypotheses and to clarify questions for investigation in more detail. The next step is actual client contact, in which the clinician conducts an interview and administers a variety of psychological tests.

The client's behaviour during the interview, as well as the content or factual data, is noted. Out of this data, the clinician begins to make his or her inferences.

Phase 2

Phase 2 focuses on the development of a wide variety of inferences about the client. These inferences serve both a summary and explanatory function. For example, an examiner may infer that a client is depressed, which also may explain his or her slow performance, distractibility, flattened affect, and withdrawn behaviour. The examiner may then wish to evaluate whether this depression is a deeply ingrained trait or more a reaction to a current situational difficulty. This may be determined by referring to test scores, interview data, or any additional sources of available information. The emphasis in the second phase is on developing multiple inferences that should initially be tentative. They serve the purpose of guiding future investigation to obtain additional information that is then used to confirm, modify, or negate later hypotheses.

Phase 3

Because the third phase is concerned with either accepting or rejecting the inferences developed in Phase 2, there is constant and active interaction between these phases. Often, in investigating the validity of an inference, a clinician alters either the meaning or the emphasis of an inference, or develops entirely new ones. Rarely is an inference entirely substantiated, but rather the validity of that inference is progressively strengthened as the clinician evaluates the degree of consistency and the strength of data that support a particular inference. For example, the inference that a client is anxious may be supported by WAIS-III subscale performance, MMPI-2 scores, and behavioural observations, or it may only be suggested by one of these sources. The amount of evidence to support an inference directly affects the amount of confidence a clinician can place in this inference.

Phase 4

As a result of inferences developed in the previous three phases, the clinician can move in Phase 4 from specific inferences to general statements about the client. This involves elaborating each inference to describe trends or patterns of the client. For example, the inference that a client is depressed may result from self verbalizations in which the client continually criticizes and judges his or her behaviour. This may also be expanded to give information regarding the ease or frequency with which a person might enter into the depressive state. The central task in Phase 4 is to develop and begin to elaborate on statements relating to the client.

Phases 5, 6, 7

The fifth phase involves a further elaboration of a wide variety of the personality traits of the individual. It represents an integration and correlation of the client's characteristics. This may include describing and discussing general factors such as cognitive functioning, affect and mood, and interpersonal-intrapersonal level of functioning.

Although Phases 4 and 5 are similar, Phase 5 provides a more comprehensive and integrated description of the client than Phase 4. Finally, Phase 6 places this comprehensive description of the person into a situational context and Phase 7 makes specific predictions regarding his or her behaviour. Phase 7 is the most crucial element involved in decision making and requires that the clinician take into account the interaction between personal and situational variables.

Establishing the validity of these inferences presents a difficult challenge for clinicians because, unlike many medical diagnoses, psychological inferences cannot usually be physically documented. Furthermore, clinicians are rarely confronted with feedback about the validity of these inferences. Despite these difficulties, psychological descriptions should strive to be reliable, have adequate descriptive breadth, and possess both descriptive and predictive validity. Reliability of descriptions refers to whether the description or classification can be replicated by other clinicians (inter-diagnostician agreement) as well as by the same clinician on different occasions (intra-diagnostician agreement).

The next criterion is the breadth of coverage encompassed in the classification. Any classification should be broad enough to encompass a wide range of individuals, yet specific enough to provide useful information regarding the individual being evaluated.

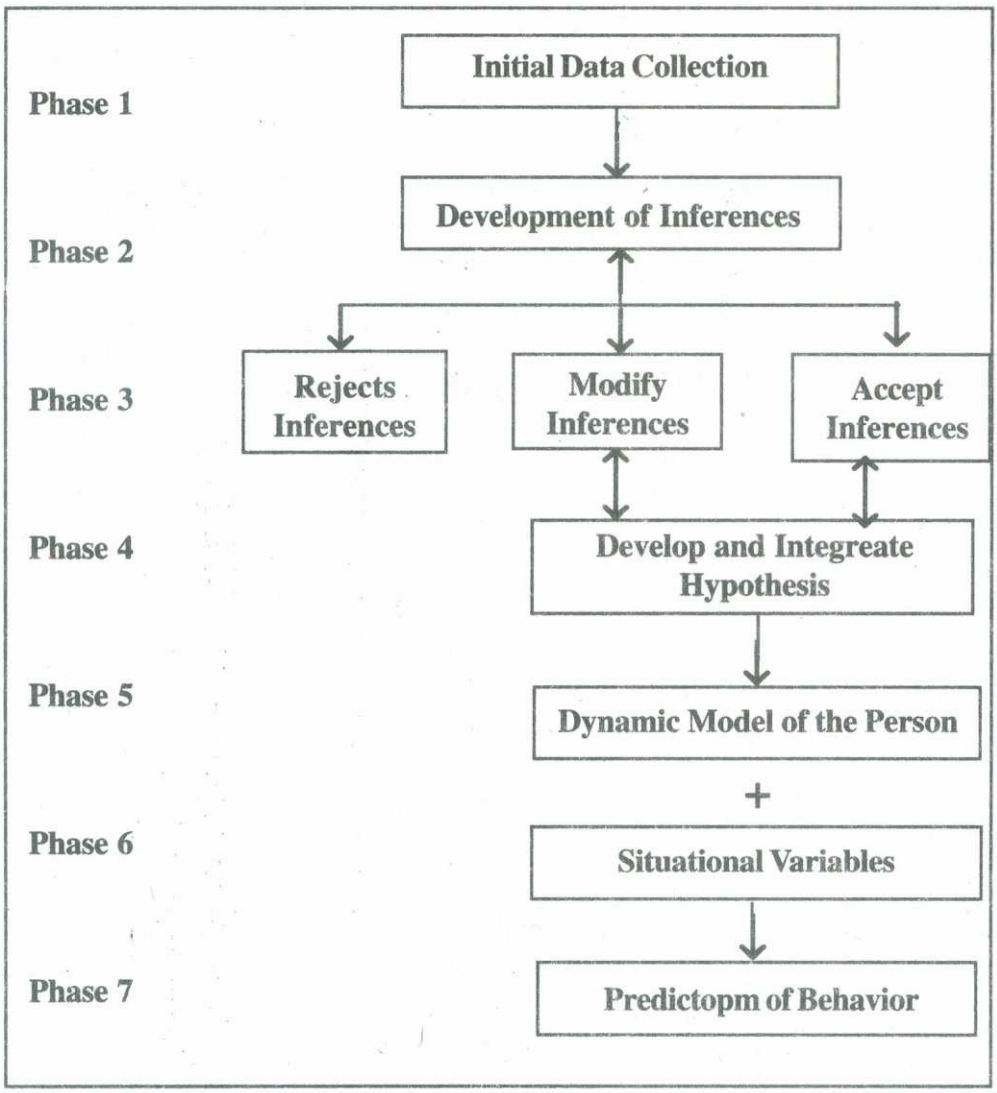

Fig. 2.1: Conceptual Model for Interpreting Assessment Data

Adapted from Maloney and Ward, 1976, p. 161

Descriptive validity involves the degree to which individuals who are classified are similar on variables external to the classification system. For example, are individuals with similar MMPI-2 profiles also similar on other relevant attributes such as family history, demographic variables, legal difficulties, or alcohol abuse?

Finally, predictive validity refers to the confidence with which test inferences can be used to evaluate future outcomes. These may include academic achievement, job performance, or the outcome of treatment. This is one of the most crucial functions of testing. Unless inferences can be made that effectively enhance decision making, the scope and relevance of testing are significantly reduced. Although these criteria are difficult to achieve and to evaluate, they represent the ideal standard for which assessments should strive.

2.5 LET US SUM UP

Sundberg and Tyler (1962) have described the course of clinical assessment as a flow through four major stages: preparation, input, processing and output. A typical assessment process involves evaluating the referral question, acquiring knowledge relating to the content of the problem, data collection and interpreting

the data. Maloney and Ward (1976) have conceptualised a seven phase approach to evaluating data. According to them these phases often occur simultaneously.

Clinical interpretation does not appear at one moment, e.g., after data are collected, as a basis for final judgement; wise and thoughtful decisions are required in all stages. In fact, assessment requires statistical and clinical prediction throughout. While improved techniques and better modes of statistical analysis and prediction should be sought in continuing assessment research, they have ultimately to be utilised by thinking and decision-making clinicians.

2.6 UNIT END QUESTIONS

1) During *input* the material collected is organised, analysed and interpreted. True or False?

2) Many of the practical limitations of psychological evaluations result from an inadequate clarification of the problem. True or False?

3) Competence in administering and scoring tests is sufficient to conduct effective assessment. True or False?

4) The end product of assessment should be a description of the client's present level of functioning, considerations relating to etiology, prognosis, and treatment recommendations. True or False?

5) Descriptive validity involves the degree to which individuals who are classified are similar on variables external to the classification system. True or False?

6) Write about the stages in assessment process as described by Sundberg and Tyler?

7) Describe in detail the different stages of psychological assessment?

2.7 SUGGESTED READINGS

Kaplan, R. M., &Saccuzzo, D. (2001). *Psychological Testing: Principles, Applications, and Issues*(5th Ed.). Pacific Grove, CA: Wadsworth.

Korchin, S.J. (2004). *Modern Clinical Psychology: Principles of Intervention in the Clinic and Community.* New Delhi: CBS Publishers & Distributers.

UNIT 3 BATTERIES OF TEST AND ASSESSMENT INTERVIEW

Structure

3.0 INTRODUCTION

Procedures used in the assessment of a particular patient should, ideally, be those best suited to answer specifically the referral questions, as these emerge from earlier assessment and are clarified by the referring and testing clinicians. For such questions may be answered either through a single standardized test or a group of tests. The first half of this unit covers the definition and uses of test batteries.

Probably the single most important means of data collection during psychological evaluation is the assessment interview. Without interview data, most psychological tests are meaningless. The interview also provides potentially valuable information

that may be otherwise unobtainable, such as behavioural observations, idiosyncratic features of the client, and the person's reaction to his or her current life situation. In addition, interviews are the primary means for developing rapport and can serve as a check against the meaning and validity of test results. The second half of this unit is concerned with the assessment interview. The skills and techniques, formats and types of interviews are discussed in detail. We start the unit with defining and describing test batteries, followed by the use of test batteries. Then we take up Assessment interview followed by skills and techniques of interview. Under this we discuss rapport, listening skills, communication, observation of behaviour etc. This is followed by presenting the various formats of interviews which includes structured, semi structured and unstructured formats of interview. Then we take up types of interviews under which we discuss the intake interviews, mental status assessment interview, crisis interviews, diagnostic interview and computer assisted interviews.

3.1 OBJECTIVES

After completing this unit, you will be able to:

- Define test batteries and describe their use;
- Define assessment interview;
- Describe the skills and techniques needed for assessment interview;
- Explain the formats of interviews; and
- Describe the different types of interviews.

3.2 TEST BATTERIES

Battery is a term often used in test titles. A battery is a group of several tests, or subtests, that are administered at one time to one person. When several tests are packaged together by a publisher to be used for a specific purpose, the word *battery* usually appears in the title and the entire group of tests is viewed as a single, whole instrument. Several examples of this usage occur in neuropsychological instruments (such as the Halstead-Reitan Neuropsychological Battery) where many cognitive functions need to be evaluated, by means of separate tests, in order to detect possible brain impairment. The term *battery* is also used to designate any group of individual tests specifically selected by a psychologist for use with a given client in an effort to answer a specific referral question, usually of a diagnostic nature.

3.2.1 The Use of Test Batteries

Although tests are used for a variety of purposes in the area of psychopathology, their use often falls into one of two categories as given below:

1) a need to answer a very specific and focused diagnostic question (e.g., does this patient represent a suicide risk?);

2) a need to portray in a very broad way the client's psychodynamics, psychological functioning, and personality structure.

The answer to the first category can sometimes be given by using a very specific, focused test. In the example given above, The typical scale of suicidal ideation

is the answer to the diagnostic question. For the second category, the answer is provided either by a *multivariate* instrument like the MMPI, or a test *battery*, a group of tests chosen by the clinician to provide potential answers.

A test battery gives a broader and firmer base for assessment than is possible with individual tests. The battery should be chosen to be as representative as possible to the particular needs of the individual patient. In the psychodynamic tradition, a common battery for testing adults for therapy planning includes, as a rule, the Wechsler Adult Intelligence scale, Rorschach, and TAT. Although the same basic battery may be used, such procedures are interpretable toward different ends. Thus, the individualisation of a psychological examination involves varying one's orientation toward the analysis and interpretation of data yielded by the *same* battery of broad gauged tests as well as putting together a unique package of different procedures for each patient.

In practice, the two alternatives are often combined and a common nucleus is used with procedures added to answer specific questions.

Sometimes test batteries are routinely administered to new clients in a setting for research purposes, for evaluation of the effectiveness of specific therapeutic programs, or to have a uniform set of data on all clients so that base rates, diagnostic questions, and other aspects can be determined. The use of a test battery has a number of advantages other than simply an increased number of tests. For one, differences in performance on different tests may have diagnostic significance. If we consider test results as indicators of potential hypotheses (e.g., this client seems to have difficulties solving problems that require spatial reasoning), then the clinician can look for supporting evidence among the variety of test results obtained.

3.3 ASSESSMENT INTERVIEW

Some assessments are more systematic (scanning the refrigerator and pantry before going to the supermarket; evaluating budgets in consideration of purchasing expensive items), and others are less so (comparison of lines to stand in at the grocery store). Similarly, assessment techniques in clinical psychology vary greatly in their purposes and goals, and the methods by which data collection is accomplished.

Most helping professionals use interviewing as a standard approach to assessing problems and formulating hypotheses and conclusions. Talking with appropriate, interested, and knowledgeable parties (the patient, family members, school teachers, physicians) is usually an important early step in conducting an assessment. Interviewing in clinical psychology entails much more than posing a series of questions to collect data about a case. Asking critical questions, carefully listening to answers, attending to missing or inconsistent information, observing nonverbal behaviour, developing hypotheses, and ruling out alternative hypotheses are all part of the interviewing process.

The interview is a thoughtful, well planned, and deliberate conversation designed to acquire important information (facts, attitudes, beliefs) that enables the psychologist to develop a working hypothesis of the problem(s) and its best solution. Although a great deal of research has been conducted on interviewing skills, the psychologist does not read a manual on how to conduct an interview and then become an expert. Effective interviewing is developed over time with

practice, supervision, experience, and natural skill. While the actual information obtained might vary greatly depending on the specific purpose of the interview, generally a list of standard data is collected and discussed (Table below).

This includes demographic information such as name, address, telephone number, age, gender, or grade in school, occupation, ethnicity, marital status, and living arrangements. Information about current and past medical and psychiatric problems and treatments are also usually obtained. The chief complaint or a list of symptoms experienced by the patient is discussed as well as the patient's hypotheses regarding the contributing factors associated with the development and maintenance of the problem(s).The interviewer often wants to know how the person has tried to cope with the problem(s) and why he or she wishes to obtain professional services now.

Table 3.1: Typical Information Requested during a Standard Clinical Interview

Identifying information (e.g., name, age, gender, address, date, marital status, education level)
Referral Source (who referred the person and why)
Chief Complaint or presenting problems (list of symptoms)
Family background
Health background
Educational background
Employment background
Developmental history (birth and early child development history)
Sexual history (sexual experiences, orientation, concerns)
Previous medical treatment
Previous psychiatric treatment
History of Traumas (e.g., physical or sexual abuse, major losses, major accidents)
Current treatment goals

Self Assessment Questions

1) Define test batteries.

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2) Describe test batteries and bring out its features.

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3) State the use of test batteries.

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4) What is assessment interview?

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5) What does an assessment interview contain?

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3.4 SKILLS AND TECHNIQUES

An interview is generally conducted as part of any psychological evaluation. Although numerous different interviewing situations exist, certain techniques and skills are necessary for nearly all types of interviews. These include developing rapport, effective listening skills, effective communication, observation of behaviour, and asking the right questions.

3.4.1 Rapport

When patients talk with a psychologist about problems they are experiencing, they are often uncomfortable sharing their intimate concerns with a complete stranger. They may have never discussed these concerns with any one before, including their best friends, parents, or spouse. They may worry that the psychologist might make negative judgments about their problems. They may feel embarrassed, silly, worried, angry, or uncomfortable in a variety of ways. An individual from an ethnic, racial, or sexual minority may fear being misunderstood or maltreated. To develop a helpful, productive, and effective interview, the psychologist must develop rapport with the person he or she is interviewing. Rapport is a term used to describe the comfortable working relationship that develops between the professional and the interviewee. The psychologist seeks to develop an atmosphere and relationship that is positive, trusting, accepting, respectful, and helpful.

Although there is no specific formula for developing rapport, several principles are generally followed. These are given below:

1) **Principle of Attention**

First, the professional must be attentive. He or she must focus complete attention on the patient without interruption from distractions such as telephone calls or personal concerns.

2) **Principle of friendly posture**

Second, the professional must maintain a rapport building posture, as for example, by maintaining eye contact and facing the patient with an open posture without a physical barrier such as a large desk impeding communication.

3) **Principle of Listening**

Third, the psychologist actively and carefully listens to the patient, allowing him or her to answer questions without constant interruption.

4) **Principle of being non judgemental**

Fourth, the psychologist is nonjudgmental and non critical when interacting with the patient, especially in regard to personal disclosures.

5) **Principle of empathy and respect for the patient**

Fifth, the professional also strives toward genuine respect, empathy, sincerity, and acceptance, without acting as a friend or a know it all type of person.

6) **Principle of creating a supportive professional atmosphere**

Sixth, the professional tries to create a supportive, professional, and respectful environment that will help the patient feel as comfortable and as well understood as possible during the interview.

3.4.2 Effective Listening Skills

In addition to the development of rapport, an effective interviewer must be a good listener.

While this may appear obvious, good listening skills are important to develop and generally do not come naturally for most people. People often find it challenging to fully listen to another without being distracted by their thoughts and concerns. Many are too focused on what they are thinking or want to say rather than on listening to someone else. Furthermore, careful listening must occur at many different levels. This includes the *content* of what is being said as well as the *feelings* behind what is being said.

Listening also involves paying attention to not only what is being said but how it is presented. For example, some one may deny that he or she is angry yet have their arms crossed and teeth clenched, thus suggesting otherwise. Listening also includes paying attention to what is not being said. Thus, listening involves a great deal of attention and skill including the ability to read between the lines.

Effective interviewers must learn to use and develop *active listening* skills, which include paraphrasing, reflection, summarization, and clarification techniques (Cormier & Cormier,1991). *Paraphrasing* involves rephrasing the content of what is being said. It means careful listening to another's story and then attempting to put the content of the story into a brief summary. The purpose of paraphrasing is to help

the person focus and attend to the content of his or her message. In contrast, *reflection* involves rephrasing the feelings of what is being said in order to encourage the person to express and understand his or her feelings better.

Summarization involves both paraphrasing and reflection in attempting to pull together several points into a coherent brief review of the message. Summarization is used to highlight a common overall theme of the message.

Finally, *clarification* includes asking questions to ensure that the message is being fully understood. Clarification is needed to ensure that the interviewer understands the message as well as helping the person elaborate on his or her message.

Examples of these techniques are provided in the following example of a couple trying to decide if they should get married. (See box below)

Edward is a 32-year-old man who has been dating Jenny, a 29-year-old woman, for several years. He feels that he cannot commit to marriage because he feels unsure if Jenny is the "right one" for him. Jenny wants to marry Edward and reports feeling frustrated that he has so many doubts. Edward further reports that he is unsure if he could stay faithful to one person for the rest of his life.

EDWARD: "I'm not much of a believer in the institution of marriage. It seems to me that it made sense when the average life span was only 30 years or so. How can some one make a decision like this during their 20s or 30s and have it be a good decision for 50 years or more? My parents are still married after 50 years but they hate each other. I don't know why they stay together. Jenny is really nice and I like being with her but who knows what the future will hold for us. She has a lot of great qualities but some characteristics drive me nuts. For example, I really don't like some of her friends. They are boring. She is really a practical person, which I like, but sometimes there is not a lot of excitement in our relationship."

Examples of active listening techniques offered by the therapist follow:

PARAPHRASE: "So you seem to be unsure if marriage to Jenny or anyone for that matter is right for you."

REFLECTION: "To some degree you feel bored in your relationship."

SUMMARIZATION: "You are unsure if marriage is right for you and you are concerned that Jenny may not be the right person for you regardless of your views on marriage."

CLARIFICATION: "When you say that your relationship lacks excitement are you also referring to your sexual relationship?"

3.4.3 Effective Communication

To conduct a successful interview, effective communication is a requirement. The professional must use language appropriate to the patient, whether a young child, an adolescent, or a highly educated adult. The interviewer generally avoids the use of professional jargon, or psycho babble, and speaks in terms that are easily understood. The interviewer tries to fully understand what the patient is trying to communicate and asks for clarification when he or she is unsure.

3.4.4 Observation of Behaviour

The interviewer pays attention not only to what is being said during a clinical interview, but also to how it is being said. Observation of nonverbal communication (e.g., body posture or body language, eye contact, voice tone, attire) provides potentially useful information. For example, a patient may describe severe depressive symptoms and suicidal thoughts, yet smile a great deal and appear energized and in good spirits during the interview.

Another patient might state that he or she feels completely comfortable, yet sits with arms and legs tightly crossed while avoiding eye contact. Inappropriate dress (e.g., T-shirt and shorts on a very cold winter day or for a job interview) or a disheveled appearance may provide further insight into the nature of the patient's difficulties.

3.4.5 Asking the Right Questions

A good interviewer must ask the right questions. All too often, inexperienced interviewers forget to ask a critical question only to remember it after the patient has left. Experience with interviewing and a solid understanding of psychopathology and human behaviour are needed in order to ask the right questions. Typical questions deal with issues such as the frequency, duration, severity, and patient's perception of the etiology of the presenting problem. A careful understanding of the symptoms as well as the patient's efforts to cope with the problem is usually important.

Self Assessment Questions

1) What are the various kills and techniques of interview? Explain

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2) How does one establish rapport?

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3) Elucidate the effective listening skills.

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4) State what effective communication is.

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5) What are the features of observation of behaviour?

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6) Explain the technique of asking the right questions.

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3.5 FORMATS OF INTERVIEWS

The most common types of interviews include initial intake interviews (first meeting overview), exit interviews (closure to a clinical relationship), mental status interviews, crisis interviews, and diagnostic interviews. The goals and purposes of these interviews are the same as the overall goals of assessment. Among these types of interview, there are three major formats: structured, semi structured, and unstructured.

3.5.1 Structured Interviews

Structured interviews are usually published or pre established and standardized lists of questions with specific directions or flowcharts of questions to ask following certain responses. These interview outlines (similar to scripts or questionnaires) are used for predetermined purposes (diagnosis, symptom, or behaviour description) and allow for comparison of responses across individuals or therapists. Since the interviews require little clinical judgment or inference, persons without graduate training in psychology can be trained to use structured interviews under supervision.

The Diagnostic Interview for Children and Adolescents (DICA-R; Reich, Jesph, &Shayk, 1991) and the Structured Clinical Interview for *DSM-IV* (SCID-I; First, Gibbon, Spitzer, Williams& Benjamin 1997) are two examples of such interviews.

3.5.2 Semi Structured Interviews

Semi structured interviews require more clinical skill and judgment. These interviews, such as the Hamilton Rating Scale for Depression (Hamilton, 1960), provide a list of questions or content areas that need to be covered. The exact wordings of the questions or order in which they are asked are determined by the clinicians. Often, the flow of a semi structured interview seems like a more natural dialogue between the clinician and client compared with a structured interview, which provides little opportunity for tangential patient self disclosure or input into the direction of the interview. Much like structured interviews, many semi structured interviews are published in manuals and provide scoring instructions and normative or comparison scores. Semi structured interviews are commonly used in qualitative research and in clinical assessments.

3.5.3 Unstructured Interviews

Unstructured interviews are clinician driven, and are usually individualized to the purpose of the assessment. Since they are not manualized and are not accompanied by administration or scoring instructions, unstructured interviews are rarely, if ever, used in research settings. The quality of data gathered by clinicians using unstructured interviews is entirely dependent on the clinicians' interviewing skills, clinical judgment, and insight. This type of interview structure is most susceptible to individual biases and requires the greatest amount of training and skill for maximum results.

Self Assessment Questions

1) Discuss format of interviews.

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2) Describe structured interviews and give example.

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3) Elucidate semi structured interview and indicate how these differ from structured interview.

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4) What are unstructured interviews?

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3.6 TYPES OF INTERVIEWS

There are many different types of interviews conducted by psychologists. Some interviews are conducted prior to admission to a clinic or hospital, some are conducted to determine if a patient is in danger of injuring herself or someone else, some are conducted to determine a diagnosis. Whereas some interviews are highly structured with specific questions asked of all patients, others are unstructured and spontaneous.

While not an exhaustive list, this section briefly reviews examples of the major types of interviews conducted by clinical psychologists.

3.6.1 Initial Intake Assessment

Initial intake interviews are designed to gain an overview of a patient's problems, strengths, and resources, and reasons for seeking assessment, treatment, or hospital admission. In some ways, it can be viewed as a needs assessment of the patient, and an opportunity for the clinician's observation, diagnosis, and short term and/ or long term clinical pathway goal planning. Intake interviews often include a combination of mental status interviews and diagnostic interviews.

3.6.2 Mental Status Assessment

Mental status interviews focus on a client's current psychological functioning. The goal of a mental status interview is to gain an overview of client mental health, and identify normal versus abnormal or unusual thinking, thought processing, behaviours, or other characteristics. This type of interview has specific components and is mostly factual and data based.

Clinicians make little to no interpretations of data collected in this type of interview, with the exception of some estimation of judgment, insight, and intellectual functioning, which maybe largely based on clinical impression.

The mental status interview goes beyond the exchange of questions and answers, and incorporates many behavioural observations. Behavioural observations include evaluation of the client's hygiene based on presentation, gait, speech (normal, pressured, slowed, slurred), eye contact, posture, behavioural manifestations of mood disorder (e.g., anxiety as represented by excessive fidgetiness or handwringing), and other observations.

Traditional questioning is used to inquire about a client's orientation to Persons (Who are you? Who brought you here? Who am I? Who is the President of India?) Places (Where are you now? What city and state do you live in? Where were you born?), and Time (What time of day is it? What day of the week is it? What year are we in? What holiday is coming up next?), thoughts, mood, affect, behaviours, short-term memory (e.g., remember this list of three objects, and I will ask you about them again later) and cognitive functioning (attention, concentration), medical status (e.g., use of medications), illicit and legal substance use, estimate of intellectual functioning, suicidal and homicidal history or current thoughts or plans, insight, and judgment. Assessment of delusions and hallucinations is typically included in this evaluation.

As mentioned, most mental status interviews are conducted as part of an intake or subsequent evaluation. Because this interview is a standard clinical method of assessment and not typically used for comparative purposes, formalised rating scales are rarely if ever used.

3.6.3 Crisis Interviews

Psychologists who work in acute psychiatric services, emergency rooms, or out patient mental health clinics are most likely to conduct crisis interviews. However, most clinical psychologists need to conduct crisis interviews periodically, regardless of their setting of employment. Crisis interviews are directed toward clients who are in acute distress due to an exacerbation or increase in psychological disturbance, or who have suffered a traumatic or life threatening incident.

Because these situations can arise in any setting (psychiatric, medical, school, research, etc.), all therapists must be prepared for the responsibility of determining

clients' imminent risk for harming themselves or someone else, or inability to care for themselves, given a heightened state of psychological arousal or psychotic episode.

Crisis interviews are more focused than intake interviews, and diagnostic interviews. Often, portions of a mental status exam, if not an entire exam, will be incorporated into this type of interview. Crisis interviews have the specific purpose of informing therapists' decisions about patients' safety, placement (psychiatric or medical hospital admission), or immediate intervention (crisis hotline leading to police outreach). Questions are typically focused on gaining information about crisis situations, chief symptom complaints, symptom duration and severity, clients' safety, resources and supports, risks, and overall client functioning. Rational and systematic clinical decision making, and knowledge and facility with procedures for individual settings (e.g., emergency help contacts, involuntary commitment procedures, steps for assisting women to leave homes of domestic violence) are two of the most important therapist attributes necessary for management of crisis situations and crisis interviews.

3.6.4 Diagnostic Interview

The purpose of a diagnostic interview is to obtain a clear understanding of the patient's particular diagnosis. Thus patient reported symptoms and problems are examined in order to classify the concerns into a diagnosis. Typically, the *Diagnostic and Statistical Manual-IV* (*DSM IV;* American Psychiatric Association, 2000) is used to develop a diagnosis based on five categories, or axes.

The *DSM IV* is used by hospitals, clinics, insurance companies, and the vast majority of mental health professionals to classify and diagnose psychiatric problems. While this is the most widely used diagnostic classification of psychiatric disorders in the United States, other classification systems exist and have both advantages and disadvantages.

The five axes for each diagnosis provide information concerning the clinical syndromes, influence of potential personality disorders, medical problems, psychosocial stressors, and level of functioning. Specifically,

Axis I includes the presence of clinical syndromes (e.g., depression, panic disorder, schizophrenia).

Axis II includes potential personality disorders (e.g., paranoid, antisocial, borderline).

Axis III includes physical and medical problems (e.g., heart disease, diabetes, cancer).

Axis IV includes psychosocial stressors currently experienced by the patient (e.g., fired from job, marital discord, financial hardship).

Axis V (Global Assessment of Functioning or GAF) includes a clinician rating of how well the patient is coping with his or her problems (1 = poor coping, 100 = excellent coping). The interview is conducted to rule out inapplicable diagnoses and rule in applicable ones. Thus, the goal of the interview is to determine whether the patient meets the diagnostic criteria of a particular disorder.

Diagnostic interviewing can be challenging. It is frequently difficult to ascertain the precise diagnosis through interview alone. Also, comorbidity may complicate the clinical picture. For instance, a patient who has been losing a lot of weight might be interviewed to determine whether he or she has anorexia nervosa, a disorder that results in self starvation. Anorexia nervosa is especially prevalent in adolescent girls. Significant weight loss may also be associated with a number of medical problems (e.g., brain tumor) or other psychiatric problems (e.g., depression).

To determine whether the weight loss symptoms might be associated with anorexia nervosa, the clinician may wish to conduct a diagnostic interview to see if the patient meets the *DSM-IV* diagnostic criteria for anorexia nervosa. Furthermore, additional possible diagnoses may need to be considered as well (e.g., depression, phobia, borderline personality). While some clinicians might choose to use a structured clinical interview, most would conduct their own clinical interview.

3.6.5 Computer Assisted Interviews

A next step in the evolution of structured interviews involves computer interviewing. As computers become more sophisticated and less expensive, programs can be developed to administer highly complex, efficient, and effective interviews. Computers can be used to ask patients questions and record their responses in a very objective manner. Numerous decision trees can be employed for appropriate follow up questions to patient's answers.

Furthermore, some patients feel more comfortable answering sensitive and potentially embarrassing questions via computer rather than talking face to face with a human interviewer. However, some people are uncomfortable with using computers in this way and prefer to talk with a professional person about problems. Computer assisted interviews have been used in clinic settings where patients can answer a variety of questions about their concerns while in a waiting area prior to their face to face meeting with a counselor. Results from the computer interview can be provided to the counselor to help in the treatment process.

Confidentiality concerns must be addressed when sensitive material is being requested in a public area (e.g., waiting room) and when access to computer files is not closely controlled.

3.6.6 Exit Interviews

Exit interviews are conducted at the end of an inpatient or outpatient treatment, medical inpatient visit, or occupational tenure. These interviews provide therapists or another designated professional or paraprofessional with an opportunity to review assessment or therapy content with clients; provide feedback on progress; help clients engage in future thinking about maintenance of treatment gains or managing future problems; create plans for future crises, relapses, or booster sessions; and gain clients' feedback on the usefulness of various aspects of the treatment. When exit interviews are conducted by the therapist at the end of treatment, these interviews are often called "termination sessions," although one could argue that ending treatment marks a new beginning for clients, rather than an ending. A termination interview provides a forum for clients to appropriately express their feelings and emotions about ending therapy.

Self Assessment Questions

1) Discuss the various types of interviews.

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2) Describe the interview in initial intake.

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3) Delineate the characteristic features of mental status assessment interview.

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4) What are crisis interviews?

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5) Discuss the diagnostic interview.

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6) How do we use the computer for interviews?

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7) Elucidate the exit interviews.

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3.7 LET US SUM UP

A battery is a group of several tests, or subtests, that are administered at one time to one person. The clinical interview is a thoughtful and deliberate conversation designed to acquire important information (facts, attitudes, beliefs) that allows the

psychologist to develop a working hypothesis of what the problem(s) is/are about. Although there are numerous examples of interviewing situations (initial intake or admissions interview, mental status interview, crisis interview, structured interview, computer-assisted interview, exit, or termination interview), several techniques and skills are necessary for all types of interviews. These include developing rapport, active listening, effective communication, observation of behaviour, and asking the right questions.

3.8 UNIT END QUESTIONS

1) A battery consists of tests used only for clinical assessment. True or False?

2) A test battery gives a broader and firmer base for assessment than is possible with individual tests. True or False?

3) An interview is generally not conducted as part of any psychological evaluation. True or False?

4) ———— is a term used to describe the comfortable working relationship that develops between the professional and the interviewee.

5) Effective listening includes the ———— of what is being said as well as the ———— behind what is being said.

6) ———— involves rephrasing the feelings of what is being said in order to encourage the person to express and understand his or her feelings better.

7) ———— Interviews are usually published or pre-established and standardized lists of questions with specific directions or flowcharts of questions to ask following certain responses.

8) ———— interviews focus on a client's current psychological functioning.

9) The purpose of a crisis interview is to obtain a clear understanding of the patient's particular diagnosis. True or False?

10) When exit interviews are conducted by the therapist at the end of treatment, these interviews are often called ————.

11) What is a test battery and explain its uses?

12) What are the factors that contribute to effective interviewing?

13) What are the different formats of assessment interviews?

14) What are the different types of clinical interviews?

15) How do you keep yourself calm and levelheaded during a crisis interview?

16) What do you do if the patient refuses to participate in the interview or is uncooperative in other ways?

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 REPORT WRITING AND RECIPIENT OF REPORT

Structure

4.0 INTRODUCTION

The psychological report is the end product of assessment. It represents the clinician's efforts to integrate the assessment data into a functional whole so that the information can help the client solve problems and make decisions. Even the best tests are useless unless the data from them is explained in a manner that is relevant and clear, and meets the needs of the client and referral source. This requires clinicians to give not merely test results, but also interact with their data in a way that makes their conclusions useful in answering the referral question, making decisions, and helping to solve problems.

An evaluation can be written in several possible ways. The manner of presentation used depends on the purpose for which the report is intended as well as on the individual style and orientation of the practitioner. The format provided in this unit is merely a suggested outline that follows common and traditional guidelines. It includes methods for elaborating on essential areas such as the referral question, behavioural observations, relevant history, impressions (interpretations), and recommendations. In this unit we start with a definition and description of what a psychological report is and how to communicate assessment results etc. Then we present the general guidelines of writing a psychological report which includes the lenth of the report, degree of emphasis, domains etc. Then we discuss the models of psychological report and the levels of report which includes three levels. This is followed by a section on format of psychological report.

4.1 OBJECTIVES

After completing this unit, you will be able to:

- Explain what psychological report is;
- Provide the general guidelines for psychological report;
- Describe how to communicate assessment results;
- Explain the general guidelines for writing the report;
- Elucidate the models of psychological report and the levels of report;
- Analyse the format of psychological report; and
- Discuss the future prospects of psychological report.

4.2 THE PSYCHOLOGICAL REPORT

The psychological report presents an opportunity for the professional psychologist to present the results of assessment in a case focused, problem solving manner. Its major purpose is to help the referral source make decisions related to the client. It thus represents the end product of assessment. An ideal report will be written according to general guidelines and in a flexible but predictable format.

The most frequent categories of reports are centered around questions related to intelligence / achievement, personality / psychopathology, and neuropsychology areas. Additional, less frequent categories include adaptive / functional, developmental, neuro behavioural, aphasia, and behavioural medicine / rehabilitation. The most frequent general issues relate to diagnosis and answering which type of treatment would be most effective for a given client. Each of the various categories of assessment require different types of assessment instruments, knowledge related to the type of difficulty, awareness of the context(educational, legal, medical, rehabilitation, forensic),and knowledge of the various resources available in the community. This knowledge will then be integrated into the report in order to make it more problem focused and relevant to the referral source.

4.3 COMMUNICATING ASSESSMENT RESULTS

After testing is completed, analysed, and interpreted, the results are usually first communicated orally to patients and other interested parties. Results are

communicated to others only with the explicit permission of the person unless extraordinary conditions are involved (e.g., the patient is gravely disabled).After a psychological evaluation, the psychologist will often schedule a feedback session to show the patient the results, explain the findings in understandable language, and answer all questions. Often psychologists must also explain their assessment results to other interested parties such as parents, teachers, attorneys, and physicians.

In addition to oral feedback, the psychologist typically prepares a written report to communicate test findings. Most testing reports include the reason for the referral and the identification of the referring party, the list of assessment instruments used, actual test scores (such as percentile ranks), the psychologist's interpretation of the scores and findings, a diagnostic impression, and recommendations. It is important to ascertain the audience for whom the report is being written.

A report directed to another mental health professional may be very different from one to a school teacher or a parent. Most psychologists avoid professional jargon so that their reports will be understandable to non psychologists. Psychologists also must handle reports confidentially and send them only to appropriate persons.

4.4 GENERAL GUIDELINES

4.4.1 Length of the Report

The *length of the report* varies considerably across various referral settings. Traditionally, psychological reports have been between four and seven single spaced pages. In medical contexts where time efficiency is crucial, psychological reports rarely exceed two pages. However, psychological reports in a wider number of contexts also appear to be getting shorter due to the cost containment and time efficiency demands of managed healthcare. In contrast, legal contexts demand far more detail, require greater accountability, typically have more complex referral questions, and involve more flexible, ample methods of reimbursement. As a result, reports tend to be 7–10 pages and sometimes even longer.

Reports are therefore influenced by and formatted according to the conventions of other health professionals working within the contexts psychologists write for.

4.4.2 Degree of Emphasis

A well written report also pays particular attention to the *degree of emphasis* given to various points. Sometimes, the evidence for a conclusion will be consistent, strong, and clear and this can then be stated accordingly in the report. Other information might be more speculative and should be written with an appropriate degree of tentativeness.

4.4.3 Domains

Test interpretations are ideally presented and organised around specific *domains*. The selection of which domains to include should be driven by the types of questions the referral source is requesting. These questions largely determine the types of assessment tools used and types of questions asked of the resulting data. Since each client is different and lives within a different context, the number of domains will vary considerably. Within a psycho educational context, relevant domains might revolve around cognitive ability, level of achievement, presence of

a learning disability, or learning style. In contrast, a report written to assess personality / psychopathology might focus more on such areas as coping style, level of emotional functioning, suicide potential, characteristics relevant to psychotherapeutic intervention, or diagnosis.

Sometimes test results are presented in a test by test fashion. This has the advantage of making it clear where the data came from. However, it runs the risk of being overly data / test oriented rather than person oriented. Research has consistently indicated that readers of reports do not feel this style is 'user friendly'. In addition, it indicates a failure to integrate data from a wide number of sources and suggests that the practitioner has not adequately conceptualised the case. It also encourages a technician oriented role rather than one in which a knowledgeable clinician integrates a wide array of information to help solve a client's problem.

4.4.4 Deciding What to Include

Consistent with the above themes, *deciding what include* is largely determined by the referral source. One general principle is that material should only be included if it helps to further understand the client. In this respect, what is unique rather than what is average is usually more important. For example, describing a client's appearance is typically not useful if they made modal responses to the test material and were dressed in average appropriate clothes. In contrast, a client who was obsessively concerned with accuracy (ignoring time concerns) and dressed in an unusually formal fashion does provide useful behavioural observations. These observations also help to place test scores in a wider context, give information related to coping style, and an indication of their personality type.

4.4.5 Raw Data and Quantitative Scores

Generally *raw data and quantitative scores* should be avoided in the impressions / interpretations section of the report. They can potentially make the report seem overly technical and cluttered. Sometimes, however, providing concrete behavioural observations or actual responses to selected items (i.e. MMPI-2 critical items) can make abstract points seem more immediate and insightful into the content of the person's thought processes. This can serve to balance out more high level abstractions. In addition, providing a clear statistic such as a percentile can sometimes make a description seem more clear and accessible. For example, a report might describe how a client with an average IQ had a quite low auditory memory. Stating they only scored in the '5th percentile' (or 'only five people out of a hundred scored in this range') can provide some precision into the magnitude of their difficulties.

4.4.6 Client Feedback

One of the crucial roles of a psychological report is to assist in providing *client feedback*. This is in accordance with client advocacy legislation and the American Psychological Association's ethical guidelines in that clients should know the types of information and recommendations being made about and for them. Such feedback is expected to be clear, accurate, direct, and understandable. This means the results need to be phrased in everyday language rather than formal psychological terminology. There has also been increasing evidence that well integrated client feedback has clear therapeutic benefits. Thus the report (and related feedback) can potentially become an integral part of therapy itself. While feedback is typically verbal, an important option is to design the written report,

or at least an edited version of the report, in such a way as to be of optimal benefit to the client.

Self Assessment Questions

1) Define and describe psychological report.

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2) What features are included in the psychological report?

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3) Delineate the general guidelines for psychological report writing.

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4.5 MODELS OF PSYCHOLOGICAL REPORTS

There are many models / approaches to psychological reports. Some of the models of reports are discussed below.

The three models for psychological reports to be discussed are the

- The Test Oriented Model,
- The Domain Oriented Model, and
- The Hypothesis Oriented Model.

In the Test Oriented Model, results are discussed on a test-by-test basis. Each test is listed by name and significant results for that test are presented. Each test is generally discussed in a separate paragraph. Little or no effort is made to compare and contrast data between the various tests (at least not in the "Results of Assessment" section). The strength of this approach is that it makes clear the source of each piece of data. This could be important in certain settings, such as forensic reports. The weakness of this model is that the reader's attention becomes focussed on the tests, rather than on the client's adaptive functioning.

It also communicates to the reader that psychological assessment is a low-level, technical skill which involves little more than giving the test and copying some interpretive statements out of a manual. It ignores the role of the psychologist as the integrator of the test data; a professional who brings to bear his knowledge of how the test was constructed, how it was normed, limits to generalisability of test data, and how to use the data in a theoretical/conceptual manner to better understand the client. The Test Oriented Model was used extensively in past, but has become increasingly unpopular in recent years.

In the Domain Oriented Model, results are grouped according to abilities or "functional domains". Separate paragraphs are usually devoted to such topics as intellectual ability, interpersonal skills, psychosocial stressors, coping techniques, intrapersonal needs, motivational factors, depression, psychotic features, etc. This model is useful when there is no specific referral question and you're not certain what use will be made of your data. For example, little background information may be available on a newly admitted patient. You're not sure why he was admitted or what factors precipitated the admission. Therefore, it is hard to know which portions of your data will be useful to the treatment team. The Domain Oriented Model is also common in neuropsychological reports, where a variety of providers may eventually become involved in the case. Each provider will focus on separate parts of the report to assist in a specific aspect of intervention. This approach is also helpful when assessment is being used to monitor treatment progress. It allows you to monitor changes in the client's functioning across a wide variety of areas. The weakness of the Domain Oriented approach is that the reader may be presented with a lot of information that has little relevance to his intended intervention. He may become so distracted by parts of the report he doesn't understand, that he fails to focus on information which could be helpful to him. This model is sometimes pejoratively referred to as a "shotgun" approach, referring to its apparent effort to hit all the possible target issues.

In the Hypothesis Testing Model, results are focussed on possible answers to the referral question(s). The idea is to present a hypothesis in the "Purpose for Evaluation" section, then present data systematically to support or refute the hypothesis. Separate paragraphs in the "Results of Evaluation" section address theoretical/conceptual issues by integrating data from the history, mental status exam and behavioural observations with data from all the tests. Tests are rarely mentioned by name. For example, information from scale 2 on the MMPI-2 may be combined with interpretive data from the MCMI dysthymia scale. If the integration of this information is consistent with the history and the mental status exam, it is included in a paragraph dealing with depression. The strength of this model lies in its efficiency and concise focus on the referral problem. The reader isn't distracted by unrelated details. The primary weakness of the model is that you don't report some of the information which is unrelated to the "purpose of the evaluation" but which could potentially be useful to other disciplines.

4.5.1 Levels of Reports

Having covered the issue of report Models, this discussion will now turn to "levels" of reports. Three levels of reports, viz., level 1, level 2and level 3 will be covered.

A "Level One" report is the copied out of the manual level. The interpretive data come directly from the manual (or computer print out) and usually follow the format. This makes for a conceptually weak report and may actually do more harm than good for the client. Keep in mind that many of the referral agents will have little understanding of the limits to generalisability and external validity of "raw" test data. This level of report is only appropriate when there are extenuating circumstances which make it impossible to interview the patient or to obtain background information. In those cases the report should be clearly qualified with a statement to the effect that...."These results represent a blind interpretation of test data and should be considered tentative until confirmed by subsequent clinical data or background information".

A "Level Two" report represents the minimum level of conceptual input which should be used for most purposes. Of all the possible interpretive hypotheses generated by the test, the only ones included in the "Results of Evaluation" are those that have been confirmed (either by the history or in the clinical interview).

A "Level Three" report represents the highest level of conceptualization. Its format is similar to a Level Two report. However, it also presents a theoretical conceptualisation of the problem. Ideally, this report will integrate all available information to:

- describe the nature of the problem and how it developed over time
- describe factors which influence and reinforce the problem
- describe any recent exacerbating factors which led to the referral
- provide suggestions for intervention based on the client's strengths, weaknesses, and coping skills.

Self Assessment Questions

1) What are the various models of psychological report?

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2) Discuss the domain oriented model.

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3) Elucidate the hypothesis testing model.

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4) Discuss the three levels of report writing.

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4.6 FORMAT FOR PSYCHOLOGICAL REPORTS

There are various ways of organising a psychological report. Some practitioners prefer to use an informal, relatively unstructured letter format. This is especially appropriate when the report will be seen by a single referral source and the referring person is known to the practitioner. Other reports might be more appropriately organised around quite structured headings (i.e. 'Referral question',

'Test results', 'Summary and recommendations'). Some reports might demand (and practitioners prefer to include) an extensive history whereas others might minimize the history in favour of spending relatively greater time elaborating on impressions and interpretations. Given the recent trends towards treatment planning and demonstrating the practical, every day relevance of assessment, some reports might place relatively greater emphasis and length into providing concrete, specific recommendations for psychotherapy planning, vocational training, educational intervention, or neuropsychological rehabilitation.

Even if reports do not formally designate specific headings and subheadings, they still typically include a predictable series of content areas. The following listing provides an outline of typical areas (from Groth Marnat, 1999;Williams & Boll, 2000):

Name:

Age (date of birth):

Sex:

Ethnicity:

Date of report:

Name of examiner:

Referred by:

i) Referral question

ii) Evaluation procedures

iii) Behavioural observations

iv) Background information

v) Test results

vi) Impressions and interpretations

vii) Summary and recommendations

An additional feature is an indication at the top of the report that the report is 'Confidential'. The report should conclude with the signature, name, and title of the author. This is crucial since it indicates that responsibility for the contents of the report is being formally accepted by the author. Identifying information is fairly straight forward (name, age, sex, etc.) but the additional features (I–VII) require elaboration.

4.6.1 Referral Question

The *referral question* sets the stage for the rest of the report. It is therefore especially important to make sure it is as clear and specific as possible (i.e. 'My understanding is that you would like me to evaluate Mr. X with particular reference to the nature and severity of his deficits, the extent of care he would require, ability to work, personality functioning, and the likelihood of any further improvement'). Often clarifying the referral question will require discussions with the referral source since it is not unusual to have an initially poorly articulated (or at least partially developed) referral question. One means of assisting with this is

to ask the referral source what decisions they need to make related to the client. Sometimes discussions with the referral source will mean indicating the sorts of questions that can and cannot realistically be answered through formal assessment. Such discussions may even result in a mutual decision that formal assessment is not appropriate for the case. A clearly articulated referral question will carry through to the rest of the report in that it provides a frame of reference for this material as well as a rationale for what is relevant to include in the sections on background information (history), impressions / interpretation, and especially the summary / recommendations section.

One effective technique is to create bulleted points in the summary, each of which provide a clear answer to each of the referral questions. However, the points need to be consistent with material presented previously in the impressions / interpretation section. A nice beginning to the referral question section (and the report in general) is to make a brief, succinct, orienting, statement related to the client (i.e. 'Mr. X is a 36year old, white, right handed, married male with a high school education who sustained a severe, diffuse closed head injury on April 12, 1998').

4.6.2 Evaluation Procedures

The *evaluation procedures* section is simply a listing of the various instruments used. Sometimes, particularly in legal settings, this includes the date when administered and the length of time they took to complete the test. It is sometimes useful to include the total time involved in the entire evaluation. If the report relied on previous records (academic, vocational, legal, medical), then the dates and, if relevant, the authors of the reports should be given (i.e. 'In addition, I reviewed the following reports by . . .').

4.6.3 Behavioural Observations

Often *behavioural observations* can provide a useful context for understanding test data. For example, low scores on cognitive tests may be the result of low motivation or perhaps a problem solving style that sacrifices speed for accuracy. These and related behavioural observations can be noted in the behavioural observations section. Behavioural observations should generally be kept concise and relevant. They should also refer to concrete, observable behaviours rather than either high level abstractions or conclusions about the client. Thus, it would be preferable to state that the client moved slowly and they were self critical (i.e. 'the client continually commented that they weren't able to do very well') rather than to make inferences (i.e. 'the client appeared depressed'). Inconsistencies in the client's behaviour might also be useful to note. These might include a young person who acts older than their stated age or a person who says they feel fine butappear anxious and defensive. Additional domains of behavioural observations include attitude toward the examiner and test situation, attitudes toward self, reaction to praise, reaction to failure, motor coordination, reaction time, and behaviours related to speech and language.

4.6.4 Background Information

One of the potentially most useful functions of the professional psychologist is to provide descriptions of relevant *background information*. This might be particularly important in a medical context where physicians neither have the time nor the appropriate training to access important client information. At the same

time, the background information section should avoid being overly inclusive. For example, it is unlikely to be useful to provide a detailed developmental history for an adult who is seeking vocational assessment. On the other hand, a detailed developmental history would be essential for an adolescent referred to assess possible learning disabilities. It is usually important to clarify where the information came from (i.e. 'The client reported that . . .' or 'The report of 3/6/98 by Dr. Y indicated that . . .'). Possible domains for history taking and inclusion in the background information section include the following: history of the problem, medical history, vocational / employment background, family background, personal history (infancy, early/middle childhood, adolescence, early/middle adulthood, late adulthood), and miscellaneous areas such as fears, self concept, recurring dreams, or specific memories.

4.6.5 Test Results

Some reports include a *test results* section which lists the actual scores on the tests. If this is done, it is often useful to translate the scores into percentiles to enable readers to more easily understand the meanings of the test scores. A further related strategy is to develop a profile sheet depicting relative high and low performances. Some times these might have cutoffs for such categories as 'impaired', 'superior', or 'dysfunctional'. In some cases the test results / scores are placed in a section within the body of the report itself. In reports, the 'test results' section is included as an appendix. It is also not unusual for reports to exclude the actual test data. This is especially the case in medical settings where concise reports are greatly valued. Actual test scores might also be excluded if it is known that the referral source is neither trained in, nor interested in, seeing the actual scores.

4.6.6 Impressions and Interpretations

The main body of the report is contained in the *impressions and interpretation* section. It represents an integration of findings based not only on test scores, but also behavioural observations, relevant history, relevant records, and additional available data. The importance of presenting the information according to domains rather than test by test has already been discussed. The selection of domains is based on answering the referral question. If ability / IQ measures have been measured, it is traditional to place these first since they usually provide an important context for understanding most other types of information. Most of the time actual IQ scores are given along with percentiles and intelligence classification (Low Average, Superior, etc.). Some authors might prefer to provide an estimate of the range of possible error of IQ scores by including the Standard error of Measure. In contrast, other authors might consider this to be too technical and test oriented and decide to omit this information. If there is a chance the IQ scores might be misunderstood, then they are sometimes excluded and only the percentiles and intelligence classifications are given.

Different types of referral categories, along with the specific referral questions, will determine the additional domains to include. For example, when assessing intellectual/achievement types of referrals, important domains might include general cognitive ability, specific strengths and weaknesses, level of achievement, aptitudes, learning style, interests, and possibly vocational interests. A neuropsychological report might not only focus on cognitive abilities and achievement but also learning/ memory, language functions, attention, visuo constructive abilities, executive function, emotional functioning, and potential and strategies for cognitive rehabilitation.

4.6.7 Summary and Recommendations

The most valuable section is usually the *summary and recommendations*. The importance of this section is that sometimes it is the only section read by allied health professionals concerned with time efficiency. The summary provides an opportunity for the practitioner to succinctly state the main conclusions of the report. As indicated previously, the summary section also provides an opportunity to make sure each one of the referral questions have been addressed. The recommendations are an opportunity to provide person focused suggestions on solving specific problems. A clear research finding is that reports are typically rated as most useful if the recommendations are highly specific rather than general. Thus a statement such as the 'client should begin individual psychotherapy' is not as useful as one that states the 'client is likely to benefit most from weekly sessions of individual psychotherapy using strategies to decrease their level of subjective distress, enhance social supports, and increase their level of awareness related to self defeating patterns in interpersonal relationships'. Once a report has been submitted, follow up contact with the referral source is advisable in order to provide ongoing feedback related to the accuracy and usefulness of the report as well as help facilitate the actual implementation of the recommendations.

A sample of a format

PSYCHOLOGICAL EVALUATION

(Facility Name Here)

Rupa Kumar
Case No.:
Admission Date: 4.6.11

Dates of Evaluation: 3.6.2011
Building No.: 11
Date of Report: 3.6.11.

Purpose for Evaluation: Rather than "Reason for Referral" the first section for the report is better called "PURPOSE FOR EVALUATION." This gives the clinical psychologist a lot more flexibility. If you us "Reason for Referral" is used the psychologist has to copy whatever the consult says. Unfortunately, many consults ask questions which tests can not answer (or else they do not ask any question at all).

This section should be used to briefly introduce the patient and the problem. Begin with a concise "demographic picture" of the patient. (e.g., This is the third inpatient admission for this 32 year old, single, white female who has 13 years of formal education and is employed as a beautician. She was admitted due to symptoms of major depression with possible psychotic features.)

Use this section to tell your reader what issues you will address in the body of the report. The reader will then know on what issues to focus, and he can be forming his own impressions while he is reading the report. . (e.g., The purpose for the current evaluation was to screen for evidence of psychosis and clarify the nature of the underlying depressive disorder.) In sum, use this section to "pose a question," which you will answer in the "SUMMARY" section.

Finally, if the evaluation takes more than 5 days to complete, you should put a progress note in the patient's chart giving preliminary test results. For example, you might conclude the "PURPOSE FOR EVALUATION" section of your report with, "Preliminary results were reported in the patient's progress

notes on 3.6.11. The current report will supplement and elaborate upon those preliminary findings."

Assessment Procedures: Refer to this section as "ASSESSMENT PROCEDURES" rather than "TESTS ADMINISTERED." This allows the psychologist to include the Mental Status Exam and the Clinical Interview as two procedures. This also helps communicate to referral sources that the psychologist do more than give some tests and copy interpretive statements out of a manual. It lets them know that the psychologist's evaluation is a professional integration of information from a variety of sources. Be sure to also note who gave the tests and how long it took. These issues are important if a case ever goes to court.

e.g.: Millon Clinical Multiaxial Inventory-III (MCMI-III)
Minnesota Multiphasic Personality Inventory-2 (MMPI-2)
Mental Status Examination
Review of Prior Psychological Assessment
Review of Prior Medical Records
Clinical Interview

This patient participated in 3 hours of testing and a 1 hour diagnostic interview. Tests were administered by Jim Smith, M.S. and interpreted by Dr. Ram Kishore and interpreted by Dr. Lavanya Seth.

Background Information : In this section present paragraphs dealing with family, social, legal, medical, family mental health, etc. issues, if needed. Only include those issues that are relevant to the "questions" posed under "PURPOSE FOR EVALUATION." Excessive, unnecessary details will distract the reader from the case that is being built in support of the psychologist's conclusions. Whenever possible, maintain chronological order when presenting background information.

Next describe the patient's history of substance abuse / mental problems, and mental health care in CHRONOLOGICAL order. Where possible, provide enough details of prior intervention efforts to clarify what was attempted and whether it was successful.

The psychologist's goal is to encourage replication of prior successes and / or avoid duplication of prior treatment failures. Also, be sure to describe the patient's behaviour and level of adaptive functioning BETWEEN prior interventions. These details will help give the treatment team an idea of what "target level" of adaptive functioning to look for in the current intervention.

Follow with a paragraph describing the onset and development of the present illness / exacerbation. Let the reader get an idea of how the current admission compares to prior admissions and what specific events precipitated the current admission. End this section with a brief paragraph summarizing staff observations, patient behaviour, level of motivation, etc. during the current admission. Keep in mind that objective observations by professional staff are one of the best sources of data. Conclude with a sentence indicating medications being taken at the time of testing.

Mental Status Examination : Focus on one's own observations and impressions. This section of the report should focus on the psychologist's objective evaluation. Avoid quoting the patient's opinion of his own mood, affect, etc. It is also best to avoid mixing in background information or test information with this section. A typical MSE for a 'normal' patient might read:

Results of mental status examination revealed an alert, attentive individual who showed no evidence of excessive distractibility and tracked conversation well. The patient was casually dressed and groomed. Orientation was intact for person, time and place. Eye contact was appropriate. There was no abnormality of gait, posture or deportment. Speech functions were appropriate for rate, volume, prosody, and fluency, with no evidence of paraphasic errors. Vocabulary and grammar skills were suggestive of intellectual functioning within the average range.

The patient's attitude was open and cooperative. His mood was euthymic. Affect was appropriate to verbal content and showed broad range. Memory functions were grossly intact with respect to immediate and remote recall of events and factual information. His thought process was intact, goal oriented, and well organised. Thought content revealed no evidence of delusions, paranoia, or suicidal or homicidal ideation. There was no evidence of perceptual disorder. His level of personal insight appeared to be good, as evidenced by ability to state his current diagnosis and by ability to identify specific stressors which precipitated the current exacerbation. Social judgment appeared good, as evidenced by appropriate interactions with staff and other patients on the ward and by cooperative efforts to achieve treatment goals required for discharge.

Resuls of Evalution: The idea is to present a hypothesis in the "PURPOSE FOR EVALUATION" section, then present data systematically to support or refute the hypothesis. Separate paragraphs in the "RESULTS OF EVALUATION" section address theoretical / conceptual issues by integrating data from the history, mental status exam and behavioural observations with data from all the tests.

Specific tests are rarely mentioned by name. For example, information from scale 2 on the MMPI-2 may be combined with interpretive data from the MCMI-III dysthymia scale. If the integration of this information is consistent with the history and the mental status exam, it is included in a paragraph dealing with depression.

Summary/Recommendations: Begin by specifically answering the questions you posed under "PURPOSE FOR EVALUATION." Then elaborate as much as needed to present your conceptualisation of the case. It's fine to include DSM diagnostic impressions, but your summary of the patient's psychological makeup is far more important. If you do include DSM labels, be sure to provide enough detail in the body of the report to support the diagnostic criteria as described in DSM. Any recommendations for treatment can also go here. For example:

Results of psychological evaluation reveal an extended history of alcohol abuse and a psychotic disorder characterised primarily by disturbance of thought content, with relative integrity of thought process and no clear indication of perceptual disturbance. The current clinical presentation appears to represent an acute exacerbation of a chronic psychotic disturbance which had its onset approximately 8 years ago. Currently, the patient appears to remain extremely distressed, anxious, paranoid, and delusional, despite self reports to the contrary. He lacks sufficient capacity/ motivation to rely on external supports and lacks sufficient personal insight to cope independently at present. The patient appears to be attempting to cope with his illness using extreme guardedness and withdrawal. During recent months he has shown no signs of aggressive ideation and is not believed to be a physical risk to himself or others at present.

It is recommended that efforts to establish a trusting relationship with this patient be continued, in order to help him cultivate a more adaptive coping/defensive pattern. Individual therapy will be more productive than group interventions. Once his guardedness has been relaxed, it will likely be beneficial to explore psychosocial issues present at the time The patient lost his job, as these appear to have partially precipitated the current psychotic exacerbation. Additionally, the patient will benefit from encouragement to explore the social and adaptive significance of his substance abuse history.

Self Assessment Questions

1) What is meant by referral questions?

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2) Elucidate how to write evaluation procedures.

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3) Describe behavioural observation in a psychological report.

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4) What type of background information is included in psychological report?

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5) What ways the test results are presented in a psychological report?

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6) Why is impressions and interpretations are important in a report?

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7) What would contain in the summary and recommendations?

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4.7 FUTURE PERSPECTIVES AND CONCLUSIONS

The above guidelines and outline for a psychological report may, in some ways, appear as a mechanical process. It should also be stressed that the most successful reports are likely to emerge from clinician and client interactions that are characterised by a high level of involvement and understanding. This is then likely to be reflected in a report that is more full, in depth, and captures the complexity and 'humanness' of the client. Technical skills and mechanical interpretation are no substitute for this process. An additional essential quality is that clinicians are well informed related to the type of problem and overall context the client is functioning in. Given that there is surprisingly little research on psychological reports, it would be crucial to expand this research base. The most likely avenue would be to investigate the interface between research on clinical judgement, psychometrics, and the ability of clinicians to interface with computer assisted interpretations in such a way as to increase the accuracy of clinician based judgements. This would need to be continually evaluated against the relative usefulness of reports with various referral sources.

4.8 LET US SUM UP

Assessment results are often communicated verbally to interested parties. After a psychological evaluation a psychologist will often schedule a feedback session to show the person who was tested the results and explain the findings in language that is understandable to a non psychologist. In addition to oral feedback, the psychologist typically prepares a written report to communicate test findings. Most psychologists avoid professional jargons so that their reports will be understandable to non psychologists. This unit outlined the way in which the referral for a psychodiagnostic test evaluation arises, the importance of its communicative nature, its place in the referral and helping process, and the fact that it can be focused in various ways. It was also pointed out that any pathology uncovered by the test data needs to be related to the referral problem. The particular importance of each section in the psychological report was defined, and a rationale was presented to reveal the logical inter connections and sequence of the various sections.

4.9 UNIT END QUESTIONS

1) The psychological report is the end product of ————————.

2) A report directed to another mental health professional is similartoone to a school teacher or a parent. True or False?

3) The *length of the report* varies considerably across various referral settings. True or False?

4) One of the crucial roles of a psychological report is to assist in providing —————.

5) The ————————— sets the stage for the rest of the report.

6) The main body of the report is contained in the ————————and ————————— section.

7) The test results provide an opportunity for the practitioner to succinctly state the main conclusions of the report. True or False?

8) Discuss the importance of psychological report?

9) Describe the general guidelines for a psychological report with examples?

10) Describe the format for psychological report by using suitable examples?

4.10 SUGGESTED READINGS

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