

Assessing clients

Picture yourself conducting a clinical interview. A 32-year-old married woman has presented to the service where you are working with difficulties getting to sleep and so you have prepared by reading about insomnia. You open the interview by asking the client to elaborate on her problem. She describes lying in bed, unable to sleep because concerns and worries spin around her mind. In addition to the symptoms you expected, the client tells you that she is overly irritable during the day, has extreme difficulty concentrating, is chronically indecisive, and feels immense fatigue. Suddenly, the seemingly simple problem of insomnia has expanded as the client describes other problems that could be part of the sleep difficulties, but could represent another problem altogether. As a clinician you are faced with a number of dilemmas:

- Are the problems related in any way? If so, which problem do you treat first?
- Are the problems manifestations of one underlying cause or multiple causes?
- What treatment is best for which problem or constellation of problems?

Clinical psychologists tackle these dilemmas with every new client. From Figure 3.1 it is apparent that the assessment process involves an objective psychometric assessment, the gathering of relevant background information during an intake interview, and an examination of the client's mental state based on observations made during the interview. Together, these data permit a description of the particular profile of symptoms, along with a formulation of the predisposing, precipitating, and maintaining factors of symptom presentation.

Diagnostic manuals represent the distillation of clinical experience and research into a format that identifies which problems tend to group into meaningful clusters. These clusters can assist therapists to plan potentially effective treatments because as scientist-practitioners they are then able to refer to and use the psychological literature that bears on the relevant diagnoses. In this chapter we will first consider current diagnostic practices and their limitations, as well as structured ways to conduct diagnostic interviews and a mental state examination. However, before considering diagnostic systems, it is necessary to define 'mental disorder'.

What is a mental disorder?

In its Tenth Revision of the International Classification of Diseases and Related Health Problems (ICD-10, WHO, 1992), the World Health Organization does not define a mental disorder. Rather, the authors note in the section on classification of mental and behavioural disorders that although they use the term disorder (in preference to 'disease' and 'illness'), it

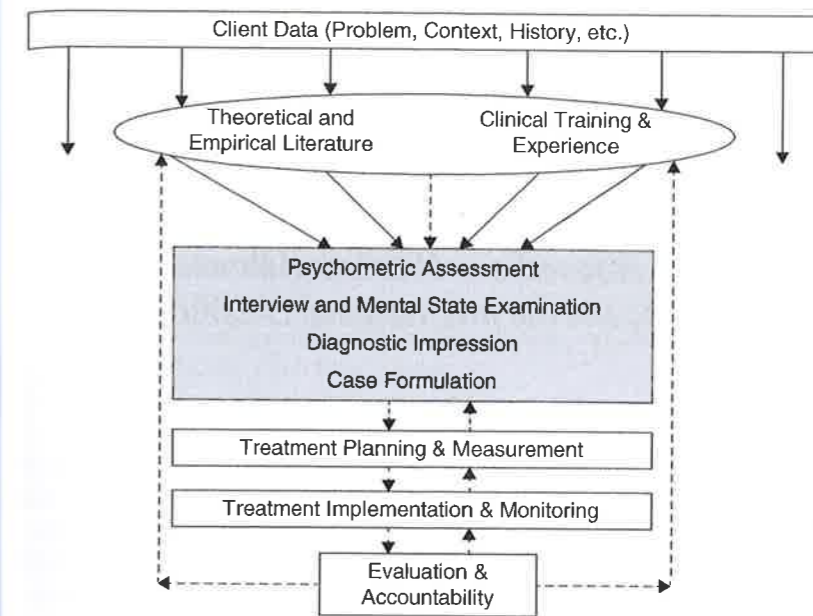


Figure 3.1 The complementary processes of testing, interviewing, and examining mental state as precursors to diagnosis, case formulation, and treatment planning.

is 'not an exact term, but is used here to imply the existing of a clinically recognizable set of symptoms or behavior associated in most cases with distress and interference with personal functions' (WHO, 1992, p. 5). In contrast, the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5, APA, 2013) does attempt to define a mental disorder. A mental disorder is a

clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are typically associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response... socially deviant behavior and conflicts that are primarily between the individual and the society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual. (p. 20)

In addition, the authors note that the definition does not include an expectable and culturally sanctioned response to a particular event (e.g., bereavement). Further, they note that the 'behavioral, psychological, or biological dysfunction' must lie within the individual, thereby excluding behaviour that is deviant (e.g., political, religious, or sexual) or conflicts with society (see Blashfield, 1998; Rounsaville et al., 2002).

Current diagnostic practices

The many different instances of psychopathology present a complex array of phenomena to be organized. Clinicians need to organize the various manifestations of psychopathology for a number of reasons. First, it is necessary to have an agreed nomenclature so that mental health professionals can share a common language. Second, a common language is needed so that information about particular psychopathologies can be retrieved. Third,

classification is a fundamental human activity that is necessary to organize the world within which we live. Presently, there are two main diagnostic systems, the American Psychiatric Association's DSM-5 (APA, 2013) and the World Health Organization's ICD-10 (1992, 1993). Both of these diagnostic systems classify disorders (rather than clients; Spitzer & Williams, 1987) and thereby assist clinicians as they try to plan treatment in a systematic, rational, and scientific way.

Diagnostic systems: the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and the *International Classification of Diseases (ICD)*

The DSM

The opening section of the DSM-5 (APA, 2013) provides a comprehensive discussion of how to use the manual. Importantly, the manual acknowledges that in addition to a mental disorder diagnosis, it is necessary to construct a clinical case formulation to identify factors that may have contributed to developing the mental disorder. Case formulation will be discussed in a later chapter but for now we will focus on diagnostic issues and postpone consideration of how to manage the complexity of moving from a description of the presenting problem to a treatment plan using a conceptual formulation of the causes of the client's presentation.

The psychological disorders that may be the reason for treatment that the DSM-5 lists are: (i) Neurodevelopmental Disorders, (ii) Schizophrenia Spectrum and Other Psychotic Disorders, (iii) Bipolar and Related Disorders, (iv) Depressive Disorders, (v) Anxiety Disorders, (vi) Obsessive-Compulsive and Related Disorders, (vii) Trauma- and Stress-Related Disorders, (viii) Dissociative Disorders, (ix) Somatic Symptom and Related Disorders, (x) Feeding and Eating Disorders, (xi) Elimination Disorders, (xii) Sleep-Wake Disorders, (xiii) Sexual Dysfunctions, (xiv) Gender Dysphoria, (xv) Disruptive, Impulse-Control, and Conduct Disorders, (xvi) Substance-Related and Addictive Disorders, (xvii) Neurocognitive Disorders, (xviii) Personality Disorders, (xix) Other Mental Disorders, (xx) Medication-Induced Movement Disorders and Other Adverse Effects of Medication, and (xxi) Other Conditions That May Be a Focus of Clinical Attention.

Each section in the DSM-5 follows a similar format. The title of the disorder (accompanied by a DSM code and a corresponding ICD code) is followed by the diagnostic criteria and a verbal description of the diagnostic features. This final section provides clarification of the diagnostic criteria and includes examples. It complements the somewhat stark listing of the diagnostic criteria, in that it provides a rich verbal picture of the disorder, thereby giving the clinical psychologist the context within which the symptoms occur and the manner in which the disorder may present. It develops a sense of the 'flavour' of each disorder, over and above a list of the criteria, and in addition to the DSM material, case studies are a useful complementary source of information. Some particularly good examples include Barnhill (2013), Meyer & Weaver (2012), Oltmans, Neale, & Davison (2003), Oltmans, Martin, Neale, & Davison (2012), Sattler, Shabatay, & Kramer (1998), and Spitzer, Gibbon, Skodol, Williams, & First (2001).

Following this section, the DSM-5 provides information on the subtypes of the disorder, associated features, specific cultural, age, and gender features, and the prevalence, course, familial patterns, and differential diagnosis (i.e., distinguishing from similar or related

disorders). By way of illustration, a Major Depressive Disorder is characterized by a period of at least two weeks with depressed mood or a loss of interest in pleasure. In addition to one or both of these symptoms, to meet diagnostic criteria, a client must also report or exhibit a total of five of the following: significant weight or appetite change, insomnia/hypersomnia, psychomotor agitation or retardation, fatigue/energy loss, feelings of worthlessness or excessive/inappropriate guilt, decreased thinking ability or concentration, or indecision, recurrent thoughts of death, suicidal ideation without plan, or suicide attempt or plan. Subsequent criteria require the clinician to ensure that the distress or impairment in social, occupational, or other important areas of functioning is 'clinically significant' and to rule out other possible diagnoses (e.g., a medical condition or the effects of a substance). The criteria for clinical significance rely upon clinical judgement and may use information from friends, family, and other third parties.

The clinician is then asked to specify the severity and other features of the disorder. The severity of a disorder is coded as mild if few, or no, symptoms in excess of those required to make the diagnosis are present (in this case five), and symptoms produce minor impairment in social or occupational functioning. It is coded as severe if many symptoms in excess of those needed to make a diagnosis are present, and severity is moderate if number of symptoms falls between 'mild' and 'severe' categories. For instance, a client with severe repeated episodes of depression would receive a diagnosis of 'Major Depressive Disorder, severe, Recurrent Episode'. The DSM diagnostic code would be 296.33 and the corresponding ICD code would be F33.2. The clinician also needs to consider a variety of specifiers that describe the course of the disorder (e.g., chronic), its recurrence, and the features that are present. By way of example, one set of features is melancholia, in which the depression involves loss of pleasure in activities and lack of reactivity to usually pleasurable stimuli in the presence of other symptoms such as 'empty mood', a depression that is worse in the morning, involves early morning waking, psychomotor agitation or retardation, significant weight loss, and excessive or inappropriate guilt.

The previous edition of the DSM permitted the clinician to code significant psychosocial and environmental problems that have occurred in the preceding year, in part acknowledging that such factors may moderate the treatment and prognosis of mental disorders. Environmental problems included negative life events, environmental difficulties or deficiencies. Psychosocial problems included relationship difficulties and the associated interpersonal stress, as well as insufficient social support or personal resources. Both psychosocial and environmental problems are relevant as they may be causally related to the onset of problems, but can also be a consequence of mental health problems. However, the DSM-5 has decided not to develop its own listing of such problems, and encourages clinicians to use the WHO's taxonomy, ICD 9's V codes (or Z codes in the ICD 10). A listing of the codes can be found in the DSM-5. Consider once more the previous example of the woman who plunged into a deep depression following her forced idle state due to a medical condition preventing her from lifting heavy objects. The situation was exacerbated by her also losing her part-time job as a carer working with disabled adults, where heavy lifting of patients was part of her daily job routine. Thus, noting the concomitant job loss as an 'Other problem related to employment' provides insight into the pervasiveness of her recent role transition from active provider for the family to 'being a burden' to her family.

The previous edition of the DSM provided the clinician's Global Assessment of the individual's Functioning (GAF). Although the measure has been criticized in terms of both reliability and validity, the information is useful in planning treatment and measuring its

impact, and in predicting outcome. Functional impairment is not the same construct as subjective distress, even though impairment and distress are frequently confounded in the concept of 'problem severity'. Separating the constructs is important because impairment is negatively related to improvement during treatment (McClellan, Woody, Luborsky, O'Brien, & Druley, 1983), clients with a high degree of impairment appear to improve to a greater degree with longer and more intensive treatment (Shapiro et al., 1994), and impairment is a predictor of relapse (e.g., Brown & Barlow, 1995). Functioning can be measured with the full 36-item or the 12-item short version of the World Health Organization Disability Assessment Schedule (WHODAS; www.who.int/classifications/icf/whodasii/en/). The scale measures the extent to which there is disability in six areas: cognition, mobility, self-care, interacting with others, life activities, and participation in society.

From the perspective of a clinical psychologist, arguably the most progressive step forward in the DSM system is a tentative move towards dimensional assessments. While medical approaches have tended to favour discrete categories, psychologists have typically viewed many constructs dimensionally. That is, while we are happy to speak casually about a person being 'intelligent', we understand intelligence to be a construct that is distributed (approximately) normally across the population. We may identify cut-points in the distribution for clinical purposes, but we tend to think about the meaning of a person's location on a distribution.

Section III of the DSM-5 lists 'emerging measures and models' and contains a set of tools to assist the clinical decision-making process. The cross-cutting symptom measures (www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures) provide dimensional assessments of constructs such as anxiety, depression, mania, memory, somatic symptoms, suicidal ideation, psychosis, sleep problems, memory, repetitive thoughts and behaviours, dissociation, personality function, and substance use. These measures can help the clinical psychologist not only in forming a diagnosis, but also by providing a richer picture of the symptom profile than a diagnostic label can achieve.

ICD-10

Despite the popularity of the DSM in many countries, the official coding system for international comparisons is the International Classification of Diseases, Tenth Revision, (ICD-10; WHO, 1992). The ICD diagnoses are presented in two volumes. The first volume includes the clinical descriptions and the diagnostic guidelines. Like the DSM-5, the ICD-10 organizes the disorders into various categories which are (i) Organic, including symptomatic, mental disorders (e.g., dementia in Alzheimer's disease), (ii) Mental and behavioural disorders due to psychoactive substance use (e.g., harmful use of alcohol), (iii) Schizophrenia, schizotypal, and delusional disorders, (iv) Mood (affective) disorders, (v) Neurotic, stress-related, and somatoform disorders (e.g., generalized anxiety disorder), (vi) Behavioural syndromes associated with physiological disturbances and physical factors (e.g., eating disorders), (vii) Disorders of adult personality and behaviour (e.g., transsexualism), (viii) Mental retardation, (ix) Disorders of psychological development (e.g., childhood autism), and (x) Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (e.g., conduct disorders).

Each disorder under each of these broad categories is listed, beginning with a description of the main clinical and important associated features, followed by diagnostic guidelines. In contrast to the DSM-5, the ICD-10 does not list explicit criteria for each diagnosis. That is,

there are no verbal descriptions that indicate the quantity and balance of symptoms required before a diagnosis can be made. Therefore, the ICD provides a degree of flexibility that is less evident in the DSM system, because sometimes clinical decisions need to be made 'before the clinical picture is entirely clear or information is complete' (WHO, 1992, p. 1). The companion volume within the ICD-10 (WHO, 1993) lists the research diagnostic criteria, and the format is much more similar to the DSM in that particular criteria are specified for each disorder.

By way of comparison and contrast, the ICD identifies three varieties of a depressive episode, ranging from mild to severe. In contrast to the DSM, where a client with a mild diagnosis must first meet the two diagnostic criteria for a Major Depressive Episode plus at least five additional criteria, a mild depressive episode in ICD would require only two symptoms from a list including depressed mood, loss of pleasure, reduced energy and fatigue, and two symptoms from tiredness, reduced concentration and attention, reduced self-esteem and self-confidence, ideas of guilt and unworthiness, bleak views of the future, ideas or acts of self-harm or suicide, disturbed sleep, and diminished appetite. The diagnostic specifiers used in DSM-5 are incorporated into the ICD by asking the clinician to code the particular category. Therefore, a client with repeated mild episodes of depression may receive a diagnosis of 'F33.0 Recurrent depressive disorder, current episode mild'. Note that the diagnostic codes are equivalent, yet the quantity and type of diagnostic criteria are not identical (see Rounsaville et al., 2002).

Both diagnostic systems acknowledge the need for cultural sensitivity when assigning diagnoses. This will be achieved by explicitly considering the client's ethnic or cultural reference groups and possible cultural explanations of a client's symptoms. For instance, the mode of expression may vary across cultures (e.g., greater somatic presentations of mood disorders in some cultures), and so too can the meaning of symptoms and causal models used by clients to explain their symptoms. Although some disorders appear culture-specific, the more usual situation facing the clinician requires sensitivity to the ways in which cultural and other social factors influence the presentation and impact of a disorder, as well as the way they are communicated to and understood by the clinician.

Conducting a diagnostic interview

Independent of the diagnostic system used, one product of an initial interview (when possible) is a diagnosis. Eliciting symptom information is a necessary, but not sufficient component of a diagnostic interview. In addition to determining which symptoms a client possesses and which they do not, the clinician aims to develop a clear picture of the client, the problem(s), and the personal, social, and environmental context within which these issues occur. The exact nature of the interview will be tailored to the client and to the problem, but a useful conceptual structure for an interview is outlined below.

The way that you meet the client will frame the dialogue. Since your aim is to assist a client discuss potentially sensitive issues, a good rapport is required. Therefore, communicate a sense of goodwill by being courteous. As discussed in Chapter 2, questioning at the outset of the interview should be open and designed to help the client talk while the clinician listens. One possible obstacle to an open dialogue is note taking. This occurs when the clinician focuses excessively on the notes at the expense of the client. Spend time building rapport with the client and respond to what the client says in a way that communicates that you understand not only what the client has said, but how the client felt. Therefore, try to

take sufficient but brief notes and in a manner that does not interfere with the flow of the interview.

Usually, a diagnostic interview will quickly move to the presenting problem(s) and the aim will be to identify the problem that the client has brought to therapy. While there may be times when tact and sensitivity dictate a more gradual introduction, clients typically arrive at a consultation prepared to tell their story. Thus, it may be helpful to encourage the client to phrase the problem in their own words. For instance, you may ask, 'I wonder if you could tell me what brought you here today?' As the client begins to respond to this question, ensure that you model good listening behaviour. Respond with verbal and non-verbal indications that you have heard and understood both the content of the speech, but also the broader emotional and social context that the person is in.

For example, a clinician might interview a client with Generalized Anxiety Disorder (GAD) in the following manner.

THERAPIST: Your referral suggests that you are having trouble with sleeping. Could you tell me a bit about the troubles you've been having?

CLIENT: Well, I just can't get off to sleep at night because these worrying thoughts keep popping into my head.

They just go around and around, so that I can't fall asleep. I'm now so tired that I feel that if I could just get a good night's sleep everything will be OK again.

THERAPIST: These worries seem to be having a huge impact on you.

CLIENT: They are. In fact, they seem to be the main problem.

THERAPIST: What sort of things do you worry about?

CLIENT: About anything and everything. I worry about my children's health, I worry about not having enough money, I worry about the house burning down, I worry about work... I even worry that I worry about worrying.

THERAPIST: Can you tell me about this 'worry about worrying'?

CLIENT: I feel I *need* to worry. If I don't, then I worry that something terrible will happen. Like when my children go out at night, I'm never sure that they'll be safe, but if I worry then I feel that things are better because I've done everything I can.

THERAPIST: Do these worries occur at times other than when you are trying to go to sleep?

CLIENT: Yes, they happen all the time. Right now I'm worrying that you might not be able to help me because I'm not being clear enough. This has been going on for years now and I don't know if I have a problem or if it's just the way I am.

THERAPIST: When people worry a lot for a long time, there can be effects in the rest of their life. Have you noticed any impact of the worry?

CLIENT: As well as the sleep, I notice that I get really tense. The muscles around my neck tighten up so much that I'm in pain.

THERAPIST: That must be exhausting as well as painful.

CLIENT: You're right. I am so tired from all the worry and tension, but I still don't seem to be able to sleep. It doesn't make sense.

THERAPIST: We'll talk about trying to make sense of your experience a little later, but for the time being I'd like to continue to get a clear idea in my head of the problems you are facing. When other people experience excessive worry and uncontrollable tension, they sometimes notice that they are more irritable or feel on edge and tense. Have you felt like this?

CLIENT: Always on edge and ... erm ... what was the other thing?

THERAPIST: Irritable?

CLIENT: Yes, often irritable at home, but never at work.

THERAPIST: How about difficulties with concentration?

CLIENT: I don't seem to have trouble concentrating, just that I concentrate on my worries.

THERAPIST: When you are trying to concentrate on your work, do your worries break into that concentration?

CLIENT: Yes, but it's not that I can't concentrate. I concentrate on the wrong thing.

A number of issues are evident in the preceding conversation. First, if you consult the DSM-5 criteria for Generalized Anxiety Disorder you can see that the clinician is asking the client about symptoms relevant to the disorder. At the beginning, the clinician begins with open questions, but towards the end of the section, the questioning becomes closed and more focused as the clinician moves to check that material was omitted because the symptoms are indeed absent, rather than the client just failing to report material even though the symptoms are present. Second, you will see that the client becomes confused when multiple symptoms are included in a single question. Try to avoid questions that contain multiple issues and requests. Third, you will see that the client and clinician do not have a shared understanding of the word 'concentration'. For the client, concentration refers more to the cognitive process, whereas the clinician is referring to the ability to focus on a particular thought. In the preceding conversation, the client took the initiative in clarifying the issue, but had the client not done this, the clinician could have been more explicit in questions. Finally, at the end of this section, the clinician would be in a position to speculate that the client may be suffering from GAD. Further questioning would clarify this but it would appear that the client has been experiencing excessive worry about a number of events more days than not for some years (DSM-5 Criterion A). There is difficulty controlling the worry (Criterion B), the worry is associated with feeling keyed up or on edge, easily fatigued, irritability, muscle tension, and sleep disturbance (Criterion C), and there is clinically significant distress and impairment (Criterion D). Criteria E and F require the clinician to determine that the worries are not better explained by another disorder. Thus, the clinician will need not only to explore GAD, but it will be necessary to entertain the possibility that the symptoms are a manifestation of other disorders (e.g., primary insomnia, major depression, and substance abuse) and hence a differential diagnosis is required to determine the best label to describe the client's problems. It is also possible that the client exhibits comorbidity, and hence two disorders (e.g., GAD and depression) are present simultaneously. Further interviewing is required and for each disorder, the DSM-5 provides details about how to make a differential diagnosis.

After the client has begun to describe the problem, the clinician is confronted with a choice of direction. On the one hand, the clinician could choose to remain with a discussion of the presenting problem and elicit personal and historical information later. The advantages of this strategy are that the interview continues to flow naturally and the client keeps relating the details of the presenting problem. However, the disadvantage is that the clinician does not have a good picture of the client as a person, the social and historical background to the problems, a sense of other psychological problems, and so on. Instead, the clinician could signal a change of direction by saying, 'Thank you. You have given me an idea of the difficulties that you are having. I would like to pursue them in more detail, but before we talk about these difficulties I was wondering if I could get some idea about you as a person?' The interviewer could then proceed to ask questions about the social and personal background. The advantages of this strategy are that the psychological problems are then unveiled in the context of the whole person. The main disadvantages are that the clinician may not know what aspects of the personal history are relevant until the problem is explicated and the interview may need to be cut short because insufficient time remains to discuss the client's difficulties before the session ends.

Assuming that the clinician has decided in this instance to remain with a discussion of the presenting problem, this could be signalled with a comment such as, 'I wonder if we could discuss the difficulty you have been mentioning in some detail. When did you first notice that something was not right?' This will direct the client to discuss the evolution of the problem; acknowledging the fact that psychological difficulties exist in a dynamically evolving system. However, within the complexity, the clinician will be focused on trying to highlight the key milestones in the problem development. This history will lead the client towards the present, at which time it will be possible to get a clearer description of the difficulties and any associated behaviours. As a mental checklist, the clinician will be aiming to identify (i) what the problem is, (ii) when it occurs, (iii) where it happens, (iv) how frequently the problem takes place, (v) with whom these difficulties arise, (vi) how distressing and (vii) impairing the problem is. In collecting this information, the clinician will also identify distal factors associated with the problem. These will be identifiable from a discussion of the environment, context, and lifestyle present when the problem began, other predisposing and triggering factors, the consequences of the problem's onset, the way the problem has changed over time and factors associated with these changes (both increases and decreases in severity and frequency). The interview will evolve from a historical discussion to consideration of the problem in its current form. The clinician might ask, 'Could you please tell me about a typical day or occurrence of the problem?' and then explore some of the maintaining factors. The clinician will also ask about the variability in the problem and factors associated with the fluctuations (i.e., moderating variables).

As far as the diagnostic aspect of an interview is concerned, the clinician will elicit a comprehensive description of the problem and its various manifestations. Clients may often focus on one aspect of the problem because it is salient to them, but remember to explicitly consider the behaviour and actions, consciously available thoughts and other cognitive processes, as well as physiological changes. The clinician also needs to ask about the frequency, intensity, topography (typical and unusual patterns), duration, and temporal sequence of symptoms. In addition, the consequences of any behaviour need to be thoroughly assessed (see Chapter 5).

After the clinician has a good sense of the presenting problem, its present manifestation, and its history, the interview can expand to provide a more complete picture of the person. The clinician might say, 'You have given me a good idea of the problems you are struggling with, but I don't think I have got a good idea about you as a person. Could you tell me something about you, apart from these difficulties?' The aim of this process is to be able to put yourself in the client's shoes and imagine what it must be like to experience the life the client has had. Therefore, it may be relevant to ask about family history (details of parents, other significant figures, brothers and sisters, as well as the childhood environment of family, school, and peers), a personal history (birth date and any significant issues, general adjustment in childhood, lifelong traits or behavioural patterns and tendencies, significant life events), schooling (duration and significant events), work history and present duties, relationships (current status, history and problems), leisure activities, living arrangements, social relationships, prior significant accidents, diseases and mental health problems, and personality (and particularly any changes).

An important aspect of a diagnostic interview is to identify the coping resources that a client can bring to bear in seeking to overcome their problems. Therefore, enquire about

coping resources and other personal strengths the individual possesses. Within this context, motivation for change is a critical dimension (see Miller & Rollnick, 2012 for an excellent discussion). The clinician will not only attempt to identify the motivations intrinsic to the person, but identify any extrinsic motivators that are present or have been successful in the past. The clinician can also try to identify the 'stage of change' that the client is in. Prochaska, Norcross, and DiClemente (1995; Prochaska & Norcross, 1998) have suggested that clients move through a series of stages. In the first instance, individuals are pre-contemplators – they have their problem, but have not yet got to the point of desiring to modify their behaviour. As a person begins to notice the impairment or becomes increasingly concerned about the distress being triggered, they move into the contemplation phase, in which they

Annotated Initial Interview Pro Forma

Interview Date: ____/____/____

Name: _____

Sex: M/F

Date of Birth: _____

What has brought you here today?

Presenting Problem

Relevant Background/Personal History

Family history
Personal history
Birth
Childhood adjustment
Schooling
Work
Relationships
Leisure
Significant illnesses/disorders
Accidents
Physical illnesses
Mental disorders/problems.
Personality

Problem History

Evolution
Distal Factors
Context of problem
Circumstances of onset
Consequences of onset
Change over time/Milestones
Variables assoc. with severity

Figure 3.2 Annotated pro forma of initial interview.

Current Problem Presentation

Proximal factors
 Typical presentation
 Variations in presentation
 Maintaining factors?
 1. Antecedents
 2. Behaviour
 3. Consequences
 Motivation for change
 Stages of change
 Mental Status Examination

Summary*Test Results**DSM /ICD Diagnosis:**Formulation*

Presenting problems
 Predisposing factors
 Precipitating variables
 Perpetuating cognitions and consequences
 Provisional conceptualization
 Prescribed interventions
 Potential problems and client strengths

Action Plan

1. Treat
 2. Refer
 3. Other

Figure 3.2 (cont.)

are considering the pros and cons of dealing with the problem. From contemplation, a client will move into preparation and action, after which time they will either relapse into any of the preceding stages or continue to manage the problem successfully.

At the end of the interview, summarize and synthesize the material covered. Often it is useful to present this summary in a provisional manner by saying, 'I will try to draw together some of the themes we have been discussing. If I miss something out or if I get a point wrong, please let me know.' It is also prudent to ask the client if there are any problems or issues which you have not asked them about or which there has not been time to discuss. This increases confidence that the main problems have been covered and also provides an opportunity for clients to raise other significant issues now they feel more at ease.

A pro forma (Figure 3.2) may assist you with note taking and structuring an interview. The text in the right hand column is a series of prompts and can function as a checklist.

Adapting diagnostic interviews for different client groups (children and the elderly)

The diagnostic interview will need to be adapted in a flexible manner to be suitable for each client. However, some general points can be made about certain client groups. One important group to consider is children. When interviewing children the clinician needs to contextualize the information in the normative developmental process. Deviations from normal childhood development need to be understood both in terms of the normative processes, but also in terms of the typical variability (see Sattler, 2008, 2014). Assessments of children may also require the collection of information from parents, teachers, other family members, and professionals. Collection of data from multiple sources provides a rich picture of the problem as well as insight into the way the problematic behaviours are observed and interpreted by individuals prominent in the child's life (see Sattler, 2008, 2014).

When interviewing the elderly, there are a variety of considerations when arriving at a diagnosis. Medical conditions, cognitive impairment, and pharmacological issues may all have a bearing on the client's presentation (Edelstein, Koven, Spira, & Shreve-Neiger, 2002). The same disorder does not always present itself in the same way in older adults as it does in younger adults. For instance, depression is more likely to present with somatic symptoms and with less dysphoria (Fiske, Kasl-Godley, & Gatz, 1998). Further, the clinician will need to entertain differential diagnostic possibilities among older adults that are less common with younger clients. For instance, depression and dementia can co-occur at times, and need to be distinguished (see Edelstein, 1998; Kaszniak & Christenson, 1994).

Screening for psychological symptoms

A large amount of information needs to be collected during a diagnostic interview and there is a risk that key issues will be missed. One way to complement the information gleaned from a diagnostic interview is to collect information from screening tests. Screening is the 'presumptive identification of unrecognized disease or defect by the application of tests, examinations or other procedures which can be applied rapidly to sort out apparently well persons who probably have a disease from those who probably do not' (Commission on Chronic Illness, 1957, p. 45). Therefore, when administered before a diagnostic interview, tests provide the clinician with an efficient means of collecting and collating symptom information, as well as giving an indication of the extent to which a client's symptom profile deviates from statistical norms.

SCL-90-R & BSI

The Revised Symptom Checklist 90 (SCL-90-R, Derogatis, 1994) is a broad symptom measure that covers nine dimensions (Somatization, Obsessive-compulsive, Interpersonal sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid ideation, and Psychoticism). Three global indices of distress can be derived from the dimensional scores. The 90 items (a briefer version is available in the form of the Brief Symptom Index; BSI, Derogatis & Spencer, 1982) are scores referring to the past seven days, including today, and the checklist takes clients about 15 minutes to complete. Responses can be interpreted in terms of the global indices, the nine dimensions, or the items themselves, and the chief advantage is that the clinician is provided with a broad range of symptom information in a very efficient manner.

General Health Questionnaire (GHQ)

Developed by Goldberg (1972), the GHQ is a 60-item scale that identifies four factor-analytically derived subscales describing Somatic Symptoms, Anxiety and Insomnia, Social Dysfunction, and Severe Depression. Briefer forms (GHQ-30 and GHQ-12) are available and the scale has been validated for use among many different samples (including geriatric, traumatically injured, and medically ill patients).

Center for Epidemiological Studies – Depression Scale (CES-D)

The CES-D is a 20-item self-report scale that assesses mood and functioning over the past seven days (Radloff, 1977). It identifies Depressed affect, Positive affect, Somatic problems, and Interpersonal problems. The scale can be abbreviated to a five-item version and has been validated in community, medical, and clinical samples.

Beck Depression Inventory (BDI)

The BDI (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) is a 21-item scale designed to assess the present severity of depression by assessing attitudes and symptoms related to depression, with the latest revision aiming to assess the existence and severity of the DSM's symptoms of depression (Beck, Steer, & Brown, 1996). Cut-off scores of 0–13 indicate minimal depression, 14–19 mild depression, 20–28 moderate depression, and 29–63 severe depression. A number of studies have supported the reliability and validity of the BDI and it is useful for measuring depressive symptoms, indicating the severity of present symptoms, and quantifying the extent of treatment changes (Beck, Steer, & Garbin, 1988; Sundberg, 1987).

Behaviour and Symptom Identification Index (BASIS-32)

Another brief screening instrument is the BASIS-32 (Eisen & Grob, 1989). This 32-item self-report inventory assesses over a one-week interval the major symptom domains and current function that required inpatient psychiatric treatment. The subscales measure relation to self and others, daily living and role functioning, anxiety and depression, impulsive and addictive behaviour, and psychosis.

Hamilton Anxiety Scale (HAS) and the Hamilton Rating Scale for Depression (HAM-D)

The Hamilton Anxiety Scale (Hamilton, 1959) is a 14-item clinician-rated scale assessing the symptoms of anxiety. The subscales are psychic and somatic anxiety. The Hamilton Rating Scale for Depression (Hamilton, 1967) is a 21-item clinician-rated scale. Both of these tests have been used with a wide variety of client groups; they are commonly used, and they have good psychometric properties.

The United Kingdom's National Health Service has introduced a good series of measures as part of its Improving Access to Psychological Therapies (IAPT; www.iapt.nhs.uk/data/measuring-outcomes/). The IAPT lists a series of outcome measures and recommends particular measures to be used for specific problems. Details can be found in the *IAPT Data Handbook*, but for present purposes one example will be highlighted.

All patients seen through the IAPT system are to be assessed in terms of depression (using the 9-item Patient Health Questionnaire; PHQ-9), general anxiety (using the 7-item Generalized Anxiety Disorder scale; GAD-7), phobias (using the IAPT Phobia Scales), functioning (using the Worker and Social Adjustment Scale), and the IAPT patient choice

and experience questionnaire. In addition, specific instruments are recommended for particular clinical presentations. Each of the scales is provided with relevant psychometric information and clinical cut-offs. For instance, the PHQ-9 can be used to monitor change in symptoms of depression over time and the clinical cut-point of 9 identifies 'caseness', such that any person who scores 10 or higher is judged to be experiencing clinically significant symptoms of depression. Clinical psychologists can use these scales not only to be accountable in their own practice, but they can also use these scores to discuss progress with their clients. In summary, each of the preceding scales provides a good screening for psychopathology. They can assist the clinician in recognizing a disorder by making the clinician aware of particular symptoms, as well as their levels and patterns. However, none of the screening instruments reviewed can indicate that a client has met diagnostic criteria for a particular disorder. Structured and semi-structured diagnostic interviews serve this function.

Structured and semi-structured diagnostic interviews: adults

Any diagnostic method must be both reliable and valid. However, the validity of a diagnostic interview and a diagnostic system are not identical. The validity of a diagnostic interview is judged by the extent to which the outcome of the interview matches onto the disorder in the diagnostic taxonomy. The validity of a diagnostic system is judged by the degree to which the disorders describe clinically meaningful clusters of symptoms. Although reliability does not guarantee validity, validity requires reliability. In the past, diagnoses were notoriously unreliable, but the decision to introduce specific diagnostic criteria for each disorder into the DSM-III (APA, 1980) successfully increased the reliability of diagnoses. Although some have suggested that the validity of the diagnoses themselves was sacrificed in the pursuit of reliability (see Rounsaville et al., 2002), another source of unreliability is the diagnostic interview itself. Clinicians may omit key questions, fail to consider all diagnostic possibilities, or be overly influenced by dramatic symptoms and hence arrive at a diagnosis that would not be obtained by a second interviewer, or even by the same clinician on a separate occasion. One way to increase diagnostic reliability in generating DSM and ICD diagnoses is to use structured and semi-structured diagnostic interviews (Summerfeldt & Antony, 2002).

Structured diagnostic interviews are particularly helpful in research (where replicability is essential), in training (where the structure can assist a novice clinician), and in practice (where use of a standardized instrument can increase the confidence in a diagnosis). A variety of instruments are available and they will be reviewed next. There are a set of dimensions along which the instruments vary (e.g., diagnostic breadth and depth, duration of the interview, extent to which clinical skill is required, target population) and thus the individual electing to use a structured diagnostic interview will need to consider the purpose of the interview. Specifically, the clinician will need to evaluate the instrument in terms of (i) coverage and content, (ii) the target population, (iii) the psychometric features of the instrument, (iv) practical issues (e.g., duration, training), (v) administration requirements and support (e.g., scoring algorithms, standardized manual; see Page, 1991a; Summerfeldt & Antony, 2002). With the release of DSM-5 new versions of structured interviews will be developed, but many of the instruments and much of the psychometric data relate to the previous editions of the DSM. Therefore, caution needs to be exercised when evaluating the generalizability to the most recent diagnostic system.

Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV)

The ADIS-IV (Brown, Di Nardo, & Barlow, 1994) is a semi-structured interview that follows a structure similar to a clinical interview and relies on the clinician to ask additional questions to follow up issues of relevance. Although its primary focus is the DSM-IV Anxiety Disorders, it also assesses Mood, Substance Use, and Somatoform Disorders due to their high rates of comorbidity with anxiety. The relatively narrow coverage can be offset by the detailed information provided by the interview about conditions, aetiology, and dimensional symptom ratings. The whole interview assessing current and lifetime disorders takes 2–4 hours in clinical samples. The reliability of the instrument is acceptable and the limited validity data upon its predecessor are supportive (e.g., Rapee, Brown, Antony, & Barlow, 1992). In addition to its use in research, the ADIS-IV is suitable as a primary diagnostic measure when used by trained mental health professionals.

Diagnostic Interview Schedule (DIS) and the Composite International Diagnostic Interview (CIDI)

The DIS-IV (Robins, Cottler, Bucholz, & Compton, 1995) is a structured diagnostic interview that is suitable for use by lay interviewers as well as mental health professionals. The diagnostic coverage is broad and is even broader in the more extensive version; the CIDI (Robins et al., 1988). The most recent version of the CIDI is compatible with both DSM-IV and ICD-10 and therefore is suitable for international comparisons (Andrews & Peters, 1998). Due to their similarity, they will be considered together. The instruments are organized in a modular format to permit customization of the interview and the structured format has permitted computerization. The administration time is 2–3 hours with clinical samples and they yield both current and lifetime diagnoses. The instruments are useful in large-scale epidemiological studies, but the level of agreement with clinical diagnoses is poor and therefore it is recommended that the findings are supplemented with other sources of data (Segal & Falk, 1997). Consequently, they are not suitable as primary diagnostic instruments in psychiatric settings.

Mini-International Neuropsychiatric Interview (MINI)

The MINI (Sheehan et al., 1999; <https://medical-outcomes.com/index/mini>) is a clinician-administered structured diagnostic interview that assesses both DSM-IV and ICD-10 criteria. Being designed to provide a valid structured interview for clinical and research contexts, it covers a broad range of disorders, but does so in around 15 minutes. The reliability and validity of this instrument are promising (Sheehan et al., 1998).

Primary Care Evaluation of Mental Disorders (PRIME-MD)

In contrast to the preceding interviews, which provide an extensive assessment of many disorders present currently and over the lifetime, the PRIME-MD is a brief (10–20 minutes; or 3 minutes using the more recent Patient Health Questionnaire; Spitzer, Kroenke, & Williams, 1999) clinician-administered interview to permit primary care physicians to rapidly identify the mental disorders commonly seen in medical practice (Spitzer et al., 1995). Comprising a 25-item, self-report questionnaire asking about general physical and mental health issues and a semi-structured interview to follow up on items that the patient has endorsed, the instrument provides a quick assessment of DSM-IV mood, anxiety, somatoform, eating, and alcohol-related disorders. Little reliability data exist and in terms of validity, its sensitivity and specificity are good, although the correspondence with DSM-IV is only moderate. Although the speed comes at the cost of breadth and depth, and the diagnoses

obtained do not map directly onto DSM-IV categories, as a quick standardized identification of psychiatric cases, the instrument performs well. Another instrument that is suitable for use by physicians in primary care is the Symptom-Driven Diagnostic System for Primary Care (SDDS-PC; Broadhead et al., 1995).

Schedule for Affective Disorders and Schizophrenia (SADS)

The SADS (Endicott & Spitzer, 1978) is a clinician-administered semi-structured interview developed to assess the research diagnostic criteria (found in the second volume of the ICD-10). The instrument assesses current and past symptoms, with other versions assessing symptoms across the whole lifetime (SADS-L; Lifetime), and changes in symptoms (SADS-C; Change). The SADS has a broad coverage of psychological disorders and the SADS-LA-IV (SADS Lifetime Anxiety for DSM-IV; Fyer, Endicott, Mannuzza, & Klein, 1995 cited in Summerfeldt & Antony, 2002) also assesses DSM-IV criteria in addition to expanded coverage of anxiety disorders. A SADS interview takes an hour with non-clinical samples, and this short duration, relative to its breadth of coverage, is achieved by a structure that permits clinicians to skip sections that are not relevant because the respondent fails to endorse screening questions or they are not germane to the interview purpose. The reliability of the SADS is excellent, when compared with the other structured diagnostic interviews (Rogers, 1995) and the validity is very good (see Conoley & Impara, 1995), particularly in the area of mood disorders, making it well-suited as a primary diagnostic screening measure.

Structured Clinical Interview for DSM-IV Axis-I Disorders (SCID)

The SCID is available in a brief clinical (SCID-CV; First, Spitzer, Gibbon, & Williams, 1997) and a more extensive research (SCID-I; First, Spitzer, Gibbon, & Williams, 1996) version. According to the website (www.scid4.org/) a revision for DSM-5 is anticipated in the near future. Importantly, versions are also available for Personality Disorders. The SCID-CV is a relatively brief interview that provides coverage of the disorders commonly seen in a mental health practice. The SCID-I comes in a variety of forms and the version designed for individuals already identified as psychiatric patients (SCID-I/P) has the most extensive coverage of mental health disorders of all available instruments, with interviews taking at least an hour. The reliability is good (Segal, Hersen & van Hasselt, 1994) and validity studies of previous versions have also been supportive of the instrument (Rogers, 1995; 2001).

Schedule for Clinical Assessment in Neuropsychiatry (SCAN)

The SCAN (WHO, 1998; <http://whoscan.org/>) is quite different from other structured interviews. Whereas other instruments focus on diagnostic categories, the SCAN seeks to describe key symptoms. The instrument comprises a semi-structured clinical interview, a glossary to rate the experiences endorsed by respondents, a checklist to rate information provided by third parties, and a schedule to assess the respondent's clinical, social, and developmental history. The data can be scored to generate DSM-IV and ICD-10 diagnoses.

Structured and semi-structured diagnostic interviews: children and adolescents

Child and Adolescent Psychiatric Assessment (CAPA)

The CAPA (Angold et al., 1995) is a structured diagnostic interview suitable for children and adolescents aged 9–17. It assesses the onset, duration, frequency, and intensity of symptoms

present in the three months prior to the interview, and permits diagnoses in both DSM-IV and ICD-10 to be made. It has a modular format that permits clinicians to use it flexibly, with the patient report version taking around an hour. The reliability and validity data are good (Angold & Costello, 2000).

Diagnostic Interview Schedule for Children (DISC)

A version of the DIS is available for children and adolescents aged 6–18 (DISC; see Shaffer, Fisher, Lucas, Dulcan & Schwab-Stone, 2000). Modelled on the DIS's highly structured format, it assesses the common psychiatric diagnoses found in children and adolescents. It has good test-retest reliability (appearing to improve with age), but validity studies have been disappointing.

Children's Interview for Psychiatric Syndromes (ChIPS)

The ChIPS (Weller, Weller, Teare, & Fristead, 1999) is a structured interview for use with children and adolescents aged 6–18, and is available in both child and parent versions. Responses to stem questions determine whether the interviewer will proceed to follow a particular line of questioning. Psychometric data on this instrument are promising (Weller, Weller, Fristead, Rooney, & Schechter, 2000).

Child Assessment Schedule (CAS)

The CAS (Hodges, Kline, Stern, Cytryn, & McKnew, 1982) is a semi-structured diagnostic interview suitable for children aged 7 and above. Symptoms are assessed in a semi-structured interview with the child and by the interviewer's observations. Taking around an hour to complete, the psychometric data are good (Broogs, Griffin, & Gross, 2002).

Interview Schedule for Children and Adolescents (ISCA)

The ISCA (Kovacs, 1997) is a semi-structured diagnostic interview suitable for children and adolescents aged 8–17 years. The instrument provides diagnoses in DSM-IV categories and takes around three hours to complete. Psychometric data are promising (Sherrill & Kovacs, 2000).

Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS)

The K-SADS is a version of the adult SADS that is designed for children of age 6 and above to yield DSM-IV diagnoses. Parent and child response versions are available, and the reliability data are good and validity data are acceptable (Ambrosini, 2000).

Structured and semi-structured diagnostic interviews: older adults

Structured diagnostic interviews have not yet been developed specifically for use with older adults and the instruments already discussed can be used. However, mental state can be assessed using the Geriatric Mental State Schedule (GSM; Copeland et al., 1976) and the GSM Schedule – Depression Scale (Ravindran, Welburn, & Hardesty, 1994) is a brief semi-structured interview for discriminating between depressed and non-depressed older adults. Other instruments, such as the Comprehensive Assessment and Referral Evaluation (CARE; Gurland et al., 1977; Gurland, Goldon, Teresi, & Challop, 1984) and the Cambridge Mental Disorders of the Elderly Examination (CAMDEX; Roth et al., 1986) provide assessments of a client's mental state. The mental state of clients is an important component of an assessment

and diagnosis with older adults, but is also relevant with clients of any age. Therefore, the assessment of mental state will be considered in some detail.

Mental Status Examination (MSE)

A Mental Status Examination (MSE) provides a template that assists a clinical psychologist in the collation and subsequent conceptual organization of clinical information about a client's emotional and cognitive functioning. By systematically basing observations on verbal and non-verbal behaviour, the aim is to increase the reliability of the data upon which subsequent diagnoses and case formulation are made. The particular perspective of the interview and the use to which the data are put will vary depending upon whether the goal is psychiatric (see Daniel & Crider, 2003; Treatment Protocol Project, 1997) or neurological (see Strub & Black, 2000), but the domains covered by the clinician are similar. Reporting an MSE also requires the clinician to be familiar with the descriptors of various symptoms, such as those found in the glossary of the DSM-5 (APA, 2000; see also Kaplan & Sadock, 2004).

Broadly speaking (and following Daniel & Crider, 2003), an MSE collates information about the client's (i) physical, (ii) emotional, and (iii) cognitive state. Under each of these domains fall a number of topic areas which are summarized in Table 3.1.

The summary of an MSE will not note every detail under each heading, but draws attention to the key features that describe the client and frame the presenting problem within a context of who the client is. Typically the description begins with a statement about their age, gender, relationship status, referrer, and presenting problem (i.e., the reason for presentation at the service on the particular occasion). For instance, the description may begin by saying, 'Gill, a 35-year old single woman, was referred by her medical practitioner, who had suggested treatment for her obesity that was contributing to hypertension.'

Physical

The description will draw attention to noteworthy aspects of the client's physical state.

Appearance

A concise summary of the client's physical presentation is given to paint a clear mental portrait. The description may refer to dress, grooming, facial expression, posture, eye contact, as well as any relevant noteworthy aspects of appearance. For instance, a clinician might note that the client 'wore an expensive, but crumpled suit. He sat slumped in the chair and was unshaven, with dark circles under his eyes.' Importantly, the aim is to describe what is observed rather than your interpretation (e.g., 'he was exhausted').

Behaviour

A description of behaviour may make reference to the client's level of consciousness extending from alert, through drowsy, a clouding of consciousness, stupor (lack of reaction to environmental stimuli) and delirium (bewildered, confused, restless, and disoriented), to coma (unconsciousness). It may also include reference to the degree of arousal (e.g., hyper-vigilance to environmental cues and hyperarousal such as observed in anxious and manic states) and mannerisms (e.g., tics and compulsions).

Table 3.1 An outline for a Mental Status Examination

PHYSICAL	
Appearance	Motor activity
Behaviour	
EMOTIONAL	
Attitude	Mood and affect
COGNITIVE	
Orientation	Attention and concentration
Memory	Speech and language
Thought (form and content)	Perception
Insight and judgement	Intelligence and abstraction

Motor activity

An account of the observed motor activity aims to describe both the quality and the types of actions observed. Reductions in movement can be variously described as a reduction in the level of movement (psychomotor retardation), slowed movement (bradykinesia), decreased movement (hypokinesia), or even an absence of movement (akinesia). Increases in the overall level of movement are referred to as psychomotor agitation, but it is also important to note minor increases in movement such as a tremor.

Attitude

The clinician will also consider the way in which the client participates in the interview, as a way of gauging their manner and outlook. These judgements will be based on the client's response both to the context of the interview, but also to the interviewer. Identifiers may be open, friendly, cooperative, willing, and responsive, or alternatively, they may be closed, guarded, hostile, suspicious, and passive. These terms will be used to describe complex sets of behaviours including attentiveness, responses to questions, expression, posture, eye contact, tone of voice, and so on.

Emotional

Moving from the physical domain, the clinician will portray the person's emotional state, once again drawing upon the verbal and non-verbal behaviour of the client.

Mood and affect

Although affect (an external expression of an emotional state) is potentially observable, mood (the internal emotional experience that influences both perception of the world and the individual's behavioural responses) is less apparent and will require the clinician to depend to a greater degree on the client's introspections. Descriptors of mood include euphoric, dysphoric (sad and depressed), hostile, apprehensive, fearful, anxious, and suspicious. The stability of mood can also be noted, with the alternation between extreme emotional states being referred to as emotional lability. The range, intensity, and variability of affect can be variously portrayed, but some important expressions are restricted (i.e., low intensity

or range of emotional expression), blunted (i.e., severe declines in the range and intensity of emotional range and expression), flat (i.e., a virtual absence of emotional expression, often with an immobile face and a monotonous voice), and exaggerated (i.e., an overly strong emotional reaction) affect. The clinician will also consider the appropriateness of the affect (and note if the emotional expression is incongruent with verbal descriptions and behaviour) as well as the client's general responsiveness.

Cognitive

The cognitive components in an MSE will be familiar to clinical psychologists, since many components are assessed more comprehensively and within memory tests. However, during the MSE, the aim is to provide a general screening which requires interpretation using clinical judgement with one outcome being to recommend further formal testing.

Orientation

A person's orientation refers to their awareness of time, place, and person. Orientation for time refers to a client's ability to indicate the current day and date (with acceptance of an error of a couple of days). Orientation for place can be assessed by asking clients where they have presented. Behaviour should also be consistent with that expected in the setting in which they have arrived. Orientation for person refers to the ability to know who you are, which can be assessed by asking the client their name or names of friends and family which you can verify.

Attention and concentration

'Working memory' (Baddeley, 1986, 1990) is the term now used in psychology to refer to the constructs called attention and concentration. The aim is to describe the extent to which a client is able to focus their cognitive processes upon a given target and not be distracted by non-target stimuli. Digit span (the ability to recall in forward or reverse order increasingly long series of numbers presented at a rate of one per second) is a common way to assess these working memory functions, and normal individuals will recall around 6–8 numbers in digits forward and 5–6 numbers in digits backwards. Another method used is 'serial sevens' in which seven is sequentially subtracted from 100. Typically people will make only a couple of errors in 14 trials.

Memory

An MSE will typically assess memory using the categories of short- and long-term memory. Although these categories do not map neatly onto models of memory in recent cognitive psychology (Andrade, 2001), the aim of the MSE is to provide a concise description of a person's behaviour and screen them in a manner that can guide further assessment. Therefore, more sophisticated assessments and analyses may follow. To assess recent or short-term memory, clients can be asked about a recent topical event or who the President or Prime Minister is. Clients can also be asked to listen to three words, repeat them, and then recall them some time later in the interview. Most people will usually report 2–3 words after a 20-minute interval. Visual short-term memory can also be assessed by asking clients to copy and then reproduce from memory complex geometrical figures (such as those in the Rey Auditory Verbal Learning Test). Long-term memory can be assessed by asking about childhood events.

Thought – form and content

During an MSE the clinician will address the client's thought processes, inferred typically from speech. Disturbances in the form of thought are evident in terms of (i) the quantity and speed of thought production. The client may jump from idea to idea (flight of ideas) or show a poverty of ideas. Thought may be disordered in terms of (ii) the continuity of ideas. The client may leave a topic of conversation and perhaps return to it much later (circumstantiality), or maybe never return (tangentiality) on the one hand or may perseverate with the same idea, word, or phrase. They may show a loosening of associations, where the logical connections between thoughts are esoteric or bizarre.

Problems in the content of thought also need to be noted by a clinician. Delusions are profound disturbances in thought content in which the client continues to hold to a false belief despite objective contradictory evidence, despite other members of their culture not sharing the same belief. Delusions vary on dimensions of plausibility, from the plausible (e.g., the CIA is spying on me) to the bizarre (e.g., the newspaper contains coded messages for me), and systematization, from those that are unstable and non-systematized to stable and systematized. The content of delusions can be persecutory (others are deliberately trying to wrong, harm, or conspire against one), grandiose (an exaggerated sense of one's own importance, power, or significance), somatic (physical sensations or medical problems), reference (belief that otherwise innocuous events or actions refer specifically to the individual), or relate to control, influence, and passivity (belief that thoughts, feelings, impulses, and actions are controlled by an external agency or force). Clients can also have delusions that are nihilistic (belief that self or part of self, others, or the world does not exist), jealous (unreasonable belief that a partner is unfaithful), or religious (false belief that the person has a special link with God). The clinician needs to consider cultural factors as well as other clinical issues in identifying delusions. For example, belief in the sovereignty of God is not a delusion of control, because this is shared by others within a culture. Also, oversensitivity to the opinions of others is not a delusion of jealousy, since clients will typically not hold the belief in the face of contradictory evidence (behavioural experiment reference) and can concede that it is conceivable that the belief is wrong. Although the distinction between strongly held false beliefs and delusions is sometimes difficult to draw, the clinician will find it easier if the focus remains on the chain of reasoning whereby a person comes to believe a particular false belief rather than solely relying upon the content of the belief.

In addition to these extreme forms of thought disturbance, there are more frequent issues such as phobias (excessive and irrational fears), obsessions (repetitive, and intrusive thoughts, images, or impulses), and preoccupations (e.g., with illness or symptoms).

Perception

Hallucinations are a perceptual disturbance in which people have an internally generated sensory experience, so that they hear, see (visual), feel (tactile), taste (gustatory), or smell (olfactory) something that is not present or detectable by others. The most frequent hallucinations are auditory and typically involve hearing voices, calling, commanding, commenting, insulting, or criticizing. Hallucinations can also occur when falling asleep (hypnagogic) or when awaking (hypnopompic).

Other perceptual disturbances include a sense that the external world is unreal, different, or unfamiliar (derealization), an experience that the self is different or unreal in that the individual may feel unreal, that the body is distorted or being perceived from a distance

(depersonalization). Perceptions can also be dulled, in that perceptions are flat and uninteresting, or heightened, in that each perception is vivid.

Insight and judgement

Insight is a dimension that describes the extent to which clients are aware that they have a problem. A strong lack of insight can be an important indicator of unwillingness to accept treatment. Insight refers also to an awareness of the nature and extent of the problem, the effects of the problem on others, and how it is a departure from normal. For instance, clients may deny the presence of a problem altogether, or may recognize the problem, but judge the cause to lie within others.

Judgement is another issue that the clinician will consider during an MSE. The ability to make sound decisions can be compromised for a number of reasons. The clinician will try to ascertain if poor decisions are the result of problems in the cognitive processes involved in the decision-making process, motivational issues, or failures to execute a planned course of action.

Speech and language

A client's speech can be described in terms of its rate (e.g., slow, rapid), intonation (e.g., monotonous), spontaneity, articulation, volume, as well as the quantity of information conveyed. At one end of the dimension of information conveyed is mutism (i.e., a total absence of speech), extending through poverty of speech (i.e., reduced spontaneous speech) to pressured speech (i.e., extremely rapid speech that is hard to interrupt and understand).

Speech is a subset within the broader domain of language. Language also includes reading, writing, and comprehension. Cognitive dysfunctions can be indicated by language disturbances (see Lezak, Howieson, & Loring, 2004 for an extended discussion) such as aphasia. Aphasia can be non-fluent, in which speech is slow, faltering, or effortful, or fluent. Fluent aphasia involves speech that is normal in terms of its form (rhythm, quantity, and intonation), but is meaningless perhaps including novel words (i.e., neologisms).

Intelligence and abstraction

A general indication of intelligence can be gained from the amount of schooling a person has had, with a failure to complete high school indicating below average intelligence, completion of high school indicating average intelligence, and college or university education indicating high intelligence.

Abstraction is the ability to recognize and comprehend abstract relationships – to extract common characteristics from a group of objects (e.g., in what way are an apple/banana or music/sculpture alike?), interpretation (e.g., explaining a proverb such as 'a stitch in time saves nine'). However, care needs to be exercised interpreting responses to abstract questions, since they may reflect the degree to which the person's cultural group has permitted exposure to the content of the sayings.

Summary

An MSE provides a useful conceptual organization for the clinician and a mental checklist to consider a client's functioning across broad domains. During a diagnostic interview it would be rare to systemically work through each area, but relevant questions are included as judged appropriate. Brief, formal versions with standard scoring of the MSE are available in the

Mini Mental State Exam (Folstein, Folstein, & McHugh, 1975; see also Treatment Protocol Project, 1997). This is an 11-item scale to measure orientation, registration, attention and calculation, recall, language, and praxis. Score ranges from 0–30 and lower scores indicate greater impairment. The chief problem is that it is less sensitive for cases with milder impairment and scores are influenced by educational level of the subject. Some other options are the Cognitive Capacity Screening Examination (CCSE; Jacobs, Bernhard, Delgado, & Strain, 1977); a 30-item screener to detect diffuse organic disorders, especially delirium, that is more appropriate for cognitively intact individuals, the High Sensitivity Cognitive Screen (HSCS; Faust & Fogel, 1989); a 15-item scale that is a valid and reliable indicator of the presence of cognitive impairment, the Mental Status Questionnaire (MSQ; Kahn, Goldfarb, Pollack, & Peck, 1960); a 10-item scale that shares the same weaknesses as the MMSE and omits some key domains of function (e.g., retention and registration), and the Short Portable Mental Status Questionnaire (SPMSQ; Pfeiffer, 1975); a 10-item scale for use with community or institutional residents that is a reliable indicator of brain injury.

Limitations of diagnosis and future directions

Diagnosis is important because without it, the social processes required for delivery of mental health services could not be justified, research would be hampered, and communication among professionals and information retrieval would be difficult. However, this is not to say that current diagnostic systems are without fault. Rather, the clinician needs to be cognizant of these weaknesses and use diagnoses accordingly.

First, following the introduction of specific criteria and a focus on observable (rather than inferred) symptoms, the reliability of diagnoses has increased. Notwithstanding the improvements in reliability, the outcomes of the DSM-5 field trials have been questioned and attention has been drawn to the low reliability of some diagnostic categories (Greenberg, 2013). Additionally, the validity of some diagnoses has been called into question. A problem with the diagnostic system is that the confidence in the validity of each diagnosis is not specified, yet not all diagnostic categories are equally valid. Second, generally there are no identifiable psychometric assessments that relate to particular diagnoses. Thus, the clinician will need to evaluate the available psychological tests and determine which tests, and which normative groups and cut-offs, are relevant for supplementing a diagnosis. Third, the diagnostic system is focused upon existing disorders and makes no reference to precursors to particular disorders. With the increasing focus on prevention and early intervention, the clinical psychologist needs to remember that there may be good reasons for intervening in specific problem behaviours, even though they may not be listed in DSM-5 or ICD-10. Fourth, many psychological models of psychopathology are dimensional and the aetiological processes are found in both normal and abnormal populations, but to varying degrees. The DSM and ICD systems are both categorical systems that identify the presence of a disorder rather than locating an individual upon a dimension. Within the area of personality disorders, there is increasing awareness of the need to consider psychopathology in a dimensional manner. For the clinical psychologist, this is relevant, as the clinician will not solely be searching for qualitatively different processes, but trying to identify the extent to which behaviour, cognition, and physiology are disturbed. Fifth, it is critical for clinical psychologists to remember that many problems worthy of intervention and treatment are not listed as clinical disorders within diagnostic systems. Relational disorders (First et al., 2002), such as couple distress, are just one example of the disorders that do not fit within the focus

of current diagnostic taxonomies upon the individual, rather than a dyad, family system, or other social groups.

Finally, perhaps the most serious criticism of the diagnoses arrived at using current diagnostic systems is that they are limited predictors of treatment outcome (Acierno, Hersen & van Hasselt, 1997). Ultimately, diagnostic systems are valuable if they can predict treatment response. Symptoms are one factor that determines outcome, but not the sole predictor; however, the DSM-5, the ICD-10, and the empirical literature tend to focus almost exclusively upon this dimension. Further, the assignment of a DSM or ICD diagnosis does not regularly imply that a specific intervention is indicated (see Nathan & Gorman, 2002, 2007). From the perspective of a clinical psychologist, the absence of indices other than symptoms is disturbing. Most psychological models of psychopathology acknowledge the important aetiological role of stressful life events (Miller, 1996), yet these factors are absent from diagnoses. Alternative systems have been proposed, including suggestions to measure (i) symptoms of behaviour, cognition, and physiology through behavioural observation, self-report, and physiological monitoring (Bellack & Hersen, 1998), (ii) maintaining factors through a functional analysis of contingencies of reinforcement and other contextual factors, and (iii) aetiology (see Acierno et al., 1997). Even though the current revision to the DSM-5 represented an attempt to form aetiological diagnostic systems (primarily based on neuroscience; see Charney et al., 2002) the goal seems unlikely to be achieved for two reasons. First, neuroscience presently remains too imprecise to provide a sufficiently solid foundation to achieve the 'goal to translate basic and clinical neuroscience research relating brain structure, brain function, and behavior into a classification system of psychiatric disorders based on etiology and pathophysiology' (Charney et al., 2002, p. 70; e.g., there is still no biological marker for any psychiatric diagnosis), and second, it fails to acknowledge that there are social and psychological factors that exert important and complicated effects. For instance, Gil, Wagner, and Vega (2000) have shown that higher rates of alcohol use by US-born Latino adolescents compared with recent immigrants are associated with the reduction over time in familism, cohesion, and social control. Thus, it seems unlikely that diagnostic taxonomies in the near future will incorporate factors such as a comprehensive symptom assessment, a systematic examination of maintaining factors, personality, and consideration of various aspects of aetiology. Nonetheless, there is room within a clinical intervention to address these important factors and this will be the focus of the next chapter.

Additional assessment and testing

Reviewing our model (Figure 3.3), it is apparent that assessment may begin concurrently with diagnosis, but it extends far beyond. The clinical psychologist (i) distils information into a case formulation, (ii) assists treatment planning in which interventions are matched to clients, and (iii) measures the degree of success. The process of assessment is indicated by the shaded area and the process is divided into matching, measurement, and monitoring which are located within an overall management structure.

- **Management** of outcomes involves the ongoing assessment and evaluation of clinical and administrative processes involved in the delivery of care.
- **Matching** refers to the process of matching the client to the appropriate treatment option. This process begins with *screening and problem description* which have been discussed earlier. Problem description is followed by treatment planning or *matching* (in which specific information is collected that aids the clinical decision-making

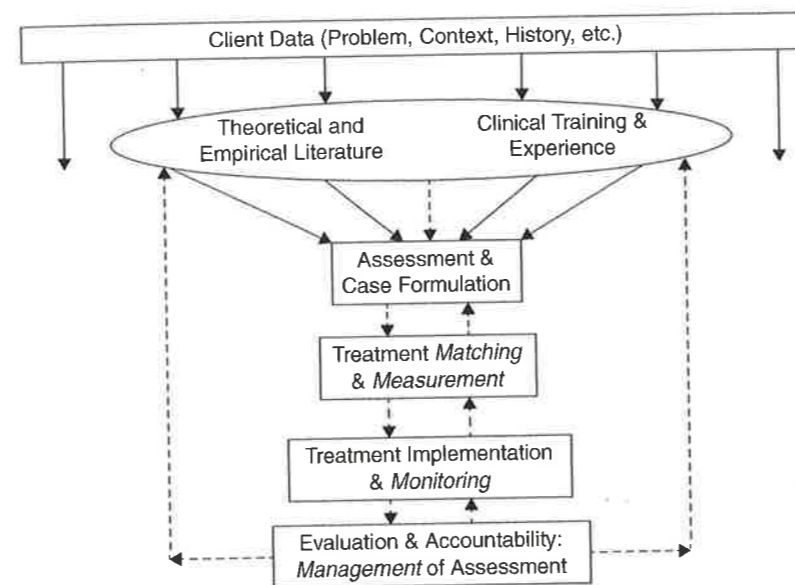


Figure 3.3 The centrality of assessment processes and techniques to the scientific practice of clinical psychology.

process). Once the problem has been accurately identified the psychologist can give thought to the most appropriate treatment (Beutler & Clarkin, 1990; Beutler & Harwood, 2000; Castonguay & Beutler, 2006). Sometimes the relevant treatment will be evident by examining a list of empirically validated treatments (e.g., Nathan & Gorman, 2007). However, at other times the picture will be more complicated, due to patterns of comorbidity and involved presentations. At these times case formulation can be used to identify potential treatments that are linked to the causal mechanisms involved.

- **Measurement** involves the pre-, post-, and follow-up assessments of a variable(s) to determine the amount of change that has occurred as a result of an intervention.
- **Monitoring** refers to the periodic assessment of intervention outcomes to permit inferences about what has produced observed changes. *Progress monitoring* determines deviations from the expected course of improvement; whereas *outcomes monitoring* focuses upon the aspects of the intervention process that bring about change.

Thus, these four activities all occur within a context of evidence-based and evidence-supported assessment. Although the concept of measurement will be familiar to a psychologist, ongoing monitoring may be less familiar (Newnham & Page, 2010). Lutz, Martinovich, and Howard (1999; see also Asay et al., 2002; Lutz, Martinovich, Howard, & Leon, 2002) distinguished treatment-focused research from patient-focused research. Patient-focused research, what we have called monitoring, asks the question, 'Is this particular client's problem responding to the treatment that is being applied?' (Lutz et al., 1999). Thus, with the move from treatment- to patient-focused research the spotlight shifts from the average client to the particular individual currently being treated.

Before describing some general principles of monitoring, a scientist-practitioner needs to consider the empirical evidence regarding monitoring. Monitoring will take time and effort on the client's part and the clinician will need to collect, score, store, collate, interpret, and feed back all data to the client. Therefore, the clinician needs to be able to justify to the client, themselves, and their employer the 'costs' incurred. To this end, work by Lambert et al., (2001) is useful. They assigned clients to treatment as usual or a condition in which their clinician received weekly feedback on their symptom change relative to expected progress. The sample was then divided into clients who were predicted to have good versus poor outcomes, based on initial assessment. For clients who were predicted to have poor outcomes, treatment duration increased and the outcomes were improved, such that twice as many clients achieved clinically significant (Jacobson & Truax, 1991) change. For clients who were expected to have a positive response to treatment, the outcomes were no better, but the number of sessions was reduced. Therefore, the provision of monitoring data to the clinicians allowed them to target therapy time to clients where it was most needed and in so doing, maximized the overall benefit.

Monitoring of clients highlights the various phases of treatment. Lutz et al. (1999, 2002) identify three phases to therapy. The client passes through *remoralization*, as subjective well-being improves, *remediation*, as symptoms begin to reduce, and *rehabilitation*, as the improvements in well-being and symptoms spread to domains of life functioning. The process of symptom amelioration will follow a log linear curve for the average client (Howard, Kopta, Krause, & Orlinsky, 1986), such that the greatest change occurs in the initial sessions, with improvement gradually flattening out. If assessments are collected during treatment (e.g., Howard, Brill, Lueger, O'Mahoney, & Grissom, 1995; Sperry et al., 1996), it is possible to plot an expected course of recovery using a variety of predictor variables. For instance, Lutz et al. (1999) used archival data on subjective well-being, current symptoms, current life functioning, global assessment of functioning, past use of therapy, problem duration, and treatment expectations to generate an expected treatment trajectory. Using a client's pre-treatment scores it is then possible to plot an expected course of improvement for each particular client, over which can be overlaid actual progress, placing boundaries around the expected trajectory of improvement so that a lower range is set by the failure boundary (e.g., scores of clients in the 25th percentile) and an upper range (e.g., mean scores of non-clinical sample). As a result, it is possible to display a graphical depiction of a client's progress through therapy relative to their expected course. Further, as the client's actual scores approach the normal range, the clinician will receive feedback that treatment is progressing optimally. On the other hand, if a client's scores approach the failure boundary, the clinician will be alerted that the treatment outcome is not optimal and an alternative treatment plan may need to be set (see Lambert et al., 2001; Mintz & Kiesler, 1982, and the next chapter for a discussion of individualized outcome measures in psychotherapy).

Thus, repeating testing during an intervention can provide an indication of the extent to which a person is changing according to expectations. Sometimes this is talked about as a 'glide path'. In the same way that an airplane approaches a runway along a glide path and deviations from the expected trajectory signal time for corrective action, the place where an individual is along a treatment trajectory provides useful information. Deviations from the expected path of improvements may signal a problem. The expected changes in symptom severity, social function, and occupational performance can all be monitored against normative references to identify if remedial action is appropriate.

Although these approaches to monitoring are more recent than efficacy and effectiveness research, the client-focused research approach typified by monitoring has great potential to bridge the gap between science and practice. Science, by its nature, is concerned with generalizable results, whereas clinical practice is concerned with the instance. By increasing the relevance of data collection to the individual client, monitoring strategies will allow clinical psychologists to collect client-relevant data that can be integrated with data available from treatment-relevant efficacy and effectiveness research. Furthermore, monitoring permits a science-informed practitioner to test and evaluate hypotheses about each client. How to monitor client progress is the topic of the next chapter.

Monitoring client progress

Clinical psychologists are referred clients who are in distress; the problems have profound impacts on their lives and the psychologist's intention is that, after some intervention, the client will leave treatment no longer distressed and with their problems resolved. One way to guide the selection of treatments to achieve this desired outcome is by using evidence-based practice. In so doing, it is possible to make inferences about the progress of the average client. Evidence-based practice draws upon efficacy studies that contrast active treatments with appropriate comparisons under controlled conditions and permit an estimate of the effect size of treatment to be made. Effectiveness studies can then examine the degree to which the effect sizes observed under controlled conditions are reproduced in clinical settings. The reduced control over the types of clients, the extent of comorbidity, and the training of therapists can all affect the extent to which effect sizes observed in efficacy studies may fail to generalize. Lambert (2013) has documented that the effect sizes tend to be smaller in clinical practice than in efficacy studies, but nonetheless, as a scientist-practitioner, it is possible to know that a given evidence-based treatment will have a particular effect size and to infer that the average client treated will experience a similar benefit. The present chapter, while not arguing against the application of evidence-based treatments, will present the case that the blind application of evidence-based treatments is not optimal clinical practice.

Monitoring and feedback is a specific therapeutic intervention

Evidence-based practice is not incompatible with practice-based evidence (Castonguay, Barkham, Lutz, & McAleavey, 2013). In evidence-based practice, we use interventions and practices that have a reliable and valid foundation in empirical findings. However, practice-based evidence allows clinicians to monitor client progress during treatment and adapt therapy accordingly. Therapists adapt treatment but they do so by allowing the clinical judgements to be guided by evidence and to be responsive to the data collected. Before describing how this can be done, let us review the evidence showing that clinical outcomes are improved by using practice-based evidence.

The pioneering research in patient monitoring and feedback was conducted by Mike Lambert and colleagues. They have published many randomized controlled trials evaluating the effectiveness of providing individualized feedback to clinicians (Harmon, Hawkins, Lambert, Slade, & Whipple, 2005; Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004; Lambert et al., 2001; Lambert et al., 2002; Whipple et al., 2003). Conducted in routine clinical settings, each of the studies was assigned to 'treatment as usual' or to a condition in which therapists were given feedback about the progress of each client during treatment. Broadly speaking, the