CONDUCTING PSYCHOLOGICAL ASSESSMENT

A Guide for Practitioners

A. JORDAN WRIGHT

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Conducting Psychological Assessment

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Preface

While many texts for students learning how to conduct psychological assessments focus, rightly so, on the use of individual tests, there is more to the process than just testing; testing is only part of the process. Comprehensive evaluations of course need to be built on a foundation of valid testing. However, while using tests properly (including accurate administration, coding, scoring, and interpretation) is necessary for good assessment, it is not sufficient. This text is meant to inform students and clinicians about the following step in learning how to conduct assessments. After clinicians have learned the ins and outs of psychological tests themselves, this text provides a step-by-step methodology for conducting entire individual assessments from beginning to end.

The major objectives of this text are

- to present the process of assessment from beginning to end in logical, clear steps that provide a basic structure for the process;
- to promote a process that necessarily takes into account the imperfection of both clinical intuition and psychological tests themselves; and
- to illustrate the process as clearly as possible through case examples.

The approach, organization, and structure of this book are meant to mirror the natural progression of individual assessment. Although many assessments are not as clean as the linear steps presented in this text might suggest, organizing them in this way can help make difficult cases easier to manage. Even when input from outside sources, murky and unclear presentation of the client, or any other roadblock complicates cases, the step-by-step method presented in this text can help simplify the process. The content of psychological assessments is most often extremely complex, nuanced, and confusing (as humans are prone to being), so the more straightforward the process of assessment can be, the better.

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A. Jordan Wright, PhD, ABAP

PART I

Conducting Psychological Assessment

Introduction to Part I

THE HYPOTHESIS TESTING MODEL

Psychological assessment has long been a mysterious, intuited process, taught to psychologists in training test by test, with components of conceptualization, integration, and report writing somewhat tacked onto the end of the process. While psychologists seem to unconsciously agree on the purpose of psychological assessment, its utility has been debated in the literature. At its most basic, psychological assessment provides a catalog of an individual's cognitive, emotional, behavioral, and psychological strengths, weaknesses and vulnerabilities, deficits, and resources. At its best, it provides dynamic insights into the inner workings of an individual, yielding invaluable information for diagnosis, potential intervention, and prognosis.

Claims for the utility of assessment have ranged significantly from merely categorizing an individual's strengths and weaknesses to clarifying diagnosis and prognosis to describing a person's personality in its entirety. While these all may be effective approaches to assessment, it is most practical and pragmatic to talk about why and how psychological assessment can be useful to the mental health field (and to related fields, such as medicine) in general. This book presents a model of psychological assessment designed to ensure that assessors provide ethical and competent services and make useful contributions to the lives of the individuals they assess.

Psychological assessment should be used to help answer whatever referral questions are present and to make clear and specific recommendations to help the individual being assessed function better in their life. While this may include an analysis of strengths and weaknesses, a diagnosis, and a description of personality structure, the central goal of making useful (and realistic) recommendations should never be forgotten. This important concept is revisited throughout this text, as it is easy to lose sight of the importance of this seemingly simple goal: determining what will be most useful to the individual being assessed in the current situation.

A few examples can illustrate how psychological assessment can be useful to different people. First, consider a high-level executive who is trying to get a promotion at work. While an assessment may include her level of cognitive and intellectual functioning and details of her personality dynamics, the ultimate goal should be to inform what would likely help her grow in such a way that she can successfully get the promotion, if possible. Some possible findings from an assessment with such an individual may relate to her interpersonal style or decision-making skills. These are areas extremely important to executives' growth, and recommendations on how to improve them can be explicitly made.

Next, consider a child presenting disruptive behavior at school (or consider the child's parents at their wits' end). An assessment can help identify what is likely underlying the disruptive behavior, which could include anything from attention deficit hyperactivity disorder (ADHD) to depression to an adjustment disorder. Recommendations for each of these problems would look very different. A child with depression would likely not benefit from psychostimulant medication, just as a child with ADHD would not benefit from antidepressant medication. An assessment can help the parents clarify what is likely going on and recommend to other service providers what type of treatment would likely succeed.

This text is a primer for the process of psychological assessment and testing rather than a guide to using any single test. Six major processes make up any psychological assessment:

1. conducting a clinical interview
2. choosing a battery of tests
3. administering, coding, scoring, and interpreting tests
4. integrating and conceptualizing information gathered from test results, the clinical interview, behavioral observations, and other sources
5. writing a psychological assessment report
6. providing feedback to the individual assessed or the referral source

While most psychological assessment texts focus on test administration, coding, scoring, and interpretation (see Groth-Marnat & Wright, 2016; Lezak, Howieson, Bigler, & Tranel, 2020; Sattler, 2018; Weiner & Greene, 2017) and while there are many works on clinical interviewing (see MacKinnon, Michels, & Buckley, 2015; McConaughy, 2013; Sommers-Flanagan & Sommers-Flanagan, 2017; Sullivan, 1970), few have focused specifically on the fourth step: the use of all data collected throughout the assessment to come up with a fully integrated, coherent picture of the individual being tested that will support clear, specific, and useful recommendations. Similarly, sample reports can be extremely useful in formatting the structure of a psychological assessment report, but few texts have focused on the conceptual content of good reports.

The Hypothesis Testing Model

The importance of psychological assessment lies in the fundamental assumption that there are aspects of our functioning that we are not entirely aware of or cannot effectively articulate. If every person had a clear and accurate understanding of what was going on for them, the only form of assessment necessary would be clinical interviews. An even more efficient method would be to administer surveys that rely on individuals' self-reporting. However, because there is not a single person who is entirely aware of all aspects of their functioning, we combine multiple methods of evaluation—including self-report, collateral reports, "objective" measures, clinical observation, and performance-based measures (including, perhaps both most controversially and most intriguingly, projective measures)—to develop a more accurate impression of current functioning. It is important to note (as most texts on psychological assessment do) that testing and assessment provide a picture of how the individual being assessed is currently functioning. While inferences about past functioning and future prognosis can be made, the tests themselves are measuring individuals at that particular moment in time, at that particular point in history. Many people not in the mental health field confuse psychologists with psychics, and it should be made clear that assessment results cannot predict the future with 100% accuracy.

There is no perfect measure. No self-report is made without bias and blind spots, no test has perfect reliability and validity, and no single method of measurement should be taken as gospel. The validity of every single test in existence has been challenged. (Some specific criticisms are addressed in the chapter on testing.) For this reason, a humble approach to using tests is necessary to build a consumer's confidence in the assertions made in the final report. The hypothesis testing model uses the strengths of each individual test, as well as clinical acumen, while assuming that each individual measure is flawed. Each individual assessment can be treated as a research study by (a) making hypotheses, (b) testing them to rule out possibilities and incorporate others, and (b) using multiple tests, multiple methods, and at times even multiple informants, which provide more solid data and allow the assessor to be much more confident in their findings. The basics of the hypothesis testing model follow.

Step 1: Initial Clinical Assessment

The first step of the hypothesis testing model is to conduct a thorough clinical interview whenever possible. You will then use the results of this interview, together with background information collected from various sources, to create hypotheses. Clinical interviews can vary dramatically from assessor to assessor (see MacKinnon, Michels, & Buckley, 2015; McConaughy, 2013; Sommers-Flanagan & Sommers-Flanagan, 2017; Sullivan, 1970 for theories on clinical interviewing). While some scholars advocate the use of structured clinical interviews (which can be especially useful for diagnostic clarity), others advocate the use of open-ended, unstructured, conversationally based interviews. One model for the process of conducting—and, more importantly, using—a clinical interview is discussed in more detail in Chapter 1. The initial clinical assessment is a combination of the information gathered from the clinical interview and other sources of report, such as referral parties, previous records, and collateral interviews. This clinical assessment has three goals: (1) assessing impairment in functioning; (2) understanding the current and developmental context and course of functioning; and (3) generating hypotheses.

The first goal of the initial clinical assessment is to assess specifically what, if any, is the impairment in functioning. Most assessments are conducted because there is some sort of impairment in the functioning of the individual being assessed. Individuals usually come for an assessment with a presenting problem or a specific difficulty they are having. These presenting problems may be reported by the individuals themselves, or they may be defined by whoever refers the individual for the assessment, perhaps a treating clinician, a primary care physician, a teacher, or any other person who knows the individual being assessed. For example, social and interpersonal functioning, emotional well-being, or behavioral problems may be affecting how well the individual can function on a day-to-day basis.

While some impairments may be overtly evident, reported openly as the referral question or presenting problem, there are often more subtle impairments in functioning, more covert issues that are impeding the person's ability to be happy, maintain stable relationships or employment, or function optimally in some way. For example, an individual may be referred for testing because he is having subjective difficulty with his parents' divorce. Upon assessment, however, it may turn out that he generally has difficulty with change and ambiguity, which may be affecting him in other areas of his life.

Occasionally, though rarely (depending on the type of practice you have), individuals present for an assessment with no real impairment in functioning but simply "to learn more about myself" or because they find it interesting (or because they are mental health professionals in training). While there may be no major impairments in functioning, there are almost certainly areas of individuals' lives that could be improved. It is important in both instances, however, to keep in mind that assessments are not entirely about weakness and impairment. While the former situation calls for specific recommendations for improving suboptimal functioning, both situations also entail a clear survey of what's going right—that is, where the strengths and aptitudes lie.

The second goal of the initial clinical assessment is to try to understand both developmental and current contextual factors that relate to the individual's functioning. Aspects of individuals' history have necessarily influenced who they are now and how they are interacting with the world. This can include early attachments, stressful or traumatic experiences, the nature of interpersonal relationship history, school history, medical history, and all other aspects of development. Cultural identity includes both historical–developmental and current influences on individuals' functioning. Current life circumstances, social supports, and other contextual issues relevant to the individual being assessed are of course also important to understand.

The third goal of the initial clinical assessment, specific to the hypothesis testing model, is to generate hypotheses. For this step, a thorough understanding of psychodiagnosis is necessary. General theories of behavior and human functioning, regardless of theoretical orientation, are also extremely important. Based on the findings of the initial clinical assessment, you should list all possible causes of the functional impairment. This step is, of

course, aspirational; it is impossible, given our current understandings of human functioning, to be able to understand and enumerate all possible dynamics and underpinnings of a single problem. However, using whatever your individual theory and orientation are as guides can help you cover your bases. This process is extremely important in determining how to approach the assessment, and it is discussed further in Chapter 1.

Step 2: Selecting Tests

Based on the hypotheses generated from step 1, the assessor selects a testing battery. The specific parameters that inform this process are addressed in Chapter 2, but essentially, tests should be chosen based on an established set of criteria, which should include their own internal psychometric properties, what exactly they assess, how they assess it, and how appropriate they are in the current circumstances with the current individual being assessed. Great care should be taken to include multiple measures of the same constructs—multiple tests to assess the same hypothesis—whenever possible. For example, if depression is a hypothesis, several psychometrically established tests should be chosen to assess depression from multiple angles; a testing battery could include self-report measures, such as the Personality Assessment Inventory (PAI), which has a specific scale and subscales for depression; collateral measures like the Adult Behavior Checklist (ABCL), which has scale for depressive problems; and even some performance-based measures, such as the Rorschach, which assesses sadness and other aspects of depression in a significantly different way. The data from these measures can be combined later with the clinical interview data and behavioral observations to make assertions about whether there is evidence for or against this hypothesis.

Step 3: Testing

To repeat, no test is perfect; no measure is without flaws and grounds for criticism. While the testing battery is malleable, able to be altered throughout the process, it is best to err on the side of including too many (rather than too few) assessment instruments to cover blind spots, evaluate constructs from multiple vantage points, and ultimately feel more confident in the data that emerge. This of course poses logistical problems, given time and monetary constraints. But the key is to remember that you can be more confident having three separate tests that report the same findings and support the same conclusions than having only one or even two. This does not necessarily mean that having two is inadequate; however, when time and other constraints permit, having more data is better, just as in any research project.

After choosing a testing battery, administration, coding, and scoring of the chosen tests are the next steps. There is no way to fake this. Nothing compensates for poverty of skill in administration, coding, and scoring. These are perhaps some of the most important steps in the entire process, which could explain why most texts, and indeed assessment courses, focus on them, and rightly so. Mistakes made in these two steps can invalidate the entire process. Whereas you can find support on all steps after these two, using supervision and consultation to interpret and beyond, you basically have one shot at correct administration of all tests per assessment, without in-the-moment help or support. The strictest discipline should be used in making sure that all tests are administered, coded, and scored in their appropriate, standardized way, unless very deliberate and defensible adaptations are used. Even slight adjustments in the standardized administration, coding, and scoring of a test can skew interpretation, which is most often based on comparison to a normative sample that was then tested in a different way.

For example, if you are administering a subtest such as Digit Span from a Wechsler intelligence test—which requires you to read numbers aloud at a specific, slow pace and the individual being assessed to repeat them back—and you read the numbers more quickly than directed, then you make the task much easier. The individual's score on your faster version of this test will be compared with a normative sample that received the test in the slower, standardized way. Your client's score will look higher than it should and not reflect their actual ability.

Even this seemingly benign and minor variation from the standardized procedure can skew the data and cause misleading results to emerge. As assessment is a stepwise, hierarchical process, all steps after administration, coding, and scoring of the tests are predicated on the assumption that administration, coding, and scoring are absolutely correct and valid.

Similarly, although it is not addressed at length in this text, the ability to apply correct interpretation of all tests used is absolutely critical to the competence of the assessor, the ethical application of assessment, and the utility of the final product. Again, many texts focus almost exclusively on the correct and appropriate interpretation of results garnered from individual test instruments (see Groth-Marnat & Wright, 2016; Lezak, Howieson, Bigler, & Tranel, 2020; Sattler, 2018; Weiner & Greene, 2017 for excellent examples). It is vital to know the limitations of each test, so that interpretation does not overstep the bounds of what each individual test is able to do. In the integration process, it is also important to understand the psychometric strengths and weaknesses, conceptual criticisms, and cultural performance of each test to judge how best to apply the results in the overall framework of the conceptualization.

Step 4: Integration of All Data

Perhaps the most delicate step of all, and unfortunately the step generally least addressed in both training and the psychological assessment literature, is the integration of all data compiled. This constitutes the mystical step in which, somehow, all the data collected coalesce into a coherent, concise, and individualized description of an entire person. This step need not be so mystical; a major focus of this text is to help assessors understand this process clearly. In the hypothesis testing model, this step is where test results and behavioral observations are combined with the initial clinical assessment data to address each of the hypotheses. Every hypothesis generated should be addressed by the testing process. A detailed explanation of this process is presented in Chapter 4 of this text.

In addition to integrating all of the data collected into themes, the process of fitting the themes together into a coherent narrative is presented. Specifically, a straightforward presentation of themes, of strengths and weaknesses, of issues and dynamics can easily lack face validity and thus buy-in from the parties receiving the feedback. A more narrative approach—telling a story of how the themes that emerged from the assessment fit and work together to explain the impairment in functioning—will make more sense to the individual being assessed and the individual who made the referral, and they will be more easily remembered by both parties. The end result is that the individuals being assessed and the referral sources will be more likely to take the recommendations made at the end of the report.[1]

Step 5: Writing the Assessment Report

Many texts provide sample reports, which vary in style, length, and even purpose. While templates of previous reports are an excellent source of reference for structuring future reports (and, indeed, an assessment report structure is presented in Chapter 5), the process of writing up individual sections has had little discussion in previous psychological assessment texts. Finding the balance between using professional language while not using too much psychological jargon is perhaps one of the hardest skills to learn. Making sure to give reports professional weight without making them too difficult to understand can at times feel more like an art than a science. While it is extremely comforting to know what sections are necessary for a good assessment report, understanding exactly

[1]It is important to note that while no systematic empirical study has been conducted on this theory that a narrative approach will affect how readily patients take recommendations, the theory is based on amassed clinical evidence.

what should go within each section and how it should be presented is extremely important and can be a delicate task. Chapter 5 of this text presents strategies for writing up assessment reports so that they are professional and straightforward and fulfill the goal of providing logical, useful recommendations.

Step 6: Providing Feedback

Although it is often given a chapter or at least a mention in texts on psychological assessment, this step perhaps shows the most variation across clinicians and scholars. No consistent model for providing feedback has been developed and adopted widely throughout the field. Although that challenge is beyond the scope of the current text, several models and guiding principles for providing feedback are presented in Chapter 6. In general, feedback should be provided at a level that, as with the write-up, is both professional and understandable. This means that based on the assessment itself and the individual being assessed, feedback sessions must be both specifically tailored and flexible. Clinical skill is perhaps most necessary during this step, as at any moment you may need to change course, empathize, console, support, or explain a concept in a different way.

For example, on hearing that they have a specific diagnosis such as a learning disorder, an individual may react in different ways. That individual may be relieved to hear an explanation for the difficulties they have been having in school. On the other hand, the individual may be upset by the diagnosis. In the latter case, an assessor must use their clinical skill and intuition to determine the course of the feedback session. The assessor may have to shift to a more explicitly supportive stance, empathizing with the difficulty of receiving the news.

Alternatively, the focus of the assessment may need to be more psychoeducational, reflecting the individual's need to more fully understand the diagnosis and its implications (dispelling any misconceptions) and to outline what can be done to alleviate the symptoms of the disorder. Although this example is obviously oversimplified, an assessor must be able to be flexible throughout a feedback session, given that individuals' reactions to feedback are as varied as individuals themselves.

One of the most useful advantages of the hypothesis testing model is that it enables you to be both clear and confident in the story you are telling, which supports clear recommendations. While clinicians have differing values when it comes to recommendations and referrals, it is ethically essential to make sure that, in the feedback session, the individual being assessed is absolutely clear as to the content of what you are presenting, including both the results and the recommendations. Depending largely on the setting, the referral questions, and your own clinical values, follow-up with the individual being assessed may be necessary to make sure they are able to follow through with the recommendations.

Again, remember that the ultimate goal of assessment is to make clear, specific, reasonable, and useful recommendations that have a high likelihood of improving a person's life and functioning. The entire (lengthy) process has been a complete failure if the person is unable for any reason to understand or engage with the recommendations. It is important to note that, of course, some clients may choose not to take the recommendations, through their own will, which should not at all be considered a failure on the part of the assessor.

Summary

The hypothesis testing model of psychological assessment treats each individual assessment case as a research study. Using a multimethod approach, every assessment should include both self-report and other measures of functioning. Additionally, every report should include both cognitive and personality–emotional measures. While cognitive and personality–emotional assessments are often presented separately (and indeed are tested quite differently), they are part of the same system that makes up the functioning individual sitting across from you in the assessment room. Integrating the results from multiple varied sources of data can seem daunting. However, by

organizing the process clearly, the hypothesis testing model takes the mystery out of conceptualizing an individual's dynamics in a comprehensive way.

The hypothesis testing model is built on a traditional model of testing, with clear additions. While almost every theory of assessment includes a clinical interview and collection of background data from multiple sources, each uses these data differently. The hypothesis testing model uses the data from the clinical interview along with background information to generate hypotheses of what is contributing to the impairment in the individual's functioning. These hypotheses drive the selection of a targeted battery of tests, ensuring that all potential dynamics and diagnoses are being addressed by the tests selected. Organizing the results generates a coherent narrative of what is happening with the individual. This narrative supports clear, specific, reasonable, and useful recommendations for improving the person's functioning. As with any research study, evidence must be amassed to support any conclusions drawn. And as is the goal of any clinical interaction, feedback and recommendations must be presented in a clear, empathic, and supportive manner.

CHAPTER 1

The Initial Clinical Assessment: Clinical Interviewing and Hypothesis Building

The first focus of the hypothesis testing model of psychological assessment, not surprisingly, is building hypotheses for what could be going on with the individual. While several different sources of information contribute to the process, the primary source is most often the clinical interview, either with the client or with the client's parents or primary caregivers if the client is a child. The ultimate purpose of the full psychological assessment is usually to identify what is most likely causing impairment in the individual's functioning (and then to make recommendations to ameliorate this impairment).

In general, the first step in an assessment is to determine what questions need to be answered for the assessment to be helpful. Individuals, family members, or other referral sources may have specific questions they want answered, such as why a child is underperforming in school, why an adult's relationships are so difficult, or what is underlying a person's problems with attention. An assessor needs to be extremely clear about what is and is not feasible to answer in a psychological assessment; the assessor may certainly need to help individuals hone their questions to be (a) realistic for the scope of psychological assessment and (b) not too limited. For example, a parent who comes in asking about their child's genetics or hormone imbalances may need a referral to a different kind of professional, or at least some education about what psychological assessments can and cannot do. As another example, many individuals present with a question of whether or not they have attention deficit hyperactivity disorder (ADHD). If the question is whether they have ADHD, a "yes" answer could be very useful; however, a "no" answer can be extremely frustrating, as it does not guide an individual toward what to do next. An assessor may help an individual alter their assessment question slightly to, "What is underlying my problems paying attention?" In this case, there is a trust and assumption that the individual is having some problems with attention, but it requires more than a yes–no answer. So if it is not ADHD, then a good psychological assessment will need to figure out what in fact *is* causing the difficulties with attention.

It should be noted that very often the referral question(s) and the presenting problem(s) may be somewhat different. That is, the questions to be answered, given by the referral source, often hint at only part of what is going on for the individual being assessed. The issues reported by either (a) the individual themselves or (b) whoever referred them for the assessment are frequently at least part of the presenting problem, often including what is impaired or is impairing their functioning. However, what is reported at first also frequently is only part of what is actually going on with the individual or is merely the result of something else of which they are not even aware—something practitioners should be prepared to consider. The nature of the presenting problem most often becomes apparent through the process of the clinical interview, the collection of other background information, and your own clinical observations (including a mental status evaluation and behavioral observations). While many texts aim to help with the *process* of clinical interviewing, including developing clinical skills like

empathizing, asking open-ended questions, and determining how best to make an individual feel more comfortable in sharing information, here we will focus on the *content* of the interview and how it can be used to inform your developing hypotheses.

The Clinical Interview

For the purposes of a psychological assessment, the clinical interview has three major components. Based on a biopsychosocial model of understanding an individual, the interview can split up information into (1) the presenting problem and its history, (2) a biopsychological evaluation, and (3) a psychosocial evaluation. The summary chart that follows (Table 1.1) may help you make sure you collect most of the necessary, relevant information you need to understand a person's difficulties, history, and context. This provides a useful framework for collecting essential information, but it does not prescribe a specific method or an order in which to do so. On the contrary, most assessors prefer to be unstructured during the clinical interview process, allowing the individual to speak freely and openly and holding back from asking specific follow-up questions unless some information remains unclear. The assessor is in charge of setting the tone of the initial session, with the goal of providing as relaxed an environment as possible. Clients may feel better about an assessment session that is relaxed and may be more likely to be open and disclose more information. The Case of David (p. 18) will illustrate how the clinical interview can unfold.

One way to think about structuring sections of a clinical interview is using a funnel method. This structure first uses broad, open-ended questioning, followed by more and more specific questions as needed. For example, when assessing current mood, you may first be quite broad and open-ended, such as, "How is your mood generally?" This may elicit a great deal of detail from the individual you are assessing, in which case you may not need too much follow-up. However, often, it can prompt some but not all the information you want and need. As such, you can get more and more specific with follow-up questions, such as, "You said your mood is 'kinda down these days.' Can you tell me more specifically what you mean by that?" Questions can clarify what individuals say and can get at aspects that they do not address unsolicited. For example, if someone states that they are down or depressed and you clarify what they mean by it, you may still need to ask more specific questions to understand

TABLE 1.1 **COMPONENTS OF THE CLINICAL INTERVIEW**

Presenting problem and history of presenting problem
Includes assessment of dangerousness to self and others
Biopsychological evaluation
Developmental history
Psychiatric history
Alcohol and substance abuse history
Medical history
Family medical and psychiatric history
Psychosocial evaluation
Family history
Educational and vocational history
Criminal and legal history
Social history
Psychosexual history
Cultural framework

the onset, severity, or chronicity of these symptoms. You may need to ask, for example, "When exactly did this episode of sadness start?" One way of socializing individuals to the clinical interview process is to explain that you will be asking quite a few questions, some broad and some very specific, not only to understand what is going on for them but also to get some background and context.

Consent

Although we will not focus on this process, obviously the first component of pretty much any and all psychological service provision is a process of informed consent. Clients and referral sources should understand, as much as is possible, what all of the services will look like, what information may end up in a final report (if applicable), who will have access to any information that emerges from an assessment, and issues related to confidentiality and limits of it. Even in court-mandated evaluations, assessments of children, and assessments of those who may ultimately be deemed unable to make decisions for themselves, every effort should be made to be transparent about the process itself so that those involved in the assessment are at least aware of what to expect. Clinicians should adhere strictly to the ethical guidelines of the American Psychological Association (APA) and the legal requirements of their state and country. Clinicians are urged to remember that consent is a process, not a form to fill out. They should work with clients and referral sources to ensure that those individuals truly understand and, when able, consent to undergoing the assessment process.

If the individual being assessed is a child or adolescent, the parent or legal guardian generally provides *consent* for the assessment in writing because children are not legally allowed to give consent for themselves. However, depending on the age of the child, they can also *assent* to the assessment, which occurs when someone not legally able to given consent provides a general agreement. The age of consent varies by state; make sure you know the law in whichever state you are practicing.

Referral Questions

After consent, generally the first component of the clinical interview (whether with an individual, parents, or a referral source of some sort) is to ask what questions they want answered with the assessment. Again, remember that these questions will guide the assessment, so they may need to be tweaked and negotiated with the individuals to ensure that they are realistic, comprehensive, and ultimately beneficial for the purposes of the assessment.

The Case of David: Referral Questions

David is a 23-year-old Hispanic client who, during an initial phone call about having an assessment conducted, stated that he is having academic difficulty in college and wants an evaluation for a learning disorder or possible attention deficit hyperactivity disorder. This is a pretty straightforward referral question, but even knowing this information it is important for you to ask, "What questions do you want answered from this evaluation?" When he states, "I want to know if I have a learning disability or ADHD," you can help guide him to a slightly better referral question. You can simply restate his question as a better one: "So you are having difficulty in school, and you want to know what's underlying that difficulty?" Certainly you do not need to educate him in the moment about how so many different things can negatively affect academic performance, including not only learning disabilities and ADHD but also a host of other things like depression, anxiety, and personality characteristics. Rewording the referral questions for him in the moment allows for (a) him to feel heard and understood and (b) you to conduct a more thorough evaluation to answer such questions, rather than assessing only for learning disabilities and ADHD.

Presenting Problem and Its History

The next component of the clinical interview, the presenting problem, is related to the issues that constitute the reason for the assessment and the history surrounding them. Clients can come in for many reasons, from specific functional impairment to subjective distress. For example, clients may present with problems on the job or in their relationships, which are specific impairments in their functioning. Others may come in because they feel bad in some way, such as depressed or anxious. Many are unclear when discussing their presenting problem, however. For example, clients who are "stuck" in therapy with a referring clinician may be unclear how to move forward in their treatment, and they are often unaware of what is specifically getting in the way of the work. Still, whatever problem emerges in the clinical interview as likely needing attention, regardless of how specific, vague, simple, or complex, constitutes at least part of the presenting problem.

Presenting Problem

The presenting problem includes whatever complaint the individual identifies as the reason for the assessment. An evaluation of danger of harm to self or others—including the possibility of self-harm or suicidality (suicidal tendencies), aggressiveness or homicidality (homicidal tendencies), and any suspicion of child abuse—should *always* be part of the initial meeting.[1] Again, the presenting problem is at times relatively straightforward, but sometimes factors can get in the way of its being clear, including guardedness on the part of the client, a client's lack of psychological mindedness and insight, or simply a diffuse or confusing client presentation. At times, the presenting problem needs to be reassessed at the end of the interview, once the client has become more comfortable and more disclosing with the assessor. When the client is somewhat vague with their presenting problem, some areas you may consider asking specifically about are presented in Table 1.2. Remember, this framework does not dictate *how* you ask about these things, only that you need to remember asking about them in some way. For example, you likely would not ask, "Do you have any delusions?" You may, however, ask, "Do you have any history of believing things that may not be quite true, such as that people are out to get you?" Rapport and clinical skill are absolutely necessary for broaching difficult areas like this.

Not all these areas will apply to every case, but they are a good way to keep yourself organized and make sure that you do not miss any vital information. You may need to preface some questions with a disclaimer that you ask them of all clients and they may not apply to the individual being assessed.

History of Presenting Problem

The assessor should always work to develop a detailed history of the problem, including when it began (date of onset); if there was a precipitating event; how continuous or intermittent the problem has been (what has been its course), including when and how it got worse or better during the time since the struggle began; and any previous assessments conducted. Inquiring into previous assessments provides an opportunity to gain a prior clinician's perspective on the history of the problem, which you can then add to the individual's self-assessment for more enlightenment. Consulting with the prior or current mental health care provider not only provides potentially rich data and cross verification but also gives the individual you are assessing a sense of continuity and coherence to their ongoing assessment and care.

[1]For detailed discussions on assessment of dangerousness, see Blumenthal, Wood, and Williams (2018); Campbell and Messing (2017); and Jobes (2016).

TABLE 1.2 **COMPONENTS OF ASSESSING THE PRESENTING PROBLEM**

Current stressors

Cognitive status complaints
- Attention and concentration
- Memory
- Language problems
- Problem solving
- Decision making
- Hallucinations
- Delusions

Emotional status complaints
- Mood
  - Helplessness
  - Hopelessness
  - Worthlessness
  - Crying
  - Manic symptoms
- Anxiety
- Appetite
- Sleep
- Energy level
- Hobbies
- Libido

Suicidal ideation
- Ideation
- Intent
- Plan
- Means

Homicidal and aggressive ideation
- Ideation
- Intent
- Plan
- Means

The Case of David: Presenting Problem

Although it is clear that David is struggling academically and would like to understand why, during the initial interview (and usually at the very beginning) you will need to find out all the relevant details about his academic functioning. You may begin by asking generally about what it is like for him at school. Then, depending on the information you receive, you might ask specific follow-up questions about certain aspects. These may include what he is studying, whether he is struggling in all of his classes or just particular ones, the specific nature of his difficulty (whether he loses concentration, has difficulty reading, cannot retain information, or simply does poorly on exams, for example), the nature of his ability to concentrate in other contexts, and, perhaps most importantly,

information about any mood or anxiety problems. He states that he simply has trouble keeping focused when reading or writing is involved, no matter where he is.

Throughout the initial phase of this first interview, it becomes clear that David truly is struggling in school, though this also seems to be the case in other areas of his life. He reports that he has difficulty paying attention to tasks that involve reading and writing. He also describes, however, that he has been struggling with "depression" (his word) for the past three years—ever since "everything fell apart." Although he was able to report on what was happening three years ago, it is also important to understand the presenting problem as it is impacting him now. Thus, you need to understand what he means by struggling with "depression." When asked about the depression itself, he reports that he gets extremely "down" many days, sometimes to the point of not being able to even go to school, which is also impacting his academic functioning. To get more specific, you may have to ask about certain aspects of depression, including appetite, sleep, motivation, and energy level. What emerges is that his appetite is reportedly "okay," that he sometimes has difficulty sleeping because he is worried about failing out of school, and that on his "down days" he is not motivated to do anything. He reports feeling as though school is hopeless and that perhaps he should just quit and "save myself the worry."

At this point, it becomes crucial for you to assess his degree of suicidal ideation (and homicidal, though it seems less likely). For David, this should not be that difficult, as it ties directly into what he is reporting. There are many ways you could ask him if he has ever considered harming or killing himself, but the important thing is to be absolutely clear about what you are asking. Do not leave room for him to misinterpret what you mean by your question. For example, a question like, "Does it ever get so bad that it's hard to go on?" is simply too vague and open for him to misinterpret. Your best bet is usually to ask, in as empathic a tone of voice as possible, "Have you ever thought about harming or killing yourself?" The same is important for assessing aggressiveness and homicidality. For both, David denies ever seriously thinking about them. Because there is minimal ideation (only nonserious thoughts) and seemingly no intent, there is no need to assess for means and a plan for either suicidality or homicidality.

The Case of David: History of Presenting Problem

With David, this is the point at which you need to do two things in the interview; because there are basically two major presenting problems (the cognitive–academic problem and the depression), you must inquire about the history of each of these. With depression (as with many other presenting problems), it is important to assess this current episode, its onset, and its course, along with as any other history of similar problems before the current episode. Because so much came out at the beginning of the interview about the depression and because he specifically mentioned that the onset was three years ago when "everything fell apart," you can start by asking what was going on for him three years ago when he first became depressed. When you do, David reports that his girlfriend, his "high school sweetheart," broke up with him. He details that she had been cheating on him when they went to separate colleges but that he did not find out until she told him while she was breaking up with him. He was already struggling academically in college, and at about the same time his best friend died in a drunk driving accident. (His friend was a passenger in a car that was hit by a drunk driver.) At this point, he had to take some time off from his studies and left college for a few years. He only recently returned to school, where he is again struggling academically.

Interestingly, David did not give you much information about the actual nature of the depressive symptoms, so you have to ask more specifically about those. At that time, three years ago, he implied that he became depressed, but you need to figure out exactly what went on with him at that time. When you ask specifically, he reports that he "got pretty depressed" and did not want to leave his dorm room for a few months. He tells you that he cut off ties with most of his friends, did not speak much to his family, lost some weight, and did not sleep much during that time. At the urging of his academic advisor (who had granted him a leave of absence from

school because of his friend's death), he entered individual psychotherapy about six months after he became depressed. When asked about the course—whether it has been pretty constant or has gotten better or worse at times—he says that it is "definitely better than it was" but that there have not been any periods since then when he was not "down" for a significant period of time.

When you are confident that you have enough information about the current episode, it makes sense to move on to whether he has any history of similar problems in the past. When you ask this, however, he simply states that he has never been depressed before and that he was "a happy child."

Because academic difficulty is not as episodic as depression, it does not make as much sense to ask about the current episode of academic difficulty. Instead, you could ask more broadly about his academic functioning in school growing up. When you do, he states that attention and concentration have always been difficult for him, telling you that he was "an average student" throughout school, "probably 'cause I didn't read that much." He tells you that his grades never fluctuated significantly and that they were always (barely) passing.

Biopsychological Evaluation

The second overarching component or the clinical interview is a biopsychological evaluation. It should be noted that there is no reason it needs to come in this order during an actual interview or that the following subsections need to be asked about together. This framework is simply presented to help you organize in your mind what information you should ultimately have from the clinical interview. This component is important in understanding the actual content of the problem, including the symptomatic and medical features of what may be impairing the client's functioning and the contextual information related to more physical, bodily, and somatic aspects of the client's history and current functioning. Assessors should ask specific questions about symptoms related to different psychiatric diagnoses and should observe them during the clinical interview and the entire assessment. Similar to medical interviews, to fully understand what is going on for a client, an assessor must inquire about early development, medical history, substance use history, and family medical, psychiatric, and substance use history.

Developmental History

Assessing developmental history can be seen as a crossover between the biopsychological and psychosocial evaluation, as it has some components that are physiological and some that are environmental and interpersonal. It begins with specific questions about the early developmental environment, including if there were any known problems during the mother's pregnancy, labor, or delivery. Following these medical questions, you should ask about significant events during infancy and childhood, including developmental milestones (such as timeliness of achieving developmental milestones like sitting up, crawling, walking, talking, and toileting). Also included should be any childhood behavioral problems, significant accidents, and traumas. Table 1.3 shows some basic yet useful information to gather during the developmental history assessment.

It is extremely important to understand that much of these data may not be easily (or at all) available to the person being interviewed. Certainly, when possible, collateral interviews are helpful at obtaining some of the missing information. For example, an adult client may not have knowledge of their mother's pregnancy or delivery but could ask their mother for more details. In other cases, though, assessors may simply not get some of this information, like in those who were adopted or are refugees. While of course it is always best to have the information, assessors need to understand how to move forward and contextualize assessment data when they do not have this information.

TABLE 1.3 **COMPONENTS OF ASSESSING DEVELOPMENTAL HISTORY**

Problems during pregnancy
Problems around birth and delivery

Developmental milestones
- Sitting up
- Crawling
- Walking
- Speaking
- Toileting
- Socialization

Childhood behavioral problems
Childhood accidents or injuries
Childhood traumas

The Case Of David: Developmental History

When you ask about his developmental history, David reports that he does not know of any difficulties with his mother's pregnancy or his birth. Similarly, he tells you he thinks he met all of his developmental milestones on time. He does tell you that he has difficulty remembering anything before about the age of 8, and he cites the age of 16 as his "most significant year" because that is when he stopped using drugs. Obviously, these are two areas you would need to ask about in further detail: anything that happened around the age of 8 and his drug use prior to age 16.

Discussing what happened at the age of 8, he says "nothing significant that I can think of." He talks briefly about his family history (see the section on family history, which follows), but he cannot identify anything specific that makes it difficult for him to remember his life before then. He does tell you that is when he began using substances, though. At this point, it makes sense to begin doing the alcohol and substance use evaluation in the interview. See the section on substance abuse that follows for the information that David discloses when discussing his drug history.

As with the suicidality assessment discussed previously, an assessment of childhood trauma should be included in this section of the interview. Asking about childhood trauma can be awkward and difficult, but again you must be clear about what you are asking. When you ask him if he ever had any traumas as a child, he simply replies no. Specifying further, just to confirm that he was never abused, raped, or neglected, again he responds that he never was.

Psychiatric History

The history of psychiatric symptoms and treatments—including information on any past hospitalizations, past harm or threat of harm to self or others, and any psychotropic medications taken in the past—is extremely important for understanding the actual course of the individual's problems. If there were previous treatments, it is always ideal to obtain a release of information to get the records of these treatments or to speak with the previous treating clinicians. This is especially critical with previous hospitalizations or a history of medication, which can be markers of more serious psychiatric conditions.

Reviewing previous records and speaking to previous treating clinicians allows you to obtain as much information and data as possible, which provides a more comprehensive assessment of the individual. Consider the example of a client referred for an assessment to evaluate her competency to care for her children. She will likely present positively or even be genuinely unaware of her own struggle with psychopathology, but a review of her