Conducting Psychological Assessment

A Guide for Practitioners

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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

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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

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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.

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[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

TABLE 1.4 **COMPONENTS OF ASSESSING PSYCHIATRIC HISTORY**

Any history of psychiatric diagnosis
Any history of psychiatric treatment
Type of professional seen
Reason for treatment
Treatment dates
Frequency of visits
Treatment duration
Treatment outcomes
Any history of psychiatric medication

psychiatric records may uncover important information (e.g., a history of psychosis, aggressiveness toward her children, or poor impulse control). This information will be crucial in deciding whether she is fit to parent her children, though obviously her current functioning and the possibility that she has changed must always be considered.

The basic information important to understanding psychiatric history is presented in Table 1.4.

Alcohol and Substance Use History

Both past and present use of alcohol and other drugs should be explored. Even social use of alcohol may affect the individual's functioning and should be discussed. For example, an individual who presents as depressed and reports the social use of alcohol may not understand how alcohol, a depressant, can exacerbate their symptoms, even in what they consider to be low doses. Included in the assessment of alcohol and other substance use should be the substance types, the onset of use (both dates and circumstances), the length of time and duration of use, the amount of use, and any previous treatments for use. It is also important to ascertain whether the individual feels that their use of substances has positively or negatively impacted their life. Additionally, attitudes about using and quitting can be extremely useful later on in the assessment process. For example, an individual who abuses alcohol but denies that this is a problem may be using the substance to cope with stress, restrict emotions, or escape reality, all hypotheses that may be supported elsewhere in the testing. Important aspects of questioning alcohol and other substance use are listed in Table 1.5.

The Case of David: Psychiatric History

You already know that David is currently in therapy, so you know he has a history of mental health treatment. When you ask him more specifically if he has ever been diagnosed with anything, he says that he was diagnosed as a child with dyslexia and was medicated at that time, though he does not remember what was prescribed. He cannot even remember when in his childhood this occurred except that it was before he was 8.

He has been in treatment for the past two and a half years, following the difficult time in his life when he had to take a leave of absence from school. He has been in weekly therapy with the same therapist since then, and he has been prescribed Wellbutrin by the school's psychiatrist, whom he sees once every three months for medication management. When you ask more about the treatment, he tells you that it is "something like" cognitive behavioral therapy and that it has been very helpful for him. Although he still struggles with depression, he says he "function[s] better" than he did before. He says he has never been to another mental health professional before.

TABLE 1.5 COMPONENTS OF ASSESSING ALCOHOL AND SUBSTANCE USE HISTORY

Alcohol use
- Past
  - Amount
  - Frequency
- Present
  - Amount
  - Frequency
- Impact of use on life

Other drug use (including abuse of prescription and over-the-counter drugs)
- Past
  - Amount
  - Frequency
- Present
  - Amount
  - Frequency
- Impact of use on life

Medical History

Despite the fact that an assessor is not a medical doctor, both present and past medical status should be explored, including any serious medical illnesses, hospitalizations, and any current or past medications. Medical history and status can significantly affect current psychological functioning. If any medications are currently being taken, make sure to note the duration, what they were prescribed to treat, and any changes in dosage or administration that have occurred during their use. It will be important to note any temporal relationships between changes in the medical history and in the presenting problem and psychological symptomatology. Consider an individual who loses consciousness and then shortly afterward becomes extremely moody and irritable. This temporal relationship between loss of consciousness and mood change may be a significant warning sign that a medical or neurological problem (e.g., multiple sclerosis) could be the root cause of the psychological presentation. It is also important to note the date and results of the individual's last comprehensive physical examination. Among other things, this serves as an indicator of the individual's investment in self-care and their level of awareness of health status. The important components to consider when assessing medical history are listed in Table 1.6.

TABLE 1.6 COMPONENTS OF ASSESSING MEDICAL HISTORY

Current medical illnesses
- Date of onset
- Course
- Treatment and medications

Past significant medical illnesses
- Date of onset
- Course
- Treatment and medications

History of loss of consciousness or head injury

The Case of David: Alcohol and Substance Abuse History

David reported earlier in the interview that he began using drugs around the age of 8 and quit using them around 16. Because he brought this information up unsolicited, there is reason to believe (a) that it is significant (though use of drugs by any 8-year-old is significant) and (b) that he will likely speak openly about it. When you ask about his history of using drugs and alcohol, he begins to tell his story of rather significant substance abuse.

David began using drugs around the age of 7 or 8, smoking one or two marijuana joints after school. By the time he was 10, he was getting drunk "frequently." When words like "frequently" arise in this context, it is important to clarify since the meaning of a word like this can vary from person to person. Specifying, he said he drank every day and got drunk at least every other day, if not more often. By age 10 or 11, he also began experimenting with other drugs, including PCP and cocaine. Arrested for public intoxication and illegal possession of narcotics, he was sent to a juvenile detention center at age 16. It was at this time he began attending Alcoholics Anonymous (AA) meetings, which he says have continually helped him remain sober and substance free since he was 16. He says that he never used any other substances and was never in any form of drug treatment other than AA.

The major question David seems to have left unanswered is why and how he began using drugs at such an early age. When you ask him, he discusses his family situation growing up, but he has no specific, concrete precipitating event other than being offered marijuana "by older kids at school." He says he was naïve, but the feeling of being high on marijuana was "too good to quit, much better than I felt in the rest of my life." At this point, a small red flag may be going up in your mind about possible depression (or anxiety or something else) going on for him at that time. When asked, however, he says he cannot remember any problems before then and that being high was simply "a great feeling."

It is relatively clear that substance use has impacted David's life significantly, though you as the assessor have to make the judgment of whether to press for more details about the impact of the drugs on his life. At this point, though, you may decide simply to move on with the interview, keeping in mind that no matter what information you get it will be limited.

The Case of David: Medical History

David denies any major current or past medical problems. When asked about his last physical exam, however, he states that he does not think he has had one since he was a child, though he is quick to add with a laugh, "I've always been healthy as a horse—well, except for all the drugs, I guess." Although some assessors may feel differently, you may want to recommend to him right then that he go for a physical exam to rule out any medical problems that may be affecting him. However, given the pattern of symptoms, it seems unlikely that his problems have a medical cause.

Family Medical, Psychiatric, and Substance Use History

Because of what is known about the heritability of both medical and psychiatric illnesses, not to mention what is known about children being raised by parents with medical, substance abuse, and mental illness, it is important to ask about any significant medical and psychiatric illnesses in both the immediate and distant family of the individual being assessed. A significant example of the impact of heredity is the research suggesting that an individual whose parent has bipolar disorder is at much higher risk for developing a mood disorder (Downey & Coyne, 1990; Hammen, Burge, Burney, & Adrian, 1990; Weissman et al., 2006). Knowing this information about someone who has come in for an assessment can alert the assessor to possible symptoms or to view current or past problems in a different light. It may be especially important to point out to the client that psychiatric illnesses

are often undiagnosed. For example, many people, upon reflection, will note that some family members were likely depressed, even though they were never formally diagnosed or treated for depression. The topics to assess related to family medical and psychiatric history are the same as when assessing the client's own medical and psychiatric history, with the addition of discussing possible undiagnosed illnesses in family members.

The Case of David: Family Medical History

David does not know of any significant medical, substance abuse, or psychiatric illnesses within his immediate or extended family. When this information is unknown or is denied by a client, there is not much more to be asked, so it likely makes sense just to move on with the interview with David.

Psychosocial Evaluation

Whereas the biopsychological evaluation focuses on the physical, physiological, medical, and biological history and context of the individual's functioning, the psychosocial evaluation is designed to examine the social, interpersonal, and experiential–functional aspects the individual's world, with both its intrapsychic and interpersonal demands. The scope of the presenting problem often reaches beyond individual symptoms. It is essential to consider that symptoms are manifested within a larger context of relating to others and that, as such, they will likely be affecting interpersonal functioning, educational and work functioning, and many other areas of life.

Family History

It is important to note both current and past family structure, such as number of siblings, who served as the primary caregivers of the individual, and number and ages of any children, in addition to any other significant details. As to the individual's current family life, if they are married or have a significant partner, you should get a description of the relationship, including its history and the quality, in the words of the person being assessed. Any significant history within the family, such as traumas or deaths, should also be included in this part of the assessment. The aspects of clients' families of origin and current families are listed in Table 1.7.

Educational and Vocational History

A thorough assessment of educational history should be discussed, including the highest level of school completed, general functioning within school (including grades, in general), and educational aspirations. It should also be noted whether there is a history of any academic difficulties, learning disabilities, and special class placements.

TABLE 1.7 COMPONENTS OF ASSESSING FAMILY HISTORY

Family of origin structure
Primary caregivers, including quality of relationship
Siblings, including quality of relationship
Significant family events
Current family status and structure
Romantic relationship
Children
Significant family events

The Case of David: Family History

The information on David's family of origin emerges throughout the initial interview, but not as a discrete line of inquiry. When asked about his developmental history earlier in the interview, he discloses that he was raised as the only child of his mother and never knew his father. David was born in New York, though his mother was originally from Chile. She has worked as a home health aide for David's whole life. He said, "It was easier not having a father 'cause I had a lot less structure," a factor he feels contributed to his ability to use drugs at such an early age. He says he thinks his father is in Chile, but he is not sure and has never "had the urge" to search for him.

To this point, David has given you quite a bit of factual information about his family of origin. What he has not shared, though, is the quality of his relationship with his mother (his only real immediate family). You may want to ask him to talk about his mother and what kind of person she is, or you may dig deeper about their specific relationship as he was growing up and now. Either way, you must somehow get information on the quality of this relationship. When asked, he describes his mother as "nice," with very little other information. When probed a bit further, he does disclose that she is "a little clueless to have let me do what I did," but he says they have a relatively good relationship now.

Additionally, information on current and past occupational functioning should be acquired, including career path, general level of work functioning and productivity, and career aspirations. Specific components of assessing educational and vocational and occupational history, as appropriate, are listed in Table 1.8.

TABLE 1.8 **COMPONENTS OF ASSESSING EDUCATIONAL AND VOCATIONAL HISTORY**

Educational history
Highest level of education completed
Years
Degree
Subject
School history
Learning disabilities
Special education
Repeating a grade
Attentional problems in school
Hyperactivity in school
Behavioral and emotional problems in school
General grades
Vocational and occupational history
Current job
Length of time working in current job
Quality of job performance
Satisfaction with current job
Past jobs
Length of time working in past jobs
Quality of job performance
Satisfaction with past jobs
Career aspirations

The Case Of David: Educational and Vocational History

For David, the educational and vocational history is actually part of the presenting problem and its history, so very little additional information is necessary. He tells you (with a smile) that he is majoring in psychology, though, as stated earlier, he is anxious about being able to finish the program. When asked if he has ever worked, he tells you that he worked at a clothing retail store through high school to help his mother pay the bills and to support his drug habit. He says that he never really enjoyed it but found it "easy to do."

Criminal and Legal History

You should note any history of legal problems. It is absolutely necessary to assess past legal involvement, including whether or the individual is on probation or parole, because this will inform how best to proceed with the assessment. For example, a detailed history of criminal behavior could support a potential hypothesis of antisocial or even psychopathic traits. As such, you would want to make sure to include in the testing battery measures to assess those traits specifically. This portion of the assessment is especially important if the individual indicated during the biopsychological evaluation that they have the potential to harm themselves or others, in that this risk, combined with a criminal history, may be magnified. Areas to consider when assessing legal history are listed in Table 1.9.

When it comes to criminal and legal history, it is extremely important to be aware of subtle and slight reactions on your part, including facial expressions. To elicit the most open and honest responses from the client, you have to work hard to appear nonjudgmental and difficult to shock when discussing illegal activity. The more you treat this information like any other background information (like what the client had for breakfast), the better your rapport will be and the more likely you will be to get valid information.

The Case of David: Criminal and Legal History

David's legal involvement ("thank God," he says) was limited to his drug arrest and time in juvenile detention. He says he is extremely grateful that all of his legal problems happened on his juvenile record and are much less likely to impact him in his adult life in the future. He denies any other involvement with the law.

TABLE 1.9 **COMPONENTS OF ASSESSING CRIMINAL AND LEGAL HISTORY**

Current criminal and legal involvement
Probation or parole
Lawsuits
Impact of current legal involvement on day-to-day life
Past criminal and legal involvement
Probation or parole
Lawsuits
Impact of past legal involvement on day-to-day life

Social History

Social history and context are essential for many reasons, including current number of friends, history of social support, and the quality of friendships. Additionally, the kinds of social networks and social activities that the individual participated in while growing up are of interest, as they may illustrate some of the reasons behind the current difficulties the individual is facing. Whether the individual has a best friend may also prove important information later in the assessment process. It is also extremely important to note any history of interpersonal difficulties. For example, because a personality disorder diagnosis almost invariably includes interpersonal impairment, a history of difficulty in the interpersonal domain may prove diagnostically meaningful. Any current significant relationships, if not described in the family history section, may be described in detail here, again including their length and quality. It is important for the assessor to know and understand the difference between making friends, having social support, maintaining friends, and having deep, meaningful relationships. The areas to consider when assessing social history are listed in Table 1.10.

The Case of David: Social History

David says he has always been extremely sociable and friendly "except when I isolate myself in my dorm room." He says he was "very popular" at the age of 16 when he stopped using drugs, which is when he met his high school girlfriend—the one who broke up with him three years ago. He says other people find him to be "happy-go-lucky and positive," so he finds making friends extremely easy. He has several very good friends at college and several good friends from high school with whom he keeps in touch. His best friend from high school, as reported previously, died three years ago in a car accident, "and I'm still mourning him, I think." He has not been in a romantic relationship since his high school girlfriend broke up with him.

David paints the picture of an extremely sociable, friendly, outgoing, happy person, not exactly what would be expected from someone who has been struggling with depression for the past three years. He seems to have an extremely good support network, though one that struggled to get him out of his dorm room for at least six months. Again, a red flag may be going up, and follow-up questioning may be warranted. You may ask if his social life was different before and after the depression and if it is different now than it was two and a half or three years ago. When asked, he admits that he did cut off ties with most people three years ago when he became depressed. He says, though, he has found it extremely easy to reconnect with them and build new relationships in the past year and a half or so since he has progressively been feeling better "with the help of therapy."

TABLE 1.10 **COMPONENTS OF ASSESSING SOCIAL HISTORY**

Current social support system
Number and quality of friends or social supports
Best friends
Current romantic relationship
Social history
History of interpersonal difficulties
History of romantic relationships

Psychosexual History

Perhaps one of the more delicate topics to assess during the clinical interview is the psychosexual history of the individual. Psychosexual functioning refers to all of the psychosocial issues related to sexuality, including history of romantic and sexual behavior and exploration, sexual adjustment and attitudes, gender identification, and sexual orientation. Although this part of the psychosocial evaluation may be more relevant in some cases than others, it is important to at least rule out the possibility that psychosexual issues may be affecting an individual's current psychological functioning. Included in this evaluation should be a history of sexual development, including whether the individual's pubertal development was on time, early, or late. Additionally, you should ask specifically about any history of sexual violence or molestation, as a victim, witness, or perpetrator. Again, there will be some cases where it is plainly evident that some areas of psychosexual history are not relevant, such as for young children. In such cases, there is no need to make the individual being assessed (or yourself) unnecessarily uncomfortable by probing into areas that clearly have no relevance.

Toward the goal of creating a comfortable environment that will produce the most accurate picture of the client possible, it is important to approach inquiry about psychosexual history in as straightforward and unapologetic a manner as possible. Any anxiety on the part of the assessor will likely engender anxiety in the individual being assessed, so it is most effective to ask questions frankly in a way that shows you are not embarrassed by their content. This will increase not only the person's comfort while being assessed but also the likelihood that they will be open and honest about topics that may be embarrassing to share in another context. Try to approach questions in this domain as if you were asking mundane questions; ask about history of sexual behavior as if you were wondering what they watch on television. Also, try to avoid judgmental terms and covert meanings—use language that is plain and honest. For example, when asking a woman about her onset of puberty, ask around what age she got her first period rather than when her "special visitor" first arrived. Some areas that may be relevant in this part of the interview are listed in Table 1.11.

The Case of David: Psychosexual History

For David, you have some of this information already, at least related to romantic relationships. When asked, he says that he is heterosexual and has only ever dated his high school girlfriend. He says they were sexually active until they broke up, "but I haven't been much interested in sex since then." When asked about his sexual development, he says it was "normal, which is a surprise considering the crowd I was hanging out with." He denies ever questioning his sexuality and ever having witnessed or been a part of sexual violence or misconduct. He does add that he feels he is ready to start dating again, though, and makes a joke about whether the assessor knows of any girls for him.

TABLE 1.11 COMPONENTS OF ASSESSING PSYCHOSEXUAL HISTORY

Sexual orientation and identity
Current sexual activity
Frequency
Partners
Level of satisfaction
Past sexual activity
Pubertal onset
History of sexual activity
History of sexual abuse, trauma, or violence

Cultural Evaluation

It is impossible to understand an individual without understanding the cultural environment in which they are functioning.[2] In this section, it is important to include specific facts—for example, the individual's primary and secondary languages and migration history, if there is one. However, it is also important to evaluate the subjective experience of the person, including their cultural, racial, and spiritual and religious identity. For example, consider a teenage boy who self-identifies as bicultural, since he was born into an Indian family but goes to school with mostly Caucasian peers. How he has reconciled his cultural identity, navigating his starkly contrasting worlds at home and at school, and how he feels about these differing worlds and himself within them may impact his current functioning considerably. Even individuals who are part of the majority culture (e.g., straight, cisgender, White males) may have less obvious but just as significant cultural, racial, or spiritual identity struggles. For individuals who immigrated to their current countries, any history of acculturation issues, even if the individual feels they have fully acculturated at present, should also be evaluated. One excellent resource for understanding cultural context and what components should be evaluated is Pamela Hays' ADDRESSING framework (Hays, 2001). Information that can be included in this section of the interview, when applicable, is given in Table 1.12.

The Case of David: cultural Evaluation

David's mother is Chilean, and David was born and raised in New York. They spoke Spanish at home, though he spoke English at school growing up. Already, there is an area of potential impact on his life that you can ask about. Additionally, when thinking about the cultural context in which David was raised, questions of ethnic and cultural identity, spiritual and religious upbringing, and current beliefs arise. You should inquire into each of these.

David tells you that he is bilingual and has never had difficulty with either Spanish or English. In fact, he says growing up that was one area that made him feel "special and smart" because he is fluent in two languages—even as he struggled with school. His mother and her entire family, most of whom are in Chile, are Catholic, so David was raised in the Catholic church. He says that he is no longer religious, though, and has not been to church since he was in juvenile detention. He says that he never really had difficulty with his cultural identity, feeling that "I am just American—New Yorkers are from everywhere." He has never been to Chile and has never met most of his extended family. He describes himself as having "a universalist worldview," and when asked what he means by that he simply states that he believes in equality throughout the world.

TABLE 1.12 **COMPONENTS OF CONDUCTING A CULTURAL EVALUATION**

Language
Immigration history
When immigrated to current country
Length of time in current community
Acculturation issues
Cultural, racial, and ethnic identity
Spiritual and religious history and identity
Sexual and gender identity
Socioeconomic status identity
Disability (developmental or acquired later in life)

[2]For a more in-depth discussion on multicultural evaluation in clinical interviewing, see Alcántara and Gone (2014) and Sommeers-Flanagan and Heck (2013).

Mental Status Evaluation

While the client is a major source of information about what is going on with their functioning, because every person's self-awareness is somewhat limited, other sources of data are essential. One of the most important tools for evaluating a person's current functioning is clinical observation. The mental status evaluation (MSE) is a useful way of organizing clinical observation data and was designed as a method for identifying, in particular, individual characteristics that are outside of the normal range of functioning. Although there are several different ways to organize information for the MSE, one basic method is described here and is summarized in Table 1.13. Additionally, a form for recording MSE data is provided in Table 1.14.[3]

Appearance and Behavior

One of the most important indicators of current functioning is how someone appears and behaves. Appearance includes not only clothing and grooming (i.e., how adequate their hygiene is) but also the level of motor activity (e.g., psychomotor retardation or hyperactivity) and coordination (i.e., fine and gross motor functioning) displayed. Behavior refers to both any abnormal or repetitive behaviors (e.g., constant shifting or throat clearing) and the individual's relatedness toward you (e.g., cooperativeness, friendliness, guardedness, eye contact). Appearance and behavior can, even before testing, clue you in to the possibility of some reasons for functional impairment. For example, a client appearing fidgety and agitated may indicate anxiety, mania, or the effects of a drug.

Consider a man who comes into your office for the clinical interview with his hair disheveled, his shirt tucked in only halfway on one side, his collar askew, and his zipper down. This significantly unexpected and inappropriate appearance can be a major clue that something is not going particularly well for him at the moment. Those words *at the moment* are extremely important: he may have sick children at home or something else that may cause situational distress. His appearance may signify something more serious as well, though, such as disorganized

TABLE 1.13 **COMPONENTS OF THE MENTAL STATUS EVALUATION**

Mental status evaluation	
Appearance and behavior	**Thought process and content**
Grooming	Goal-directed thinking
Motor activity	Hallucinations and delusions
Relatedness	Depressive and anxious ideation
	Suicidality and homicidality
Speech and language	
Speech patterns	**Cognition**
Receptive language	Attention and concentration
Expressive language	Memory
Mood and affect	**Prefrontal functioning**
Self-reported mood	Judgment
Observed affect	Planning and impulse control
Mood–affect congruence	Insight

[3]For a more in-depth discussion on the mental status evaluation, see Sommers-Flanagan and Sommers-Flanagan (2017).

TABLE 1.14 **FORM FOR RECORDING MENTAL STATUS EVALUATION DATA**

Mental status evaluation

Appearance: _____ Grooming: _____

Motor activity: _____

Coordination: _____

Gross motor: _____

Stance and posture: _____

Gait: _____

Balance: _____

Fine motor: _____

Abnormal movements and repetitive behaviors: _____

Relatedness (circle):	**Normal**	**Abnormal**	
	Cooperative	Hostile	Uncooperative
	Relaxed	Guarded	Unrelated
	Friendly	Seductive	Withdrawn
	Good eye contact	Poor eye contact	Clinging

Comments: _____

_____

Speech and language (circle):

Receptive:	**Normal**	**Abnormal**		
Expressive:				
Volume:	Low	Normal	Loud	
Pitch:	Monotone	Normal	Exaggerated	
Quality of voice:	Hoarse	Normal	Harsh	Nasal
Articulation:		Normal	Abnormal	
Rhythm:	Clutter	Normal	Stutter	Pauses
Rate:	Slow	Normal	Rapid	Pressure and push

(Continued)

TABLE 1.14 (*CONTINUED*)

Vocabulary and grammar

Age appropriate:	Yes	No
IQ appropriate:	Yes	No
Idiomatic (slang):	Yes	No

Comments: _____

_____

Affect and mood (circle):

Affect:	**Normal**	**Abnormal**		
Range:	Expressive or good range	Flat	Constricted	Labile
Type:		Angry	Irritable	
		Anxious	Sad	
	Appropriate to situation	Inappropriate to situation		
Mood:	**Euthymic**	**Abnormal**		
	Happy	Elevated	Depressed	Angry
		Mild	Mild	Mild
		Moderate	Moderate	Moderate
		Severe	Severe	Severe
	Appropriate to situation	Inappropriate to situation		
Congruent:	Yes No			

Comments: _____

_____

Thought process (circle):

Normal	**Abnormal**	
Goal directed	Tangential	Flight of ideas
Logical	Circumstantial	Slow thinking
Abstract reasoning	Magical thinking	Rapid thinking
	Concrete thinking	Loose associations

Comments: _____

_____

TABLE 1.14 (*CONTINUED*)

Thought content (circle):	**Normal**	**Abnormal**
	Hallucinations	Delusions
	Not present	Not present
	Auditory	Paranoid
	Visual	Grandiose
	Olfactory	Body image
	Tactile	Ideas of reference
	Mood incongruent	Mood incongruent
	Mood congruent	Mood congruent
		Other: _____

Depressive ideation	**Suicidality**	**Aggressiveness**	**Homicidality**
Not present	Not present	Not present	Not present
Worthlessness	Ideation	Ideation	Ideation
Excessive guilt	Plan	Plan	Plan
Self-reproach	Intent	Intent	Intent
Low self-esteem			
Helplessness			
Hopelessness			

Comments: _____

_____

_____

_____

Memory (circle): **Normal** **Abnormal**

Comments: _____

_____

_____

_____

Attention and concentration (circle): **Normal** **Abnormal**

_____

(Continued)

TABLE 1.14 (*CONTINUED*)

Comments: _____

_____

_____

_____

Alertness (circle):

Lethargic/sleepy	Alert	Hypervigilant	

Judgment and planning (circle):

Judgment:	Poor	Fair	Good
Impulse control:	Poor	Fair	Good

Comments: _____

_____

_____

_____

Insight (circle):

Poor	Fair	Good

Comments: _____

_____

_____

_____

thinking and behavior associated with psychosis. Whatever it signifies, it is extremely important to note because ultimately whatever emerges from the assessment should ideally explain why he came in so disheveled.

Alternatively, consider a woman who comes in wearing inappropriately tight and seductive clothing, showing significant amounts of cleavage. Already you have clinical information (i.e., clues) as to some possibilities of some things that may affect her functioning. When you consider that she is being assessed as part of a custody evaluation for her children, her overly seductive attire may make sense, especially when the assessment reveals her underlying personality and coping structure. She may simply be working hard to be seen favorably by the

assessor, which on one hand may relate to her desperation to get her children back but on the other hand may reveal some sort of narcissistic or histrionic presentation or poor judgment.

Finally, consider a woman who comes in for the clinical interview, makes very little eye contact, looks down at the floor, fidgets with her hands constantly, and does not seem to answer questions directly. This behavior is likely significant for one of many reasons. She clearly seems to be somewhat anxious, though her anxiety could be related to many different things, including social–stranger anxiety, fear of what her assessment will reveal, or generalized anxiety. Alternatively, she could have interpersonal skills deficits related to some type of autism spectrum disorder. Whatever the reason for the behavior, it is important to note and to incorporate into the assessment—her behavior is significant clinical data that must be used or explained by the results of the assessment.

Speech and Language

A person's language functioning critically affects your ability to adequately assess them in all other domains of functioning. For example, if you observe that the client does not understand what you are saying, you will need to adjust the selection of tests for the battery to make sure they will be able to comprehend the test instructions. Similarly, if an individual's vocabulary is so limited that they cannot make their point known, then much of the information from the clinical interview will need to be interpreted with this barrier in mind.

Language should be evaluated separately for receptive and expressive elements. Receptive language refers to language comprehension; you should note whether the person seems to understand all that you are saying and whether they require you to repeat questions, comments, and instructions. Expressive language refers to the individual's actual use of language to make their points known, including the developmental vocabulary level, clarity of expression, and appropriateness of word use. Aspects of speech such as volume, rate, and tone should be evaluated separately from the language itself.

Consider a client who comes in for an assessment and during the clinical interview does not seem to understand clearly the questions you are asking, despite the fact that you are being clear and simple in your language. This same client may have difficulty understanding the directions for some of the testing instruments, especially the more complicated ones. (For example, the figure weights subtest of the Wechsler scales has long and somewhat confusing directions because the task itself is somewhat conceptually novel and difficult.) Not only is this good clinical information—difficulty understanding language could certainly impair interpersonal relationships, educational and occupational functioning, and so forth—but it also informs what alterations to your testing battery may need to be made. This person with clear receptive language difficulties may benefit from a cognitive evaluation that uses a language-free intelligence measure, for example, such as the TONI-4, CTONI-2, or UNIT 2. Difficulties with receptive language can be related to several things, including an organic or neurological problem, overwhelming anxiety, or even psychosis. As with any aspect of mental status, this information should provide more data to the whole picture of what is going on for them, and the ultimate picture of the client should make sense in connection with this receptive language difficulty.

Consider another client who comes in with loud, pressured, cluttered speech. Her expressive language is so pressured that she trips over her words, stutters, and at times gets so overwhelmed by the rate of her words that she cannot get a single one out. Again, there are many possibilities as to why this may be happening for her: she could be overwhelmed by anxiety within the current situation, she could suffer from a more pervasive anxiety disorder, she could have some sort of neuropsychological or cognitive condition, or something else entirely different could be going on. It is important to capture this information here, however, so that you can work it into the assessment results to contribute to the overall picture of the client.

Mood and Affect

An important distinction in the MSE is the difference between mood and affect. Mood refers to the current emotional state of the individual, as reported by the client themselves. Affect refers to the observed emotional state of the individual, such as what their facial expression or general body language communicates to you as the assessor. While it is important to evaluate mood and affect separately, it is extremely important to decide whether both are appropriate to both the situation and each other. This latter concept, whether the individual reports a mood similar to the affect that you observe, is known as mood–affect congruence. Affect can be mood incongruent for many reasons, and noting this will be important later in the assessment. For example, consider a woman who reports feeling sad and depressed but does not stop laughing or smiling throughout the entire interview. The fact that she does not seem depressed to you, contrary to her own report, may prove notable when you are reviewing the results from her testing.

Alternatively, many individuals may report feeling fine, despite the fact that their affect is notably depressed (e.g., they do not smile or even look at you during the interview, they speak slowly, they sigh often). This mood-incongruent affect may inform you about their levels of insight, their feelings about mental illness, or even fears of being diagnosed as depressed. Not only will this incongruence be additional data for the assessment, but it also can help inform you to be slightly gentler and reassuring during the whole process.

Thought Process and Content

Just as it is important to evaluate the emotional state of the individual, evaluating the thought process and content can provide you with extremely useful pieces of data when you create a picture of what may be going on for an individual. Thought process refers to how an individual thinks, whether in a goal-directed, logical way or in a way that suggests some problem in thinking, such as tangential, circumstantial, magical, or concrete thinking. An individual who, when asked questions, consistently goes off topic in a seeming stream-of-consciousness delivery can be labeled as having tangential thought process. A person with tangential thinking may have actual cognitive or thought difficulties, possibly including dementia or psychosis, though it may be attributable to other factors, such as current emotional distress or anxiety. Someone with circumstantial thinking will eventually veer back onto the point and answer the question, though in a roundabout way. Circumstantial thinking, while sometimes difficult to follow, usually does not indicate a serious functional problem, though it may inform some difficulties in communication and interpersonal functioning. Again, when evaluating this domain, it is important that you have evaluated the individual's language abilities, as this is the primary mode by which you can observe thought process.

Consider a client who comes in and seems to be thinking quite slowly and in a concrete way. When you ask him about his difficulties, he can consider only very specific, concrete examples, such as getting fired from his job recently and not understanding why. He may have difficulty even coming up with hypotheses as to why he might have been fired, though he reports that his former boss told him that he was making multiple errors in his tasks. All this information comes out slowly, and he seems unable to think abstractly about why his boss may have fired him. This concrete and slow thought process is important to note because it may relate to low cognitive ability, a rigid personality style, or some other possible cognitive deficit. Again, this will likely fit into the picture of the client that emerges from the assessment.

Thought content refers to what the individual thinks about. Specifically, we are most interested in abnormal thought and perceptual content, such as hallucinations and delusions. It is important to be extremely vigilant in distinguishing what are true hallucinations and delusions from other perceptual and thought experiences. For example, a man who reports seeing a ghost outside of his bedroom window may be hallucinating. However, because hallucinations require that there is no external stimulus, whether he is simply misinterpreting another

stimulus, like a tree blowing in the wind, is crucial to evaluate. If he is actually misperceiving one thing as another, the perceptual phenomenon is actually an illusion, not a hallucination.

Similarly, a delusion is a fixed, false belief held as true despite concrete evidence to the contrary, so beliefs that seem odd to you need to be probed carefully to see if there might be any validity to them. For example, whereas it may be a delusion for some of us to think we are being followed constantly (this would be an example of a paranoid delusion), a woman who is going through a divorce and whose soon-to-be ex-husband has hired a private investigator may not be delusional in thinking she is being followed. There is actually evidence that her belief may be true (e.g., seeing the same man in the same car everywhere she goes) rather than evidence to the contrary.

Additionally, depressive, manic, aggressive, suicidal, and homicidal ideation should be noted. Much of this information will have been reported by the individual being assessed during the biopsychological evaluation. Often, however, much of this ideation will come out in the interview or assessment process more organically. For example, a man asked specifically about depressive ideation may deny it, but later in the process, after struggling with a cognitive task (e.g., block design on a Wechsler intelligence scale), may say to himself, "I am always so stupid! I'm always failing at stuff—I'm just so worthless." This would qualify as depressive ideation, despite the fact that he directly denied it previously. Similarly, a woman going through a divorce and undergoing a custody evaluation may deny any aggressive ideation toward her ex-husband when asked initially, but, later in the assessment, it may become clear that she "hate[s] the jerk" and actually has thoughts of harming him. These are clear examples of how the mental status evaluation requires the consideration of both the report of the individual being assessed and the observations of you as the assessor.

Cognition

Although you will be testing cognitive functioning later, clinical impressions of different domains of cognitive functioning should be noted from the interview so that any suspected abnormalities can be included in the hypotheses generated later. Additional testing may be required as a result of these noted abnormalities. The major areas of cognition captured in the MSE are alertness, attention, concentration, and memory. Just like the other domains, you should be most interested in what is clinically outside of normal limits. For example, with alertness, note whether the individual looks sleepy, slumped in their chair and looking at the floor throughout the clinical interview (noted as *lethargic* in the MSE), or is particularly alert to everything you are doing and follows all of your movements and writing with great attention (noted as *hypervigilant* in the MSE). Similarly, with attention, concentration, and memory, make note of any conspicuous problems that seem to be interfering either with the assessment process itself or the individual's life in general. For example, while you will often test short-term memory in the assessment, it would be notable if a person does not remember seemingly important details of their childhood or schooling. This impairment in memory may have organic or more dynamic roots, but either way it is important information when creating hypotheses of what could currently be impairing their functioning. Moreover, if a person cannot concentrate on the questions you are asking in the interview, it is likely that their concentration in other situations may be compromised as well.

Prefrontal Functioning

The final domain of the MSE is concerned with those higher order skills and functions associated with the functioning of the prefrontal cortex area of the brain. Although attention and concentration are largely associated with the prefrontal cortex, the functions in this prefrontal functioning section are more related to personality variables such as judgment, planning, and insight. Your clinical evaluation of these domains will inevitably fall short—these domains of functioning are complex and difficult to assess, especially with clinical observation alone. It is nevertheless useful to evaluate them broadly. Specifically, in considering the self-report of the clinical

interview, you should evaluate how appropriate you think the individual's judgment has been in the past. An individual who has been arrested multiple times for selling drugs likely does not have the best judgment (either for continuing to commit the act or continuing to get caught). Consider a woman who comes in for a custody evaluation and is extremely belligerent, oppositional, and caustic in her interaction with the assessor. While she may be angry about the situation (and perhaps rightly so), this strategy is a very bad one for getting the assessor to "be on her side," hopefully ultimately to report that she would be the best choice to primarily parent the child. Frustrating or angering the person who will help decide whether you get primary custody of your child shows poor judgment, even though the assessor may understand why the woman is upset in general.

Planning refers to how well the individual seems to consider the future when acting; additionally, how well you feel they control impulses is important in understanding the capacity for planning. Planning and impulse control are thus highly intertwined, and both constitute prefrontal functioning. Consider a client mandated for an assessment because of extreme delinquent behavior—vandalizing public property. It will be important to assess whether these acts of delinquency were planned and premeditated or were the result of poor impulse control. The same behaviors can have very different roots, and potential treatment for either of these situations would look very different.

Insight refers to how aware the person is (a) that they have difficulties and needs support or help, (b) that they play a part in their own problems, and (c) of the specific issues that need addressing. A man currently mandated to a drug rehabilitation program by the court may report that he understands that his drug use served as a way of coping with negative emotions, which would constitute good insight. Alternatively, he may simply see his current situation as an impediment to his being able to enjoy himself on drugs again; this would constitute poor insight.

This section of the MSE can be especially useful in determining how an individual is functioning developmentally. For example, children are not expected to have extremely high insight—it is not expected for a child to understand the role they play in their own difficulties. This capacity generally develops throughout adolescence. An adult man who has extremely low insight into his problems, however, may be conceptualized as functioning, at least in this domain, as a preadolescent. It may then be important to begin to think about his other areas of functioning in terms of normative development, especially judgment, planning, and impulse control. It would not be unusual for that adult man with extremely poor insight to also have what could be considered preadolescent-level functioning in other domains, including extremely naïve judgment and difficulty delaying gratification.

Hypothesis Building

Once data have been gathered through completion of the clinical interview, the collection of background information from other sources (e.g., from the person who referred the individual, from other collateral sources, from medical records), and the mental status evaluation, it is time to pose the question: What could be going on for this person? To answer this question effectively, you need a clear and comprehensive knowledge of psychodiagnosis. If, for example, you do not remember that impairment in attention can be a symptom of depression, you may forget to include this as a viable hypothesis for an individual who presents with poor attention. If your only hypothesis is that the person may have a disorder of attentional ability (i.e., attention deficit hyperactivity disorder), then you may not choose to test for depression or any other possible cause of impaired attention. For extra assistance on the potential causes of symptoms, from a *DSM-5* perspective, consult the *DSM-5 Handbook of Differential Diagnosis* (First, 2013), which includes a list of symptoms with all their likely diagnostic causes. That being said, a *DSM-5* perspective is only one of many perspectives.

Also important is a thorough knowledge of cognitive, personality, behavioral, and emotional functioning from whichever theoretical perspective to which you subscribe. The process of generating hypotheses for what is affecting an individual's functioning applies to any theoretical orientation. Consider a man who presents with

interpersonal difficulties, for example. A hypothesis from a psychodynamic perspective may include the possibility that his object representations are chaotic and thus impairing interpersonal relations. A hypothesis from a cognitive perspective may include the possibility that he has an underlying schema of worthlessness, feeling that he does not deserve positive relationships, which sabotages his interpersonal relations.

The same presentation, considered from a multicultural perspective, may generate a hypothesis that a combination of racial discrimination and acculturation issues may be impairing interpersonal functioning, as social norms and conventions may be very different here from his culture of origin. The important point is that you should generate hypotheses for all (or as many as you can enumerate) the potential causes of the functional impairment. One hypothesis should always be that the individual's functioning is normative and functional—that nothing is wrong: this is the null hypothesis. In most cases, though, you will reject this hypothesis on the basis of the simple fact that the individual was referred, either by themselves or by someone else, for difficulties in functioning, as well as the clinical interview, which usually reveals some impairment.

Identify Impairments

The first task in the process of hypothesizing is to clearly lay out the precise impairments in functioning. This often requires some degree of simplification (at times even oversimplification). Whereas you have amassed many pieces of data from different sources, at this point it is important to take a step back and try to understand, as broadly as possible, in what domains this individual's functioning is impaired.

For example, a woman going through a divorce may complain of the stress of the separation and elaborate on what a jerk her soon-to-be ex-husband is. She may complain of a lack of support and unfair treatment by her husband's attorney and the judge. She may complain that her own attorney has no idea what he is doing and "obviously hates women." And these complaints may only be the tip of the iceberg. When taking a step back, however, a complicated picture of a woman clearly in distress can be made clearer and simpler. The first step is to list the impairments in functioning. Currently, she has reported one major impairment—stress related to the divorce. We can also ascertain another major impairment from our clinical observation: interpersonal difficulty (we may also feel that her insight is somewhat impaired). While *interpersonal difficulty* is a broad term, she has reported a lack of support in general, has blamed others for her current situation[4] and generally negative feelings toward even those individuals who are trying to help her. Thus, there is substantial reason to believe that she has interpersonal difficulty, at least enough so that it merits further investigation during the assessment.

Enumerate Possible Causes

The next step of the hypothesis-building process is to try to enumerate all the logical possible causes for each of the broad areas of impairment in functioning. First and foremost, we must consider the fact that there may be nothing abnormal occurring—our null hypothesis posits, for this woman, that she is reacting as anyone would to a divorce and that her functioning is unimpaired in any domain. Considering the alternative—that she does have functional impairments—generates several other hypotheses as well. She reported stress related to her divorce, and, although this term is vague, it should raise a red flag of possible anxiety, depression, and, most likely, adjustment difficulties. It is important not to jump to the conclusion that this is an adjustment disorder, even if this is likely our best hypothesis. Because we have not yet taken into consideration her functioning prior to the divorce, the duration of her symptoms, or many other factors, we cannot confidently say that this definitely does not constitute a mood or anxiety disorder.

[4]Remember, this is only a hypothesis. It may turn out that others truly are victimizing her. But given her global insistence that others are against her, it stands to reason that she may be playing a significant part in her interpersonal difficulties.

As with any assessment, two hypotheses must be ruled out across the board. The first is a substance use disorder. There is a possibility that her current anxious state, above and beyond her situation, is exacerbated by the use of a substance—cocaine, for example. It is important to note that hypotheses may not be mutually exclusive—she could very easily have both an adjustment disorder and a substance use disorder, which exacerbates the former. The second hypothesis that must be considered for every assessment is that the impairment in functioning is due to a general medical condition. For example, a brain tumor can cause both mood and anxiety symptoms. While it is unlikely in this case (since we seem to have a logical precipitating external event), because we are not medical doctors we cannot confidently rule out this possibility without at least current medical information (medical records or a recent physical can be extremely useful).

Another major hypothesis, given her interpersonal difficulties, would be a personality disorder. Regardless of your personal feelings about personality disorders, it must be considered that this is one thing that can get in the way of interpersonal functioning. That being said, it is only one thing. As we will be testing this woman for depression in our assessment anyway, knowing that depression can also interfere with socialization, we will need to be mindful of whether the interpersonal impairment exceeds what would be expected of a woman with depression. Other hypotheses of what could impair interpersonal relationships could include social anxiety, systematic discrimination by society as a whole, or even psychosis (in the form of paranoid delusions, such as that others are conspiring against her). This list of possibilities is hardly exhaustive. (For example, Asperger's syndrome can impair interpersonal functioning, though it is unlikely in this case because of her history of significant relationships and no evidence of the other symptoms of the disorder.) But when generating hypotheses, you want to try to be as expansive as possible, enumerating as many possibilities as you can come up with for each impairment in functioning. Many of these will be ruled out quickly and easily in the testing process, but each will help inform what tests you choose for the assessment battery. These hypotheses are crucial for the next step in the process, selecting tests—you must know what you are trying to rule in or rule out to decide how to proceed with testing.

Summary

The task of generating hypotheses as to what may be impairing an individual's functioning requires the synthesis of a large amount of information. Beginning with the referral questions—whether they come from the individual themselves or from someone else who referred the person for the assessment—clues as to what may be happening will begin to emerge during the initial clinical assessment. This is merely the beginning. So much information about the person comes from the clinical interview and your clinical observation, including the mental status evaluation. From all of the information gathered, a picture of the individual's functioning will begin to emerge, though it may seem at least initially to get more and more complex (rather than clearer) as data accumulate.

After gathering all the data from collateral resources (e.g., medical records, consulting previous treating clinicians), the clinical interview, and your own clinical observations and mental status evaluation, the next task is to consolidate the data so that you can begin hypothesizing a cause. This begins with taking a step back and looking at what are truly the areas of impaired functioning, including subjectively felt distress, reported impairments, and other problems that may be outside of the person's awareness, such as a pattern of difficulties with other people. Finally, once the major areas of impairment have been identified, using your comprehensive knowledge of psychodiagnostics and cognitive, personality, emotional, and behavioral functioning, a list of as many potential causes as possible for each of the impairments should be generated. This list will inform the next step of the assessment process. That next step is to choose a battery of tests to help you evaluate the validity and probability of each hypothesis you are considering.

CHAPTER 2

Selecting Tests

Central to the process of psychological assessment is the appropriate selection of psychological tests to assess specific areas of an individual's current functioning. Doing so allows the assessor to gather data beyond simply what they can observe and what the individual being assessed can directly report. A clear and deep understanding of exactly what different tests measure and how they go about measuring it is crucial to building an assessment battery that will most accurately illuminate an individual's functioning. This chapter presents a comprehensive, though not exhaustive, overview of important considerations involved in making appropriate and informed test selections.

General Considerations

At this point in the assessment (after the clinical interview and review of collateral information), you should have generated some hypotheses to explain what could be going on for the individual being assessed. Human functioning is complex, and testing these hypotheses therefore is most often complicated and multifaceted, which is why all assessments should include evaluations of both cognitive and personality, emotional, and behavioral functioning. In other words, it is impossible to understand an individual's emotional functioning without at least an idea of their cognitive functioning and vice versa.

Why Test?

The primary question when determining how to match the choice of tests to the hypotheses generated is why test? It is important to understand precisely what information you need to gather to evaluate the validity of each of your hypotheses. It is just as important, though, to understand what kind of information would be better obtained from tests than from clinical observation, self-report, or others' reports. For example, an individual may report difficulties with attention (self-report), and you may also have noticed that their attention wandered during the clinical interview (clinical observation). Obviously, though, it would be insufficient to leave it at that.

In this case, it is necessary to get two more pieces of information to determine what is going on. First, you would want to collect some norm-referenced information about attention to determine just how serious (e.g., outside the norm, impairing their functioning) the difficulty is. Using norm-referenced measures like the Child Behavior Checklist (CBCL), the Behavior Assessment System for Children, Third Edition (BASC-3), or the ASEBA Adult Self-Report (ASR) provides more standardized information about how an individual's attention compares with others their age. Second, you would want to determine what their attentional capacity is under

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best circumstances—that is, what is their brain capable of doing under the most ideal circumstances. Using measures like the Conners' Continuous Performance Test, 3rd Edition (CPT-3), the Test of Variables of Attention (T.O.V.A.), or the Test of Everyday Attention (TEA) will provide information related to optimal performance of attention. Because attention difficulties can be symptomatic of many disorders, the likely source of the poor attention could be one of several things. Since the causes may range from a mood disorder to an anxiety disorder to attention deficit hyperactivity disorder (ADHD), each of these pieces of information, along with details about other emotional functioning, will be needed to determine what is actually going on for the individual being assessed.

The Multimethod Approach

Every effort should be made to approach each hypothesis from as many different angles as is reasonably possible. Within constraints of time and resources, the more data that can be gathered using the largest possible selection of methods and informants, the more confidence in the strength and validity of the conclusions drawn will increase. This approach is known as the multimethod approach to psychological assessment (Meyer et al., 2001), and its goal is comprehensiveness. Using multiple tests to evaluate many separate areas of functioning not only increases the scope of the assessment but can also provide convergence of evidence across tests to create stronger arguments for some hypotheses over others.

For example, if an individual complains of feeling "depressed"—which can mean very different things to different people—further inquiry may be needed. Support for this hypothesis of depression will likely come from self-report, symptom-focused measures (e.g., the Structured Clinical Interview for *DSM-5* [SCID-5] or the Beck Depression Inventory-II [BDI-II]), as these ask questions that are likely very similar to what would be asked in the clinical interview. You can be much more confident in the likelihood of an actual clinical depression (as opposed to, e.g., nonpathological sadness) if evidence of the depression also emerges from self-report personality inventories (e.g., the Minnesota Multiphasic Personality Inventory, 2nd Edition [MMPI-2], the Minnesota Multiphasic Personality Inventory-2-Restructured Form [MMPI-2-RF], or the Personality Assessment Inventory [PAI]) and on non-self-report, performance-based measures (e.g., the Rorschach Performance Assessment System [R-PAS]).

If evidence of depression comes from the individual's self-report during the interview and from use of the BDI-II, the MMPI-2-RF, the R-PAS, and the Thematic Apperception Test (TAT), there is a great deal of convergent evidence that the hypothesis of depression is strongly supported, and you can confidently state that the individual is likely experiencing significant depressive symptomatology. Moreover, while all these tests converge on the broad category of depression, each specific test can offer a more nuanced picture of the quality of the depressed episode. For example, the BDI-II and MMPI-2-RF may qualify the depression as specifically melancholic, while strong themes of loss and loneliness may emerge in the responses to the R-PAS and TAT—a seemingly small but important quality that can be extremely important in terms of treatment. This type of depression is very different from a depression centered primarily on low self-esteem, for example, and may be treated very differently by a mental health professional.

When asking why you should test, consider that these small nuances, though they could likely be obtained through clinical interviewing and through the process of psychotherapy, may take much longer to emerge in these conditions, especially if the individual is not necessarily aware of them themselves. In this example, a reason for testing could include determining both whether the individual meets criteria for major depressive disorder or is just nonpathologically sad, along with how the depression would be categorized (e.g., rooted in loneliness, hopelessness, low self-esteem) so that specific, targeted treatment recommendations can be made.

Very often, it is considerably easier to rule out a hypothesis than to confirm it. For example, if "poor attention" is a hypothesis for a specific child and the child's attention scale on both the BASC-3 (a norm-referenced measure of typical, everyday functioning) and all scales on the CPT-3 (a performance-based measure of optimal attention functioning) are unremarkable, it is extremely unlikely that there is an attention deficit.

However, though an unremarkable score on the CPT-3 can rule out a hypothesis of attention deficit, low performance on this scale is insufficient to confirm the same hypothesis. Poor performance on that measure may be due to poor attention related to prefrontal cortex problems or to any other number of factors that may impede attention in the moment, such as anxiety, fatigue, hunger, or strong emotions. Thus, to confirm a hypothesis of impairment in the attention system (rather than just attention problems secondary to some other factors), additional administrations of measures would need to be undertaken, such as readministering the CPT-3 on a different day or using alternative measures like the Test of Everyday Attention for Children (TEA-Ch).

A Standard Battery

Very often, psychologists will have a standard battery of tests that constitutes the base of most of the assessments they conduct. In addition to a thorough clinical interview, a good standard battery includes the following:

- a broad measure of cognitive ability, such as a Wechsler Adult Intelligence Scale (WAIS) or the Stanford-Binet Intelligence Scales, 5th Edition (SB5)
- a screening test to supplement cognitive areas not covered in the broad measure of cognitive ability, such as the Bender Visual–Motor Gestalt Test, 2nd Edition (Bender-2), which assesses basic visual perception, basic fine motor accuracy, visual–motor integration, and short-term visual memory; or the Delis-Kaplan Executive Function System Trail Making Test (D-KEFS Trails), which can add fine motor speed and cognitive switching
- several multimethod measures of personality, emotional, and behavioral functioning, such as
  - a self-report, symptom-based measure (e.g., the SCID-5 or ASEBA ASR) for adults or self- and collateral-report, symptom-based measures (e.g., the BASC-3) for children
  - a self-report inventory, such as the MMPI-2, MMPI-2-RF, or Millon Clinical Multiaxial Inventory, 4th Edition (MCMI-IV)
  - some performance-based or projective measures, such as the R-PAS and the TAT

This kind of standard battery will address a number of basic hypotheses from different angles and will paint a comprehensive picture of how an individual is currently functioning. For example, a common standard battery for adults could be the Bender-2, WAIS-IV, ASEBA ASR, MMPI-2-RF, R-PAS, and projective drawings like the House-Tree-Person. Many general assessments of functioning, including those of individuals who present with mood, anxiety, and psychotic disorders, will be mostly adequately addressed with this standard battery without much need to supplement with additional tests. The Bender-2 and WAIS-IV can rule out gross neurological and cognitive impairment and can elucidate an individual's cognitive strengths and weaknesses. The MMPI-2-RF, ASEBA ASR, and performance-based techniques (R-PAS and projective drawings), combined with the clinical interview and clinical observation, can broadly evaluate an individual's emotional and personality functioning. Specifically, mood, anxiety, and psychotic symptoms can be reliably captured by these different personality and emotional functioning measures.

New hypotheses may develop during the testing. For example, notable and interesting results from the WAIS-IV may warrant further investigation into a specific area of cognitive functioning. Even if there were no presenting complaint about attention, a significantly low score on the Working Memory Index (WMI) may warrant

further investigation to see whether attentional impairment is the underlying cause of the poor performance on the WMI tasks. Additional tests of executive functioning (such as the Wisconsin Card Sorting Test [WCST] or D-KEFS Trails) may prove useful as well, especially if attention is examined and determined to be unimpaired. Similarly, some evidence for a personality disorder may emerge from some of the performance-based tasks, so adding a self-report inventory that is more sensitive to personality pathology than the MMPI-2-RF, such as the MCMI-IV, can be useful in building evidence for or ruling out some sort of personality pathology.

Test Characteristics

When conducting psychological assessments, be vigilant as to the currency of your knowledge of what tests are available to use, what each test measures, and how each test measures what it measures. (This sentence alone may serve as an assessment of vocal articulation.) Resources like the *Mental Measurements Yearbook* and *Tests in Print* provide descriptions and reviews of most available tests. Additionally, Strauss, Sherman, and Spreen's (2006) *A Compendium of Neuropsychological Tests*, Lezak, Howieson, Bigler, and Tranel's *Neuropsychological Assessment,* 5th Edition (2020), and other similar texts can be useful for specific subdomains of assessment. Reviewing journals like *Assessment*, *Psychological Assessment*, *Journal of Personality Assessment*, and *Journal of Psychoeducational Assessment* can also help keep you current on the state of psychological tests.

Different tests are differentially sensitive to varied aspects of personality, emotional, and behavioral functioning. For example, self-report, symptom-focused measures generally identify current states of functioning and overt characteristics of which individuals are themselves aware. For example, states such as current anxiety and characteristics such as low self-esteem are easily identified by self-report measures such as the SCID-5 and the Symptom Checklist-90-Revised (SCL-90-R).

More enduring personality traits, including underlying motivations, biases, attitudes, and dispositions that may not be entirely consciously understood by the individual being assessed, are better uncovered by self-report personality inventories and performance-based measures like projective tests. An individual may have a predisposition toward self-sabotaging behaviors in the face of success but may be largely unaware of this. Although self-report, symptom-focused measures will likely not uncover this trait, measures such as the MCMI-IV and TAT are much more sensitive to these types of data.

Reliability

When deciding on tests to use in a battery, you must ensure that each one has adequate psychometric properties. That is, each test used should be both reliable and valid. Reliability has to do with the consistency with which a test measures whatever it measures. A test that measures depressive symptoms, for example, if given to the same person with the same symptoms at a different time, should consistently detect the symptoms; this is one type of reliability. While this may be difficult to assess personally (because an individual's symptoms are not, in fact, consistent over time), you should be able to easily find statistics on a test's reliability in both the test's manual and the major publications of test materials, *Mental Measurements Yearbook* and *Tests in Print*. There are four major types of reliability to consider when looking at tests.

The first is *inter-rater reliability*. Inter-rater reliability is the consistency with which multiple examiners obtain the same data from a given test. For example, if clinicians are trying to rate the quality of warmth during an interaction between a parent and her infant child playing together using some kind of warmth rating system, inter-rater reliability would be extremely important—that is, the system should be set up such that independent raters give relatively the same warmth ratings to the interaction they are watching. If the raters vary drastically on their warmth ratings, even though they are watching the exact same interaction (and this variation occurred consistently), the rating scale would have low inter-rater reliability and thus the ratings would not be meaningful.

For these types of measures, where clinician rating or scoring is integral to the measure itself, inter-rater reliability must be adequate.

The second type of reliability is *split-half* or *alternative forms reliability*. Split-half reliability refers to taking half the items of a single test (usually every other item) and correlating them with the other half of the items. If the test is meant to measure a single construct (e.g., the Beck Depression Inventory is made up of items that are all supposed to be assessing depression), then correlating two halves of the test should yield very good split-half reliability. This type of reliability is harder to assess when the test is not meant to yield a measure of a single construct. For example, the MMPI-2 has many different constructs that it attempts to measure (e.g., clinical scales range from somatic signs to depression to antisocial tendencies). Thus, all the items are not assumed to relate to each other in a consistent way.

Similarly, alternative forms reliability relates to giving two different versions of a test to a single individual (though, obviously, a whole sample of these would be needed to calculate a test's reliability). For example, many cognitive tests have alternative forms, such as the Peabody Picture Vocabulary Test, Fifth Edition (PPVT-5). The PPVT-5 consists of a list of vocabulary words increasing in difficulty along with corresponding picture items for the client to choose from. Alternative forms of this test simply include different test items (vocabulary words and corresponding picture items) of approximately equivalent difficulty throughout. Giving the same individual the two different forms of this test should theoretically yield very similar scores, as the task is the same, the construct is clear, and the test itself has alternative forms reliability.

The third form of reliability to consider is *test–retest reliability*, with the idea being that the exact same test given twice to the same person should yield very similar results. Like the other forms of reliability, this type makes sense in connection with some tests but not others. One necessary assumption about any test scrutinized for test–retest reliability is that the construct it is measuring should not have changed drastically. For example, a test of how well a client slept the night before, given on two separate occasions several weeks apart, may not have good test–retest reliability because the construct (sleep quality) is not expected to be necessarily stable. Just because the assessor gets two drastically different outcomes from this same test given twice two weeks apart does not mean that the measure is unreliable. The client's sleep may actually have changed during the past two weeks.

It makes more sense to evaluate this type of reliability on tests that measure more enduring traits. Tests of cognitive ability (IQ tests), for example, purport to measure a relatively stable trait. Thus, if an assessor gives a Wechsler Intelligence Scale for Children, 5th edition (WISC-V) to a client twice within six months, the results should be relatively consistent. The major limitation, however, is that on many performance-based tests, there is a practice effect—that is, taking the test once actually allows a client to practice and get better at some of the tasks (e.g., block design). Therefore, their performance the second time, if not enough time has passed, will likely improve. Nevertheless, measures that test supposedly enduring or consistent traits should have good test–retest reliability.

The final kind of reliability is *internal consistency* (α). This type of reliability, without getting too technical, basically takes each item of a single test and correlates it with every single other item on the test. Again, tests that measure a single construct should be able to yield high internal consistency (as should single scales from tests that measure multiple things). For example, the narcissistic scale from the MCMI-IV should have good internal consistency (a high α). All the individual items from this scale should be highly intercorrelated. If they are not, then they are not consistently measuring whatever it is that they are measuring.

When it comes to reliability, it is important to understand which type of reliability each individual test you are considering using should logically have. Inter-rater reliability does not make sense for a computer-administered (and scored and interpreted) test such as the CPT-3, nor does internal consistency make sense for a performance-based psychomotor task such as the finger tapper (during which the client taps their finger as many times as possible in a given time limit to test for psychomotor speed). Additionally, reliability is a prerequisite for

validity—that is, there is generally no discussion of whether a measure is valid (measures what it says it measures) if the test has not yet been proven to be reliable. However, reliability alone does not imply validity. Validity must be measured separately.

Validity

Publications like *Mental Measurements Yearbook* and *Tests in Print* and individual test manuals also contain statistics on validity. Validity refers to how accurately and precisely a test measures what it is supposed to measure. For example, a test that measures depressive symptoms should in fact measure symptoms related to depression as opposed to symptoms related to anxiety (or ability in mathematics). As with reliability, because validity is a difficult concept to prove, there are multiple types of validity to consider when looking at tests.

The first type of validity to consider, *face validity,* is not really a true measure of how valid a test is. Instead, it pertains to how valid a test seems to the person taking it. Does the test seem as though it is measuring what the assessor claims it is measuring? For example, a self-report measure that is supposed to measure level of depression and asks questions about sadness, feeling blue, and lack of interest in usual activities is high in face validity—all those questions seem to be measuring depression. Face validity should not be confused with actual validity, however. Many tests may seem valid, but when actually tested for validity (e.g., compared with other measures that have been deemed valid) they do not hold up. Additionally, a lack of face validity can be an asset of a test. Measures high in face validity are especially susceptible to response bias. For example, an individual who wants to appear very depressed will have an easier time achieving this goal on a measure with high face validity for depression. Malingering is much more difficult with a test that has low face validity. Self-report inventories vary in their face validity (and many have validity scales), and performance-based emotional and personality measures, including projective techniques, generally have the lowest face validity. The actual validity of a measure, however, is independent of its face validity.

Content validity refers to whether the items of a test cover the range of items that are necessary to reflect the construct the test is supposed to measure. For example, a new test of depression should obviously include items on sad mood, but it should also have items related to appetite, sleep, psychomotor and vegetative symptoms, enjoyment of activities, and all the other symptoms known to be related to depression. Most generally, content validity is evaluated by independent experts in the field, and a measure is often assumed to be content valid when it has been evaluated for other types of validity. That is, it is assumed to be taken care of during test development, whereas the other types of validity are generally evaluated once a measure has been completely created.

Criterion-related validity is probably the most common type of validity used to evaluate psychological tests, perhaps because it is relatively easy to understand and measure. It is measured by comparing the test of interest with other, outside measures of the same construct. For example, that new test of depression can be given to a sample of clients within a clinic who are also evaluated using a SCID-5, independent clinician ratings, and a BDI-II. If the new measure relates well to these other measures known to accurately diagnose depression (this is even better because it includes both self-report and an independent examiner's rating), it would be said to have high criterion-related validity. Specifically, this is referred to as *concurrent validity* because the new measure is given at the same time as the established ones.

Predictive validity relates to the new measure being administered now and the criterion (an outside, valid measure that should be validly predicted by the new measure) being administered in the future. A good example of this is looking at whether tests of academic ability (e.g., the Scholastic Aptitude Test [SAT]) are predictive of academic functioning in the future (e.g., as reflected by college grades). If the SAT claims to measure potential for success in college, then it should in fact do so; SAT scores measured at one point in time should be related to college grades measured a few years later. It should have predictive validity.

The final type of validity to consider when choosing tests is *construct validity*. This is generally the hardest type to prove, and it is the most convincing argument that a test measures what it says it measures. Harder to assess, construct validity means that research has shown that a test is significantly associated with the theoretical trait or construct it claims to measure. This goes beyond criterion-related validity, which relates the new test to another measure. This type of validity relates the new test to the theoretical construct itself. That new test of depression should in fact measure the construct of depression (not just correlate with a BDI-II, which is a single self-reported measure of depression).

One of the most common ways researchers try to establish construct validity is through a multitrait–multimethod matrix (MTMM). This matrix compares the new measure with established measures that test for the same construct but in a different way (a different method) and with measures that test different constructs but in the same way as the new measure. For example, consider a new measure of depression that is performance based. (For this hypothetical new measure, it is posited that depressed individuals will respond to puzzles a certain way, so this measure uses puzzles to test for depression.) An MTMM would need the new measure to be compared with (a) several measures that measure depression but in a non–performance-based way, perhaps a BDI-II, SCID-5, and a psychiatrist evaluation; (b) measures that specifically do not measure depression but use the same method (e.g., performance-based tests such as Matrix Reasoning and Visual Puzzles from the WAIS-IV); and (c) ideally at least one measure that measures a different construct using a different method—for example, a self-reported inventory of vocational interest. The matrix would then look at associations between the new test and each of these other tests.

The new test, in attempting to establish construct validity, would need to have a high correlation with the same-trait, different-method measures (the BDI-II, SCID-5, and psychiatrist evaluation) and low correlation with any test that measures a different construct (Matrix Reasoning, Visual Puzzles, and the vocational interest test), even if the same method (performance-based puzzle) is used. By establishing that the construct— and not the way it is being measured—is driving the scores on the new test, researchers can argue that they have established good construct validity of their new test.

Another way many measures build an argument for construct validity is through factor analysis. Psychological measures most often rely on a matrix of data—a large group of questions aimed at understanding the different facets of a psychological construct or trait, knowing that there will be error in self-report, others' report, clinical observation, and even behavioral performance at any given moment. As such, test developers often use factor analysis to evaluate the underlying structure of the large set of questions. That is, they use the statistical relationships between all of the test's items to determine if they are likely measuring a single construct or if some items are measuring something different. The factor determined to be evaluated by a set of questions represents a test's internal structure, which builds on evidence that it is measuring what it purports to measure. Again, research on individual tests' validity should appear in their individual test manuals, and they can also be found in publications like *Mental Measurements Yearbook* and *Tests in Print*. Tests used in the individual assessment process should be both reliable and valid. Validity and use of measures with different populations will be discussed later in this chapter.

Test Types

Tests fall into three structure and two purpose categories.

Self-Report, Symptom-Based Measures These measures can take several forms, most often as surveys or structured or semistructured interviews. They ask direct questions about symptoms and generally have very high face validity. As such, they are very useful in some ways, such as understanding exactly what symptoms an individual is struggling with. However, they are also extremely susceptible to response bias. That is, if an individual wants to

appear as if they have depression, they can do so quite easily on these measures. Similarly, if they want to deny any difficulties, it is again quite easy to do so on these measures.

The most widely used examples of such tests for adults are the Symptom Checklist 90-Revised (SCL-90-R), the Brief Symptom Inventory (BSI), the Structured Clinical Interview for the *DSM-5* (SCID-5) and for the *DSM-5* Personality Disorders (SCID-5-PD), and the Diagnostic Interview for Anxiety, Mood, and Obsessive-Compulsive and Related Neuropsychiatric Disorders (DIAMOND). These are broad-based measures of multiple symptoms that cut across different diagnostic presentations. For children, similar measures include the CBCL, Conners Comprehensive Behavior Rating Scales (CBRS), Schedule for Affective Disorders and Schizophrenia for School-Aged Children (K-SADS), Personality Inventory for Children, 2nd Edition (PIC-2), and BASC-3. These child measures are often completed by caregivers or teachers. While some of these are comprehensive measures and aggregate around scales, they are primarily measures of symptoms being presented by a child or adolescent.

In addition to broad measures of symptoms, targeted measures of symptoms of specific disorders are widely used. Common examples of these measures include the Beck Depression Inventory, 2nd Edition (BDI-II), the Beck Anxiety Inventory (BAI), the Hamilton Rating Scale for Depression, and the Alcohol Use Disorders Identification Test (AUDIT). Many such measures assess specific symptoms as understood by the individual being assessed, so it is crucial to be aware of all the different aspects of these measures, including their appropriate use, the populations on which they were normed, and their psychometric properties, to ensure that you are using them properly.

Self-Report Inventories These measures, while still based on self-report, are qualitatively different from symptom-based measures. They take into consideration the combined responses to items on the inventory and use them to create a profile of the individual being assessed. Rather than placing importance on any one individual item (as do most of the symptom-based measures), they cluster many responses together to discern the type of person being evaluated. Included in these responses may indeed be individual symptoms. For example, the PAI contains a depression scale in which some items ask specifically about low mood. However, many items on the PAI depression scale are not simply *DSM-5*–defined symptoms of a major depressive episode. Because the measure has many items that do not clearly fit on a single scale and because responses are on a 4-point scale (from false to very true), it is much less likely than self-report, symptom-focused measures to be biased either by the level of insight of the person being assessed or by intentional skewing of presentation. That is, many individuals being assessed may purposely skew their presentations either toward more pathological (if, for example, they are applying for disability benefits and want to appear worse off than they actually are) or toward the less pathological (which is much more common, as many individuals may be somewhat guarded when meeting an assessor, a stranger, who is probing into very personal matters).

One of the greatest benefits of these self-report inventory measures is that they almost invariably have safeguards built in to assess the validity of the individual's approach to the test. For example, if an individual is responding randomly to items on the measure—say, because of low motivation for testing or poor reading ability—these self-report inventories have scales that look specifically at this style, considering pairs of items that should always be answered in the same direction. If an individual has several pairs of these items answered in opposite directions, there is evidence that they were responding randomly to items. Similarly, many inventories (e.g., the MCMI-IV, MMPI-2-RF) include scales of defensiveness, exaggeration, and a tendency toward presenting oneself in an overly favorable light.

The most common examples of these self-report inventory measures are the MMPI-2, MMPI-2-RF, MCMI-IV, and PAI. Each of these measures has a slightly different focus. While the MMPI-2 has the longest history and the widest use (Butcher & Rouse, 1996), each has a slightly different focus and different strengths. For example,

the PAI maps much more clearly and easily onto the *DSM-5* (actually, it is still aligned with the DSM-IV-TR) because it was developed to discriminate between DSM-IV axis I disorders. The MCMI-IV is much more sensitive to personality disorders and character styles than the other measures because it was developed to characterize how an individual approaches the world, including interpersonally. For adolescents, each of these measures has forms created for and normed on younger populations, including the MMPI-A (adolescent version), the MMPI-A-RF, the Millon Adolescent Clinical Inventory (MACI), the Millon Adolescent Personality Inventory (MAPI), the Millon Preadolescent Clinical Inventory (M-PACI), and the PAI-A (adolescent version). It should be noted that there are significant limitations with child assessments, as most of these are truly built around self-report and younger children are both unreliable reporters and unable to complete self-report questionnaires. As such, many evaluations of younger children rely more heavily on collateral-report symptom focused measures (like the BASC-3 or CBRS), which include some aspects of these self-report inventories, but are primarily symptom and behavior focused.

Performance-Based Measures These measures require the individual being assessed to perform some type of task that is evaluated by the assessor, most often by comparing performance to norms of a large sample of same-age (or same-grade) individuals who were administered the same measure in the same way. These tests are inherently less biased by insight and motivated skewing of self-report, but they are generally indicative only of the functioning of the individual at that very moment in time, which, in turn, is highly influenced by many factors, including many that are transient. For example, if a man being assessed gets very little sleep one night, which may be unusual for him, his performance on a measure of attention may be severely compromised, while on any other day he may perform quite well on the same measure. It is important to understand this fact when interpreting all performance-based measures.

Included in the general category of performance-based measures are tests of optimal cognitive and neuropsychological functioning, performance-based thinking and personality measures, and projective emotional and personality measures. General cognitive measures such as the WAIS-IV, SB5, and the Woodcock-Johnson Tests of Cognitive Ability (WJTCA), as well as their child and adolescent counterparts, require individuals to perform multiple tasks that assess many discrete areas of cognitive functioning. Neuropsychological measures, such as the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS), the Wechsler Memory Scale, 4th Edition (WMS-IV), and the Bender-2, along with countless other measures of specific neuropsychological functioning, similarly require performance of relatively brief tasks that assess very specific areas of cognitive functioning.

The R-PAS is a performance-based measure that provides information primarily about how one's brain organizes and approaches ambiguous situations. That is, it is a necessarily ambiguous task (inkblots), and everyone's brain approaches it differently, which can be a representation of how one approaches ambiguity in everyday life (as much of our lives include ambiguity, including interpersonal relationships). Although not uncontested, much effort has been put into developing and evaluating the variables of this measure in a way that provides strong empirical support of their validity. Most importantly, the R-PAS measures a number of variables that are measured on other self-report tests, but in a way that is far less susceptible to motivated manipulation on the part of the person being assessed. It is simply very difficult to fake a Rorschach in a purposeful way that misleads the assessor in the way you want to, unless you know the test and its variables quite well.

Perhaps most controversially, projective measures of personality and emotional functioning constitute the final measures that are considered performance based. Included in this category are storytelling techniques such as the TAT, incomplete sentence techniques such as the Rotter Incomplete Sentence Blank (RISB), and projective drawings such as the Draw-a-Person, House-Tree-Person, and Kinetic Family Drawings. Additionally, children's projective measures include the Children's Apperception Test (CAT), the Roberts Apperception Test for

Children (RAT-C), HART incomplete sentence stems, and a host of other brief measures. While psychologists (and, indeed, researchers) disagree on the psychometric properties and clinical utility of projective measures, it is important to understand their strengths and weaknesses clearly before making your final judgment of them. While many are not standardized in terms of scoring and interpretation—for example, the TAT has many coding and interpretive schemes, but none has emerged clearly as the standard of practice in the field or established a strong enough empirical base to do so—attempts are being made to make these measures empirically stronger.

For example, Westen's Social Cognition and Object Relations Scale-Global Rating Method (SCORS-G; Westen, 1995) for the TAT represents an effort to standardize and codify a method for coding and interpreting narrative projective material, and it has indeed established a good empirical base through peer-reviewed publications. However, it has still struggled to get a foothold on widely used clinical practice, perhaps because of difficulty learning and applying the technique; its primary application in research rather than clinical practice; history rooted in psychoanalytic theory (as with all projective techniques), which continues to decline in the field; or even just poor marketing to professionals. Ultimately, controversy around projective techniques lives on (see the following section on the controversy over projective measures). When deciding on potentially using projective techniques, though, it is important to understand that the strength of projective techniques lies in their ability to bypass common defenses in psychological assessment to reveal underlying emotional and personality content.

Another strength of projective techniques is their ability to obtain more nuanced clinical information than standardized self-report inventory measures. For example, while a PAI can give you levels of depression (including levels of cognitive, affective, and physiological aspects of depression), projective measures may be able to help the assessor determine the quality of this depression. The TAT and sentence completion tasks, for example, may be able to uncover whether the depression is highly related to low self-esteem, loneliness, loss, helplessness, hopelessness, or some other dynamics. Even though there are self-report survey measures of hopelessness, an assessor may not think to include it in the battery (and, in fact, an assessor could not realistically include objective measures of every possible dynamic that may underlie a depression). Therefore, projective measures may be useful in this way. Because of the controversy over the reliability and validity of projective measures, however, they should generally never be used alone; their usefulness is truly within a larger battery of tests that includes self- and other-report measures and clinical impressions. One advantage of the hypothesis-testing model for psychological assessment is that each piece of data from any measure, including projective measures, is evaluated only in terms of how well it converges with data from other measures; this way, projective data are not relied on in isolation from other data.

Typical-Functioning Measures These tests aim to help the assessor understand how the person being assessed typically functions in their everyday life. Most often, these measures rely on self- and collateral-report data or clinical observation. For example, in understanding how a child typically behaves in school, an assessment could include a review of school records and report cards; reviews of records from other organizations or agencies with relevant knowledge of the child; interviews with corroborative sources like teachers and teacher's aides; and teacher-report measures of typical functioning, such as the BASC-3, CBCL, or CBRS. Additionally, an assessor may choose to do a school observation, ideally using a systematic technique for collecting behavioral observation data, such as the Behavioral Observation of Students in Schools (BOSS). Together, all of these data would give a pretty complete picture of how a child is functioning in school in general. Interestingly, many performance-based measures of personality, emotional, and behavioral functioning are considered typical-functioning measures. For example, the R-PAS and projective measures provide information about how you interact with the world and about your personality and emotional world, respectively, on the whole, not just under best circumstances.

What is most important to understand about typical-functioning measures is that they do not necessarily reflect what individuals are able to do under ideal circumstances; they simply reflect the actual everyday

functioning of the person. When deciding on what tests to use in an assessment battery, it is important to understand this distinction, as this may be crucial in answering some questions but insufficient with others.

Optimal-Functioning Measures The second type of test relating to function and purpose is the optimal-functioning measure, which is aimed at understanding what a person is capable of doing under the most ideal circumstances. Most cognitive and neuropsychological measures are optimal-functioning measures, assessing cognitive skills in the best possible context (usually in a quiet room with little distraction with an assessor trained to be friendly offering one-on-one attention). Even when certain skills are not evident in an individual's everyday life, they may be able to demonstrate them when other things are not getting in the way. For example, a child who struggles significantly with mental math in class when surrounded by peers and perhaps a teacher they dislike may in fact be able to perform mental math adequately under better circumstances (in an assessment office). Rather than relying just on their typical functioning (poor mental math) to diagnose a math disorder, the optimal functioning that is significantly better may signify the need to better understand the child's anxiety or interactions with a particular teacher. Especially with cognitive and neuropsychological functioning, it is always best to compare typical functioning to optimal functioning to understand the likely underlying causes of any problems. This is tougher with emotional and personality functioning, as very often there is no real distinction between typical and optimal functioning in these areas; that is, someone who is depressed in their typical daily life would be considered depressed, even if under best possible circumstances they can look less depressed.

The Case (Controversy) of Projective Measures

Projective techniques are controversial, and it seems they may always be controversial. Research has both supported and refuted the use of projective measures in the study of personality and emotional functioning, but perhaps more important is their origin, rooted in psychoanalytic theory focused on projecting parts or pieces of the self onto ambiguous stimuli. Somehow this concept of projection has become both taboo in the eyes of more empirically minded psychologists (at times, perhaps, so much so that the emotional reaction does not allow for fair appraisal of the research literature) and heavily relied on in clinical practice (again, perhaps at times to the point that practitioners turn a blind eye to evidence against their validity).

Despite all the controversy in the literature on projective techniques, they are simply in high clinical demand—clinicians use and rely on them frequently (Piotrowski, 2015). Even the strong proponents of their utility, however, must understand that their usefulness and validity improve significantly when used not in isolation but in conjunction with other measures of personality and emotional functioning (Bornstein, 2017; Weiner, 1966). Finding a way to appreciate what they can add while remaining humble, skeptical, and conservative about the data they produce is extremely difficult—perhaps again because of the emotional reaction psychologists tend to have about projective measures—and this is where the hypothesis-testing model, aggregating data across tests to build evidence for themes, can be most helpful.

Excluding the Rorschach (now used not as a projective technique of personality and emotions), the three most widely used projective measures of personality and emotional functioning are sentence-completion tasks like RISB, narrative story-telling tasks like TAT, and projective drawing tasks like Draw-a-Person, House-Tree-Person, and Kinetic Family Drawings. Research has proven unequivocally that establishing the validity or invalidity of these measures is extremely difficult. For each published article establishing some valid use of one of them, there is an equally compelling article criticizing its validity and vice versa. However, researchers seem to be actively trying to improve the validity of these measures, most often by creating and researching a more standardized approach for coding, scoring, and interpreting them.

A good example of this attempt to improve validity of a widely used projective measure is the RISB, one of several projective measures that use sentence stems as the stimulus and clients' completion of these sentence stems as the projective data. While most often used to provide nuanced, intuitive data for assessments such that clinicians glean what they imagine to be significant from responses or interpret them based on their own, generally psychoanalytic, theory, this method is extremely difficult to evaluate for reliability or validity because it is so necessarily unstandardized. Even unstandardized, researchers found that they could consistently discriminate between certain pathological and nonpathological populations, including youth who are delinquent as opposed to those who are not and individuals who use drugs as opposed to those who do not (Fuller, Parmelee, & Carroll, 1982; Gardner, 1967), suggesting some degree of reliability, validity, and utility for the test itself. More recently, however, Rotter and his colleagues have created an objective scoring system that is proving to have both good reliability (Rotter, Lah, & Rafferty, 1992) and good validity (Haak, 1990; Lah, 1989). While this scoring system is not yet widely enough used to evaluate its utility, it represents significant progress toward establishing a more reliable and valid method for using the RISB.

In some ways easier and in some ways more difficult to evaluate is the TAT, which uses black-and-white, somewhat ambiguous prints that for the most part include pictures of people within them as stimuli and stories produced by the client as the projective data. With a long and varied history of use, the TAT has spawned countless different scoring and interpretive methods, so many that evaluating the psychometrics of the TAT as a method itself becomes extremely difficult. While the sheer number of systems can be frustrating, the fact that so many researchers have attempted to improve the test's reliability and validity is heartening. Historically, the psychometric properties of the TAT have been found to be extremely weak (e.g., Winter & Stewart, 1977); however many attempts have been made to rectify this by creating standardized, researchable methods of interpretation (Bellak & Abrams, 1997; Meyer, 2004; and, as previously discussed, Westen, 1995). Certainly, progress has been made toward this end (Tuerlinckx, De Boeck, & Lens, 2002).

Less hopeful and more frustrating have been attempts to validate projective drawing tasks, such as the Draw-a-Person, the House-Tree-Person, and the Kinetic Family Drawings. Projective drawing tasks have no presented stimulus; rather, they require the client to produce drawings from scratch (of a person and another person of the opposite sex; of a house, tree, and person; or of a family doing something together) and use this as interpretable projective data. While some researchers have found this technique to be useful in discriminating between individuals with and without mental illness and to predict psychological adjustment in general (Cohen, Hammer, & Singer, 1988; Hammer, 1997; Lehman & Levy, 1971; Yama, 1990), others have found it to fail to discriminate even between patients with severe schizophrenia and those without any mental illness (Wanderer, 1969). In fact, in general, researchers have found interpretation to be highly affected by nonprojective influences, such as artistic ability and general intellectual functioning (Feher, VandeCreek, & Teglasi, 1983). In addition, most research has uncovered the poor psychometric properties of projective drawings in general and has failed to produce any evidence of their validity (Killian & Campbell, 1987; Piotrowski, 1984).

Regardless of these failures to validate the technique, clinicians still widely use the drawings within assessment batteries, and many clinicians and even researchers believe that they can help evaluate a client's general level of adjustment (Hammer, 1997). Projective drawing tasks are widely used, and there is no evidence that their use will stop at any point soon. Thus, finding a way to incorporate data produced by them into a larger battery that includes objective measures is extremely important.

Unfortunately, the controversy over projective techniques in psychological assessment seems unlikely to be reconciled any time soon. The reality of clinical practice of assessment is that many, if not most, practitioners use projective measures, even if they find them only anecdotally useful and employ their own intuitive methods for interpreting them. The research literature on projectives is nowhere near clear-cut enough to recommend either adopting or abandoning the measures, though it is certainly convincing enough to warrant careful and conservative use of them. Data should be understood clearly within the context of where they came from—knowing that projective drawing techniques can be influenced so heavily by artistic ability, for example, can help the assessor take extreme results that emerge from them (but that are found in no other measure) slightly less seriously. The hypothesis testing method necessarily incorporates a conservative and humble use of projective techniques, given that data that converge on other tests' results are viewed as more convincing and useful.

Practical Considerations

In addition to the specific characteristics of measures, deciding what tests to use often depends on practical considerations. Most important are the time and cost associated with the use of the tests under consideration. A balance must always be struck between getting enough data from tests and creating an assessment protocol that is not overly cumbersome and ultimately prohibitive. Although more data is generally better, there comes a point in every assessment when you can make confident conclusions without the addition of extra information. Some tests (e.g., the Wechsler intelligence scales) have shorter forms. The Wechsler Abbreviated Scale of Intelligence, 2nd Edition (WASI-II) is a four-subtest cognitive measure that assesses cognitive functioning in a much less specific way than the WAIS-IV or WISC-V; entire domains of functioning (working memory and processing speed) are not included. However, if it is clear that the presenting problem has nothing to do with cognitive functioning, it may be worth using this significantly shorter measure because the extra information obtained by the WAIS-IV or WISC-V is unlikely to be significantly more useful in the conclusions drawn.

For example, an extremely cognitively high-functioning individual who was recently bereaved may require more emotional testing than cognitive, and a full WAIS-IV is unlikely to add critical information to the fact that their educational and occupational functioning is extremely good. Other measures have short forms as well; the most important caveat when considering short forms of measures is to check the psychometric properties of the short forms, as they will have been assessed separately from the longer forms. In addition to time, the cost of tests can also affect the decision of which to use. Although this chapter will not address specifics about test cost, it is important just to note that this is a factor involved in the decision process.

Other practical considerations in test selection include the age and functional capacity of the individual being assessed. Every test is developed and normed on a specific age group, and this should be presented clearly in the test's manual. Using a test with an individual who is outside the age range it was normed on means you will be comparing their performance inappropriately with that of others of different ages. Similarly, you must consider the level of functioning of the individual to make sure each test will be appropriate. An adult whose cognitive functioning is extremely impaired and who has a second-grade reading level should not be administered the PAI, for example, because the items were written at a fourth-grade reading level.

Cultural Concerns

This text does not specifically address the multicultural concerns associated with individual tests, but much research has been conducted on many psychological tests to determine specific cultural biases and whether there are specific populations for which certain tests are less effective. Although a bit dated, Suzuki, Ponterotto, and Meller's (2008) *Handbook of Multicultural Assessment (Clinical, Psychological, and Educational Applications)* (3rd ed.) offers a good overview of many commonly used tests and their functioning on diverse populations. Similarly, Groth-Marnat and Wright's (2016) *Handbook of Psychological Assessment* (6th ed.) includes a section on each test's performance with diverse populations within each test's chapter. As stated in the Introduction, no test is perfect: No individual measure can be entirely free of cultural bias, and no test is optimal for use with every single population. Thus, it is important to be vigilant about the research on use of individual tests on different cultural populations. Because with the hypothesis testing model you are simply building up data from which to draw conclusions, the data based on interpretations of individual tests should be tempered by the consideration of how well the tests perform within the culture of the individual you are assessing. This topic is discussed further in Chapter 3.

Familiarity

The final practical concern of import when deciding which tests to use in a battery is your own specific knowledge, training, and familiarity with the tests themselves. Ethical use of measures requires specific training on each individual measure, including supervised use of the tests. Even when an update to a measure is introduced (e.g., when the WISC-V was introduced as an update to the WISC-IV), you must undergo specific training on the measure, no matter how apparently similar it is to the original, even if this training is a webinar presented by the test publisher or something similarly basic. There may be subtle differences that can easily go unnoticed but are extremely important in the administration, coding, scoring, or interpretation of the new tests, so specific training must be undertaken. The more tests you are trained in, the more options you will have in your future career as an assessor for building effective assessment batteries. For example, many psychologists are trained only in the MMPI-2, which leaves them with only one option for selecting a self-report inventory measure, leaving out options that might be equally or more appropriate such as the MMPI-2-RF, the MCMI-IV, or the PAI. These clinicians are limited in how well they can perform assessments in the future, especially if an assessment specifically calls for one of these other self-report measures. While all psychologists will have preferences, even favorites, when it comes to test selection, simply having the option to use more and different tests is an important part of being a well-rounded assessor.

Psychological Assessment Measures

This section presents some of the most widely used measures of psychological assessment in the broad domains of adult and child cognitive and personality, emotional, and behavioral testing. The purpose of this list is to give a broad overview of the utility of individual tests. The list is by no means exhaustive, and (obviously) training in each of these tests is absolutely necessary before it can be used in a psychological assessment.

Cognitive Assessment

When assessing cognitive functioning in adults, there are various performance-based measures from which to choose. Some are broad measures of overall abilities (such as the WAIS-IV), whereas some are more direct, individual measures of specific cognitive abilities (such as the D-KEFS Trail Making Test). Many cognitive abilities are discrete, such that performance in one area of cognitive functioning may be relatively independent from performance in another area. Think about verbal functioning and nonverbal functioning. Many individuals who are extremely intelligent when it comes to verbal functioning and are able to use and understand language to a very high degree also struggle when trying to read a map. (This example is made without judgment about asking for directions.) These verbal and map-reading cognitive abilities are relatively independent.

However, many cognitive abilities are hierarchical and interdependent. For example, consider memory, a complex cognitive process that includes many steps. When considering the cognitive abilities of memory and attention, you would not expect an individual with extremely poor attention to perform well on a measure of memory. If the information presented originally did not enter into the individual's mind because they were so distracted by other stimuli (as is often the case with poor attention), then how would they be expected to remember that information? These kinds of relationships are what make cognitive assessment of individuals complicated.

Table 2.1 lists some of the most widely used tests of cognitive functioning. Again, for comprehensive discussions of each of these tests, see either their respective manuals or such texts as Groth-Marnat and Wright's (2016) *Handbook of Psychological Assessment* (6th ed.) or Sattler's (2018) *Assessment of Children: Cognitive Foundations and Applications* (6th ed.).

TABLE 2.1 **WIDELY USED COGNITIVE ASSESSMENT INSTRUMENTS AND TESTS**

	Adult assessment	Child assessment
General intellectual functioning	• Wechsler Adult Intelligence Scale, 4th Edition (WAIS-IV) • Stanford-Binet Intelligence Scales, 5th Edition (SB5) • Woodcock-Johnson Tests of Cognitive Ability (WJTCA)	• Wechsler Intelligence Scale for Children, 5th Edition (WISC-V) • Wechsler Preschool and Primary Scale of Intelligence, 4th Edition (WPPSI-IV) • Stanford-Binet Intelligence Scales, 5th Edition (SB5) • Woodcock-Johnson Tests of Cognitive Ability (WJTCA)
Mental status	• Mini-Mental State Exam (MMSE)	• Mini-Mental State Exam (MMSE)
Visual–motor integrative functioning	• Bender Visual–Motor Gestalt Test, 2nd Edition (Bender-2) • Beery-Buktenica Developmental Test of Visual–Motor Integration, 5th Edition (Beery-VMI)	• Bender Visual–Motor Gestalt Test, 2nd Edition (Bender-2) • Beery-Buktenica Developmental Test of Visual–Motor Integration, 5th Edition (Beery-VMI)
Verbal functioning	• Peabody Picture Vocabulary Test, 5th Edition (PPVT-5)	• Peabody Picture Vocabulary Test, 5th Edition (PPVT-5)
Nonverbal functioning	• Test of Nonverbal Intelligence, 4th Edition (TONI-4) • Comprehensive Test of Nonverbal Intelligence, 2nd Edition (CTONI-2) • Raven's Progressive Matrices	• Test of Nonverbal Intelligence, 4th Edition (TONI-4) • Comprehensive Test of Nonverbal Intelligence, 2nd Edition (CTONI-2) • Universal Nonverbal Intelligence Test 2 (UNIT-2) • Naglieri Nonverbal Intelligence Test, 2nd Edition (NNAT-2) • Raven's Progressive Matrices
Attention	• Test of Everyday Attention (TEA) • Conners' Continuous Performance Test, 3rd Edition (CPT-3) • Test of Variables of Attention (T.O.V.A.) • Conners Continuous Auditory Test of Attention (Conners CATA)	• Test of Everyday Attention for Children (TEA-Ch) • Conners' Continuous Performance Test, 3rd Edition (CPT-3) • Conners Kiddie Continuous Performance Test, 2nd Edition (K-CPT-2) • Test of Variables of Attention (T.O.V.A.) • Conners Continuous Auditory Test of Attention (Conners CATA)
Memory	• Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) • Wechsler Memory Scale, Fourth Edition (WMS-IV) • Rey Auditory Verbal Learning Test • California Visual Retention Test • Bender Visual–Motor Gestalt Test, 2nd Edition (Bender-2)	• Bender Visual–Motor Gestalt Test, 2nd Edition (Bender-2) • Children's Memory Scale (CMS) • NEPSY, 2nd Edition (NEPSY-II) • Repeatable Battery for the Assessment of Neuropsychological Status Update (RBANS)

(*Continued*)

TABLE 2.1 (*CONTINUED*)

	Adult assessment	Child assessment
Broad academic achievement	• Wechsler Individual Achievement Test, 3rd Edition (WIAT-III) • Woodcock-Johnson Tests of Achievement, 4th Edition (WJ IV ACH)	• Wechsler Individual Achievement Test, 3rd Edition (WIAT-III) • Woodcock-Johnson Tests of Achievement, 4th Edition (WJ IV ACH)
Working memory and executive functioning	• Delis-Kaplan Executive Function System (D-KEFS) • Wisconsin Card Sorting Test (WCST)	• Delis-Kaplan Executive Function System (D-KEFS) • Wisconsin Card Sorting Test (WCST)

Note: Most broad measures of intellectual functioning also have measures of visual–motor integrative, verbal, nonverbal, and working memory functioning.

Personality, Emotional, and Behavioral Assessment

As discussed previously, there are many measures of personality, emotional, and behavioral functioning. Whereas cognitive assessment is almost exclusively performed using performance-based assessments, personality and emotional assessments generally include self-report, symptom-focused measures, self-report inventory measures, and some performance-based measures. Additionally, whereas many of the individual domains of cognitive functioning can be assessed using a single test (or even a subtest), assessment of personality and emotional functioning necessitates the use of multiple measures to rule out or confirm hypotheses about individual functioning. That is, a single performance-based measure such as the T.O.V.A. can rule out the likelihood of attention problems, but it's necessary to use several different measures to rule out depression.

For example, using only a SCID-5 to assess depression will provide little more information than a clinical interview asking about depressive symptoms. Because the SCID-5 is a self-report, symptom-focused measure, if an individual wants you to know that they are depressed, they will tell you so. If not, though, the individual can simply hide the fact that they are depressed. Inventories and performance-based measures are less susceptible (though not impervious) to these individual, situation-specific motivational factors. On the other hand, performance-based measures such as the R-PAS or TAT have debatable validity and certainly have more potential for error. Thus, to assess for depression, using multiple measures improves the confidence of your findings. Table 2.2 presents many of the most widely used tests to assess personality and emotional functioning.

Other Assessment

Not included in these lists of tests are more complex neuropsychological tests; for a list of these, see Lezak, Howieson, Bigler, and Tranel's *Neuropsychological Assessment* (5th ed.) (2020). Additionally, a comprehensive list of vocational assessments, including the Strong Interest Inventory (SII) and the Self-Directed Search (SDS) can be found in texts like Wood and Hays's (2013) *A Counselor's Guide to Career Assessment Instruments* (6th ed.).

Summary

When selecting tests, there are two overarching issues to consider.

1. What questions do you need answered to address your hypotheses?
2. Do you know and trust everything about the tests themselves and their use with the population you are assessing?

TABLE 2.2 **WIDELY USED PERSONALITY AND EMOTIONAL INSTRUMENTS AND TESTS**

	Adult assessment	Child assessment
Self-report, symptom-focused measures		
General symptomatology	• Structured Clinical Interview for the *DSM-5* (SCID-5) • Structured Clinical Interview for the *DSM-5* Personality Disorders (SCID-5-PD) • Diagnostic Interview for Anxiety, Mood, and Obsessive-Compulsive and Related Neuropsychiatric Disorders (DIAMOND) • Symptom Checklist 90-Revised (SCL 90-R) • Brief Symptom Inventory (BSI)	• Schedule for Affective Disorders and Schizophrenia for School-Aged Children (K-SADS) • Children's Version of the SCID (KID-SCID) • Behavior Assessment System for Children, Third Edition (BASC-3) • Conners Comprehensive Behavior Rating Scales (CBRS) • Child Behavior Checklist (CBCL) • Personality Inventory for Children, 2nd Edition (PIC-2)
Specific psychopathology	• Beck Depression Inventory (BDI) • Beck Anxiety Inventory (BAI) • Anxiety Disorders Interview Schedule (ADIS) • State-Trait Anxiety Inventory	• Conners Rating Scales, Revised (CRS-R) • Beck Youth Inventories, Second Edition (BYI-2) • Children's Depression Inventory (CDI)
Self-report inventory measures	• Minnesota Multiphasic Personality Inventory, 2nd Edition (MMPI-2) • Minnesota Multiphasic Personality Inventory-2 Restructured Form (MMPI-2-RF) • Millon Clinical Multiaxial Inventory, 4th Edition (MCMI-IV) • Personality Assessment Inventory (PAI)	• Minnesota Multiphasic Personality Inventory, Adolescent Version (MMPI-A) • Minnesota Multiphasic Personality Inventory-Adolescent Restructured Form (MMPI-A-RF) • Millon Preadolescent Clinical Inventory (M-PACI) • Millon Adolescent Clinical Inventory (MACI) • Personality Assessment Inventory-Adolescent (PAI-A)
Performance-based measures	• Rorschach Performance Assessment System (RPAS) • Thematic Apperception Test (TAT) • House-Tree-Person, Draw-a- Person, Kinetic Family, and other Projective Drawings • Rotter Incomplete Sentence Blank (RISB)	• Rorschach Performance Assessment System (RPAS) • Children's Apperception Test (CAT) • Roberts Apperception Test for Children, 2nd Edition (RATC) • House-Tree-Person, Draw-a-Person, Kinetic Family, and Other Projective Drawings • Rotter Incomplete Sentence Blank (RISB)

Note: Many of the child self-report measures are completed by a guardian, teacher, or other adult figure.

There is no substitute or replacement for specific training on the appropriate administration, coding, scoring, and interpretation of individual measures. Part of this training should include a clear understanding of all the different psychometric properties, practical considerations, benefits, and potential blind spots of each test. No test is perfect, and no single test will prove a hypothesis definitively (which is why you need a degree and generally a license to conduct psychological assessment). Taken together, though, in conjunction with clinical and collateral information and clinical observation, individual tests can help you build a solid argument to rule out some hypotheses of what is going on with an individual and support others.

CHAPTER 3

Testing

Several textbooks focus exclusively on the testing step of the psychological assessment process, which includes administrating, coding, scoring, and interpreting individual psychological assessment measures. These texts are generally either organized such that each chapter is a specific test (e.g., Groth-Marnat & Wright, 2016; Lezak, Howieson, Bigler, & Tranel, 2020; Sattler, 2016) or focus entirely on a single test (e.g., Ben-Porath, 2012; Grossman & Amendolace, 2017; Meyer, Erard, Erdberg, Mihura, & Viglione, 2011; Morey, 1996), and without thorough knowledge and skill in this most primary step of the assessment process no psychological assessment can be valid. While the entire process of psychological assessment has been and will remain relatively consistent, tests change constantly due to improvements, updated norming, and advancements from research. As such, competence in psychological assessment is often equated with updated knowledge of exactly how to use the most recent tests and versions of tests. Again, you cannot be competent at psychological assessment without being extremely knowledgeable and skilled at the testing process. This chapter presents a few general considerations for testing rather than detailed information about specific testing instruments.

Preparing for Testing

Cultural Considerations

Psychological tests do not measure constructs consistently across every person from every culture. Consequently, it is extremely important to understand the impact culture can have on performance of any test. For example, when the MMPI-2 is given to samples of clients with the same diagnoses, clients from different ethnic backgrounds—even from similar national cultures—register differently on individual scales (Suzuki, Ponterotto, & Meller, 2008). Even this nuanced, small detail is important in understanding how to interpret a test given to any client. At times, the cultural background of the client may even preclude you from giving a specific test, simply because it has not been appropriately normed on that population. You cannot blindly assume that a test's normative sample is representative of the entire national population—it is even less so for the entire international population. You should read the test's manual carefully to understand the cultural makeup of the normative sample; then you should look for the empirical research on use of those individual tests on clients with cultural backgrounds similar to the background of the client you are testing. Suzuki, Ponterotto, and Meller's (2008) book, while slightly dated, is an excellent resource for understanding the impact of culture on the assessment process. Additionally, Groth-Marnat and Wright's (2016) book includes a discussion of the use of individual tests with

Conducting Psychological Assessment, First Edition. A. Jordan Wright.

different populations. Just because a test produces slightly different scores for different groups of people does not necessarily mean that it is biased. Differences in scores for different groups of people may actually represent real group differences, based on cultural norms, cultural understandings of individual items, or the way the groups are differentially treated by society. As such, it is important to understand the nuances of group differences in scores on individual tests when applying them to an individual from (especially) a marginalized group.

Age Considerations

Assessing individuals of different ages entails very different approaches to testing. Obviously, the tests are different for testing adults and for testing children (e.g., a Wechsler Adult Intelligence Scale, 4th edition [WAIS-IV] versus a Wechsler Intelligence Scale for Children, 5th edition [WISC-V]). Beyond different tests, though, age considerations can impact even the type of information you gather for an assessment. When assessing adults, you are often limited to self-report and individual testing measures; occasionally, you may have other resources available, such as a case worker, a spouse, a current therapist, or previous medical records. Most often, however, you must rely almost entirely on the client themselves for background information.

When assessing children and adolescents, however, assessments generally include a much more complex matrix of reporters of background information. Collateral interviews with parents are most common, but interviews and collateral-report measures with teachers, principals, counselors, and other important figures in the children's lives are common. In addition, many assessors conduct school visits to observe child clients in their school environment. (It is rare, though not unheard of, that an assessor would visit an adult client's place of work to observe them there.) Strategizing about how to collect as much data as possible on child cases is important when preparing to assess children, and engaging as many sources of information as possible is usually the best strategy.

The other major consideration that differentiates preparing to assess a child client from assessing an adult is the structure of the testing itself. Children become fatigued and lose concentration much more easily than (most) adults. As a result, you should prepare to both shorten sessions as needed and balance the measures administered to child clients as much as possible. That is, you must take into consideration what is likely to hold a child's attention and to produce the most motivation from them. For example, administering a Bender Visual-Motor Gestalt Test, 2nd Edition (Bender-2), WISC-V, and WIAT-III in the same session will likely prove unmanageable for most children (not to mention most assessors). Three cognitive tests in a row (especially long ones like the WISC-V and the Wechsler Individual Achievement Test, 3rd edition [WIAT-III]) will likely produce wandering attention, waning motivation, and flat-out fatigue by the end. You would expect a child to perform more poorly toward the end of the testing session than at the beginning.

Three strategies are most useful for addressing this problem: shortening sessions, providing interim activities for reinforcement, and varying the types of measures administered. At times, sessions must simply be cut short because the child has lost interest or motivation. However, having several games or activities at the ready before the testing session begins may prove extremely useful; some children need a quick game of toy basketball or running around in between tests to motivate them to continue, while others need different reinforcement—drawing or writing on a chalkboard, for example. Board games with quick, easy play can be invaluable (e.g., Connect 4), but board games that require longer, extended play may distract too much from the testing session. Plan carefully what may reinforce, in between tests, the child's ability to concentrate on the tests when they are supposed to.

Finally, varying the types of tests administered as you go will help reduce fatigue from the monotony of taking the same type of test over and over. For example, after administering a WISC-V (if there is still time left in the session and the child is not too exhausted), consider giving a drawing task (e.g., projective drawings) or a projective storytelling task (e.g., the Children's Apperception Test [CAT] or the Roberts Apperception Test for

Children [RAT-C]). This way, after having had to concentrate and use their school brain for one test, they can switch to a more imaginative, playful measure. While this is also not a bad strategy to use when testing adults, it is almost necessary when testing most children.

When and Where to Test

Most testing occurs in therapy offices, consultation rooms, or specifically designated testing rooms. However, there are times when this is not necessarily possible. Some considerations are important when deciding where to test a client, and this generally has to do with normative procedures of the majority of the testing instruments available. Specifically, as you are generally trying to get the optimal performance out of the client (optimal, in this case, meaning that the client gives effortful attempts with a minimum of error caused by the client, the assessor, or the environment), you should find a neutral area in which to test. Neutral areas generally consist of rooms with very little distraction, including intrusive noises, excessive decorations, or some sort of emotional connection with the client. Testing a client in their home, for example, opens the testing itself to a great deal of error: phones are more likely to ring and distract the testing; people are more likely to walk in and affect the performance of the client; and being in a certain, familiar room may impact the way the client responds to certain measures. In general, most tests are normed in neutral places, so introducing such emotional attachment and familiarity to the place of testing may introduce a systematic source of error. As such, it is best to find an unfamiliar, quiet, calm, neutral place in which to administer tests.

Deciding when to do testing can be tricky. Choosing the optimal times of administering tests may simply not be feasible given your and your clients' schedules, so at times you must simply settle for whenever you can meet. However, you must understand how this could impact the testing itself. For example, it is always best not to do testing before or during mealtimes—you do not want clients to be impacted by hunger, low blood sugar, or tiredness. However, this may simply not be possible. Children have school all day and may be able to meet only at 4:00 or 5:00 p.m. Adults may not be able to miss work and may be able to meet only at 6:00 p.m. These are not optimal times because they overlap with mealtimes and follow a long day of work or school; as a result, the client may be tired. While this may be unavoidable, you should (a) do everything you can to make the conditions of testing such that the client is less likely to be tired, such as asking them to bring a snack and having shorter, less ambitious testing sessions; and (b) understand, during interpretation, that this may impact the client's performance on the tests. As stated previously, test order can help counteract the effects of being tired or hungry, such that you do not have a 4-hour session beginning with easier measures and ending with measures that require concentration. For example, when giving the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS), which requires great concentration, short- and long-term memory, and active mental processing, it is best to give this at the beginning of any given session rather than after several other measures. Projective storytelling tasks, such as the Thematic Apperception Test (TAT), however, are less affected by fatigue, so they can occur later in a session.

Building Rapport

While, in general, rapport is built during the clinical interview (usually the first phase of the assessment process), it is important to understand your role as an assessor, which is different from the role of a therapist. When testing, it can often seem robotic and harsh (usually because you must read directions verbatim out of a manual), and this can be a stark contrast from your demeanor during the clinical interview. What is important to understand about your role, however, is your own professional boundaries when you are conducting an assessment. Again, this can be a balancing act between warmth and structure. A client may not be open, even in self-report personality measures, with an assessor they find cold or simply do not like. However, too much empathy may make a client

uncomfortable, as it is coming from a stranger. Rapport is extremely important in assessment, though finding the balance between warmth and structure is not always easy.

Your primary role during the testing phase of an assessment is to administer the tests as accurately as possible—that is, your administration of the tests should be by the book and standardized so that they are comparable to how the normative sample received them. Consider, for example, that you decided during the WISC-V to both inform and congratulate a client every time they arrive at a correct answer (which is not part of the standard administration). This could impact the approach the client takes to the test in significant ways—for example, becoming so discouraged when an answer is incorrect that they lose motivation to continue, beating themselves up about it. This makes it impossible to compare them directly with the normative sample, who were administered the test in a different way. While this might improve rapport, your primary role as an assessor is to administer the tests in a valid way.

There are times, however, when you must flip to the other side of the continuum of structure. Consider, for example, that an individual is filling out a Personality Assessment Inventory (PAI) and endorses items that they are having suicidal thoughts. At this point during the testing, after the standard administration of the test you would likely become more of a therapist in your role with the client, certainly assessing for suicidality but also empathizing with the client's difficulty. For example, you may abort the planned testing and instead employ the Collaborative Assessment and Management of Suicidality (CAMS) approach (Jobes, 2016). You may choose to postpone any more testing for that day and spend the rest of the session simply processing the suicidality (and what it was like for them to reveal it to you). Your professional boundaries in a situation like this may shift from the standard administrator of tests to the caring professional that you are. Warmth, empathy, and humor, while they may not be as present during the actual test administration, are absolutely appropriate between tests, at the beginning and ending of sessions and at any other point during the assessment.

Testing

Standard Administration

The first and most fundamental skill in the testing process is standard and accurate administration of the tests themselves. The importance of standardized administration cannot be overstated. Because performance on tests is almost always gauged by comparing the score achieved by an individual client with the scores achieved by a large normative sample, you must ensure that the way the person you are assessing receives the test is the same as everyone in that normative sample received it. This is the only way that you can confidently compare the individual's performance with that of their peers (i.e., the normative sample). In the best-case scenario, an error in administration of a test is minor and will not affect the score drastically, if at all.

Consider administration of the Similarities subtest on the WISC-V. A minor administration error might be overquerying on a single response. That is, because some responses to questions require queries (prompts for further information to give the respondent an opportunity to improve their response) and some do not, if you queried a response that explicitly does not need a query, this would constitute a minor error. But this error could be easily corrected in the next stage of the testing process—you would simply score the response as if you had not queried, and it would not affect the subtest score. More subtly, making multiple errors of this kind could still affect the test. For example, if you consistently overquery, the individual being assessed may get frustrated or may feel that they are performing worse than they actually are. This may subtly affect their subsequent performance.

At its worst, poor administration can cause a test to be completely invalid or unscorable. Take, for example, the Letter-Word Identification subtest of the Woodcock-Johnson Tests of Achievement, 4th Edition (WJ IV). This is a relatively straightforward subtest in which the individual being assessed is visually presented a list of

written words to pronounce aloud. There are specific rules to reach basal (getting a certain number of consecutive items correct, making it highly likely that all the unadministered items below that, which are theoretically easier, would likely be correct and thus the individual is given credit for them) and ceiling (getting a certain number of consecutive items incorrect, making it likely that the unadministered items above that, which are theoretically harder, would be incorrect and thus the subtest is discontinued). From the start point, the individual must get six consecutive items correct to reach basal for this subtest and receive credit for the lower unadministered items.

If a client does not reach basal, lower items must be administered, until either the lowest six consecutive items administered are correct or the first item is administered. An error in administration for this subtest could include not reaching basal but not reversing appropriately. Not reaching basal invalidates a subtest because you cannot get an accurate score for it—you can no longer assume (by convention) that all of the items below the first administered item would have been correct, so you cannot get an accurate score to compare with a normative sample. Thus, there would be no way of knowing compared with others their age or at their grade level how well the individual reads words.

In between these best- and worst-case scenarios lie many errors in administration that can affect either an individual's performance on a test or the ultimate score of it. Incorrect placement of stimulus items, not reading the directions verbatim, errors in recording the responses, and countless other minor errors can affect the testing. This is the reason that graduate training focuses (and rightly so) intensely on the testing process.

As an illustration, while you are training on specific tests, try an exercise that is analogous to the effects of improper administration (though it is truly an exercise on problems with scoring tests). The first time you administer a WISC-V, calculate all of the Index and IQ scores before your teacher or supervisor has helped you correct the coding of the individual items on subtests. Compare the final scores with those you calculate from the same WISC-V after it has been corrected for minor coding errors. Sometimes it may even out, but you may be surprised just how much minor errors can affect the ultimate scores.

A similar exercise may come up when you are learning the Rorschach. The first time you try to code a protocol on your own, enter those codes into the scoring program you are using (e.g., the online Rorschach Performance Assessment System [R-PAS] scoring program). Then enter the corrected protocol into the same program and see just how much difference those small errors make in the conclusions drawn from the test. Although these are really exercises about errors in coding, they are analogous to what can happen with small administration errors, as these administration errors can easily affect scoring in a small way. These exercises emphasize just how important correct and standardized administration of tests is for the tests to give accurate, reliable, and valid information about the person being assessed.

Cultural Considerations

There may be rare occasions when slight variations from the standardized procedure may be warranted, though this should be done thoughtfully, deliberately, and avoided if possible. When a client comes from a group underrepresented by the normative sample of a specific test, for example, the standardized administration becomes less important, as interpretation will be conducted within the context of understanding that comparing the client to the normative sample is not necessarily valid. Additionally, in certain cases, especially when for cultural reasons a client is not entirely acquainted with the assessment or psychotherapeutic process, slight alterations in the standardized administration procedure may be necessary in the service of maintaining or building any sort of alliance. Whenever standardized procedures are altered, it is extremely important that the assessor understand exactly how that might affect the scores on the test, such that interpretation is consistent with these alterations. That is, any variation from standard administration should be done for a very specific and defensible reason, and interpretation of scores from tests administered in altered ways should be made cautiously.

Testing the Limits

The testing process can be affected by many factors. Hopefully, test scores are most affected by whatever construct they are measuring. For example, cognitive tests ideally are most affected by the level of cognitive functioning of the individual being tested, emotional measures are most affected by the emotional state of the person, and memory tests are affected by their memory functioning. However, many other factors can impact performance on individual psychological tests. Performance can be affected by very transient state factors, such as tiredness from not sleeping well the night before. It can also be affected by motivational factors, such that boredom, carelessness, and purposely trying to perform poorly (even as far as malingering), all which can alter performance on individual tests.

Because many factors can impact performance on any one test, sometimes you may need to test the limits. That is, you may need to go back and alter the standard administration of a test (a) to assess whether something is getting in the way of the individual's performance, (b) to find out whether the individual has potential for higher functioning, or (c) to evaluate the meaning of some responses more deeply. There are many different ways to test the limits, so many things fall under the testing-the-limits umbrella. For example, if you think that an individual being tested knows a word presented on the Vocabulary subtest of the WISC-V but earned 0 points, you could later go back and ask specifically about that word in several different ways, such as asking the individual to use it in a sentence or asking about related forms of the word. This would be a type of testing the limits to find out whether there might have been motivational factors involved originally or if the problem is with expressive ability rather than knowledge of the word itself.

Another example would be if an individual reached ceiling on a subtest, and you went back later and administered some items that are above the ceiling that were originally unadministered to see if there is in fact potential for higher functioning than the subtest score itself revealed. If you had questions about the specific content of a response, you could test the limits by later going back to the response itself and asking specific probing questions about it. For example, if a child's response to an item on the Vocabulary subtest of the WISC-V or to a TAT card related to a very in-depth description of fear, you may go back to the response later and ask whether the child has ever experienced that type of fear and in what situations. Because all these procedures are outside of the standard administration of the tests, they are considered testing the limits. But they can each yield extremely important data to use when you are interpreting everything together. Testing the limits illustrates one major reason that the process of psychological assessment has not been entirely computerized from beginning to end—computers can reliably administer, code, score, and now even interpret many tests, but nuanced clinical data and interpretation cannot be adequately obtained without a trained assessor.

The most crucial aspect of testing the limits is the fact that it is done outside the standard administration of the test itself. That is, you must complete the entire standardized administration of a test before you can go back and test the limits. Testing the limits could significantly affect how the individual performs on the rest of the test if it were conducted in the middle of the test's administration; it could affect their confidence level, emotional state, level of fatigue, or any other minor (or major) factor that could affect the rest of the testing. Therefore, testing the limits must happen only after you have completed the entire, standard administration of the test. This way, you have both the results of the norm-based, comparative results of tests and more nuanced, clinical data that can help you in interpreting those normative results and in conceptualizing all the data together later in the assessment process.

Coding and Scoring Tests

Coding Versus Scoring

Although this is not a general convention in the testing process, it may be helpful to differentiate between the processes of coding and scoring. In general, coding is the process of applying a coding system to the responses

of an individual being assessed. Scoring, in contrast, is the computation of scores based on cumulative and composite numbers derived from coded responses. For example, on the WISC-V Vocabulary subtest, you will have to decide whether an individual response merits 0, 1, or 2 points. To do this, you must apply the coding scheme that was developed for the subtest and is presented in the manual, so that you can be confident that everyone in the normative sample had their responses coded in the same way. When you add up all the points of the Vocabulary subtest to arrive at the subtest raw score and when you convert this raw score into a standard score and build composite index and IQ scores, you are scoring the test.

This distinction can be important because when you consider that you are coding individual items rather than scoring them (i.e., you are applying the coding scheme given to you), you can feel better about leaving your personal judgment somewhat more out of the process. For example, consider a vocabulary test that asks an individual to define the word *frog*. When asking what a frog is, there are many possible responses, and the manual will present a coding scheme to determine which responses earn, for example, 0, 1, and 2 points. When you look at the coding scheme, you may notice that a response that is listed as a 2-point (highest quality) response is *toad*. That is, when an individual is asked what a frog is, it is considered an optimal response to say that a frog is a toad. Personally, you may have a reaction to this—a frog is specifically and explicitly not a toad. These two animals are not the same thing at all. If I were coming up with a score by myself, I might consider giving this type of response 1 point, if I were feeling generous. But 2 points? It is at these moments when it is helpful to remember that you are merely applying the coding scheme from the manual to the responses—you are not trying to come up with a score by yourself. From the exercises presented previously, you can understand why standardized coding and scoring of tests is just as important as standardized administration, so applying the coding schemes of individual tests is crucial.

Interpreting Tests

Perhaps one of the most important skills that sets psychologists apart from members of all other professions is the ability to interpret testing instruments. This is likely the major reason that this is the focus of most of the best graduate-level texts on psychological assessment. Although this book does not discuss interpreting individual tests, some considerations are important for interpreting all tests. First and foremost, as the assessor you are the one interpreting the test. You should be confident that you are adequately trained and competent to interpret each test. You should make sure you have the appropriate training and, as needed, supervision on interpretation of tests.

This is especially important in view of the current prevalence of computer-interpreted tests. While these are extremely useful, no computer interpretation program will understand the nuances of the individual you are assessing; they simply are not able to integrate all the information you as an assessor have into interpreting test scores. Take, for example, the Millon Clinical Multiaxial Inventory, 4th Edition (MCMI-IV) interpretation software. It is invaluable for scoring and giving interpretive hypotheses—it even gives diagnostic considerations based on the measure. However, books have been written and new research comes out all the time about nuanced interpretation of the MCMI-IV. As helpful as the interpretative software is, it does not replace the expertise of a well-trained psychologist who is current on the literature.

One reasons to remember that you are the one interpreting tests is to use additional information available to you in the interpretation of each test. For example, as presented previously, the timing of testing can impact a client's performance on certain tests, and this information should be integrated into your overall interpretation of the measures. Additionally, you must always revisit the cultural considerations previously discussed. Knowing that most tests' validity varies by culture, you must understand and integrate how this may have affected the results that emerged from the tests.

Perhaps most importantly, you should monitor your own biases and preconceptions. Supervision and consultation can be extremely useful in this regard, but it is important to understand your own biases—about culture, about tests, about certain diagnoses, and about any other factor that may impact your interpretation of tests. As well-trained a psychologist as you may be, you are still a human with biases, attitudes, motivations, and personality characteristics that may affect the way you interpret tests. While there is no way to eliminate this, simply being mindful of it can go a long way toward minimizing its effect on your interpretation.

Summary

You cannot conduct psychological assessment without knowing the ins and outs of the process of psychological testing, including appropriate administration, coding, scoring, and interpretation of individual testing instruments. You likely spent much of your graduate assessment coursework training on individual tests, which is the foundation of any valid, ethical assessment. Many excellent texts focus on this aspect of the assessment process, and the importance of understanding the standard administration, coding, scoring, and interpretation of tests cannot be overstated.

CHAPTER 4

Integrating Data

Perhaps the most mystifying (some say intuitive) stage within the psychological assessment process is integrating the data from multiple, extremely varied sources into a coherent picture of the individual being assessed. If you are merely listing strengths, weaknesses, and symptoms, the process is rather straightforward. Similarly, if you report your findings test by test, there is very little room for error. However, listing symptoms and reporting findings alone lack the coherence and explanatory power to support your conclusions. Presenting an explanatory model for the impairment in functioning by truly integrating the data in a coherent and interesting way makes the process more complex, but the results are more meaningful. This chapter will present a method for taking data from all sources and integrating the data clearly and logically.

The complexity of integration of data and conceptualization constitutes a major reason only accredited professionals are legally allowed to conduct psychological assessment. Whereas administration, coding, scoring, and even some interpretation of tests could be learned relatively easily by many people, this part of the process requires a much higher level of thinking that is based on a comprehensive understanding of psychological theory and psychodiagnosis. Such an understanding can derive from a range of theoretical perspectives.

Using the method outlined in this text, you can just as easily conceptualize a case from a cognitive, psychodynamic, or developmental perspective. Regardless of orientation, excellent supervision is necessary to hone and improve these skills of conceptualization. While the process outlined in this chapter will help organize the method for integrating data and conceptualizing the case, it is not intended as a substitute for good supervision and feedback. Professional supervision is essential to support you in your efforts to present a clear and logical argument that backs up your conclusions and recommendations. For an in-depth discussion of principles of good psychological assessment supervision, see Wright's (2019) *Essentials of Psychological Assessment Supervision*.

Bear in mind the limitations of individual tests and the results they provide. While the current text is not meant to be a survey of individual tests, it is essential to the process of conceptualization that you ultimately have confidence in the measures you are using. Without this, you cannot be confident about the data that you are now trying to integrate. It is extremely important during this conceptualization process to approach the data with humility, understanding that no single finding from any single test should be given as much weight as the results that emerge consistently across tests, especially across methods or reporters (e.g., from both self-report and performance-based measures, from self-, parent, and teacher reports).[1] A single example (Paul) will be provided

[1]For more detailed information on the strengths and limitations of individual tests, so that you can know which results to afford even slightly greater weight, consult texts that focus on the measures themselves (e.g., Groth-Marnat & Wright, 2016; Lezak, Howieson, Bigler, & Tranel, 2020; Sattler, 2018).

Conducting Psychological Assessment, First Edition. A. Jordan Wright.

throughout this chapter to illustrate the process as it unfolds; remember, though, that the content of this specific example is less important than how it illustrates the process.

Step 1: Accumulating the Data

The first step of the integration process is to gather your data in a single place. To begin with, this simply means creating a list, by test, of all the results of the personality, emotional, and behavioral functioning measures, regardless of their apparent usefulness or importance. You should include in this list any symptoms or issues that came from the clinical interview as well as salient behavioral observations. Writing out all the evidence in a single list accomplishes several goals (besides overwhelming you with a very long list). Primarily, it allows you to pull together your individual data in a common place so that you can ensure that each nugget of data is accurate (coming directly from test results) and ultimately usable in a final report. An assessment is like a puzzle, with the data as the individual puzzle pieces. This step allows you to lay out all the pieces of the puzzle on the table before you begin to put them together to form a picture. In addition, this step will make the ultimate task of writing up the report much easier because you will have laid out all the evidence from the tests in one place for easy reference. The creation of this list also sets you up for the next step—identifying themes that have emerged from the amassed evidence.

There are two crucial aspects to this step of the process. First—and there is no substitution for this—the data that emerge from tests must flow logically from the test scores and empirically-driven use of those test scores. That is, all interpretations of test scores should align with what is known about the tests themselves in the most contemporary literature whenever possible, understanding that some measures, like projective techniques, may be based more on widely accepted clinical practice than on empirically driven recommendations for interpretation. There is no substitution for accuracy in the interpretation of tests and their data. Second—and this is more specific to the process presented in this book—you should pull out data from tests as interpreted nuggets of information. That is, each piece of data (finding) from each test should be explained in narrative, clear terms. It is simply not good enough to list a scale score in the theme chart that you are building. For example, if you gave the Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF), rather than putting "ANP *T* score = 86," you should write out exactly what that means: "high proneness toward anger." This kind of statement is much more usable in an ultimate report, and it takes the burden of reinterpreting what $T = 86$ means later in the process. There are certainly tests where you may have to reinterpret or at least reword some findings to make them more usable; tests with interpretive printouts that have very psychoanalytic language, for example, may need to be reworded in plainer language. Additionally, you may need to split certain nuggets of data into multiple nuggets. Consider a finding from a test that says something like, "Problematic understanding of self and others." It is likely going to be more useful in the long run to separate it into problematic understanding of self and problematic understanding of others, two separate and important issues.

The Case of Paul—Accumulating the Data (Step 1)

Paul was a 30-year-old, mixed-race male who presented for an assessment at the urging of a family member in the mental health field and because he was "generally frustrated with life." He had an extensive drug and legal history, having been to drug rehabilitation several times and having been in prison several times, both for drugs and for robbery. He had a long history in the foster care system but had lived with both his mother and father at different points during his childhood, though he had been taken away from them, as they were abusive and neglectful. At the time of the assessment, he was mostly unemployed, except for occasional jobs as a stuntman and in shows during which he would mutilate himself (piercing and cutting himself in many areas on his body).

His cognitive testing revealed that he was functioning in the average range compared with others his age, with high average verbal ability. Table 4.1 presents the data that emerged from Paul's personality, emotional, and behavioral testing and some nuggets of data from the clinical interview and behavioral observations. Remember, the assumption is that all the data presented are based on measures that were administered, coded, scored, and interpreted in a way that is consistent with the empirical literature and common clinical practice. The data themselves must be valid for any other part of the process to be valid.

TABLE 4.1 **ACCUMULATION OF PAUL'S DATA**

Millon Clinical Multiaxial Inventory, 4th Edition (MCMI-IV)
Drug dependence
Depression
Disinhibited tendencies
Emotional dysregulation
Antisocial behaviors
Anger
Passive-aggressive tendencies
Shallow interpersonal interactions
Identity diffusion
Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF)
Family problems
Views relationships with others as dangerous
Depression
Low substance abuse
Disorganization in thinking
Extremely high anger proneness score
Tightly guarded emotions
Disregards others' rights and needs
Personality Assessment Inventory (PAI)
Drug abuse
Aggression
Depression
Suicidality
Antisocial attitudes and behavior
Weak identity
Manipulative interpersonal behaviors
Erratic emotionality
Rorschach Performance Assessment System (R-PAS)
Oppositional tendencies
Acts out behaviorally
Unmet needs for closeness
Intellectualizes
Emotionally guarded
Underlying anger and resentment

(Continued)

TABLE 4.1 (*CONTINUED*)

Views self as damaged
Views future pessimistically
Loneliness and neediness
Works hard to dampen down emotions
Insecure about himself
Confused thinking
Preoccupied with own needs at the expense of others
Difficulty establishing and maintaining close and lasting relationships
Mistaken impressions of people
Thematic Apperception Test (TAT)
Lots of drug use
Interpersonal relationships are composed of games
Does not understand others well
No clear understanding of who he is
Sadness, which turns to anger and blowing up
Guarded about emotions
Qualified negative emotions with overly happy and idealistic ones
Anger about life
Rapid shift in emotion
Loneliness
Helplessness
Thrill about breaking rules
Family is disconnected and confusing
Other people can be frightening and confusing
Restriction of emotions
Behavioral observations and other data
Long drug history
Few friends or close relationships
Reported being frustrated with life, but no more detail
Self-mutilation
Score of 65 on the dissociative experiences scale (DES), which suggests high likelihood of dissociative experiences
History of aggressive behavior
"Abandoned by my father" at a young age
At times illogical in his presentation
Reported transient suicidal ideation
Reported that he is "searching for myself"

When you are listing the major results from the measures, it is recommended to do so in a table with a small, empty column on the left and each individual piece of data constituting a row in the column on the right. After completing your list, you are ready to begin the next step of the process.

Step 2: Identifying Themes

The next step in the integration process involves categorizing the data and results into coherent themes. At times, the themes emerge obviously and easily and coalesce into a convenient, descriptive picture of the individual being assessed. Most often, however, it is more difficult to begin to categorize all of the results into themes that are meaningful. There are two methods for identifying themes initially: one uses seven traditional psychological themes and the other uses more of an intuitive, grounded theory approach.

It is strongly recommended that when you first try to apply this process, you begin with the seven traditional psychological themes, which have been adapted from seminal work by J. D. Mayer (1998, 2005), Blais and Smith (2014), and Blais and Hopwood (2017) with specific additions. When determining what theme each nugget of data belongs to, the categories are *self, others, thinking, feeling, behavior, coping*, and *context*. Data relating to the self system include anything about identity, feelings and beliefs about the self, self-centeredness and self-focus, locus of control, locus of evaluation, and similar constructs. It is important (for the self theme and all the others) that the data are truly explaining the theme, in a very proximal way, not just tangentially related to it. For example, a nugget that reveals that an individual has an interpersonally passive style may be related to low self-esteem or a weak identity, but alone it is an interpersonal and social piece of data, not a self piece of data.

The second theme includes information related to the other system, including anything social, relational, or interpersonal. Data in the other theme category may include interpersonal perception, feelings about others, social skills development, social behavior (e.g., withdrawal, hypersexuality), and anything else that involves internal thoughts or feelings about or external behavior related to interpersonal relationships. The third and fourth themes have to do with thinking and feeling. It is important to distinguish the thinking, thought process, thought content, and cognitive functioning theme in the personality, emotional, and behavioral section from the data that emerge from the cognitive functioning section, which are most often optimal performance measures. For example, even if a client does extremely well on all optimal-performance measures of attention (e.g., the Test of Variables of Attention [T.O.V.A.], Conners' Continuous Performance Test, 3rd Edition [CPT-3], and Test of Everyday Attention [TEA]), problems with attention may still emerge on the typical-performance measures (like self-report surveys), and this may in fact reflect real problems with attention (maybe not attributable to attention deficit hyperactivity disorder [ADHD]). All these data about everyday cognitive functioning, including attention or executive functioning problems, confusion, and depressive or anxious ideation, would go into the thinking theme, while all information related to the emotional and affective world of the person would go into the feeling theme. Common data included in the feeling theme are sadness, anxious feelings, problems with emotion regulation or rapidly shifting emotional states, irritability, and other such emotional or affective data.

It is very common that a single nugget of data may straddle more than one theme. For example, feelings about the self may appear to fit into both the feelings and self themes. While some pieces of data may in fact fit and need to go into two different themes at this point (they will not end up in more than one theme—the process for deciding will be discussed later), it is recommended that you privilege self and other above thinking and feeling. That is, if it is a thought or feeling about the self, put it into the self theme. If it is a thought or feeling about others, put it into the others theme. This will leave the thinking and feeling themes a bit cleaner about cognitive and affective content and process that is not about the self or others.

While these first four themes (self, others, thinking, and feeling) stem directly from the work of Mayer (1998, 2005), Blais and Smith (2014), and Blais and Hopwood (2017), the next three themes have been added in to account for a wealth of information that emerges from psychological tests that does not easily fit into those four themes. The first additional theme is behavior. The behavior theme, much like thinking and feeling, should

not really include data that is directly about behavior toward others (data that should be coded as others). Instead, behaviors that lie outside of the first four themes should land here, including information like substance abuse, problematic eating behaviors, impulsivity, and acting out behaviors in general.

The final two themes were added for very different reasons. The sixth theme, coping, emerged because of so many psychological measures that include information specifically about the coping and resiliency of an individual. This sometimes includes the general capacity someone has to cope with everyday experiences, coping resources (both internal and external–social), and exhibiting behaviors of resiliency, as well as specific information about how one copes, such as internalizing versus externalizing coping strategies or maladaptive tension reduction activities related to managing emotions. Because so many measures include some aspects of coping—and because coping stretches across thinking, feeling, and often interpersonal systems—it was added to this model.

The final theme added to the present model is context. Unfortunately, still too few psychological measures (and indeed psychological assessments) include a deliberate discussion of contextual factors contributing to the person's current functioning. However, some methods and measures definitely include information about cultural context (such as acculturative stress), family stress, or current life circumstances (like going through a divorce). Additionally, information related to trauma and traumatic stress and adverse childhood experiences (ACEs) should be coded under the context theme, as they can play significant roles in precipitation and maintenance of psychological problems or distress. Certainly, clinical interview information often predominates this theme, but it is important to try to get some actual test data to support this theme as well whenever possible.

While it is recommended that clinicians start with these seven traditional psychological themes, another strategy for creating initial themes is more organic, derived from the data themselves in a grounded theory fashion. These more organic themes may include obvious symptoms or syndromes that are emerging across measures; for example, if there are data from multiple sources about anxious thoughts, feelings, and behaviors, you could simply have an "Anxiety" theme that extracts each of these pieces of data and aggregates them together. Themes can

TABLE 4.2 **SEVEN TRADITIONAL PSYCHOLOGICAL THEMES TO CATEGORIZE DATA**

Theme	Example data included in the theme
Tier 1[a]	
Self	Identity, self-esteem, self-focus, thoughts and feelings about the self, locus of control, locus of evaluation
Others	Any social, interpersonal, or relational thoughts, feelings, or behaviors
Tier 2[b]	
Thinking	Cognitive and thought styles and problems, attention or executive functioning problems, confusion, depressive or anxious ideation
Feeling	Emotional and affective information, sadness, anxious feelings, problems with emotion regulation or rapidly shifting emotional states, irritability
Behavior	Substance use, problematic eating, erratic spending, impulsivity, acting out behaviors
Tier 3	
Coping	Coping resources, adequacy of coping efforts, coping styles (internalizing versus externalizing), problematic or maladaptive coping techniques
Context	Current life circumstances, cultural factors, family stress, trauma history, adverse childhood experiences (ACEs)

[a] Privilege these first if data seem to fit in more than one.

[b] Privilege these above Tier 3 themes if data seem to fit in more than one.

include specific symptoms, like anxiety or interpersonal withdrawal, and personality or character styles or characteristics, such as discomfort with emotions or negatively interpreting all ambiguous stimuli. A good theme is clearly and straightforwardly described by the data. Again, it is important that all the data are truly, proximally related to the theme, not tangentially related to it.

Some pieces of evidence may not fit obviously into one theme over another, even once you have privileged some themes over others. When a piece of evidence really could fit into more than one theme, label it with both theme labels. For example, consider a piece of emerging data stating that an individual needs more support from others than is typical for their age. This could logically fall into both the others and coping categories. You could choose to privilege the others category and use that, but in this case you may want to put it both places. (How to deal with this will be discussed later.) Finally, if a piece of data truly does not fit into any theme, you can label it "Miscellaneous." We can deal with miscellaneous data later when we finalize our themes.

Step 3: Organizing the Data

The next step is simply a mechanical, procedural step for reorganizing the data, such that they are organized by theme rather than by test or measure. This provides you with a visual means to accomplish the next step, finalizing the themes. This step of organizing the data is simply a matter of reformatting the results from the previous step. A table is created that lists themes in the left-hand column and individual measures (including tests, clinical interview, behavioral observations, and mental status information) in the top row. Each box within the table will contain individual nuggets of data from each of the tests that support the themes. This step is like taking all the blue pieces of the puzzle and assembling them in a way that they naturally fit so that you have a full blue puzzle section. Again, bear in mind the limitations of certain tests. It is recommended that measures with less empirical evidence and widely accepted standardized, validated coding systems (such as projective drawings) be situated more toward the right-hand side of the table. More highly validated measures will yield results about which you can be more confident and should be situated toward the left of the table. However, given that no test is perfect, it is important to take into account results that are revealed across multiple measures when thinking about how confident you can be about the themes that emerge.

For any piece of data that you have initially decided to put in more than one theme, you need to find a way to tag it somehow in this new data table. Tagging data may involve highlighting the data cell a certain color, bolding the font, or putting an asterisk (*) next to the data nugget. However you decide to tag it, these data should be copied and pasted into both of the themes you identified and marked so that it is clear and obvious that they are data you have double tagged. This will be extremely important in the next step of the process.

Step 4: Finalizing Themes

The next step in the process is harder. Take a bird's-eye view of the data within each initially identified theme, figure out what the data are saying about the individual, and rename the themes something more qualitatively meaningful. This process requires being flexible and extremely knowledgeable about different psychological constructs and theories. You may be able to read across a single theme—actually reading aloud all the nuggets of data in that category aloud—and quickly and easily identify what the data are saying about the self-concept of the individual, for example. All data may point to low self-esteem, at which point you could rename your self theme low self-esteem. However, most often the data do not tell a clear and simple story, so you may have to begin shifting things around to make clearer and more coherent themes. As long as you have enough data across enough methods to support a theme, you can be confident about it; whenever you have data that emerge from only one test or that contradict other data, you have some work to do to finalize your themes.

The Case of Paul—Identifying Themes (Step 2)

The data from Paul's testing are presented in Table 4.3, with initial themes identified and labeled. It is important to note that it was necessary to make several passes at the data to identify and label all the themes before arriving at the final result as presented here.

TABLE 4.3 **LABELING PAUL'S THEMES**

Themes	
	MCMI-IV
Behavior	Drug dependence
Feeling	Depression
Behavior	Disinhibited tendencies
Feeling	Emotional dysregulation
Behavior	Antisocial behaviors
Feeling	Anger
Others	Passive-aggressive tendencies
Others	Shallow interpersonal interactions
Self	Identity diffusion
	MMPI-2-RF
Context	Family problems
Others	Views relationships with others as dangerous
Feeling	Depression
Behavior	Low substance abuse
Thinking	Disorganization in thinking
Feeling	Extremely high anger proneness score
Feeling	Tightly guarded emotions
Others	Disregards others' rights and needs
	PAI
Behavior	Drug abuse
Others	Aggression
Feeling	Depression
Feeling	Suicidality
Behavior	Antisocial attitudes and behavior
Self	Weak identity
Others	Manipulative interpersonal behaviors
Feeling	Erratic emotionality
	R-PAS
Behavior	Oppositional tendencies
Behavior	Acts out behaviorally
Others, context	Unmet needs for closeness
Feeling[a]	Intellectualizes
Feeling	Emotionally guarded

TABLE 4.3 (*CONTINUED*)

Themes	
Feeling	Underlying anger and resentment
Self	Views self as damaged
Feeling	Views future pessimistically
Feeling, others	Loneliness and neediness
Feeling	Works hard to dampen down emotions
Self	Insecure about himself
Thinking	Confused thinking
Self, others	Preoccupied with own needs at the expense of others
Others	Difficulty establishing and maintaining close and lasting relationships
Others	Mistaken impressions of people
Others	Excessive attention paid to how others react to him
	TAT
Behavior	Lots of drug use
Others	Interpersonal relationships are composed of games
Others	Does not understand others well
Self	No clear understanding of who he is
Feeling, Behavior	Sadness, which turns to anger and blowing up
Feeling	Guarded about emotions
Feeling	Qualified negative emotions with overly happy or idealistic ones
Feeling	Anger about life
Feeling	Rapid shift in emotion
Feeling	Loneliness
Self	Helplessness
Behavior	Thrill about breaking rules
	Behavioral observations and other data
Behavior	Long drug history
Others	Few friends or close relationships
Feeling	Reported being "frustrated" with life, but no more detail
Behavior	Self-mutilation
Thinking	Score of 65 on the dissociative experiences scale (DES), which suggests high likelihood of dissociative experiences
Others	History of aggressive behavior
Context	"Abandoned by my father" at a young age
Thinking	At times illogical in his presentation
Feeling[a]	Reported transient suicidal ideation
Self	Reported that he is "searching for myself"

[a] Some of these initial themes could be debated. For example, I have chosen to categorize "Intellectualizes" within the feeling theme, as it is directly a comment on how he deals with his emotions (even though it could be thought of in the thinking theme). Similarly, whereas suicidal ideation is in actuality a thinking piece of data, it is so heavily related to depressive feelings that I chose to categorize it with the feeling theme.

The Case of Paul—Organizing the Data (Step 3)

The next step of reorganizing Paul's data into the different orientation of table is a straightforward process of copying and pasting each individual nugget of data into its own new cell of the table. It does not matter what order you put the themes in down the left column, but it is best to put stronger measures toward the left of the table with slightly weaker data (such as less evidence-supported measures or at times self- or other-reported measures when it is expected that these data may be skewed) toward the right. Any data nugget that has been categorized in more than one place should be identified somehow. In this case, the boxes are filled in gray. Paul's data are presented in Table 4.4.

TABLE 4.4 **PAUL' S ORGANIZED DATA**

Measure: Concept:	MCMI-IV	MMPI-2-RF	PAI	R-PAS	TAT	Behavior, other
Behavior	Drug dependence	Low substance abuse	Drug abuse	Oppositional tendencies	Lots of drug use	Long drug history
	Disinhibited tendencies		Antisocial attitudes and behavior	Acts out behaviorally	Sadness, which turns to anger and blowing up	Self-mutilation
	Antisocial behaviors				Thrill about breaking rules	
Feeling	Depression	Depression	Depression	Intellectualizes	Sadness, which turns to anger and blowing up	Reported being "frustrated" with life, but no more detail
	Emotional dysregulation	Extremely high anger proneness score	Suicidality	Emotionally guarded	Guarded about emotions	Reported transient suicidal ideation
	Anger	Tightly guarded emotions	Erratic emotionality	Underlying anger and resentment	Qualified negative emotions with overly happy and idealistic ones	
				Views future pessimistically	Anger about life	
				Loneliness and neediness	Rapid shift in emotion	
				Works hard to dampen down emotions	Loneliness	
Others	Passive-aggressive tendencies	Views relationships with others as dangerous	Aggression	Unmet needs for closeness	Interpersonal relationships are composed of games	Few friends/ close relationships

TABLE 4.4 (*CONTINUED*)

Measure: Concept:	MCMI-IV	MMPI-2-RF	PAI	R-PAS	TAT	Behavior, other
	Shallow interpersonal interactions	Disregards others' rights and needs	Manipulative interpersonal behaviors	Loneliness and neediness	Does not understand others well	History of aggressive behavior
				Preoccupied with own needs at the expense of others		
				Difficulty establishing and maintaining close and lasting relationships		
				Mistaken impressions of people		
				Excessive attention paid to how others react to him		
Self	Identity diffusion		Weak identity	Views self as damaged	No clear understanding of who he is	Reported that he is "searching for myself"
				Insecure about himself	Helplessness	
				Preoccupied with own needs at the expense of others		
Context	Family problems			Unmet needs for closeness		"Abandoned by my father" at a young age
Thinking		Disorganization in thinking		Confused thinking		Score of 65 on the dissociative experiences scale (DES), which suggests high likelihood of dissociative experiences
						At times illogical in his presentation

For example, one theme may have enough cross-method data to support two full, separate themes. The self theme may have enough data within it to support both identity and self-esteem. These are two separate constructs psychologically, and certainly a person could have weak self-esteem with a strong sense of identity, weak self-esteem and a weak sense of who they are, or strong self-esteem with either weak or strong identity. As long as there are enough data across methods to support each of these themes, separate them out and label them accordingly. Similarly, the feeling theme may have enough cross-method data to support a theme about emotional content (e.g., depressive details) and a separate theme about emotional process (e.g., poor emotion regulation). The others theme may have enough information about interpersonal behavior (e.g., withdrawal and avoidance) and interpersonal perception (e.g., fear and distorted understanding of others) to support two separate themes. As you read across the themes, look for instances where a single theme is actually robustly describing two different aspects of the individual.

Another thing you may notice while reorganizing is that two themes may tell a better story if they are combined. This commonly happens when emotional distress data are spread across several themes, like thinking and feeling. If depressive ideation and hopelessness (thinking) and sadness and melancholy (feeling) emerge in the table in different themes, it may make more sense to create a depression theme and to reorganize the data accordingly. Anxiety data similarly often emerge across thinking and feeling themes. You may need to figure out a way to do this when a theme simply does not have enough cross-method data to support anything. For example, a behavior theme may include significant substance use from one test but nothing else from any other measure. So this could be combined with the coping theme (where there may be several nuggets of data related to maladaptive coping behaviors). Again, you must ensure that every final theme has enough data to support it, ideally across methods and certainly across measures, whenever possible.

At times, you may need to significantly reorganize the data into themes that are more cohesive. For example, consider a thinking theme that has cross-method data about confusion and negative ruminations and a feeling theme that has cross-method data about depressed feelings and emotional dysregulation. You may decide to reorganize these two themes into three new themes: confusion, emotional dysregulation, and depression (which includes both depressed feelings and negative ruminations). As long as all three of those new themes have enough cross-method data to support them, these are more coherent, solid descriptions of an individual.

The goal is to account for how much data across different tests and methods support each theme. Those with evidence from only a single test or not much evidence at all should be reconsidered. While going through this process, take another look at the miscellaneous data, to see either if they all hold together and tell a story on their own or if the individual data nuggets might fit nicely into one of the new themes. Also, perhaps most importantly, scan each of the new (final) themes individually to make sure all of the evidence you have categorized holds together conceptually. That is, it is extremely important to make sure that all of the individual pieces of data together truly describe the theme that has been identified and labeled anew.

Data in More Than One Theme

For data that are tagged as fitting into more than one theme, you need to make a decision about where each nugget fits best with the story being told by the rest of the data. Your goal is to keep the data nugget in only one theme and delete it from the other. For example, consider the piece of data that suggested an individual needs more support from others than most others their age, which we originally labeled to fit into both the others and coping theme. When reading across the others and coping themes, considering all the other data that emerged from other methods and measures, decide where it converges with the other data best. This way, you will not privilege it too much by putting it in your final themes more than once. For example, if the others theme is full of evidence of passivity and dependency, it could easily align and fit in well there. Alternatively, if the coping theme is full of data about weak and ineffective coping with everyday life, it could fit in well there. Of course, sometimes

it may fit in well both places, in which case it will likely matter less where it ends up since the conceptualization and story you will be telling about the individual is pretty clear and consistent.

Dealing With Conflicting and Contradictory Data

People are often messy, as are data that emerge from psychological tests. Some data can contradict other data, some data do not quite make sense, or a theme can just be confusing. Reconciling conflicting data is no easy task, but it is perhaps one of the most important tasks for the clinician to accomplish. Otherwise, we are asking lay audiences to make a determination of what test to believe, what data to privilege, and ultimately what conclusions to draw in an assessment. That is our job, not theirs. As such, it is vital that assessors truly understand how to contend with discrepant data. The method for dealing with discrepant or conflicting data involves five steps.

Step 1: Double-Check All Coding and Scoring If a single nugget of data seems to contradict the preponderance of data in a theme, first go back where it came from and ensure that it is valid. While this may be unquestionable on some measures, such as computer-based, self-report, computer-scored measures like the MMPI-2 or PAI, data that emerge from measures more complicated to code or score should be scrutinized. For example, R-PAS data may be skewed simply because of coding errors. Similarly, school-based observation measures are highly susceptible to lapses in rater attention. If the discrepant data nugget is the result of problematic coding or scoring, simply fix it and reinterpret the data; then you are done reconciling the conflicting data. If fixing coding or scoring does not ameliorate the situation, proceed to step 2.

Step 2: Identify Apparent Discrepancies Many constructs in psychology may appear contradictory but really are not. For example, if multiple sources reveal low self-esteem and one self-report test suggests that the individual presents as highly self-confident, this may sound like discrepant or contradictory data. However, the literature on narcissism (e.g., Akhtar & Thomson, 1982; Horowitz, 1989; Kernberg, 1975; Raskin, Novacek, & Hogan, 1991; Rhodewalt & Morf, 1998) widely acknowledges that highly presented self-esteem can simply be a defense (and often not a strong one) against and a mask for low self-esteem.

Another example can emerge from the others theme, in which an individual may seem to demonstrate very strong social skills and a very weak capacity for close relationships. These are two different skills: the ability to socialize and make friends and the ability to be vulnerable and form close, deep relationships. Many people are simply good at one and not the other, though many are also good or bad at both. This only seems like a discrepancy but is not.

When there is an apparent discrepancy, the job of the clinician is to explain, or psychoeducate, the psychological constructs clearly—often in the report as well as in feedback—to the intended audience so that they understand why it is not a contradiction. You may need to add a sentence in a report stating clearly that many people with low self-esteem develop a defense or coping mechanism of presenting themselves with an extremely favorable view of themselves but that this simply masks low self-esteem. Similarly, you may need to present a detailed description about the difference between having social skills (or being sociable) and forming deep, vulnerable, meaningful relationships, which are important for support. If the discrepant data nuggets are simply apparent discrepancies, you must address that clearly in the write-up, feedback, and conceptualization to reconcile them. If the discrepancy is actual instead of apparent, proceed to step 3.

Step 3: Identify Process and Method Effects Different methods and measures—even those that use the same variable name—are collecting data in different ways and, more often than not, different data altogether. A self-report measure and a performance-based measure are susceptible to different things. Self-report is prone to response bias, including both intentional and unintentional skewing of responses. Performance-based measures

are often vulnerable to situational factors like incorrect administration, fatigue, and problematic rapport. A self-report measure like the MCMI-IV may reveal adequate levels of independence from others (e.g., a low score on the dependent scale), whereas a performance-based measure like the R-PAS may show heightened dependence (with an elevated oral dependent language variable). A process interpretation would include the nuance that the individual is working to appear as if they are independent but in fact has underlying dependent needs.

Similarly, a self-report and a performance-based measure may have different data related to self-esteem. These discrepancies may reveal that an individual is working to appear as if they feel better about themselves (i.e., self-reported) than they actually do (i.e., performance based), or they may highlight that an individual is trying to appear worse off than they actually are. Though the discrepant data are real, you can explain them based on the differing methods and processes through which they were obtained. If the data are consistently different by method, adding this nuance to the conceptualization reconciles the discrepancy. If the data discrepancy cannot be explained this way, move on to step 4.

Step 4: Identify Context Effects Consider two different measures that provide contradictory evidence of anxiety: one showing significant anxiety and the other not. If both measures are the same method (and as such cannot be explained via method effects), then you should consider if there were different circumstances under which the individual responded to them. The hope is that self-report inventories tap a broader construct than simply experienced anxiety in the moment (i.e., that they reflect a broader pattern of symptomatology in the individual's everyday life), but situational factors may certainly affect how a person responds to measures. These may be quite subtle, such as one measure administered on the first day of testing revealing higher anxiety than the second, administered later in the process when the individual is more comfortable with you and the process. Or it may be more robust, such as one measure being given at a time when an individual is gainfully employed and the other at a time when they have just been fired from their job.

It is often very difficult to discover what the situational differences may have been when two different, mono-method measures have been given under different circumstances and reveal differing evidence. You may have to go back and piece together some evidence from the process to understand the subtle circumstantial differences. Another strategy is to bring the data back to the individual being assessed, present the discrepancy, remind them when they took the two different measures, and ask them why they think the results may have emerged differently at the two different time points, a strategy adapted from Therapeutic Assessment (Finn, 2007). Any process you use to determine different circumstances for two different measures is imperfect; your own deductions may be flawed, as may those of the person being assessed. Nevertheless, it might actually elicit some very real situational changes in an individual's life that have had a real, major impact on their functioning—as these often happen after the clinical interview has been completed. Any additional contextual evidence should be incorporated into the conceptualization—or, if it is substantial enough, into the presenting problem or background information. When the change is subtler, it may be incorporated as evidence of how susceptible the individual is to contextual or situational stimuli. For example, a person whose anxiety levels (or self-esteem, or any other internal variable that represents some sort of subjective distress) fluctuate quickly and easily based on minor stimuli may be highly reactive or susceptible to even slight stressors in their environment, which may be an important factor in their personality. If contextual information emerges that explains why differing data were revealed on different measures, you have explained the discrepancy successfully. If not, move to step 5.

Step 5: Acknowledge Test Error and Outlier-Driven Discrepancies Because every psychological (and educational and even behavioral) measure is approximating some underlying psychological construct, they all include noise, method variance, and other forms of test error. Too often, this is not acknowledged, which is what makes the hypothesis testing model so useful. When making clinical assertions, data from different methods and measures form a safety net of evidence so that we can feel more confident in those assertions. For example, when something

like clinically significant anxious symptomatology emerges across the clinical interview, self-report inventories, and performance-based measures, you can feel very confident that the levels of anxiety are in fact clinically significant and not just normative levels of anxious discomfort. This could be harder to assert confidently if it came only from an interview, as different people use terms like *anxious* and *anxiety* to mean very differing levels of discomfort.

When there are discrepant data and steps 1–4 do not help us get to an explanation, we need to accept that we may have some outlier or test error-driven data that do not accurately reflect what is going on with the person being assessed. We of course need to be careful about this—we need to use our knowledge of psychometrics and cultural performance of different tests to decide if the types of potential errors that emerged are likely. We also need to make sure that we understand which of the pieces of discrepant data are the outliers. That is, if we have two measures that revealed contradictory data, we need to be deliberate about which piece of data we think is the outlier. The primary way of deciding this is by looking at the preponderance of data; if five measures say one thing and one measure contradicts, it is more likely that that latter piece of data is the outlier. This may require adding a measure to the battery to help decide which piece of data to discard. Using your clinical knowledge and comparing the data to what you know from the clinical interview and observation can also be useful in this decision-making process. Ultimately, we need to admit that our measures are imperfect and at times produce data that are not reflective of the person's actual experience. These data can ultimately be discarded.

The Case of Paul—Finalizing Themes (Step 4)

In the process of restructuring the themes into a table, some of the themes that were loosely labeled before (e.g., behavior) become clearer in their meaning (i.e., antisocial behavior). Others seem to encompass too much (e.g., emotion). Interestingly, the one piece of evidence marked as miscellaneous seems somehow related to other categories, but hopefully the conceptualization phase will illuminate how. Also, the family theme was too sparse, so it was combined with the interpersonal theme. Paul's data are presented in Table 4.5.

The behavior category seems relatively straightforward, with nearly all the data supporting a singular "story" about Paul's antisocial behaviors (including impulsivity, sensation seeking, drug history, and actual antisocial behaviors). The piece of data about his sadness turning into anger and blowing up will be useful in ultimately conceptualizing where the antisocial behaviors come from, but in this case it seems that this particular piece of data really fits better within the story being told in the feeling category. As such, we cross out the nugget—I left the part about "blowing up" since that part of it aligns really well with the rest of the antisocial and oppositional behaviors and acting out—so that it lands only in one place in the end.

TABLE 4.5 **PAUL'S REORGANIZED DATA**

Measure: Concept:	**MCMI-IV**	**MMPI-2-RF**	**PAI**	**R-PAS**	**TAT**	**Behavior, other**
Antisocial behavior	Drug dependence	Low substance abuse	Drug abuse	Oppositional tendencies	Lots of drug use	Long drug history
	Disinhibited tendencies		Antisocial attitudes and behavior	Acts out behaviorally	~~Sadness, which turns to anger and~~ "blowing up"	Self-mutilation
	Antisocial behaviors				Thrill about breaking rules	

The major difficulty to contend with in this theme is the individual piece of discrepant data from the MMPI-2-RF, which revealed no problems with substance abuse. Most of the other measures, including Paul's self-reported history, seem to contradict this. As such, we must go through the process of reconciling the discrepant data.

Step 1: Double-check all coding and scoring. Because the MMPI-2-RF was administered on its online platform and scored automatically, there is no problem with the way it was coded or scored. This does not account for the discrepancy, so we move to step 2.

Step 2: Identify apparent discrepancies. When considering if this is an actual or apparent discrepancy, we need to consider psychological theories and research. There is nothing about this finding that might render it an apparent discrepancy. There is no significant difference in the type of data it collects (current and historical substance use) from the other measures, and there is no logical psychological reason someone would both have and not have a substance abuse history. As such, we move to step 3.

Step 3: Identify process and method effects. In analyzing whether method effects may be at play, we look at the method and process by which the MMPI-2-RF collected data on Paul, along with the other measures that contradicted this finding. Because the MMPI-2-RF, MCMI-IV, and PAI are all self-report inventories (the same method), the contradictory findings are not consistent within method; that is, most of the self-report inventory measures said one thing, and the MMPI-2-RF said the opposite. As such, method effects do not explain the discrepancy, and we move to step 4.

Step 4: Identify context effects. In this case, it is very unlikely that context effects are at play, simply because substance use (current and historical) is less of a state variable than something like anxiety, self-esteem, or sadness. That is, it is unlikely that someone would have a history of substance use one day and then on another day somehow not have the same history. Further, in this case, Paul was administered the MMPI-2-RF and the PAI on the same day during the same session, so the context was not significantly different between the two measures. Thus, context effects do not adequately explain this discrepancy, and we must move to step 5.

Step 5: Acknowledge test error and outlier-driven discrepancies. At this point, we must acknowledge that no test is perfect and that they are all susceptible to multiple forms of error. It is definitely possible that Paul, when filling out the MMPI-2-RF, opted for some reason not to disclose his drug history even though he decided to acknowledge it on other measures. We cannot be sure why, but it is pretty clear that the preponderance of data suggests that he has a significant history of substance abuse. As such, we will ultimately discard this singular piece of information (i.e., the MMPI-2-RF's nugget that Paul has no significant history of substance abuse problems).

Measure: **Concept:**	**MCMI-IV**	**MMPI-2-RF**	**PAI**	**R-PAS**	**TAT**	**Behavior, other**
Feeling	Depression	Depression	Depression	Intellectualizes	Sadness, which turns to anger ~~and "blowing up"~~	Reported being "frustrated" with life, but no more detail
	Emotional dysregulation	Extremely high anger proneness score	Suicidality	Emotionally guarded	Guarded about emotions	Reported transient suicidal ideation
	Anger	Tightly guarded emotions	Erratic emotionality	Underlying anger and resentment	Qualified negative emotions with overly happy/ idealistic ones	

Measure: Concept:	MCMI-IV	MMPI-2-RF	PAI	R-PAS	TAT	Behavior, other
				Views future pessimistically	Anger about life	
				Loneliness and neediness	Rapid shift in emotion	
				Works hard to dampen down emotions	Loneliness	
The first step in looking at this wealth of feeling data is to cross out the "blowing up" part of the nugget that we decided fits better in the antisocial behavior theme, which leaves the sadness turning into anger part of the nugget. Next, we have to read across all the data to determine what story is being told about Paul by these data. In doing that, we will have to decide about the "loneliness and neediness" data nugget—whether it belongs here or fits better with the interpersonal data. In thinking about these data, it seems that it may work better to separate the data into the content of Paul's emotions (including depression and anger, primarily) and his emotional process (generally discomfort with and dysregulated emotions).						
Depression and Anger	Depression	Depression	Depression	Underlying anger and resentment	Sadness, which turns to anger	Reported being "frustrated" with life, but no more detail
	Anger	Extremely high anger proneness score	Suicidality	Views future pessimistically	Anger about life	Reported transient suicidal ideation
				Loneliness ~~and neediness~~	Loneliness	
Discomfort With and Dysregulated Emotions	Emotional dysregulation	Tightly guarded emotions	Erratic emotionality	Intellectualizes	Guarded about emotions	
				Emotionally guarded	Qualified negative emotions with overly happy and idealistic ones	
				Works hard to dampen down emotions	Rapid shift in emotion	
At this point, these seem to be pretty solid themes (angry depressive states and discomfort with his overwhelming emotional states), and we simply need to reconcile the one piece of repeated data. In looking at the angry depression theme, as well as glancing at the others theme, it seems the best way to organize the nugget is by splitting it up into loneliness (which aligns well with depression) and neediness (which is more interpersonal in nature).						

Measure: Concept:	MCMI-IV	MMPI-2-RF	PAI	R-PAS	TAT	Behavior, other
Aggressive Interpersonal Behavior	Passive-aggressive tendencies	Views relationships with others as dangerous	Aggression	~~Unmet needs for closeness~~	Interpersonal relationships are composed of games	Few friends and close relationships
	Shallow interpersonal interactions	Disregards others' rights and needs	Manipulative interpersonal behaviors	~~Loneliness and neediness~~	Does not understand others well	History of aggressive behavior
				Preoccupied with own needs at the expense of others		
				Difficulty establishing and maintaining close and lasting relationships		
				Mistaken impressions of people		
				Excessive attention paid to how others react to him		
When looking at the interpersonal functioning of Paul, the overwhelming narrative that emerges in the data has to do with his aggressive and passive-aggressive behaviors toward others, rooted in his mistaken and overly negative expectations of others. We could decide to split this up into two separate themes: one for his interpersonal behavior (aggressive and manipulative) and one for his interpersonal perception and feelings. However, if we did split it up that way, there would not actually be that much cross-method data to support the latter theme (about viewing others mistakenly as more dangerous than they are). As such, we can leave these as a single theme, label it with the majority of data (the aggressive behavior), and build the nuance of his interpersonal perception into the fuller description when we write it up. Additionally, if we look at the two gray pieces of data (unmet needs for closeness and neediness), we see that these do not fit in nicely with the aggressive interpersonal behavior presentation. As such, these nuggets will be moved together to the context theme. Paul's preoccupation with himself at the expense of others is much better aligned with the aggressive interpersonal behavior than with the emerging self data, so we will maintain it in this theme and delete it from the self.						

Measure: Concept:	MCMI-IV	MMPI-2-RF	PAI	R-PAS	TAT	Behavior, other
Weak Identity	Identity diffusion		Weak identity	Views self as damaged	No clear understanding of who he is	Reported that he is "searching for myself"
				Insecure about himself	Helplessness	
				~~Preoccupied with own needs at the expense of others~~		

While there is some evidence of low self-esteem (from the R-PAS and TAT, in the form of seeing himself as damaged and helpless), this theme is overwhelmingly telling the story that Paul is unclear in his own identity. We have two choices. We can either call it weak identity and in the description in the report include that there is also some negative self-image, or we could move the low self-esteem data to the depression category since helplessness especially is a signature symptom of depression. Either way, these data would not change the overarching themes. The depression theme would stay depression, and the weak identity theme would stay weak identity either way these two data points are categorized.

Measure: / Concept:	MCMI-IV	MMPI-2-RF	PAI	R-PAS	TAT	Behavior, other
Weak family support	Family problems			Unmet needs for closeness		"Abandoned by my father" at a young age
				~~Loneliness~~ ~~and~~ neediness		

Having already decided that the R-PAS data belong in this category, we can untag them (in this case unfilling the gray boxes). This theme is also relatively straightforward to interpret. The most important feature of themes is that they hang together across methods and measures whenever possible. Thus, it is less important to have a great deal of data for a single theme than to have agreement across measures. In this case, even though there are only four nuggets, they cross three methods (self-report in an interview, self-report inventory, and a performance-based measure). So we can feel confident that this contextual factor of weak family support is real and important in Paul's functioning. As always, the actual name of the theme, which aims to tie together all of the data in a succinct way, could be labeled differently. But in this case, the unmet needs for closeness combined with the family problems and abandonment by his father seem to tell the story that he has not had and does not have enough support from his family.

Measure: / Concept:	MCMI-IV	MMPI-2-RF	PAI	R-PAS	TAT	Behavior, other
Confused thinking		Disorganization in thinking		Confused thinking		Score of 65 on the dissociative experiences scale (DES), which suggests high likelihood of dissociative experiences
						At times illogical in his presentation

This final category again includes very few data nuggets, but they certainly converge across methods and measures to describe some confusion in Paul's thinking. The dissociative piece of data is interesting, as it certainly could be related to his confusion in thinking (and can certainly stay here). However, it could also be argued that it might fit better with the dampening down of his dysregulated emotional states, as it may serve as a coping mechanism. For now, though, we will leave it here.

Step 5: Conceptualizing

Once the themes have been finalized, the fifth and final step is to conceptualize what is going on for the individual. This is where the puzzle pieces are finally put together to create a larger picture, one that ties the emergent data (themes) to psychological theory. Rather than simply reporting the themes as the findings of the assessment,

the hypothesis testing model requires integrating the themes into a narrative describing what is occurring for the individual assessed, aiming to make the results clearer, more coherent, and more understandable to the person being assessed (in addition to the referral parties or anyone else receiving the feedback). The more easily the results can be understood, the more likely the individual will follow up on the recommendations made as a result of the assessment.

As with pulling out the themes from the data, constructing the narrative occasionally happens quite easily, but more often it is not that clear. Although several different narratives could be created for the same set of themes, each one is as valid as the others as long as they proceed logically from the data and the psychological theory employed. The themes primarily support the conclusions, diagnosis, and recommendations, and the narrative simply organizes these data in a more accessible way. If one of the themes is like the blue section of the puzzle being assembled, this final step is like connecting the larger blue section to the larger green section as well as to all the other sections to create a full, coherent picture.

For example, if you have one theme labeled "low self-esteem" and another labeled "interpersonal isolation," they could be placed in a narrative in several different ways. In one case, it could be asserted that the low self-esteem constricts social comfort and thus likely impedes the individual's ability to function interpersonally. The case could just as easily be made, though, that the lack of socialization contributes to feelings of inadequacy. More likely, these problems are somewhat reciprocal and reinforce each other; low self-esteem constricts social comfort and impedes interpersonal functioning, which reinforces low self-esteem.

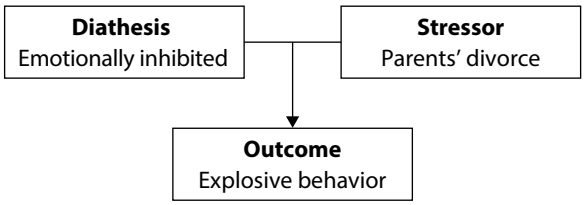
A third variable may even explain both the low self-esteem and interpersonal isolation, such as early childhood abuse or a lack of family support. It could be argued that the low support, in the context of a history of abuse, has led to a lack of interpersonal trust, making it difficult to establish interpersonal relationships. Additionally, the early abuse could lead to feelings of worthlessness and inadequacy if the individual feels somehow guilty about or responsible for it. Regardless of how the narrative is told, however, low self-esteem and lack of interpersonal relationships, together with other supporting data, support a conclusion and diagnosis of, for example, depression and the subsequent recommendations of psychiatric consultation, psychotherapy, and possibly other means of support such as social clubs. Although this example is condensed and relatively straightforward, it illustrates the point that no one narrative is necessarily correct and that multiple narratives can emerge from the same themes. Several examples of common psychological theories that can help organize themes into narrative structures follow.

Diathesis–Stress Model of Conceptualization

The first, and often the most straightforward, way to conceptualize how themes combine to explain the functioning of an individual is adapted from the diathesis–stress model (Zubin & Spring, 1977). Simply put, themes can often be categorized into the following three types: (1) *diatheses*, or what the individual contributes to the situation in terms of personality style or general approach to the world; (2) *stressors*, or what is going on or has gone on in the environment; and (3) *outcomes*, or what symptoms or more temporary issues are currently occurring for the individual as a result of the interaction of stressors and diatheses.

Simply put, this model posits that diatheses and stressors interact to cause or at least contribute heavily to the outcomes. For example, consider a teenage boy referred for assessment because of behavior problems like explosiveness at school. Testing reveals that he has a general style of inhibiting his emotions and that his parents recently got divorced. The diathesis would be his emotionally inhibited style, the stress would be his parents' divorce, and the outcome (likely one of a few) would be his explosive behavior. The model is shown in Figure 4.1.

FIGURE 4.1 **DIATHESIS–STRESS MODEL OF CONCEPTUALIZATION**



Developmental Models of Conceptualization

A second set of models for fitting themes into a narrative uses developmental theories. Although both are developmental in nature, they are slightly different in practice.

Developmental Mismatch Model

In the developmental model that focuses on mismatch, themes constitute evidence of different developmental levels of functioning, such that there is either delayed or uneven development along some part of the individual's functioning. Most often, this model is appropriate when the current functioning (represented by the themes) is not adequate to meet the demands of the chronological age or life stage. In general, symptoms or current functioning occur because of the mismatch between the individual's current developmental level, including their coping capabilities, and the demands being placed on them.

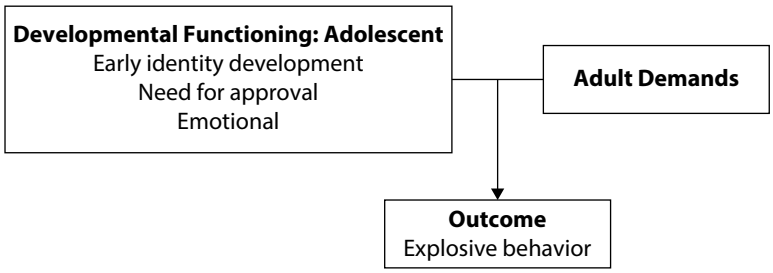
For example, that same teenager with behavioral problems may be acting out for a very different reason. Suppose instead that living in his newly divorced mother's home, he has had to take on the responsibilities of the adult male in the house, disciplining his younger siblings, earning money by taking a part-time job, and even serving as the primary means of emotional support for his mother. Other themes about his functioning might also emerge to help understand at what developmental level he is generally functioning, including what demands he should be able to cope with.

His developmental level, because he is an adolescent, is likely not (and should not be) equal to that of a fully developed adult male who can handle the responsibilities of being the father figure to a family. For example, themes may emerge from the tests revealing that he is actively trying to search for and find his identity (e.g., trying many different hobbies, questioning who he is in terms of his racial and spiritual identity). He has a strong need for peer approval and some erratic emotionality, despite his general tendency to restrict his emotion. These themes represent very normative developmental tasks and signs for a teenager.

However, the demands being placed on him at home are simply more than he can handle at the moment, given his normal social-emotional development. While at home, coping with these adult demands, he may act "appropriately," helping his family cope with the transition of divorce. At school, though, where he does not have the same demands, expectations, or responsibilities as at home, he acts out in an explosive way. It is no surprise that an adolescent who had to hold all his impulses and emotions in at home might spill during school, seeming impulsive and oppositional. The model is shown in Figure 4.2.

Another example is an adult who has all the demands of most others their age but whose personality and emotional profile reveals that they are functioning with some aspects that are more common for the normative developmental level of adolescence, such as weak identity and affective dysregulation. Similar to the teenage boy we just discussed, the adult would have developmental functioning more on the level of an adolescent while

FIGURE 4.2 **DEVELOPMENTAL MISMATCH MODEL OF CONCEPTUALIZATION**



struggling with demands of adulthood like working, living independently, and navigating adult romantic relationships. Again, this mismatch in the demands of the person's everyday life and the level of functioning (and thus capability to meet those demands) could easily contribute to some problematic behavior, such that the model would look very similar to Figure 4.2.

Developmental Themes Models

One of the most face valid ways to explain how themes fit together into a conceptual framework is to consider each theme from a developmental perspective, determining which themes and constructs are more core to an individual's makeup (or developmentally early) and which ones are not. For example, consider constructs like weak identity development, lack of trust toward other people, anxiety, and low self-esteem. If we consider Erikson's stages of psychosocial development (Erikson, 1963), which is a widely used psychological theory, constructs like trusting others (trust vs. mistrust, generally from birth to about 1 1/2 years of age) and identity development (identity vs. role confusion, generally during adolescence) are developmentally earlier than symptoms like anxiety and low self-esteem, which are often more symptomatic (or "right now" types of issues).

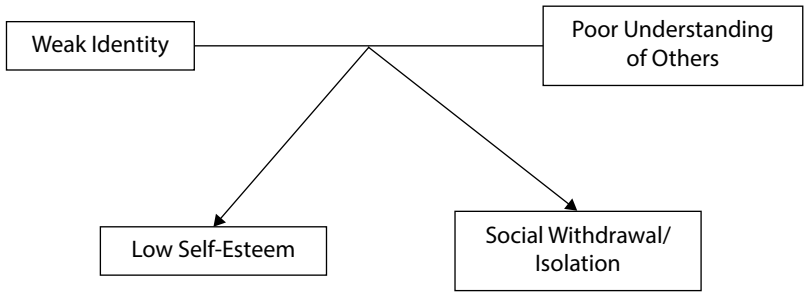
As another example, consider an individual who presents with significant problems with attention. If it is determined in the cognitive assessment that this is a biological–cognitive problem with attention, then this is a core problem around which the person's entire personality and emotional world has developed. It is developmentally early. If the cognitive assessment reveals that attentional problems are not biological–cognitive in nature (suggesting that they are secondary to some other problem), then the attention problems that emerge in the typical functioning measures are more likely a right-now type of symptom or issue.

Consider an adult case in which four themes emerge: weak identity, low self-esteem, social withdrawal and isolation, and a poor understanding of other people. If we consider these four constructs from a developmental point of view, we can argue that understanding of self and others are developmentally quite early tasks, whereas low self-esteem is more of a symptomatic consequence and social withdrawal is a symptomatic behavior. Figure 4.3 shows what this looks like, such that a poor understanding of self and others contributes to both low self-esteem and social withdrawal.

Interpersonal Circumplex Model of Conceptualization

Another useful theory, especially in the evaluation of adult personality functioning, is the interpersonal circumplex model of personality functioning (Leary, 1957; Wiggins, 1982), one of several empirical models posited in the literature. The model proposes that personality (at least from the interpersonal perspective) can be understood along two axes: dominance and affiliativeness. Each axis is bipolar, such that the extremes on either end are generally less adaptive than somewhere in the middle. The dominance axis spans from extreme passivity and

FIGURE 4.3 **DEVELOPMENTAL THEMES MODEL OF CONCEPTUALIZATION**



nonassertiveness (which includes aspects of being unassured) at the low end to overly domineering and overbearing (which includes overconfidence) on the high end. The affiliativeness axis spans from cold and hostile on the low end to overly nurturing and agreeable on the high end. Many iterations of this model, all very similar with only tweaks of wording, can be found in the literature, and one is included below, in Figure 4.4. The idea is that the place on the two continua where an individual falls represents a personality type.

Common Function Model of Conceptualization

A fourth model that is often suggested by the themes is the common function model. In general, this model applies when each of the themes seems to be contributing the same function (usually defensive) for the individual. For example, that same adolescent boy whose parents recently divorced may be employing several different techniques to avoid experiencing overwhelming emotions. In addition to the explosive behavior, themes may emerge such as somatic complaints, shallow relationships, and a preoccupation with video games. Each of these could be understood as a means by which this boy is working to keep emotions out of his awareness. In this

FIGURE 4.4 **INTERPERSONAL CIRCUMPLEX MODEL OF CONCEPTUALIZATION**

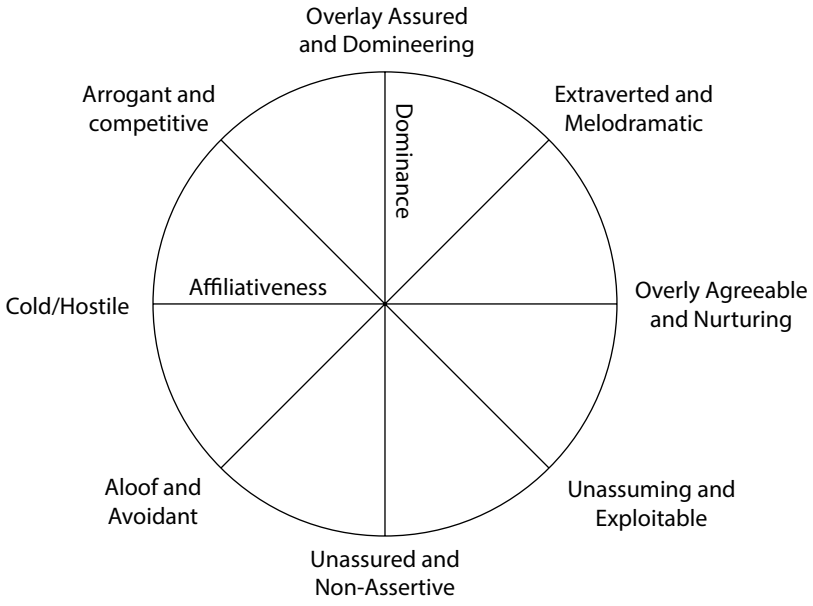
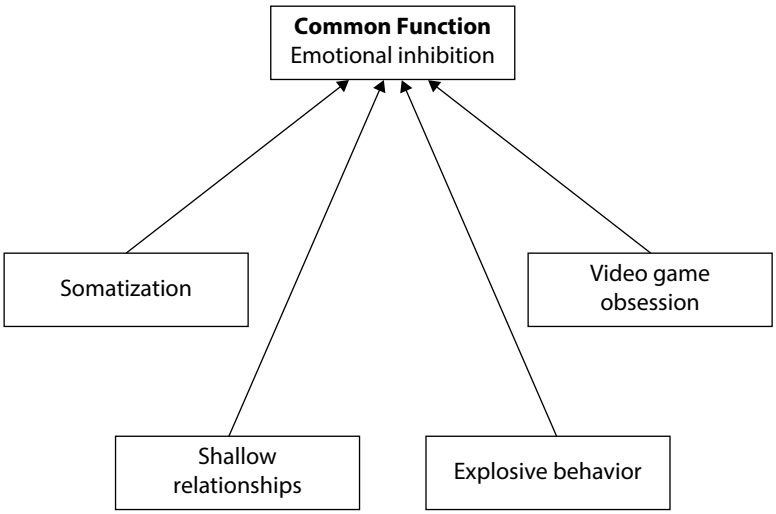


FIGURE 4.5 **COMMON FUNCTION MODEL OF CONCEPTUALIZATION**



model, each theme represents a defensive strategy he is using to avoid having to feel the intense emotions that might be triggered by his currently turbulent home life. The model is shown in Figure 4.5.

Complex Models of Conceptualization

Most often, the narrative model that emerges from the data is more complex than the models just described, with multiple layers and feedback loops. However, the fact that narratives often do not fit perfectly into any of the models previously presented does not preclude their use. Rather, they may serve as a baseline template from which to start, building other layers as needed. Consider the adolescent boy whose parents are divorcing. The themes that emerge may fit into a model based on the diathesis–stress model—only with more layers. He has a tendency to hold in his emotions, and his parents recently divorced; both are still viable as diathesis and stress, respectively. Perhaps acting out in school is not the only outcome.

Academic difficulty may be another surfacing theme in the assessment, though cognitive testing revealed no organic reason for any difficulty with school. Having used the diathesis–stress model as a starting place, you may notice that the "academic difficulty" theme does not seem to be a logical outcome of the diathesis (emotional inhibition) and stress (parents' divorce). However, it may be an outcome of the combination of the acting out in school and not having adequate time or support to do his homework because of the divorce. The diathesis–stress model is still the basis for the narrative, but an added layer of complexity is necessary to explain the themes in a coherent and logical way. The model is shown in Figure 4.6.

Consider again the adult struggling with weak identity, low self-esteem, social withdrawal and isolation, and a poor understanding of other people. While the developmental construct point of view (Figure 4.3) may be a strong start, we may decide that the actual mechanisms are slightly more complex. Again, from a developmental point of view, we can argue that understanding of self and others are developmentally quite early tasks, whereas low self-esteem is more of a symptomatic consequence and social withdrawal is a symptomatic behavior. However, we may also decide, based on our knowledge of psychology and human behavior, that low self-esteem also contributes to social withdrawal. Figure 4.7 shows what this new, slightly more complex model looks like, such

FIGURE 4.6 **COMPLEX MODEL OF CONCEPTUALIZATION**

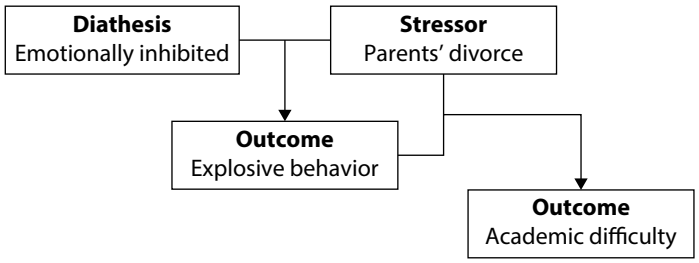
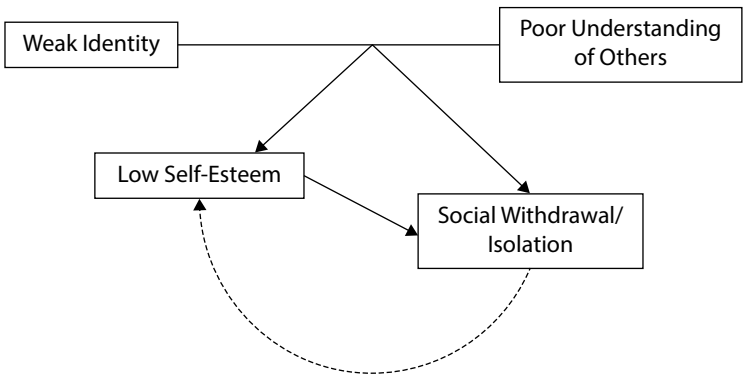


FIGURE 4.7 **COMPLEX MODEL OF CONCEPTUALIZATION**



that a poor understanding of self and others contributes to both low self-esteem and social withdrawal, whereas low self-esteem also contributes to the social withdrawal (which in actuality likely reinforces the low self-esteem).

The Case of Paul—Conceptualizing

A few different options for conceptualizing the case of Paul are now given. These constitute only some of the many possible narratives. As always, the task at this point is to create a logical narrative among the themes so that it presents a coherent narrative, situated within psychological theory. We have to connect the following themes:

- Antisocial behavior
- Angry depression
- Discomfort with overwhelming emotional states
- Aggressive interpersonal behavior
- Weak identity
- Weak family support
- Confused thinking

Diathesis–Stress Model Conceptualization for Paul

In trying to apply the diathesis–stress model of conceptualization, we must try to divide the themes into (a) traits that are inherent within Paul (i.e., ones he likely developed at an early age and brings to the picture, or *diatheses*); (b) external issues that affect his functioning (i.e., *stressors*); and (c) states that are more situational or transient (i.e., *outcomes*). As long as you can make a convincing argument for how each theme relates to the others, Paul will be more likely to receive feedback and take recommendations.

For Paul, the most straightforward place to start is with the stressor, as really only one of the themes that emerged is more contextual in nature. Paul struggles with a lack of necessary support from his family, including closeness and even presence (of his father). From a diathesis–stress model perspective, the idea is that many people may have weak family support but that in interaction with his particular diatheses (e.g., personality, underlying traits) this missing support can contribute to significant problems (outcomes). As such, we will put this contextual factor—his lack of family closeness and support—at the top of our model as the stressor.

What is more difficult in Paul's case is deciding which themes are part of the diathesis and which are part of the outcomes. Often it makes sense to think about behaviors as outcomes because they are generally psychologically considered outcomes of underlying causes (e.g., underlying thoughts, drives, dynamics, depending on theoretical orientation). In Paul's case, the behaviors are antisocial behaviors (including substance use) and aggressive interpersonal behaviors. Some themes may seem more likely to be outcomes because they are more transient or situational in nature. An example is his angry depression, which is current; the clinical interview ruled out a more long-standing depressive disorder.

The one theme that seems more difficult to determine whether it is an outcome of or part of the diathesis is Paul's confused thinking. We may need to account for the severity of the confusion. For example, if it is psychotic and outside the bounds of a depressive episode, it may be a psychotic disorder and may work better in the diathesis. If it is less severe (such that it is idiosyncratic thinking) and occurs within the bounds of a depressed state or is more dissociative and a bit paranoid but as a defense mechanism (i.e., used for escape, much like his substance abuse may have been), then it may fit better as an outcome. This decision should be based on clinical information and your own impression of Paul. During his testing sessions with the assessor, Paul does not seem to be, at his core, illogical or loose in his associations. At times his stories were somewhat incoherent, but this does not seem to be a trait that is fundamental to who he is. So his confused thinking will be considered an outcome in this case.

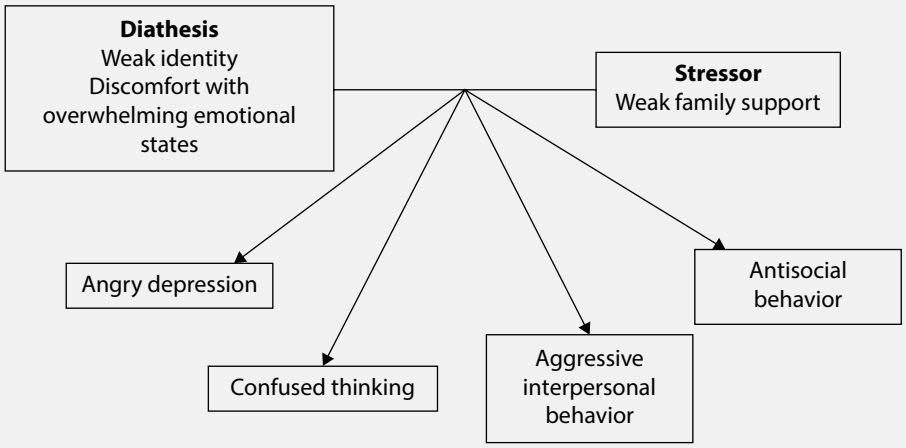
This leaves Paul's weak sense of who he is (identity) and his dysregulated underlying emotional states and subsequent attempts not to allow himself to feel them (discomfort). These are easily argued as core, underlying traits (diatheses): emotional regulation (and tolerating emotions) and understanding who you are in the world are developmentally generally early tasks and certainly affect how you interact with the world greatly. The diathesis–stress model for Paul is shown in Figure 4.8.

This model makes intuitive sense for the most part. In general, it is certainly arguable that an individual with weak identity and discomfort with his underlying, overwhelming emotions, who also has had to face the world without adequate support from his family, would develop some specific, symptomatic difficulties (e.g., anger, depression, a need to cope by using drugs). Even the idea that keeping strict control over his feelings may lead to some spilling like confused thinking is arguable. However, there are some problems with this model, which can be addressed later in a more complex model. For example, his substance abuse is more likely a way to escape the anger and depression rather than an outcome alongside them. However, this model is logical and arguable, and it would contribute to an adequate report and feedback.

Developmental Mismatch Model Conceptualization for Paul

When thinking developmentally about Paul, there does seem to be a mismatch in his general developmental functioning and his chronological age, which represents the developmental level of the everyday demands being placed on him. That is, as an adult he must navigate adult relationships, work to earn a living, and live

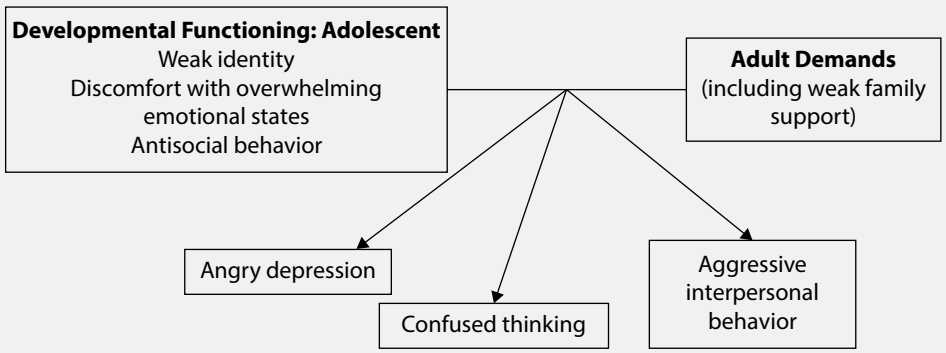
FIGURE 4.8 **DIATHESIS–STRESS MODEL FOR PAUL**



independently (especially independently given his lack of family support). However, many of his themes represent the normative functioning of an early adolescent; that is, many of the themes represent developmental tasks that are normative and appropriate to navigate throughout adolescence. For example, an adolescent is not expected to have a clear identity yet, whereas an adult is. Erratic emotionality, emotional guardedness, and antisocial behavior (at least limit pushing and experimentation) are traits associated normatively with adolescents. Even some confusion in logic is somewhat expected of an adolescent, whose executive functioning is not yet fully developed, though we can decide whether to make that part of his developmental picture or an outcome. Given this mismatch in his adolescent-level developmental functioning and the adult demands of his life, it makes sense that some of the outcomes have emerged. Anger, depression, and interpersonal difficulty can all logically be associated with this developmental mismatch, as could general confusion. The developmental mismatch model for Paul is shown in Figure 4.9.

Much like the diathesis–stress model for Paul, this model makes intuitive sense, and he would likely easily understand it. An additional benefit is that it normalizes some of the themes that could be heard as rather pathological. For example, weak identity can sound quite negative and pathological, but when it is conceptualized

FIGURE 4.9 **DEVELOPMENTAL MISMATCH MODEL FOR PAUL**



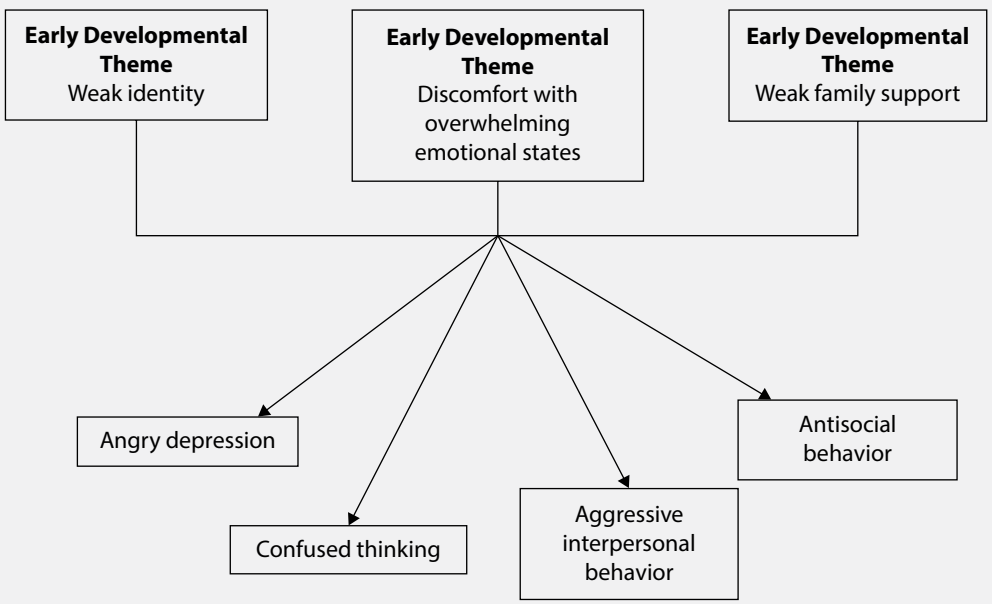
along the developmental continuum as entirely normal for everyone to struggle with at some point in their life it may be less overwhelming and negative. Psychologically, it is very likely that things were happening during Paul's adolescence when most people land on more solid identities to delay his development in this area—and unfortunately also making it harder for him to achieve as an adult. Situating some of the themes developmentally may help Paul really understand what is going on with him. However, before committing to this model, we will consider some others.

Developmental Themes Model Conceptualization for Paul

Similar to the developmental mismatch model, we need to evaluate each of the themes from the perspective of when they were likely developed or arrested or should have been reconciled in order to determine which are likely more developmentally early and have contributed to those that represent more current but less enduring functioning. Similar to the previous model, emotion regulation and tolerance of emotional states and identity development jump out as more developmentally early themes. In actuality, if we wanted to make more than two layers in this model, the emotion regulation details may even precede the identity development difficulties developmentally. Additionally, because we know the weak family support began early (with his father abandoning him), these three themes can constitute the earlier or top layer of the model. Again, we will need to be able to explain in a clear, intuitive way how we would expect an individual who has struggled with these three things from an early age to develop angry depression, some confusion in thinking, aggressive interpersonal behavior, and antisocial behavior (including substance abuse). The developmental themes model for Paul is shown in Figure 4.10.

Similar to the developmental mismatch model, this model seems generally acceptable. That is, someone with overwhelming emotions who is working hard to suppress them and who has weak family support can certainly develop anger and resentment, which is represented in this model by the angry depression and ultimately the aggressive interpersonal behavior. Similarly, someone who does not understand who he is and does not have adequate support can certainly become somewhat confused in his thinking. Finally, someone with such emotional

FIGURE 4.10 **DEVELOPMENTAL THEMES MODEL FOR PAUL**

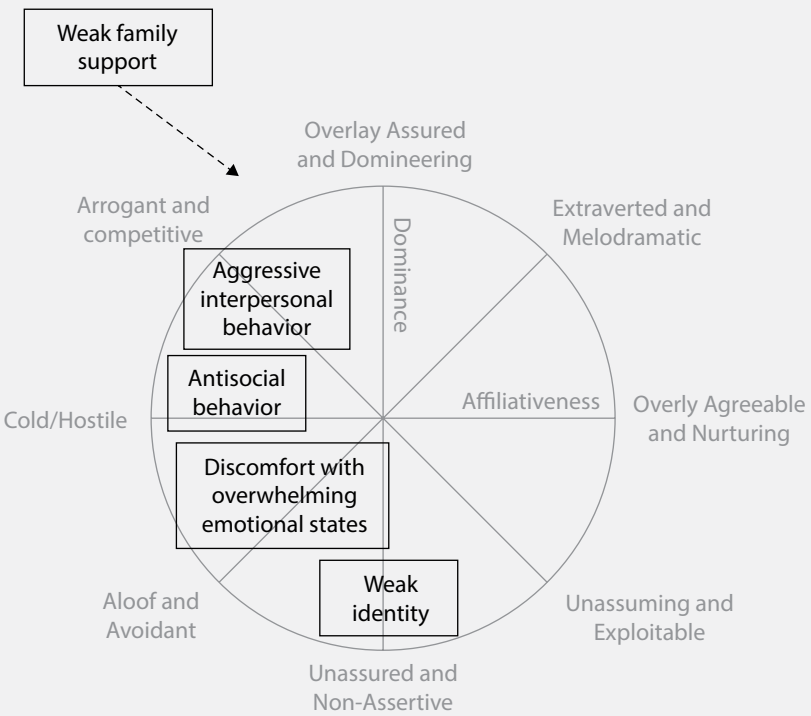


discomfort, weak support, and ultimately resentment may certainly want to escape his emotional experience using drugs and disregard general rules by acting out behaviorally. Each of these things is psychologically defensible—though, again, a more complex model may be even more representative of what is likely going on for Paul. For example, it is likely that his substance abuse was also driven, at least in part, by his angry depression. So we will consider other models as well.

Interpersonal Circumplex Model Conceptualization for Paul

The first issue we have to contend with when using the interpersonal circumplex model is that it does not generally account for contextual or precipitating information. In this case, as in many, we will have to add that weak family support is part of the general context and circumstance in which Paul's personality developed. But when thinking specifically about the axes of dominance and affiliativeness, we have to decide which of the themes actually fit into this model and which do not. Remember that the interpersonal circumplex model is meant to describe a person's personality from an interpersonal perspective (though it certainly includes aspects of personality related to self-functioning). As such, some themes and constructs simply will not fit into the model, especially because themes that emerge from personality, emotional, and behavioral assessment (often just called *personality assessment*) include personality as well as emotional and behavioral symptoms. As such, the first step in applying the interpersonal circumplex model to Paul's theme data is to determine which themes truly do fit into the model. For Paul, his weak identity and discomfort with his own overwhelming emotional states certainly fall along the unassured end of the dominance continuum. Similarly, the antisocial and aggressive behaviors fall along the hostile end of the affiliativeness continuum (though with more active, dominant components to them). The remaining themes do not fit easily into the interpersonal circumplex, so we will leave them out to begin with. The first step of the interpersonal circumplex model for Paul is shown in Figure 4.11.

FIGURE 4.11 **INTERPERSONAL CIRCUMPLEX MODEL PART 1 FOR PAUL**

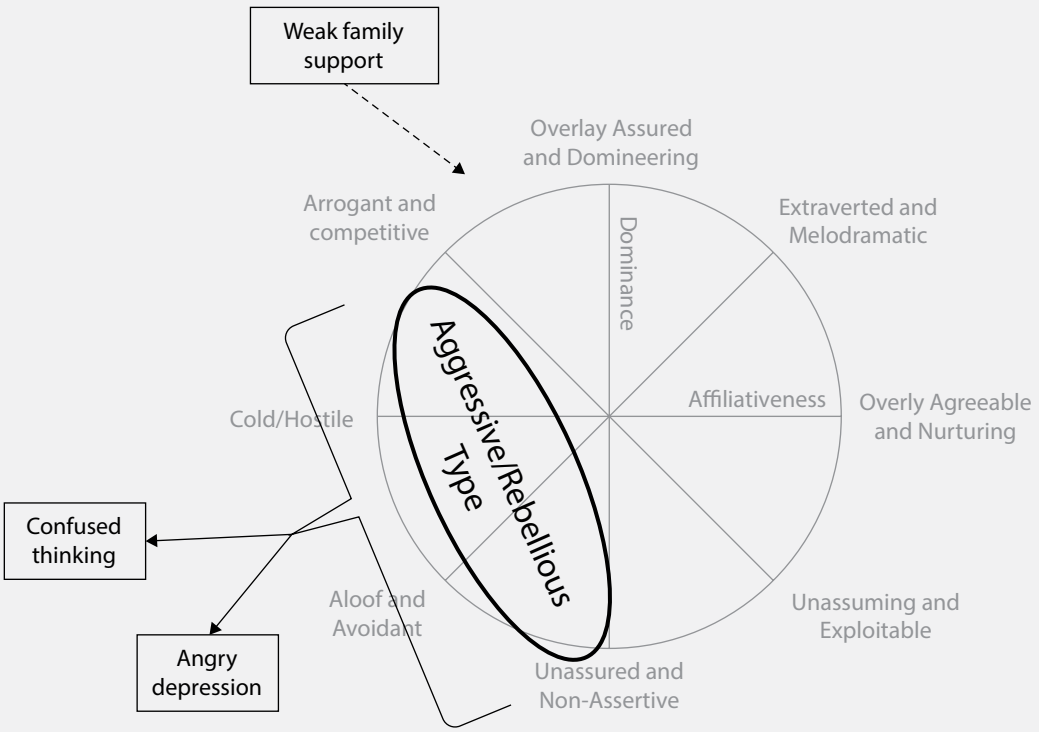


With the interpersonal personality themes all hovering around a similar area in the circumplex, we can characterize Paul as a generally aggressive/rebellious personality type, which includes some sensation-seeking tendencies and some disregard for rules, norms, and others. His specific type of rebelliousness, especially with his substance abuse, is related to some insecurity in who he is and what he feels. We can describe this personality type in the report, tying together the four themes that contributed to it.

The next step is thinking about the remaining themes, especially whether it is psychologically logical that they would result from someone who is interacting with the world with this particular personality type. That is, in a report and feedback, could you make a logical argument that someone who has developed this somewhat insecure, but ultimately aggressive and rebellious style of relating to the world could easily develop an angry depression and some confused thinking? The final interpersonal circumplex model of Paul's functioning is presented in Figure 4.12, and it represents a very psychological theory-driven model of what is underlying Paul's current difficulties.

A true marriage between psychological theory and the data that emerged from Paul's assessment, this interpersonal circumplex model represents a strong case conceptualization as long as you can explain how an insecure but aggressive–rebellious personality type can contribute to angry depression and confused thinking. In this case, the angry depression seems to be an easy logical conclusion. However, how this personality type contributes to confused thinking is somewhat more difficult to justify using psychological theory or research. It could certainly be argued, especially with all of the mechanisms used to distance Paul from reality (e.g., substances, sensation seeking, aggression). That is, his personality type works hard to distance himself from his everyday reality (especially his emotions and connection with other people); as such, he has developed some confusion in the way he thinks. But this may be too big a logical leap for the average audience to understand. As with all the models, as long as you can create a psychologically logical and coherent argument (narrative), it is a viable option for fitting the data.

FIGURE 4.12 **INTERPERSONAL CIRCUMPLEX MODEL PART 2 FOR PAUL**



Common Function Model Conceptualization for Paul

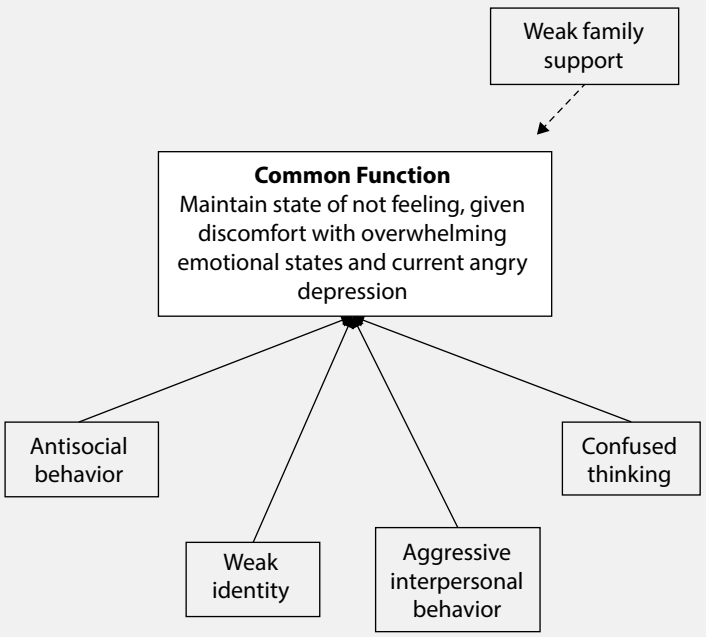
The common function model for Paul is somewhat difficult to conceptualize, mostly because there are simply a great number of themes. However, especially given the antisocial behavior and drug use, he does seem to be working hard to cope with his emotions. Specifically, he seems to be trying to keep tight control over his emotions, given his current anger and depression. That is, because of his erratic emotions, which are currently characterized by anger and sadness, he is employing many tactics to keep himself from having to consciously feel them. Certainly his antisocial behavior, substance abuse, and interpersonal guardedness are easily seen as serving this purpose. The harder themes to justify would be his somewhat confused thinking and his weak sense of identity. However, as long as in the narrative you can justify that these are also serving the purpose of dealing with his emotions, this model is viable. The common function model for Paul is shown in Figure 4.13.

While this model is not perfect, it has several advantages. Again, as with the previous models, it makes intuitive psychological sense to think about Paul in this way. That is, anyone with erratic and generally angry and sad feelings would want to find ways to suppress and not feel them. In addition to this, however, in terms of recommendations for treatment, this model places specific emphasis on building healthier and more effective ways to deal with his emotions. While his use of drugs and acting-out behaviors do help him avoid his loneliness and anger, they are far from the healthiest way to deal with these feelings even though they may feel overwhelming to him. This emphasis may be a good one in terms of having him focus on his own treatment in the future.

Complex Model Conceptualization for Paul

When considering a more complex model for Paul's functioning, it helps to think about some of the strengths of the previous models. The diathesis–stress model for Paul places good emphasis on what seems to be most core to who he is, while the common function model emphasizes his style of coping. The added benefit of creating a more complex model for Paul is the fact that you are not limited to two layers and therefore can build more

FIGURE 4.13 **COMMON FUNCTION MODEL FOR PAUL**



sophistication and application of psychological theory. A more complex model will have several layers. In Paul's case, it makes sense to first think about what he brings to the picture: a weak identity and emotional dysregulation and guardedness. While this may be seen as a diathesis, they also fit the core of a developmental themes model, two areas that are developmentally somewhat early in normative development and in Paul lagging. The weak family support, also aligned with both the diathesis–stress model and developmental models, also lands at the top of our complex model.

When considering the outcomes of his emotional dysregulation and discomfort, his poor sense of who he is, and having to navigate the world without adequate support, the next logical level (again, taken from the common function model) includes his anger and depression and his confused thinking. Erratic emotions, especially for someone who does not have a clear sense of who he is and how to deal with them, can be extremely alarming and disruptive. They can influence both feelings (angry depression) and thinking (confused thinking).

Returning to the strength of the common function model, the next layer of a more complex model would include how he attempts to cope with the angry depression and confused thinking. The major way he seems to cope is by distancing, both from his emotions (antisocial behavior, including sensation seeking and substance abuse) and from other people (interpersonal distancing through aggressive and passive-aggressive means). Figure 4.14 shows this complex model (only one of many possibilities) for Paul.

While this model pulls together the strengths of some of the other models, including a developmental–diathesis emphasis as well as one placed on his ineffective strategies for coping with his negative emotions, it may still be slightly too simplistic. Each layer of the model, when described in its narrative form, will flow logically to the next so that Paul is more likely to connect with the story. However, it may make even more psychological and even intuitive sense to discuss feedback loops and more complex contributions. Although this may look overly complicated in Figure 4.15, in explaining it narratively it can be relatively straightforward. For example, while it is clear that an angry depression and some confused thinking may contribute to aggressive interpersonal behavior, Paul's aggression toward others can serve to reinforce his loneliness, a core component of his angry depression.

This final, complex model still pulls together the strengths of some of the other models while building in feedback loops and reinforcing dynamics, all of which will ultimately inform treatment recommendations.

FIGURE 4.14 **COMPLEX MODEL PART 1 FOR PAUL**

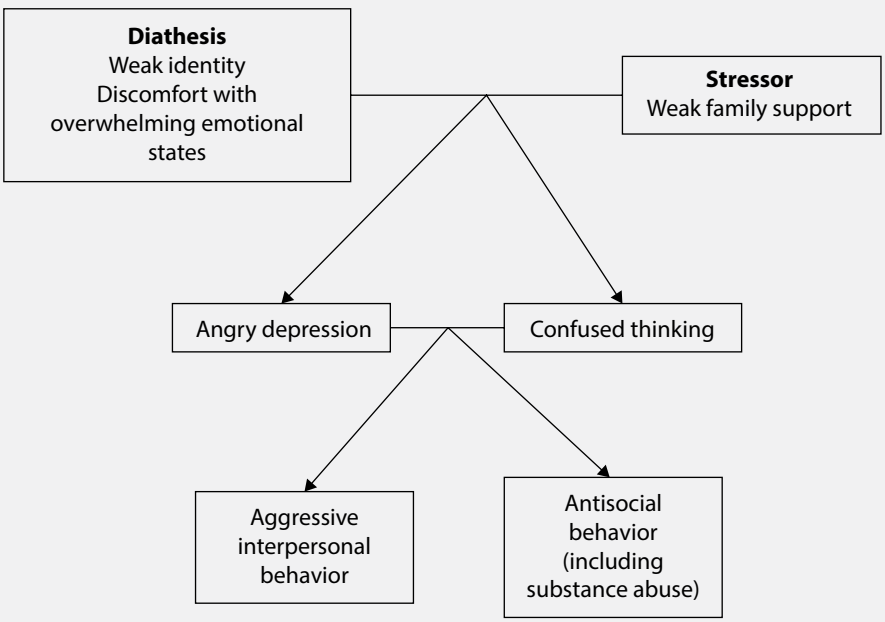
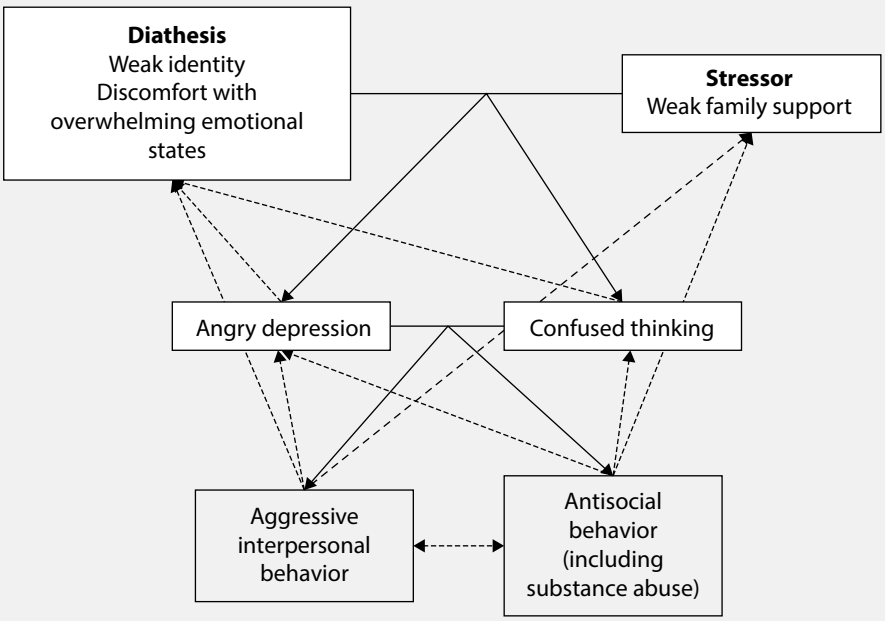


FIGURE 4.15 **COMPLEX MODEL PART 2 FOR PAUL**



Summary

The process of integrating test data and creating a coherent conceptualization of the issues presenting in an assessment case can easily be the most daunting, mystical part of the entire assessment process. This process need not be magical or scary. While it will become much easier with more clinical and theoretical knowledge, supervision, and especially practice, breaking down the process into its basic steps can make it more manageable.

The first step in the process is collecting and recording all your data—from tests, the clinical assessment (including the clinical interview, collateral information, and a mental status evaluation), and behavioral observations—into a single place. The second step is to begin categorizing these data within a psychological framework (using the traditional seven psychological themes or allowing the data to dictate some themes).

The third step is to lay out these data, which have been categorized into initial themes, in a chart, making it easy to determine (a) whether you have enough evidence to support each of the themes and (b) whether the themes make conceptual sense, such that all of the data used to support each theme truly do describe the theme.

The fourth, and one of the more challenging steps, is to go through the data to see what themes coalesce in a cohesive and useful way; this is a process that becomes easier and clearer with practice. Themes can represent anything from symptoms to strengths, defenses to personality style characteristics, and coping mechanisms to evidence of maladaptive processes. These themes can illuminate how an individual organizes their emotional world, both their thought process and thought content, and how they feel about themselves and others, among other aspects of their functioning.

The fifth and final step is to use the themes to conceptualize the case, using one of many psychological models as a basis for conceptualization. At times, the conceptualization will be extremely evident from the themes. However, the conceptualization is often less obvious, in which case several template models can be useful in

explaining how the themes fit together to describe the person. Each of the models may have different emphases, and thus different implications for treatment, but each one includes and explains each of the themes in a logical way that can be understood by those receiving feedback.

After completing this process, you will have a clear conceptualization that incorporates all the data that emerged from the tests as well as your clinical observation. The clearer this conceptualization is to you, the easier it will be both to write up and to convey to others. The narrative structure of the conceptualization (and later, the write-up) gives the assessment face validity, such that the person being assessed is much more likely to understand and remember the results and to follow through on recommendations made based on the results.

CHAPTER 5

Writing Reports

Although different authors, and indeed different supervisors, will have different expectations when it comes to writing up psychological assessment reports, most reports typically have general similarities and will differ only slightly according to the needs of the different placements and settings in which you will work. This chapter presents one format for writing up reports, but its ultimate goal is to provide useful guidelines for (a) the type of information that should be presented and (b) effective ways of presenting that information. These guidelines should be useful regardless of the write-up format you use. One of the most difficult tasks involved in writing a psychological report is to balance the language to make it both professional and easily understood by all parties who may read it. This means that the language used in reports should be relatively free of psychological jargon, unless you define terms explicitly and clearly within the report itself. However, language cannot be so informal that it undermines the psychologist's authority. Finding the balance in language and writing style between obtuse and authoritative is a challenging task indeed, and this chapter is meant to help make the process less daunting.

The Report Format

The format for psychological assessment reports presented in this chapter is designed to be a logical outgrowth of the hypothesis testing model. Specifically, each section is presented clearly and simply, building an argument first for the hypotheses generated, then for the conclusions drawn. While you will not report all hypotheses posited—or the conclusions about each—the argument put forth in the report should explicitly support the conclusions, diagnosis (when applicable), and recommendations. Sometimes it will be useful to list some of the hypotheses that were ruled out. For example, a child who is referred for an attention deficit hyperactivity disorder (ADHD) evaluation may turn out instead to be depressed, which can similarly impair attention. Not only will the report make a strong argument for the diagnosis of depression, but it will clearly present the evidence that the hypothesis of an ADHD diagnosis was not supported by the findings of the testing and was therefore rejected. Ultimately, the report should present a cohesive, compelling argument that supports the conclusions drawn. The major sections of the report are presented in Table 5.1. Not all sections will be appropriate for all assessments, but these primarily cover the majority of clinical assessments you might conduct.

Conducting Psychological Assessment, First Edition. A. Jordan Wright.

TABLE 5.1 **MAJOR SECTIONS OF THE ASSESSMENT REPORT**

The psychological assessment report
Identifying information
Referral source and questions
Measures administered/evaluation procedures
Testing notes
Client description[a]
Presenting problem and its history
Relevant background information
Biopsychological evaluation
Psychosocial evaluation
Behavioral observations
Mental status evaluation (MSE)
Overall interpretation of test findings
Cognitive (and academic) functioning
Personality and emotional (or emotional and behavioral) functioning
Vocational functioning (if tested)
Summary
Diagnostic impressions
Recommendations
Signatures
Appendices
Test results
Feedback addendum

[a] The term *client* will be used throughout; however, *patient* and *student* are also widely used. Whatever term you use, make sure it is consistent throughout the entire report.

Identifying Information

Sometimes presented as a template with different fields to be filled in according to each case, the identifying information section includes the bare essentials for identifying both the person being assessed and yourself as the assessor. Typically included in this section are name of the individual being assessed; the individual's sex, age, and date of birth; the individual's ethnicity; the name of the assessor and their supervisor, if applicable; the date of the report; and the dates of assessment. One way to organize this section is presented in Table 5.2.

TABLE 5.2 **IDENTIFYING INFORMATION**

Client:	Date of report:
Gender:	Assessor:
Age:	Supervisor:
Date of birth:	Dates of assessment:
Ethnicity:	

Example

Name:	Donald Q. Diddlewatt	**Date of report:**	1/14/2020
Gender:	Male	**Assessor:**	A. Jordan Wright, PhD
Age:	34	**Supervisor:**	N/A
Date of birth:	10/18/1973	**Dates of assessment:**	12/20/2019; 12/23/2019; 12/27/2019
Ethnicity:	African American		

A few conventions for the information are presented in this section. For example, you can use the term *sex* instead of *gender*, but you should be absolutely clear about the difference between the two. If you use gender, you should be very deliberate in using the client's self-identified gender identity rather than necessarily their sex assigned at birth. Because this is a brief heading, rather than a discussion of gender identity, the more straightforward, biological term sex may be more appropriate at this point. Additionally, the age reported should be the individual's age at the date of the report, not necessarily their age during the assessment. Because the date of the report is listed clearly at the beginning of the report, the convention is that it is easier to understand that the age listed is the age at this date. Also, follow all conventions related to titles and degrees when reporting your own and your supervisor's names. Do not write Dr. So-and-So; report the name followed by the highest degree earned—Johann X. Supervisor, Ph.D., for example.

Similar to sex and gender, you can choose whether to put *race* or *ethnicity* in this section. Either way, it is best to use the term that the individual uses to describe themselves (or their child, if it is a child evaluation). An American of Chinese descent, for example, may identify themselves using Chinese American, Asian American, Chinese, or even Amerasian. If they identify as any of these, use this term in the identifying information. If for any reason an individual being assessed does not self-identify their ethnicity (this may be the case in settings in which you have extremely limited time for the assessment, for example), use general current social convention to identify their ethnicity. This same client, if they did not identify their own ethnicity, would, according to current convention, be identified as Asian American. These sociopolitical conventions are subject to change, so if you are unsure of an racial or ethnic designation it is wise to confer with a supervisor or colleague.

Referral Source and Questions

Just as these are most often the first points of information known to you as the assessor, the source and reason for referral are among the first pieces of information introduced to the reader of the report. As with the rest of the report, it is best to be as specific as possible. This section should include the specific relationship of the individual being assessed to whoever referred them for the assessment and the specific questions they want answered with the current assessment. The referral questions are often highly interrelated with the presenting problem, discussed later in this chapter. However, you may need to work with the referral source (whether it is a parent, a referring clinician, a school, or the client themselves) to clarify and tailor the referral questions to adequate assessment questions (as discussed in Chapter 1). For example, if a therapist has referred a client because treatment has stopped progressing, the referral question could be, "The client was referred by his therapist to make recommendations for the most appropriate psychotherapy intervention strategies." For someone who may be depressed or anxious, the referral question may simply be, "The client was referred for an assessment to determine what is underlying his current problems in functioning, including some symptoms of anxiety and depression." Most often, the general referral questions will be explained in further detail in the presenting problem section.

Example

Referral Source and Questions

Mr. Diddlewatt was referred for an assessment by his current therapist, Fiona R. Snodgrass, LCSW, who has been working with him for about 3 years. Ms. Snodgrass reported that the client has become "significantly more hostile" lately, with no apparent cause. The referral was made to assess his current emotional functioning, to learn what is likely underlying his hostile behavior, and to make specific treatment recommendations.

Measures Administered/Evaluations Procedures

The title of this section is typically either "Measures Administered" or "Evaluation Procedures." Both convey the methods you used to conduct the assessment. Although it is probably the most straightforward section of the entire report, keep a few conventions in mind. First, write the formal name of each test administered in its entirety, followed in parentheses by the abbreviation that you plan to use throughout the report, for example, Wechsler Intelligence Scale for Children, 5th Edition (WISC-V). Any reviews of records, collateral interviews, and the clinical interview should be listed here as well.

There are several choices for the format of this section. Some assessors prefer to list measures alphabetically so that other professionals can search for specific measures quickly and easily. Others prefer to list them thematically, such that measures of background information (e.g., clinical interview, collateral interviews, reviews of records) come first, cognitive measures (aptitude, neuropsychological, and academic achievement tests) come next, and tests of personality, emotional, and behavioral functioning (self-report measures, performance-based measures, and projective measures) come last. This format mirrors the structure of the report, so it makes intuitive sense. A final option is to list measures in the order they were administered. Also optional is listing the date each measure was administered next to the measure itself.

Example

Measures Administered

- Clinical interview—12/20/19
- Collateral interview with current therapist—12/20/19
- Bender Visual-Motor Gestalt Test, 2nd Edition (Bender-2)—12/23/19
- Wechsler Adult Intelligence Scale, 4th Edition (WAIS-IV)—12/20/19
- Minnesota Multiphasic Personality Inventory—2—Restructured Form (MMPI-2-RF)—12/23/19
- Personality Assessment Inventory (PAI)—12/23/19
- Millon Clinical Multiaxial Inventory, 4th Edition (MCMI-IV)—12/27/19
- Inventory of Altered Self-Capacities (IASC)—12/27/19
- Rorschach Performance Assessment System (R-PAS)—12/27/19
- Thematic Apperception Test (TAT)—12/23/19

Testing Notes

This section does not necessarily need to be in every psychological assessment report. The purpose of this section is to note any circumstances that might make the current assessment different from a standard assessment. That is, any circumstances that may impact the results of the assessment significantly and that are different from what would generally be expected of any normal assessment should be reported.

For example, any variation on standardized administration of tests should be noted, as should the reason for the variation. If you made an error while administering a subtest, for instance, you would indicate in this section that, due to assessor error, the score obtained from that subtest was rendered invalid and replaced by another subtest in the calculation of the index score. For example, if the validity of the Information subtest of the WAIS-IV were compromised for some reason, it could be replaced by the comprehension subtest when calculating the Verbal Comprehension Index (VCI) and the Full Scale IQ (FSIQ). Another example would be when an individual is assessed in front of a one-way mirror, behind which sits a class of graduate students studying assessment. In this case, the fact that the assessment is being conducted in front of the mirror may impact the results of the assessment. Another example might be the setting in which the testing takes place. If you are required to assess an individual on an inpatient unit at their bedside, for instance, this would represent a significant variation from the standard administration of the tests being used.

At the end of this section, you should always include a statement of whether the results of the current assessment should still be considered a valid representation of the individual's current functioning. Generally, minor variations in the testing circumstances should not alter the assessment enough to invalidate your conclusions. However, if an individual being assessed exhibits extremely low motivation or even oppositional behavior, such that they could be said to have been endeavoring to undermine the results of the assessment, it would be helpful to include a note indicating that, for this reason, the results of the current assessment should be interpreted with caution.

Example

Testing Notes

The client exhibited behaviors during the WAIS-IV that are consistent with guardedness and motivated failure. Specifically, he complained about the length of several subtests and asked, "Can I just give up?" Even when encouraged to continue, he responded, "I don't know" without giving any effort. As such, the results of this particular measure should be considered an underestimate of his actual cognitive abilities.

Client Description

This should serve as a brief introduction of who the client is, how they presented and appeared during the assessment, and their level of engagement. This description is a combination of factual information about their demographic profile as well as clinical observations. The purpose is to provide the reader of the report with a visual image of the person who sat across from you in the room during the assessment. You should pay special attention to a comparison of the person's physical appearance and behavior to what would be considered normative. For example, if a man gets overly frustrated with himself and begins to yell at himself during the assessment, this should be stated clearly.

It is important to avoid judgmental language throughout this section. For example, if an adult woman is dressed provocatively, with tight-fitting and low-cut clothing, avoid saying she was dressed "inappropriately"; simply report the facts of her attire as objectively as possible. Other basic behavioral observations can be included in this section, if you think that they contribute to the reader's mental picture of the person being assessed. For example, if an adolescent boy made no eye contact with you and spoke in a barely audible volume throughout testing, providing these details can be very illustrative for the reader. Especially if you do not include a Notes on Testing section, the final sentence of this section should always relate to the person's engagement in the assessment, such as, "The client was open with the assessor and appeared to make effortful attempts on all tests administered; as such, the present evaluation is likely a good reflection of her current functioning."

Example

Client Description

Mr. Diddlewatt is a light-skinned, African American man who was 34 years old at the time of testing. He is tall with a very thin, lanky build, and he looks slightly older than his stated age. He typically looked tired, with large dark circles under his eyes. He was dressed appropriately in baggy jeans and a tight t-shirt, though he wore the same outfit to all assessment sessions. He was very talkative, friendly, and extremely cooperative throughout the assessment process. He appeared to engage effortfully in all measures administered; as such, the present evaluation is likely a good representation of his current functioning.

Presenting Problem and Its History

As stated in Chapter 1, the presenting problem may be significantly more complicated than what the individual or a referral source presents as the chief complaint (if they complain of anything at all). At this point you have compiled all of the data collected from (a) the referral source; (b) the clinical interview; (c) collateral measures (including parent interviews for children, reviews of medical and psychiatric records, and consultations with previous mental health providers, whenever possible); and (d) your own clinical observations and mental status evaluation and synthesized it into areas of functional impairment and hypotheses. Therefore, this section should flow easily and directly from the work you have already done.

A useful way of organizing the presenting problem section is to include a paragraph for each major problem. The presenting problem includes all areas of problematic functioning, including subjectively felt distress (such as low mood or anxiety), concrete specific impairment (such as unemployment or divorce), and global areas of impairment or suboptimal functioning (such as difficulties with interpersonal functioning or socialization in general). While there is no agreed upon formula for structuring this section, in general the most salient difficulty or most impaired area of functioning should be listed first, followed by the somewhat less crucial difficulties.

It is important to reserve this section for the problems the individual is facing currently. There will be an opportunity in the background information section to discuss past difficulties that are no longer problematic for the person. Additionally, where necessary, make sure to include the sources of the different pieces of information. If the entirety of the information you have included in this section is derived from the self-report (clinical interview) of the individual being assessed, there is no need to keep repeating that they reported the information. However, if some of the information was obtained through self-report and some was provided by a referring professional, it is important to make this distinction known.

Within this section, the history of presenting problems provides context for the individual's current problems and functioning. Specific issues that should be addressed here are the duration of the problems presented and any history of similar difficulties. Specifically, you should always make effort to present the onset of any problems (timing and circumstances, whenever possible) and the course of the problems (e.g., episodes, times when it was not a problem). Any additional information that may further illustrate the nature of the presenting problem in a way that makes it more easily understood by the reader should be included as well. For example, if part of the presenting problem includes difficulty sleeping (insomnia), any information related to sleep throughout the individual's life can be considered for inclusion. Details such as when the individual began sleeping alone as a child, any previous difficulties with sleep, and a history of a night shift work schedule might be important in understanding what is happening for the individual. Additionally, this section can go into more detail about what exactly has happened during the course of the presenting problem. For example, it is a good idea to include what reportedly goes through the mind of the individual when they cannot sleep, as well as any history of similar thoughts or thought patterns. Again, this section

needs to include a contextual and historical picture of the current problems in functioning because this history may be extremely important in understanding why the current problems are occurring for the individual.

There are two ways to think about organizing this section. With a paragraph for each individual problem, you may present the current problem and its history within a single paragraph before moving on to the next problem. Alternatively, you may want to describe all the current problems in individual paragraphs and then present each one's history, again in individual paragraphs. Most importantly, a reader should be able to understand clearly what is going on for the person being assessed currently and some historical context about each individual problem.

Relevant Background Information

The relevant background information section can take many forms. Most importantly, however, it should include at least two overarching, major areas: the information from the biopsychological evaluation and the information from the psychosocial evaluation. You can use subheadings for these, but in general you can try to convey the most relevant biopsychological and psychosocial information in one or a few paragraphs each. Another way of organizing it is to create subheadings for all the biopsychological and psychosocial evaluation subsections. However, this can be tedious and overwhelming for both you and the reader. Sometimes, a few paragraphs are sufficient to cover the major points of relevant background information. If you have conducted a thorough clinical or collateral interview, you will always have more information than is useful for the purpose of the report; your challenge is to limit the information to what is most useful and relevant while making it clear that you have evaluated all the different areas that are relevant to the individual's functioning.

Example

Presenting Problem and Its History

According to his current therapist, Mr. Diddlewatt has recently become "more hostile" in general. When asked specifically about this issue, Mr. Diddlewatt described feeling angrier and "more keyed up" than usual. He stated that his anger tends to be focused on his boss, with whom he has always had a "difficult" relationship. Moreover, he reported yelling at one of his friends after what he, in retrospect, considered only minor annoyances, such as her being 15 minutes late for a dinner with him. Even when describing this incident, he seemed to become agitated, as indicated by increasing vocal pressure and volume.

Mr. Diddlewatt reported that he has struggled with his anger for many years. He reported that he had been expelled from several different middle schools because of getting into fights with peers and "blowing up" at teachers. While he was seemingly better during high school and beyond, he stated that he continued to feel angry, even if he did not express it as he had in middle school. When asked specifically what he was most angry about, he said that it began with anger toward his parents, who he felt were unsupportive of him. This was compounded by the fact that he was the only Black student at any of his schools growing up in a small Southern town, and he faced a great deal of discrimination and "hate" from the other children, as well as from the teachers.

In addition to his anger, Mr. Diddlewatt reported that he fears dying more than he feels he should. To cope with this fear, he needs "everything to be perfect," including having all the furniture in his house facing in the exact same direction so that as many things as possible "are predictable." Additionally, he has constant thoughts of death and dying, and he mentally plays out all the different ways he could die "so that I won't be surprised when it happens."

He reported that his anxiety about death "is relatively new" and that he had always been a bit of a perfectionist, liking everything "in its proper place." However, the extent of his thinking about death and dying, which increases his need for things to be in place, reached its current level only several months ago. He could not

identify any triggers—nobody close to him had passed away or was harmed, and he had not had a birthday or injury that may have spotlighted his mortality. "It just started randomly. I know it's crazy, but I just can't stop it."

Mr. Diddlewatt also reported some difficulties sleeping, stating that his thoughts often race at night and he cannot get to sleep. Additionally, he described how he has had some loss of energy, though during the clinical interview he seemed extremely alert and energetic. He stated that he had stopped socializing recently, except for with his girlfriend, because he is afraid he will not be able to control his temper with his friends and lose them entirely. He also added that socializing "is so much work." He also reported that he is not eating very much lately.

Mr. Diddlewatt reported a period of about a year when he thinks he was "probably depressed," feeling "down" most of the time and unable to accomplish even the most basic tasks like brushing his teeth and washing dishes. When asked for details about this period, he said he was so depressed that he could not work, that he cut off contact with almost all of his friends and family, that he slept and ate excessive amounts, and that nothing made him happy. This period occurred about 5 years ago, but he managed to "pull myself out of it" and regain a normal level of functioning for him since that time. He reported, "I haven't been depressed like that again since then, thank god."

A major note on this section (which will apply to all of the sections) concerns verb tense. The tense you use for verbs throughout a report can get confusing. It is best to keep clear in your mind exactly what is present and ongoing and what is in the past. Throughout the report, whenever discussing what the individual being assessed reported, use past tense to show that they reported it in the past. It is very tempting to use language like "He reports. . ." and "She states. . ." But by the time the report is written, these actions are in the past, so the past tense should be used. However, you should evaluate the content of whatever was reported for its own proper tense: whatever is ongoing is denoted with present tense; whatever is in the past is denoted with past tense. For example, for a woman who is struggling with insomnia, you might write, "The client reported that she has difficulty both falling asleep and staying asleep throughout the night." These sleep problems are ongoing, so although she reported it in the past to you the present tense is used for the difficulty itself. However, how she used to cope with this may be put like this: "The client reported that she used a prescription sedative to ensure that she fell asleep." Because she no longer employs this tactic, the entire sentence is presented in the past tense.

Example

Relevant Background Information

Mr. Diddlewatt is the only child of parents who are still currently married and residing in the small Southern town in which he grew up. They were reportedly one of the only Black families in the town, and he was the only Black student in every school he attended through high school. He reported difficulty with his parents, feeling they were never supportive of him or understanding of his difficulties in school. His mother did not work, and his father worked many hours in a factory. He reported that his mother's behavior was "erratic" and his father's work schedule was "hectic," so he feels he had no significant relationships with adults when he was a child. Currently, he speaks to his parents about once a month, though he says these conversations are "always cold and businesslike."

Mr. Diddlewatt identifies as a heterosexual male, and he is currently not in a romantic relationship. He reported one significant romantic relationship with a woman while he was in college, but since then he has not had a serious relationship with a woman. He has "a group of friends" with whom he socializes on a regular basis, but he does not have a best friend or even a person he considers himself close to. He reported that he knows he has

"issues" related to getting close to others. He has sex occasionally with women he meets online, but none of these involvements ends up becoming a relationship beyond the sexual contact.

Much of Mr. Diddlewatt's past is characterized by feeling targeted and victimized by others because of his race. As an African American growing up in a small Southern town that was predominantly White, he reported that he struggled significantly with his own racial identity. He reported times growing up when he "pretended not to be Black," making sure his haircut, clothes, and voice were as similar as possible to those of his White peers. His parents never discussed with him the struggle of being Black in an intolerant town, and he feels resentful that they never shared their own experiences. Although he found relief moving to a large New England city, which he experienced as more tolerant, he reported that since leaving his hometown, "I just don't think of my race anymore—it's just easier that way." On occasions when he is forced to consider his own race, such as when his boss calls him racist, derogatory names, he becomes extremely angry, and "I become that middle schooler who got into so many fights again."

Mr. Diddlewatt reported that he has been in therapeutic treatment only once before. In middle school, after being expelled from one middle school, his new school required him to see the guidance counselor once a week for about 3 months, which he did not feel was helpful. He has been in his current therapy for about 3 years, which he reported is "much more helpful" than his previous experience. Although he was evaluated by a psychiatrist as part of the intake process for his current treatment, he stated that he has never actually considered the issue of psychotropic medication, and he has not seen the psychiatrist since that first visit. He had been depressed for 1 year (about 5 years ago), but, because he felt he had pulled himself out of the depression, he did not see the need to consider medication.

His current therapy, by both his and his therapist's report, is interpersonally oriented and supportive. The major area of focus has been how his feelings about his parents have affected his current relationships with other people, which are very often characterized by a lack of trust, a lack of genuineness, and a "tinge of anger and resentment," by his own report. He reported liking his current therapist and finding the therapy "useful."

Academically, Mr. Diddlewatt maintained "decent" grades in mainstream education throughout his schooling, going to college in a large New England city that was "more diverse and more accepting" than the town in which he grew up. He majored in business and received a BA from a small liberal arts college. He worked in banks most of his adult life, and he currently holds a position doing clerical and administrative tasks in a large bank, a job he has had for 2 years, which he reportedly does not like. He has "a racist boss," with whom he argues at least once a week. His boss's boss seemingly appreciates Mr. Diddlewatt's work and productivity, as he will not allow him to be fired, even after outright confrontations with his boss.

He denied any past or present criminal or legal involvement.

Mr. Diddlewatt reported no difficulties with his mother's pregnancy with him or during birth. Although he was not completely sure, he denied any delays in any developmental milestones, feeling he sat up, walked, talked, and potty trained at generally appropriate ages. He denied any abuse, by his parents or anyone else, and any other traumas as a child.

He also denied any history of significant medical illness or substance abuse. He did report some experimentation with marijuana in college, though he denied using it since graduating. He reported that he drinks socially, rarely actually getting intoxicated. He reported drinking "a glass of wine with dinner if I go out with friends or on a date," but rarely more than that.

He reported very little history of medical or psychiatric illness in his family "that I know of." He described his mother as "erratic," often rapidly fluctuating between "disengaged and overly energetic." Specifically, he recalled several periods in which she did not leave her bedroom for several weeks at a time. At other times, she seemed "almost frazzled," with so much energy that she could not seem to control herself. During these periods, she would volunteer for many different charities, rush him around from place to place in a way that did not make sense to him, yell excessively at him and his father, and declare loudly that she was "extremely disappointed" with all the people in her life. She was never diagnosed with any disorder and never received any treatment. Mr. Diddlewatt denied any other family history of erratic behavior or psychiatric treatment.

Behavioral Observations

The behavioral observations section is the place where you should describe, in greater detail than in the description of client section, behaviors that occurred during the process of the assessment. Behaviors an individual reports enacting outside the assessment sessions should be stated in the presenting problem or background information sections rather than here. Because this section is expressly concerned with how an individual behaves during the assessment process, it is extremely important to include any and all notable behaviors observed, even if they were also included in another section (such as in the description of client, in the mental status evaluation, or in the overall interpretation of test findings). No test session behavior should be listed elsewhere that is not also covered in this section.

The behavioral observations section should always include at least some information on how well the individual related to you throughout the assessment, including use of eye contact, conversation appropriateness, comfort in disclosing personal information, and general cooperativeness and friendliness. In this section, it is imperative that you support any claims you make about the individual's functioning with concrete, behavioral evidence. For example, if you state that someone "seemed anxious during the clinical interview," you should support that claim with the evidence that led you to that conclusion. In this case, you might describe how the person shifted around in their seat constantly, made only sporadic eye contact with you, and seemed to stutter when trying to make a point despite not seeming to struggle with stuttering in general. All these behavioral observations serve as evidence of your claim that the individual "seemed anxious" during sessions. Feel free to employ the useful phrase "as evidenced by" throughout this section. Using this phrase will force you to include the concrete, behavioral evidence for any conclusions you have drawn.

In addition to general comments about relatedness, any other behaviors that you feel may constitute good illustrative information for a point you will make later in the report should be included here. For example, constant and persistent starting over and redrawing on all tasks that involve drawing (e.g., Bender Visual-Motor Gestalt Test, 2nd Edition [Bender-2]) may be salient to you, as it may seem excessive. Moreover, even if during testing it did not seem too important, if testing reveals that the individual has extreme perfectionistic tendencies, then the constant restarting and redrawing may be a good illustration of how this personality characteristic may impact their functioning. In either case, it is important to include this information here so that you can use it later to illustrate exactly what you mean by a certain psychological construct or term.

Example

Behavioral Observations

Mr. Diddlewatt was cooperative throughout the assessment process. He maintained eye contact well throughout the entire assessment, even when discussing difficult topics. He frequently and comfortably initiated conversation. He gave concise answers to questions, and at times it was difficult to elicit more detailed responses. During the assessment, he at times seemed anxious or overly energized, as evidenced by shaking his leg repeatedly, fidgeting with his fingers, and cracking his knuckles. Additionally, during several cognitive tasks, he made self-deprecating remarks, stating that he was "bad at math" and making generally negative statements about his performance on the tasks, even at times yelling at himself aloud. Despite this, he displayed good effort on all tests administered.

Mental Status Evaluation

The mental status evaluation (MSE) is the only section of the entire report (other than the appendix of test scores, should you choose to include one) that is generally aimed toward other mental health professionals.

As such, it is the only section of the report in which you can use psychological jargon without shame. Phrases like, "Her affect was mood incongruent and inappropriate to the situation" would be taboo anywhere else in a report because most readers would have no idea what you are talking about; in the MSE, however, this language is entirely fitting.

The mental status evaluation section should be a concise paragraph that includes at least a note on all the major areas of the MSE (presented in Chapter 1). That is, no matter how relevant or irrelevant the individual's functioning on any one domain appears, you must report on it. This is an area in which there can be a true balance of strengths and areas of concern. In many cases, much of the MSE will appear "within normal limits" or "unremarkable"— phrases used regularly to indicate that an area or domain of functioning is not significantly outside of the norm of adaptive or functional behavior. Usually only some of the MSE constitutes functioning outside of the norm of adaptive behavior, so the paragraph can include both positive and negative attributes. The MSE is based almost entirely on your clinical observation. This format—both what is unimpaired and what seems unusual to you—forces you to consider the entire person sitting across from you, including their strengths.

Remember from Chapter 1 that six major areas of the MSE need to be addressed: (1) appearance and behavior; (2) speech and language; (3) mood and affect; (4) thought process and content; (5) cognition; and (6) prefrontal functioning. As you proceed through each section, you will note which domains the person being assessed is functioning within normal limits and which ones their functioning is outside of what would be considered normative. Including concrete examples of this non-normative functioning will both illustrate your point and lend a degree of seriousness to your argument. That is, it is important not to simply state that a domain is outside of the normal range but also to explain exactly how it is outside of the normal range with specific supporting examples.

Example

Mental Status Evaluation

Mr. Diddlewatt arrived on time for appointments and called ahead of time to reschedule those he could not keep. He was casually and appropriately dressed, and he was cooperative throughout the assessment process. His motor activity was slightly agitated during sessions, shaking his leg repeatedly and fidgeting with his fingers, but it was generally within normal limits. He spoke in an appropriate volume. His rate of speech was fairly quick and pressured at times, especially when discussing more emotionally difficult topics. He used language well, but he expressed a lack of understanding in relation to certain emotions. For example, he asked what anxiety was and how it was different from being energetic. His mood was reportedly "fine," except for some reported anger at work, and his affect during testing was both mood congruent and appropriate to the situation, as he smiled and laughed throughout sessions. Mr. Diddlewatt's thought process was goal directed. His thought content centered primarily on his own death, though he denied suicidality. Homicidality was also denied, though he reported feeling at times as though he wants to harm his boss—he denied that he would ever actually follow through on this feeling. No hallucinations were reported, and no delusions were elicited. His attention, concentration, and memory all appeared intact. Mr. Diddlewatt's insight was poor; he struggled to identify anything other than the racism of others as causes for any of his current difficulties. His judgment and impulse control were within normal limits.

Overall Interpretation of Test Findings

The structure of this section constitutes the bulk of the work you have done in the assessment; as such, it is generally one of the most important sections of the report. This section also will vary the most from report to report and, especially, from psychologist to psychologist. The structure presented here represents one clear and logical

way of organizing your interpretations. The presentation should include at least two sections: cognitive (and academic) functioning and personality and emotional (or emotional and behavioral for children) functioning. If you have included other areas, they may have their own sections, too; for example, you may have assessed adaptive functioning (especially in an evaluation for intellectual development disorder) or vocational functioning (when this is a referral question). Certainly the sections and the structure of each will vary depending on the referral questions, measures administered, setting, and individual preferences of the assessor. The structure that follows represents one solid way of organizing information.

Cognitive (and Academic, If Assessed) Functioning

The cognitive functioning section is the first step to understanding how an individual relates to the world and what may be impacting their current functioning. It is important to understand exactly what you are testing and presenting in this section, especially as the personality and emotional (or emotional and behavioral) functioning section often also includes some cognitive information. Most often, you are presenting information about a person's optimal cognitive functioning in this section. That is, you are presenting what their brain is capable of doing under the best possible circumstances, which include a quiet room with little to no distraction, one-on-one attention from an assessor, and a generally friendly environment (physically and relationally between the assessor and client). It is often useful to begin this section with a standard preface paragraph, such as: "The client was administered several measures to assess her current cognitive functioning. It should be noted that these measures evaluate her cognitive ability under ideal conditions and in the most ideal context; as such, they represent her cognitive ability, rather than how she actually functions in her daily life."

The cognitive section offers a picture of cognitive strengths and weaknesses, all of which likely impact how the person is functioning. No assessment should be without some sort of cognitive evaluation; it is impossible to fully understand what is going on for an individual if you do not at least have an idea of how they are generally functioning cognitively. For example, if a teenager is referred for an assessment because they are having behavioral difficulties in school, it may turn out that their ability to effectively use language to express themselves represents a significant weakness for them. This, in turn, may help explain (a) why they may be having difficulties in school and (b) why they may express frustrations by acting out rather than expressing themselves with words.

Alternatively, it could be very important to find that there is no cognitive weakness at all. In this case, we would want to focus more heavily on their emotional and behavioral functioning to see how they are currently feeling and how their experience of these emotional states might be impacting their overall functioning. A third case may be that the cognitive functioning section reveals extreme strengths in intellectual aptitude, which may contribute to them being bored in classes that are moving too slowly for them. This boredom may translate to behavioral problems in class. Whatever the case, it is important to start with a basis of how the individual is functioning in terms of their cognitive abilities.

Depending on the referral questions and the types of testing conducted, the cognitive functioning section can generally take one of three forms.

When Cognitive Functioning Is Secondary In general, when the cognitive testing is not the major focus of the assessment and you have given only a broad-based aptitude test (e.g., Wechsler Adult Intelligence Scale, 4th edition [WAIS-IV] or even the brief Wechsler Abbreviated Scale of Intelligence, 2nd edition [WASI-II]), the format can be a straightforward description of cognitive strengths and weaknesses by domain. In most cases, one introductory paragraph summarizing all the findings, followed by a paragraph for each subdomain (index) is all that is needed.

The first paragraph contains a general breakdown of broad domains of functioning. It is extremely important to know exactly how to interpret tests of intelligence. For example, there are instances in which you will not report an FSIQ simply because it is misleading. That is, the subdomains that make up the FSIQ are so drastically (and significantly) different that the broader FSIQ is rendered meaningless. (If the verbal comprehension, perceptual

reasoning, and working memory indices are high average, while the processing speed index is extremely low, reporting that the FSIQ is in the low average range would be misleading.) In these cases, this first paragraph will consist of a basic comparison of the four subdomains of cognitive functioning. From the WAIS-IV, these would be Verbal Comprehension, Perceptual Reasoning, Working Memory, and Processing Speed. In general, though, especially when the individual indices do hang together generally well, you can report the FSIQ in this first paragraph, especially as it has been found to be the most meaningful score functionally (McGill, Dombrowski, & Canivez, 2018).

The final sentences of this paragraph should include conclusions drawn from the findings. This may tie the findings to real-life information for the individual being assessed (such as tying significant strength in verbal ability to known success academically), or it may focus on how any of the findings may be expected to impact the individual (such as slow processing speed interfering with the speed with which the person completes projects at work).

Each of the theme paragraphs of this section will represent a separate subdomain of functioning, usually as dictated by the cognitive test given. For example, if using the WISC-V, each of the indices (Verbal Comprehension, Visual Spatial, Fluid Reasoning, Working Memory, and Processing Speed) would get its own paragraph, each with its own heading to make clear what the paragraph is about. The order in which you present these paragraphs will depend on the data that emerge from the test itself. If there are no interesting subdomains (e.g., if all the indices are in the average range, with no significant differences between any two), you would likely start with the domains that are most representative of overall functioning (verbal comprehension, visual spatial, and fluid reasoning), followed by those domains that are more susceptible to interference from emotional, personality, or situational variables (working memory and processing speed).

However, if some findings particularly stand out, it may make more sense to start with the highest domain or index (the greatest strength), and the others should follow in decreasing order until the greatest weakness is presented last. For example, if an individual exhibits a significantly higher verbal comprehension compared with the other domains, with the working memory score being significantly lower, you might present the paragraphs in the order from greatest strength to greatest weakness as follows: verbal comprehension, fluid reasoning, visual spatial, processing speed, and working memory.

Each of these paragraphs should have the same structure. They should each start with a general statement of the individual's performance on that index compared with others their age. This sentence should not include the name of the index (which is usually the heading of the paragraph) but should rather be a clear description of what exactly the domain is assessing. For example, for the verbal comprehension index, you might state: "The client's performance on tasks that assess her ability to both understand and use language fell within the average range of functioning compared with others her age." This sentence makes clear exactly what the domain assesses. The use of a qualitative range, rather than an index score, allows anyone reading the report to understand how the individual performed.

Following this statement of general functioning in the domain, you should report any interesting subtests (i.e., subtests that are meaningful because of how the individual performed on them). That is, any subtest that is a significant normative strength or weakness (i.e., a strength or weakness compared with same-aged peers) or a significant ipsative strength or weakness (i.e., a strength or weakness compared with the individual's own functioning) should be described. Additionally, even subtests that are not normative or ipsative strengths or weaknesses, if they represent something important, should be reported. For example, in a paragraph on working memory, it may be important to highlight that both auditory and visual working memory, each represented by a different subtest, were average. If there are no interesting subtests, you can make a general statement that all the subtests that make up this domain fell within the same range of functioning. Similar to the description of the domain, the specific descriptions within the paragraph should focus on the person's abilities rather than on what the task required them to do (unless this illustrates the abilities nicely).

For sentences within cognitive domains, you can simply state the level of performance and the description of the skill itself, such as: "The client exhibited very strong ability to use language in abstract and nuanced ways (WISC-V Similarities, 95th percentile), representing a specific strength in her overall abilities." Another possible sentence structure is to include (a) a description of what the task required of the individual, (b) the skills assessed by the task, and (c) how the individual performed on the task (i.e., whether it was a strength or a weakness, or the qualitative range of their score). For example, a significant ipsative strength on the vocabulary subtest may be reported like this: "The client exhibited a significant strength compared with her own overall functioning on a task that required her to define words, which assesses her word knowledge, long-term memory, and ability to express herself clearly." This sentence clearly defines the precise area of her functioning that constitutes the strength. Above all, the information in this section should be specifically about the person being assessed more than about the tasks themselves.

The final sentence of each of these subdomain paragraphs should be a general statement of what these findings might indicate. While this may vary from report to report, in general it is important to state why the individual may have performed the way they did on that index. For example, good performance on verbal comprehension is often an indicator of intellectual ambition and good schooling. A closing sentence for this paragraph may be written like this: "This strong performance in the verbal domain likely reflects that she has taken advantage of both formal and informal educational opportunities and is ambitious about her education." While this sentence is tentative (using words like *likely*), it is a good hypothesis about why an individual may be strong in the verbal domain.

Example

Cognitive Functioning

The client was administered several measures to assess his current cognitive functioning. It should be noted that these measures evaluate his cognitive ability under ideal conditions and in the most ideal context; as such, they represent his cognitive ability rather than how he actually functions in his daily life.

In general, the client exhibited varied performance across his different domains of functioning. Specifically, while his perceptual reasoning and working memory both fell within the average range of functioning compared with others his age (50th and 57th percentiles, respectively), he exhibited a significant strength in his verbal comprehension (76th percentile). He exhibited a weakness compared with his own overall functioning in his processing speed (14th percentile). While his strong verbal ability will help him thrive academically and in other work-related functions that require sophisticated use of language, his relatively slow speed of processing information may frustrate him and require him to take longer to finish projects than he might expect.

Verbal Comprehension. On measures of general verbal skills, such as verbal fluency, ability to understand and use verbal reasoning, and verbal knowledge, the client's performance fell within the high average range of functioning compared with others his age (WAIS-IV Verbal Comprehension Index, 76th percentile). He exhibited a significant strength on a task requiring him to explain the conceptual similarities between terms, which assesses his abstract understanding of language and use of words in complex and abstract ways (WAIS-IV Similarities, 98th percentile). His good verbal ability reflects intellectual ambition and knowledge gained from both formal and informal educational opportunities.

Visual Perception and Reasoning. On tests that measure nonverbal reasoning, visuospatial aptitude, and induction and planning skills, the client performed within the average range compared with others his age

(WAIS-IV Perceptual Reasoning Index, 50th percentile). Tasks in this domain involve nonverbal stimuli such as designs, pictures, and puzzles and assess the individual's abilities to examine a problem, draw on visuospatial skills, organize thoughts, and create and test possible solutions. All the subtests that make up this domain fell within the average range of functioning.

Auditory Working Memory. On tasks that assessed the ability to memorize new information, hold it in short-term memory, concentrate, and manipulate the information to produce some result or reasoning outcome, the client's performance fell within the average range compared with others his age (WAIS-IV Working Memory Index, 57th percentile). All the subtests that make up this domain fell within the average range of functioning, suggesting adequate attentional and fluid reasoning skills.

Processing Speed. The client's performance on tasks that measure the ability to focus attention and quickly scan, discriminate between, and respond to visual information within a time limit fell within the low average range of functioning compared with others his age (WAIS-IV Processing Speed Index, 14th percentile). Specifically, the client struggled with his speed of drawing shapes matched to numbers as quickly and accurately as possible within a limited period of time, which requires both speed in processing information and in drawing (WAIS-IV Coding, 9th percentile). On a task that required less graphomotor (drawing) speed but assessed his speed of processing nonverbal information, his performance was also not strong but average for his age (WAIS-IV Symbol Search, 25th percentile). This suggests that his drawing speed is generally slow.

When Cognitive Functioning Is Primary When cognitive questions are primary and you have given multiple measures to assess different areas of cognitive and neuropsychological functioning, a slightly different structure is more appropriate.[1] This may be the case in an evaluation of problematic attention or executive functioning, screening for dementia, or some other evaluation of cognitive ability. This section will contain many subsections, primarily because you have assessed many separate areas of cognitive and neuropsychological functioning. The overall structure may be different from the previously presented cognitive functioning section, and the format within each subsection may vary from other cases. The following sections will be included in your write-up only if they are relevant to the questions being asked and you have administered tests to evaluate them. Additionally, they may be presented in a different order; often, it is important to group skills together that make intuitive sense. For example, if you have a section on visual–motor integration, you may want to first have a visual perception section and a fine motor skills section since these more basic skills necessarily affect the more complex integrative skills.

The first paragraph of this cognitive functioning section provides a general overview of the major areas of functioning, similar to the previously presented structure. What may be added to this is any evidence of general cognitive decline. General indicators of current cognitive functioning (e.g., the WAIS-IV FSIQ), an estimate of premorbid level of functioning (e.g., the Wechsler Test of Adult Reading [WTAR]), and a comparison of the two are included in this section if cognitive decline is a question. This comparison makes it clear whether there is evidence for a decline in overall functioning. That is, if your measure of current intellectual functioning is significantly lower than your measure estimating premorbid functioning, then there is evidence of a possible decline in functioning. In addition to this information, a general summary of how the client performed across all the different domains of cognitive functioning should be included here.

[1] *Cognitive evaluations*, often including neuropsychological screening, refer to the use of a battery of cognitive tests to identify areas of neuropsychological impairment. Neuropsychological testing is much more detailed and targeted, and it both takes much more training and uses a different format for writing up than a neuropsychological screening report. For further information on neuropsychological testing, see Lezak, Howieson, Bigler, and Tranel (2012).

Motivation. Especially if and when a client may be motivated not to give their best effort on cognitive assessments (such as secondary gain for appearing impaired), you may have several actual test indicators of level of motivation. Putting together the data from any measures of malingering and motivation, you will make a presentation of whether poor motivation or the potential for faking were likely factors affecting the testing. This section is building an argument for whether motivation has likely affected the test results, so you should present the test evidence and make a conclusion based on it. For example, you may have several measures of effort such as a Wechsler Digit Span (Axelrod, Fichtenberg, Millis, & Wertheimer, 2006), the Forced Choice condition of the California Verbal Learning Test, Second Edition (Wolfe, Millis, Hanks, Fichtenberg, Larrabee, & Sweet, 2010), and the Test of Memory Malingering (TOMM; O'Bryant, Engel, Kleiner, Vasterling, & Black, 2007). If performance on several of these measures of motivation and malingering was adequate, it could be presented as, "The client's adequate performance on three brief tasks measuring motivation (WAIS-IV Digit Span, 63rd percentile; CVLT-II Forced Choice, 50th percentile; TOMM, 58th percentile), each falling within the average range compared with others her age, suggests that motivational factors likely did not interfere with her performance on the testing." Note that the specifics of the tests are secondary to the conclusion drawn from her adequate performance on them.

Orientation. This section is a statement regarding the individual's orientation to person, place, time, and situation most often as measured by the Mini-Mental State Exam (MMSE) or a similar measure. Unless the individual is not adequately oriented, a single sentence stating that they are oriented to all four domains (Person, Place, Time, and Situation) will suffice here. This information could also go in the MSE section rather than here. When an individual is not oriented, you will state this clearly and use it as evidence when you conceptualize what is going on for the person.

Fine Motor Functioning. Motor functioning is a basic skill that may underlie other domains of functioning and their assessment. For example, processing speed is most often assessed using pencil-and-paper tasks, such as a trail-making task and the Coding and Symbol Search subtests of the Wechsler scales. Thus, impairment in motor functioning will affect performance in tasks assessing speed of processing. To avoid erroneously reporting a deficit in processing speed when the problem is actually in motor coordination, speed, or functioning, this section should be presented first. Often you will have measures of both fine motor accuracy (such as the Motor subtest of the Bender-2) and fine motor speed (such as the Motor Speed subtest of the Delis-Kaplan Executive Function System [D-KEFS] Trail Making Test). If there is any weakness or impairment, you should discuss the implications of these deficits on other areas of functioning.

Visual Perception and Reasoning. Visual perception and reasoning generally represent one major area of nonverbal information processing. Some tests and tasks measure complex visuospatial reasoning skills that rely on combinations of several more basic visuospatial skills. For example, the Visual Puzzles subtest of the Wechsler scales includes visual processing and complex nonverbal reasoning skills. However, some tasks are much more straightforward visual perception tasks. For example, the Bender-2 and the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) include subtests of pure visual perception (no reasoning necessary), so if an individual performs poorly on more complex reasoning tasks you can distinguish if the problem is actually perceptual or has more to do with visual intelligence. It is important to understand what each task is really tapping, despite what scale they end up on. For example, the Block Design subtest of the Wechsler scales is a visual–spatial (or perceptual reasoning) task, but it actually requires visual reasoning, visual–motor integration, and processing and fine motor speed (as it is timed). As such, it is recommended that a separate section for

visual–motor integration be included, to make this visual perceptual reasoning section more straightforwardly about visual perception and reasoning.

Visual–Motor Integration. Because several measures include tasks related to the integration of visual perceptual abilities and fine motor skills and because this skill is often extremely important in school, where students often have to copy material off the board being presented to them, adding a section on visual–motor integration can be useful. For example, the Bender-2 Copy Phase requires an individual to use a pencil and paper to copy designs presented visually to them. This task requires basic perceptual skills, basic motor skills, and higher order coordination and integration of these two skills, similar to the Block Design task of the Wechsler scales. Although broad-based measures do not produce index scores for visual–motor integration (and in fact often include visual–motor tasks in other scales, like visual–spatial or processing speed), you can pull the information from the tasks themselves to make conclusions about current visual–motor functioning.

Fluid Reasoning. Depending on whether this was evaluated, fluid reasoning can be included as a section. Fluid reasoning relates to the ability to understand underlying conceptual relationships among pieces of information, to use reasoning to figure out and apply appropriate rules, and to solve generally novel types of problems. You should include a description of what fluid reasoning is, and it is often useful to include how and why this is important in everyday functioning (usually related to educational functioning, as it is important for solving novel problems and applying previously acquired knowledge to new information).

Processing Speed. Similar to fine motor functioning, processing speed is a domain of functioning that may affect multiple other domains. For example, memory may be adequately encoded, but, because an individual is slow to process the incoming information, not as much will enter their awareness, which may result in what could appear to be poor memory functioning. Measures of processing speed are presented, again focusing on evidence of any impairment and implications of that impairment. It should be clear to you, though, exactly what is being assessed by tasks of processing speed; often, processing speed tasks are brief visual–motor speed tasks, which can be affected not just by poor processing speed but also by other issues, including poor graphomotor speed, visual perceptual weakness, and attentional difficulties. This should not discount the fact that an individual may have slowed processing speed, but you should just be mindful when interpreting scores that processing speed tasks often employ multiple skills.

Memory. Given that memory impairment is one of the most common complaints you will likely receive for this type of assessment, memory is an extremely important domain of cognitive functioning in neuropsychological screening assessments. It is critical to distinguish between the concept of memory and the domain of working memory, which, while related to memory, should not be included here. Whereas memory is a process of taking in information and encoding it for future retrieval, working memory requires manipulation of that information and involves more prefrontal cortex operations than memory. In this section, a clear comparison of the different types of memory (e.g., immediate auditory memory, delayed visual memory) should be presented. Additionally, whenever possible, if there are problems in memory functioning you should try to explain where in the process of memory the problems lie. That is, memory relies on multiple processes, including attention, encoding, storage, and retrieval. Free recall problems can represent difficulties in any or multiple of these processes, and you should try to report where in these stages the problem lies. More importantly, implications of variation across the different types of memory and different parts of the memory process should be explained clearly, focusing on the implications of the impairment or deficit for the cognitive functioning of the individual being assessed.

Language. Language functioning consists of different areas of skill, including verbal fluency, vocabulary, expressive ability, and comprehension. Many broad measures of intellectual ability and neuropsychological status (such as the WAIS/WISC and RBANS, respectively) will provide broad measures of verbal functioning. What is most important in this section is to tease apart all the different components of verbal functioning and present them clearly so that any area of deficit is clear and specific. For example, if an individual performs poorly on the Vocabulary subtest of the WISC-V, a task that requires them to define words presented both aloud and in written form, there are several possible implications. First, the individual's word knowledge may simply be poor. However, they may actually have difficulty with verbal expressive ability, despite knowing intuitively what each word presented means. As this subtest is a measure of expressive vocabulary, another test of receptive vocabulary may be given (such as the Peabody Picture Vocabulary Test, 5th Edition [PPVT-5]), which assesses word knowledge separate from expressive ability. If performance on the PPVT-5 is adequate, then you can make a clear conclusion about the deficit being more specifically in expressive ability rather than word knowledge or long-term word memory. Each subdomain of verbal functioning should be presented clearly and separately, again always including implications of these deficits.

Executive Functioning. Executive functioning is a measure of processes related to the prefrontal cortex and controlling one's mental processes. The term executive functioning generally needs a note of introduction and definition in the report, as it is not as clear as the other terms, such as language and attention. While there are different ways to organize all of this information, one useful way is to include an overall section on executive functioning and then subsections on components that make up or are directly related to executive functioning. Because attention deficit hyperactivity disorder (ADHD) is often a potential hypothesis in assessments in which cognitive testing is primary, it is often useful to include detailed information on attention and related functions within this domain. As such, this section often includes four subsections: selective attention, sustained attention, working memory, and impulse control and related functions.

The first subparagraph can address *selective attention*. There are certainly reasons to disaggregate attention from executive functioning; for example, you may want to address attention earlier on in the write-up because it informs so many of the other skills to be assessed, such as memory. However, because attention and other executive functions are implicated in attentional disorders, it is often useful to include it within executive functioning. Selective attention refers to the ability to focus attention when there are distractors and distractions present. Similar to all the other subsections, specific details about the tests themselves, in addition to how the individual performed on each subtest, may not be necessary. Simply stating (a) what was assessed, (b) how the individual performed on that assessment, (c) whether there is evidence of impairment, and (d) implications of any impairment is usually adequate for these attention subsections (and others) of the cognitive functioning section.

A separate subparagraph can address *sustained attention*, or concentration. Some assessors choose to combine all the attention information into a single section, but it can be extremely useful to separate these two skills (selective and sustained attention) for the reader. Sustained attention has to do with maintaining attention across a longer period of time, especially on a task that is not very engaging or exciting. This is often assessed on continuous performance tasks by evaluating how response time to stimuli and accuracy decrease as the task progresses for an extended period of time. Becoming slower to respond, more inattentive, or even more impulsive as a task progresses may be good evidence of difficulty sustaining attention.

Another subparagraph can address *working memory*. Similar to attention, some assessors choose to separate this out and present it on its own, often because it is included as a separate index on many general intelligence tests. However, within the context of an assessment that is looking specifically at cognitive functioning, working memory represents a clear ability related to controlling one's own mental functions. As such, it is extremely useful to conceptualize it as a part of executive functioning. Also, similar to the term executive functioning, include

a clear definition of what working memory is, because it is different from memory. You should explain that this domain focuses on the ability to concentrate, take in and hold onto new information in short-term memory, and manipulate the information in some way to produce some result or reasoning outcome. While it requires attention, it includes a component of mental work to be done on the information; as such, it can be weak because of poor attention and also when attention is adequate.

Finally, you can include a subparagraph on *impulse control and related functions*. While you can decide to separate these out in a different way, and how you organize the information will often rely on what measures you have administered, much of executive functioning includes controlling one's own cognitive functions such that they inhibit their reflexive responses and deliberately change their strategies. Again, thinking hierarchically about these skills, it is often useful to begin with pure measures of cognitive impulse control, such as commissions on a continuous performance task; that is, can the individual simply inhibit their reflexive response? Then, you can present the abilities that build from this. You may have a measure of first controlling the impulse to respond in a certain way and then switching cognitive sets and strategies for responding, such as in the Number–Letter Switching task of the D-KEFS Trails. You may present a separate measure of first controlling impulses and then self-monitoring and adapting to feedback, such as in the Wisconsin Card Sorting Test (WCST). Whatever measures you choose to use, try to present it in a way that builds on the actual skills and abilities needed to complete the tasks given.

Cognitive Summary. This last paragraph of the cognitive functioning section is extremely important in pulling together all of the strengths and weaknesses presented in the previous paragraphs. Its goal is to make clear what is going on cognitively with the individual overall. Similar to the previous cognitive summary sections presented, this paragraph provides an opportunity to explain what the pattern of strengths and possible impairments may mean, including implications for diagnosis, prognosis, and treatment. Only interesting findings should be reported to simplify and clarify the picture being presented in the report.

Example

Cognitive Functioning

The client was administered several measures to assess his current cognitive functioning. It should be noted that these measures evaluate his cognitive ability under ideal conditions and in the most ideal context; as such, they represent his cognitive ability rather than how he actually functions in his daily life.

Based on the results of testing, the client's estimated IQ, prior to emotional or physical factors interfering with his functioning, falls within the high average range compared with others his age (WTAR, 79th percentile). His current FSIQ on the WAIS-IV fell within the average range compared with others in his age range (45th percentile). Based on the difference between his high average estimated previous IQ and his average current IQ, there is evidence of some decline in overall functioning.

Motivation. Two brief memory tasks (Double Digits and TOMM) were administered to assess the client's motivation for testing. The client's adequate performance, both falling within normal limits, indicates that motivational factors did not interfere with his performance on the testing.

Orientation. The client was alert and oriented to place, person, date, and situation based on his average performance on the MMSE.

Fine Motor Functioning. On measures assessing his ability to control his fine motor functioning deliberately and carefully, the client exhibited no difficulties in his actual motor ability, both in his deliberate control of his fine motor functioning (Bender-2 Motor subtest, 51st–100th percentile) and in his speed of fine motor movement (Trails Motor Speed, 75th percentile). His control of his movement is not currently impaired.

Visual Perception and Reasoning. On measures of visual perceptual ability, including nonverbal reasoning, visuospatial aptitude, and induction and planning skills on tasks involving nonverbal stimuli such as designs, pictures, and puzzles, the client performed within the average range compared with others his age (WAIS-IV Perceptual Reasoning Index, 50th percentile). Specifically, he showed no actual difficulty in his basic abilities with visual perception (Bender-2 Perception subtest, 26th–100th percentile; RBANS Line Orientation, 50th percentile), while his more complex nonverbal reasoning skills are generally average compared with others his age (WAIS-IV Visual Puzzles, 63rd percentile). His nonverbal reasoning ability is generally average for his age.

Visual–Motor Integration. The client's ability to integrate his visual understanding with his fine motor coordination is similarly average for his age. On tasks requiring him to copy complex drawings as precisely as possible without time restraint, which requires perceptual ability and the coordination between that ability and fine motor control, he performed in the average range compared with others his age (Bender-2 Copy, 55th percentile; RBANS Figure Copy, 63rd percentile). On a task requiring him to use blocks to recreate complex designs presented to him within a time limit, the client performed in the low average range compared with others his age (WAIS-IV Block Design, 16th percentile). It should be noted that, since it is timed, this task requires both visual–motor integration abilities and speed, and his processing speed is not strong. Similar to his visual–spatial reasoning ability and his fine motor skills, his integration of these two abilities is generally average, when speed and time are not factors.

Processing Speed. The client displayed significant weakness on tasks that required him to act within a time limit. Specifically, his ability to solve motor tasks quickly and efficiently was generally below average to low average compared with others his age (D-KEFS Trails Number–Letter Sequencing, 4th percentile; WAIS-IV Processing Speed Index, 14th percentile). His speed of performing nonverbal problem-solving tasks is weak for his age.

Memory. The client displayed some variation in his memory functioning, with some impairment in his ability to learn and recall complex information. Specifically, his ability to learn meaningful information was intact (RBANS Story Memory, 50th percentile; RBANS Story Recall, 59th percentile). However, less interesting information, such as a list of random words and geometric designs, was more difficult for him to learn and remember (RBANS List Learning, 4th percentile; RBANS list recall, 1st percentile; RBANS Figure Recall, 0.7th percentile; Bender-2 Recall, 14th percentile). The fact that he also struggled on a task to recognize whether words presented had been part of the word list learned earlier (RBANS List Recognition, 1st percentile) suggests that his memory deficit is primarily due to difficulty learning the information in the first place.

Language. Overall, the client demonstrated a relative strength in his language abilities when compared with other areas of cognitive functioning. His general ability to use and understand language fell in the high average range of functioning compared with others his age (WAIS-IV Verbal Comprehension Index, 76th percentile). Specifically, his general fund of vocabulary and knowledge fell within the average range (PPVT-4, 59th percentile; WAIS-IV Information, 63rd percentile), while his ability to express himself clearly is high average (WAIS-IV Vocabulary, 84th percentile). His abstract and complex understanding and use of language is also strong for his age (WAIS-IV Similarities, 84th percentile). His ability to understand and use language is strong for his age.

Executive Functioning. The client was administered several tasks to evaluate his control over his mental functions. He exhibited significant difficulties in his selective and sustained attention, though his abilities to work with information in his mind and control his impulses are adequate.

> *Selective Attention*. The client's selective attention, the ability to focus on one thing when there are distractions present and quickly determine correct (relevant) versus incorrect (irrelevant) stimuli, is somewhat variable. On very brief tasks of selective attention and speed, he performed generally adequately (D-KEFS Trails Visual Scanning, 50th percentile; WAIS-IV Cancellation, 37th percentile). However, on a much more boring task that lasted an extended period of time, the client's ability to focus when distractions were present was very weak (CPT-3 Omissions, 94th percentile [better than 6% of same-aged peers]; CPT-3 Detectability,

95th percentile [better than 5% of peers]). As such, he has significant weakness in his ability to focus his attention, especially when a task is longer and uninteresting.

Sustained Attention. The client's ability to sustain his attention across time on a boring, tedious task was similarly weak. Specifically, on a boring task that continued for an extended period of time, although his response time to stimuli stayed generally constant (CPT-3 HRT Block Change, 28th percentile [better than 72% of same-aged peers]), he became significantly more inaccurate as the task progressed (CPT-3 Omissions by Block Change, $p < .10$; CPT-3 Commissions by Block Change, $p < .10$). Similarly, on another boring task that continued for an extended period of time, he had some difficulty maintaining the rules for how to respond in his head as the task progressed (WCST-IV Nonperseverative Errors, 9th percentile). His ability to keep his attention focused for an extended period of time is weak.

Auditory Working Memory. On tasks that assessed his ability to concentrate, take in and hold onto new information in short-term memory, and manipulate the information to produce a result or reasoning outcome, the client's performance fell within the average range compared with others his age (WAIS-IV working memory index, 57th percentile). His performance was average across all tasks of auditory working memory, exhibiting no difficulties or deficits.

Impulse Control and Related Functions. On a task evaluating his ability to control his basic cognitive impulses, requiring him to respond to stimuli in the opposite way than his impulses would guide him, he exhibited adequate ability to control his behavior (CPT-3 Commissions, 37th percentile [better than 63% of same-aged peers]). His ability to first control his impulses and then apply a new strategy that was given to him to a task was also generally adequate (D-KEFS Trails Number–Letter Switching, 50th percentile). His ability to first control his impulses then monitor himself and adapt to feedback given to him in the moment was generally strong (WCST-4 Perseverative Errors, 84th percentile). His cognitive abilities to control his impulses and his other mental functions are generally adequate.

Cognitive Summary. The client's estimated possible IQ, prior to emotional or physical factors interfering with his functioning, falls within the high average range, whereas his current measured IQ falls within the average range, suggesting a likelihood of some cognitive decline. Specifically, he showed deficits in his attentional abilities and in his speed of processing information. Additionally, he showed deficit in memory, though this is likely due to his poor attention, as he exhibited difficulty learning nonmeaningful information. He showed strength in his ability to understand and use language.

Deficits in processing speed and attention can be the result of several different factors. Included in the possible causes of these weaknesses are attentional deficit (such as in ADHD), processing disorders, emotional disturbance, anxiety, low motivation, and personality characteristics like perfectionism. Motivational factors did not seem to be affecting his performance, so it appears that there are true processing and attentional inefficiencies present for him.

When Cognitive and Academic Functioning Are Primary When academic questions are primary to the referral, specifically when there is the possibility of a learning disorder, the structure of the cognitive functioning section will change slightly. If you are working from a discrepancy model, the specific strengths and weaknesses within cognitive ability and aptitude may not be as important. It is generally more important in this case to compare and contrast cognitive ability with academic achievement—that is, you will make a comparison between what an individual should be able to achieve and what they actually are achieving, specifically in school domains. However, a patterns of strengths and weaknesses (PSW) model will include both ability and academic achievement details. Either way, the cognitive and academic functioning section on these reports should have three major sections: cognitive ability, academic achievement, and cognitive summary.

The cognitive ability section can be identical to either of the formats presented previously, with multiple subsections related to subdomains of functioning. Because much of school achievement is highly dependent on

verbal functioning, it may be more important to highlight that verbal ability is critical in how an individual is expected to perform academically, if no other factors (like poor schooling or attention difficulties) get in the way. Verbal ability is especially important for reading and writing. Mathematics achievement, however, can be dependent on several areas of ability, including visual perceptual reasoning ability and working memory. Thus, it is important to report the results of these indices. However, it may be less important to report specific subtest strengths and weaknesses, again because the comparison of achievement and ability may be the focus when answering the referral questions rather than the minor variations within the ability domains. As such, the cognitive ability section may be significantly shorter than the cognitive functioning section of the previously presented report type.

The academic achievement section is based on achievement testing (e.g., Wechsler Individual Achievement Test, 3rd Edition [WIAT-III] or Woodcock-Johnson Tests of Achievement) and is often included when an individual is having difficulty in one or more school or academic domains. This section refers to how well the individual has learned and can apply skills in reading, writing, mathematics, and academic oral language. The academic achievement section can have a subsection for each of these four domains of school achievement. Within each subsection or domain of achievement, a concise report of how the individual performed on the tests of achievement should be presented in a similar way to the cognitive ability subdomain paragraphs. Each section should first state generally how the person performed across all tasks, such as that the client's reading achievement fell within the average range. Then, details should be presented, often hierarchically from most basic skills to most complex. Finally, there should be a sentence that summarizes what the findings may mean (e.g., the client is likely reading by word recognition more than phonetically, as they are comprehending adequately despite poor phonetic reading).

The final section is the cognitive and academic summary. This is where you can make preliminary conclusions about the likely presence or absence of a learning disorder. Although you cannot make the diagnosis based on the aptitude and achievement testing alone—other factors that must be considered include educational opportunity, sensory impairment, and history of educational supports and response to them—you can state clearly whether the achievement performance on the academic domains is significantly lower than would be expected given the individual's measured aptitude or ability. If achievement in all academic domains is equal to what would be expected, given ability, you can confidently rule out a learning disorder.

Example

Cognitive and Academic Functioning

General Cognitive Ability

The client was administered several measures to assess his current cognitive functioning. It should be noted that these measures evaluate his cognitive ability under ideal conditions and in the most ideal context; as such, they represent his cognitive ability rather than how he actually functions in his daily life.

In general, the client exhibited varied performance across his different domains of functioning. Specifically, while his perceptual reasoning and working memory both fell within the average range of functioning compared with others his age, he exhibited a significant strength in his verbal ability. He exhibited a weakness compared with his own overall functioning in his processing speed.

Verbal Comprehension. On measures of general verbal skills, such as verbal fluency, ability to understand and use verbal reasoning, and verbal knowledge, the client's performance fell within the high average range of functioning compared with others his age (WAIS-IV Verbal Comprehension Index, 76th percentile). He exhibited a significant strength on a task requiring him to explain the conceptual similarities between terms, which assesses his abstract understanding of language and use of words in complex and abstract ways (WAIS-IV Similarities, 98th percentile). His good verbal ability reflects intellectual ambition and knowledge gained from both formal and informal educational opportunities.

Visual Perception and Reasoning. On tests that measure nonverbal reasoning, visuospatial aptitude, and induction and planning skills, the client performed within the average range compared with others his age (WAIS-IV Perceptual Reasoning Index, 50th percentile). Tasks in this domain involve nonverbal stimuli such as designs, pictures, and puzzles and assess the individual's abilities to examine a problem, draw on visuospatial skills, organize thoughts, and create and test possible solutions. All the subtests that make up this domain fell within the average range of functioning.

Auditory Working Memory. On tasks that assessed the ability to memorize new information, hold it in short-term memory, concentrate, and manipulate the information to produce some result or reasoning outcome, the client's performance fell within the average range compared with others his age (WAIS-IV Working Memory Index, 57th percentile). All the subtests that make up this domain fell within the average range of functioning, suggesting adequate attentional and fluid reasoning skills.

Processing Speed. The client's performance on tasks that measure the ability to focus attention and quickly scan, discriminate between, and respond to visual information within a time limit fell within the low average range of functioning compared with others his age (WAIS-IV Processing Speed Index, 14th percentile). Specifically, the client struggled with his speed of drawing shapes matched to numbers as quickly and accurately as possible within a limited period of time, which requires both speed in processing information and in drawing (WAIS-IV Coding, 9th percentile). On a task that required less graphomotor (drawing) speed but assessed his speed of processing nonverbal information, his performance was also not strong but average for his age (WAIS-IV Symbol Search, 25th percentile). This suggests that his drawing speed is generally slow.

Academic Achievement

The client's academic abilities are varied, with generally adequate academic oral language use and mathematics skills but significant weakness in his reading and writing abilities and the speed with which he can perform basic mathematical operations.

Academic Oral Language. The client's academic oral language abilities are generally average for his age and level of education (WIAT-III Oral Language, 70th percentile). Specifically, his ability to understand and make sense of spoken language presented to him aloud and listen for details is average (WIAT-III Listening Comprehension, 63rd percentile), as is his ability to express academic information clearly and completely (WIAT-III Oral Expression, 73rd percentile).

Mathematics. The client's mathematical abilities are in the high average range compared with others at his level of education and age (WIAT-III Mathematics, 82nd percentile), though he exhibited some weakness in his speed and accuracy of performing basic mathematics. His knowledge of mathematical concepts is strong (WIAT-III Math Problem Solving, 92nd percentile), as was his performance when given unlimited time to solve progressively difficult math problems with pencil and paper (WIAT-III Numerical Operations, 84th percentile). However, he exhibited weakness in his speed and accuracy of performing basic arithmetic operations, which are extremely weak for his level of education (WIAT-III Math Fluency, 5th percentile).

Reading. The client exhibited low average achievement in reading for his age and level of education (WIAT-III Total Reading, 13th percentile). He showed low average basic reading skills, including both his understanding of phonetics (WIAT-III Pseudoword Decoding, 14th percentile) and ability to read actual words by recognition (WIAT-III Word Reading, 19th percentile). His ease, speed, and accuracy of reading aloud is also low average (WIAT-III

Oral Reading Fluency, 21st percentile). These skills have affected his ability with reading comprehension, which is also low average compared with others his age with the same level of education (WIAT-III Reading Comprehension, 18th percentile). He exhibited weakness in his reading abilities

Writing. Similar to his reading abilities, the client's writing abilities are in the low average range compared with the written expression ability of others his age and with his level of education (WIAT-III Written Expression, 14th percentile). The client's spelling ability is average (WIAT-III Spelling, 25th percentile). However, his ability to construct grammatical and meaningful sentences is weak (WIAT-III Sentence Composition, 5th percentile), contributing to generally below average ability to express himself clearly in an essay (WIAT-III Essay Composition, 4th percentile). His writing ability, similar to his reading ability, emerged as a significant weakness for him.

Cognitive and Academic Summary

Whereas the client's overall cognitive ability is generally average for his age, he exhibited specific strength in his verbal abilities and weakness in his speed of processing information. On tests of academic achievement, the client performed generally adequately in his ability to use academic language and in his overall ability in mathematics. However, he showed weakness in both reading and writing ability and in his speed of performing mathematics, suggesting the possibility of learning disorders.

Personality and Emotional or Emotional and Behavioral Functioning

The personality and emotional functioning (or for kids emotional and behavioral functioning) section of the report is one of the most difficult to write. Even after you have pored over all the data and conceptualized what is currently going on with the individual you have assessed, being able to present it in a clear and cohesive way poses a difficult challenge. For example, it is absolutely vital here to maintain a balance between not using too much jargon and making it sound professional. The purpose of this section is not only to present the conceptualization (discussed in depth in Chapter 4) but also to do it in a way that makes sense to the reader and is compelling enough to support the recommendations that will be made later in the report.

One strategy that has proven useful ahead of this section is to state clearly that, while there are certainly strengths and weaknesses in the individual's personality, emotional, and behavioral functioning, this section will focus on areas in need of support. In contrast to the cognitive functioning section, in which all areas assessed are presented and characterized as strengths or weaknesses, it is impossible to test every single emotional, personality, and behavioral variable and present them all. Tests are selected in this section to follow up on difficulties presented in the clinical assessment (interview, review of materials, behavioral observations). As such, this section will focus more on negative, problematic, or atypical functioning than on a balanced picture of a person's overall functioning. One way of articulating this is: "The client was administered several measures to assess her current personality and emotional functioning. It should be noted that the focus of these measures is on areas of need rather than a comprehensive overview of all personality and emotional strengths and weaknesses. As such, this section will necessarily focus on areas of her functioning that need support."

The first paragraph of this section should always address the overall characterization of the individual's current functioning—no test information should be included. Rather, you should simply present the story of all the themes and how they interact. Ideally, if someone were to read only this single paragraph of the report, the reader should come away with a good idea of what is occurring within the individual you assessed—that is, this paragraph should comprehensively present the narrative of what is going on for the individual that is affecting their functioning. Extremely important to this paragraph is that it should set out the structure for the remainder of this section. The story should flow clearly from theme to theme, and the subsections following this paragraph should flow directly from the story. For example, if the narrative explains that the combination of the person's

low self-esteem and lack of social support is currently contributing to depression, the subsections that follow should be (a) low self-esteem, (b) lack of social support, and (c) depression. The evidence for each of these will be presented in the subsequent subsections, but this opening paragraph has created a clear, logical structure for the rest of the personality and emotional functioning section.

Each subsequent paragraph—with its own subheading—should address the individual themes. Parallel to the cognitive functioning section, each paragraph should have the same structure, with a general opening sentence briefly outlining the entire theme, with no mention of any test, followed by the evidence supporting the theme itself. Even better, when possible, is to summarize the entire theme in the first sentence and to situate the theme within the overall conceptualization or narrative. Each individual subsection, based on each individual theme, should include a synthesis of test evidence in support of its conclusions. The key here is synthesis. While it may be easier to list all of the evidence by test (such as all the evidence from the Minnesota Multiphasic Personality Inventory—2 [MMPI-2], followed by all the evidence from the Rorschach, and so on), similar themes from each of the tests should be compiled and reported together. For example, in a theme presenting that an individual is struggling with emotional distress, rather than stating that the MMPI-2 revealed depression and anxiety, and the Personality Assessment Inventory (PAI) revealed depression and anxiety, it would be better to report that the emotional distress includes symptoms of depression (MMPI-2, PAI) and anxiety (MMPI-2, PAI).

In effect, each theme paragraph is presenting the reader with a concise synthesis of your conclusions, such that the reader does not have to do the work of sifting through all of the evidence to understand your reasoning. Often, general themes that emerge from one test (e.g., the PAI) can be elaborated on or illuminated by themes from another (e.g., a projective test, such as the Thematic Apperception Test [TAT]). For example, the PAI may reveal depressive symptoms, but the TAT may further indicate the nature and quality of the sadness by, for example, identifying themes of helplessness or hopelessness. In this way, you can present general themes first and then provide more specific details, even within a single paragraph or subsection on a major theme.

It is important in these paragraphs that evidence comes clearly and directly from the tests administered. If the PAI reveals something specific, simply state that your conclusion was supported by data from the PAI. Make it absolutely clear where each piece of information came from. That being said, you should then present an integration and synthesis of these findings—do not make the reader interpret. Additionally, test evidence should be primary in these paragraphs. While behavioral observations and clinical interview information (from the presenting problem or background section) may be directly related to the theme, use these data only as supporting evidence later in the section.

An even better strategy is to use the test evidence to explain why or how either the individual may have reported something or you may have observed something. For example, if testing revealed that a man has a personality tendency toward passive-aggressive behavior, and during the testing he made sarcastic remarks about how stupid testing is, you might state toward the end of the paragraph: "This passive-aggressive tendency may explain why throughout testing he made sarcastic remarks and rolled his eyes when new tasks were presented." This way, the behavioral observation is presented as an additional piece of data to support the theme, but it is secondary to test data, which should always take precedence.

These theme paragraphs should be fair and tempered, such that you are not overstating your conclusions. Do not be afraid to present both positive and negative attributes within each theme subsection. While you may feel strongly about a certain conclusion and interpretation, make sure that the test evidence truly supports it. If not, temper your conclusions with words such as *likely* and *may*. For example, if the examinee exhibits feelings of worthlessness on several tests and you feel strongly that the feelings are probably long-standing and pervasive because of what they have reported about the nature of their early childhood environment, you could state, "It is likely that these feelings of worthlessness began early in her life, given her family circumstances." Or you could state, "These current feelings of worthlessness may have begun early in her life, given her challenging

family circumstances." However, try not to be too tentative about conclusions drawn from a great deal of data. That is, if something like low self-esteem emerges across methods and measures, do not state that the individual "may struggle" with low self-esteem. State clearly and confidently that the individual "is struggling" with low self-esteem.

The final sentence of each of these paragraphs can again connect the themes back to the overall conceptualization or narrative or to the following theme, such that it places the entire subsection back into the context of the individual's overall functioning. For example, the final sentence of a paragraph on a theme about anxiety may place it in the context of the theme of social isolation that follows it: "This anxiety not only causes internal discomfort, but it also contributes to her difficulty interacting comfortably with others."

Example

Personality and Emotional Functioning

The client was administered several measures to assess his current personality and emotional functioning. It should be noted that the focus of these measures is on areas of need rather than a comprehensive overview of all personality and emotional strengths and weaknesses. As such, this section will necessarily focus on areas of his functioning that need support.

The results of the assessment revealed that the client is harboring extremely resentful and angry feelings about the very real racist society in which he was raised. Given his upbringing, he has adopted an avoidant style of coping with the world, such that he tends to deal with his emotions and difficult external situations by avoiding thinking about or engaging with them. Additionally, to decrease the number of situations he needs to avoid, he has adopted a style of perfectionism, attempting to control as much as possible and not be surprised by external events. Thus, his anger and resentment toward the racist world he grew up in is avoided. Avoiding dealing with his anger, however, has led to several difficulties. Namely, because he works so hard to keep his angry feelings out of his awareness and wants everything to be perfect, he has developed some anxiety, related to fear of having to deal with these difficult emotions and circumstances. This anxiety has generalized to many fears. Additionally, his avoidant and perfectionistic styles have contributed to him having developed low self-esteem and some emptiness. While his avoidant style was useful growing up, to cope with the racist treatment he experienced and his unsupportive parents, his anger and resentment are now so great that they spill out in explosive, angry outbursts. His anxiety, low self-esteem, and explosive outbursts contribute to difficulty relating to and becoming close with other people.

Resentment. The client is harboring a great deal of anger and resentment toward the world around him, specifically because he feels that he has been discriminated against his whole life. Specifically, he struggles with a pervasive underlying feeling of anger and resentment toward the world in general (MMPI-2-RF, R-PAS). Additionally, he has developed some attitudes that are oppositional toward others he thinks are treating him unfairly (MCMI-IV, R-PAS). Specifically, his anger seems to stem from racial sources (TAT). From years of actually being discriminated against and treated unfairly, growing up in a predominantly White Southern town, he began to harbor resentment for the fact that he was treated differently and, in actuality, unfairly. He reported feeling discriminated against while growing up and currently having a "racist" boss, which is stirring up his longstanding feelings of anger. However, he never learned how best to express his anger, and he does not generally process it, given his avoidant style of coping with it.

Avoidant Style. The client has developed a style of dealing with the world and his own emotions by avoiding thinking about or engaging with them, a strategy that served him well growing up but is breaking down somewhat now. Rather than dealing with situations, difficulties, and feelings that come up in his life, he tends to avoid them

and distract himself (MMPI-2-RF, MMPI-2, IASC). He does not have adequate resources to cope with his own emotions even if he wanted to (R-PAS, TAT). Having grown up with parents who encouraged him not to process his emotions and to "buckle down" and focus on his studies rather than discuss difficulties in school, it was adaptive and appropriate for him to develop this avoidant style. The result now, however, is that his resentment continues to build up inside him, and he avoids dealing with it.

Perfectionism. One of the ways the client tries to avoid dealing with negative emotions or circumstances in his life is by being extremely perfectionistic so that there are fewer problems in his life. He has a tendency to be overly concerned with being correct and perfect, overly bound by rules and regulations in everything he does (MCMI-IV, MMPI-2-RF). This tendency serves the purpose of making sure he is rarely surprised by anything (MCMI-IV, MMPI-2-RF); the more control he has over situations and the less error there is in what he does, the more predictable his life can be. This tendency is present across contexts, from work to interpersonal relationships, over which he tries to maintain strict control (TAT). When his control over situations fails, it often brings up emotions that he is either unwilling or unable to cope with due to his avoidant style or significant anxiety.

Anxiety. The client's avoidance of emotions, especially his anger, has contributed to significant anxiety; the more he avoids dealing with his anger, and the more it increases with everyday instances of discrimination, the more he fears that he will have to at some point cope with this scary emotion. The client struggles significantly with a great deal of anxiety (MMPI-2-RF, R-PAS, MCMI-IV, TAT). Specifically, he fears all the complexities of the outside world (MCMI-IV, TAT), and he spends a great deal of mental energy trying to simplify situations in his mind and make them more concrete and easier to understand (R-PAS). The complex world, full of difficulties to cope with, is overwhelming to him (MCMI-IV, TAT). This general anxiety about the unpredictable nature of the world likely explains his reported fears of dying and constant thoughts of how it might happen.

Low Self-Esteem. In addition to anxiety, his avoidant style and general anger contribute to low self-esteem and feelings of emptiness; because he was unable to process his emotions and situations growing up, he was unable to create a positive and stable self-image, including a healthy racial identity. Overall, the client is highly self-critical (MCMI-IV, MMPI-2-RF, R-PAS). However, he tends not to show this low self-esteem to others, trying to avoid it by employing a defensive technique of appearing self-confident and self-assured (MCMI-IV). This self-confidence, however, is merely a mask for his low self-image (TAT). He struggles with an underdeveloped identity, especially his racial identity, which contributes to poor self-image (MCMI-IV, TAT, IASC). His low self-esteem explains his self-deprecating remarks during the testing, when he seemed to genuinely feel that he was performing poorly and saw himself negatively because of that poor performance.

Explosiveness. The client's way of coping with his own anger and negative emotions, avoiding them and not addressing them at all, is currently not working; his level of anger is too great for him to hold in, and it is coming out explosively in different situations, beyond what the situations actually deserve. He has a tendency to act impulsively when he feels out of control of situations (MCMI-IV, R-PAS), and these impulsive acts can take the form of exaggerated anger (MMPI-2-RF). Moreover, he has a fear that he cannot control his anger due to experiences when he felt out of control (TAT). This supports his report that he has been getting disproportionately angry with others, including his friends, for relatively minor annoyances. This explosiveness has also contributed to his anxiety and low self-esteem, and together these contribute to difficulties with other people.

Interpersonal Difficulties. Related to his avoidant style, perfectionistic tendencies, resentment toward the world, and the resultant anxiety, low self-esteem, and explosive behaviors, the client has difficulties maintaining significant relationships with others. It should be noted that he has good social skills and a highly developed understanding of social norms and appropriate behavior (R-PAS, MCMI-IV). However, he has difficulties sustaining significant relationships (R-PAS, MMPI-2-RF, IASC). He both finds it difficult to trust people and also fears the strong feelings associated with interpersonal relationships (TAT). Given his avoidant style and perfectionistic tendencies, the unpredictable nature of relationships and the feelings they provoke create anxiety within him (TAT, MMPI-2-RF). While he is able to sustain his relationship with some friends, currently, his angry outbursts at them seem to reflect both his anger exploding out of him and a way of distancing himself from these significant relationships.

Vocational Functioning

In reports in which there is a vocational question and you have administered vocational interest (and even aptitude) tests, you will likely want to include a separate, short section on vocational functioning. Major tests of vocational interest (e.g., Strong Interest Inventory [SII]) often include professions of individuals with similar profiles to the person being assessed, a breakdown of vocational area priorities (such as with the RIASEC model), and even priorities in terms of work environments. All of these are important to include in this section, though later (in the summary section), you will synthesize these findings with the cognitive and personality findings in order to make a realistic recommendation based both on interests (presented here) and capabilities (both in terms of cognitive abilities and personality style). This section is particularly straightforward in terms of reporting what emerges from whatever vocational tests you have given. As you can see from the example that follows, not much interpretation is necessary when reporting the vocational interest findings.

Although this section seems relatively straightforward, assessments that include vocational testing are often more complicated. The ultimate goal of vocational assessments is to synthesize data from four areas—vocational interests, cognitive aptitude, work–style preferences, and personality functioning—to make recommendations for jobs and careers in which the client is most likely to succeed. The interest and work–style section presented here is only the first step of this entire process.[2]

Example

Vocational Functioning

The client was administered a test of interest in different domains of work functioning (SII). In terms of general occupational themes, not only does he tend toward jobs that involve researching and analyzing, but he also feels that he wants to be in a position to manage others and their work. In terms of his preferences for his work environment, he prefers to work alone and dislikes taking risks, but he is highly comfortable taking charge and motivating others, expressing his opinions easily. The testing suggested careers of possible interest like computer analyst positions, teaching math or science, or working in the medical field.

Summary

If audiences read only one section of a report, it is most often the summary section. The most important rule of the summary section is that it should not include any new information. Without exception, any statements made about current functioning, behavioral observations, or anything else must have been presented previously in the report. Even though you may be synthesizing information in a slightly new way—for example, by integrating the emotional findings with the cognitive findings—the information presented about each of the individual domains (e.g., emotional, cognitive) should have been presented previously in their respective sections.

The structure of the summary should mirror the structure of the report. The first paragraph should include a few points of description of the individual being assessed and the referral questions and presenting problems. The second paragraph should clearly restate the most important cognitive findings. The third paragraph should be a retelling of the narrative that began the personality and emotional functioning section. At the end of this paragraph can be a synthesizing statement pulling together the cognitive and emotional findings. If there was vocational testing, the next paragraph should restate the most important findings from the vocational interest testing and should integrate the cognitive and personality findings into a coherent presentation of what the individual would be both interested in and have aptitude for doing.

[2]For a more detailed and comprehensive review of vocational assessment, see Walsh, Savickas, & Hartung (2013).

Example

Summary

Mr. Diddlewatt is a light-skinned, 34-year-old African American man who was referred for an assessment by his current therapist of 3 years because he has reportedly become "more hostile" lately. He also reported constant fears of dying and thoughts about ways it may happen in addition to difficulties sleeping, some loss of energy, poor appetite, and recently having stopped socializing with everyone except some close friends.

Cognitively, the client has experienced a significant decline in his functioning overall. Specifically, he showed deficits in his attentional abilities and in his speed of processing information. Additionally, he showed deficit in memory, though this is likely due to his poor attention, as he exhibited difficulty learning non-meaningful information. He showed strength in his ability to understand and use language.

Emotionally, the client is harboring extremely resentful and angry feelings about the very real racist society in which he was raised. Given his upbringing, he has adopted an avoidant style of coping with the world, such that he tends to deal with his emotions and difficult external situations by avoiding thinking about or engaging with them. Additionally, to decrease the number of situations he needs to avoid, he has adopted a style of perfectionism, attempting to control as much as possible and not be surprised by external events. Thus, his anger and resentment toward the racist world he grew up in is avoided. Avoiding dealing with his anger, however, has led to several difficulties. Namely, because he works so hard to keep his angry feelings out of his awareness and wants everything to be perfect, he has developed some anxiety related to fear of having to deal with these difficult emotions and circumstances, which has generalized to many fears. Additionally, his avoidant and perfectionistic styles have contributed to him having developed low self-esteem and some emptiness. While his avoidant style was useful growing up, to cope with the racist treatment he experienced and his unsupportive parents his anger and resentment are now so great that they spill out in explosive, angry outbursts. His anxiety, low self-esteem, and explosive outbursts contribute to difficulty relating to and becoming close with other people.

In terms of work, not only does he tend toward jobs that involve researching and analyzing, but he also feels that he wants to be in a position to manage others and their work. In terms of his preferences for his work environment, he prefers to work alone and dislikes taking risks, but he is highly comfortable taking charge and motivating others, expressing his opinions easily. The testing suggested careers of possible interest like computer analyst positions, teaching math or science, or working in the medical field. Given his strong verbal functioning and his perfectionistic tendencies, it is likely that he would succeed in careers like these, though his high standards for others and anger may contribute to some problems as a manager.

Diagnostic Impressions or Conclusions

Generally, in a clinical assessment, a full diagnosis should be included for each individual assessed. Regardless of your personal feelings about formal diagnosis, this is the standard professional language we currently use to communicate with others in the psychological community. Avoid using "diagnosis deferred," as this generally indicates that you simply did not do enough testing. A thorough assessment should always yield a clear diagnostic picture, and if it does not then you should consider doing more testing in order to accomplish this goal. The format for the diagnostic impressions can be found in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5*; American Psychiatric Association, 2013) or *International Statistical Classification of Diseases and Related Health Problems, 10th Edition (ICD-10*; World Health Organization, 2004).

In general, the structure of paragraphs in this section should be fairly simple and straightforward. Begin with a clear statement that the client currently meets criteria for the specific disorder (each diagnosis should get its own paragraph). Include the diagnostic codes for the disorder in that sentence. Then follow up with a clear and succinct list of diagnostic symptoms and criteria that contribute to the diagnosis. These should be aligned both with

the data presented in the report and the listed criteria in the diagnostic manual being used. As with the summary section, no new information should be presented here. If you are listing a symptom or criterion, it should have emerged somewhere else in the report as well (even if just in the presenting problem or background sections).

At times, when there were specific diagnostic questions raised in the referral questions that were not supported in the assessment, a paragraph describing that the client does *not* meet criteria for that disorder is useful, including specific reasons that you have not applied the diagnostic classification. It is often useful to begin this paragraph with the phrase, "It should be noted. . ."

There are circumstances under which a goal of the assessment has nothing to do with diagnosis. For example, some vocational assessments or pre-employment evaluations are really meant to make some general conclusions (followed by recommendations) that are not formally diagnostic in nature. As such, you can include a Conclusions section instead of a diagnosis section.

Example

Diagnostic Impression

Currently, the client meets criteria for major depressive disorder, recurrent, moderate (*DSM-5* code 296.32; *ICD-10* code F33.1), with anxious distress. Specifically, he currently exhibits depressed mood most of the day for most days (by his own report) and diminished interest in activities, sleep disturbance, psychomotor retardation, feelings of worthlessness and low self-esteem, and recurrent thoughts of death. Additionally, he is struggling with significant anxiety, and he has struggled with similar episodes in the past.

Additionally, the client currently meets criteria for attention deficit hyperactivity disorder, predominantly inattentive presentation (*DSM-5* code 314.01; *ICD-10* code F90.0). Specifically, he has difficulties with sustaining attention, being easily distracted, missing details, being disorganized at times, is forgetful, and avoiding tasks that require sustained attention.

Recommendations

In the end, the entire purpose of psychological assessment is usually to provide clear, direct, specific, and useful recommendations for improving an individual's functioning and life. It is vitally important to make this section extremely clear, such that it can be easily followed by any reader, remembering that your audience may include other mental health professionals, the individual who was assessed, parents or guardians, or school personnel, among others. Much like other sections, the format of this section will vary from psychologist to psychologist. However, there are two overarching considerations when it comes to treatment recommendations. First, are the recommendations aligned with data and conclusions of the assessment? Second, are they clear, specific, and reasonable?

When it comes to ensuring that the recommendations are aligned entirely with the data and conclusions of the assessment, three considerations are recommended. First, there are a few diagnoses (many fewer than you might think) that have a single, specific evidence-based recommendation associated with them. For example, currently specific phobias have a single treatment that has a strong evidence base behind it, exposure therapy. Adult ADHD has only one treatment with strong evidence: cognitive behavioral therapy (CBT). The websites for the Society of Clinical Psychology (div12.org) and the Society of Clinical Child and Adolescent Psychology (effectivechildtherapy.org) are good resources for finding evidence-based treatments for specific disorders. However, most

disorders do not have a single, specific treatment modality that stands out as most effective, including depressive and anxiety disorders and even borderline personality disorder (BPD). While dialectical behavior therapy (DBT) is certainly the most widely known and talked about treatment for BPD, there are currently three other types of therapies with research support, and you should resist making a DBT recommendation simply because that is what you are aware of.

When a single treatment modality is not clearly recommended for the diagnosis, try your best not to be overly biased about treatment orientations. That is, certainly there are more psychodynamically trained individuals who see the benefits of this form of treatment across the board, just as more CBT folks may be biased more toward recommending CBT. There is a great deal of research on client characteristics and their impact on treatment success, helping differentiate which types of treatment are more and less likely to be successful. Some of these client characteristics include their readiness to change, their level of subjectively felt distress, their level of general resistance, and others. A summary of the research in these areas is presented in the *Handbook of Psychological Assessment* (Groth-Marnat & Wright, 2016) chapter on treatment planning. Each client characteristic variable helps you make an informed, evidence-based decision about what kinds of treatment are likely to be most effective, and you should consider all the variables when making your decision. For example, all the variables may be pointing toward CBT being the most effective treatment, but if you find that a client is in a precontemplation phase in the stage of change model, CBT is contraindicated and not likely to be too effective. Someone in this stage will be much more receptive to motivational interviewing, which will help them move to a later stage of change, at which point CBT will be more effective. It is strongly recommended that client characteristics be considered when ultimately deciding on treatment recommendations.

If and when neither the diagnosis nor the client characteristics point you toward a single preferred treatment modality recommendation, the third consideration relates to your conceptualization. When the diagnosis is something emotional or personality oriented, you have developed a sophisticated, psychological theory–driven conceptualization of what is going on for the person. You can use this to determine specific recommendations, including how to prioritize them. If you have underlying problems related to understanding the self (identity) and others contributing to social withdrawal, for example, you could easily expect that therapeutic work on better understanding the self and others should reduce the level of social isolation. It is often helpful to think about targeting the more underlying issues, as resolving them should resolve some of the more outcome symptoms. This is of course not the case when there are very serious or distressing outcome symptoms, like suicidal ideation, which would need to be a first target of treatment. But otherwise, you can make recommendations that target the different themes from your conceptualization. Analogous to the Modular Approach to Therapy for Children With Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC; Chorpita & Weisz, 2009), you may recommend a modular approach of different interventions to target different themes from within your conceptualization.

Once you have decided on the actual treatment and other recommendations, the next question to ask is if they are presented in a way that is clear, specific, and reasonable. Clarity can be achieved by using clear formatting. When deciding how to organize recommendations, consider who will be reading the report and how they would be most likely to benefit from the information being presented. For example, in a child evaluation, if you have recommendations for the school, for parents, and for treatment for the child across multiple diagnoses, think about how school personnel will read the report. Rather than presenting recommendations by diagnosis (e.g., multiple recommendations for a learning disorder diagnosis, multiple for ADHD, and multiple for anxiety), try to collapse all the school recommendations together, all the parent ones together, and so forth. Additionally, using bullet points in a recommendations section can help with clarity.

When it comes to specificity, ensure that all the work from an assessment is worth it for a client (or their family). A recommendation like, "The client should get therapy," may be clear and reasonable, but it is not specific enough; you have so much information from an assessment that can help an individual improve their life, it is a waste not to use it. Think about how specific a particular client will need a recommendation to be made, such that they will not make a mistake when trying to follow through with it. Vague treatment recommendations can lead a client to unethical or problematic forms of treatment. Some clients will need the recommendations to be so specific as to include a specific referral, including a name, phone number, and website, to help them land where they will be most helped.

Finally, always consider how reasonable the recommendations are. For example, if you recommend that an individual take a 4-month vacation, that may be clear, specific, and even aligned with your data and conclusions; however, in most cases it will not be feasible, given the constraints of a working person's life. While this example may seem clear-cut, many times it may be more difficult to discern. Frequently recommendations are made for types of treatment that individuals may not have access to. For example, recommending a DBT program for someone who has BPD may, in theory, be the best course of action. But if there are no DBT programs available to the person, for geographic or financial reasons, the recommendation is not a reasonable one.

Example

Recommendations

Given the client's current functioning, the following recommendations are being made:

- The client should consult with a psychiatrist regarding his depression and anxiety. Although medication is not being recommended, a consultation with a psychiatrist should be undertaken to see if psychotropic medication may be helpful with his current depression.
- The client should continue in his current weekly talk therapy. Issues that should be addressed in therapy include:
  - processing negative emotion, especially his anger toward his parents and toward the racist world he both grew up in and currently lives in
  - helping build a positive self-identity, including his racial identity
  - decreasing his anxiety through cognitive-behavioral techniques
  - decreasing his perfectionistic tendencies and increasing his ability to cope with less-than-perfect results, using exposure techniques
  - increasing his capacity for closeness with others, which interpersonal therapy (IPT) or relational psychodynamic techniques can help him with so he learns to tolerate the unpredictable nature of close relationships
- Career counseling may be useful in terms of helping the client decide if he wants a career change and how best to go about it.

Signatures

All reports should be signed and dated, both by you as the assessor and by your supervisor, who should be a licensed psychologist (if applicable). The only major concern is that signatures should not be on a separate page

by themselves. For legal reasons, there must be at least some other content text on the page with the signatures to ensure that the signature page cannot simply be detached and easily placed onto an altered report.

Example

Signatures

_____ _____

Emily B. Student, MA
Assessor

Date

_____ _____

A. Jordan Wright, PhD
New York State Licensed Psychologist
Supervisor

Date

Appendices

Although you may or may not choose to include an appendix in your report, should you elect to include one there are two types that may be particularly useful. First, you might include an appendix with the scores from each of the cognitive measures (and even some other measures, like adaptive functioning). This is especially useful for neuropsychological screenings and when the referral source is another psychologist, who may be interested in looking at the raw data as a quicker language for how the individual is functioning, rather than reading the entire report. However, where this is not the case, you should exercise caution in including these scores, given that their interpretation is legally and ethically reserved for licensed psychologists and those under their supervision. Consider an example of a man with an FSIQ from the WISC-V of 90. You may not have reported this in the report, especially if their verbal comprehension is a 130 and the FSIQ is being pulled down by presently impaired processing speed, which in this case was impaired due to depression. The FSIQ of 90 is an underestimate of this individual's functioning, but they, their parents, or their school may not realize this if they look at the appendix and see this number. In this case, listing the data from the cognitive tests could actually do more harm than good. As you would in other areas of clinical practice, you should exercise sensitivity and consideration when deciding whether or not to include an appendix of cognitive scores.

The second appendix that may be useful is actually more accurately referred to as an addendum. This addendum is a general progress note regarding the feedback session, and it is useful when the individual being assessed had a strong, specific reaction to the assessment feedback. Others who read the entire report, such as the individual's therapist, may find this information useful. You can include the reactions of the person being assessed, including any areas that they disagreed with or reacted poorly to. Also include the general demeanor of the individual during the feedback and a plan for any follow-up regarding recommendations. This addendum should take the form of a progress note in whatever structure is appropriate for the setting in which you are conducting the assessment.

Example

Appendix: Addendum—Feedback Session

1/21/2020: Feedback Session, 60 minutes

Mr. Diddlewatt came in for his feedback session. He was in generally good spirits, smiling and friendly toward the assessor. While receiving feedback, he paid very good attention, interrupting to ask questions throughout whenever he did not understand a concept. While he reported agreeing with most of the report, he reported disagreeing with the idea that he may need psychotropic medication. While he remained mostly resistant to this idea, he did agree to follow up with his therapist about the possibility of consulting a psychiatrist, "if she agrees that it would be helpful." He agreed to all other recommendations and was given two copies of the report—one for himself and one for his therapist. Further, he gave consent for the assessor to call his therapist and give her the feedback verbally, in addition to the copy of the report.

Summary

The psychological assessment report should present a clear, cohesive, and comprehensive argument that supports your conclusions and, most importantly, your recommendations. The recommendations made in the report should stem directly from (a) what you know about the client and what is going on for them and (b) what you know about the research on treatments of choice for different disorders, clients, and specific problems. Taken together, the report from start to finish should flow and be relatively easy to read, such that you have minimized anything disjointed within it. Perhaps the greatest challenge is the balance between making the report readable and accessible, but also making sure it sounds professional. Supervision is key in terms of editing first reports. Once you have written a good number of reports, however, you can use statements and even entire sections from previous reports in writing up new reports. There is no ethical dilemma when plagiarizing your own past reports (or even language from this chapter!)—there simply is no need to reinvent the wheel. If you have stated before that someone has a weakness in verbal functioning, for example, you do not need to find a new, interesting way to say this. Find your old report, and copy and paste that section into your new report. The only danger is that you must reread and edit these sections to make sure they make conceptual sense for the individual you are currently assessing.

CHAPTER 6

Providing Feedback

Providing feedback on psychological assessments can be a very delicate and difficult process. As with the rest of the assessment process, but often even more so, it requires both the technical skill of an assessor and the therapeutic skill of a clinician. The feedback session, more than any other session in the assessment process, is a hybrid between a testing session and a therapy session. The key to effective feedback resides both in the content of the feedback and in the process, which requires all the skills of an effective therapist. This process is made particularly challenging by the fact that it is unlikely that a therapeutic alliance has been firmly established over the relatively brief course of the testing. An effective feedback session will include clear and specific feedback from the assessment, all of which should culminate logically in useful and specific recommendations.

Just as important, an effective feedback session will include constant checking in with the individual receiving feedback to ensure that they are adequately comprehending and following the results and recommendations and to empathically gauge any reactions and feelings that they may be having. Receiving feedback about your functioning from a relative stranger who purports to know things about you that you might not even be aware of is an understandably bizarre and awkward process. For this reason, many individuals receiving feedback will have feelings about the feedback, ranging from relief to ambivalent to strongly negative, and most often mixed. The most effective feedback sessions both permit and encourage this dynamic interplay between the information being presented and the individual receiving it.

The process that takes place between the time of finishing the assessment and report and actually providing live feedback should be characterized by conscious, deliberate, and thoughtful planning. There are several decisions to be made about how the feedback session will occur. You should always think about each of these issues carefully, doing your best to anticipate how each may affect the individual receiving the feedback.

Before the Feedback Session

To Whom Am I Giving Feedback?

In general, you will give feedback to the person you assessed. There may be exceptions to this rule, but when there are, the circumstances generally dictate to whom you give the feedback. That is, you will generally give feedback to whoever your client is, whether that is the individual you are assessing, a court, an agency, or someone else. For example, if you are doing a forensic evaluation for the court, the court is your client and will receive the feedback. If you are charged to do a custody evaluation, an inpatient evaluation, or some other assessment by a third party, this third party generally dictates to whom you give feedback.

Conducting Psychological Assessment, First Edition. A. Jordan Wright.

Considering What Will Be Most Helpful

Often when you do a psychological assessment of an individual, they have come in for help and specific recommendations, which may include providing beneficial feedback not only to the individual but also to others involved in that person's care. Specifically, in consideration of what might be of greatest benefit to the person being assessed, you might ask yourself, "Are there others who can be enlisted to assist in the goal of improving this person's overall functioning?" If so, then you might consider giving feedback to these individuals as well. For example, if you are making a recommendation for psychotherapy to address specific issues, the current or eventual therapist would likely find the specifics of the report (provided in written or verbal format, at the assessor's discretion) to be useful in the treatment of the individual. If you are recommending a psychiatric consultation, giving the psychiatrist the feedback would likely improve the care of the individual by providing them with additional information to assist in diagnostic clarification, for example.

If there are medical issues in addition to psychological problems and your recommendations include the coordination of medical and mental health care, giving feedback to the individual's doctor will improve the likelihood of this outcome. For example, a diabetic individual who presents with somatic symptoms beyond what would be expected from the diabetes alone can truly benefit if their primary care physician and mental or behavioral health professional communicate often and openly. Because it is often very difficult to parse out which symptoms are related to the diabetes and which may be more psychosomatic in nature, coordinating between health care providers, each of whom has expertise in different areas of this individual's functioning, improves the chances of treating them effectively.

For all of the providers to be on the same page, giving feedback to each of them (in addition to the individual who was assessed) may be warranted. Obviously, to provide this kind of additional feedback you must get permission from the client (which again could be the individual being assessed, a court or agency, or someone else), generally in the form of a signed release form. This ensures that you may legally give feedback to someone other than your client, and ideally it ensures that the client understands why giving feedback to a third party would be useful.

If a colleague has requested the assessment, whether it is to help inform a treatment that has stalled for some reason or to provide clarification on the issues impacting their client, you may be able to provide feedback to the individual you are assessing and to their therapist concurrently. Having a person's therapist in the feedback session with you and the person you have assessed has several benefits. First and foremost, the assessment feedback can serve as the basis of a shared language and experience between the individual and the therapist, such that, regardless of how they feel about the feedback itself, they at least know what exactly was said in the feedback session.

In addition, as the therapist and the client will generally have a stronger working alliance, the therapist can help to clarify any aspects of the feedback in a way that can be more easily heard by the individual. Furthermore, this process can help avoid any splitting between providers, which can often happen when there are two distinct mental health providers involved. If you and the therapist appear as a clear, collaborative team in the feedback session, there is less room, as a result of the feedback, for the person who was assessed to idealize one and devalue the other. This is not foolproof, obviously. This risk is always present when a third person is involved in the therapeutic dyad. But the more collaborative and cooperative the two mental health providers can be, the less likely this splitting will occur.

Diagnostic Considerations

When deciding to whom you should give feedback, diagnosis may also be a consideration. Although this is a complicated matter worthy of a more extensive explanation than this chapter affords, a general rule of thumb is that the decisions as to who gets feedback and exactly how become more difficult when a personality disorder is involved. Again, as some form of psychotherapeutic treatment will likely be recommended, providing feedback to the mental health provider can enable them to use feedback to provide better treatment, in general.

Including the mental health provider in the feedback session may be especially important in the case of personality disorders. This is because the individual who was assessed and given feedback may often disagree with, take offense to, or somehow distort the feedback to fit in with their self-image. The feedback can often be distorted as it is passed verbally from them to their provider—it can become a game of telephone, in which whispers are passed from one person to the next, becoming increasingly distorted until the content itself is almost unrecognizable. Thus, the more direct feedback you can give to the client's providers, the better.

What makes this difficult in the case of several personality disorder diagnoses (most notably the Cluster B personality disorders) is that the person you assessed may simply not want the feedback given to their providers. Legally and ethically, you generally cannot give feedback to anyone other than the individual you assessed without their willing, informed consent (with the exception of special cases, such as court-mandated evaluations). Thus, an additional task and challenge in feedback sessions becomes providing a clear and concise rationale to the individual for how they will benefit from your extending the report or verbal feedback to their mental health providers.

Another example of when a diagnosis may influence who will get the feedback is when a young adult comes in for an evaluation and is ultimately diagnosed with a developmental disability, such as intellectual developmental disorder (IDD). The ultimate take-home message with an IDD diagnosis is that the individual cannot safely and wisely make major decisions for themselves, such as financial and medical decisions. As such, it is often extremely useful (if not necessary) to involve a caregiver in the feedback session, since one recommendation is often that they apply for legal guardianship over the person with IDD. Never the easiest feedback to give, feedback sessions in this case really should include a family member whenever possible.

Developmental Considerations

When the individual assessed is a child, there are several key factors to consider when deciding who should receive feedback. First, it is generally best to give some sort of feedback to the child assessed. Because many children do not clearly understand the purpose of assessment, you want to avoid making it even more mysterious by having no clear outcome. Bearing in mind the age of the child, you must strategize carefully as to how best to give the feedback. For very young children, for example, it generally makes sense to give feedback to parents or guardians alone first, without the child present, so that you can be clear with the feedback and the parents or guardians can ask candid questions. Then, it may be useful to give feedback to the child with the parents in the room, all together. In this case, the parents can hear exactly what kind of language you are using with their child, so that they know how to talk about it later with them. Additionally, having parents in the room may make feedback less frightening or overwhelming for the child.

On the other hand, for preadolescents and adolescents, although both the child and their parents or guardians will need to receive feedback, the structure of the sessions will likely be quite different from that required for younger children. One option that tends to work well is to give feedback to the adolescent first, alone, followed by inviting the parents into the room with the adolescent to give them the feedback all together. This can mitigate some of the adolescent's typical (and reasonable) fears that you will be disclosing something different to their parents than you did to them; the parents will never receive feedback without the adolescent present.

You can also enlist the adolescent to help give their parents feedback in a way that they think they will best be able to understand and take in. This strategy can empower the adolescent to have some control over how feedback is given to their parents so they will hopefully feel less undermined or betrayed by the information you must disclose to the parents. The first half of the session, with the adolescent alone, can also be treated as a heads-up for what you will be disclosing to the parents, constantly checking in with the adolescent to see how they will react to this information being shared with their parents. Again, the key is anticipating how giving feedback to other important people may affect the individual who was assessed, especially given their age and level of development.

Do I Give a Copy of the Report?

Although there is no ethical or legal rule about whether to give the written report to the person you have assessed (though the setting in which you work may have some guidelines), one guiding principle that may be helpful is to err on the side of transparency and disclosure by providing the written report unless there is a compelling reason not to. Although there may be many reasons that giving a written report to the person you assessed may be unwarranted, there are a few reasons that seem to come up more often than others. The first and most important reason for not providing the individual assessed with a copy of the report is that you have determined that doing so is likely to be harmful or unduly distressing.

Determining whether giving the report will harm an individual is a clinical judgment call that can benefit from supervision or consultation. Most often, the consideration of potential harm is related to something that emerged in the content of the report or the diagnosis given. Although mental health professionals differ on their views on diagnosis (e.g., stigmatizing as opposed to informative and supportive of better treatment), there are times when giving an individual a specific diagnosis may be damaging, and you should consider both the nature of the diagnosis and the individual whom you have come to know during the course of the assessment. Similarly, if a theme emerged on the assessment that you feel would truly be harmful for the person to hear (and see and keep), then you may be best advised to find a way to frame and convey that theme verbally rather than in writing. Providing a verbal context for a particularly sensitive theme will likely allow the person being assessed to better take in and understand the feedback. As in all clinical work, you will do well to allow yourself to be guided by the do no harm ethic.

The other major consideration when deciding whether to give a copy of the written report to the individual being assessed has to do with the level of their functioning. Specifically, a comprehensive written report may simply be too overwhelming and complicated for some individuals to understand and be able to tolerate. An individual who is cognitively functioning within the borderline intellectual functioning range, for example, may not be able to use a full written report. In these cases, the person may benefit from receiving a brief breakdown of the full report. You may create a cheat sheet, a one-page summary of the report with the major findings and themes and the recommendations. The cheat sheet provides the individual with an easily comprehensible written account of the assessment findings that they can revisit later as a reminder of the most salient details of the feedback session.

How Should I Structure the Session?

There is no single optimal way to structure a feedback session for all individuals assessed. In general, though, you can apply four major structures to the session that will help you organize the assessment content into a presentation the individual can understand. Which one of these you choose, or whether you choose a different structure entirely, will depend on your own personal style, the nature of the feedback being given, and the specific functioning of the person receiving the feedback. The key to deciding what format the session should take lies in anticipating what will be most readily heard and understood by the individual in a way that will encourage them to follow up on the recommendations offered.

The first—and most straightforward—way to structure a feedback session is to follow the format of the assessment report. Often, when you have decided to give a copy of the written report to the individual who was assessed, it simply makes sense to structure the session around the structure of the report. After orienting the person to the major headings, you can then go back to the beginning and go through the report together, section by section, giving a verbal explanation of everything that is written and clarifying anything that is unclear (obviously, all the while constantly checking in with the person to gauge their understanding and reactions). This structure will naturally lead to the recommendations, which will be emphasized in the session, followed by a plan for follow-up (which is discussed subsequently).

Another way to frame the session is around major referral questions. If the client (or you and the client together, or the referral source) had several clear, testable assessment questions to address, you can restate each question, present the assessment data that informed the conclusion on the question, answer the question, and follow up with specific recommendations based on the answer to the question. This organizing framework often makes a great deal of sense to the individual being assessed and focuses the feedback session specifically on what the client really wants to know.

A third potentially useful structure for the feedback session is to organize the entire session around the recommendations. That is, you focus on conclusions and specific recommendations that relate to the findings, followed closely by the reasons for the recommendations, based on the findings themselves. Clearly, if the result is something positive or that does not need addressing, then there may be no specific recommendation connected to it. This structure can be useful if you think that, for whatever reason, the individual may be overwhelmed by hearing all the results or if you anticipate resistance to the recommendations that would be best addressed by more explicitly emphasizing their rationale.

While it may be more challenging to present your findings clearly, using this structure does a particularly effective job of emphasizing the recommendations aimed at improving the person's functioning, which after all is the ultimate goal of the assessment. By summarizing each of the recommendations again at the end of the session, you have simply presented the recommendations more times than you would if the session were structured linearly around the report. Simply repeating the recommendations a few times may actually work wonders with individuals ambivalent about following them.

The fourth structure for a feedback session leverages Finn's (2007) levels of information. Level 1 information is highly aligned with the individual's way of viewing themselves. For example, a client who comes in do understand what is underlying their anxiety will know that they have anxiety; as such, giving feedback that they are struggling with anxiety would be considered level 1 information. Similarly, a client who comes in struggling with attention and ultimately meets criteria for a diagnosis of attention deficit hyperactivity disorder (ADHD) will very much understand, agree with, and really embody the truth of that diagnosis, which would be considered level 1 information. Level 2 information is not entirely aligned with how a person sees themselves but is not too discrepant from their self- and worldview. For example, a client who presents with a history of interpersonal difficulties may be told that they struggle with weak social skills. While they may not have framed themselves in this way, it may be only a slight adjustment of how they view themselves, aligned with a great deal of evidence they can pull from within their own lived experience. Level 3 information, which Finn argues is most likely to cause shame (and any other negative reaction) is the most discordant with how a person views themselves. For example, a person with a personality disorder who feels that others do not understand and respect how special they are (i.e., narcissistic personality disorder) may have a difficult time understanding and integrating the fact that they have fragile self-esteem; they may simply not be aware of this. Level 3 information is often the most difficult feedback to give (and this chapter will discuss how best to approach it when clients are resistant to feedback).

The goal of a feedback session organized around Finn's levels of information is to use level 1 and level 2 feedback to pave the way for level 3 feedback. That is, you can create buy-in with the person, especially using level 1 information, such that they are very much in agreement with the feedback they are receiving. This increases the likelihood that they will hear and accept the more difficult (level 3) information in the feedback. This structure also assures that you will have plenty of time to process the level 3 information; that is, the level 1 and generally level 2 information should not need much discussion, explanation, or processing. It should be relatively quick to move through in the feedback session. That will leave more time to struggle through the level 3 information, which is often the target of recommendations.

Should I Disclose the Diagnosis?

Perhaps the most controversial decision to make before doing a feedback session is whether to disclose your diagnostic impressions with the person you have assessed. This may be moot if you have decided to provide the individual with a copy of a report that clearly states the diagnosis. Without getting into a philosophical discussion of the merits of diagnosis (and you may have your own personal opinions about diagnosing, which is perfectly appropriate), you should simply let yourself be guided by the same consideration as when deciding whether to give a copy of the written report: (Try to) do no harm. Diagnosis can be stigmatizing. Depending on the setting you work in, a diagnosis can follow an individual for a lifetime. Diagnosis can also be extremely organizing and informative (and many people find themselves relieved to be able to place a name on their suffering), especially when it comes to deciding which treatments will likely be effective. You must simply weigh, as best you can, the pros and cons of disclosing the diagnosis. Again, in the service of transparency and genuineness, you may consider disclosing your diagnostic impressions unless there is a compelling reason not to.

One challenge of disclosing diagnosis is finding a way to explain exactly what the diagnostic label means, beyond what it sounds like it means. For example, a woman who was clearly depressed was given a diagnosis of major depressive disorder (MDD), and although she knew she was depressed she had a very strong reaction to the word *major*. These are the sorts of labels and details that we in our profession use so often that we begin to take for granted how this might sound to someone who is not in our field. Once it was explained exactly what the MDD label meant (including the fact that there is no such thing as a minor depressive disorder), her anxiety reduced significantly. Psychoeducation about exactly what different diagnostic labels mean is absolutely crucial in a good feedback session. Again, showing empathy for a person receiving a diagnostic label as part of the assessment feedback will help you avoid taking these labels for granted.

During the Session

Framing the Session

How you introduce the feedback session can be key to setting the tone and expectations for whoever is receiving feedback. In general, it is important to make sure that the client (or other parties) are clear about what the feedback session is and is not. It is also important to set the tone to make clear just how much interaction will be expected, how questions will be handled, and any other issues that may arise during the session itself.

One highly empathic and often attuned way to begin a feedback session is to warn the client, parents, or whomever else that the feedback from an assessment is going to be a weird process. Find a way to word this that feels natural to you. That is, you as an assessor do not know the client very well at all, certainly not as well as whoever is getting feedback—themselves, a parent—and you are about to tell them all sorts of things about the client that emerged from the assessment. This is inherently a bizarre and often uncomfortable situation. Beginning with this allows space in the room for discomfort, questions, and other reactions. It can be helpful to make this explicit. Because of the bizarre nature of this process, give the person permission to have questions, reactions, or concerns throughout. At times and with some clients, it can be helpful to psychoeducate them about the Johari window (Luft & Ingham, 1955). Specifically, there is information that is known to the self, not known to the self, known to others, and not known to others. While there is certainly a great deal of information about a client that is known to themselves but not to you as an assessor, some information can emerge from an assessment that is simply not known to the individual themselves, and this can be weird to hear from a near stranger.

After joining with a client (or parent or someone else) around how strange the situation is, you can frame the legal and ethical parameters of the report itself. That is, make clear who has access to the report, where it will go,

whom you will and will not talk to, and what is required for follow-up. Often, in clinical assessments, the report (and feedback) is the property of the client or parents; they can do whatever they want with it. While you may recommend that they share the results with a school, treatment providers, attorneys, or other interested parties, you should make absolutely clear that what they do with the report and information from feedback is their decision. Obviously, there are many circumstances when it is not, such as forensic cases, pre-employment screenings, and other such assessments in which the client is not actually the person being assessed. It is again important to make explicit the limits of what you can do; you may be willing to share feedback with or send the report to a third party, but you need to make clear that you need written consent from them to be able to do this. As a side note, many times you may have a blanket release of information from the beginning of assessment to involve some third party like a teacher or therapist. While legally this may cover permission to offer feedback to them, it is important for clients to know the content of the feedback before consenting to release that information to a third party. That is, when we are considering informed consent, clients should know what information will be shared with a third party before they consent to release it.

Once the legal and ethical parameters are clear, it is important to discuss the limitations of the assessment process and report. For example, if the background section of the report is based on information from a clinical interview, it can be important to emphasize that there may be some minor factual errors in this section of the report, just based on the fact that you were writing or typing the information and may have made a mistake. I often let them know that if there are factual errors, they can let me know and I will correct them quickly and easily. It is important to emphasize that the errors are factual in nature. You are not inviting them to argue interpretation of tests or assertions made from your psychological expertise, but you can acknowledge that it is not uncommon that between notes from the interview and reorganizing that information for the report, minor factual errors can be made.

Additionally, at times it may be important to remind clients multiple times throughout the feedback session that the assessment findings cannot describe every aspect of a person. Specifically, especially when it comes to personality, emotional, and behavioral functioning, assessments tend to emphasize those areas that are outside of the norm, in need of improvement or support, or are otherwise interesting (and often negative). It can be helpful to contrast the fact that in the cognitive assessment you tested across many cognitive areas, and you will present strengths and weaknesses. However, in the personality, emotional, and behavioral section, it would be impossible to test every emotion, personality trait or characteristic, or possible behavior. As such, the feedback around these areas tends to focus on those areas that are in need of supports. You can often remind them that these areas were the real reason they came in for an assessment (usually) and that to be most helpful you will be focusing on these areas. This means that this section of feedback will necessarily sound overly negative and deficit focused. However, you can remind them that you have done this to ultimately be as helpful as possible.

Next, it is important to set parameters and frame the feedback process as a whole. In many assessment contexts, you will have flexibility in how you follow up and what can happen after this session. However, in some contexts, you may not. If the feedback is this one session and there is no room for follow-up, make that clear. If you have flexibility to extend the feedback process in multiple ways, make that explicit. For example, you may be able to offer some time for the individual to digest the information and follow up with questions for you in a variety of ways. If you have a preference for method, state that; if you would prefer minor questions to be posed to you over email, make that clear, for example. If you have the flexibility to schedule a phone call or even another in-person meeting to clarify, process, and answer any questions the individual might have, state that clearly. If you do not have flexibility to offer follow-up (for example, if you work in an agency that requires you to terminate and deactivate cases entirely after the feedback session), offer suggestions of how they should follow up if they do have questions or need clarification. For example, you may point them toward their own therapist to process the content of the assessment feedback.

Finally, it is important to frame the feedback session, in terms of what content you will be covering and how. If you are organizing the feedback session around the structure of the report, you may state clearly that there are multiple sections and you will be discussing each one, such as cognitive ability, academic functioning, and personality and emotional functioning, followed by a discussion of recommendations. If you are framing the feedback around specific referral questions, you can remind the client that they had four overarching questions, and you will be addressing each one individually, followed by recommendations. However you are planning to structure the session itself, it is helpful to frame that for the client. Often, a session presentation can be helpful at organizing both your own discussion of the material and the client's understanding of what is being discussed (which can often be quite a bit of information and quite overwhelming).

As will be done multiple times throughout the feedback session, even before beginning with the content of the assessment feedback, stop and ask if all is clear and if they have any questions. Even if they say no, take stock of their facial expressions and body language. If they are having any sort of reaction to what is being presented, stop and ask them about it. You want to make every effort to convey to the person receiving feedback that you welcome their input, questions, and discussion; this can be explicit ("Please stop me at any point and ask me questions, especially if anything is unclear.") and subtler (stopping and asking for input at multiple points throughout the session).

A Session Presentation

There certainly is no empirical study of using a feedback presentation to frame and organize a feedback session, but many students and practitioners have used this method and found it extremely helpful. Without presenting all details and nuance, a slideshow-type presentation can anchor the content of a feedback session, especially as it is often unwise to give a copy of the report during the session for a client to follow along with. Giving a copy of the actual report at the beginning of a feedback session is almost daring a client to read it and tune you out; for this reason, it is usually better to give feedback and then give a copy of the report for the client to take home, read, and digest. But without the physical report to look at during a feedback session, we are asking a lot of those receiving feedback in terms of organizing the information within their own minds. As such, a feedback presentation slideshow can offer some grounding and organization and a point of focus in the room other than your face while you are going through the information, which can at times get uncomfortable.

How you structure a feedback slideshow, which can easily be presented on a laptop in the feedback room, can vary. In addition to presenting a snapshot of the findings, it can be extremely useful for including some reminders throughout, such as cognitive testing being focused on what an individual is capable of doing under ideal circumstances (as opposed to how their brains behave in their everyday, real life) or personality, emotional, and behavioral assessment focusing primarily on areas of need rather than including every strength and weakness. Primarily, though, the presentation is meant to ground some of the actual substantive feedback.

When using a presentation, it is important to start with a slide that specifically states that the presentation is not a replacement for or full representation of the comprehensive report. A statement can be used like: "The information in this presentation is intended to guide the feedback session and does not include all information from the comprehensive evaluation. Please refer to the full written report for more comprehensive, detailed information from the assessment." Having this in writing at the beginning of the presentation forces you to state it clearly out loud and emphasizes how important this point is to the individual receiving feedback.

A next slide that can help organize the content of a feedback session can include a list of the guiding referral questions. Sometimes these are clear and specific, such as, "What is underlying John's difficulties in academics?" Other times, they may be broader, such as, "What are John's specific cognitive, academic, emotional, and behavioral strengths and weaknesses?" Whatever the guiding questions are, it is often useful that they frame and structure

the feedback session. If you start with questions that are specific, you can keep that specific question on the slide while you add the information (including test data) that informs it. With broader guiding questions, you may be setting the feedback session up to include sections on cognitive ability, academic performance, and emotional and behavioral functioning. However you structure the presentation and feedback session, these guiding questions should be revisited and answered later on in the presentation or session.

You may want to include a slide just on general observations, especially for child evaluations in which you are giving feedback to parents. While the behavioral feedback you may have for parents may emphasize problematic behaviors, any positive behaviors, such as cooperativeness, good effort, and appropriate interpersonal interaction, can be emphasized in a behavioral observations slide. This can sometimes soften the impact of negative and clinical feedback, and it also conveys that you have interacted with a real human being with strengths and weaknesses. At times it is hard for parents to remember that they have a good kid who is struggling rather than a problematic kid. And just because this is important in child evaluations should not diminish how important this can be in adult evaluations as well. That is, adults can also easily forget that they are struggling but doing the best they can rather than just being problematic. Additionally, if there were behaviors in the session that may have affected the actual assessment data, it is important to include this clearly. For example, evidence of lack of effort or motivation should be made clear so that you can later justify the findings from cognitive tests as likely underestimates of an individual's functioning. In general, your observations can both inform the findings and humanize the process.

Whether you are presenting all cognitive ability data as a whole or using the cognitive ability data to answer specific questions throughout, you can include a slide to explain to the individual getting feedback that cognitive ability data are based on optimal performance measures. You can include a slide with content similar to, "Note: The measures used to evaluate current cognitive ability are looking at what John is able to do under ideal conditions and in the most ideal context. As such, the findings represent what his brain can do rather than how he actually functions in his everyday life." A statement like this can educate the person about the difference between optimal performance measures and typical performance measures, and it can help clarify why findings from cognitive tests may not align with how they see themselves or their children. For example, performance-based attention tests may reveal no cognitive problems with attention, which may not align with very real attention problems in everyday life (where there are contextual, relational, emotional, and other factors included in the environment). Again, having a slide with this information on it forces you to remember to convey this information to your audience, as well as emphasizing that it is important.

Similarly, whenever you are presenting the personality, emotional, and behavioral data, whether throughout to answer specific questions or all together in a personality snapshot of the person assessed, include a slide with content related to the fact that the findings focus on areas of need, rather than a comprehensive picture of strengths and weaknesses. Here is some example content: "Note: The emotional and behavioral assessment focuses only on areas in need of support, rather than all possible emotions. As such, it does not highlight John's many emotional strengths." Again, including a slide with this content forces you to explain this clearly to whoever is receiving feedback. You can again explain that to be most helpful this part of the testing aims to pinpoint the areas that need additional support or intervention.

The rest of the first part of the presentation should be organized however you aim to give feedback. If you are organizing around referral questions, you can include a slide with a reminder of the question, followed by a snapshot of the data that inform the conclusions about that question, perhaps followed by a clear and specific statement answering the question. If you are organizing around general profile areas, such as cognitive, academic, adaptive, vocational, and personality and emotional, then you can have slides that focus on each of those. They may be organized differently by profile area. For example, for cognitive functioning, you may have a slide with cognitive strengths followed by a slide with cognitive vulnerabilities. The same may be true for adaptive behavior functioning and academics. However, for other profile areas, you may include more of an emotionalor vocational

profile, including bullet points of information related to whatever emerged from the assessment to inform the conclusions.

The second half of the presentation should be reserved for conclusions and, most often, recommendations. Conclusions may restate the organizing questions and statements answering them, and they may also include a clear description of any diagnostic classifications for which the individual assessed meets criteria. When listing diagnoses, it is important to use headings and descriptors (often bullet point lists) to clarify. For example, if a client meets criteria for intellectual developmental disorder (IDD), just writing this on a slide is not enough. You should include what specific criteria contribute to meeting that diagnosis, such as delayed cognitive development and difficulties in everyday functioning (which can get more specific, like difficulties in communicating effectively and difficulties overseeing their own health and safety in the home). While of course you will be discussing the nuance and criteria more specifically aloud in a feedback session, it can still be important for people to see some details on slides in addition to hearing them from you.

The final section of the feedback presentation is often the action plan or recommendations slides. Again, you can decide how best to organize this section, including how much detail to put on the slides themselves. Remember that you do not need to include all the details from the report on these slides and in fact that will likely be quite distracting. If you are recommending specific school accommodations, you may want to list the major ones and not include all the details about what classroom teachers should do to accommodate the learner. If you are recommending therapy, you may want to include some details about what kinds of therapy you are recommending but not include all the nuances of what those treatments should target and how they should focus. The presentation is meant to be a guide, not as a replacement of either the report or your explanations. However, as with previous slides, having a clear slide or set of slides focused on recommendations emphasizes how important this part of the feedback is. In most clinical evaluations, your ultimate goal is to provide recommendations that are likely to enhance or improve the individual's functioning. Having this slide ensures that you focus on it for a substantial portion of your feedback, not undermining the recommendations by rushing through them.

How Is the Session Going?

When thinking about the feedback session as a hybrid of assessment and psychotherapy, gauging how the session is going moment to moment becomes extremely crucial. Just as you were attuned to behavioral observations during the assessment, you should remain observant of any and all reactions, even if they are nonverbal, on the part of the person receiving feedback. Often the sheer volume of the information being provided can make the feedback overwhelming, such that individuals cannot process it quickly enough to verbalize their reactions. However, very often people cannot hide reactions on their faces or in their bodies, so you should stay aware of any change in demeanor, posture, affect, or any other nonverbal signs—even minor—indicating that they may be having a reaction to something you have said. If you notice behavioral reactions, you should stop and make sure that the individual is following what you are saying and provide answers to any questions they might have.

Although they can feel a bit halted and stop-and-start, the best feedback sessions include regular checking in with the person receiving feedback to make sure first that they understand everything that is being said. But this is merely the first step. A good feedback session will include providing an atmosphere that communicates to the person receiving feedback that it is entirely acceptable, and even encouraged, for them to have reactions to what is being presented. It should feel okay for them to be surprised or disappointed and even to disagree with what is said, and you should make every effort to minimize any shame on their part for asserting their reactions, feelings, and opinions. It is not hard to empathize with these reactions when you take time to understand how foreign and bizarre this process is—almost any reaction is reasonable to have in what is an unusual and uncomfortable situation. Individuals being assessed should be encouraged to share their reactions freely and openly within the

session (as well as in the future, potentially, with their therapist, if that is consistent with the recommendations you are providing).

When gauging the flow of the session, there may come a point when a reaction to the feedback is so strong that it may be necessary to stop the feedback part of the session and shift into a more psychotherapeutic stance. If at all feasible, you should be flexible enough to hold off on the feedback and reschedule it for a future date while using the rest of the current session to process whatever emotions and thoughts were elicited by the feedback so far. Remember that it should be acceptable for the person to be angry with you or to feel hurt or sad. Your clinical training will have prepared you to tolerate these emotions and to process them empathically with the person in whatever way you feel is appropriate.

Again, the ultimate goal is to work toward recommendations in a way that will allow the person to hear them, understand them, and ultimately follow through with them. If reactions to some of the content of the report are potentially getting in the way of the person taking the recommendations, shift the flow of the session to make sure that they can emotionally prepare to come back for another session to complete the feedback. Although this may sound relatively straightforward, an individual's reactions to feedback can be unpredictable, so be prepared for anything to happen within the session.

Dealing With Disagreement

Feedback sessions can often go fairly well, with clients or other stakeholders easily accepting all the findings, conclusions, diagnoses, and recommendations. However, there are also times when a client or other person receiving feedback may be somewhat resistant to any number of ideas you present to them. This, in part, is the nature of our chosen field—at times we understand things about other people that they do not easily know, understand, or are able to hear. And often, especially in clinical assessment, when they came specifically because things are not going as well as they could in their lives, we have to convey difficult and sometimes unpalatable ideas. First and foremost, it is absolutely fine for people to be resistant to or disagree with some of the information we present in feedback sessions. This is not a sign of failure on your part in any way. However, you need to anticipate some resistance and know how to address it. Four steps are useful when addressing clients or others receiving feedback disagreeing with your findings, and they assume that you are generally quite confident in the accuracy of your assertions and that multiple measures and methods have supported the information in a way that makes you fairly confident that they are reflective of the client's actual functioning.

The first strategy to employ when someone disagrees with a particular point within your feedback is to make sure they understand exactly what you are saying. That is, the first step is to clarify. Very often, people react quickly and emotionally when they hear specific words or phrases, even if they are not central to what you meant to say. Additionally, they can misunderstand what you say, especially if at times you accidentally use language that, while very familiar and understandable to those in the field, may not be as easy to grasp for those not in the field. So the first step is to try to convey what it is you said that they disagreed with in a slightly different way to ensure that they are in fact disagreeing with the construct itself rather than some aspect of the way you said it. Many resistances and disagreements can be solved simply by making clear exactly what it is you were trying to convey or saying it in a slightly different way.

When and if clarifying does not work, the next strategy to try is to provide psychoeducation about the construct in question. There are many areas of functioning that people think about a great deal. For example, consider a client who comes in with depression and is told that they have low self-esteem. This is likely very congruent with how they view themselves (i.e., likely level 1 information), as people often think about themselves and think about how they think about themselves. However, other areas of functioning may be more foreign for an individual to think about. For example, consider a client who struggles with their identity. Many people do

not think deliberately or explicitly about their own identity (though some do), so when they are told that they struggle with a clear sense of their own identity they may have a reaction. Doing some psychoeducation about the idea of identity development, including exactly what is meant by identity and when and how most people struggle with identity moratorium and development (such as the ideas proposed by Marcia, 1966), can help a client better understand what you mean, and potentially change their resistant position on the idea. As part of this psychoeducation process, you can even ask a client to come up with some real-life examples that illustrate your point for you. For example, you could ask them to think of a time when they went along with what other people wanted rather than thinking through what they themselves wanted. Providing psychoeducation about the construct itself is a more detailed and specific way of clarifying what you mean to try to build alignment with the client or others receiving feedback.

If and when psychoeducation about the idea does not work, the next strategy to employ is to provide psychoeducation about the process of assessment, with a focus on where the data for the construct in question emerged from. Many times, resistance to findings come from results of cognitive assessments that do not align with how an individual understands their own experience, such as with attention, memory, or working memory. These situations would require a clearer and restated explanation of the nature of optimal performance tests versus actual functioning in everyday life, which is much more complex with many more factors influencing functioning. When resistance about personality characteristics occurs, most often at least some of the data in support of your conclusions emerged from self-report measures. You can decide just how much detail to go into, but you can make clear that these ideas came up on multiple tests that the client filled out about their own personality and functioning. Depending on the level of resistance and how important a construct you believe this is, you can even go so far as to pull out the actual measures from which it emerged and show scales or even individual items they endorsed that contributed to the conclusion. There are certainly circumstances in which this is overkill, and it may be OK not to have 100% buy-in on a construct or idea from a report, in which case you can move on to the final strategy. But it is always important for you to at least try to get the person receiving feedback to at least understand where ideas came from, as the (again, weird) process can be somewhat mysterious and opaque.

As a final recourse, you can acknowledge that you do not necessarily need full buy-in and agreement across every single finding in every single assessment, and you can take a live-with-it approach, similar to an agree-to-disagree approach but infused with some hope and without giving up your professional expertise. You can certainly say to whoever is receiving feedback that it is OK for them not to agree with the feedback right now but ask them to live with it for a bit and encourage them to monitor themselves and their own thoughts, feelings, or behaviors (whichever are appropriate the construct that is the point of contention) for evidence for and against the piece of feedback. You can encourage them to seek out some outside data, such as from their own therapist or others in their life, to inform their position. It is important to mirror back that this particular finding does not align with how they view themselves (or their child or someone else), and that that is OK. However, you should encourage them not to close themselves off entirely from considering that it may in fact be true for them. These conclusions were not developed capriciously—they are based on amassed data from multiple sources and methods. You can stand confidently in your assertions, even with strong pushback, and still allow for the client to doubt. Hopefully, though, your confidence and prior arguments will at least open them up to the possibility that whatever information you've presented is at least in some way or partially true for them in their experience, even if they may not come to that agreement until much later.

How Will I Follow Up?

An ethical and logistical piece of the feedback session is collaborating with the individual you assessed about how best to follow up on the recommendations made. There may be instances in which you feel that the

recommendations are clear enough that the person needs no further assistance in following through on them. For example, if you make a recommendation for psychotherapy at the clinic in which you work, and together with the person you assessed you fill out the necessary forms during the feedback session, there is probably no need to follow up with the person themselves (though you may want to follow up with the clinic to ensure that the referral has been made appropriately). Additionally, if the individual can easily (and will likely readily) take the recommendations, again there may be no need to follow up with the individual. For example, if someone were referred for vocational testing to help with career decisions and the recommendations included discussing certain aspects of the assessment with their therapist, whom they already see, it is extremely likely they will do so.

However, sometimes it is necessary to follow up with the individual to make sure they understand and follow through on the recommendations. Even with the most specific recommendation (e.g., you may have provided the name and number of an appropriate therapist or clinic), because it is presented along with a potentially overwhelming amount of additional information during the feedback session you may arrange with the person to speak on the phone the following week to check in and make sure there were no difficulties with the referral process. Sometimes individuals will have delayed reactions to the feedback that may render them ambivalent about taking the recommendations. Moreover, referrals do not always go smoothly—the person may be turned down by the recommended treatment provider for a host of reasons (e.g., medical insurance, a long waitlist). Thus, to ensure that the person is not left with deep ambivalence or a lack of alternative resources, you should make sure to find a way to follow up with them so that the recommendations can be followed through on.

Some individuals will choose not to follow through on the recommendations; this is entirely acceptable (unless they are mandated for some reason). However, the reason that a person does not follow through should never be because they did not understand the recommendations, did not have a chance to discuss reactions to the recommendations, or did not have alternatives if one of the recommendations ended up being unfeasible. Make the plan to follow up a collaborative process with the person who was assessed, and do it before the end of the feedback session. This conveys a caring and empathic stance, ensuring that the person will have support from you until the recommendations are carried out successfully, while it still maintains the boundary that you are doing the psychological assessment and not psychotherapy with the individual.

Summary

The feedback session is often the culmination of the process of psychological assessment. It constitutes the entire purpose of assessment—to give some sort of feedback and recommendations to enhance or improve an individual's life or functioning in some way. More than any other session in the assessment process (including the clinical interview, which can often bring up a great deal of conflicting emotion), people have strong reactions to the feedback session. The session requires spontaneity and flexibility on the part of the person who is giving the feedback, such that the need to convey the content of the feedback is balanced with the real, live needs of the real, live individual receiving the feedback.

There are times when feedback sessions simply do not go well (or are subjectively felt not to have gone well by the assessor, at least), and sometimes the information that emerges from the assessment is very difficult for a person to hear. An angry, hurt, disappointed, sad, or even cutoff reaction does not necessarily mean that the feedback session went poorly. Remembering that the ultimate goal of the feedback session is to have the person hear, understand, and hopefully take the recommendations, allowing them to be angry or sad may actually contribute to this goal being met.

PART II

Case Studies in Psychological Assessment

Conducting Psychological Assessment, First Edition. A. Jordan Wright.

Introduction to Part II

CASE STUDIES IN PSYCHOLOGICAL ASSESSMENT

The six case studies in this section present the entire process of psychological assessment from beginning (referral) to end (feedback and follow-up). The cases were chosen not to represent exhaustively all the types of cases possibly referred for assessments; such a collection of cases would be impossible to compile. Instead, they were chosen merely as illustrations of the assessment process itself. Three adult and three child cases were chosen, with varied referral reasons, presentations, and amounts of information available.

The cases are presented as closely as possible to the way they were actually conducted (except, of course, for many details that were changed for the purpose of protecting the identities of the actual clients assessed—most are hybrids of multiple clients and some fictitious information). In addition to trying to present the process as it unfolded, an attempt has been made to present the logic and thinking behind each step, including consideration of alternatives when appropriate. For example, when deciding on a model for conceptualizing personality, emotional, and behavioral functioning—rather than just presenting the final model—an attempt has been made to discuss each of the possible models considered before deciding on the one that was chosen. In doing so, it is hopefully clear that the final conceptualization chosen by the assessor is one of several viable options and is in no way a correct version. More important in this text than the final product (the report) is the process the assessor goes through, systematically, for each individual assessment.

It is important to note that none of the cases presented here include the raw data from individual tests and measures. While this could be an important educational tool, the assumption must be made in each of these cases that the tests and measures themselves were administered, coded, scored, and interpreted in a valid way. As administration, coding, scoring, and interpretation of individual tests and measures is the focus of most assessment texts (and also the bulk of graduate assessment training), a decision was made not to include that information to avoid detracting from the major purpose of this text and instead to illustrate the process of assessment rather than just the content. Again, assume that the data themselves are valid and focus on how they are used, put together, and ultimately explained to others in writing and feedback.

CHAPTER 7

A Woman With Poor Attention

Andrea Fisher was a 28-year-old White woman who was referred by her therapist to evaluate why she has so much reported difficulty with maintaining attention. Her therapist (in the referral) reported many hallmark symptoms of attention deficit hyperactivity disorder (ADHD), including problems focusing, difficulty initiating tasks, procrastination, and some disorganization. From the referral, it seemed like a straightforward ADHD case.

The Clinical Interview

Andrea arrived at her initial clinical interview appointment unaccompanied and on time. She and the assessor discussed consent, including both going over the forms and talking in depth about limits to confidentiality. She notably had no questions, concerns, or clarifications requested during the consent process, and she signed the consent forms.

For this assessment, a semistructured clinical interview was used to collect the background and contextual information. The interview is organized into overall domains (e.g., presenting problem, cognitive complaints, mood complaints, developmental history, medical history), with broad questions to start and more specific follow-up questions about specific symptoms as needed. Below presents the overarching structure of the interview, without every single specific question included. The assessor first oriented Andrea to the process, letting her know that he was going to ask her lots of questions—some broad and some very specific and some that may not apply to her because they are the same questions he asks everybody.

Presenting Problem: OK, I'm going to start with the broadest and probably most important question. What questions do you want answered with this assessment?

Andrea began by discussing her difficulties with attention and executive functioning, almost as if she had read the symptoms off a website. She discussed her distractibility, even when she truly wanted to engage in a task and enjoyed it, such as when she is writing. She also discussed difficulty concentrating for longer periods of time, such as when reading a book, though she said she had no difficulties when watching an engaging movie. She also discussed difficulties beginning new tasks, especially if she needs to start a new task after having finished another task. She also said she has particular trouble starting a task when she has only limited time to work on it, even if that time is quite long, "even if it's 8 hours." She said she procrastinates often, including "random Internet searching" and other mindless activities.

With the list of very ADHD-like symptoms rolling out of Andrea's mouth, the assessor had to stop her and ask again what questions she wanted answered. Although she had given quite a bit of presenting problem, it was

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unclear why she felt she needed the assessment. Many adults with ADHD symptoms go straight to their primary care doctors and get a prescription for a stimulant, for example. She stopped and said, "Oh. Um. . .I guess I just want to know why I have so much trouble." She said she was "pretty disorganized," forgetting things and losing things, and that she had been disorganized in high school but was "able to do decently." She said she thought she probably had ADHD, but she was not sure because she only really noticed her symptoms "as bad as they are now" when she became depressed around 5 years ago.

At this point, Andrea had brought up a very different presenting problem from her cognitive complaints—depression. Knowing that attention, motivation, processing speed, and other cognitive difficulties can be secondary to depression, the assessment suddenly got more interesting. That is, teasing apart any attentional and executive functioning difficulties that are likely secondary to depression versus those that are genuinely discrete and attributable to ADHD is a good assessment question, in that testing can certainly add information that a symptom-based interview alone often cannot. As such, the assessor asked Andrea to discuss her depression.

Andrea reported a history of pretty significant depressive symptoms, including "shitty" mood and even some recent suicidal ideation. The assessor had to query just what she meant by "shitty" mood, and she clarified that she was sad, "mopey," and generally lethargic most of the day, most every day for the past 5 years or so. She said that she thought about suicide last September (a few months before the present assessment) but that she "talked it out" with her therapist and did not think she actually wanted to harm herself. She said she just "thought about dying." She tied her thoughts about death to "a lot of shame about not having regular employment" because at the time she was working as a freelance writer and having a difficult time securing consistent employment. She said she was extremely overwhelmed at the time. In addition to her low mood, she endorsed feelings of helplessness and worthlessness in the past as well as not wanting to get out of bed in the morning and some anxiety that "crops up" at times.

"Good news, though!" she joked with the assessor. She reported that about a month before the assessment she got a full-time job as a fact-checker for a political website and online publication. Although writing is her passion, she reported that "a ton" of her symptoms "have gotten way better" since she started this job. However, she also reported that her "attention crap" makes it extremely difficult to manage both her full-time job and her freelance writing, "not to mention spending time with my boyfriend." She reported that her mood is currently "good-ish" but that she is "still very tired" a lot of the time.

The assessor asked just a bit more about the onset of her depression to try to understand the history of this part of the presenting problem, and she reported no notable triggers or significant changes at the time she noticed her depression begin. She said it did not get significantly better or worse throughout the past 5 years but was just "always there" until she got this new job, when it got better.

Cognitive Status Complaints: Alright, now I'm going to ask you lots of more specific questions. Remember, some will not really have anything to do with you, but I ask them to everyone. We've talked about your attention and concentration. Do you have any other problems with your thinking, like with your memory?

Andrea noted that because her attention and related functions are "so bad," she had not thought about other difficulties and could not come up with any. The assessor asked specifically about verbal memory, nonverbal memory (such as remembering where she put things), language comprehension, word finding, visuospatial reasoning (such as difficulty finding her way around), problem solving, decision-making, hallucinations, and delusions—all part of the semistructured clinical interview. She discussed losing things like her keys and phone "constantly," and she asked if that was different from "my ADHD stuff." She also said she was "terrible" at making decisions, as small as what to have for dinner to as large as what kinds of jobs to apply for. She denied the other difficulties, though, including unusual perceptual experiences and delusional thinking.

Emotional Status Complaints: We've talked about your depression and a little bit of anxiety. Some of these questions are going to be a bit redundant, but bear with me. Tell me about your mood in general.

Andrea talked very briefly about her history of depressed mood that is "somewhat better" now. She also discussed being somewhat unfulfilled in her present job but said that working full-time, writing freelance, and then thinking about applying for new jobs at the same time "is making my brain melt." So she said she will continue with her current job for the time being.

As part of the semistructured clinical interview, the assessor then asked briefly about different areas of emotional functioning. For items she had already discussed, he reiterated what she said and asked her to confirm. For items she had not yet discussed, he asked her to discuss them. Some of the items she had already discussed included her sleep, energy level, helplessness, hopelessness, worthlessness, and suicidal ideation. However, she had not yet discussed her appetite, libido, worrying and anxiety, possible history of manic episodes, and aggressive and homicidal ideation, so the assessor asked about each of these individually. She reported that she is somewhat "irregular" in her eating, some days overeating and other days skipping multiple meals. She said she could not trace any of these patterns to her mood, history, or context, though. She also reported low libido ("less than my boyfriend would like") and denied a history of any manic or hypomanic episodes or aggressive or homicidal ideation.

She spent a bit more time describing her anxiety. She said it "is not overwhelming" but that she feels her stomach "turn" when certain things happen, like when her boyfriend does not answer his phone when she calls or when other people are arguing in front of her. She reported that she does not argue with other people, but even if she hears others arguing it makes her feel uncomfortable. She said that she could not remember if she always had this anxiety or if it was just since she had been depressed, but it has "certainly been around awhile."

Family Context and History: OK, can you tell me a little about your family history?

Andrea started by saying, "Thank god for my family. They are my emotional support system." She said she and her older sister were raised by her "loving" mother and father, who are still married. She was born and raised in New York, and she is "very close" with her whole family. She said she was "pretty close" with her sister, who is 1 1/2 years older than Andrea—they play tennis together every week. However, she also said that her sister had a lot of emotional and behavioral difficulties as they were growing up, which meant she "was the center of everything" and Andrea did not always get as much attention from her parents. She said that, as a result, she became very close with her grandmother, who she said also "raised me." She said she was still close to her now. When asked, she could not identify any specific, major family stresses that occurred throughout her life that had a significant impact on her or her family.

When prompted (as part of the semistructured interview protocol), Andrea discussed her current relationship with her boyfriend, whom she has been with for about 2 1/2 years and currently lives with. She said that he "is nice to me" and that they have a generally positive relationship, including him being "very supportive when I'm down." She said that they "are solid" and will probably get married.

Developmental History: Switching gears, do you know of any problems your mother had with her pregnancy with you or your birth or delivery?

Andrea reported that she did not know of any difficulties with her mother's pregnancy or her birth or delivery, and when asked she said she thinks she met all of her developmental milestones appropriately and on time.

Medical History: OK, do you have any major medical illnesses currently, or did you in the past?

Andrea said she has never had any "serious" medical problems. She did report that at some point as a child (she was unsure what age she was) she hit her head on a door, but she said it was not serious at all. She said that she did not lose consciousness or have any visible effects from the incident, and she did not require any medical attention or a trip to the hospital. "I don't even know why I brought it up," she said with a bit of a shrug. When asked, she also denied any significant medical illnesses in her immediate family. She also reported she had had a full physical examination about 6 months ago, with nothing notable emerging.

Educational and Vocational History: Tell me about your education and work history.

Andrea said she got a bachelor of arts in writing from an Ivy League liberal arts college. She said she "did well" in high school in most classes, getting grades in the "A range" across the board except for in math, "which is just not my strength." When asked as part of the semistructured interview, she denied any history of learning disabilities, never repeated a grade, was not in special education, and did not have behavioral problems in school. She did reiterate that she had trouble focusing throughout school, "but I was able to manage."

When asked, she reported that she was "satisfied to do [her current fact-checking job] for now" but that she would prefer to be a full-time writer. She currently publishes articles on politics "occasionally" as a freelance writer, but she would rather be doing these kinds of articles as her full-time job. She reported that she had previously worked as a writer for "several different" political magazines and websites but none of them as a full-time staff writer. She said that she "must be" good as a fact-checker, as she just had her review after her probationary period and was officially hired full time.

Psychiatric History: OK, tell me about your history in therapy.

Andrea said she has been seeing her therapist for about 1 1/2 years, and she said she did not know "what kind of therapy it is" (when asked about the theoretical orientation of the treatment). She said she "should have started therapy a lot earlier than I did," but she had such difficulties with motivation when she was depressed that it was hard for her to reach out and engage in any form of treatment. She said her boyfriend encouraged her to get "professional support" and even researched and found her therapist. She reported that therapy "has been useful," especially when she had some thoughts of death a few months before the assessment. When asked as part of the semistructured interview protocol if she had received a formal diagnosis, she said, "I don't know, depression probably?" She said that she had been very consistent with showing up to her therapy and trying to "work hard in it," and she reported that she had never seen a psychiatrist or been prescribed any psychiatric medications.

Substance Use History: OK, tell me about your history and current use of substances, including alcohol and any other drugs.

Andrea said that she drinks alcohol socially, usually about one or two drinks per week if her boyfriend "drags me out" to dinner with his friends. She said she does not actually like the taste of alcohol, so she "nurses" a glass of wine "to be sociable." She denied any other use (past or present) of any substance, including tobacco, marijuana, and prescription medications.

Legal History: Do you have any current involvement with law enforcement or other legal issues?

Andrea looked at the assessor a bit confused, and he reminded her that the interview questions are meant for everyone and some may not apply to her at all. She said she did not have any problems with or involvement in any legal matters.

Social and Psychosexual History and Context: Tell me a bit more about your social life, now and in the past.

Andrea said that she had "a bunch of friends growing up," describing that she was much more sociable when she was a kid than she is now. She said now she has only a few friends; other than her boyfriend, they do not live in New York, so she does not see them. She said that she occasionally socializes with her boyfriend's friends but "not when I can help it" and only rarely. She said she thinks her boyfriend is "my best friend, I guess," but they generally do not "get too deep with things." She said she feels supported by him and knows he "will be there if I need him," just like her parents. She said that she could not think of a single friend she has made since college (other than her boyfriend).

When asked as part of the semistructured interview protocol about her sexual orientation and gender identity, she reported that she is "a boring, straight, White female." She reported that she has infrequent sexual intercourse with her boyfriend, primarily due to her own low libido, but that "we are fine with it." She denied any history of sexual abuse or trauma.

Cultural Evaluation: So you're a straight, White female—can you tell me anything else about your cultural identity?

Andrea reiterated that she is "boring and White." She said that she was raised "White and Catholic" and participated in "Catholic stuff with my family" throughout her childhood. However, she reported that she does not actively participate in any religious or spiritual activities currently and has not even thought about religion or spirituality "in a long time."

Current Stressors: OK, a few last questions. What would you say are your biggest stressors in life at the moment?

Andrea reiterated that her disorganization and problems with attention make it very difficult for her "to juggle my new job and my freelance writing." She said that this was her "only big stress" at the moment.

Current Medications: And finally, are you currently on any medications?

Andrea said that she is not currently taking any medications, aside from birth control pills, which she has been on since adolescence.

Mental Status Evaluation

Appearance and Behavior

Andrea was well groomed and casually and appropriately dressed for all sessions. She was tall and of average build. She had no difficulty engaging the assessor or adapting to the testing situation and was cooperative and friendly throughout.

Speech and Language

Andrea was open and articulate, and her speech was generally goal directed and logical, though slightly slow. She had no difficulties with receptive language and understood all the directions on all of the tests administered.

Mood and Affect

Andrea reported that her mood was "tired" during the clinical interview and generally "OK" throughout the rest of the assessment process, and her affect was generally mood congruent and appropriate to the situation. She showed minimal emotion during the clinical interview, even when discussing distressing topics, but she smiled at the assessor when appropriate.

Thought Process and Content

Andrea's thought process seemed clear and logical, free of hallucinations and delusions. Her logic was linear. Her thought content was currently free of suicidal and homicidal ideation and of hopelessness and helplessness.

Cognition

Andrea was alert and engaged throughout the assessment. Her attention, concentration, and memory seemed intact.

Prefrontal Functioning

By self-report, Andrea had difficulty with areas of planning, organization, and procrastination. However, none of these difficulties was exhibited overtly during the assessment process. Further, she exhibited generally adequate insight and judgment in the moment.

Hypothesis Building

Now that the clinical assessment (the clinical interview and the mental status evaluation) has been completed, the information gathered can be used to create hypotheses for what might be going on for Andrea.

Identify Impairments

Andrea identified two major areas of impairment in her life: her executive functioning and her social-emotional functioning. For the former, she identified problems with attention, concentration, and other areas of executive functioning, like organization, planning, and initiation. For the latter, she identified significant symptoms related to a mood (depressive) disorder, including low mood, lethargy, helplessness, worthlessness, irregular sleep and eating patterns, and a history of suicidal ideation. She added some potential symptoms of anxiety, though these seem to be less intrusive into her actual functioning, and an extremely limited social network.

Enumerate Possible Causes

Thinking first about Andrea's attention difficulties, there are a few major reasons she might be struggling with focus. The obvious first major hypothesis is attention deficit hyperactivity disorder, which she said she "probably" has and also discussed a number of symptoms that align with the diagnosis. While there is still significant controversy and disagreement in the field about ADHD assessment and diagnosis (e.g., see Gualtieri & Johnson, 2005; Marshall, Hoelzle, & Nikolas, 2019; Nikolas, Marshall, & Hoelzle, 2019), most agree that at least some standardized assessment (at least rating scales) and some cognitive testing are useful. Her problems with attention and executive functioning, though, could also be related to her mood symptoms, as she reported noticing them specifically at the onset of what she considers a depressive episode. It is complicated, though, as she reported an amelioration of her depressive symptoms recently but also noted continued problems with attention and executive functioning. While it seems she is significantly struggling with attention

and executive functioning problems (rejecting the null hypothesis that her attention is within normal limits), the major hypothesis seems to be an ADHD process or a depressive process as the underlying cause of the cognitive problems.

Her emotional distress symptoms certainly seem to be related to some sort of mood disorder, such as major depressive disorder (MDD) or persistent depressive disorder or dysthymia (PDD). Although we could consider a bipolar disorder of some sort, she denied any history of manic or hypomanic episodes, so this does not seem like a useful hypothesis. Additionally, many researchers are questioning the utility of distinguishing between mood and anxiety disorders, given their extremely high comorbidity, the similarities in effective treatments, and ultimately some uncertainty about whether they are actually phenomenologically separate disorders at all (e.g., Barlow, Allen, & Choate, 2016). As such, in this case, with depressive features clearly more salient than anxious symptoms, it may not be too important to include an anxiety disorder in the list of possible hypotheses.

The final impairment that needs some consideration is Andrea's significantly limited social network. Many disorders result in limited socialization, and depression can certainly be a leading suspect in this case. However, there are additional potential disorders to consider, especially those that are specifically interpersonally oriented. These include social anxiety, autism spectrum disorder (though this is not a realistic hypothesis in this case), and multiple personality disorders. While Andrea did not endorse specific anxiety about interacting with others (which would flag social anxiety), we need to deliberately rule out a personality disorder (especially avoidant and schizoid).

You should always consider that (a) the presenting problems have an etiology in substance use and (b) the presenting problems have an etiology in a medical condition. Andrea specifically denied any significant substance use, so unless she is misleading the assessor it is unlikely that substance use is the cause of her difficulties. Related to a medical condition, she denied any medical illnesses and reported a recent and unremarkable physical exam, so a medical etiology is also unlikely. Accordingly, it will be assumed that the symptoms are primarily psychological in nature.

Selecting Tests

For the cognitive hypothesis related to her attentional difficulties, the first step is to understand her overall intellectual ability, which can be measured with the Wechsler Adult Intelligence Scale, 4th Edition (WAIS-IV). As part of this overall understanding, as always, the Bender Visual-Motor Gestalt Test, 2nd Edition (Bender-2) can add some other basic cognitive skills, including fine motor skills, visual–perceptual ability, and short-term visual memory. Importantly, though, we also want to better understand her attentional and executive functioning. To add detail to attentional and executive functioning, we can add a continuous performance test, such as the Test of Variables of Attention (T.O.V.A.) and some measures of cognitive control and executive functioning, such as the Trail Making Test from the Delis-Kaplan Executive Function System (DKEFS Trails) and the Wisconsin Card Sorting Test, Computer Version Fourth Edition (WCST-IV). These cognitive tests are optimal performance tests, such that they engage her attention and executive functions under best possible circumstances to see what her brain can do. A rating scale of attention and executive functioning can evaluate in a more quantitative way than the clinical interview Andrea's typical (everyday) attention and executive functioning. For this evaluation, we will use the Comprehensive Executive Function Inventory, Adult (CEFI, Adult). Other self-report emotional measures will have information on attention as well.

For the personality, emotional, and behavioral assessment—and specifically to evaluate mood, anxiety, and personality disorder-related symptoms—several self-report measures can be used. Because of the depressive and anxious symptoms, the Personality Assessment Inventory (PAI) offers useful and straightforward measures of these kinds of symptoms (with a focus on understanding how severe they are and what aspects are being experienced). The Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF) also adds extremely

useful information about emotional and personality functioning. Because of the suspicion of a personality disorder, we will add the Millon Clinical Multiaxial Inventory, Fourth Edition (MCMI-IV) and the Inventory of Altered Self-Capacities (IASC) to the battery. Even though the latter measure is geared more toward borderline personality disorder, it may add some information about Andrea's interpersonal functioning. To add a different method to the battery, we can include the Rorschach Performance Assessment System (R-PAS), which can offer additional information about cognition as well as self- and other functioning.

Thus, our assessment's battery of tests will consist of

- Bender-2
- WAIS-IV
- T.O.V.A.
- DKEFS Trails
- WCST-IV
- CEFI, Adult
- PAI
- MCMI-IV
- MMPI-2-RF
- IASC
- R-PAS

Accumulating the Data

On the Bender-2, Andrea's performance was unimpaired (for motor and perception) and extremely strong (for copy and recall). On the WAIS-IV, her overall ability was also extremely strong for her age (Full Scale IQ of 126, 96th percentile), with functioning that high average or better across the board. Her performance on typical tasks that evaluate ADHD symptoms—the T.O.V.A., WCST-IV, WAIS-IV Cancellation, and D-KEFS Trails—was quite good, with no specific evidence of impairment under the best possible circumstances. Table 7.1 shows the results from her performance-based cognitive testing.

When we reorganize these data based on what they are actually assessing, many of the indices stand alone. For example, in the present evaluation, there is only one real measure of verbal functioning, the WAIS-IV Verbal Comprehension Index (VCI). When we ultimately discuss her verbal ability in the report, we will base it entirely on the results from the VCI (which of course uses different verbal skills and tasks to evaluate her verbal functioning). However, other measures converge around similar constructs, especially those related to executive functioning. If we organize those findings to look across measures, we see a picture of unimpaired and even good executive functioning, including attention. Table 7.2 shows reorganized data for different executive functions.

Table 7.3 shows the data that emerged from Andrea's personality, emotional, and behavioral measures. While the order of presented measures and methods is not extremely important, those that are broader and have stronger empirical evidence are listed first (the broad-based self-report measures), followed by those that tap into more specific aspects of her functioning (such as the IASC), and finally those that are performance based (R-PAS). The final set of data nuggets listed are from the clinical interview and observations. While of course not every piece of information that emerged from the clinical interview can be included in the data table, a small number of nuggets that seemed especially salient or important have been included, remembering that self-report in a clinical interview setting is another method used in an integrative, multimethod assessment.

TABLE 7.1 **ANDREA'S COGNITIVE DATA**

Test	Index or scale	Classification
WAIS-IV	Full Scale IQ	Superior
	Verbal Comprehension Index	Very superior
	Perceptual Reasoning Index	Average
	Working Memory Index	High average
	Processing Speed Index	High average
	Cancellation Subtest	High average
Bender-2	Copy	Very superior
	Recall	Very superior
	Motor	Unimpaired
	Perception	Unimpaired
D-KEFS Trails	Visual Scanning	High average
	Number Sequencing	Average
	Letter Sequencing	High average
	Number–Letter Switching	High average
	Motor Speed	Average
T.O.V.A.	Reaction Time Variability	Within normal limits
	Response Time	Within normal limits
	Commission Errors	Within normal limits
	Omission Errors	Within normal limits
	d´	Within normal limits
	Errors by Quarter	No significant increase
	Response Time by Quarter	No significant increase
	d´ by Quarter	No significant change
WCST-IV	Total Errors	Average
	Perseverative Errors	Average
	Nonperseverative Errors	Average

Identifying Themes

In looking at the data, we could begin to address some of the themes that clearly seem to be emerging across measures (such as anxiety or somatic concerns); however, we will begin identifying themes with Andrea's data using the seven traditional psychological themes: self, others (social), thinking, feeling (emotion), behavior, coping, and context. The preliminary themes for Andrea's data are presented in Table 7.4.

Organizing the Data

Andrea's reorganized data are presented in Table 7.5. When the data are reorganized and examined within themes, some are relatively straightforward in telling a consistent story about an aspect of Andrea, whereas others need to be reorganized. For example, the Self theme is relatively straightforward: This is a woman who struggles with a weak and generally negative view of who she is. Similarly, the Others theme tells the story of a woman who

TABLE 7.2 **ANDREA'S ORGANIZED EXECUTIVE FUNCTIONING–RELATED DATA**

Test: / Theme:	WAIS-IV	D-KEFS Trails	T.O.V.A.	WCST-IV
Selective attention	Good selective attention (Cancellation subtest)	Good selective attention (Visual Scanning)	Good selective attention (Reaction Time Variability, *d´*, and Omission Errors)	
Sustained attention			Good sustained attention (Errors by Quarter, Response Time by Quarter, *d´* by Quarter)	Unimpaired sustained attention (Nonperseverative Errors)
Working memory	High average verbal working memory (Working Memory Index)			
Impulse control and related functions		Good impulse control and applying new strategies (Number–Letter Switching)	Unimpaired impulse control (Commission Errors)	Average impulse control, self-monitoring, adapting to feedback (Perseverative Errors)

TABLE 7.3 **ACCUMULATION OF ANDREA'S DATA**

Personality Assessment Inventory (PAI)

Anxious rumination
Some confused thinking
Overly passive in interactions with others

Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF)

Low positive feelings and anhedonia
Somatic and gastrointestinal complaints
Prone to obsessive rumination
Self-doubt
Emotionally restricted
Socially avoidant

Millon Clinical Multiaxial Inventory, 4th Edition (MCMI-IV)

Some guardedness
Self-protective aloofness
Weak and fragile self-image
Inhibited anger, anxiety, and resentment
Self-deprecation—plagued by self-doubt
Denies desire for closeness and affection
Sadness with recurring periods of anxiety

TABLE 7.3 (*CONTINUED*)

Social awkwardness and shyness
Some confusion in thinking
Distracted by inner thoughts that intrude on social communication
Generalized anxiety
Distracted thinking
Dysphoric mood
Inventory of Altered Self-Capacities (IASC)
Nonsignificant interpersonal conflict
Nonsignificant identity impairment
Nonsignificant affect dysregulation
Rorschach Performance Assessment System (R-PAS)
Limited internal capacity to cope with day-to-day life
Deliberate, thoughtful thinking strategy
Uses thoughts to blunt her emotions
Thinking disturbance and confusion
Drawn to inconsistencies and nuance in the environment in a way that can overwhelm her thought processes
Dysphoric distress
Problematic understanding of self
Problematic understanding of others
Negative self-evaluation
Self-critical
Efforts to deaden emotions
Some physical concerns
Comprehensive Executive Function Inventory—Adult (CEFI-Adult)
Problems with attention
Extremely strong emotion regulation
Difficulties with planning, organization, initiation, and multitasking
Clinical Interview and Behavioral Observation Data
Problems with attention and executive functioning
History of hopelessness and worthlessness
Significant history of sadness
Some anxiety
Few friends
Not very open with her boyfriend

has developed ways of pushing others away from her, including guardedness, aloofness, and avoidance. However, some of the themes need further scrutiny, and some need reorganizing.

Finalizing Themes

A few things need to happen to finalize Andrea's themes. Starting with the easiest tasks, after scanning each theme across tests and measures, several (as stated previously) are generally pretty clear and consistent. The Self theme

TABLE 7.4 **IDENTIFYING ANDREA'S THEMES**

Themes	
	Personality Assessment Inventory (PAI)
Thinking	Anxious rumination
Thinking	Some confused thinking
Others	Overly passive in interactions with others
	Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF)
Feeling	Low positive feelings and anhedonia
Feeling	Somatic and gastrointestinal complaints
Thinking	Prone to obsessive rumination
Self	Self-doubt
Feeling	Emotionally restricted
Others	Socially avoidant
	Millon Clinical Multiaxial Inventory, 4th Edition (MCMI-IV)
Others	Some guardedness
Others	Self-protective aloofness
Self	Weak and fragile self-image
Feeling	Inhibited anger, anxiety, and resentment
Self	Self-deprecation—plagued by self-doubt
Others	Denies desire for closeness and affection
Feeling	Sadness with recurring periods of anxiety
Others	Social awkwardness and shyness
Thinking	Some confusion in thinking
Thinking and Others	Distracted by inner thoughts that intrude on social communication
Feeling	Generalized anxiety
Thinking	Distracted thinking
Feeling	Dysphoric mood
	Inventory of Altered Self-Capacities (IASC)
Others	Nonsignificant interpersonal conflict
Self	Nonsignificant identity impairment
Feeling	Nonsignificant affect dysregulation
	Rorschach Performance Assessment System (R-PAS)
Coping	Limited internal capacity to cope with day-to-day life
Thinking	Deliberate, thoughtful thinking strategy
Feeling	Uses thoughts to blunt her emotions
Thinking	Thinking disturbance/confusion
Thinking	Drawn to inconsistencies and nuance in the environment in a way that can overwhelm her thought processes
Feeling	Dysphoric distress
Self	Problematic understanding of self
Others	Problematic understanding of others

TABLE 7.4 (*CONTINUED*)

Themes	
Self	Negative self-evaluation
Self	Self-critical
Feeling	Efforts to deaden emotions
Feeling	Some physical concerns
	Comprehensive Executive Function Inventory—Adult (CEFI-Adult)
Thinking	Problems with attention
Feeling	Extremely strong emotion regulation
Thinking	Difficulties with planning, organization, initiation, and multitasking
	Behavioral Observations and Other Data
Thinking	Problems with attention and executive functioning
Thinking	History of hopelessness and worthlessness
Feeling	Significant history of sadness
Feeling	Some anxiety
Others	Few friends
Others	Not very open with her boyfriend

can easily be renamed "Weak and Negative Self-Image" or something like that, and the Others theme can be renamed "Interpersonal Guardedness" or something similar to reflect the multiple measures that revealed her efforts to distance herself from others.

Only one piece of data straddles two different themes and will ultimately need a decision made about where it should end up. The MCMI-IV nugget about Andrea being distracted by inner thoughts that intrude on social communication was initially categorized as both Thinking (distracted) and Others (blocks social communication). Interestingly, in this case, it could genuinely fit in either place. Many of the Thinking data nuggets point to Andrea's thinking being overwhelmed and distracted, and many of the Others data nuggets (discussed as telling the story of a woman who is guarded from others) focus on her problems interacting effectively and comfortably with others. As such, either place it ends up would be acceptable. Somewhat arbitrarily, we will place it in the Others theme.

One obvious need is to move the single piece of data from the Coping theme somewhere else. We need to look across all the different themes to determine where it may logically fit in. The limited ability to cope could relate to her being overwhelmed in her thinking, to her negative self-evaluation, or to her emotional distress, which is clearly emerging in her Feeling theme). In this case, especially because there is some anxiety (in addition to the depressive feelings), we can lump it in with the emotional distress data. While we are moving this nugget, we can also glance through the Thinking data and move any of the nuggets that actually relate to emotional distress, even though cognitive in nature, such as anxious rumination, hopelessness, and worthlessness. These data can move to the Feelings theme, as there are clearly going to be enough data to support some emotional distress, if not separate themes for anxiety and depression.

This leaves us with two themes: Thinking and Feeling. In looking at the Thinking theme, there are several ways to conceptualize what is going on for Andrea. Specifically, some data clearly point toward some confused thinking, and some reflect the problems with attention that she presented initially. These could potentially sustain two separate themes, but the single nugget from the MCMI-IV related to distracted thinking, as well as the

TABLE 7.5 **ANDREA'S ORGANIZED DATA**

Test: Theme:	PAI	MMPI-2-RF	MCMI-IV	IASC	RPAS	CEFI-Adult	Interview and Observation
Thinking	Anxious rumination	Prone to obsessive rumination	Some confusion in thinking		Deliberate, thoughtful thinking strategy	Problems with attention	Problems with attention and executive functioning
	Some confused thinking		Distracted by inner thoughts that intrude on social communication		Thinking disturbance and confusion	Difficulties with planning, organization, initiation, and multitasking	History of hopelessness and worthlessness
			Distracted thinking		Drawn to inconsistencies and nuance in the environment in a way that can overwhelm her thought processes		
Others	Overly passive in interactions with others	Socially avoidant	Some guardedness	Nonsignificant interpersonal conflict	Problematic understanding of others		Few friends
			Self-protective aloofness				Not very open with her boyfriend
			Denies desire for closeness and affection				

			Social awkwardness and shyness				
			Distracted by inner thoughts that intrude on social communication				
Feeling		Low positive feelings and anhedonia	Inhibited anger, anxiety, and resentment	Nonsignificant affect dysregulation	Uses thoughts to blunt her emotions	Extremely strong emotion regulation	Significant history of sadness
		Somatic and gastrointestinal complaints	Sadness with recurring periods of anxiety		Dysphoric distress		Some anxiety
		Emotionally restricted	Generalized anxiety		Efforts to deaden emotion		
			Dysphoric mood		Some physical concerns		
Self		Self-doubt	Weak and fragile self-image	Nonsignificant identity impairment	Problematic understanding of self		
			Self-deprecation—plagued by self-doubt		Negative self-evaluation		
					Self-critical		
Coping					Limited internal capacity to cope with day-to-day life		

TABLE 7.6 **ANDREA'S FINALIZED DATA**

Test: Theme:	PAI	MMPI-2-RF	MCMI-IV	IASC	RPAS	CEFI-Adult	Interviewand Observation
Overwhelmed thought processes	Some confused thinking		Some confusion in thinking		Deliberate, thoughtful thinking strategy	Problems with attention	Problems with attention and executive functioning
			Distracted thinking		Thinking disturbance and confusion	Difficulties with planning, organization, initiation, and multitasking	
					Drawn to inconsistencies and nuance in the environment in a way that can overwhelm her thought processes		
Interpersonal guardedness	Overly passive in interactions with others	Socially avoidant	Some guardedness	Nonsignificant interpersonal conflict	Problematic understanding of others		Few friends
			Self-protective aloofness				Not very open with her boyfriend
			Denies desire for closeness and affection				
			Social awkwardness and shyness				

			Distracted by inner thoughts that intrude on social communication				
Emotional distress	Anxious rumination	Prone to obsessive rumination	Sadness with recurring periods of anxiety		Limited internal capacity to cope with day-to-day life		History of hopelessness and worthlessness
		Low positive feelings and anhedonia	Generalized anxiety		Dysphoric distress		Significant history of sadness
			Dysphoric mood				Some anxiety
Discomfort with emotions		Somatic and gastrointestinal complaints	Inhibited anger, anxiety, and resentment	Nonsignificant affect dysregulation	Uses thoughts to blunt her emotions	Extremely strong emotion regulation	
		Emotionally restricted			Efforts to deaden emotion		
		Somatic and gastrointestinal complaints			Some physical concerns		
Weak and negative self-image		Self-doubt	Weak and fragile self-image	Nonsignificant identity impairment	Problematic understanding of self		
			Self-deprecation—plagued by self-doubt		Negative self-evaluation		
					Self-critical		

MMPI-2-RF finding that she is prone to obsessive rumination, actually helps us make a decision to keep them together in a single them of her thought processes being overwhelmed.

The Feeling theme also seems to converge around two major points: Certainly there is a great deal of emotional distress (both depressive and anxious symptoms), but there are also data relating to her efforts to inhibit, overregulate, and blunt her emotional experiences. Unlike the Thinking data, these are harder to justify keeping together, as the former are more related to the emotional content and the latter more emotional process. As such, we can separate these into two separate themes, one for Emotional Distress and one for her efforts to dampen down her emotional experience. In this case we can use the phrase Discomfort with Emotions to reflect the underlying reasons for her wanting to overregulate her emotions, though we could also call it something more directly related to her overregulation. When looking at the Emotional Distress data, again we have two distinct stories being represented: one related to sadness and dysphoria and one related to anxiety. We can decide either to separate those (there are certainly enough data across methods and measures to sustain both of them) or keep them together (again, thinking about them as internalizing symptoms, rather than discrete issues). For the sake of not being overwhelmed by the number of themes, in this case we will keep them together. The final themes with data are presented in Table 7.6.

Conceptualizing

Remembering that the task at this point is to try to create a logical narrative among the themes, applying psychological theory so it presents a coherent story, we have to connect the following themes:

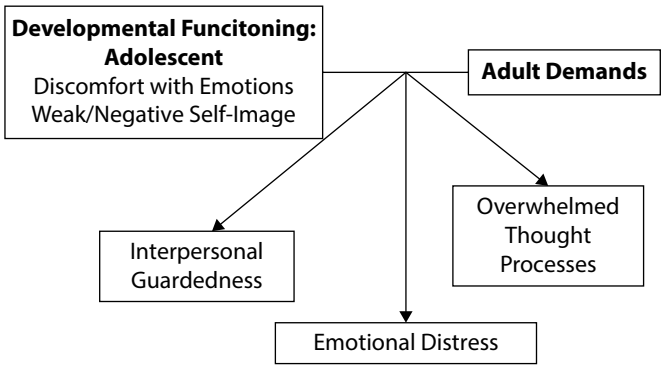
- overwhelmed thought processes
- interpersonal guardedness
- emotional distress
- discomfort with emotions
- weak and negative self-image

Before deciding on the most logical way to fit all these themes together, we will first consider some of the model templates presented in Chapter 4. However, none of the themes lend themselves easily to being an external or contextual stressor, so we will not force a diathesis–stress model. Similarly, it is difficult to identify a common function within these five themes. Whereas there could be functions of protecting herself from negative emotions and some of the themes could easily represent that aim (such as her interpersonal guardedness), it is harder to argue that her problems with self-image or overwhelmed thoughts somehow achieve this goal. As such, we will try a developmental mismatch model, a developmental themes model and an interpersonal circumplex model for conceptualization.

Developmental Mismatch Model

The developmental model for Andrea is interesting, though ultimately it is probably a tough case to make since many of the themes are not specifically tied to normative developmental stages. Nevertheless, we will try it. As an adult, she should be comfortable feeling and tolerating her own emotions and should have a clear sense of who she is in the world. What characterizes her current developmental functioning, however, are some problems in these areas. Emotion regulation (and tolerance) issues and especially identity development are tasks more typically associated with the developmental period of adolescence. Accordingly, Andrea's developmental functioning and her real-world demands (those of an adult) are not on the same developmental level, which can cause problems. The leftover themes (guardedness, overwhelmed thinking, and emotional distress) will need to be outcomes in this model. Andrea's developmental model is shown in Figure 7.1.

FIGURE 7.1 **DEVELOPMENTAL MISMATCH MODEL FOR ANDREA**



This model generally makes some intuitive sense. As discussed in Chapter 4, placing some difficulties along a normal developmental trajectory and conceptualizing them simply as delayed processes that everyone goes through—instead of posing it as a weak identity—can be a palatable and kind way to present difficulties. Additionally, an assessor can sympathize with how difficult it must be to have to develop this outside the contexts that are built for it (e.g., high schools are ideal places to try on different identities, different friend groups), which further reinforces why the delay in this developmental area can cause difficulties (outcomes). In the end, though, this may be too oversimplified to be as useful as some other models for Andrea.

Developmental Themes Model

If we loosen our model a bit and think about the developmental trajectory of normative and adaptive, typical human development, we can begin to understand Andrea's themes in a more hierarchical way. This requires a good understanding of the literature on normative and abnormal development across the life span and awareness of the potential vulnerability caused by asynchronous development within an individual (e.g., Silverman, 1997). In Andrea's case, the one theme that does not indicate a developmental line (the different aspects of human functioning that grow and develop; A. Freud, 1963) is Emotional Distress, which can manifest at any and all levels of development. As such, it will be treated as an outcome in this model.

The skill of developmentally tolerating and regulating emotions is likely to generally improve across the life span for typically developing individuals. Some research has suggested that the preschool years are key for the development of frustration tolerance and self-regulation strategies (e.g., Chaplin, Klein, Cole, & Turpyn, 2017; Cole & Jacobs, 2018; Kochanska, Coy, & Murray, 2001). That is, individuals can begin quite early in development suppressing and guarding their own emotional experience rather than fully experiencing and communicating it. Developmentally for Andrea this is the earliest problem represented by her themes.

Being overwhelmed by thoughts and having a thinking process that is disorganized and obstructed could also be an outcome of other difficulties. However, if we look at the literature on the development of more logical thinking processes, we again find some evidence that it should develop continually throughout the life span. However, Piaget's theory of cognitive development posits that the formal operational stage of development, in which logical and symbolic thinking are tolerated and positively used, is a task generally for adolescence (Kuhn, Langer, Kohlberg, & Haan, 1977; Piaget, 1972) and aligns temporally with Erikson's stage of identity development (Erikson, 1963). These adolescent developmental tasks—developing a clear identity and using logical and symbolic thought purposefully—represent the next developmental level in Andrea's model.

To evaluate Andrea's guardedness toward getting close to others, we again need to consult that social development literature, and again we look to Erikson's models of psychosocial development. Socially, Erikson would place the capacity for intimacy (versus guardedness) in early adulthood, placing it later than the adolescent problems of her identity and clarity of thinking. In the end, we develop a model where an individual who has difficulty tolerating her own emotions and then developing a clear sense of who she is, becoming overwhelmed in her thought processes. These problems contribute to her developing a style of pushing others away, all of which ultimately leads to emotional distress. The developmental themes model for Andrea is shown in Figure 7.2.

There are two major considerations when evaluating this model. First, the arrows in the graphical representation of the model are somewhat misleading, implying causality (or at least contribution). While a weak and negative self-image may certainly contribute to some interpersonal guardedness, is there a clear psychologically defensible reason that discomfort with emotions contributes to an overwhelmed thinking process or that interpersonal guardedness contributes to emotional distress? These things may be related, but we need to make sure they are likely related to proceed with this model.

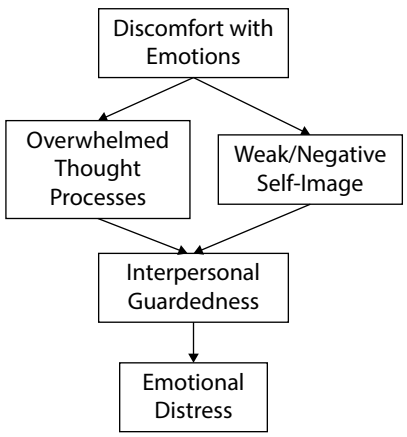
Second, we need to consider if the model makes intuitive and internally coherent sense. We need to think of a typical audience member (in this case perhaps Andrea herself) and whether it would make intuitive sense that someone who is extremely uncomfortable with her emotions and thus works hard to suppress them would likely develop an overwhelmed thought process. This may take a bit more explanation than, for example, someone with emotional discomfort having difficulty developing a clear sense of who she is in the world. In the end, this may be too linear and have too many levels to prove useful for Andrea.

Interpersonal Circumplex Model

One of the biggest advantages of the interpersonal circumplex model for organizing and conceptualizing data is how it separates personality functioning from emotional and behavioral functioning. That is, all the themes that fit neatly onto the interpersonal circumplex constitute personality (from the perspective of this model), and themes that do not fit compose outcomes from the personality type and its interaction with the world. In Andrea's case, a few themes are clearly interpersonally and self-oriented, which fit nicely on the model; the leftover themes can easily be distinguished as outcomes.

The first and most obvious component in this model is Andrea's interpersonal guardedness and pushing others away, which falls firmly on the cold and hostile side of the affiliativeness continuum. Her weak and negative

FIGURE 7.2 **DEVELOPMENTAL THEMES MODEL FOR ANDREA**



identity can be conceptualized as unassured, which falls down at the bottom of the dominance continuum. Finally, her discomfort with emotions, while not specifically self- or other oriented, can be conceptualized on the more aloof (introverted) corner of the model. The remaining themes constitute outcomes of her personality type interacting with the world. The initial interpersonal circumplex model for Andrea is shown in Figure 7.3.

Figure 7.4 presents the modified and clarified interpersonal circumplex model, which characterizes her personality more clearly as aloof and avoidant. Ultimately, this personality style is ineffective and leads to both emotional and thinking distress. This is a relatively useful way of conceptualizing Andrea's difficulties in functioning, especially as the two outcomes represent her two presenting problems: her depression and her problems with attention and executive functioning. As a way of Andrea understanding herself, her style of interacting with herself and the world is not optimal and is leading to her current (and past) difficulties. Additionally, this model

FIGURE 7.3 **INITIAL INTERPERSONAL CIRCUMPLEX MODEL FOR ANDREA**

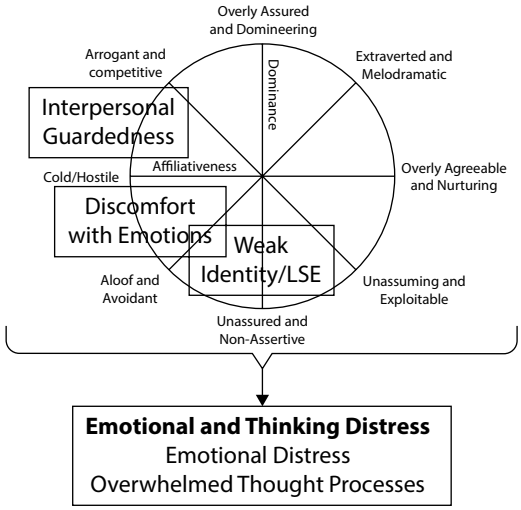
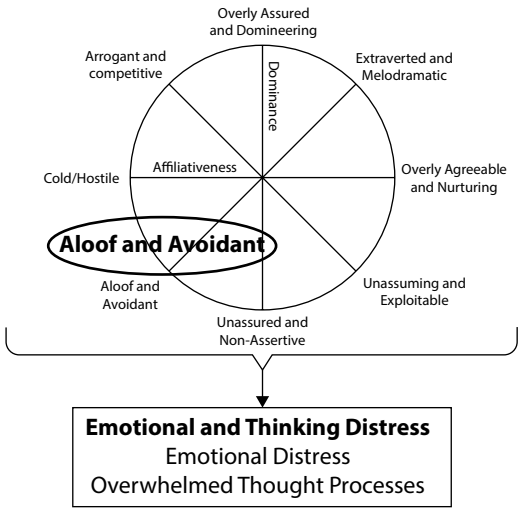


FIGURE 7.4 **FINAL INTERPERSONAL CIRCUMPLEX MODEL FOR ANDREA**



certainly steers us toward clear recommendations of how to intervene with Andrea since it conceptualizes her aloof and avoidant personality style as the underlying contributing factor to her current distress. Effective therapy would target her aloof and avoidant style, which should then translate into an alleviation of emotional and thinking symptoms. In the end, this may be a useful way to represent the findings in the report.

Complex Model

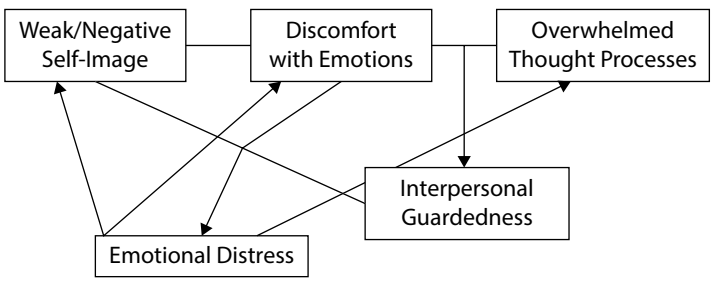
Each of the aforementioned models has benefits and limitations for understanding Andrea's functioning. Any could be used for the final report, and the interpersonal circumplex model especially seems to have promise in this case. However, thinking about the themes in a slightly more complex way may lead to a more logical way to link several of them. When considering some of the strengths of the previously considered models, especially the two developmental ones, it becomes clear that developmentally three of the themes can be treated as more core to who Andrea is and how she has developed: her discomfort with emotions, her weak and negative self-image, and her overwhelmed thought processes. If these constitute a core layer to her functioning, all we have to contend with is how they likely interact to contribute to the two remaining themes: interpersonal guardedness and emotional distress.

While interpersonal guardedness likely has its roots in many things (potentially including adverse interpersonal experiences previously experienced by Andrea), the two core themes that seem more directly linked to it are her discomfort with emotions and her overwhelmed thought processes. That is, a person who is overwhelmed both in her thinking and in her emotions can develop a style of pushing others away; relationships with others are almost entirely complex, nuanced, and emotional, all of which are overwhelming to Andrea. As such, she guards herself against all the nuance and messiness that can unravel her.

Similarly, while emotional distress is very likely multiply determined and caused by many contributing factors, some of the themes are likely more linked to it than others. Specifically, there seems to be less of a direct connection between her overwhelmed thinking processes and her emotional distress than some of the other constructs. Her negative self-image can easily contribute to emotional distress, and it would not take a great deal of explanation to convince Andrea or others of this link. Likewise, her discomfort with her emotions and attempts to overcontrol and restrict them can easily be linked to emotional distress since suppressing emotion is often not an effective coping strategy. Finally, adding some nuance and levels to the model, her style of pushing others away and isolating herself can also contribute to emotional distress, leaving her less social support than she needs. This reinforces and worsens her negative self-image, her discomfort with emotions, and especially her attention and other executive functions.

This formulation represents a hybrid of the strengths of the previous developmental conceptualizations but with more freedom and flexibility to think about what is psychologically logical and (ironically) with more simplicity. While it looks somewhat complicated in diagram form, a narrative can present this model in a way that truly links the themes in a narrative and convincing way. The complex model for Andrea is shown in Figure 7.5.

FIGURE 7.5 **COMPLEX MODEL FOR ANDREA**



Report Writing

Before the report can be written, the final step of determining diagnosis and recommendations must be addressed. Recalling the possible causes enumerated in the earlier stages of the assessment process, the first hypothesis to consider is ADHD. This was ostensibly the primary reason for her referral, and both she and her therapist did a good job of listing off many of the diagnostic symptoms of the disorder when describing Andrea's struggles. However, based on the testing, and given the fact that ADHD is classified and understood as a neurodevelopmental disorder, her prefrontal functioning (e.g., ability to focus, sustain attention, work with information in her head, adapt to changing conditions) appears intact under ideal circumstances (i.e., the testing environment, which was free of random distraction and has individual attention from a generally friendly person). While she does have problems with attention and some executive functions in her everyday life, based on the testing it is not because her brain cannot do it; other things seem to be getting in the way, consistent with the onset of her cognitive difficulties coinciding with her depression. Thus, we rule out ADHD.

Her emotional functioning, on the other hand, does seem to be present, significant, and impairing her functioning in multiple ways, including subjective distress (sadness and anxiety), cognitive difficulties (executive functioning, including attention), and also likely her social isolation. So the decision comes down to the specific disorder that seems most appropriate for Andrea given the symptoms. We need a disorder that can account for her many years of consistently depressed mood and anxious symptoms. This could be a mixed anxious–depressive disorder (categorized in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* [*DSM-5*] as an other specified depressive or anxiety disorder). However, the long-standing nature of the difficulties—including not just low mood but also fatigue, sleep disturbance, poor concentration, low self-esteem, and hopelessness—suggests the presence of persistent depressive disorder (dysthymia), with anxious distress. Moreover, while she reported that her depressive symptoms have remitted, in actuality some of them like fatigue, some currently experienced dysphoria and anxiety, and low self-esteem have persisted. As such, her dysthymia is in partial remission.

The final hypothesis originally developed was the possibility of a personality disorder. This requires some thought because Andrea's interpersonal style (especially) is problematic, and her current social isolation does not seem entirely attributable to her emotional distress. However, she does have at least one significant interpersonal relationship, her boyfriend, even though she admitted that their relationship is not very deep. Two disorders to consider are avoidant personality disorder and schizoid personality disorder—though she does not meet full criteria despite having some symptoms of each. Further, even though her style is causing some difficulties in her life, a personality disorder diagnosis will not be given because of her significant intimate relationship with her boyfriend and no evidence that her personality style negatively affects her work. A style will be presented in the diagnosis section, however, as therapy would benefit from focusing on it.

Mood and anxiety disorders generally tend to respond well to most types of treatment (e.g., Khan, Faucett, Lichtenberg, Kirsch, & Brown, 2012), and there are no widely accepted specific treatments of choice for dysthymia. For this reason, we need to move away from diagnosis-driven treatment recommendations. The next step is to consider Andrea's individual characteristics and whether they contraindicate any specific types of treatment. Her functional impairment is low, so outpatient, weekly psychotherapy should be adequate. Her subjective distress is moderate, there is low complexity (though the personality trait focus adds some complexity), she has low social support, and it seems she has low reactance, all of which point to a recommendation of cognitive behavioral therapy (CBT). However, it is unclear just how motivated she is to change—that is, she may be in an earlier stage of change)—given that she thinks her depressive symptoms have dissipated significantly. However, as long as she understands and agrees that her depressive disorder is underlying her attention and executive functioning difficulties, then she should be ready to work and change. In addition,

she has been in therapy for a while and has seen gains, so it is likely that she will not be too resistant to direct techniques.

CBT is a good option, then, for Andrea given her characteristics and the wide availability of these types of services where she lives. However, we also want to consider our conceptualization, and some other easily accessible types of treatment may also work. Schema therapy (which integrates many aspects of CBT) may target her underlying, early maladaptive schemas and her core emotional needs in a more direct way. Accelerated experiential dynamic psychotherapy (AEDP) may also help her tolerate her own emotional states in a more targeted, straightforward way. Remembering that depressive disorders tend to respond generally well to most psychotherapeutic treatments, we can be a bit less prescriptive and confident in a single modality and focus on treatment goals.

One additional, useful recommendation—again understanding the literature—is to provide a psychiatric consultation. Research has shown that the combination of psychotherapy and psychiatric medication may be slightly more effective than either alone (Khan et al., 2012). As always, because we are not psychiatrists we will discuss only the possibility and the potential benefits of psychiatry and will carefully avoid recommending medication specifically. Now that diagnoses and recommendations have been determined, we can write the report.

Confidential Psychological Assessment Report

Identifying Information

Name:	Andrea Fisher	**Date of report:**	2/28/20
Sex:	Female	**Assessor:**	A. Jordan Wright, PhD
Age:	28		
Date of birth:	1/1/1992	**Dates of**	1/21/20; 1/25/20;
Ethnicity:	White	**assessment:**	2/11/20; 2/13/20

Referral Source and Questions

The client was referred by her therapist to determine what is underlying her problems with attention and other executive functions, like organization, planning, and multitasking.

Measures Administered

- Clinical interview
- Bender Visual-Motor Gestalt Test, 2nd Edition (Bender-2)
- Wechsler Adult Intelligence Scale, 4th Edition (WAIS-IV)
- Test of Variables of Attention (T.O.V.A.)
- Delis-Kaplan Executive Function System, Trail Making Test (Trails)
- Wisconsin Card Sorting Test, Computer Version Fourth Edition (WCST-IV)
- Comprehensive Executive Function Inventory, Adult (CEFI)
- Personality Assessment Inventory (PAI)
- Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF)

- Millon Clinical Multiaxial Inventory, 4th Edition (MCMI-IV)
- Inventory of Altered Self-Capacities (IASC)
- Rorschach Performance Assessment System (R-PAS)

Client Description

Andrea Fisher is a 28-year-old, straight, White female, who is currently in a relationship. She currently works as a fact-checker for a political website and is also a freelance writer. She was casually dressed and appropriately groomed throughout the assessment and looks her stated age. She was cooperative throughout the assessment, making appropriate eye contact, answering all questions, and appearing engaged. She appeared to make effortful attempts on all measures administered. She arrived on time for all appointments, but she presented as somewhat fatigued, including speaking at a somewhat slow pace.

Presenting Problem and Its History

The client reported that she has difficulty with "self-management and organization," noting that she "put[s] off work and [does] way less than [she] intended." She reported that it is difficult for her to get started on a task and that once she completes a task it is challenging to then start another task. The client reported that these challenges occur even when the task is interesting and something she wants to work on, such as writing her own articles. She noted that structure and routine help her complete tasks but that she has trouble adjusting when structure is removed or routines change. The client reported that she finds it particularly challenging to start a task if there is a limited amount of time for her to work ("even if it's 8 hours") and she has other engagements later in the day, and she often engages in procrastination behaviors, such as "random Internet searching." She reported feeling that this difficulty with initiating tasks and sustaining attention has impacted her postcollege life and career. The client reported that, despite wanting to find a new job, she feels like working on job applications simultaneously with her current fact-checking position "is making my brain melt." The client also reported difficulty with decision making and being forgetful (e.g., with errands, scheduling, where she put her phone). The client reported that she was disorganized in high school but was "able to do decently." She reported that she did not notice these symptoms until 2014 (about 6 years ago), when she was "depressed" and found it challenging to be productive. She reported that her symptoms are particularly problematic as she manages her jobs as a fact-checker and a freelance writer.

The client reported a history of depressive symptoms for the past 5 years but that she has been feeling "way better" over the previous month since she started her new job. She reported a history of passive suicidal ideation in September of last year, but she denied a plan or actual intent to harm herself, and she reported that she discussed these thoughts with her therapist. The client reported feeling overwhelmed at that time and noted feeling "a lot of shame about not having regular employment." She reported feelings of helplessness and worthlessness in the past, but these have reportedly gotten better over the previous month. The client reported that her current mood is "good-ish," but that she is "still very tired," with some difficulty waking up in the morning. She also reported that some anxiety "crops up," such as when her boyfriend does not answer his phone or when people are arguing.

Relevant Background Information

Psychosocial Evaluation

The client earned a bachelor of arts in writing from a prestigious liberal arts college. She reported that she "did well" in high school with grades in the "A range" but that her grades were lower in math. She currently works as a fact-checker for a political website and has held this position for about 2 months. She feels she is doing well in the job; she just successfully completed her probationary period and officially began full-time. She reported

feeling "satisfied to do [this job] for now." She is also currently a freelance writer focusing on politics, although she reported difficulty writing as many articles as she would like because of her reported attention and organizational concerns. She has previously worked as a writer for several political magazines and websites, but she has never been fully satisfied with her jobs.

The client currently lives with her boyfriend, with whom she has been in a relationship for about 2 1/2 years. She described that her support system also includes her mother, father, and sister. She reported having "a bunch of friends growing up" and that she has only a few friends now, though most of them live out of town. She reported that she has not made many friends since she graduated from college.

The client reported that she and her older sister were raised in New York by their mother and father. She reported that her parents are currently married and that she has a positive relationship with them, considering them to be her emotional support system. The client has a "pretty close" relationship with her sister, reporting that they play tennis together weekly. She also noted that her sister "was the center of everything" as they were growing up because she had emotional difficulties. The client reported that she also has a close relationship with her grandmother.

The client reported that she is "White and Catholic," though she does not actively participate in religious activities. She stated that growing up she participated in "Catholic stuff with my family."

Biopsychological Evaluation

The client reported no difficulties with her mother's pregnancy with her or her birth, and she met all developmental milestones (e.g., crawling, walking, talking, toilet training) on time. She denied any history of major medical illnesses, hospitalizations, or surgeries. She reported that she once hit her head on a door as a child but did not lose consciousness or require medical attention. She reported that she has about one to two alcoholic drinks per week and denied any other past or present substance use.

The client reported that she has been seeing a therapist for about 1 1/2 years. She denied any formal psychiatric diagnosis but reported a 5-year period of feeling depressed, with symptoms decreasing in the month prior to the present assessment (when she secured her new job). The client reported past thoughts of suicide in September 2019, but she denied any plan or actual intent to harm herself and denied any past suicidal behaviors. She reported that she felt "overwhelmed" at the time and discussed these thoughts with her therapist. She reported previous symptoms of helplessness, hopelessness, and worthlessness during that period, but she stated that these have decreased significantly since she began her new job. She denied ever seeing a psychiatrist or being prescribed psychiatric medication.

Behavioral Observations

The client was cooperative throughout the assessment and seemed to give effortful attempts on all tests administered. At times, she appeared visibly fatigued and tired, though she insisted on persisting with the testing sessions without postponing.

Mental Status Evaluation

The client was appropriately dressed and groomed throughout the assessment and looked her stated age. She was cooperative throughout the assessment, making appropriate eye contact and answering all questions. She appeared to make effortful attempts on all administered tests. Her speech was slightly slow, and her language was goal directed. Her motor functioning was unremarkable. Her mood was "tired," and her affect was generally mood congruent and appropriate to the situation. Her thought content was reported as free of delusions and current hopelessness, helplessness, or worthlessness. The client denied current suicidal and aggressive

or homicidal ideation. Her attention and concentration were adequate throughout, and her memory functioning appeared intact. Her insight was fair, and her judgment seemed generally adequate in the moment.

Overall Interpretation of Test Findings

Cognitive Functioning

The client was administered several measures to assess her current cognitive functioning. It should be noted that these measures evaluate her cognitive ability under ideal conditions and in the most ideal context; as such, they represent her cognitive ability rather than how she actually functions in her daily life.

The client's overall performance across multiple domains of cognitive functioning was generally superior compared with others her age, with significant strength in her verbal abilities. It is important to note that she exhibited no cognitive problems with her attention or executive functions, and, as such, any difficulties she is experiencing in these areas are not due to cognitive ability problems.

Fine Motor Skill. On measures assessing her ability to control her fine motor functioning deliberately and carefully, the client exhibited no difficulties in her actual motor control (Bender-2 Motor Subtest, 76th–100th percentile) or in her speed and ease of using her fine motor skills (Trails Motor Speed, 63rd percentile). Her control of her movement is not currently impaired.

Visual Perception and Reasoning. On measures of visual perceptual ability, including nonverbal reasoning, visuospatial aptitude, and induction and planning skills on tasks involving nonverbal stimuli such as designs, pictures, and puzzles, the client performed within the average range compared with others her age (WAIS-IV Perceptual Reasoning Index, 63rd percentile). Although this is average, it represented a weakness compared with her overall strong functioning. She showed no difficulty with her basic abilities with visual perception (Bender-2 Perception Subtest, 76th–100th percentile) and performed in the high average range on more complex nonverbal reasoning skills (WAIS-IV Visual Puzzles, 84th percentile).

Visual–Motor Integration. The client's ability to integrate her visual understanding with her motor coordination was variable, with her performance ranging from the average range to very superior range compared to others her age. On a task requiring her to use blocks to recreate complex designs presented to her within a time limit, the client performed in the average range compared with others her age (WAIS-IV Block Design, 63rd percentile). On a task requiring her to copy complex drawings as precisely as possible without time restraint, which requires perceptual ability and the coordination between that ability and fine motor control, she performed in the very superior range compared with others her age (Bender-2 Copy, 99.8th percentile). It should be noted that the former task requires both visual–motor integration and motor and processing speed, whereas the latter does not. As such, her actual ability to integrate her visual and motor functioning is strong, though her speed of working is weaker.

Memory. The client completed a brief test of short-term visual memory. Her ability to recall visual information that was previously presented to her was very superior compared with others her age (Bender-2 Recall, 99.8th percentile). She exhibited no difficulty with remembering information.

Language. On measures of verbal ability, including verbal comprehension, ease of use of verbal skills, verbal knowledge, and the ability to express herself clearly and completely, the client's performance fell within the very superior range compared with others her age (WAIS-IV Verbal Comprehension Index, 99.9th percentile), representing her greatest strength. Her ability to express herself clearly is extremely strong for someone her age (WAIS-IV Vocabulary, 99.9th percentile), as is her abstract understanding of language and use of words in complex and abstract ways (WAIS-IV Similarities, 99th percentile). Her ability to understand and use language effectively is very strong.

Processing Speed. The client's ability to focus attention and quickly scan, discriminate between, and respond to visual information within a time limit (knowing she was timed) was in the high average range compared with others her age (WAIS-IV Processing Speed Index, 77th percentile), although this represented a slight weakness compared with her overall strong cognitive ability. Her working speed was variable on simple tasks (Trails Number Sequencing, 16th percentile; Trails Letter Sequencing, 75th percentile) and unimpaired on more complex, short-term speed tasks (WAIS-IV Coding, 75th percentile; Symbol Search, 75th percentile). She did not exhibit any deficit in her speed of processing information, though its variability reveals some occasional difficulties.

Executive Functioning. The client completed several tasks that evaluate executive functions, such as attention, working memory, impulse control, adapting to changing conditions, and monitoring herself in her strategies. Her performance on these tasks was generally average and unimpaired.

Selective Attention. The client's selective attention—the ability to weed out essential versus nonessential information, quickly determine correct versus incorrect stimuli, and focus her attention when distractions are present—was generally comparable to others her age, with scores ranging from average to the high average (WAIS-IV Cancellation, 84th percentile; Trails Visual Scanning, 63rd percentile; T.O.V.A. RT Variability, 53rd percentile; T.O.V.A. D Prime, 50th percentile; T.O.V.A. Omission Errors, 50th percentile).

Sustained Attention. The client's sustained attention—the ability to concentrate and keep vigilant on a boring task in a consistent manner—is also generally average and unimpaired for her age. On a boring task that lasted an extended period of time, she was able to maintain her attention over time. Specifically, she did not display an increase in errors as the task progressed (T.O.V.A. Errors by Quarter, *n.s.*), and the time it took her to respond to stimuli was consistent as the task progressed (T.O.V.A. Response Time by Quarter, *n.s.*). On another task that required her to hold rules in her head for how to respond, she was able to maintain her attention to keep the rules in her head as the task progressed (WCST-IV Nonperseverative Errors, 63rd percentile).

Auditory Working Memory. On tasks that assessed her ability to learn and memorize new information, hold it in short term memory, concentrate, and manipulate that information to produce some result or reasoning outcome, the client's performance fell within the high average range of functioning compared to others her age (WAIS-IV Working Memory Index, 90th percentile).

Impulse Control and Related Functions. The client's control over her impulses is generally intact. On a task measuring the client's cognitive ability to control her impulses and respond to stimuli in the opposite way than her impulses would want her to, she performed well (T.O.V.A. Commission Errors, 50th percentile). On a task that required her to control her impulses and to change her strategy midway through the task, she performed in the average range (D-KEFS Trails Number–Letter Switching, 84th percentile). On another task that required her to control her impulses, self-monitor, and adapt to feedback in the moment, her performance also fell within the average range compared with same-aged peers (WCST-IV Perseverative Errors, 66th percentile), again showing no difficulties. Her basic cognitive ability to control her impulses is unimpaired, as are her ability to change strategies when prompted and to adapt to feedback when making decisions.

Personality, Emotional, and Behavioral Functioning

The client was administered several measures to assess her current personality, emotional, and behavioral functioning. It should be noted that the focus of these measures is on areas of need rather than a comprehensive overview of all of her personality, emotional, and behavioral strengths and weaknesses. As such, this section will necessarily focus on areas of her functioning that need support

The assessment revealed that while the client has many strengths, she struggles with several core, underlying problems. Specifically, she struggles with a weak and generally negative understanding of who she is, a significant discomfort with experiencing her own emotions, and a thinking style that is complex and nuanced, but ultimately overwhelmed. Her discomfort with emotions and somewhat overwhelmed (and thus unclear) understanding of other people have contributed to her having developed a generally guarded approach to interpersonal relationships. Additionally, her negative self-image, discomfort with emotions, and social disconnection have all contributed to her currently experiencing some emotional distress, in the form of primarily depressive but also anxious symptoms. This emotional distress worsens her difficulties with attention and other executive functions.

Weak and Negative Self-Image. The client currently struggles with not having a clear sense of who she is and being overly self-critical. The client struggles to understand herself clearly (MCMI-IV; R-PAS). Additionally, she tends to be self-deprecating, doubting her abilities (MMPI-2-RF; MCMI-IV; R-PAS), and her self-evaluation is often based on unrealistically high standards she sets for herself (R-PAS).

Discomfort With Emotions. The client feels uncomfortable with both experiencing and expressing her internal emotional states, particularly those that are more negative. The client tends to be generally emotionally restricted (MMPI-2-RF; R-PAS), especially related to feelings of anger and resentment (MCMI-IV). She makes efforts to maintain very strict control over her emotional experience and expression (IASC; CEFI; R-PAS), much preferring to think than feel (R-PAS). As is common in individual who are uncomfortable with their emotions, the client tends to experience some of her negative emotional states more as physical symptoms, such as gastrointestinal distress (MMPI-2-RF; R-PAS).

Overwhelmed Thought Processes. While the client's thinking is generally complex, sophisticated, and nuanced (consistent with her extremely strong verbal cognitive abilities), it can also become somewhat overwhelmed and confusing. The client is drawn so much to inconsistencies and nuances in the environment that her thought processes can become overwhelmed (R-PAS), at times getting confused (PAI; MCMI-IV; R-PAS). Her overwhelmed thought processes, as well as related functions like organization and planning (CEFI), are what ultimately impair her ability to maintain attention (CEFI; MCMI-IV).

Interpersonal Guardedness. The client's discomfort with emotions and difficulty understanding others have contributed to her experiencing challenges in relating to others and tending to be somewhat disconnected and guarded. The client struggles with some social awkwardness and shyness (MCMI-IV), some of which is related to difficulty communicating clearly because she is so often distracted by her inner thoughts (MCMI-IV). Additionally, the client does not always clearly and accurately understand others, including their motivations (R-PAS). Ultimately, she employs a self-protective aloofness and often chooses not to participate in social situations (MMPI-2-RF; MCMI-IV). When not aloof, however, she can be overly passive in her interactions with others (PAI).

Emotional Distress. The client's negative self-image and discomfort with emotions contribute to her experiencing some emotional distress. While the client is uncomfortable experiencing and especially expressing emotions, she is currently struggling with low mood, sadness, and low pleasure in her life (MCMI-IV; MMPI-2-RF; R-PAS). Additionally, she struggles with some symptoms of anxiety, including rumination (PAI; MMPI-2-RF; MCMI-IV). These symptoms of distress are related to her having inadequate coping skills to effectively handle stresses in her life (R-PAS).

Summary

Andrea Fisher is a 28-year-old, straight, White female who presented for an evaluation to assess what is underlying her reported difficulties with attention and other executive functions, like organization and planning. She also reported a history of depression. She was cooperative throughout the assessment, making appropriate eye contact, answering all questions, and appearing engaged. She appeared to make effortful attempts on all administered tests.

Cognitively, her overall performance across multiple domains of functioning was generally superior compared with others her age, with significant strengths in her verbal abilities. It is important to note that she exhibited no cognitive problems with her attention, and, as such, any attentional difficulties that the client may be experiencing are not due to cognitive ability problems.

The client's personality, emotional, and behavioral functioning includes several underlying struggles. The client struggles with a weak and generally negative understanding of who she is, a significant discomfort with experiencing her own emotions, and a thinking style that is complex and nuanced, but ultimately overwhelmed. Her discomfort with emotions and somewhat overwhelmed (and thus unclear) understanding of other people have contributed to her having developed a generally guarded approach to interpersonal relationships. Additionally, her negative self-image, discomfort with emotions, and social disconnection have all contributed to her currently experiencing some emotional distress, primarily in the form of depressive symptoms but also anxious symptoms. This emotional distress worsens her difficulties with attention and other executive functions.

Diagnostic Impression

Currently, the client meets criteria for persistent depressive disorder, with anxious distress, in partial remission (*DSM-5* code 300.4; *ICD-10* code F34.1). The client experienced a 5-year period of depressed mood coupled with marked distress in different areas of her life (e.g., personal, occupational); her depression has partially but not fully remitted. During that 5-year period, the client exhibited symptoms of depressed mood and related symptoms (e.g., fatigue, sleep disturbance, poor concentration, hopelessness, and helplessness) as well as some anxiety (e.g., gastrointestinal distress, worry).

It should be noted that the client does not currently meet criteria for attention deficit hyperactivity disorder (ADHD) based on this evaluation. However, she is experiencing symptoms of inattention as a function emotional distress that would benefit from being addressed. Specifically, her ruminative tendencies and overwhelmed thinking style contribute to poor attention and other problems with executive functioning in her everyday life.

It should also be noted that the client does not currently meet criteria for any personality disorder; however, she has some traits that would benefit from being addressed. Specifically, her self-protective aloofness and avoidant interpersonal style contribute to difficulties interacting with others in a fulfilling way.

Recommendations

1. It is recommended that the client continue in her individual psychotherapy treatment, which should use a cognitive behavioral therapy (CBT), accelerated experiential dynamic psychotherapy (AEDP), or schema therapy approach to address her personality, emotional, and attention-related symptoms. Treatment should be tailored to the client's high intelligence and thus can incorporate many theoretical components to create an individualized approach. Each of the psychotherapy treatments can help the client:
    - identify her negative emotional states and develop skills to feel comfortable with experiencing and expressing her emotions;
    - develop a clearer understanding of the relationship between her problems with attention, mood, and anxiety symptoms and her procrastination behaviors;

- identify and challenge maladaptive schemas and automatic thoughts underlying depressive and anxious symptoms;
- improve sleep hygiene to reduce sleep disturbances (specifically, CBT-I can be employed);
- develop useful strategies to cope with her anxiety, such as worry time, relaxation training, and mindfulness skills;
- reduce fatigue and low mood through behavioral activation using reward planning and activity scheduling for activities she derives pleasure and mastery from (e.g., writing);
- challenge her avoidant interpersonal tendencies through role-play and graded exposure; and
- use the therapeutic relationship as a model for healthy and safe interpersonal relationships.

2. It is recommended that the client seek consultation from a psychiatrist to explore the potential benefits of medication to help reduce her depressive and anxious symptoms.

_____ _____

A. Jordan Wright, PhD
New York State Licensed Psychologist

Date

Feedback

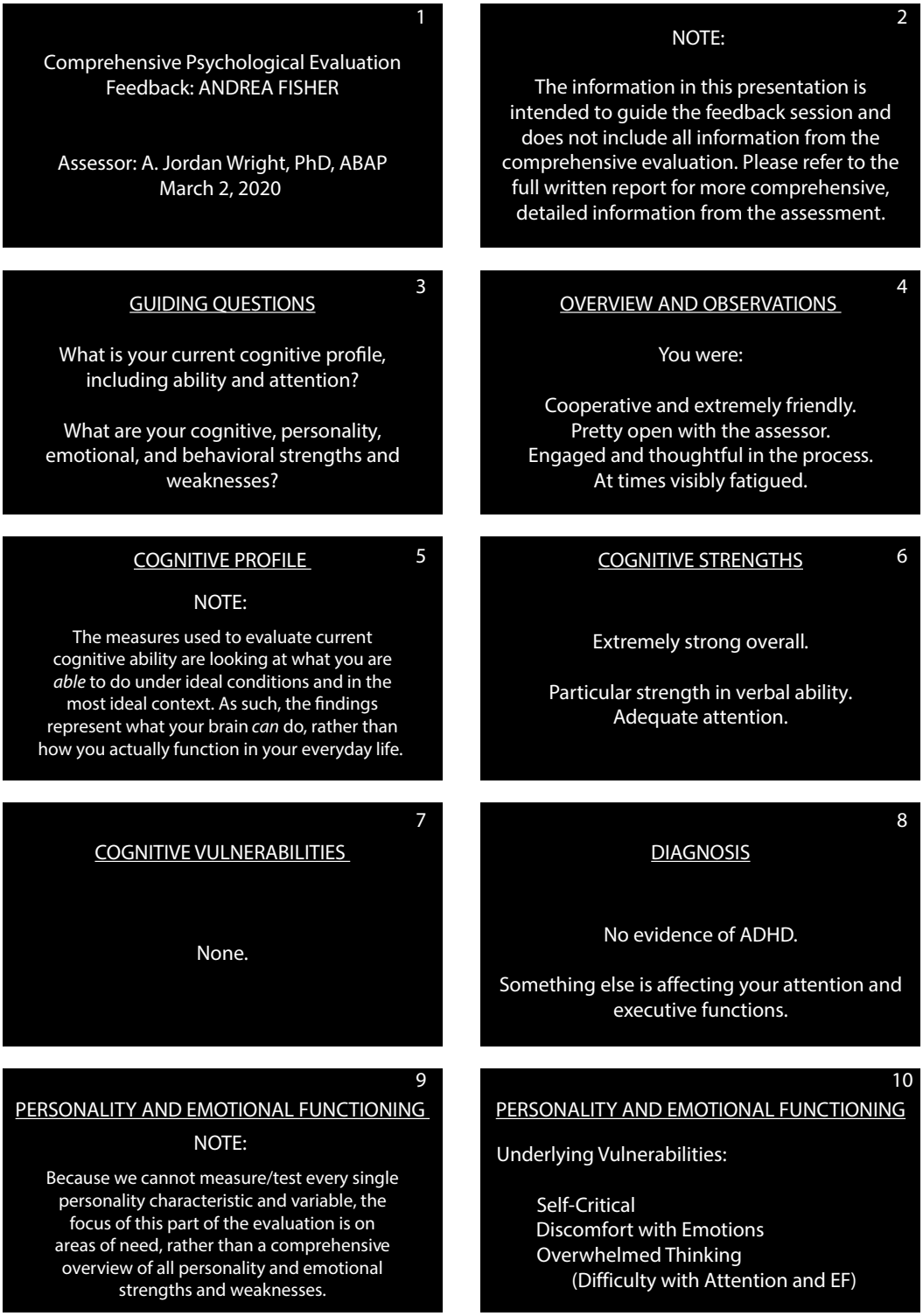
Preparation for Feedback

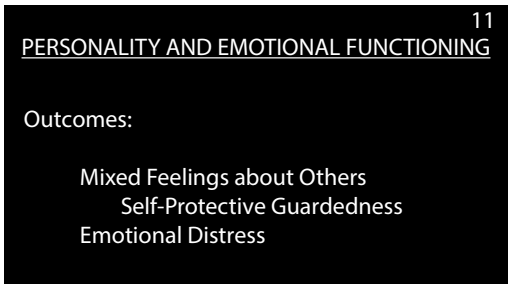
The process of feedback for Andrea should be relatively straightforward, and it is unlikely that she will have any sort of negative reaction to the findings or diagnosis because she knows she has struggled with significant depression and anxiety. However, the one potentially troubling finding to which she may react is that she does not have ADHD (even though that is good news). Obviously, there is a reason she and her therapist wanted a formal comprehensive evaluation rather than just sending her to a psychiatrist (or even primary care physician) to get medication for ADHD. This means that at least part of her is open to the fact that something else is going on. But in the end, the assessor will need to discuss how the alleviation of her depressive and anxiety symptoms (as well as her underlying dynamics of suppressing emotion, underdeveloped and negative identity, and interpersonal guardedness) will likely result in improved organization, focus, planning, and initiation.

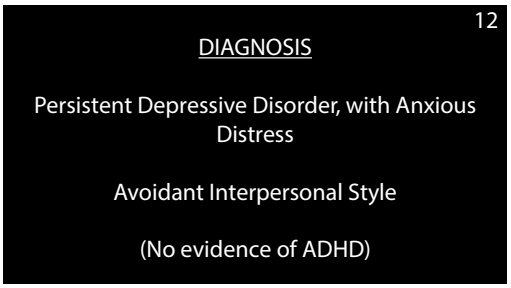
As is typical for feedback sessions, the assessor decided to give the feedback verbally (with the use of a feedback presentation) before giving Andrea the actual report. He wanted to ensure that she was really focused on the feedback the assessor was giving and had an opportunity to ask questions or discuss reactions without the distraction of holding and wanting to look at the report. The plan was to discuss the cognitive feedback first and then the personality and emotional functioning, with plenty of time for reactions and questions. Additionally, the plan was to talk about diagnosis throughout, noting that the cognitive findings did not indicate an ADHD process and giving a preview that other issues were impairing her executive functioning.

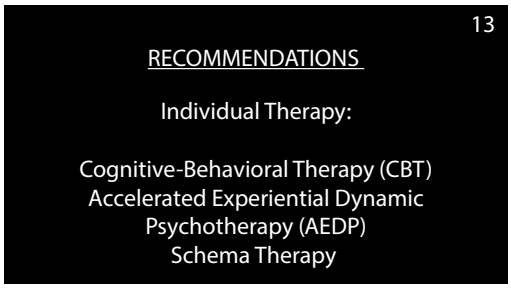
Feedback Presentation

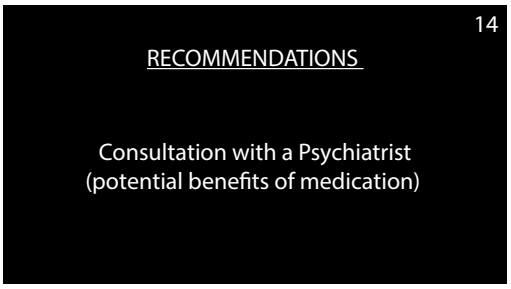
The assessor decided to create a feedback presentation for the case to organize and guide the feedback session.











Feedback Session

After framing the session in the standard way, discussing how bizarre the situation is to hear about yourself from a near stranger, noting that some things will be known to her and some likely may not be, discussing the process as a whole and noting that there may be factual errors in the report, offering to meet with her again if she had questions or concerns about the report, and framing the session itself, the assessor brought up the presentation on his computer. The real feedback began with a review of the guiding questions and an overview of Andrea's approach to testing, which was quite open and seemingly genuine.

The feedback session then turned to Andrea's cognitive functioning. Rather than go through every subdomain of cognitive functioning (even though they are all in the report), the assessor focused on the fact that she is extremely intelligent. He joked with her that he hoped this was not a surprise and how particularly strong her verbal ability is. They spent some time talking about what this means in life, and he tied verbal strength to overall success in life, especially in academic and occupational endeavors but also in her likelihood of benefitting from therapy (e.g., Høglend, 1999). To clarify, the feedback presentation had animated text, such that not every slide came up with all of its text together; therefore, the assessor could talk at length about overall cognitive strength and particular strength in verbal ability before anything about attention was even presented on the screen.

The next piece of feedback given was on her attentional and executive functioning ability. Although focusing on the optimal functioning (performance-based) testing, the assessor did first acknowledge that Andrea does seem to have everyday problems with attention, organization, planning, and initiation. Anticipating some possible resistance to finding out she has no actual, neurocognitively driven attentional or executive functioning difficulties, the assessor chose to include a bit of psychoeducation about the prefrontal cortex, problematic prefrontal functioning in ADHD, the other difficulties that can impair attention and executive functioning, and even about how the testing worked. That is, he discussed the survey instruments (e.g., CEFI Adult, PAI, MMPI-2-RF) as trying to figure out how she functions in her day-to-day life but the performance-based measures (e.g., WAIS-IV, T.O.V.A., WCST-IV, D-KEFS Trails) as trying to figure out what her brain was capable of doing under the best

possible circumstances. He presented the major discrepancy between the findings from the typical and optimal performance measures, clarifying that it means there is no evidence of ADHD.

Andrea seemed to have some reaction to this news on her face, so the assessor stopped and asked her to discuss her thoughts with him. She said she was a bit disappointed "'cause I seem so ADD!" The assessor reiterated that this does not mean that she does not have problems with her attention and other executive functions but that "other stuff" is getting in the way. She asked what it was that was getting in the way, and the assessor said that was coming up in the feedback. Before moving on, though, the assessor also discussed briefly why this was good news, focusing on the fact that if and when she treats the "other stuff" that is negatively impacting her cognitive functioning, she should see improvement in it without the need for ADHD-focused treatment or medications. She seemed hesitant but agreed to move forward with the feedback.

The feedback session moved to her personality, emotional, and behavioral functioning findings. The assessor presented (and they emerged one at a time on the presentation slides) Andrea's underlying or core vulnerabilities. In the presentation, some alternate wordings were used throughout, knowing that nuance and discussion would unfold in the session. For example, instead of weak and negative self-image, on the slide the assessor wrote "Self-Critical." The discussion that followed, though, did in fact focus on both the weak identity and the low self-esteem. This appeared difficult for Andrea to hear, as she looked down sadly at this point. In fact, she was crying softly, not because she was upset about receiving this feedback but because she knew she identified very closely with not truly knowing who she is and not feeling good about herself. Although only the first of five themes to be presented, the assessor took a bit of time on this one, trying to find ways to empathize, support, and understand her experience in the moment. Binding herself back together extremely quickly, she joked, "I guess we should maybe get to some more crap!" Understanding that this was feedback and not a therapy session, the assessor decided to move on and even joked back with her about the next theme (which seemed incongruous, since she had just cried): discomfort with emotions.

This theme seemed much less interesting to her, or she at least had much less of a reaction to it in the moment. She had no questions about it but simply nodded along. "Yep, that's me," she said. Appreciation and accepting the buy-in he was getting from Andrea, the assessor moved to the next theme, which is her overwhelmed thinking processes (which includes her difficulties with attention and executive functioning). The assessor focused on her style of thinking, which is deliberate and highly focused on details, at times to the point of becoming confused. He also touched on the ruminative quality of some of her depressive and anxious thoughts and ultimately how all this can affect her attention and other executive functions. The assessor asked her to imagine trying to complete some of the cognitive tasks they did in the testing sessions while at the same time actively thinking about or worrying about other things. For example, he asked her to remember the Digits Backward task from the WAIS-IV and think about whether her brain was overthinking things and going "a mile a minute" while she tried to do that task. Her eyes opened wide, and she said, "It's no wonder I can't get everything done!"

The next slide and theme focused on her interpersonal guardedness, and again this theme was cast slightly differently in the feedback session, focusing on her mixed interpersonal feelings and the self-protective nature of her avoidant style. Interestingly, when hearing about the mixed feelings, she had difficulty identifying any part of her that actually wanted closeness with others. In fact, there was not very much test evidence supporting that she did in fact want closeness with others. So they shifted and focused really on the guardedness, aloofness, and avoidance behaviors. Although sometimes difficult to discuss, the assessor did bring up that even her romantic relationship, based on how she described it, was not very intimate and vulnerable. Although some people may get defensive about this kind of feedback, Andrea absolutely did not, agreeing entirely that she is not that close with her boyfriend.

Finally, the assessor presented the emotional distress theme, highlighting the persistent nature of (especially) the depressive and anxiety symptoms. There were two major take-home points from the emotional distress theme for Andrea. First, her depression has not entirely fixed itself since she got her job; there are lingering symptoms of fatigue, anxiety, and sleep difficulties. Second, the assessor highlighted just how much depressive and anxious symptoms can negatively affect attention and executive functioning (e.g., Cotrena, Branco, Shansis, & Fonseca, 2016; Shields, Moons, Tewell, & Yonelinas, 2016). The assessor reiterated the example of trying to focus, multitask, or initiate tasks when her mind is so preoccupied with anxious and depressed thoughts, not to mention that she is fatigued, which also makes everything more difficult. She seemed to understand this idea (especially because it had been repeated several times throughout the feedback session by the assessor), and the feedback session moved to diagnosis and recommendations.

The diagnosis needed some explanation, as it was a phrase that Andrea had not heard before. The assessor simply described what persistent depressive disorder (dysthymia) means and focused on the requirement that it has lasted more than 2 years (hers had lasted at least 5). Her reaction to the avoidant interpersonal style (the assessor made it absolutely clear that this was not a formal diagnostic category) was amazing: "Duh."

Finally, the assessor presented recommendations. He explained that the majority of recommendations were actually for her therapist, not her, as they are different types of psychotherapies and therapeutic goals. But he also explained them to her so she had an understanding of what each looks like and focuses on. She listened intently (though the assessor had a feeling that she was not actually taking in much information at this point as her mind was likely thinking of many different things), and she nodded. The assessor then discussed consulting with a psychiatrist. He made it clear that he was not recommending that she go on medication—since that was a value call on her part—but instead cited literature supporting the collaborative use of therapy and medication. He focused on the fact that the decision of whether to try medication would always be Andrea's, even if she went to a psychiatrist to consult. She said almost immediately that she wanted a recommendation of "a good one" from the assessor.

At the end of the session, Andrea thanked the assessor and asked him if he would send the report to her therapist and speak to them to give feedback and guidance. The assessor gave her a consent form to sign, but he suggested that she read the report first before giving consent to release it to her therapist just so she is fully informed about what would be sent. She agreed and later that day emailed a scanned consent form to the assessor to release the report and discuss the findings with her therapist. Her therapist happened to be knowledgeable about the multiple modalities of treatment recommended, which was helpful. A few months later, Andrea's therapist contacted the assessor to update him: Not only had a mix of AEDP and CBT (along with selective serotonin reuptake inhibitors) helped Andrea emotionally, but her attention and executive functioning difficulties also had been ameliorated to the point that she was writing her freelance pieces at a rate she was happy with and publishing quite a bit while continuing to excel at her fact-checking job. The therapist also reported that Andrea had begun "trying to make friends," and she was socializing independently from her boyfriend at least once a week. Finally, Andrea's therapist reported that their therapeutic relationship had deepened significantly as (from an AEDP perspective) Andrea was challenged to be more emotional and vulnerable with her therapist.

Summary

Andrea presented for what seemed to be a straightforward ADHD evaluation, and while she certainly struggled with attention and other executive functions the assessment revealed a much more complicated personality and emotional picture that underlay her cognitive difficulties. While her persistent depression had gotten significantly

better just before the evaluation (likely related to both her getting a new job and to her work in individual therapy), it was only in partial remission with some symptoms persisting, including her cognitive problems. In understanding what was going on and, as a result, engaging in targeted, appropriate treatment for it, Andrea saw rapid improvement in her mood, cognitive symptoms, productivity, and interpersonal functioning. Andrea's case highlights why it is inadequate to ask, "Do I have ADHD?" If the answer is yes, that can be extremely helpful; if the answer is no, then a client is left not knowing what is going on. The better question is, "What is underlying my difficulties with attention?" This may require significantly more testing, but ultimately the assessor can report feedback that is comprehensive, integrated, and targeted toward improving the client's functioning. Andrea's functioning improved saliently following her assessment.

CHAPTER 8

A Woman With Interpersonal Problems

Shelly Stevens was a 24-year-old White woman referred by her therapist for an assessment for diagnostic clarification and treatment recommendations. She had a long history of "attachment issues" (according to the referring therapist) and some recent stalking behaviors. Her therapist stated that she wanted to know how best to help her, as she had been seeing her for many years (since Shelly's adolescence) with seemingly very little progress.

The Clinical Interview

Shelly arrived at her initial clinical interview appointment on time, though she brought her mother with her. Her mother said very clearly that she did not intend to stay but was there just "to make sure Shelly made it OK" and to pay for the assessment. When she left, the assessor went over informed consent with Shelly, with especial care to focus on limits to confidentiality. Shelly said she wanted all the information from the assessment to go to her therapist. The assessor said he was happy to discuss the results with her therapist at the end but that he would ask for her written consent after she knew exactly what emerged from the assessment. Shelly looked puzzled, and the assessor further explained that any number of things could come out in any assessment, possibly (but unlikely) something she would not want her therapist to know. He reiterated that once she had received feedback, she could then sign a release of information form so the assessor could discuss the results with her therapist. She signed the consent forms and said, "Alright, hit me!"

For this assessment, a semistructured clinical interview was used to collect the background and contextual information. The interview is organized into overall domains (e.g., presenting problem, cognitive complaints, mood complaints, developmental history, medical history), with broad questions to start and more specific follow-up questions about specific symptoms as needed. The overarching structure of the interview is presented, but not every specific question is outlined. The assessor first oriented Shelly to the process, letting her know that he was going to ask her lots of questions—some broad and some very specific and some that may not apply to her because they are the same questions he asks everybody.

Presenting Problem: First is the Big One. What Questions do You Want Answered with this Assessment?

Shelly reported that she has "attachment issues" (the same phrase used by her therapist in the referral), stating that she has always had difficulties with relationships but that they have worsened since she was assaulted a few times. At

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this point, she simply stopped talking and stared at the assessor. The assessor very briefly empathized with how hard it can be to discuss these things, especially with a stranger. He asked her if she could tell him more about the assaults, and they would get back to the relationship difficulties. She reported that she had been sexually assaulted when she was in high school and again in college. She told the assessor that the assault in high school was a boyfriend who tried to have sex with her against her will, and the assault in college "may have been rape." When asked to clarify, she stated that she had been at a party, had a few drinks, and was unclear exactly what happened because it "happened so quickly and didn't really hurt." She stated that she thinks she was probably raped but could not be sure.

"Anyway," she continued, and went on to describe a boyfriend she had over the past year that resulted in the stalking behaviors. She reported that she had a boyfriend, and he was the first person she told about her two sexual assaults. He was so sympathetic and understanding "that I really felt heard for the first time." He broke up with her several months ago, but she reported that she "went overboard" by setting up several fake online social media accounts to friend him and ask him about herself. She even showed up outside his apartment several times, took videos, and posted them online. "I don't know what I was thinking. I wasn't really thinking," she reported. The story she told about all the different ways she pursued him were somewhat confusing and included some contradictions. She reported that he had taken out a restraining order against her and that she was facing charges for cyberstalking but that she just wanted to "figure myself out so I can have healthier relationships."

When asked about her history of "unhealthy relationships" (the assessor made sure to use her phrasing to ask about the history of the presenting problem), she reported that she has "never" had a healthy one. She said that friends came and went, and she had never had "a good breakup with a guy," though she had dated several for 3–6 months each. She also reported that she struggles with "24/7 underlying anxiety" and depression and "moments when they are worse." She also reported that she sometimes abuses diet pills, and she had a suicide attempt when she was 20 years old. She denied current suicidal ideation.

Cognitive Status Complaints: Ok, Now I'm Going to Ask You Lots of More Specific Questions. First, Do You Have Any Major Problems with Your Thinking that You're Aware of, Like Your Memory or Concentration or Other Things Like that?

Shelly reported that, in general, everything was fine, except that "I have ADD [attention deficit disorder]." When asked for details, she reported always having trouble focusing in school. Her primary care doctor had prescribed her (and continued to refill) Adderall when she was in middle school, which she took every day (without any medication vacations). She said it helped her focus and get things done. It should be noted that, even though the assessor asked her to come to testing sessions off her medication, she did not do so—though she admitted it readily—so no testing was conducted while she was off medication. When asked specifically, she denied any problems with verbal or nonverbal memory, language comprehension, word finding, or visuospatial aptitude, and she denied both hallucinations and delusions. She did report some difficulties with problem solving and decision-making, laughing, "For someone as genius as I am, I have a shitty time making decisions!"

Emotional Status Complaints: Ok, So You Mentioned some Anxiety and Depression. Tell Me More about those.

Shelly discussed how she feels she "always [has] a low-grade, underlying anxiety and depression" but how there are "definitely" times when each is worse. She reported that these feelings have "pretty much always been there, I think," and she could not identify specific triggers or stressors for when each would "flare up." She said the times when her anxiety and depression were worse "are sporadic and random." She discussed her anxiety mostly being thoughts like ruminative worries and her sadness being more affective, related to melancholy sadness. She did also say, though, "even with all my faults, I'm awesome."

Once Shelly answered the general question about her emotional status, the assessor asked a series of more specific questions. She denied problems with her appetite, though she did report using diet pills to lose weight. (She was quite thin, though not significantly underweight.) She said she did not have problems with her sleep, appetite, enjoyment in usual activities, or libido, and she denied a history of true manic behavior and current suicidal or homicidal ideation. When discussing her suicide attempt from about 4 years ago, she reported that it was right after the sexual assault (possible rape) in college. She asked if it was OK not to discuss it, and the assessor decided not to press the issue. She did report it was an overdose of pills and that she was unsure whether she genuinely wanted to die.

Family Context and History: Now I'm Going to Ask You a Bit About Your Family. Can You Tell me about Your Family History?

As soon as the assessor asked this question, Shelly looked down and appeared to tear up, taking a moment, sniffling a bit, then taking a deep breath before speaking. She then told the somewhat lengthy story of her early life. She reported that she had been found by child protective services around 2 years old in her home, where her mother had overdosed. She did not know many details, but she reported that her file said the home was extremely dilapidated and she was very malnourished, seemingly having been neglected for a while. She reported that she was told she could not walk or talk at that point. She was placed in foster care and "bounced around" foster homes for about 6 years until her mother (the one who brought her in to the session) adopted her at 8 years old. She is the only child in the home and was raised by her mother, who works as a nurse. She reported a currently good relationship with her mother but said, "It was pretty rocky through my childhood and adolescence." She said her mother loves her very much and does "pretty much anything she can do to help me."

Developmental History: I Know this May be Tougher Information for You to Access Because of Your Foster Care History, But Do You Know Anything about Your Biological Mother's Pregnancy with You or Delivery?

Shelly reported that she had very little information about anything having to do with her life before 2 years old, other than her father was notably absent and her mother overdosed on drugs when she was around 2. When asked, she reiterated that she could not walk or talk at all by the time she was 2, but she said she thinks she gained those and other developmental skills "pretty quickly" when she entered the foster care system. She said that by the time she started school, "I looked just like all the other kids."

Medical History: Ok, Do You Have any Major Medical Illnesses Currently, or Did You in the Past?

Shelly denied any current or past major medical illnesses. "*Physically*, I'm pretty damn healthy! It's just psychologically that I'm fucked up!" she said, laughing. When asked, she denied any history of head injury or loss of consciousness.

Educational and Vocational History: Can You Tell me about Your Education and Work History?

Shelly reported that she had earned a bachelor's degree in theater from a small, local liberal arts college. She said she loves acting and has been working as an actress in small productions since college, but she has not earned enough money to be independent and still lives with her mother. She said that she also works as a waitress at a local restaurant sometimes to supplement her income, "usually when I'm between shows." She said she was a "mediocre" student through high school but managed to pass and do much better in college, "because I love acting." She reported wanting to continue acting professionally.

Family Medical History: Can you tell me anything about your family's (both biological and adoptive) medical history?

"Other than her being an addict?" Shelly asked, laughing. She then reported not knowing any more about her biological family, and she denied any medical problems in her adoptive family.

Psychiatric History: OK, tell me about your history in therapy.

Shelly told the assessor that she had been seeing her current therapist (the one who referred her for an assessment) "off and on" for about 9 years, throughout most of high school and all of college and beyond. When asked for details, she said that there were periods she saw her weekly, but sometimes she did not see her for several months at a time. She said that this was most often because she saw her therapist "when I really need to," but when she felt she did not need it as much she stopped going. She said her mother always encouraged her to go consistently, whether she felt she needed it at that moment or not. Shelly also said she "tried" a course of dialectical behavior therapy (DBT) about 2 years ago, at the recommendation of her therapist. However, she did not like the group or the people running it so she "didn't get much out of it." When asked, she denied having seen a psychiatrist at all in the past, except for a brief evaluation after her suicide attempt, and she said the only medication she had ever been on was the Adderall.

The assessor asked her if she had ever had a formal mental health diagnosis. "Other than fucked up?" she joked, then said she thinks her therapist diagnosed her with anxiety and depression. She said she did not know for sure, but that was all. "Oh, and the ADD, duh!"

Substance Use History: OK, tell me about your history and current use of substances, including alcohol and any other drugs.

Shelly said that she drinks alcohol occasionally, but never more than one drink, "because of the addiction stuff" in her biological family. She denied use of any other substances, past or present.

Legal History: Can you tell me about any history of legal involvement, including for the stalking stuff you talked about earlier?

Shelly reiterated that she is currently facing charges for cyberstalking her ex-boyfriend, who has a restraining order against her, but that she has no other history of legal involvement. She said that her case was a misdemeanor offense, and she was scheduled to appear before a judge in the next week (before our first testing session). She said she was going to plead guilty and express her remorse for her behavior, and she had a letter from her therapist that she was engaged in treatment with her and was seeking a psychological evaluation with me. (Of note, she pled guilty and received only a suspended sentence and the restraining order from her ex-boyfriend.)

Social and Psychosexual History and Context: Tell me a bit more about your social life, now and in the past.

Shelly said that she does not currently have any significant friendships and generally no real history of social support. She said that she has had "friends come and go," but none have lasted. She said that her mother "is my best friend" because "she's the only one who has stuck with me." She said that in school she tended to be alone or get into fights (not physical) with people. She said that college was "a bit better"; she did not get into fights and was friendly with other people in her theater program but never really getting close to anyone. She reiterated that she

has had several past romantic relationships—she identifies as heterosexual—but they were "all very screwed up." When asked to elaborate, she said, "I'd rather not." She said that she is not currently in a romantic relationship and is not currently sexually active.

Cultural Evaluation: Can you tell me more about your own cultural identity, including how you identify?

Shelly looked a bit puzzled at this question, and the assessor tried to clarify, explaining that he was asking about her ethnic identity, racial identity, and spiritual or religious identity. She chuckled and said, "Um, none of those. . ." When asked to clarify, she said she identifies as White and has not thought much about her race, ethnicity, or her religion. She said her mother is not religious, nor were any of her foster homes growing up, so it is not something she has actively thought about.

Current Stressors: OK, a few last questions. What would you say are your biggest stressors in life at the moment?

Shelly paused and thought for a moment, then said, "Everything." After a moment of letting that hang in silence, the assessor asked her to say a bit more about that. Shelly clarified that she is "stressed" about fixing herself because she does not want to be a stalker and wants to have a happier and healthier life. She said that she wants relationships with other people and wants to be able to get close to them but that she does not think she knows how to do that. The assessor took this moment to empathize with how difficult it must be to see herself behaving in ways she knows are not good but also not being able to stop herself.

Current Medications: And can you tell me all the medications you're currently on?

Shelly said that she is only on Adderall and no other medications, including birth control.

Mental Status Evaluation

Appearance and Behavior

Shelly was well groomed and casually and appropriately dressed for all sessions. She was average height and thin, though not noticeably underweight at all. She had no difficulty engaging the assessor or adapting to the testing situation and was cooperative and friendly throughout.

Speech and Language

Shelly was open and articulate, and her speech was generally goal directed and logical, except for when she was describing her stalking behavior toward her ex-boyfriend. She discussed the multiple ways she pursued him both online and in person, but some of the details did not make sense and some contradicted each other. She had no difficulties with receptive language and understood all the directions on all the tests administered.

Mood and Affect

Shelly reported that her mood was "fine" throughout the assessment process, and her affect was generally mood congruent and appropriate to the situation. She showed a good range of emotion during the clinical interview, tearing up and looking sad when discussing distressing topics, joking appropriately with the assessor, and smiling when appropriate.

Thought Process and Content

Shelly's thought process seemed clear and logical, free of hallucinations and delusions. She became slightly confused when discussing the stalking behaviors, but in general her logic was linear. Her thought content was currently free of suicidal and homicidal ideation, though she reported anxious ideation.

Cognition

Shelly was alert and engaged throughout the assessment. Her attention, concentration, and memory seemed intact.

Prefrontal Functioning

By self-report, Shelly has a history of extremely poor insight, planning (considering consequences), and judgment. However, she exhibited healthy insight into the fact that her interpersonal behaviors are extremely problematic and that she wants to improve her functioning to have healthier relationships with others.

Hypothesis Building

Now that the clinical assessment (the clinical interview and the mental status evaluation) has been completed, the information gathered can be used to create hypotheses for what might be going on for Shelly.

Identify Impairments

There seem to be three major areas of impairment in Shelly's current functioning. The first, and most straightforward, is some reported difficulty with attention. It is hard to determine just how significant these difficulties with attention currently are, given that she has been on Adderall every day for the last 10 or so years (which she reported has helped her focus significantly). However, this is still an area of potential impairment.

The other two areas of impairment are her emotional functioning—including what seem like symptoms of both anxiety and depression (e.g., a past suicide attempt)—and her interpersonal functioning, which she admitted is extremely problematic, both in her lack of relationships and support and in her self-admitted problematic behavior with others.

Enumerate Possible Causes

Thinking first about Shelly's attention difficulties, there are a few major reasons she might be struggling with focus. The obvious first major hypothesis is attention deficit hyperactivity disorder (ADHD), which has already been diagnosed by her primary care physician. While there is still significant controversy and disagreement in the field about ADHD assessment and diagnosis (e.g., see Gualtieri & Johnson, 2005; Marshall, Hoelzle, & Nikolas, 2019; Nikolas, Marshall, & Hoelzle, 2019), most agree that at least some standardized assessment (at least rating scales) and cognitive testing are useful. Of course, many other hypotheses could be equally possible for why she has difficulty focusing, including it being secondary to emotional distress (such as anxiety or depression) or emotional dysregulation. Alternatively, although she experiences herself as having difficulty focusing, it may not be outside of the normal range (the null hypothesis that she does not actually have a deficit in attention).

Related to her emotional distress, she does seem to be presenting with symptoms of anxiety and depression, so those are solid hypotheses. Additional hypotheses could include an adjustment disorder, a bipolar disorder, or emotional difficulties related to a personality disorder. Similarly, her interpersonal difficulties seem to present the

likely possibility of a personality disorder of some sort, though it is important not to jump to a conclusion on which one since many tests will look at multiple personality disorders concurrently.

You should always consider that the presenting problems have an etiology in (a) substance use and (b) a medical condition. Shelly specifically denied any significant substance use, so unless she is misleading the assessor it is unlikely that this is the cause of her difficulties. Related to a medical condition, she denied any medical illnesses, and her difficulties (especially the interpersonal ones) are so long-standing and consistent and unrelated to known medical conditions that a medical etiology is also unlikely. Accordingly, it will be assumed that the symptoms are primarily psychological in nature.

Selecting Tests

For the cognitive hypothesis related to her attentional difficulties, the first step is to understand her overall intellectual ability, which can be measured with the Wechsler Adult Intelligence Scale, 4th Edition (WAIS-IV). As part of this overall understanding, as always, the Bender Visual-Motor Gestalt Test, 2nd Edition (Bender-2) can add some other basic cognitive skills, including fine motor skills, visual–perceptual ability, and short-term visual memory. Importantly, though, we also want to better understand her attentional and executive functioning. For detail to attentional and executive functioning, we can add a continuous performance test, such as the Conners' Continuous Performance Test, Third Edition (CPT-3) and some measures of cognitive control and executive functioning, such as the Trail Making Test from the Delis-Kaplan Executive Function System (DKEFS Trails) and the Wisconsin Card Sorting Test, Computer Version Fourth Edition (WCST-IV). Additionally, a rating scale of attention and executive functioning can be administered, in this case the Comprehensive Executive Function Inventory, Adult (CEFI, Adult). Other self-report emotional measures may also have information on attention.

For the personality, emotional, and behavioral assessment, several self-report measures of typical functioning can be used. Because of the depressive and anxious symptoms, the Personality Assessment Inventory (PAI) offers useful and straightforward measures of these kinds of symptoms (with a focus on understanding how severe they are and what aspects are being experienced). Because of the suspicion of a personality disorder, we will add the Millon Clinical Multiaxial Inventory, Fourth Edition (MCMI-IV) and the Inventory of Altered Self-Capacities (IASC) to the battery. Additionally, the poor boundaries suggest the possibility of problems with psychological differentiation, so a self-report measure on this construct may be useful; as such, we will add the Differentiation of Self Inventory, Revised (DSI-R; Skowron & Schmitt, 2003). To add a different method to the battery, we can include the Rorschach Performance Assessment System (R-PAS), which can offer additional information about cognition as well as self- and other functioning.

Thus, our assessment's battery of tests will consist of

- Bender-2
- WAIS-IV
- CPT-3
- DKEFS Trails
- WCST-IV
- CEFI, Adult
- PAI
- MCMI-IV
- IASC
- DSI-R
- R-PAS

Accumulating the Data

On the Bender-2, Shelly's performance was unimpaired (for motor and perception) and average (for copy and recall). On the WAIS-IV, her overall ability was low average for her age (full scale IQ [FSIQ] of 82, 12th percentile), with functioning that hovered around low average and average across the board (low average perceptual reasoning and working memory, average verbal comprehension and processing speed). While her performance on typical tasks that evaluate ADHD symptoms, like the CPT-3, WCST-IV, and D-KEFS Trails, was adequate, it is important to remember that she was on her Adderall during testing. Her weakest performance emerged on tasks of working memory, and she performed far below average on the WAIS-IV Cancellation subtest (2nd percentile), which is both a test of processing speed and selective, deliberate attention. Table 8.1 shows the results from her performance-based cognitive testing.

If we reorganize these data based on what they are actually assessing, many of the indices stand alone. For example, in the present evaluation, there is only one real measure of verbal functioning, the WAIS-IV Verbal Comprehension Index (VCI). When we ultimately discuss her verbal ability in the report, we will base it entirely

TABLE 8.1 **SHELLY'S COGNITIVE DATA**

Test	Index or Scale	Classification
WAIS-IV	Full Scale IQ	Low average
	General Ability Index	Low average
	Verbal Comprehension Index	Average
	Perceptual Reasoning Index	Low average
	Working Memory Index	Low average
	Processing Speed Index	Average
	Cancellation Subtest	Low
Bender-2	Copy	Average
	Recall	Average
	Motor	Unimpaired
	Perception	Unimpaired
D-KEFS Trails	Visual Scanning	Average
	Number Sequencing	Average
	Letter Sequencing	Average
	Number–Letter Switching	Average
	Motor Speed	Average
CPT-3	Detectability (d')	Good performance
	Omissions	Average
	Commissions	Good performance
	Perseverations	Average
	Variability	Good performance
	HRT Block Change	Average
	Omissions by Block Change	Consistent performance
	Commissions by Block Change	Consistent performance
WCST-IV	Total Errors	Average
	Perseverative Errors	Average
	Nonperseverative Errors	Average

on the results from the VCI. However, other measures converge around similar constructs, especially those related to executive functioning. If we organize those findings to look across measures, we see a picture of generally adequate executive functioning, including attention, when assessed on her medication. However, we also see some indications that she continues to struggle with some areas of attention, even when tested on her medication. Table 8.2 shows reorganized data for different executive functions.

Table 8.3 shows the data that emerged from Shelly's personality, emotional, and behavioral measures. While the order of measures and methods presented is not extremely important, those that are broader and have stronger empirical evidence are listed first (such as the PAI and MMPI-2-RF), followed by those that tap into more specific aspects of her functioning (such as the DSI-R and IASC). The final set of data nuggets listed are from the clinical interview and observations. Not every piece of information that emerged from the clinical interview could be included, so there is a small number that seemed especially salient or important (remembering that self-report in a clinical interview setting is another method used in an integrative, multimethod assessment).

TABLE 8.2 **SHELLY'S ORGANIZED EXECUTIVE FUNCTIONING–RELATED DATA**

Test: / Theme:	WAIS-IV	D-KEFS Trails	CPT-3	WCST-IV
Selective attention	Weak selective attention (Cancellation subtest)	Average selective attention (Visual Scanning)	Good selective attention (Variability, Detectability, and Omissions)	
Sustained attention			Good sustained attention (HRT Block Change and Omissions and Commissions by Block Change)	Good sustained attention (Nonperseverative Errors)
Working memory	Low average verbal working memory (Working Memory Index)			
Impulse control and related functions		Good impulse control and applying new strategies (Number–Letter Switching)	Good impulse control (Commissions)	Average impulse control, self-monitoring, adapting to feedback (Perseverative Errors)

TABLE 8.3 **ACCUMULATION OF SHELLY'S DATA**

Personality Assessment Inventory (PAI)

Significant unhappiness, pessimism, and hopelessness

Low self-esteem, feels ineffectual

Difficulty concentrating and making decisions

(Continued)

TABLE 8.3 (*CONTINUED*)

Anxiety (worry and tension)
Perfectionistic and rigid or inflexible
Ruminates
Traumatic events and stress
Peculiarities in thinking and logic
Socially isolated, few interpersonal relationships
Difficulty interpreting normal nuances of interpersonal behavior
Confusion, distractibility, and difficulty concentrating
Emotional lability
Episodes of poorly controlled anger
History of intense and volatile relationships
Preoccupied with consistent fears of being abandoned or rejected by others
Suspiciousness and hostility toward others
Hypervigilance, questioning motives of others
Extremely sensitive in interactions with others
Resentment toward others
Impulsivity and risk-taking
Weak identity and fluctuating self-esteem
Feels a significant lack of support in her life
Can be callous toward others' feelings and experience

Millon Clinical Multiaxial Inventory, 4th Edition (MCMI-IV)

Anxiety (generalized)
Bipolar spectrum symptoms
Persistent and major depression symptoms
Post-traumatic stress disorder (PTSD) symptoms
Some schizophrenic spectrum symptoms
Alternatively dependent and avoidant, with borderline features
Bitter toward others but also toward self
Irritable and emotionally dysregulated
Low self-esteem
Pessimistic
Low self-efficacy
Interpersonally submissive
Mistrustful of others
Some interpersonally antisocial and exploitive traits
Acts out behaviorally
Feels inept
Difficulty with taking perspective and being cognitively flexible

Differentiation of Self Inventory—Revised (DSI-R)

High emotional reactivity and affective dysregulation
Problems taking an "I" position (low differentiation)—weak identity cohesion
Copes with interpersonal difficulties by fusing with others (low differentiation)

TABLE 8.3 (*CONTINUED*)

Inventory of Altered Self-Capacities (IASC)—all greater than 99.9th percentile

Interpersonal conflict (history of)
Idealization and disillusionment
Abandonment concerns
Identity impairment: both wishes she understood herself better and tends to lose herself in different situations and with different people
Susceptibility to influence—highly susceptible to doing whatever others want to avoid abandonment
Affective dysregulation: both inadequate skills to manage emotions and general instability of emotion
Tension reduction activities (reacts to painful internal states with externalizing behaviors that, although potentially dysfunctional, distract, soothe, or otherwise reduce internal distress)

Rorschach Performance Assessment System (R-PAS)

Cognitive processing focuses on common, easy to achieve, and straightforward components; simple, straightforward thinking
Thinking disturbance, psychopathology
Disordered (confused) thinking and logic
Feelings of helplessness in the face of stressors
Problematic understanding of self
Problematic understanding of others—leads to disturbed interpersonal relations
Does not view relationships as supportive and cooperative
Inflexible thinking
Difficulty with perspective taking
Openness to immediate impressions and relatively unfiltered and unmodulated experience
Tendency toward reflective imagination, passive fantasy, and rumination
Some trauma experiences
Needs mirroring support
Narcissistic and pleasurably self-involved traits
Preoccupation with aggressiveness of others, in the world

Comprehensive Executive Function Inventory—Adult (CEFI-Adult)

Problems with attention
Problems with impulse control
Problems with emotion regulation
Problems with other executive functions, including planning, organization, self-monitoring, and working memory

Clinical Interview and Behavioral Observation Data

History of being sexually assaulted
Neglect and foster care history
Stalking of her ex-boyfriend
Ruminative worries
Melancholy sadness
Thinks she is "awesome"
Suicide attempt 4 years ago
No significant friendships
History of tumultuous romantic relationships
Wants closeness but does not know how to get it

Identifying Themes

As always, we could begin to address some of the themes that clearly seem to be emerging across measures (such as anxiety or problems with emotion regulation); however, we will begin identifying themes with Shelly's data using the seven traditional psychological themes: self, others (social), thinking, feeling (emotion), behavior, coping, and context. The preliminary themes for Shelly's data are presented in Table 8.4.

TABLE 8.4 **IDENTIFYING SHELLY'S THEMES**

Themes	
	Personality Assessment Inventory (PAI)
Emotion	Significant unhappiness, pessimism, and hopelessness
Self	Low self-esteem, feels ineffectual
Thinking	Difficulty concentrating and making decisions
Emotion	Anxiety (worry and tension)
Thinking	Perfectionistic and rigid and inflexible
Thinking	Ruminates
Context	Traumatic events and stress
Thinking	Peculiarities in thinking and logic
Social	Socially isolated, few interpersonal relationships
Social	Difficulty interpreting normal nuances of interpersonal behavior
Thinking	Confusion, distractibility, and difficulty concentrating
Emotion	Emotional lability
Emotion	Episodes of poorly controlled anger
Social	History of intense and volatile relationships
Social	Preoccupied with consistent fears of being abandoned or rejected by others
Social	Suspiciousness and hostility toward others
Social	Hypervigilance, questioning motives of others
Social	Extremely sensitive in interactions with others
Social	Resentment toward others
Behavior	Impulsivity and risk-taking
Self	Weak identity and fluctuating self-esteem
Social	Feels a significant lack of support in her life
Social	Can be callous toward others' feelings and experience
	Millon Clinical Multiaxial Inventory, 4th Edition (MCMI-IV)
Emotion	Anxiety (generalized)
Emotion	Bipolar spectrum symptoms
Emotion	Persistent and major depression symptoms
Context	PTSD symptoms
Social	Some schizophrenic spectrum symptoms
Social	Alternately dependent and avoidant, with borderline features
Social and Self	Bitter toward others but also toward self

TABLE 8.4 (*CONTINUED*)

Themes	
Emotion	Irritable and emotionally dysregulated
Self	Low self-esteem
Emotion	Pessimistic
Self	Low self-efficacy
Social	Interpersonally submissive
Social	Mistrustful of others
Social	Some interpersonally antisocial and exploitive traits
Behavior	Acts out behaviorally
Self	Feels inept
Thinking and Social	Difficulty with taking perspective and being cognitively flexible
	Differentiation of Self Inventory–Revised (DSI-R)
Emotion	High emotional reactivity/affective dysregulation
Self	Problems taking an "I" position (low differentiation)—weak identity cohesion
Social	Copes with interpersonal difficulties by fusing with others (low differentiation)
	Inventory of Altered Self-Capacities (IASC)
Social	Interpersonal conflict (history of)
Social	Idealization and disillusionment
Social	Abandonment concerns
Self	Identity impairment: both wishes she understood herself better and tends to lose herself in different situations and with different people
Social	Susceptibility to influence—highly susceptible to doing whatever others want to avoid abandonment
Emotion	Affective dysregulation: both inadequate skills to manage emotions and general instability of emotion
Behavior	Tension reduction activities (reacts to painful internal states with externalizing behaviors that, although potentially dysfunctional, distract, soothe, or otherwise reduce internal distress)
	Rorschach Performance Assessment System (R-PAS)
Thinking	Cognitive processing focuses on common, easy to achieve, and straightforward components; simple, straightforward thinking
Thinking	Thinking disturbance, psychopathology
Thinking	Disordered (confused) thinking and logic
Emotion	Feelings of helplessness in the face of stressors
Self	Problematic understanding of self
Social	Problematic understanding of others—leads to disturbed interpersonal relations
Social	Doesn't view relationships as supportive and cooperative
Thinking	Inflexible thinking
Social	Difficulty with perspective taking
Thinking	Openness to immediate impressions and relatively unfiltered and unmodulated experience
Thinking	Tendency toward reflective imagination, passive fantasy, and rumination
Context	Some trauma experiences
Coping and Social	Needs mirroring support
Self	Narcissistic and pleasurably self-involved traits

(Continued)

TABLE 8.4 (*CONTINUED*)

Themes	
Social	Preoccupation with aggressiveness of others and in the world
	Comprehensive Executive Function Inventory–Adult (CEFI-Adult)
Thinking	Problems with attention
Behavior	Problems with impulse control
Emotion	Problems with emotion regulation
Thinking	Problems with other executive functions, including planning, organization, self-monitoring, and working memory
	Behavioral Observations and Other Data
Context	History of being sexually assaulted
Context	Neglect and foster care history
Social	Stalking of her ex-boyfriend
Thinking	Ruminative worries
Emotion	Melancholy sadness
Self	Thinks she is "awesome"
Behavior	Suicide attempt 4 years ago
Social	No significant friendships
Social	History of tumultuous romantic relationships
Social	Wants closeness but does not know how to get it

Organizing the Data

Shelly's reorganized data are presented in Table 8.5. When the data are reorganized and examined within themes, some become clearer and more specific, whereas others need to be reorganized. For example, the context theme is relatively straightforward; this is a woman who both developed around and sustained repeated traumatic incidents—including disrupted early attachments (within a neglectful early life) and later sustained assaults—which have affected both her development and her current functioning. Similarly, the behavior theme tells a clear story of a woman with difficulties with behavioral impulse control. However, some of the themes could do with some reorganizing.

Three pieces of data need reconciling to decide where they best fit. Two of these nuggets, though, are compound nuggets. That is, they include two distinct aspects within a single piece of data that apply to two different themes. For example, the MCMI-IV finding that she is "bitter toward others but also toward self" can easily be split into two pieces of data: "bitter toward others" can fit nicely into the others/social/interpersonal theme, whereas "bitter toward self" can fit easily into the self theme. The same is true for the MCMI-IV finding that she has "difficulty with taking perspective and being cognitively flexible," which can be split into problems with perspective taking (the social theme) and difficulty being cognitively flexible (a thinking nugget). The final piece of data that seems to straddle two themes is the R-PAS finding that she "needs mirroring support," which means she has a heightened need for external support, attention, and approval from others. The need aspect of this finding speaks directly to difficulties coping with the world (and so would fit nicely into the coping theme), and the specific need is interpersonal in nature (and so would also fit in the social theme). In the present assessment, it is actually the only nugget that speaks to coping, which is ultimately not enough to sustain a full theme. This makes the decision is easy: this piece of data will be added to the social theme. We are lucky that, for this assessment, there are no pieces of data that we really need to think hard about where they fit best.

TABLE 8.5 **SHELLY'S ORGANIZED DATA**

Test: / Theme:	PAI	MCMI-IV	DSI-R	IASC	R-PAS	CEFI	Interview and Observation
Emotion	Significant unhappiness, pessimism, and hopelessness	Anxiety (generalized)	High emotional reactivity and affective dysregulation	Affective dysregulation: both inadequate skills to manage emotions and general instability of emotion	Feelings of helplessness in the face of stressors	Problems with emotion regulation	Melancholy sadness
	Anxiety (worry and tension)	Bipolar spectrum symptoms					
	Emotional lability	Persistent and major depression symptoms					
	Episodes of poorly controlled anger	Irritable and emotionally dysregulated					
		Pessimistic					
Self	Low self-esteem, feels ineffectual	Bitter toward ~~others, but also toward~~ self	Problems taking an "I" position (low differentiation)—weak identity cohesion	Identity impairment: both wishes she understood herself better and tends to lose herself in different situations and with different people	Problematic understanding of self		Thinks she is "awesome"
	Weak identity and fluctuating self-esteem	Low self-esteem			Narcissistic and pleasurably self-involved traits		
		Low self-efficacy					
		Feels inept					
Thinking	Difficulty concentrating and making decisions	Difficulty with ~~taking perspective and~~ being cognitively flexible			Cognitive processing focuses on common, easy to achieve, and straightforward components; simple, straightforward thinking	Problems with attention	Ruminative worries

Test: Theme:	PAI	MCMI-IV	DSI-R	IASC	R-PAS	CEFI	Interview and Observation
	Perfectionistic and rigid or inflexible				Thinking disturbance and psychopathology	Problems with other executive functions, including planning, organization, self-monitoring, and working memory	
	Ruminates				Disordered (confused) thinking and logic		
	Peculiarities in thinking and logic				Openness to immediate impressions and relatively unfiltered and unmodulated experience		
	Confusion, distractibility, and difficulty concentrating				Tendency toward reflective imagination, passive fantasy, and rumination		
Context	Traumatic events and stress	PTSD symptoms			Some trauma experiences		History of being sexually assaulted
							Neglect and foster care history
Interpersonal	Socially isolated, few interpersonal relationships	Some schizophrenic spectrum symptoms	Copes with interpersonal difficulties by fusing with others (low differentiation)	Interpersonal conflict (history of)	Problematic understanding of others—leads to disturbed interpersonal relations		Stalking of her ex-boyfriend
	Difficulty interpreting normal nuances of interpersonal behavior	Alternately dependent and avoidant, with borderline features		Idealization, disillusionment	Does not view relationships as supportive and cooperative		No significant friendships

	History of intense and volatile relationships	Bitter toward others, ~~but also toward self~~		Abandonment concerns	Difficulty with perspective taking		History of tumultuous romantic relationships
	Preoccupied with consistent fears of being abandoned or rejected by others	Interpersonally submissive		Susceptibility to influence—highly susceptible to doing whatever others want to avoid abandonment	Needs mirroring support		Wants closeness but does not know how to get closeness
	Suspiciousness and hostility toward others	Mistrustful of others			Preoccupation with aggressiveness of others and in the world		
	Hypervigilance, questioning motives of others	Some interpersonally antisocial and exploitive traits					
	Extremely sensitive in interactions with others	Difficulty with taking perspective ~~and being cognitively flexible~~					
	Resentment toward others						
	Feels a significant lack of support in her life						
	Can be callous toward others' feelings and experience						
Behavior	Impulsivity and risk-taking	Acts out behaviorally		Tension reduction activities (reacts to painful internal states with externalizing behaviors that, although potentially dysfunctional, distract, soothe, or otherwise reduce internal distress)		Problems with impulse control	Suicide attempt 4 years ago

Finalizing Themes

A few things need to happen before Shelly's themes can be finalized. Starting with the easiest tasks, after scanning each theme across tests and measures a few (as stated previously) are generally pretty clear and consistent. The context theme can easily be renamed traumatic stress (or something similar) to highlight the important of her trauma history both on her personality development and her current emotional functioning. The behavior theme is also quite straightforward and can be renamed impulse control problems (or something similar) to reflect the multiple measures that revealed her acting-out, risk-taking, and generally impulsive behaviors.

Another relatively straightforward theme, which requires a decision, is the self theme. Some data clearly converge around two aspects of the self: self-esteem and identity. There are enough data across measures to sustain two different themes: one for low self-esteem and one for unclear or weak identity development. However, as it becomes clearer that we will have a large number of themes, we may want to leave these together for now as a theme of weak identity and low self-esteem. Although these are different psychological constructs, they are obviously intimately tied together, so we can think about them as a package deal for now.

The thinking theme has a great deal of information in it, and we need to make sense of it all. There is information about her rigidity as a thinker, about her problems with attention and concentration, and about confusion. We could split this into two themes: one about cognitive rigidity and one about her thought processes being easily overwhelmed (encompassing both the confusion and the problems with attention and concentration). Alternatively, similar to how the two self themes are so intimately tied together, a rigid thinking process can be easily overwhelmed, so these two ideas can be combined and maintained as a single theme: rigid and easily overwhelmed thinking. Remember that there is no correct way to decide whether to split this into two themes or maintain it as one; the decision to keep it as one was made simply because we have a great number of themes already and the two constructs (rigidity and easily overwhelmed) are intimately tied together and can be told as a single, coherent story.

For the emotions theme, similar to the self and thinking themes, the data seem to cluster around two different general ideas. In this case, a great deal of data seem to be revealing that Shelly has problems regulating her emotions; in addition, a great deal of data seem to be uncovering her emotional distress, including anxiety, depression, and helplessness. Although we still have a great number of themes, emotional dysregulation and emotional distress are actually not as intimately tied as the constructs that emerged in the self and thinking themes. That is, these are quite independent constructs: feeling bad and having difficulty regulating and controlling emotions. In this case, even though we can always decide to retain these as a single theme, the decision was made to disaggregate these two constructs and have two separate themes: emotional distress and emotion dysregulation (which we will likely call something less jargony in the final report).

The social theme is perhaps the most complicated in this particular assessment. She obviously has interpersonal difficulties, and they are clearly complex. A good first place to start is to try to separate data that are informing underlying interpersonal traits (such as her feelings, thoughts, and attitudes about others) and data that are informing behaviors and outcomes (such as interpersonal behavior and actual levels of relationships or social support). As a first step, when looking at the behaviors and outcomes, what emerges is a picture of a woman with confusing, paradoxical, and ultimately ineffective interpersonal behaviors. She is submissive, aggressive, conflictual fusing, isolating, stalking, and exploitive. Ultimately, this behavior leaves her with interpersonal conflict and tumultuous interpersonal relationships. How we label this to make it understandable is not entirely easy. We could go with something like *confusing interpersonal behavior* or inconsistent social behavior; in this case the vaguer term *problematic interpersonal behavior* was chosen. Each of these theme titles has merit, and each is absolutely accurate in its representation of Shelly's behavior.

When examining the rest of the interpersonal data (those that inform the more underlying thoughts, feelings, and attitudes about others), the data continue to paint a complex and nuanced picture of Shelly. Some of the data reveal her difficulties understanding others (difficulty with perspective taking, hypervigilant, always expecting and assuming the worst, mistrustful). Other data seem to converge around her interpersonal ambivalence (feelings), including wanting closeness and having dependent needs on one hand but being resentful, bitter, and extremely negative toward others on the other. The negativity toward others is certainly heavily related to the difficulties understanding others, so one way of organizing all these data would be around the conflicted feelings, with the problems with interpersonal perception feeding the negative side. Alternatively, we could separate these out, as one is really about interpersonal perception and the other is about conflicted interpersonal feelings. As always, each possibility has merits (and some problems), and in this case the data were separated into difficulties understanding others and conflicted feelings about relationships. As such, our final themes with data are presented in Table 8.6.

Conceptualizing

Remembering that the task at this point is to try to create a logical narrative among the themes by applying psychological theory so that it presents a coherent story, we have to connect the following (more than is usually ideal) themes:

- emotional distress
- emotional dysregulation
- weak identity and low self-esteem
- rigid and easily overwhelmed thinking
- traumatic stress
- problematic interpersonal behavior
- difficulties understanding others
- conflicted feelings about relationships
- impulse control problems

Before deciding on the most logical way to fit all these themes together, we will first consider some of the model templates presented in Chapter 4: a diathesis–stress model, a developmental mismatch model, a developmental themes model, and an interpersonal circumplex model for conceptualization.

Diathesis–Stress Model

In applying the diathesis–stress model of conceptualization, we must try to divide the themes into (1) traits inherent within Shelly that she likely developed at an early age and that she brings to the picture (diatheses), (2) external issues that affect her functioning (stressors), and (3) states that are more situational or transient (outcomes). It is important to categorize each of our nine themes into these three types. As always, the more convincing these categorizations are, the more likely Shelly is to accept the recommendations given.

For Shelly, this model is not so straightforward. While the stressor is obvious—traumatic stress—discriminating between diatheses and outcomes is more difficult. Several themes are easily outcomes, as they are generally not seen as inherent to an individual and their personality. Emotional distress, problematic interpersonal behavior, and impulse control problems are all quite symptomatic and fit nicely into outcomes. Low self-esteem is also commonly an outcome (though weak identity could be conceptualized as diathesis).

TABLE 8.6 **SHELLY'S FINALIZED DATA**

Test: / Theme:	PAI	MCMI-IV	DSI-R	IASC	R-PAS	CEFI-Adult	Interview and Observation
Emotional distress	Significant unhappiness, pessimism, and hopelessness	Anxiety (generalized)			Feelings of helplessness in the face of stressors		Melancholy sadness
	Anxiety (worry and tension)	Persistent and major depression symptoms					Ruminative worries
		Pessimistic					Suicide attempt 4 years ago
Emotion dysregulation	Emotional lability	Bipolar spectrum symptoms	High emotional reactivity and affective dysregulation	Affective dysregulation: both inadequate skills to manage emotions and general instability of emotion		Problems with emotion regulation	
	Episodes of poorly controlled anger	Irritable and emotionally dysregulated					
Weak identity and low self-esteem	Low self-esteem, feels ineffectual	Bitter toward self	Problems taking an "I" position (low differentiation)—weak identity cohesion	Identity impairment: both wishes she understood herself better and tends to lose herself in different situations and with different people	Problematic understanding of self		Thinks she is "awesome"
	Weak identity and fluctuating self-esteem	Low self-esteem			Narcissistic and pleasurably self-involved traits		
		Low self-efficacy					
		Feels inept					

Rigid and easily overwhelmed thinking	Difficulty concentrating and making decisions	Difficulty being cognitively flexible			Cognitive processing focuses on common, easy-to-achieve, and straightforward components; simple, straightforward thinking	Problems with attention	
	Perfectionistic and rigid and inflexible				Thinking disturbance, psychopathology	Problems with other executive functioning, including planning, organization, self-monitoring, and working memory	
	Ruminates				Disordered (confused) thinking and logic		
	Peculiarities in thinking and logic				Openness to immediate impressions and relatively unfiltered and unmodulated experience		
	Confusion, distractibility, and difficulty concentrating				Tendency toward reflective imagination, passive fantasy, and rumination		
Traumatic stress	Traumatic events and stress	PTSD symptoms			Some trauma experiences		History of being sexually assaulted

(Continued)

Test: Theme:	PAI	MCMI-IV	DSI-R	IASC	R-PAS	CEFI-Adult	Interview and Observation
							Neglect and foster care history
Problematic interpersonal behavior	Socially isolated, few interpersonal relationships	Some schizophrenic spectrum symptoms	Copes with interpersonal difficulties by fusing with others (low differentiation)	Interpersonal conflict (history of)			Stalking of her ex-boyfriend
	History of intense and volatile relationships	Alternately dependent and avoidant, with borderline features		Susceptibility to influence—highly susceptible to doing whatever others want to avoid abandonment			No significant friendships
	Can be callous toward others' feelings and experience	Interpersonally submissive					History of tumultuous romantic relationships
		Some interpersonally antisocial/ exploitive traits					
Difficulties understanding others	Difficulty interpreting normal nuances of interpersonal behavior	Mistrustful of others		Abandonment concerns	Problematic understanding of others—leads to disturbed interpersonal relations		~~Wants closeness but~~ does not know how to get closeness
	Suspiciousness and hostility toward others	Difficulty with taking perspective			Difficulty with perspective taking		

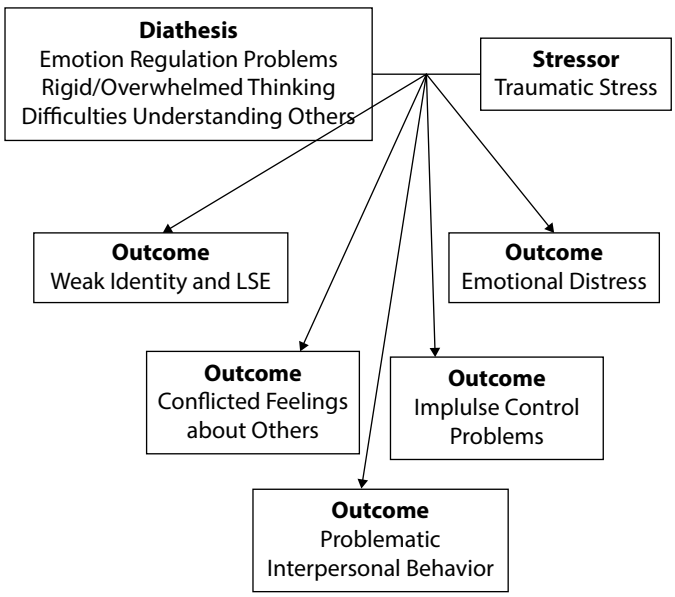
	Hypervigilance, questioning motives of others				Preoccupation with aggressiveness of others and in the world		
Conflicted feelings about relationships	Preoccupied with consistent fears of being abandoned or rejected by others	Alternately dependent and avoidant, with borderline features		Idealization and disillusionment	Does not view relationships as supportive and cooperative		Wants closeness ~~but does not know how to get closeness~~
	Extremely sensitive in interactions with others	Bitter toward others			Needs mirroring support		
	Resentment toward others						
	Feels a significant lack of support in her life						
Impulse control problems	Impulsivity and risk-taking	Acts out behaviorally		Tension reduction activities (reacts to painful internal states with externalizing behaviors that, although potentially dysfunctional, distract, soothe, or otherwise reduce internal distress)		Problems with impulse control	

Three of the themes really seem more developmentally early and constitute characteristics more inherent to who Shelly is as a person (diatheses). These include her difficulties controlling her emotions and with her thinking (both the rigid, easily overwhelmed thinking style and her problematic understanding of others). Less clear is how her weak identity and conflicted feelings about others would fall in this model. As noted previously, weak identity can be developmentally early (akin to weak understanding of others), whereas low self-esteem is often conceptualized as more symptomatic (outcome). We could separate these out as different themes if we wanted, at this point, to help with this decision. Because we will not likely end up using this conceptualization anyway, for the purposes of this exercise we will just keep this theme as is and consider it an outcome.

The conflicted feelings about others theme, on the other hand, is quite difficult to fit nicely into either part of the diathesis or an outcome. It seems to fit better between these levels: Her feelings are certainly influenced heavily by her problems in thinking and regulating her emotions as well as a traumatic history (which would leave most of us conflicted in our feelings about others), but her conflicted feelings also seem to be heavily influencing her behaviors (especially interpersonal) and feelings (distress). However, again for the purpose of this exercise, we will make a decision one way or the other, and in this case we will consider it an outcome. The diathesis–stress model for Shelly is shown in Figure 8.1.

When considering the viability of this model, we have to decide whether it makes intuitive sense with the three categorized parts. That is, would the diathesis posed, combined with the external stressor, likely cause the outcomes? *A woman who has difficulties regulating her feelings and thoughts and understanding others appropriately, when dealing with a particularly traumatic history, could develop impulse control problems, conflicted feelings about others, problematic interpersonal behavior, weak identity and low self-esteem, and emotional symptoms such as anxiety and depression.* This model is certainly arguable and relatively intuitive, though it may be too oversimplified based on what we know about human psychology. Shelly would likely easily understand how each of the outcomes could come from the diathesis–stressor interaction, but in actuality some of the outcomes are extremely likely to be influenced by more than just what is proposed in this model; that is, some of the outcomes are likely also influenced by some of the other outcomes.

FIGURE 8.1 **DIATHESIS–STRESS MODEL FOR SHELLY**



Developmental Mismatch Model

The developmental model for Shelly is interesting, though ultimately probably a tough case to make, especially because it would likely be difficult to make palatable in feedback. As an adult, she should have good control over her thoughts and feelings, understand herself and others quite well, and have good control over her behaviors. What characterizes her current developmental functioning, however, are problems in each of these areas. It is tough to think about what developmental age this problematic underlying functioning represents, though it is actually most appropriate for the everyday, normative functioning of a child. Accordingly, Shelly's developmental functioning and her real-world demands (especially the demands of dealing with a traumatic history) are not on the same developmental level, and this would likely cause problems.

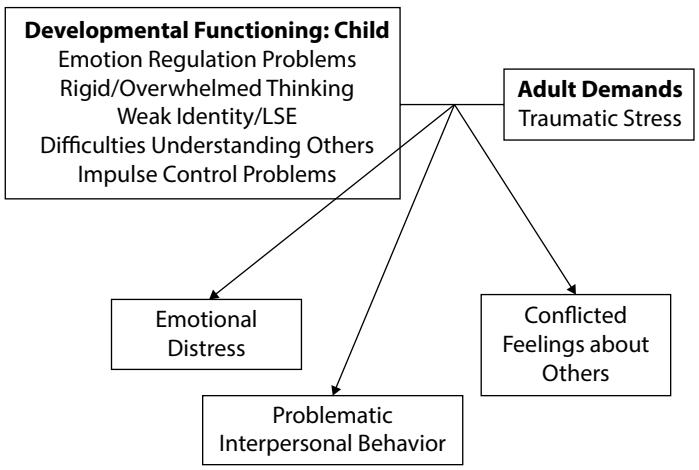
Not too dissimilar from the diathesis–stress model for Shelly, some of her behavioral functioning (such as impulse control problems) and symptoms (like low self-esteem related to weak identity) are now more core to the model rather than to outcomes. This leaves conflicted feelings about others, problematic interpersonal behavior, and emotional distress as outcomes of the developmental mismatch. Shelly's developmental model is shown in Figure 8.2.

This model (like the diathesis–stress model) generally makes intuitive sense. Although placing some difficulties along a developmental trajectory and normalizing them as processes that everyone goes through (sometimes delayed) is often a kind and approachable way to present them, in this case conceptualizing Shelly as functioning more at the level of a child does not seem so kind. That is, her developmental functioning is so far behind her current age that she may have a difficult time hearing and accepting this conceptualization. This model, in the end, is likely too negative and potentially insulting to be useful for Shelly.

Developmental Themes Model

If we loosen our model a bit and think about the developmental trajectory of normative and adaptive, typical human development, we can begin to understand Shelly's themes in a more hierarchical way. To make this model work, though, we first have to separate out the contextual (traumatic stress) theme; a great deal of her trauma (neglect and early disrupted attachments) happened extremely early and influenced how everything developed, and some came later (assaults), likely exacerbating problematic functioning. The context is not strictly developmental and time bound, so it needs to be presented as separate from the developmental themes.

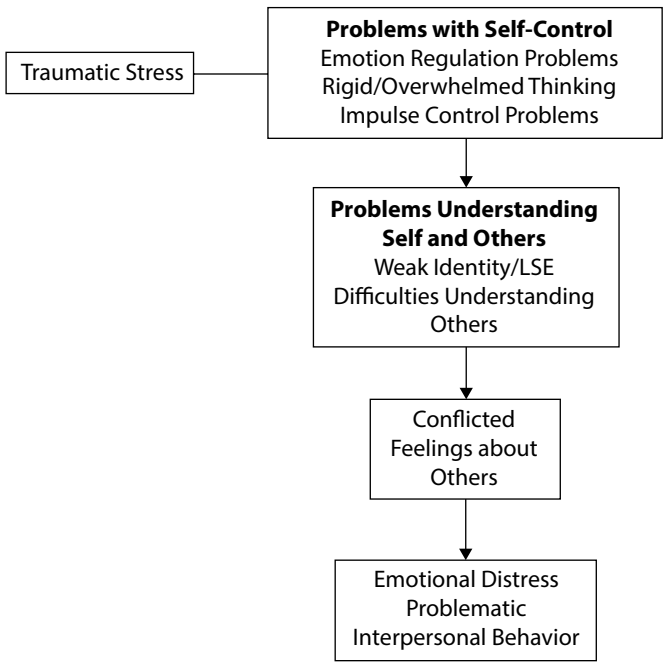
FIGURE 8.2 **DEVELOPMENTAL MISMATCH MODEL FOR SHELLY**



Thinking more about the developmental tasks and their typical timelines, similar to previous models, we still have some that are extremely early. Control over thoughts, emotions, and behaviors are developmental tasks that children struggle with and master relatively early in their lives. As such, her emotion regulation problems, rigid and overwhelmed thinking, and impulse control problems constitute the earliest layer of this developmental model. Understanding of self and others, however, is a slightly later task, as identity and intimacy development are more adolescent in nature. Her conflicted feelings about others, while also firmly rooted in that later intimacy versus isolation stage, is likely also heavily influenced by her later traumatic experiences and thus can be conceptualized slightly later than the identity and intimacy development (understanding) themes. Finally, the more in-the-moment symptoms of emotional distress and problematic interpersonal behavior come last developmentally since they can of course emerge at any time in development but are current and contemporary problems for Shelly. The developmental themes model for Shelly is shown in Figure 8.3.

This model is arguable, makes intuitive sense (for those who know and understand normal psychological and psychosocial development), and would not be a tough model to explain. Further, while the traumatic stress has been pulled out from the actual developmental model, the narrative could highlight how traumatic stress at each of the levels could influence the difficulties she currently experiences. For example, her level of neglect, early attachment disruptions, and history in foster care certainly affected how well she controls her emotions, thinking, and behavior. Similarly, her attachment history influenced her understanding of both herself and others. Her early and later traumas (in addition to her problematic development, including her problems understanding others) have heavily influenced her feelings about others. And finally, all these problematic developmental themes have led to both her problematic interpersonal behavior and her current emotional distress. This model takes quite a bit of the onus and blame off Shelly and explains her problems in functioning within the context of her trauma history, which may certainly appeal to her. However, the unidirectional and linear fashion of the model may also be oversimplifying her functioning somewhat.

FIGURE 8.3 **DEVELOPMENTAL THEMES MODEL FOR SHELLY**



Interpersonal Circumplex Model

One of the biggest advantages of the interpersonal circumplex model for organizing and conceptualizing data is how it separates personality functioning from emotional and behavioral functioning. That is, all the themes that fit neatly onto the interpersonal circumplex constitute personality (from the perspective of this model), and themes that do not fit constitute outcomes from the personality type and its interaction with the world. The other major benefit of the interpersonal circumplex model in this particular case is that Shelly certainly has a host of interpersonal difficulties, so it can hopefully inform what is underlying them.

Similar to the previous model, Shelly's trauma history needs to be pulled out and separated from the others, as it served as the context and a heavy influencer of how and why her personality developed the way it did. As such, in this model, it will sit at the very top, as an explanation for why and how her personality developed. The weak identity and low self-esteem theme sits nicely in the low dominance, unassured part of the circumplex. However, her interpersonal themes are more confusing from this model's perspective because she is neither consistently cold, hostile, and domineering nor consistently submissive, exploitable, and passive. In fact, what characterizes her interpersonal functioning is the confused and variable nature of it. On the model, the best way to graphically display this is by splitting her interpersonal functioning into two separate themes of being alternately overly hostile and overly submissive. The remaining themes constitute outcomes of her personality type interacting with the world. The initial interpersonal circumplex model for Shelly is shown in Figure 8.4.

Figure 8.5 presents the modified and clarified interpersonal circumplex model, which characterizes her personality more clearly as alternately dominant and submissive, hostile and passive. Ultimately, this interpersonal personality style is ineffective and leads to turmoil in her emotions, thinking, and behavior. This is another useful way of conceptualizing Shelly's difficulties in functioning, and the traumatic stress contributing to her problematic personality development is likely an easy way for Shelly to understand her behaviors. However, how this personality type leads to some of the outcomes in the model may be tougher to explain. Specifically, her personality

FIGURE 8.4 **INITIAL INTERPERSONAL CIRCUMPLEX MODEL FOR SHELLY**

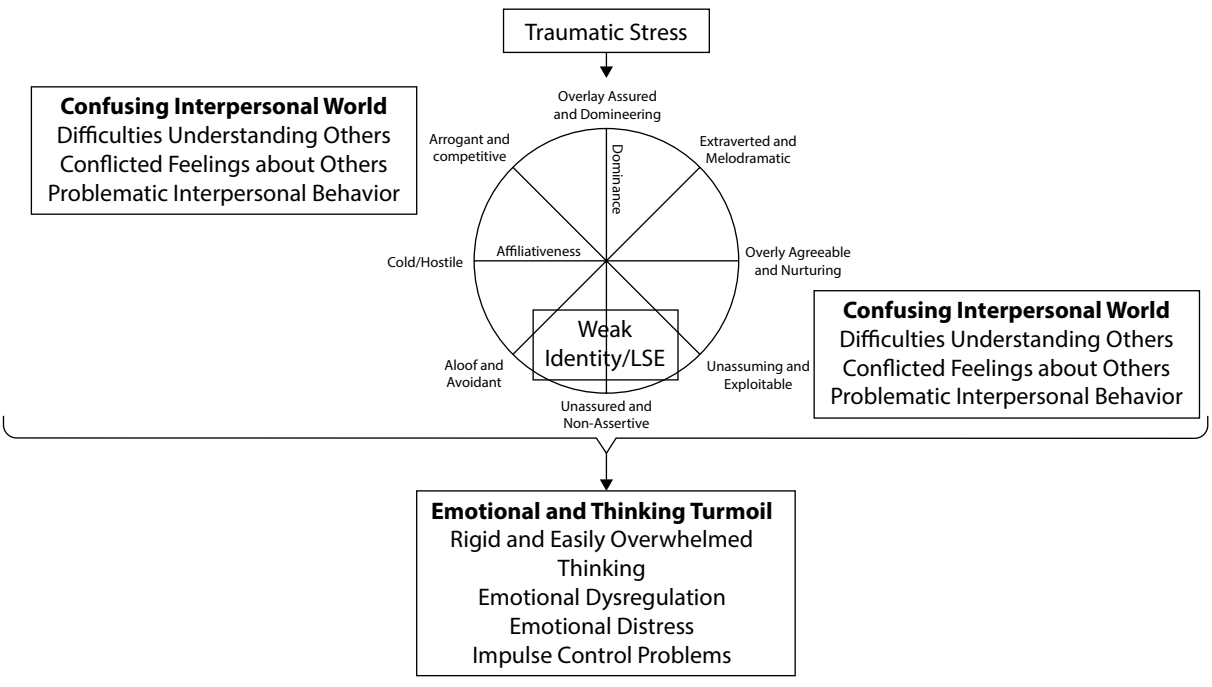
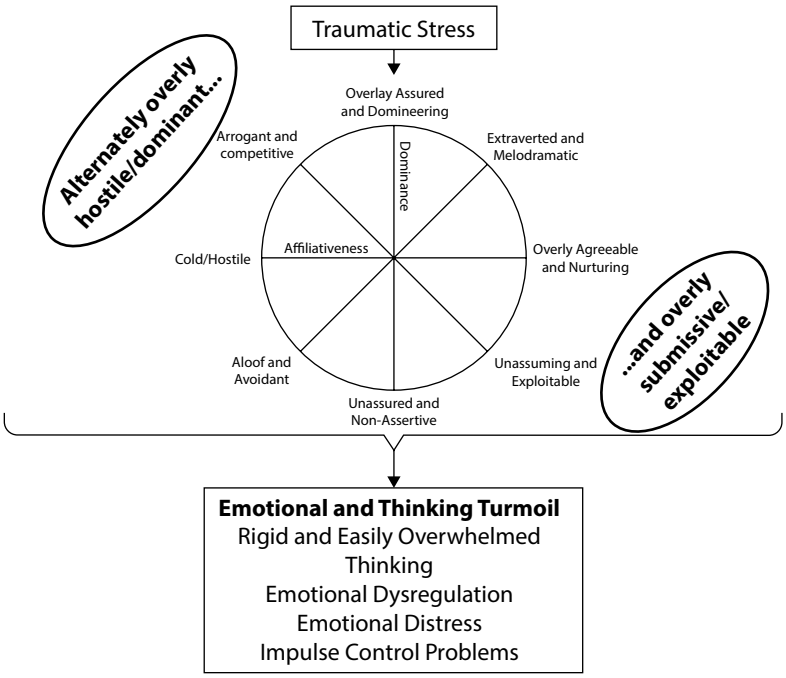


FIGURE 8.5 **FINAL INTERPERSONAL CIRCUMPLEX MODEL FOR SHELLY**



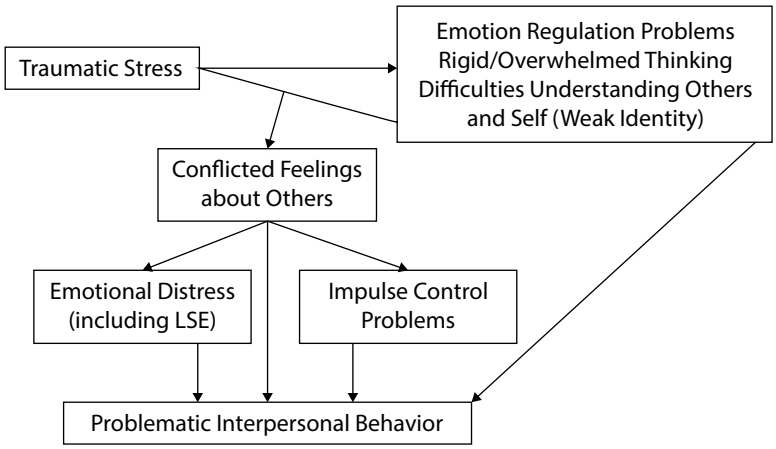
contributing to emotional distress and impulse control problems is somewhat straightforward. However, there seems to be an ordering problem with the overwhelmed thinking and feeling; that is, it is probably more likely (and intuitive) that her dysregulated thinking and feeling actually inform how she is with others rather than the other way around (or at the very least they are bidirectional). Still, separating out her personality style from her emotional and behavioral functioning could be a useful way of Shelly understanding herself and her difficulties.

Complex Model

Each of the aforementioned models has benefits and limitations for understanding Shelly's functioning. Any could be used for the final report. However, thinking about the themes in a slightly more complex way may lead to a more logical way to link several of them. When considering how some of the models' strengths can contribute to a more complex model, one slight tweak in the themes can help. The weak identity and low self-esteem theme can be disaggregated and reconstituted within two other themes. The weak identity data can merge with the difficulties understanding others data to create a new theme: difficulties understanding self and others. The leftover low self-esteem data can then be combined into the emotional distress theme as one component of her current distress.

Having pared down our themes to eight instead of nine, we can now begin to build our model. We can maintain the strength of several of the conceptual models' assertion that her traumatic early childhood served as a problematic context for the development of her personality. Additionally, we can maintain the thinking about the interaction between her problematic underlying characteristics (diatheses) and the traumatic stress. As such, the traumatic stress needs two roles in the model: a problematic and causal context for the development of the diathesis and an interactive stressor with the diathesis. If the earliest developmental themes are used for the diathesis, then we have a picture of a woman whose underlying difficulties are her problems regulating both her thoughts and feelings and understanding both herself and others. Combined with the ongoing traumatic stress,

FIGURE 8.6 **COMPLEX MODEL FOR SHELLY**



these underlying traits can certainly lead a person to develop deeply conflicted and confusing feelings about others; allowing for a middle layer in our model solves our earlier problem of having to decide whether the theme of conflicted interpersonal feelings was either part of the diathesis or an outcome.

Thinking about (psychologically) logical outcomes from the model built so far, her conflicted feelings about others can certainly contribute to both her emotional distress (now including her low self-esteem) and her impulse control problems along with her problematic (and confusing) interpersonal behavior. This behavior is also informed by pretty much every other theme, and her behavior (and its outcomes) likely reinforces her emotional distress, too.

This formulation represents a hybrid of the many strengths of the previous conceptualizations, but with more freedom and flexibility to think about what is psychologically logical. While it looks somewhat complicated in diagram form, a narrative can present this model in a way that truly links the themes in a narrative and convincing way. The complex model for Shelly is shown in Figure 8.6.

This model explains Shelly's difficulties well. *Her trauma history contributed to her developing difficulties regulating both her thinking and feeling and to understanding both herself and others. Combined with her ongoing traumatic stresses, her underlying difficulties with regulation and understanding led to her having deeply conflicted feelings about other people, on one hand wanting closeness and on the other expecting that they will let her down, harm her in some way, or abandon her. Together, these problems have led to emotional distress (including some anxious and depressive symptoms) and problems controlling her impulses, as well as ineffective, problematic, and paradoxical behaviors toward others. These behaviors have left her somewhat isolated, lonely, and resentful, which further reinforces her emotional distress.* Although this model is not necessarily more valid than any of the others, it is certainly psychologically viable and will likely make sense to Shelly in feedback.

Report Writing

Before the report can be written, the final step of determining diagnosis and recommendations must be addressed. Recalling the possible causes enumerated in the earlier stages of the assessment process, the first hypothesis to consider is ADHD. Because this was not the primary concern in the present evaluation and because she was tested while she was taking her ADHD medication (Adderall), it is hard to determine from the data that emerged whether she truly meets criteria for ADHD. However, given the previous diagnosis, current medication, and

some lingering inefficiencies in her executive functioning (even when tested while she was on medication), it is fair to assert that she meets criteria for ADHD "by history." Adding that phrase clarifies that it is a historical diagnosis and that there is no evidence to dispute it from the present evaluation.

Related to her emotional and personality functioning, the early hypotheses included an anxiety disorder, a mood disorder (depression or bipolar), and a personality disorder. While she does have some anxiety and depressive symptoms, they do not seem to rise to the level of their own disorders outside of what will clearly end up being some sort of personality disorder. From the personality standpoint, her paradoxical interpersonal behaviors—in addition to her identity problems, affective instability, feelings of emptiness, and issues with anger—all strongly support a diagnosis of borderline personality disorder (BPD), which also most often comes with a level of emotional distress. This diagnosis also explains her past suicide attempt. Her trauma history and early invalidating environment contributed to her developing a personality with multiple systems that are dysregulated, including her self-system, affective system, thinking system, and perhaps most pronounced her interpersonal system. Her self-reported attachment issues and recent history of stalking (efforts to avoid abandonment) are further evidence of this disorder, and while borderline personality disorder may be stigmatized within the mental health field and in broader society it does explain her current functioning rather accurately.

Related to recommendations, borderline personality disorder is one of those diagnoses that has only a few, specific treatments with a solid evidence-base behind them for treatment. Currently, there are four primary types of psychological treatments with evidence support for BPD: dialectical behavior therapy (DBT), mentalization-based therapy (MBT), schema-focused therapy (SFT), and transference-focused psychotherapy (TFP; APA Division 12, n.d.). Selecting which of these is most appropriate in the present case may come down to either access (what she is reasonably going to be able to get, in her area and with her finances) or perhaps which is likely to be the best match for her specific personality. For example, it is possible that someone with stronger intellectual resources may benefit more from one of the treatments that is more focused on cognitive understanding, like MBT or SFT. However, in the absence of specific reasons ruling any of these out, the recommendations could simply include multiple options for her to consider pursuing. Additionally, regardless of personal feelings about medication treatment, there is strong evidence to support psychopharmacological intervention for at least some of the symptoms associated with BPD (e.g., Ripoll, 2013). While as a psychologist we may never outright recommend medication treatment, ethically we should recommend at least a consultation with a psychiatrist to determine whether medication treatment may significantly benefit her. Now that diagnoses and recommendations have been determined, we can write the report.

Confidential Psychological Assessment Report

Identifying Information

Name:	Shelly Stevens	**Date of report:**	2/28/20
Sex:	Female	**Assessor:**	A. Jordan Wright, PhD
Age:	24		
Date of birth:	1/1/1996	**Dates of**	1/21/20; 1/25/20;
Ethnicity:	White	**assessment:**	2/11/20; 2/13/20

Referral Source and Questions

The client was referred by her therapist to clarify any possible diagnosis and for recommendations for treatment, given the client's "attachment issues" and recent stalking behavior.

Measures Administered

- Clinical interview
- Bender Visual-Motor Gestalt Test, 2nd Edition (Bender-2)
- Wechsler Adult Intelligence Scale, 4th Edition (WAIS-IV)
- Conners' Continuous Performance Test, 3rd Edition (CPT-3)
- Delis-Kaplan Executive Function System, Trail Making Test (Trails)
- Wisconsin Card Sorting Test, Computer Version Fourth Edition (WCST-IV)
- Comprehensive Executive Function Inventory, Adult (CEFI)
- Personality Assessment Inventory (PAI)
- Millon Clinical Multiaxial Inventory, 4th Edition (MCMI-IV)
- Inventory of Altered Self-Capacities (IASC)
- Differentiation of Self Inventory, Revised (DSI-R)
- Rorschach Performance Assessment System (R-PAS)

Client Description

Shelly Stevens is a 24-year-old, White woman who lives with her mother and works as an actress and occasionally a waitress. She was well groomed and dressed casually and appropriately. She was extremely cooperative with the assessor throughout the assessment process, and she seemed to make effortful attempts on all tests administered.

Presenting Problem and Its History

The client reported that she has a history of "attachment issues." Specifically, she reported that she has always had difficulties with relationships, both with friends and with boyfriends. She reported that she had a boyfriend over the past year who broke up with her a few months ago and whom she began to stalk significantly, both over social media and physically. She reported that she set up several fake social media accounts to friend him and ask him about herself; she also went to his apartment, took videos of herself in front of it, and posted those online. She reported that he has a restraining order out against her and that she is facing charges of cyberstalking. She stated that the reason she took such drastic and desperate measures was that she really felt that he understood her deeply and she "went overboard."

The client reported that she had been sexually assaulted twice, once in high school and once in college. She reported that in high school her boyfriend tried (unsuccessfully) to force her to have sex with him and that in college she was "probably raped." When asked to clarify, she reported that she was at a party in college drinking and was assaulted by a boy at the party but that it "happened so quickly and didn't really hurt," so she was unsure if he had actually penetrated her. She reported that her ex-boyfriend was the first person she had told about these two assaults, and he was compassionate and understanding, which is why she felt so connected to him.

She reported that she has had a history of "unhealthy relationships," stating that she has "never" had a healthy one. She reported that she has not had lasting relationships with friends, and she has never had "a good breakup with a guy." She reported that she does not have a good history of or current context of social support, except for her mother. She reported that in school she tended to be alone or get into fights (though not physical ones) with others. She did report some improvement in her social life in college, but while she was friendly with others she did not have any close relationships, even then.

The client additionally reported that she struggles with anxiety and depression and that she at times abuses diet pills. She reported that she had a suicide attempt when she was 20 years old, just after she had been sexually assaulted in college. She reported that she overdosed on pills, but she is unsure whether she genuinely wanted to die. She denied current suicidal ideation.

Relevant Background Information

The client was adopted by her mother, a nurse, when she was 8 years old, after having been neglected by her birth mother, who died from an overdose when the client was about 2 years old. She reported that when she was found by child protective services her home was in disrepair, she was significantly malnourished, and she was not yet walking or talking. From 2 years old until she was adopted at the age of 8, she reportedly lived in multiple foster homes. She reported that once in foster care she caught up with her developmental milestones, including walking and talking. She reported that she has a generally positive relationship with her mother, who is her "best friend." She also reported that she does not have significant friendships or a history of strong social support; she reported that she has had "friends come and go," but she has not had lasting friendships. She also reported that she has a history of romantic relationships that were "all very screwed up." She identifies as heterosexual and is currently not in a relationship or sexually active.

The client earned a bachelor's in theater from a small, local liberal arts college in 2018. She has no history of diagnosed learning disabilities, but she was previously diagnosed with attention deficit hyperactivity disorder (ADHD) and prescribed Adderall, which she currently takes. She reported no major medical problems or head injuries. She reported that she uses alcohol very rarely and denied any other drug use. She has been in therapy with her current therapist "off and on" for about 9 years, throughout most of high school, college, and beyond. She reported that she engaged in dialectical behavior therapy (DBT) several years ago but did not like the group or the people running it, so she did not get much out of it. However, she reported that she would like to try DBT again.

Behavioral Observations

The client was extremely cooperative throughout testing. She gave effortful attempts on all tests administered. At times, she became laughed wildly at some of the test items and wanted to engage with the assessor about how "ridiculous" they were. She was generally open and seemed genuine when discussing difficult topics with the assessor, though some of the details of her recent history of interaction with her ex-boyfriend was confusing and contradictory.

Mental Status Evaluation

The client was appropriately dressed and groomed for her appointments, where she showed up on time, accompanied by her mother. She was cooperative and friendly with the assessor throughout, making appropriate eye contact throughout the evaluation and attempting to answer questions directly and clearly. However, some of her reported history did not make coherent sense, especially when reporting on her recent interactions with her ex-boyfriend. She seemed to persist and give full effort on all activities. She exhibited no psychomotor retardation or agitation. Her speech included a full range of voice, and her language was specific and goal directed. Her mood was reportedly "fine," and her affect was consistently mood congruent and appropriate to the situation. Her thought process was clear and goal directed for the most part, and her thought content was currently free of delusions. She reported some anxious and depressive ideation, including some hopelessness, helplessness, worthlessness, and emptiness. The client denied hallucinations and suicidal and aggressive and homicidal ideation. Her attention and concentration were adequate throughout, and her memory functioning appeared intact. Her insight and judgment were weak, by self-report, though her observed insight was somewhat better, with her acknowledging her poor interpersonal behavior.

Overall Interpretation of Test Findings

Cognitive Functioning

The client was administered several measures to assess her current cognitive functioning. It should be noted that these measures evaluate her cognitive ability under ideal conditions and in the most ideal context; as such, they represent her cognitive ability rather than how she actually functions in her daily life. Additionally, it should be noted that she was evaluated while on her ADHD medication (Adderall).

The client's overall performance across her multiple domains of cognitive functioning was generally low average compared with others her age, with specific significant strengths in her verbal ability and her speed of processing information, which were both average. It should be noted that her attention and executive functioning abilities are intact, though she was evaluated on her ADHD medication (Adderall).

Fine Motor Skill. On measures assessing her ability to control her fine motor functioning deliberately and carefully, the client exhibited no difficulties in her actual motor ability, both in her deliberate control of her fine motor functioning (Bender-2 Motor subtest, 51st–100th percentile) and in her speed of fine motor movement (Trails Motor Speed, 50th percentile). Her control of movement is not currently impaired.

Visual Perception and Reasoning. On measures of visual perceptual ability, including nonverbal reasoning, visuospatial aptitude, and induction and planning skills on tasks involving nonverbal stimuli such as designs, pictures, and puzzles, the client performed within the low average range compared with others her age (WAIS-IV Perceptual Reasoning Index, 10th percentile). Specifically, she showed no difficulty in her basic abilities with visual perception (Bender-2 Perception subtest, 26th–100th percentile), whereas her more complex nonverbal reasoning skills are low average to average compared with others her age (WAIS-IV Visual Puzzles, 25th percentile; WAIS-IV Matrix Reasoning, 9th percentile). Her nonverbal reasoning ability is not a strength but is also not significantly impaired.

Visual–Motor Integration. The client's ability to integrate her visual understanding with her motor coordination is similarly low average to average. On a task requiring her to copy complex drawings as precisely as possible without time constraint, which requires perceptual ability and the coordination between that ability and fine motor control, she performed in the average range compared with others her age (Bender-2 Copy, 70th percentile). On a task requiring her to use blocks to recreate complex designs presented to her within a time limit, the client performed in the low average range compared with others her age (WAIS-IV Block Design, 9th percentile). It should be noted that this task requires both visual–motor integration abilities and speed, as it is timed. Similar to her visual–spatial reasoning ability, her integration of it with motor skills is low average to average.

Memory. The client's short-term memory, which was assessed only briefly using a visual memory task, is average for her age. On a measure of immediate (short-term) memory, the client exhibited average performance compared with others her age with remembering visual information previously presented to her (Bender-2 Recall, 73rd percentile). She exhibited no difficulty with either learning or remembering information.

Processing Speed. The client's ability to focus attention and quickly scan, discriminate between, and respond to visual information within a time limit (knowing she was timed) was also average compared with others her age (WAIS-IV Processing Speed Index, 30th percentile). She processes and responds to information generally with similar speed to others her age.

Language. On measures of verbal ability, including verbal comprehension, ease of use of verbal skills, verbal knowledge, and the ability to express herself clearly and completely, the client's performance fell within the average range compared with others her age (WAIS-IV Verbal Comprehension Index, 27th percentile). Her ability to express herself clearly is adequate for her age (WAIS-IV Vocabulary, 25th percentile), as is her general fund of verbal knowledge (WAIS-IV Information, 25th percentile). Her abstract understanding of language and use of words in complex and abstract ways is also adequate (WAIS-IV Similarities, 37th percentile). Her ability to understand and use language effectively is average for her age.

Executive Functioning. The client was given tasks to evaluate her ability to control her cognitive functions, including attention, working memory, and impulse control and related skills.

Selective Attention. The client's ability to focus on one thing when distractions are present and quickly determine correct (relevant) versus incorrect (irrelevant) stimuli (assessed while she was on her ADHD medication) is currently adequate (CPT-3 Omissions, 32nd percentile [better than 68% of same-aged peers]; CPT-3 Detectability, 14th percentile [better than 86% of peers]). It should be noted that on tasks that required both selective attention and processing speed, she performed much more poorly (WAIS-IV Cancellation, 2nd percentile; Trails Visual Scanning, 9th percentile). Her selective attention is generally adequate for her age, when medicated, with some weakness when under time pressure.

Sustained Attention. The client's ability to sustain her attention across time once engaged in a task (even a boring, tedious one) emerged as unimpaired. Specifically, on a boring task that continued for an extended period of time, her response time to stimuli stayed generally constant (CPT-3 HRT Block Change, 55th percentile [better than 45% of same-aged peers]), and she did not become significantly more inaccurate as the task progressed (CPT-3 Omissions by Block Change, $p > .10$; CPT-3 Commissions by Block Change, $p > .10$). Similarly, on another boring task that continued for an extended period of time, she was able to maintain the rules for how to respond in her head even as the task progressed (WCST-IV Nonperseverative Errors, 63rd percentile). Her cognitive ability to concentrate over a period of time is also currently intact when medicated.

Auditory Working Memory. On tasks assessing her ability to concentrate, learn new information, hold it in short-term memory, and manipulate that information to produce some result or reasoning outcome, the client's performance was low average for her age (WAIS-IV Working Memory Index, 9th percentile). Working memory is dependent on attention but also requires skills in working with verbal information in her head. Although not significantly impaired, her working memory ability is not strong.

Impulse Control and Related Functions. On a task evaluating her ability to control her basic cognitive impulses, requiring her to respond to stimuli in the opposite way than her impulses would guide her, she showed strong ability to control her behavior (CPT-3 Commissions, 18th percentile [better than 82% of same-aged peers]). Her ability to control her impulses and apply a new strategy that was given to her to a task was also good (Trails Number–Letter Switching, 63rd percentile). Further, her ability to control her impulses, monitor herself and her strategies, and then adapt to feedback given to her in the moment was also adequate (WCST-4 Perseverative Errors, 66th percentile). Her cognitive abilities to control her impulses and her other mental functions are currently good while on her ADHD medication.

Personality, Emotional, and Behavioral Functioning

The client was administered several measures to assess her current personality, emotional, and behavioral functioning. It should be noted that the focus of these measures is on areas of need rather than a comprehensive overview of all of her personality, emotional, and behavioral strengths and weaknesses. As such, this section will necessarily focus on areas of her functioning that need support.

The assessment revealed that the client has experienced significant traumatic stress in her life, beginning with her early attachment and environmental deprivation (which has significantly affected her personality development) and her later sexual assaults (which also affect her current emotional functioning). The underlying difficulties in personality development that emerged, related to her early deprivation, include a thinking process that is overly rigid and easily overwhelmed, difficulties regulating her underlying emotional states, and significant difficulties understanding both herself and others. These underlying struggles, combined with her more recent traumatic experiences, have contributed to deeply conflicted feelings about other people, both longing for closeness and support (and fearing and expecting abandonment) and deeply mistrusting that others will be there for her. All these conflicts have contributed to her currently experiencing significant emotional distress, including

symptoms of both anxiety and depression, as well as having problems controlling her impulses. Her difficulties understanding others, conflicted feelings about others, emotional distress, and impulse control problems result in significantly inappropriate behavior with other people, including both overly attached, submissive, and dependent behaviors and aggressive, resentful, and hostile behaviors.

Traumatic Stress. The client has a significant history of traumatic stress, beginning with early attachment disruptions and having reported several sexual assaults throughout her life. She has experienced specific traumas that have affected her development and that continue to affect her, including anxious and intrusive thoughts about them (PAI, MCMI-IV, R-PAS). During the clinical interview, in addition to her early trauma and foster care history, she discussed two separate sexual assaults. While her early attachment disruptions affected how her personality functioning developed, the sexual assaults likely worsened any of her thinking, emotional, self, and especially interpersonal functioning.

Rigid and Easily Overwhelmed Thinking. The client's thought processes are generally quick to judgment, difficult to reevaluate or change, and ultimately easily overwhelmed. The way that she understands the world is generally based primarily on the easiest to understand material, without a great deal of nuance and somewhat hasty (R-PAS). Once she feels she has an understanding, it is very difficult for her to be flexible, reevaluate her beliefs, or change her perspective (PAI, MCMI-IV). In addition to being rigid, she tends to think about situations over and over, moving further and further away from the facts of reality while ruminating on the information in her head (PAI, R-PAS). Ultimately, however, her thinking becomes overwhelmed and confused (PAI, R-PAS), negatively affecting her attention and other executive functions, like organization and planning (PAI, CEFI).

Problems With Emotion Regulation. The client's internal emotional states are turbulent and uncontrolled, quickly and overwhelmingly shifting between strong, intense feelings. The client struggles with strong underlying emotional states that shift quickly (PAI, MCMI-IV, DSI-R, IASC, CEFI). These shifting emotional states can make her extremely irritable (MCMI-IV) and include poorly controlled anger (PAI). She does not have enough skills to manage and control these rapidly shifting and intense emotional states (IASC, CEFI), which can ultimately be overwhelming and affect her behaviors and interpersonal relations.

Difficulties Understanding Herself and Others. The client's trauma history and early attachment disruptions have left her with significant difficulty understanding both herself and other people. She struggles both with understanding who she is in general (PAI, IASC, R-PAS) and with maintaining a consistent and coherent sense of who she is in different contexts (DSI-R, IASC). Related to others, she has significant problems understanding the normal nuances of interpersonal interactions, including what motivates and influences other people's thoughts, feelings, and behaviors (PAI, R-PAS). This includes a significant specific problem with taking others' perspectives or seeing situations from any perspective other than her own (MCMI-IV, R-PAS). Specifically, she most often assumes that others are going to be hostile toward her, abandon her, or have otherwise malicious intentions (PAI, MCMI-IV, R-PAS), maintaining a suspicious attitude toward them (PAI, MCMI-IV).

Deeply Conflicted Feelings About Others. Related to her difficulties understanding herself and others, she has developed deeply conflicted feelings about relationships (especially deep, vulnerable ones) with others, on one hand longing for closeness and wanting to rely on others and on the other hand expecting them to abandon her or otherwise let her down. The client longs to depend on others and be close with them (PAI, MCMI-IV, IASC, R-PAS). However, based on her significant history of disrupted attachments, she expects and fears that others will abandon her or let her down (PAI, MCMI-IV, IASC, R-PAS), feeling significant resentment and anger toward other people in general (PAI, MCMI-IV, IASC). She is extremely sensitive in social interactions (PAI), and she can easily feel unsupported and ultimately resentful (PAI, MCMI-IV, IASC, R-PAS). Her deep internal conflict, both longing for and fearing relationships with others, significantly impairs her ability to have effective relationships.

Emotional Distress. All her underlying difficulties and her history of traumatic stress have contributed to the client currently experiencing significant emotional distress, in the form of both depressive and anxious feelings. The client struggles with significant depressive feelings, pessimism, and emptiness (PAI, MCMI-IV),

including significant low self-esteem (PAI, MCMI-IV). One way she tries to cope with her underlying low self-esteem is by projecting an appearance of very high self-confidence, working hard to convince herself and others that she deserves respect (R-PAS). However, this defense is rarely effective. In addition to her depressive feelings, she struggles with general worry and anxiety in her life (PAI, MCMI-IV). Related to both are feelings of helplessness in the face of stressors, feeling that she cannot effect necessary change in her life (MCMI-IV, R-PAS).

Impulse Control Problems. The client's underlying, overwhelmed emotional and thought states contribute to her having difficulty controlling her impulsive behaviors, which she often uses to distract and soothe herself from her current emotional distress. The client struggles with maintaining appropriate control over her behaviors, often acting impulsively and without thinking about potential consequences (PAI, MCMI-IV, CEFI). These behaviors can appear disruptive or aggressive (MCMI-IV), as well as dysfunctional and risky (PAI, IASC), but they serve to distract, soothe, or otherwise relieve her internal distress (IASC).

Problematic and Contradictory Interpersonal Behavior. All the client's problematic history, underlying traits, and current emotional and behavioral struggles have contributed to behaviors in her interactions with others that are both problematic and oftentimes paradoxical and confusing. Based on her suspiciousness and fear that others will abuse or abandon her, at times she adopts a cold, callous, and distancing stance with others, avoiding them and pushing them away (PAI, MCMI-IV). Other times, however, easily fluctuating between overwhelmingly negative and overwhelmingly positive feelings about others (MCMI-IV, IASC), she becomes overly submissive, passive, and obedient (MCMI-IV, IASC), getting to such an extreme point that she fuses with others, losing her own identity nearly entirely (DSI-R, IASC). Still other times, based in her significant resentment, she can become hostile, manipulative, and exploitive of others (PAI, MCMI-IV). These problematic and contradictory behaviors have led to significantly rocky and volatile relationships with others in the past and very few current significant supportive relationships (PAI, IASC).

Summary

Shelly Stevens is a 24-year-old, White female who currently lives with her mother and works as an actress and occasionally a waitress. She was referred for psychological assessment to evaluate what is underlying her "attachment issues" and recent stalking behavior, including possible diagnoses and recommendations for treatment. She was significantly neglected in early childhood, including physical malnourishment, to the point of not meeting appropriate developmental milestones (walking and talking) by 2 years old. At 2, she was reportedly found in her home, where her mother had died of a drug overdose, and put into foster care. After living in multiple foster homes, she was adopted at 8 years old by her mother, a nurse. She reported a significant history of interpersonal difficulties and struggles with anxiety, depression, diet pill abuse, and one previous suicide attempt. She also reported having been sexually assaulted twice, once in high school and once in college. She currently has no significant interpersonal relationships except for her mother.

Cognitively, the client's overall performance across her multiple domains of cognitive functioning was generally low average compared with others her age, with specific significant strengths in her verbal ability and her speed of processing information, which were both average. It should be noted that her attention and executive functioning abilities are intact, though she was evaluated on her ADHD medication (Adderall).

The client's personality, emotional, and behavioral functioning is heavily influenced by significant traumatic stress in her life, including both early attachment and environmental deprivation (which has significantly affected her personality development) and later sexual assaults (which also affect her current emotional functioning). The underlying difficulties in personality development that emerged, related to her early deprivation, include a thinking process that is overly rigid and easily overwhelmed, difficulties regulating her underlying emotional states, and significant difficulties understanding both herself and others. These underlying struggles, combined with her more recent traumatic experiences, have contributed to deeply conflicted feelings about other people, both longing for closeness and support (and fearing and expecting abandonment) and deeply mistrusting that others will be there for her. All of these conflicts have contributed to her currently experiencing significant emotional distress, including symptoms of both anxiety and depression, as well as having problems controlling her impulses.

Her difficulties understanding others, conflicted feelings about others, emotional distress, and impulse control problems result in significantly inappropriate behavior with other people, including both overly attached, submissive, and dependent behaviors and aggressive, resentful, and hostile behaviors.

Diagnostic Impression

Currently, the client meets criteria for borderline personality disorder (*DSM-5* code 301.83; *ICD-10* code F603). Specifically, she exhibits patterns of instability in her interpersonal relationships, self-image, and emotions, including efforts to avoid abandonment (including her poor boundaries with her ex-boyfriend), identity problems, affective instability, feelings of emptiness, and issues with anger. Additionally, she has a history of suicidal behavior.

Additionally, the client meets criteria for attention deficit hyperactivity disorder (ADHD; *DSM-5* code 314.00; *ICD-10* code F90.0), by history. It should be noted that the present evaluation did not assess her ADHD thoroughly, as she was on her ADHD medication (Adderall) during the testing. It should also be noted, though, that her performance on attention and executive functioning tasks, while medicated, was generally intact; as such, her medication seems to be helping with her attentional difficulties.

Recommendations

1. The client should share the results of this evaluation with her treatment providers, including the referring therapist.
2. The client should work again with dialectical behavior therapy (DBT), given her diagnosis and her desire to try it again. Alternative forms of treatment that have empirical support for the treatment of borderline personality disorder include transference-focused psychotherapy (TFP), mentalization-based therapy (MBT), and schema-focused therapy (SFP), all of which are also tailored toward better self-regulation and more appropriate interpersonal perception and behavior.
3. The client may consider working with a psychiatrist to determine the potential benefits of psychiatric medication to treat borderline personality disorder.

_____ _____

A. Jordan Wright, PhD — Date

New York State Licensed Psychologist

Feedback

Preparation for Feedback

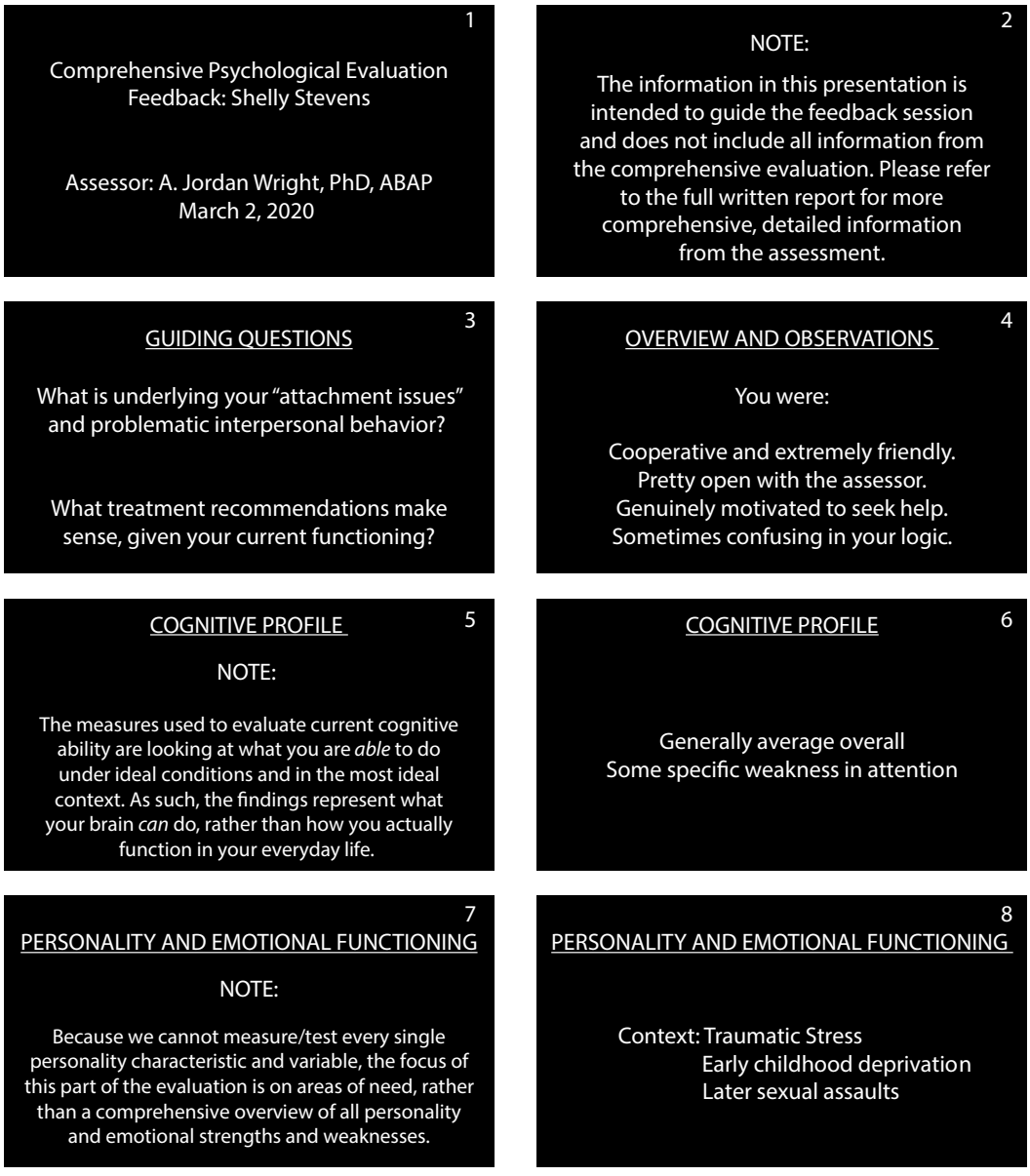
When considering exactly what feedback to give and how to give it to Shelly, the most challenging aspect is likely to be giving the actual diagnosis of borderline personality disorder, especially not knowing if she has ever heard the term and also thinking about just how stigmatized it is and how scary it can seem if you look it up online. The major driving question, though, is if there is a strong likelihood that telling her the diagnosis of BPD might cause her any kind of harm, such as causing her to decompensate or act out in some way that is physically dangerous to herself or others. Given her long history in therapy, her acknowledgment of interpersonal and "attachment" problems, and the fact that she had tried dialectical behavior therapy before, it is unlikely that telling her the diagnosis will make her unravel in any way. Additionally, her average verbal ability does not preclude her from understanding the diagnosis at all. As such, it was decided to disclose the diagnosis (as well as all the other problematic dynamics that emerged from the assessment).

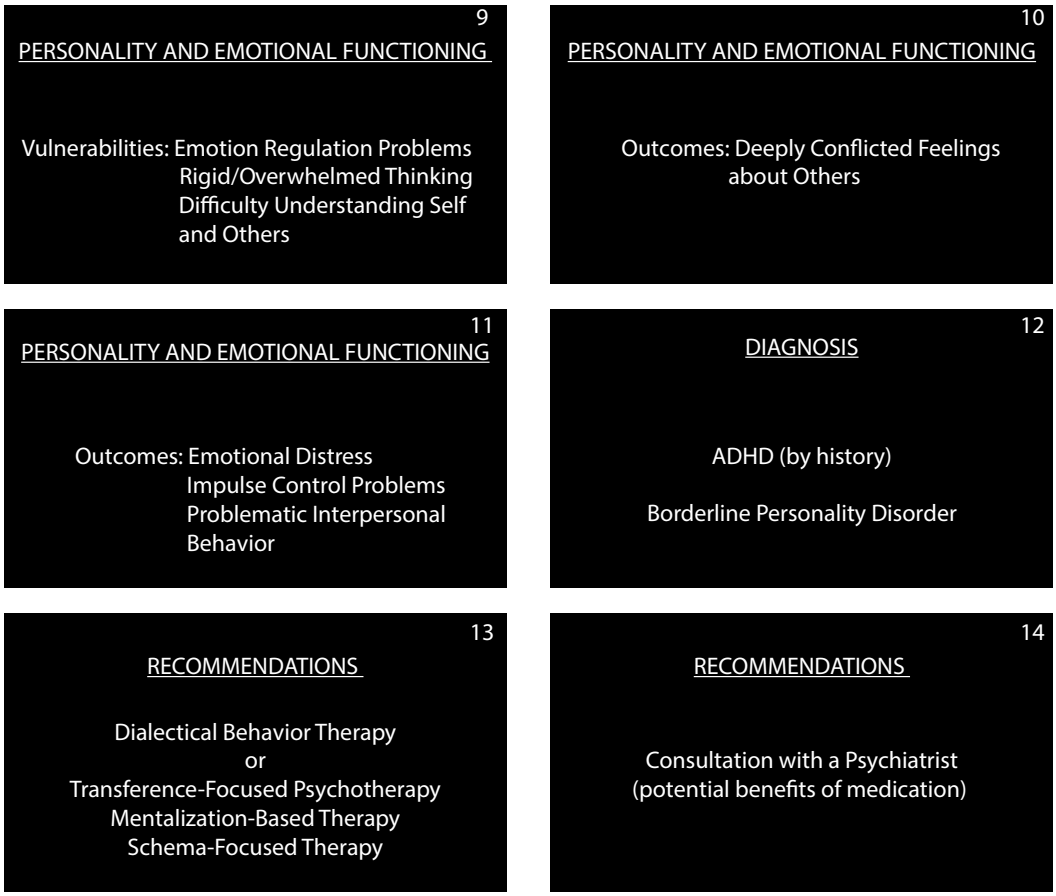
As is typical for feedback sessions, the assessor decided to give the feedback verbally (with the use of a feedback presentation) before giving Shelly the actual report. He wanted to ensure that she was really focused on

the feedback the assessor was giving and had an opportunity to ask questions or discuss reactions, without the distraction of holding and wanting to look at the report. The plan was to discuss the cognitive feedback first and then the personality and emotional functioning, with plenty of time for reactions and questions. Additionally, the plan was to present the narrative personality and emotional feedback, pause, then move on to the diagnosis from a symptom-first strategy. That is, when discussing the diagnosis, rather than presenting the term borderline personality disorder and then describing its symptoms, the assessor will re-present the symptoms (in more *DSM-5* terms), get agreement on them, then discuss the taxonomic terminology that the mental health profession has for this cluster of symptoms. Care has been taken in trying to ensure as little shame as possible (with a focus on the impact of her traumatic stress) and to present the label of BPD as the way the mental health community organizes and labels her particular cluster of symptoms, rather than the scary-sounding label, to minimize a negative reaction.

Feedback Presentation

The assessor decided to create a feedback presentation for the case to organize and guide the feedback session.





Feedback Session

Shelly brought her mother in for the feedback session. Before beginning, the assessor met with Shelly alone to discuss this decision and ensure that she really wanted her mother present even before knowing what the feedback was. She stated that she had no secrets from her mother and that though they have been through "rough patches" she knows her mother always wants to help her. So she wanted her to be present for feedback. At that point, we let her mother come back into the room to be a part of the feedback session.

After framing the session in the standard way, discussing how bizarre the situation is to hear about yourself from a near stranger, noting that some things will be known to her and some likely may not be, discussing the process as a whole and noting that there may be factual errors in the report, offering to meet with her again if she had questions or concerns about the report, and framing the session itself, the assessor brought up the presentation on his computer. The real feedback began with a review of the guiding questions and an overview of Shelly's approach to testing, which was quite open and seemingly genuine. The assessor then discussed quite briefly the cognitive assessment. He made a decision to frame her overall functioning as average even though it was low average overall. Technically, low average is still in the average range, and there did not seem to be any advantage for making this distinction. In discussing some of the specifics quite briefly, the assessor did explain that some of the functioning was in the lower part of the average range, and some was solidly average for her age. He discussed her slight problems with attention, though he noted that her attention and executive functioning were generally fine, which meant that her Adderall seemed effective. He paused to ask for reactions or thoughts, but they had none at this point. So the assessor moved on to the personality and emotional functioning section, where the bulk of the session would focus.

The session turned to Shelly's personality and emotional functioning. The slide with the context of her traumatic stress came up and stayed up while the assessor discussed the impact of early childhood deprivation, disrupted early attachment, and later sexual assaults can have on an individual. Shelly became tearful as she listened to how important it is for young children to have secure attachments and what disruptions can do to personality and emotional development. She discussed how lucky she is to have her mother, who loves her so much and wants to help her, but she talked about how "messed up" all her other relationships are just because her biological mother "screwed everything up for me." The assessor worked hard and spent time trying to empathize with how difficult her life is and how tough it must be to think about her traumatic history as a major contributor since there is nothing she can really do to change any of that. Her mother kept her hand on Shelly's arm the entire time, trying her best to comfort her. Then Shelly asked to continue to hear "exactly how it's all messed me up," with an uncomfortable laugh.

The next slide focuses on the underlying vulnerabilities that she developed within the context of her early deprivation: her emotional dysregulation, her rigid and easily overwhelmed thinking processes, and her difficulties understanding both herself and other people. None of these themes seemed like a surprise to her or her mother. She had examples to share for each of the themes, including moments when she became overwhelmed by her emotions, moments when she became overwhelmed by her thoughts (and reported that she seemed to dissociate a bit), examples of expecting the worst from others even when they did not "objectively deserve it," and her feelings of emptiness, unclear identity, and low self-esteem (jumping ahead). The assessor focused on how these things tend to develop out of adverse early childhood experiences, trying to normalize the developmental trajectory given her context. She had no concerns about any of these first themes, so they continued to the next slide.

The theme of having deeply conflicted feelings about others got its own slide, largely because it is such a central and defining characteristic of Shelly's disorder and functioning and also because of its centrality in the interpersonal circumplex model, which, while not ultimately used, is still important to consider. Her conflicted feelings fuel most everything else and ultimately answer the primary referral question of what is underlying her interpersonal problems. So the assessor discussed the underlying ambivalence, framing it as "part of you" wanting one thing and "another part of you" wanting the exact opposite. Again, Shelly identified clearly with this idea, with examples of feeling lonely, resentful at not getting the support she craves, and isolated on one hand and examples of assuming others will ultimately let her down, abandon her, or harm her in some way, and pushing them away on the other hand. She said that she had not heard it put in this way before, but she is always "internally struggling" about other people. She said that it can become "all-consuming" for her, making her anxious, angry, and depressed. The assessor again tied her underlying ambivalence to her traumatic experiences, both in early disrupted attachment and in her later experiences of sexual assault. He empathized with how confusing it must have been for someone she cared about (like her high school boyfriend) to behave in a way that was so violating. The assessor tried once again to emphasize again how "normal" and expected it is that she would develop these underlying conflicted feelings given her lack of early clear loving attachment and her later betrayals by people she cared about.

The topic of her emotional distress (as well as her pushing people away) led directly to the final slide of outcomes, on the topics of emotional distress, impulse control problems, and problematic interpersonal behavior. With very little reaction to the emotional distress or impulse control problems, the assessor spent more time on her paradoxical, confusing, and alternating problematic behaviors with other people, again focusing on how her conflicted feelings about closeness with others fuels her behaviors with them. She discussed how she "flips" from doing whatever other people want to feeling resentful and pushing them away "hard." In her own terms, she discussed the textbook BPD symptom of idealization and devaluation and the resulting behaviors of them.

The next slide had animation when it was shown to Shelly. This way, the only thing showing when the assessor moved to it was the word "DIAGNOSIS." The assessor was careful not to spring the BPD diagnosis on Shelly without first thoroughly discussing the symptoms (as previously discussed), so the slide did not yet disclose it. The assessor discussed briefly the ADHD diagnosis and the limitations of the current assessment to definitively rule it in or out (because she was on her Adderall during testing). He then discussed that she had one more diagnosis, stating that the diagnosis encompasses multiple symptoms she struggles with: feelings of emptiness, identity problems, emotional instability, anger problems, and instability in relationships, including efforts to avoid being abandoned. He also discussed that the diagnosis often comes with some suicidal behavior along with some of the dissociation symptoms she just disclosed in this session (even though these were not evident in the assessment itself). She asked at this point if it was borderline personality disorder (clearly a term with which she was familiar), and the assessor told her it was. She reported that she did not know all that much about BPD but that she suspected she had it because her therapist "sent me to DBT."

The assessor spent some time describing what BPD is, including some of Linehan's (summarized well in Linehan, 2015) theories as to its etiology, rooted in an invalidating environment. He also discussed some of the ways the mental health field has evolved in its understanding of BPD and why it may not benefit Shelly to look online too much about the diagnosis. She was warned that she may find dated websites with information about how difficult it is to treat (which is much less so believed now that there are research-supported treatments), how mental health practitioners dislike working with people with BPD (again, not so much the case anymore), and even social networks of individuals struggling with BPD who may have very different presentations than she has. He discussed the *DSM-5* criteria of needing five of nine symptoms, which means two different people can have the same diagnosis and only overlap in a single symptom. Shelly and her mother seemed to understand and accept the diagnosis, and she asked, "So there are research-supported treatments—like DBT again?"

The assessor moved to the recommendations, which included trying DBT again (especially since she explicitly said she was interested), along with some alternatives to DBT. Additionally, the assessor discussed consulting with a psychiatrist about the potential benefits that medication may have for BPD, and Shelly's eyes widened with excitement. "There are meds that can help?" she asked. Ending on a slightly brighter note than the heaviness of most of the session, the assessor discussed some of the research about how some medications may benefit individuals with BPD while also emphasizing that a discussion with a psychiatrist would be much more beneficial, as they would have expertise in this area and the assessor (a psychologist) does not. She told her mother in the moment she wanted to see a psychiatrist and try "another round of DBT," which her mother was extremely supportive of in the moment. The assessor reiterated that they should bring to his attention any factual errors in the report and to raise any questions or concerns they had or let him know if they needed help finding appropriate resources (a psychiatrist and a DBT program). They were both extremely appreciative, and the assessor gave them a copy of the report. They did not follow up with any questions or concerns, but the referring therapist sent a brief note to the assessor several months later thanking him for the thorough assessment and confirming that Shelly did indeed find a psychiatrist, go on medications, and begin a DBT program.

Summary

Shelly was obviously struggling in her life, and it is certainly possible that a thorough clinical interview (or a structured diagnostic interview) would have come to the same diagnostic conclusion as the full integrative assessment did. However, the focus on her underlying conflicted feelings about closeness with others, which she had not for herself conceptualized in that way before, seemed to really resonate with her. Additionally, the careful consideration of her early deprivation, attachment disruptions, and her later traumatic sexual assault experiences

and their impact on her personality and emotional development is an important conceptual framework that can decrease the shame experienced by someone whose behavior causes significant distress for herself and others. While her trauma history does not exonerate her from taking responsibility for her problematic behaviors (such as her stalking behavior), it can help her take some of the self-blame (and thus guilt and shame) away and perhaps make her more open to getting help. Further, while she self-reported both anxiety and depression and likely would have endorsed symptoms related to both anxiety and mood disorders on a structured clinical interview, the assessment revealed that these are much more likely symptoms of her dysregulated and problematic underlying emotional system rather than true separate disorders. With good treatment tailored to addressing borderline personality disorder, she should see a decrease in the emotional distress symptoms.

CHAPTER 9

A Young Man Who Steals

Jeremy Chambers, a 21-year-old man, was referred for a psychological assessment by his mother, who found the assessor online. Jeremy and his mother actually lived in Chicago (the assessor is in New York), but they decided that the assessor was the right person to conduct the assessment, so they planned to travel to New York for a few days. In early communication with his mother, she reported that Jeremy was having several "difficulties with impulse control," including "a compulsion to steal," smoking, and being "obsessed with porn." When the assessor contacted Jeremy to schedule the appointments, they agreed to have two full days of assessment (with an optional third day, if needed), as he would be traveling to New York just for the assessment and only for a short time. The assessor already knew this would pose an interesting challenge, as he would not have much time to decide on a battery of tests after the clinical interview. Thus, he prepared to include many different tests in the battery, if needed.

The Clinical Interview

Jeremy came slightly early for the first day of testing. He arrived with his mother, a Caucasian woman about 50 years old, who met the assessor and then left Jeremy to do the assessment alone. Jeremy was quite tall and looked Caucasian, and he had no defining accent. He looked slightly older than 21 years old, though this was partially because of his height. He made excellent eye contact right from the beginning of the assessment, and he was extremely cooperative and friendly. There was nothing remarkable about his appearance at the beginning of the assessment.

An open-ended, unstructured clinical interview was utilized for the present assessment. After discussing and signing consent, the assessor asked Jeremy a few factual identifying information questions. He confirmed that he was 21 years old, giving his date of birth. When asked his ethnicity, he reported that he is "half Black, even though I don't look it." His native language is English, having been born and raised in Chicago. He is currently single and is living with a roommate in Chicago.

As a note on the presentation of this clinical interview, the sections that follow are not categorized into the biopsychological evaluation and psychosocial evaluation, as the flow of the clinical interview did not follow this structure. The subsections presented in the text reflect as closely as possible the clinical interview as it actually unfolded, as opposed to artificially grouping sections of information that did not present themselves sequentially. That is, the presentation that follows presents how the clinical interview happened chronologically, along with the overarching questions the assessor asked Jeremy. Clarification questions and comments were used throughout the interview, but they are not presented here.

Conducting Psychological Assessment, First Edition. A. Jordan Wright.

Presenting Problem: So why are you here for an assessment? What questions do you want answered with it?

Once basic identifying information was gathered, the assessor began the clinical interview with an assessment of the presenting problem. Jeremy immediately echoed, almost verbatim, what his mother had reported on the application form, stating that he has "difficulties with impulse control." Interestingly, after this statement, he simply looked at the assessor and grinned silently. After a moment, the assessor asked him to clarify what he meant by difficulties with impulse control, asking specifically "what it looks like" in his life. He looked down for a moment, then openly disclosed that there is "behavior I'm not proud of," behavior that reportedly causes family problems and that he does not want to engage in anymore. He works in retail stores, and he reported that he occasionally steals money from these stores. He reported that "I've gotten caught a few times, [and] I've gotten out a few times."

Additionally, he reported that he currently smokes cigarettes. Interestingly, when he reported this, he stated that he currently smokes, then he paused while looking at the assessor intently, then completed the sentence by clarifying cigarettes. The assessor made a note of this behavior, for when he revisited the topic of substance use later in the interview, when rapport had more solidly been built. The assessor also noted that Jeremy did not mention anything about pornography, which his mother had discussed ahead of time. The assessor decided not to address it at this point in the interview, again because he wanted to assure more solid rapport before addressing a topic as potentially sensitive as this one.

When asked his mood, he reported that "I am optimistic and happy." He stated that he occasionally gets into "a bad mood," but he "keep[s] an eye on the positive to get through it."

History of Presenting Problem: Can you tell me a little bit about when these impulse control problems all started?

For Jeremy, in this clinical interview, this single open-ended question was enough to get him to begin disclosing much of his history and current situation. Rather than addressing the impulse control problems per se, he began by discussing his educational and social history, as well as providing information about his family.

Jeremy reported that he graduated from high school in 2016 and went to college for a year, but he left school after a year because he became frustrated that he was not "actually learning anything or building my résumé" but rather just going to classes. As if he had researched exactly what the assessor would need to know, he began to describe his social history in high school, stating that he had one or two close friends growing up, but that he never had a large group of friends. Now, he has a best friend, the youth director at his church. He reported that he also lives with a roommate, who is also "alright, I guess." He also reported that he was "lazy" in high school, rarely doing his homework but always going to class and doing well because "I picked up stuff easily in class."

Jeremy then began to describe his family, reporting that his mother is a retired teacher who lives near him in Chicago and his father works for a hotel in Antigua (in the Caribbean), where his father is originally from. They divorced when Jeremy was 3 years old. He lived with his mother for about 10 years, who never remarried "or even dated another man." He then moved in with his father (in Antigua) when he was 12 years old and lived with him for 4 years. He stated that he had "a happy childhood," which he stated as if to end the conversation about his family.

As the assessor was writing notes, Jeremy smiled and reported that he had been previously diagnosed with "ADD [attention deficit disorder]," apologizing for being "all over the place." He reported going to a psychiatrist when he was younger because he was "angry at what turned out to be the divorce." His father was currently on his seventh marriage—Jeremy's mother was his father's first marriage—and he was angry when his father left. He was prescribed Ritalin, which he took until seventh grade, when he moved in with his father, who took him

off the medication. His psychiatrist also provided individual, weekly therapy from ages 8 to 12 years old, when he moved to Antigua.

History of Presenting Problem (Revisited): So, about your impulse control problems. . .

The assessor felt the need to refocus the discussion on the presenting problem, as Jeremy had not yet responded to the history of his difficulties with impulse control. He began to talk about his first job, which was at a small clothing store when he was 17 years old. He worked there for about 1 1/2 years, and during the final 6 months of working there he began to steal money. He reported that he took money to buy Christmas presents and intended to pay the money back, but he never did. There was apparently a lot of money coming into the store, and nobody noticed. He reported that this is when his stealing "got out of hand." However, he got caught by his manager. The first time he got caught, he apologized "profusely" and promised to pay the money back. The second time he got caught, he lied about how much he had taken, and he agreed to work to pay off what he owed. The third (and final) time he got caught at this job, his manager threatened to call the police, at which time he sold his car to pay the money back and left his job.

He reported that his next job was washing dishes, so there was no money around for him to steal. But his following job was at a store that sold audio and visual equipment; he reported that he is "very good at" retail jobs, which is why he returned to this industry. Because he was reportedly making "good money," he did not steal, though he reported that he gave a few free accessories to friends "here and there." However, a customer complained that he was drunk at work one day, which he claimed he was not. He was fired from this job, after which he reported that he had an entire year without stealing, working in a jewelry store. He left the jewelry store and worked at a clothing store, where he went three months without stealing. He planned to steal $100 from the store, but his boss found out his plan to steal and fired him. He then went back to the jewelry store.

Although he spent about two months back at the jewelry store without stealing, he then began not ringing up sales, changing figures, and taking money from the register. "It started small, but then it snowballed," so much that he was stealing about $200 a week. He was caught and fired. He then went to work at another electronics store, which he stated he loved and at which he was making good money, even though he did not like the owner. He began not ringing up certain items he sold, which gave him about $300 a week of extra money. "I didn't want to do it, but I kept doing it." He left this job a week before the current clinical interview, knowing he was "screwing up an awesome job." He lied and told his friend (the youth director) that he was leaving the job because he was going bankrupt, and he called his mother and father, who "all came together to help me," finding the referral for the assessor, "who I've heard is just the best."

Criminal and Legal History: So did you ever have legal problems with all of this?

Jeremy reported that he had never been arrested or had any legal difficulties as a result of his stealing: "I just got fired." He did report that he when he was 18 he got into a minor car accident, and he had been driving with a suspended license, of which he was unaware. Because of his suspended license, he spent 1 1/2 hours in jail, paid a fine, and was released. He denied any other legal involvement.

Psychosocial History: Can I ask you about significant relationships?

Jeremy reported that he has never "really" had a significant relationship, his longest being about 5 months in duration. He stated that he dated this girl during his year in college, but he has not had any significant relationships since then. He quickly pointed out that he would eventually like to be married and have children, but he needs to find "the right one" for this to happen.

Jeremy then reported that he is a volunteer leader at his church, and he is very close with a male youth director at the church, who is "quite a bit older" (17 years older) than Jeremy and leads the youth ministry. He reported that this man is really his only friend. Jeremy and this youth director spend much time together and with the children in the church, with whom he has established deep relationships. They take them on retreats, sometimes spending entire weekends with the children. He paused at this point, while the assessor continued writing notes. He took a deep breath and reported feeling "hypocritical," though, as a church volunteer who commits crimes like stealing. As he said this, he looked away from the assessor for the first time in almost the entire interview so far. At this point, the assessor tried to empathize with Jeremy, stating that it must be hard for him to feel that way. Jeremy paused for a moment, but then he seemingly pulled himself together and stated that, in the future, he would be happy working entirely in the youth ministry. He felt he needed to "sort myself out" before he could commit himself to youth ministry, though.

Alcohol and Substance Use History: You mentioned that you currently smoke. Any other use of substances, like alcohol or other drugs?

Because Jeremy had now disclosed some negative feelings and shameful behaviors to the assessor, the assessor felt he could revisit the issue of substance abuse. Jeremy vigorously denied drinking, stating that he rarely drank any alcohol and had never been drunk. He then repeated that he smokes cigarettes. When prompted again about other drugs, he did disclose that his roommate smokes marijuana often, and that he had tried it occasionally, but he actually did not like "the feeling of not being in control," so he very rarely smoked it with his roommate.

Developmental and Medical History: Okay, have you ever had any medical problems?

Jeremy reported having had his last general physical exam about 2 years ago, with no problems emerging. He repeated that he had been diagnosed with "Attention Deficit Disorder" as a child, and he also reported that he was healthy all through birth and childhood, except for having spinal meningitis at around 15 months of age. He also reported that one of the reasons he wants to quit smoking was medical, as his grandfather had emphysema from smoking. When prompted for other family medical problems, he reported that his grandmother had diabetes, his great-grandfather was an alcoholic, and his family had several members with heart disease and high blood pressure.

Multicultural Evaluation: Okay, and you mentioned that you're half Black, even though you don't look like it. . .

Jeremy laughed and stated that "it's never been an issue" because he looks Caucasian. When he was in Antigua with his father, he had many Black classmates, but where he lived in Chicago he was one of very few. But because he did not look Black (or of mixed race), most people at school did not even notice, he reported. He spoke only English at home, and he reported no difficulties with his cultural identity.

When probed a bit further on his cultural identity, he explained that his father, born and raised in Antigua, was "very proper" and not very affectionate. His mother, on the other hand, was born and raised in a middle-class White family in the South, and Jeremy described her as "an amazing woman, so warm." He said that he had not been exposed to his father's culture much as a child, as he mainly lived with his mother until he was a teenager. He further reported that "I just don't think about it that much." Although a bit wary to push the subject with him, the assessor decided to continue asking about his cultural identity, but from another perspective. The assessor asked if Jeremy had difficulty adjusting to the culture of Antigua when he moved there at 12, or with the culture of Chicago when he moved back. Jeremy simply replied, "Nope," and after a few moments of silence, he continued, saying that he is "very adaptable," able to fit into almost any situation pretty easily.

Family History: Do you have any brothers or sisters?

It should be noted that the clinical interview on the first day of testing ended after the multicultural evaluation. After reviewing his notes that night, the assessor felt there were a few more things he wanted to know, so at the beginning of the second session, he asked Jeremy if he could "fill a few holes" from the original interview. The first was his family make-up. Relatively straightforward when asked if he minded, Jeremy answered simply, "Nope." He reported that he was an only child.

The assessor then asked for some clarification about why he moved to live with his father when he was 12 years old. Jeremy reported that during the summer before seventh grade, he simply decided he wanted to go live with his father. "It was my own decision." Although prompted further, he denied any other reason that he may have wanted to leave his mother or be with his father at that time. He reported that his mother was the most important person in his life, and even when he was living with his father, he "answered more to her than him."

Psychosexual History: Okay, I want to ask you about your sexual history. . .

Jeremy reported, "Well, I've had sex, but I'm not sexually active now," and then looked at the assessor in silence. The assessor prompted him for further information, and he reported that he had been sexually active with the girl he dated in college, but he had not engaged in sex since then. It was at this point when the assessor referred to the original discussions with his mother and informed Jeremy that she had said he was addicted to pornography. Jeremy, without hesitation, said, "I'm not" in a cool and somewhat detached manner. The assessor worked hard to normalize the experience of watching pornography, stating that many people are curious about, watch, and enjoy pornography, but Jeremy simply denied it, continuing to look coolly into the assessor's eyes. The assessor decided not to push the matter any further, and they began the second round of testing at this point.

Mental Status Evaluation

Appearance and Behavior

Jeremy's appearance was actually impeccable. He was dressed extremely well, wearing a casual suit to both sessions. He was friendly, cooperative, and exceedingly well-mannered. However, at times he seemed to be trying very hard to engage the assessor, sometimes in overly familiar ways. For example, he laughed and joked with the assessor excessively, and at times he mirrored the assessor's behavior, including his posture (crossing and uncrossing his legs whenever the assessor did), his tone of voice, and at one point taking his own watch off when the examiner took his watch off to time a subtest of the WAIS-IV.

Speech and Language

Jeremy was extremely articulate, clearly understanding all questions and comments by the assessor and expressing himself clearly and succinctly. His speech was appropriate in rate and volume throughout the assessment.

Mood and Affect

Jeremy reported mostly euthymic mood currently, characterized by optimism. His affect was mood-congruent and appropriate to the situation, with no overt signs of anxiety or depression. Of note, when discussing his problems, Jeremy did not display any notable change in affect, generally laughing and joking throughout.

Thought Process and Content

Jeremy's thought content was free of hallucinations and delusions, though he exhibited some shame related to his youth ministry and stealing. He denied any suicidal or homicidal and aggressive ideation. His thought process was goal directed and appropriate.

Cognition

Jeremy was alert throughout the clinical interview, and his attention and concentration seemed unimpaired. His memory seemed generally intact.

Prefrontal Functioning

Jeremy exhibited appropriate judgment during the sessions, though his history is characterized by impulsivity and poor judgment.

Hypothesis Building

Now that the clinical assessment (the clinical interview and the mental status evaluation) was completed, the information gathered can be used to create hypotheses for what is going on for Jeremy.

Identify Impairments

Jeremy's major impairment in functioning seems to be centered on his compulsion to steal, which has affected his occupational functioning, his family, and his subjective well-being. However, there also seems to be another issue that may (or may not) be influencing his current functioning. There is something related to his interpersonal and social functioning that may be impaired—it was difficult to tell from the initial clinical interview, and it did not help that the assessor had to begin testing during the same session as the clinical interview and complete it the following day, without much time to reflect on or review the interview data. With his history of having few friends, not dating, and having only one person (other than his mother) he is close to (a man 17 years older than he is), along with the bizarre feeling the assessor experienced when interacting with him, Jeremy seemed to have some sort of relational difficulty.

Enumerate Possible Causes

Due to his denial of subjectively low mood and other symptoms of depression (he reported no change in sleep, appetite, or interest in usual activities), it is unlikely that he is suffering from a mood disorder. However, there could be several other causes of his stealing. First, his behavior could be a response to anxiety, such that it would be a compulsion. If this were the case, he would likely qualify for obsessive-compulsive disorder (OCD), as his stealing could be seen as a compulsion. If this behavior is not compulsive and is simply a problem with impulse control related to stealing, the next hypothesis would be kleptomania. Further, though, if there is evidence that the stealing is only one of several impulse control problems (e.g., if there is evidence that he is impulsively using pornography in a way that impairs his functioning), then he might meet criteria for a general (or other specified) impulse control disorder. Finally, although unlikely, his behavior could be a residual effect of the attention deficit hyperactivity disorder (ADHD) that was diagnosed in his childhood.

Remembering that these are only hypotheses about what could be going on with Jeremy, given the potential impairment in interpersonal functioning some type of personality disorder will also be posited as a hypothesis. At this point, however, it is unclear which, if any, personality disorder would be the most appropriate candidate, so this hypothesis will have to remain somewhat vague as we begin to select tests.

You should always consider (a) that the presenting problems have an etiology in substance use and (b) that the presenting problems have an etiology in a medical condition. For Jeremy, there seems to be little possibility that either of these is the case. First of all, he denied any significant use of substances (though his marijuana use may be more significant than he reported). Additionally, because of the nature of his problems, they do not fit the pattern commonly associated with medical conditions. Stealing behavior on its own is unlikely due to any medical condition, especially at his young age (there is a chance that the personality changes caused by dementias, typically at a much later age, could lead to stealing behavior). Moreover, his interpersonal problems (if there are truly any) do not seem to have changed significantly at any point in his life, so again a medical etiology is unlikely. Finally, he received a full physical exam 2 years ago (though a more recent one would be better) that revealed no significant medical problems. As such, it will be assumed that the symptoms are primarily psychological in nature.

Selecting Tests

Selecting tests for the current assessment was slightly tricky, as some of the decision had to be made before the clinical interview was completed, as testing had to be conducted in the same session. However, a battery of tests was selected from the initial discussions with his mother, and it was then evaluated, given the clinical interview and subsequent hypotheses, to make sure testing would be adequate. Cognitively, because there were no specific questions about his cognitive functioning (though a confirmation of his ADHD diagnosis could be useful, if time allowed), tests of general intellectual functioning were chosen: the Bender Visual-Motor Gestalt Test, 2nd Edition (Bender-2) and the Wechsler Adult Intelligence Scale, 4th Edition (WAIS-IV). When evaluating these tests against the hypotheses generated, it was decided that these tests should be adequate to address the hypotheses. The WAIS-IV was given on the first day and coded and scored while Jeremy was completing a self-report survey, to see if anything remarkable or abnormal emerged and would warrant further cognitive testing.

The other hypotheses included anxiety, impulse control, and personality disorders. Before the assessor even knew this, though, he chose a general battery that would assess Jeremy's emotional functioning. To balance the methods used, the assessor made sure to employ self-report, symptom-focused measures, self-report inventories, and performance-based techniques. For self-report, symptom-focused measures, he had chosen to use the Beck Anxiety Inventory (BAI), the Yale-Brown Obsessive Compulsive Scale (Y-BOCS), and a Beck Depression Inventory, 2nd Edition (BDI-II). After the interview, during which he had already overly denied symptoms of depression, the assessor chose not to use the BDI-II in the final battery.

For the self-report inventory, as he did not know ahead of time exactly what the presenting problem would be, he chose to use the Minnesota Multiphasic Personality Inventory, 2nd Edition (MMPI-2). For the performance-based techniques, the Rorschach Performance Assessment System (R-PAS) was chosen. This constituted the battery for the first day (which had to be prepared ahead of time). Given the hypotheses posited from the clinical interview, these emotional measures should be adequate to determine whether or not Jeremy is struggling with an anxiety or impulse control disorder. However, because a hypothesis of a personality disorder emerged from the clinical interview, the assessor decided that on the second day he would add the Millon Clinical Multiaxial Inventory, 4th Edition (MCMI-IV) and the Inventory of Altered Self-Capacities (IASC). These measures' strength is their sensitivity to personality and character styles; together with the other measures, they should reveal any personality pathology.

Thus, our assessment's battery of tests consists of

- Bender-2
- WAIS-IV
- BAI

- Y-BOCS
- MMPI-2
- MCMI-IV
- IASC
- R-PAS

Accumulating the Data

On the WAIS-IV, Jeremy performed within the superior range compared with others his age overall, with his verbal ability falling within the very superior range. His Working Memory Index (WMI) was a 119, and he scored a 16 on Cancellation, so the assessor decided not to add any measures to further evaluate ADHD. He also performed well on the Bender-2, revealing no major memory difficulties.

Table 9.1 shows the results from each individual emotional/personality measure administered.

TABLE 9.1 **ACCUMULATION OF JEREMY'S DATA**

BAI

No evidence of significant amounts of self-reported anxiety

Y-BOCS

Subclinical range on severity of obsessions and compulsions

MMPI-2

Passive-aggressive tendencies
Low self-esteem
Pessimism
Insincere in relationships
Persisting and intense anger, with difficulties expressing it appropriately
Anger toward family members
Narcissism
Dependency
Immaturity
Impulsivity
Hedonism
Impatience
Possible gender role confusion
Low boredom tolerance
Strong need to be around people
Feels misunderstood
Low obsessiveness

MCMI-IV

Manipulative
Relationships with others are a means to an end
Weak identity
Some grandiosity
Low self-esteem

TABLE 9.1 (*CONTINUED*)

Oppositionalism
Extreme sociability
Feels inferior to others
Dependent
Highly controlled in social situations

R-PAS

High interpersonal cognition
Tends to cope by spontaneously reacting with the world rather than thinking through things deliberately
Views self as damaged and flawed
Good skills in understanding and managing interpersonal interactions
Oppositional tendencies
Guarded and distancing style of interacting with others
Unrealistic views of himself
Very high awareness of others
Narcissistic-like traits
High dependency needs

IASC

Abandonment concerns
Identity impairment—wishes he knew himself better
Identity impairment—loses himself in different situations

Clinical interview and behavioral observation data

No strong early male figure in life
Strong female figures salient throughout life
Stealing behaviors
Self-deprecating remarks
Some shame around stealing vs. church volunteering
Accompanied to appointments by mother
Mother responsible for organizing the assessment
High social comprehension on WAIS-IV
Matching behaviors of examiner
Laughing and joking with examiner excessively
Few friends

Identifying Themes

As always at this stage, each piece of data will need to be categorized into one of the seven traditional psychological themes (self, other, thinking, feeling, behavior, coping, and context). While some pieces of data may fit in more than one theme, we will remember that the self and other themes take primacy over thinking and feeling (i.e., feelings about the self would be categorized as self; thoughts about others will be categorized as others). Additionally, in this case, there are some data that emerge that simply rule out hypotheses. For example, a non-significant finding on the Y-BOCS, showing no significant OCD symptomatology, is extremely important but may not end up aligning cleanly with the other thinking (not obsessive) or behavior (not compulsive) data. The preliminary themes for Jeremy are presented in Table 9.2.

TABLE 9.2 **LABELING OF JEREMY'S THEMES**

Themes	
	BAI
Feeling	No evidence of significant amounts of self-reported anxiety
	Y-BOCS
Thinking and Behavior	Subclinical range on severity of obsessions and compulsions
	MMPI-2
Other	Passive-aggressive tendencies
Self	Low self-esteem
Thinking	Pessimism
Other	Insincere in relationships
Feeling	Persisting and intense anger, with difficulties expressing it appropriately
Feeling and Other	Anger toward family members
Self	Narcissism
Other	Dependency
Self and Behavior	Immaturity
Behavior	Impulsivity
Behavior	Hedonism
Behavior	Impatience
Self	Possible gender role confusion
Behavior	Low boredom tolerance
Other	Strong need to be around people
Other	Feels misunderstood
Thinking	Low obsessiveness
	MCMI-IV
Other	Manipulative
Other	Relationships with others are a means to an end
Self	Weak identity
Self	Some grandiosity
Self	Low self-esteem
Behavior	Oppositionalism
Other	Extreme sociability
Self	Feels inferior to others
Other	Dependent
Other	Highly controlled in social situations
	R-PAS
Other	High interpersonal cognition
Coping and Behavior	Tends to cope by spontaneously reacting with the world rather than thinking through things deliberately
Self	Views self as damaged and flawed
Other	Good skills in understanding and managing interpersonal interactions
Behavior	Oppositional tendencies
Other	Guarded and distancing style of interacting with others

TABLE 9.2 (*CONTINUED*)

Themes	
Self	Unrealistic views of himself
Other	Very high awareness of others
Self	Narcissistic-like traits
Other	High dependency needs
	IASC
Other	Abandonment concerns
Self	Identity impairment—wishes he knew himself better
Self	Identity impairment—loses himself in different situations
	Behavioral observations and other data
Context and Other	No strong early male figure in life
Context and Other	Strong female figures salient throughout life
Behavior	Stealing behaviors
Self	Self-deprecating remarks
Feeling	Some shame around stealing vs. church volunteering
Other	Accompanied to appointments by mother
Other	Mother responsible for organizing the assessment
Other	High social comprehension on WAIS-IV
Other	Matching behaviors of examiner
Other	Laughing and joking with examiner excessively
Other	Few friends

Organizing the Data

Jeremy's reorganized data are presented in Table 9.3. When organizing the data, the BAI and Y-BOCS are combined into a single column, simply because they have so little data that they do not each need their own column. Some of the data that were categorized within two themes are easily reconciled. For example, the Y-BOCS finding of low obsessions and compulsions can be easily split into thinking (obsessions) and behavior (compulsions). Other multiply assigned data will need to be evaluated and reconciled later. What becomes quite salient is that several of the themes simply do not have enough data across measures and methods to sustain themselves as they are. For example, the Thinking theme has low obsessiveness from the MMPI-2 and Y-BOCS and some pessimism from the MMPI-2; not enough to sustain any theme. Similarly, the feeling theme has only some anger from the MMPI-2, no evidence of significant anxiety from the BAI, and some self-reported shame from the clinical interview; again, not enough to sustain a theme. As the only context data are from the clinical interview and have been assigned to both the context and other categories, we can go ahead and decide not to include a context theme and assign those to the other category only. The coping theme similarly has data from only a single source. These data will need to be redistributed somehow.

Finalizing the Themes

Some of the themes need some significant reorganization, as discussed previously, especially as many of them are simply too anemic (have too little data across measures and methods) to sustain themselves. In order to feel

TABLE 9.3 **JEREMY'S ORGANIZED DATA**

Test: Theme:	MMPI-2	MCMI-IV	R-PAS	IASC	BAI and Y-BOCS	Interview and Behavioral Observations
Other	Passive-aggressive tendencies	Manipulative	High interpersonal cognition	Abandonment concerns		No strong early male figure in life
	Insincere in relationships	Relationships with others are a means to an end	Good skills in understanding and managing interpersonal interactions			Strong female figures salient throughout life
	Anger toward family members	Extreme sociability	Guarded and distancing style of interacting with others			Accompanied to appointments by mother
	Dependency	Dependent	Very high awareness of others			Mother responsible for organizing the assessment
	Strong need to be around people	Highly controlled in social situations	High dependency needs			High social comprehension on WAIS-IV
	Feels misunderstood					Matching behaviors of examiner
						Laughing and joking with examiner excessively
						Few friends
Self	Low self-esteem	Weak identity	Views self as damaged and flawed	Identity impairment—wishes he knew himself better		Self-deprecating remarks
	Narcissism	Some grandiosity	Unrealistic views of himself	Identity impairment—loses himself in different situations		
	Immaturity	Low self-esteem	Narcissistic-like traits			
	Possible gender role confusion	Feels inferior to others				

Thinking	Pessimism				Subclinical range on severity of obsessions ~~and compulsions~~	
	Low obsessiveness					
Feeling	Persisting and intense anger, with difficulties expressing it appropriately				No evidence of significant amounts of self-reported anxiety	Some shame around stealing vs. church volunteering
	Anger toward family members					
Behavior	Immaturity	Oppositionalism	Tends to cope by spontaneously reacting with the world rather than thinking through things deliberately		Subclinical range on severity of ~~obsessions and~~ compulsions	Stealing behaviors
	Impulsivity		Oppositional tendencies			
	Hedonism					
	Impatience					
	Low boredom tolerance					
Coping			Tends to cope by spontaneously reacting with the world, rather than thinking through things deliberately			

confident in our assertions, we need themes to have robust data from across measures. So, in this case, we must really think about how to reorganize the data significantly to make it make sense.

Two of the categories are relatively straightforward. The behavior category is clearly painting a picture of a young man with impulse control problems. When looking at all the data within this theme, the two pieces that have been assigned to both behavior and another theme (immaturity as also potentially thinking and the R-PAS coping style as potentially coping, as the only piece of data in that category), both seem to fit nicely. As such, we will retain each of those pieces of data here, delete them from the other categories, and finalize this theme as impulsivity. This helps us understand the stealing behaviors as more likely impulsive acts than compulsive acts, potentially. This also means we will delete the coping theme entirely.

The self category clearly has information in it related to identity development and self-esteem. The identity data clearly show that he has a weak understanding of who he is, and so these data can be extracted to create their own weak identity theme. What are left are some seemingly contradictory data, with both evidence of low self-esteem and grandiosity. When evaluating the contradictions within the data, we will employ the five-step process for reconciling discrepant data. First, we will look at the coding and scoring, to ensure accuracy. The MMPI-2 and MCMI-IV are computer-administered, self-scoring tests, which means that while the data are not necessarily perfect, the coding and scoring of them should not have mistakes. The R-PAS data need to be reviewed, though, as it is a much more difficult measure to code. When reviewing the R-PAS protocol, the assessor determines that those responses that were coded as morbid (relating to viewing himself as damaged or flawed) and as reflections (relating to narcissistic-like traits) were accurately coded, so we move on to the second step of the process for reconciling contradictory data.

The second step is to identify whether the discrepancy is a true contradiction or if it is simply an apparent discrepancy, such that in actuality (based on our knowledge of human psychology) the two seemingly contradictory constructs can indeed coexist within the same person. In this case, given what the field of psychology knows about narcissism and self-esteem (e.g., Cain, Pincus, & Ansell, 2008), it is clear that this is simply an apparent discrepancy. That is, many manifestations of narcissism are actually a thinly veiled defense against low self-esteem and vulnerability. Because these two constructs can and often do coexist in the same individual, we do not need to further explore the seemingly contradictory data. We have now understood and can explain it: He struggles with underlying low self-esteem, even though he works hard to counteract it by appearing confident and trying to elicit praise and admiration from others.

This leaves us with three themes remaining: thinking (a weak theme), feeling (another weak theme), and others (a jam-packed theme). Our task now is to try to understand what the data within these three themes (together) are saying about Jeremy. The fact that one piece of data (the MMPI-2 finding of anger toward his family) straddles two of the themes that we are about to merge, try to understand, and relabel is easy to deal with—we can simply delete it from one of the themes and leave it with the other. Some of the data in these themes seem to be truly about his interactions with other people quite broadly (peers, etc.), however some seem to be quite specific to his family and his independence. If we separate those data that seem to be more about family out, we can see some clearer pictures emerging; the data related to his family reveal that he is having underlying conflict in his relationship with his own independence, having both high dependent needs and some anger and resentment toward his family at the same time. This is strengthened if we move the oppositional nugget from behavior to this theme, as it seems less impulsive and more deliberate.

The remaining other theme data tell the story of a young man who maintains strict control over how others view him, likely as a protective mechanism so that he does not feel abandoned by others. He is highly socially savvy, highly aware of what is happening in social situations and able to manipulate them. Two individual pieces of data can be reorganized in this theme. First, the MMPI-2 pessimism fits nicely in this theme, relating to his low expectations of others (it could arguably fit into other themes as well, such as his low self-esteem or

TABLE 9.4 **JEREMY'S FINALIZED DATA**

Test: Theme:	MMPI-2	MCMI-IV	R-PAS	IASC	BAI and Y-BOCS	Interview/Behavioral Observations
Weak identity	Possible gender role confusion	Weak identity	Unrealistic views of himself	Identity impairment—wishes he knew himself better		
				Identity impairment—loses himself in different situations		
Underlying low self-esteem	Low self-esteem	Some grandiosity	Views self as damaged and flawed			Self-deprecating remarks
	Narcissism	Low self-esteem	Narcissistic-like traits			Some shame around stealing versus church volunteering
	Feels misunderstood	Feels inferior to others				
Impulsivity	Immaturity		Tends to cope by spontaneously reacting with the world rather than thinking through things deliberately		Subclinical range on severity of ~~obsessions and~~ compulsions	Stealing behaviors
	Impulsivity					
	Hedonism					
	Impatience					
	Low boredom tolerance					

(Continued)

TABLE 9.4 *(CONTINUED)*

Test: Theme:	MMPI-2	MCMI-IV	R-PAS	IASC	BAI and Y-BOCS	Interview/Behavioral Observations
Problems with individuation	Anger toward family members	Dependent	High dependency needs			No strong early male figure in life
	Dependency	Oppositionalism	Oppositional tendencies			Strong female figures salient throughout life
	Persisting and intense anger, with difficulties expressing it appropriately					Accompanied to appointments by mother
						Mother responsible for organizing the assessment
Control over social situations	Passive-aggressive tendencies	Manipulative	High interpersonal cognition	Abandonment concerns		High social comprehension on WAIS-IV
	Insincere in relationships	Relationships with others are a means to an end	Good skills in understanding and managing interpersonal interactions			Matching behaviors of examiner
	Strong need to be around people	Extreme sociability	Guarded and distancing style of interacting with others			Laughing and joking with examiner excessively
	Pessimism	Highly controlled in social situations	Very high awareness of others			Few friends
(Leftover data)	Low obsessiveness				Subclinical range on severity of obsessions and compulsions	
					No evidence of significant amounts of self-reported anxiety	

his disappointment with his family). Second, the MMPI-2 finding that he feels misunderstood, while it could remain here in the theme around maintaining strict control over social situations, may fit better in the low self-esteem theme.

There are some leftover data, some of which may be useful in our themes and some which may not be. The shame he feels about stealing and being hypocritical as a church volunteer can fit into the low self-esteem theme, as shame certainly feeds low self-esteem. What is left is a lack of evidence of obsessive thinking and of anxiety; while these are important, given our diagnostic hypotheses, in determining what is not going on, they are not as useful in determining what is going on. Jeremy's finalized data are found in Table 9.4.

Conceptualizing

Remembering that the task at this point is to try to create a logical narrative among the themes so that it presents a coherent story, we have to connect the following themes:

- identity problems
- underlying low self-esteem
- impulsivity
- problems with individuation
- control over social situations

Before deciding on the most logical way to fit all these themes together, we will first consider the model templates presented in Chapter 4: the diathesis–stress model, the developmental mismatch model, the developmental themes model, the interpersonal circumplex model, and the common function model for conceptualization.

Diathesis–Stress Model

In applying the diathesis–stress model of conceptualization, we must try to divide the themes into (1) traits that are inherent within Jeremy that he likely developed at an early age and that he "brings to the picture" (diatheses), (2) external issues that affect his functioning (stressors), and (3) states that are more situational or transient (outcomes). It is important to categorize each of our five themes into these three types. Remember that as long as you can make a convincing argument for how each theme relates to the others, Jeremy will be more likely to receive feedback and take recommendations.

For Jeremy, several of the themes could be either part of the diathesis or outcomes. Thus, there are several different "stories" that could be constructed that would adequately describe what is currently affecting Jeremy's functioning. When thinking about stressors, however, because we got rid of any context theme, it is less straightforward (and may ultimately preclude us from using this model). However, the closest thing to a stressor in our five themes seems to be his problems with individuation (his dependency on his family, but also his resentment and anger toward them). That is, given whatever type of person he is (whatever we decide is the diathesis in this case), because he has some issues with his family environment this interaction has led to some problems (whatever we decide the outcomes are). More specifically, he seems to have had a difficult time negotiating the task of balancing dependency on his family with fostering his own independence, which seems to lead, at least in part, to the possibility that his mother is and/or was over-functioning. This struggle has left him with anger and resentment toward his family, which is in itself at odds with his dependency. Because his family environment did not support the healthy negotiation of this individuation process, given the early divorce and significant change of environment right at the moment when he should be developing his individual identity (around 12 years old), this external stressor has led to some problems in his life.

More difficult is the decision about what is more core to who Jeremy is as a person and what is more of an outcome of his personality and early family difficulties. An argument could be made for several of our themes to be diatheses, but for the sake of (somewhat arbitrarily) choosing one, we will choose his need for control over how others see him and how situations play out in general as the diathesis. It can easily be argued that he is simply the type of person whose temperament leans toward a more controlling nature, rather than this being an outcome of something else (though this alternate explanation could also easily be argued).

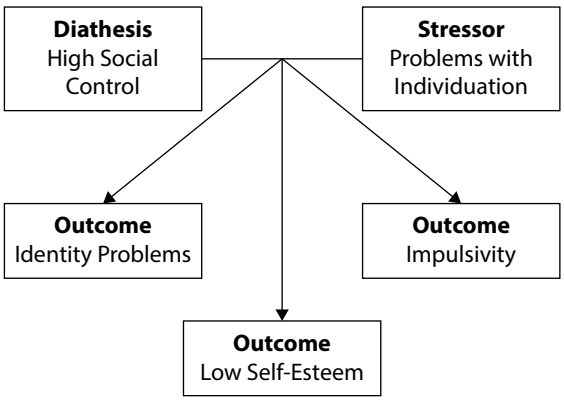
Because his need for control is at odds with his dependency, he has developed feelings of inadequacy and ineffectiveness, generally feelings of low self-worth. This low self-esteem is an outcome. Low self-esteem can be easily understood as an outcome in most cases, as it is general practice to try to understand the root cause of low self-esteem, rather than viewing it as core to the individual themselves. Also due to his controlling nature interacting with his struggle with dependency on his family, especially his mother, Jeremy had difficulty developing a clear identity of his own, potentially including his gender identity. Finally, his impulse control problems seem also to be an outcome, as underlying resentment about his struggle between wanting to be in control and independent and his dependency on his mother at times "spills" out, causing him to act impulsively. The diathesis–stress model for Jeremy is shown in Figure 9.1.

This model is not overly complex, and it appears to be arguable. The key to this model is explaining it in a way that makes intuitive sense. For example, the idea that impulse control problems would stem from the interaction between his difficulty individuating and being socially controlling by nature may not make sense without clearer explanation that the underlying resentment that is caused by the interaction at times "leaks" out as impulsive behavior. This explanation makes clearer what may not be obvious. However, before deciding on using this model, let us consider other models as well.

Developmental Mismatch Model

When considering the developmental mismatch model for conceptualizing Jeremy, it is interesting to note that he had some significant disruptions in what might be considered a normative and adaptive developmental environment—the divorce of his parents when he was quite young and his significant change of environment when he was 12 years old. As such, thinking developmentally may be useful for understanding what may be impacting his current functioning. Looking at his needs, wishes, and identity, we need to figure out at what developmental level he is generally functioning. Again, does he most closely resemble the feelings, needs, and attitudes normal for an infant, a child, a preadolescent or adolescent, or an adult? Remember that the developmental model will work only if there

FIGURE 9.1 **DIATHESIS–STRESS MODEL FOR JEREMY**



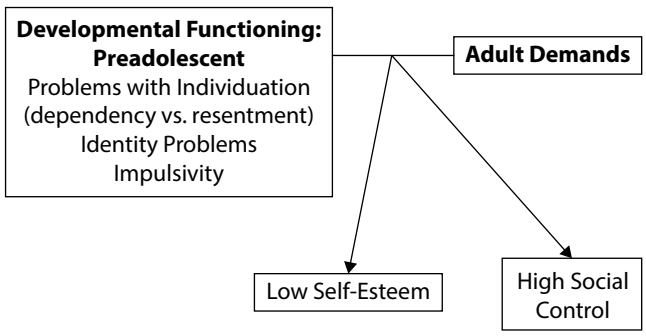
is a discrepancy between the level at which he is functioning and the actual age-related demands being placed on him (which, as an adult, are adult-level demands). It is not interesting to say that he is functioning at the level of an adult and has adult demands being placed on him; this scenario should not lead to any problems. This model is compelling only when his level of functioning falls below what is being expected of him, such as being an adult with adult demands but functioning as a child. This mismatch between functioning and demands would likely lead to problems. It seems as though Jeremy is currently struggling functionally, arguably because he is functioning at an earlier developmental level than required by the adult demands that are being placed on him in life.

Jeremy is first and foremost functioning extremely well cognitively. His emotional and personality functioning, however, seem to be at a much earlier developmental stage than his chronological age. Specifically, he is struggling between the need to be dependent on a parent and feeling resentful about this dependency, an early stage of the separation-individuation process (Mahler, Pine, & Bergman, 2000). It should be noted that this process of separating and individuating from parents is necessary and normative for individuals during their preadolescence and adolescence in Western cultures. Additionally, he seems to be in the process of identity moratorium (Marcia, 1966; 1991), the process of being curious about and trying different identities, especially around his gender identity. Finally, he is displaying poor impulse control, associated normatively with preadolescent or adolescent functioning.

Because he is functioning at this less developed level that is inadequate to meet the (adult) demands being placed on him, there are two primary outcomes. First and foremost, he is experiencing low self-esteem, resulting from not feeling successful or adequate. Second, to cope with these felt inadequacies, he attempts to exert control over his environment and other people as much as possible. This helps him decrease the amount of unpredictability in his environment, increasing his ability to cope with the world. The developmental mismatch model for Jeremy is shown in Figure 9.2.

Like the diathesis–stress model, this model is not overly complex, but the emphasis of the argument in the report would be slightly different. In terms that are not too psychological, it would be necessary to explain exactly *how* the themes that represent more normative struggles in preadolescent developmental functioning in fact do so for him, even though he is an adult. This would make a part of the assessment report psychoeducational, such that it informs the reader about human development. It is not difficult, though, to understand how an individual functioning at this level, in interaction with adult demands, can lead specifically to the outcomes of low self-esteem and wanting to keep tight control over situations. Thus, the model has an inherent logic that most readers would easily identify. Again, the drawback of this model is that many of the themes together make up the preadolescent developmental functioning domain, such that they are not interacting dynamically or

FIGURE 9.2 **DEVELOPMENTAL MISMATCH MODEL FOR JEREMY**



interestingly. Thus, many of the subsections on themes would seem parallel rather than related directly to each other. Additionally, a challenge in writing this up would be finding a way to do so that is not too demeaning or patronizing to Jeremy, as being told he is functioning as a preadolescent could elicit a pretty negative reaction (especially given his fragile narcissism).

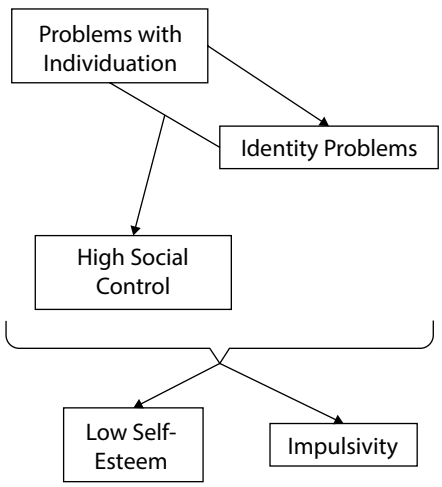
Developmental Themes Model

The developmental themes model, similar to the developmental mismatch model, tries to conceptualize any struggles an individual is having along a normative developmental trajectory. That is, we all develop certain skills, traits, personality characteristics, identities, and so forth at different times in our lives, and some people who struggle (especially as adults) may simply not have resolved the necessary crises of development when they should have. As is clear from the developmental mismatch model, this is certainly true for Jeremy. However, instead of being tied to a single developmental level of functioning and a single developmental level of demands, the developmental themes model allows for more differentiation.

If we consider Erikson's (1963) seminal and widely used work in psychosocial stages of development, Jeremy has some difficulties that are representative of a lack of reconciliation of several of the conflict stages. The earliest one that Jeremy seems to have continued struggles with is autonomy versus shame and doubt, the conflict normatively reconciled around age 2 or 3 years (when his parents separated and divorced) and represented by his difficulties with individuation. Erikson's theory posits that each phase paves the way for the next, so having difficulty with an early one can cause difficulties with later ones. This seems to be the case for Jeremy, who also struggles with the developmental conflict of identity versus role confusion, the conflict normatively reconciled in adolescence (when Jeremy had a significant transition in his life, moving to his father's in Antigua) and represented by his identity problems.

Jeremy's problems with individuation contribute to and also interact with his identity problems to cause even more developmental struggles. Specifically, they do not put him in a socially–emotionally–healthy position to navigate the conflict and task of young adulthood, which is Intimacy versus Isolation, represented by his working hard to overcontrol social situations in a guarded and less-than-genuine way. Together, these developmental tasks that still need reconciling are contributing to some significant current difficulties, namely, his low self-esteem and his problems controlling his impulses. Figure 9.3 presents Jeremy's developmental themes model.

FIGURE 9.3 **DEVELOPMENTAL THEMES MODEL FOR JEREMY**



This model makes psychological sense for those who understand the Eriksonian developmental framework, but even without needing to do a great deal of psychoeducation a reader could likely understand pretty intuitively how someone who struggles with being both dependent on and resentful toward his parent may then struggle to develop his own identity; how someone who struggles with becoming independent and knowing who he is may want to maintain strict control over his social environment to reduce surprises (and expected letdowns); and ultimately how all these underlying struggles can contribute to a young man feeling not great about himself and some of his overcontrol spilling out in impulsive acts. This feels like it makes so much intuitive sense that it is likely the model we will go with for the final report; however, we will first consider two other models.

Interpersonal Circumplex Model

A great advantage of the interpersonal circumplex model for organizing and conceptualizing data is how it separates personality functioning (at least as conceptualized interpersonally) from emotional and behavioral functioning. That is, all the themes that fit neatly onto the interpersonal circumplex constitute personality, and those themes that do not constitute outcomes from the personality type and its interaction with the world. While his primary presenting problem related to his stealing and impulse control problems, Jeremy does still struggle interpersonally, so this model may prove useful in this case.

Most of Jeremy's self and interpersonal themes converge around the lower half of the circumplex, including his problems with identity development and low self-esteem and his dependency needs, all of which represent functioning on the low end of the dominance continuum, as well as slightly leaning toward higher affiliativeness. However, his overcontrol of social situations, including guardedness, manipulativeness, and passive-aggressiveness, falls on the opposite corner of the circumplex, more on the domineering, controlling, and less affiliative corner. The leftover theme of impulsivity would be an outcome of whatever personality is described by this particular configuration on the interpersonal circumplex. The initial interpersonal circumplex model for Jeremy is shown in Figure 9.4.

Figure 9.5 presents the modified and clarified interpersonal circumplex model, which characterizes Jeremy's personality more clearly as unassured and passive, but also socially controlling. This mix of interpersonal functioning is unlikely to be effective at getting his needs met, as his guarded and controlling nature is unlikely to

FIGURE 9.4 **INITIAL INTERPERSONAL CIRCUMPLEX MODEL FOR JEREMY**

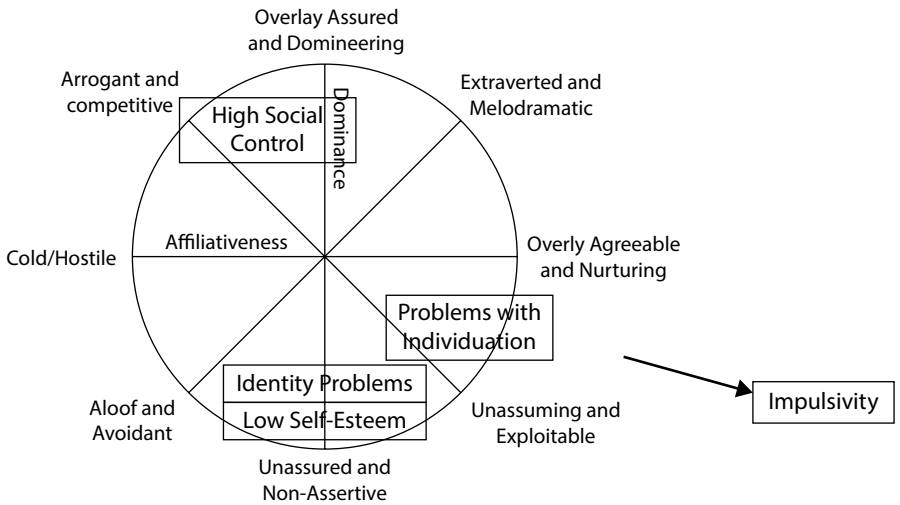
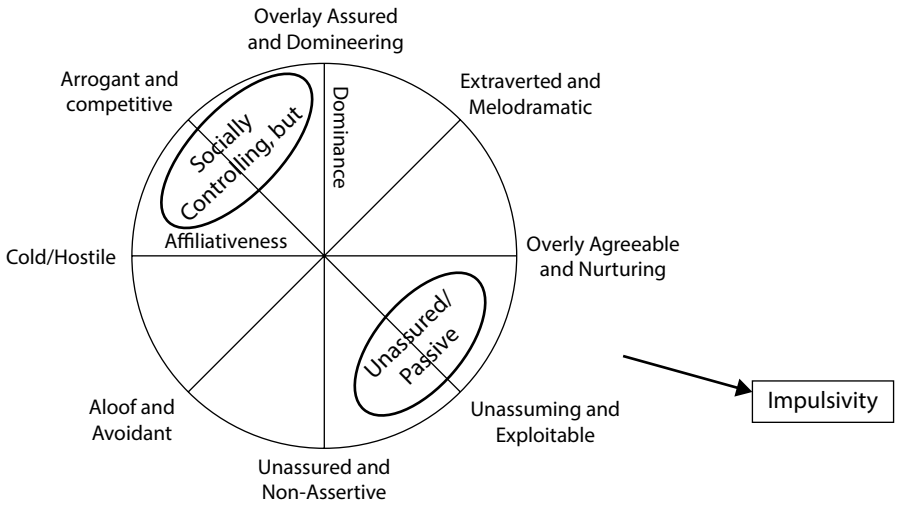


FIGURE 9.5 **FINAL INTERPERSONAL CIRCUMPLEX MODEL FOR JEREMY**



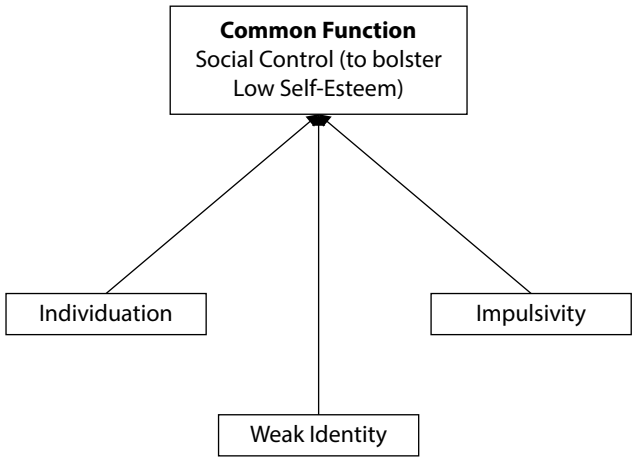
allow others to get close to him and ultimately get his dependent needs met and bolster his self-esteem. In this model, the struggle with this approach to interpersonal relationships, which will undoubtedly repeatedly let him down, leads to his difficulties controlling his impulses. This needs to be explained clearly to a reader, though, as it may not be entirely intuitive. One way to explain it could be that his underlying interpersonal struggles cause tension, which spills out in his impulsive (tension reduction) behavior, such as stealing. This conceptualization may be an interesting way to understand Jeremy, but it may ultimately not be as useful as some of the other models that keep the five themes separate but related.

Common Function Model

The common function model explains the themes together as all serving a common purpose (often this purpose is served by one or two of the themes). Generally, the first step is to evaluate each of the themes to identify the overall defensive or coping strategies of the individual. This model is difficult for Jeremy because the themes that emerged from the testing seem not to be clearly related to coping strategies. Therefore, it may be difficult to conceptualize each of the themes as serving a common purpose. However, if forced to create a model focusing on a common function, there may be a way to argue that each of the themes serves the common purpose of trying to control the world around him. That is, each of the themes represents an effort to maintain control over how others view him (for the purpose of bolstering his self-esteem, which is highly dependent on how he imagines others view him).

His individuation issues, which combine dependent needs with a strong longing for independence from a family he sees as controlling, along with subsequent resentment, could represent an attempt to be an individual with independent functioning while still having his mother meet some of his needs. His identity difficulties could represent an attempt to overly control how others see him in any given situation, at the expense of creating a true core personality. Finally, his impulse control problems could represent an attempt to gain attention and feel effective in some way since the results of his poor impulse control do not place him in any significant danger (such as using alcohol excessively might) but rather seem selectively minor enough to act out his independence. This model is not the easiest argument to make in Jeremy's case, but if written appropriately it could make sense. The common function model for Jeremy is shown in Figure 9.6.

FIGURE 9.6 **COMMON FUNCTION MODEL FOR JEREMY**



This model focuses on a major dynamic that seems to be affecting Jeremy's functioning currently—the fact that he works hard to manipulate and control situations so as to maintain control over how others view him, which is how he evaluates his own self-esteem. The model does not spend time explaining this dynamic or where it came from, but it clearly describes a pattern that could easily be addressed in psychotherapy. Obviously, describing his dependence–independence issues, weak identity, and impulse control problems as ultimately efforts to control his environment is not the easiest argument to make, but if it is written effectively this narrative becomes both compelling and useful in terms of informing recommendations. However, rather than stretching these logical connections, it is probably more useful to employ one of the other models to explain Jeremy's emotional functioning.

Report Writing

Before the report can be written, one final step is necessary: determining the diagnosis and recommendations. Our original hypotheses included OCD, kleptomania, another impulse control disorder, ADHD, and a personality disorder. When looking at the evidence that emerged on the tests, a few of these hypotheses can be ruled out relatively easily. While Jeremy reported a previous diagnosis of attention deficit and clearly presents with impulsivity, no evidence of ADHD emerged from the testing (his WAIS-IV Cancellation performance was extremely strong and his Working Memory Index was strong; these are good indicators that he is able to selectively attend and sustain attention well, respectively). Additionally, he was able to tolerate 2 full days of testing with very little difficulty and exhibited no hyperactive or impulsive behaviors during the assessment. Additionally, no anxiety (in general form) actually emerged from the testing; in actuality the BAI, Y-BOCS, and MMPI-2 revealed low levels of obsessiveness, so there is no evidence of OCD. Thus, ADHD and OCD can be ruled out and not ascribed to him. That leaves us with kleptomania, another impulse control disorder (potentially of the other specified type), and a personality disorder as possible conclusions.

The major questions for Jeremy's diagnosis are (a) whether there is evidence of any impulse control problems other than the stealing and (b) whether the stealing relieved tension above and beyond monetary need. That is, kleptomania generally relates to stealing objects of insignificant value (often objects that could be afforded otherwise) in order to relieve some sort of tension. If there is no evidence of impulsivity other than stealing and the stealing represents something beyond needing money, then he would meet criteria for

kleptomania. If there are other impulse control problems in addition to the stealing or if the stealing is truly for the money, then he would meet criteria for an other specified impulse control disorder. In this case, it seems that his impulsive behavior is centered almost completely on stealing. In fact, much of his other behavior actually seems overly controlled. Additionally, he reported not wanting to steal any longer but not being able to control himself rather than doing it because he needed the money. Consequently, he seems to meet criteria for kleptomania.

The next major consideration is the question of a possible personality disorder. It is clear that Jeremy has some features of narcissistic personality disorder, including some grandiosity related to his low self-esteem. Moreover, he has some features of dependent personality disorder as well, which was clear from the testing data. The first question at this point is whether these personality characteristics significantly impair his functioning. Although this is debatable, it seems that his social functioning is significantly impaired by his style of relating to others. He has an extremely limited social support system, especially outside his immediate family. Therefore, because he does not meet full criteria for any one personality disorder, Jeremy is given the diagnosis of other specified personality disorder, with dependent and narcissistic features.

Recommendations, as will be presented in the assessment report that follows, need to be determined carefully and deliberately, or else the entire point of the assessment is missed. The first consideration is whether specific treatments are recommended for the diagnoses, kleptomania and other specified personality disorder, with narcissistic and dependent features. As a side note, Jeremy does want to quit smoking nicotine, so he will be referred to a specific smoking cessation program in Chicago, in addition to any other referrals and recommendations made. This is because the methods for this specific symptom (smoking) are well understood and well researched, so the methods used in a smoking cessation program are likely to work for Jeremy.

Treatment of kleptomania is unfortunately not well studied or understood at this point (Zhang, Huang, & Liu, 218). Similarly, there is very little efficacy research on the treatment of any personality disorder other than borderline personality disorder, and certainly not a specific, trait-specified one like Jeremy has. There are some proposed ideas, such as those by Mullins-Sweatt and colleagues (2019), but nothing yet compelling enough to put into practice. Therefore, it is important to consider Jeremy's specific characteristics in determining the appropriate type of treatment (as delineated in chapter 14 of Groth-Marnat & Wright, 2016).

Much of the research focuses on "to CBT or not to CBT (cognitive behavioral therapy)," trying to determine if any characteristics contraindicate the use of more directive, clear, thought- and behavior-changing techniques. Many of his characteristics are aligned with him being able to use CBT well, including his externalizing coping style (acting out via stealing), a low level of social support, seemingly low reactance (because he is asking for help and seems open to it), and his preparation and action stage of change related to his kleptomania. It is likely CBT techniques will be useful for his kleptomania. Additionally, there is some specific support for exposure and response prevention techniques for kleptomania (e.g., Olbrich, Jahn, & Stengler, 2019), so those CBT techniques can be used in the treatment as well.

However, some characteristics, especially related to his personality disorder, may contraindicate CBT techniques as a first point of intervention. Specifically, his subjective distress is pretty low, and his stage of change related to his interpersonal functioning seems more aligned with the precontemplation phase, or maybe contemplation. For these symptoms, a more exploratory or motivational interviewing approach to treatment is more likely to be effective to begin with, maybe followed by CBT—or in this case perhaps even interpersonal therapy (IPT), as it has begun to be studied for use with personality disorders (e.g., Bateman, 2012) and this particular disorder is heavily interpersonal in nature. From our developmental themes model of conceptualization for

Jeremy, a more exploratory psychotherapy may certainly help what we have considered to be more core issues of difficulties individuating and developing his identity (while CBT and IPT tools could certainly address his overly controlled social behaviors).

In the end, we will land on three overall treatment recommendations. First, the smoking cessation program can help alleviate that single symptom. Second, to address his problematic impulse control problems (his kleptomania) CBT techniques will be recommended, including exposure and response prevention. Finally, to address his underlying difficulties (his personality disorder), it will be recommended that he engage in a supportive and exploratory psychotherapy (with components of motivational interviewing) related to his identity development and individuation process, followed by specific CBT or IPT techniques to address his problematic interpersonal functioning.

Confidential Psychological Assessment Report

Identifying Information

Name:	Jeremy Chambers	**Date of report:**	2/28/2020
Sex:	Male	**Assessor:**	A. Jordan Wright, PhD
Age:	21	**Dates of assessment:**	1/13/2020; 1/14/2020
Date of birth:	1/1/1999		
Ethnicity:	Mixed-Race (Black and White)		

Referral Source and Questions

Jeremy Chambers was referred by his mother to evaluate the underlying reasons for his "impulse control problems," including a compulsion to steal and smoking cigarettes.

Measures Administered

- Clinical interview
- Bender Visual-Motor Gestalt Test-Second Edition (Bender-2)
- Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV)
- Beck Anxiety Inventory (BAI)
- Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)
- Minnesota Multiphasic Personality Inventory-Second Edition (MMPI-2)
- Millon Clinical Multiaxial Inventory, Fourth Edition (MCMI-IV)
- Inventory of Altered Self-Capacities (IASC)
- Rorschach Performance Assessment System (R-PAS)

Client Description

The client is a mixed-race (half Black, half Caucasian) male who was 21 years old at the time of testing. He is a tall, affable young man who looks Caucasian and has no defining accent. He is courteous and personable and smiles and laughs often, and he seemed to give full effort on all measures administered.

Presenting Problem and Its History

The client reported that he has "difficulties with impulse control." When asked to clarify what he meant by this, he stated that there is some "behavior I'm not proud of," which causes difficulties within his family. He reported that he no longer wants to behave in this way, but he is having difficulty stopping. Specifically, he has been fired from several retail jobs for stealing money and merchandise. Additionally, he reported that he currently smokes cigarettes and would like to quit.

The client reported that his first episode of stealing money occurred during his first job in high school, when he stole money initially to buy Christmas gifts, intending to pay it back. After that episode, he said it "got out of hand." He was caught three times by this employer, the third time having to sell his car to repay what he had taken. After that, he had several other jobs. At each of the retail jobs he held, he continued to steal either merchandise or money from his employers, each time getting caught and being fired. He left his most recent retail job because he wanted help with his problem of stealing. Although he has been fired from many jobs, he has never had any formal legal problems as a result of his stealing.

Background Information

Psychosocial Evaluation

The client lives with a roommate in Chicago. Aspiring to work full-time in his church's youth ministry, he has been living in Chicago since he dropped out after a year of college. He has had and lost many jobs, mostly in retail (which he says he is "very good at").

The client's parents divorced when he was 3 years old. He lived with his mother, who is currently single, for about 10 years in Chicago. His mother is a retired middle school teacher who currently lives near him in Chicago. He then moved to Antigua to live with his father for about four years. The move was his own decision, wanting to spend more time with his father. His father works for a hotel in Antigua. He reported that his mother is the most important person in his life.

The client reported that he has very few friends, and this has always been the case. He has one real friend, a youth director at his church, who is "quite a bit older" than he is (17 years older). The client has reportedly never had a serious romantic relationship with a woman, his longest lasting about five months while he was in college. He reported that he is not currently sexually active.

The client reported that he does not "think about" his cultural identity much, except for feeling hypocritical for devoting time and energy to his church but committing crimes like stealing. Although his father is a Black Caribbean man with a very "proper" demeanor and his mother is a "warm" and caring White woman from the South, the client reported that because he looks Caucasian, he never had difficulty with his racial identity. He further reported that he had no difficulties transitioning back and forth between Chicago and Antigua growing up.

Biopsychological Evaluation

The client reported no difficulties with his mother's pregnancy with him or his birth, and he met all developmental milestones (e.g., crawling, walking, talking, toilet training) on time. He reported that he was diagnosed with spinal meningitis at around 15 months of age. Other than this, he denied any significant medical problems. Additionally, he denied significant medical and psychiatric problems in his family, except for a great-grandfather with alcoholism and other family members with heart disease, diabetes, emphysema, and high blood pressure.

The client was diagnosed with attention deficit disorder (ADD) as a child, and he saw a psychiatrist who both monitored his medication and provided therapy from 8 to 12 years old. He was prescribed and taking Ritalin for

several years, until his father took him off the medication. His previous therapy revealed that he was "angry at what turned out to be the divorce" of his parents. His father is currently married to his seventh wife—the client is the son of his father's first wife.

The client denied use of any substances, except for cigarettes and "occasionally" trying marijuana.

Behavioral Observations

The client exhibited no problem adjusting to the testing situation, very cooperative and amiable to both the assessor and the assessment itself. Often smiling, he maintained a personable, friendly demeanor throughout the testing sessions. He seemed to concentrate relatively well on the tasks for someone his age.

The client joked often about the length of the tests and testing sessions, specific items (especially on the MMPI-2), and the nature of the R-PAS. At several points he apologized for his performance on the R-PAS; he apologized for not being "good at it," claiming all he really saw were inkblots on cards. When apologizing, he had a genuinely ashamed look on his face but continued to make eye contact with the assessor.

Often trying to engage the assessor, including joking and laughing, the client noticeably never exhibited any behaviors that would make the assessor view him negatively. During the WAIS-IV, when the assessor took off his watch to time one of the subtests, the client mirrored him by taking his watch off simultaneously. He employed many other such mirroring behaviors, including crossing and uncrossing his legs simultaneously with the assessor, throughout testing. When discussing his problems, the client did not display any notable affect.

Mental Status Evaluation

The client was somewhat formally and impeccably dressed, well groomed, and extremely cooperative and friendly throughout the testing process, maintaining appropriate eye contact, even when discussing difficult topics. At times he seemed overly familiar with the assessor, joking and laughing excessively and mirroring his behaviors. His motor activity was within normal limits. He was open and talkative, asking appropriate questions and disclosing information freely. Both his receptive and expressive language use were extremely good. His mood was reportedly euthymic and characterized by optimism, and his affect was mood-congruent and appropriate to the situation, except for his continued smiling and joking while discussing difficult topics. His thought process was goal directed, and his thought content was free of hallucinations, delusions, and suicidal and homicidal ideation. His memory seemed within normal limits, and his attention and concentration were very good. His insight is fair, but his history is characterized by poor impulse control and judgment.

Overall Interpretation of Test Findings

Cognitive Functioning

The client was administered several measures to assess his current cognitive functioning. It should be noted that these measures evaluate his cognitive ability under ideal conditions and in the most ideal context; as such, they represent his cognitive ability rather than how he actually functions in his daily life.

The client's cognitive ability is generally extremely strong across the different domains of his functioning, with a specific strength in his verbal abilities, which are very superior compared to others his age. He exhibited a slight

personal weakness (compared to his own extremely strong abilities) in the speed with which he processes information, though his processing speed is average for his age.

Fine Motor Skill. On a measure assessing his ability to control his fine motor functioning deliberately and carefully, the client exhibited no difficulties in his actual motor ability (Bender-2 Motor Subtest, 51st–100th percentile). His control of his movement is not currently impaired.

Visual Perception and Reasoning. On tests that measure nonverbal reasoning, visuospatial aptitude, and induction and planning skills on tasks involving nonverbal stimuli such as designs, pictures, and puzzles, the client performed within the high average range of functioning compared with others his age (WAIS-IV Perceptual Reasoning Index, 86th percentile). Tasks in this domain assess the client's abilities to examine a problem, draw on visual–motor and visuospatial skills, organize thoughts, and create and test possible solutions. He exhibited no difficulties in his basic visual perceptual abilities (Bender-2 Perception subtest, 26th–100th percentile), and he exhibited strong complex visual processing, mental flexibility, and visual logic skills (WAIS-IV Matrix Reasoning, 84th percentile).

Visual–Motor Integration. The client's ability to integrate his visual understanding with his motor coordination is similarly strong. On a task requiring him to copy complex drawings as precisely as possible without time constraint, which requires perceptual ability and the coordination between that ability and fine motor control, he performed in the average range compared with others his age (Bender-2 Copy, 68th percentile). On a task requiring him to use blocks to recreate complex designs presented to him within a time limit, the client performed in the superior range compared with others his age (WAIS-IV Block Design, 91st percentile). Similar to his visual–spatial reasoning ability, his integration of it with motor skills is strong.

Verbal Comprehension. On measures of general verbal skills, such as verbal fluency, ability to understand and use verbal reasoning, and verbal knowledge, the client's performance fell within the very superior range of functioning compared with others his age (WAIS-IV Verbal Comprehension Index, 99th percentile). He exhibited a specific significant strength compared with both his peers and his own overall functioning in his ability to express himself clearly and completely (WAIS-IV Vocabulary, 99th percentile). He also has extremely strong ability to use language in complex and nuanced ways (WAIS-IV Similarities, 99th percentile). Additionally, he exhibited strong understanding of social situations, appropriate social norms and behavior, and expressive ability (WAIS-IV Comprehension, 95th percentile). Compared with his own overall performance, his verbal ability constituted a significant strength. His extremely strong verbal comprehension reflects knowledge gained in both formal and informal educational opportunities and demonstrates intellectual ambition and good ability to retrieve information from long-term memory.

Selective Attention. The client's ability to focus on a task when distractions are present was evaluated only briefly using a single task. His ability to maintain his attention, focus on targets with distractions present, and respond appropriately was extremely strong for his age (WAIS-IV Cancellation, 98th percentile).

Verbal Working Memory. On tasks that assessed the ability to memorize new information, hold it in short-term memory, concentrate, and manipulate information to produce some result or reasoning outcome, the client's performance fell within the high average range compared with others his age (WAIS-IV Working Memory Index, 90th percentile). Tasks in this domain require sustained attention and concentration, as well as fluidity of mental processing.

Memory. The client's short-term memory, which was assessed only briefly using a visual memory task, is high average for his age. On a measure of immediate (short-term) memory, the client exhibited high average performance compared to others his age with remembering visual information previously presented to him (Bender-2 Recall, 77th percentile). He exhibited no difficulty with either learning or remembering information.

Processing Speed. The client's only slight cognitive weakness, compared with his own very high functioning, was on tasks that measure the ability to focus attention and quickly scan, discriminate between, and respond to visual information within a time limit, though it fell within the average range of functioning compared with others his age (WAIS-IV Processing Speed Index, 27th percentile). All the subtests that make up this index fell within the average range. The client's processing speed—the rate at which he can carry out cognitive processes—would not be considered impaired, though it is slightly lower than would be expected given his otherwise excellent cognitive functioning.

Personality, Emotional, and Behavioral Functioning

The client was administered several measures to assess his current personality, emotional, and behavioral functioning. It should be noted that the focus of these measures is on areas of need rather than a comprehensive overview of all of his personality, emotional, and behavioral strengths and weaknesses. As such, this section will necessarily focus on areas of his functioning that need support.

The results of the assessment revealed that the client has in the past and is currently struggling with the process of individuating from his family; that is, he is more dependent on his family than most others his age, but he also holds anger and resentment toward them, wanting to be more independent. His problems becoming independent have contributed to him not having fully formed his identity, which, together with his dependency, has contributed to him using a great deal of energy overly controlling social situations to get his needs met, for fear that others will abandon him. These underlying difficulties have contributed to underlying low self-esteem, despite his efforts to present as if he feels good about himself, as well as his tendency to relieve his underlying tension states by acting impulsively, including his stealing behaviors.

Difficulties With the Individuation Process. The client struggles with very conflicting dynamics in his family, both heavily depending on them, more so than most others his age, and harboring anger and resentment toward them because he does not feel independent from them. At his core, the client is a highly dependent person for his age, needing to rely on others for a great deal of support and to help him make decisions (MMPI-2; MCMI-IV, R-PAS). This dependent dynamic can help explain why his mother was responsible for organizing the assessment and even accompanied him to the assessment sessions. However, he also harbors some anger and resentment toward his family, though he has difficulties expressing it appropriately (MMPI-2). He even at times behaves in deliberately oppositional ways in order to assert his own independence (MCMI-IV; R-PAS). This internal tension about his family has made it difficult for him to develop a clear, independent identity and sense of who he is and wants to be as an adult.

Identity Problems. The client has not yet developed a clear sense of who he is and wants to be in the world. He has a weak sense of who he is, unclear of what kind of person he is and can be and wishing he knew himself better (MCMI-IV; IASC). At times he even loses a sense of who he truly is in different situations, adapting himself so much that he loses a coherent and stable sense of self (IASC). It should be noted that some of how he views himself is unrealistic and not based on true data (R-PAS), and some of his difficulties with identity development may relate to some gender-role or sexuality confusion (MMPI-2). Ultimately, though, he struggles to have a clear sense of who he is.

Control of Social Situations. The client's conflicted individuation process and lack of coherent and stable identity have contributed to him overly controlling situations, for fear that others will abandon him. He has a strong need to be with others and is extremely sociable (MMPI-2; MCMI-IV), however he is extremely concerned that others will abandon him and is generally pessimistic (IASC; MMPI-2). Extremely aware of and knowledgeable about how others function and having excellent social skills (R-PAS; WAIS-IV Comprehension), he has

adopted a style of being highly controlled, guarded, and insincere in social situations, even when he does not appear to others to be (MMPI-2; MCMI-IV; R-PAS). These skills can be manipulative and even passive-aggressive, using others as a means to the end of gaining their support, but not being genuine or vulnerable with them (MMPI-2; MCMI-IV). This overly controlled style of interacting with others can explain the excessive joking with the assessor, as well as his matching behaviors, and can also explain why he has so few friends in his life, as it is not ultimately an effective strategy for maintaining close relationships.

Underlying Low Self-Esteem. His underlying difficulties have contributed to him having developed underlying low self-esteem, despite the fact that he works hard to appear as if he feels good about himself. Currently, the client does not feel good about himself, feeling inferior to others and viewing himself as damaged or flawed (MMPI-2; MCMI-IV; R-PAS). He feels misunderstood by others (MMPI-2), and he reported some shame related to his stealing behaviors as a contrast to his volunteering at his church. However, he works hard to combat his low self-esteem by portraying himself to the world as feeling extremely good about himself and overinflating his sense of self-worth (MMPI-2; MCMI-IV; R-PAS). However, this is an ineffective strategy and can seem insincere and grandiose to others, ultimately not changing his underlying self-criticism.

Impulse Control Problems. His underlying tensions and conflicts find some immediate release and relief in his impulsive behaviors, which can temporarily give him the illusion of control over his life and identity. The client is somewhat immature in how he copes with the world, being impulsive and impatient and having a very low tolerance for boredom (MMPI-2). His style of coping is generally characterized by spontaneously acting, rather than thinking through things (and consequences) deliberately (R-PAS). He tends to benefit (at least temporarily) from instant gratification (MMPI-2), which is related to his stealing behaviors. It should be noted that his problems with impulse control (including his stealing) do not seem to be related either to anxiety or to actual OCD-type compulsions (BAI; Y-BOCS).

Summary

Jeremy Chambers is a personable, friendly 21-year-old mixed-race (half Black, half Caucasian) male who was referred for assessment for "impulse control problems," specifically a compulsion to steal. Additionally, he has very few friends and not much history of friendships or romantic relationships. He was cooperative and friendly throughout the assessment, and he seemed to give full effort on all measures administered.

Cognitively, he exhibited extremely well-developed general abilities across the different domains of his functioning, with specific extreme strength in his verbal abilities. While only a weakness compared to his overall strong functioning and not to others his age, he did exhibit only average speed of processing information. This slightly slower speed of processing information is likely related to his style of maintaining strict control over situations.

Emotionally, the client is struggling with the process of individuating from his family; that is, he is more dependent on his family than most others his age, but he also holds anger and resentment toward them, wanting to be more independent. His problems becoming independent have contributed to him not having fully formed his identity, which, together with his dependency, has contributed to him using a great deal of energy overly controlling social situations to get his needs met, for fear that others will abandon him. These underlying difficulties have contributed to underlying low self-esteem, despite his efforts to present as if he feels good about himself as well as his tendency to relieve his underlying tension states by acting impulsively, including his stealing behaviors.

Diagnostic Impression

Currently, the client meets criteria for kleptomania (*DSM-5* code 312.32; *ICD-10* code F63.3). Specifically, he fails to resist his impulses to steal objects that are not needed and feels relief of tension at the time of committing the theft. The theft behavior is not related to vengeance and is not related to any delusion or hallucination.

Additionally, because of his own concern with smoking, he will be given a diagnosis of tobacco use disorder (*DSM-5* code 305.1; *ICD-10* code F17.200).

Finally, the client currently also meets criteria for an other specified personality disorder, with narcissistic and dependent features (*DSM-5* code 301.89; *ICD-10* code F60.89). His patterns of self- and other relatedness are problematic and causing impairment in his functioning, especially his social and occupational functioning. His self-relatedness is characterized by problems with his identity development and low self-esteem, which he attempts to bolster with overly grandiose sense of self-importance and need for admiration. His other relatedness is characterized both by his overdependence on his family and his strict control over social situations, to the detriment of genuine, connected relationships and lasting social support.

Recommendations

Given the client's current functioning, the following recommendations are being made:

1. The client should engage in individual psychotherapy for his kleptomania behaviors. Specifically, CBT with the use of exposure and response-prevention will help him be able to tolerate the impulses to steal and the underlying discomfort that arises when he does not act on these impulses.
2. Additionally, exploratory, supportive psychotherapy should be used, along with motivational interviewing techniques, to help him develop a clearer sense of who he is and individuate from his mother appropriately. Following this work, CBT or IPT techniques can help him address his problematic interpersonal functioning and ultimately gain more friendships and support from others.
3. Finally, the client should engage in a smoking cessation program to address his tobacco use.

_____ _____

A. Jordan Wright, PhD
New York State Licensed Psychologist

Date

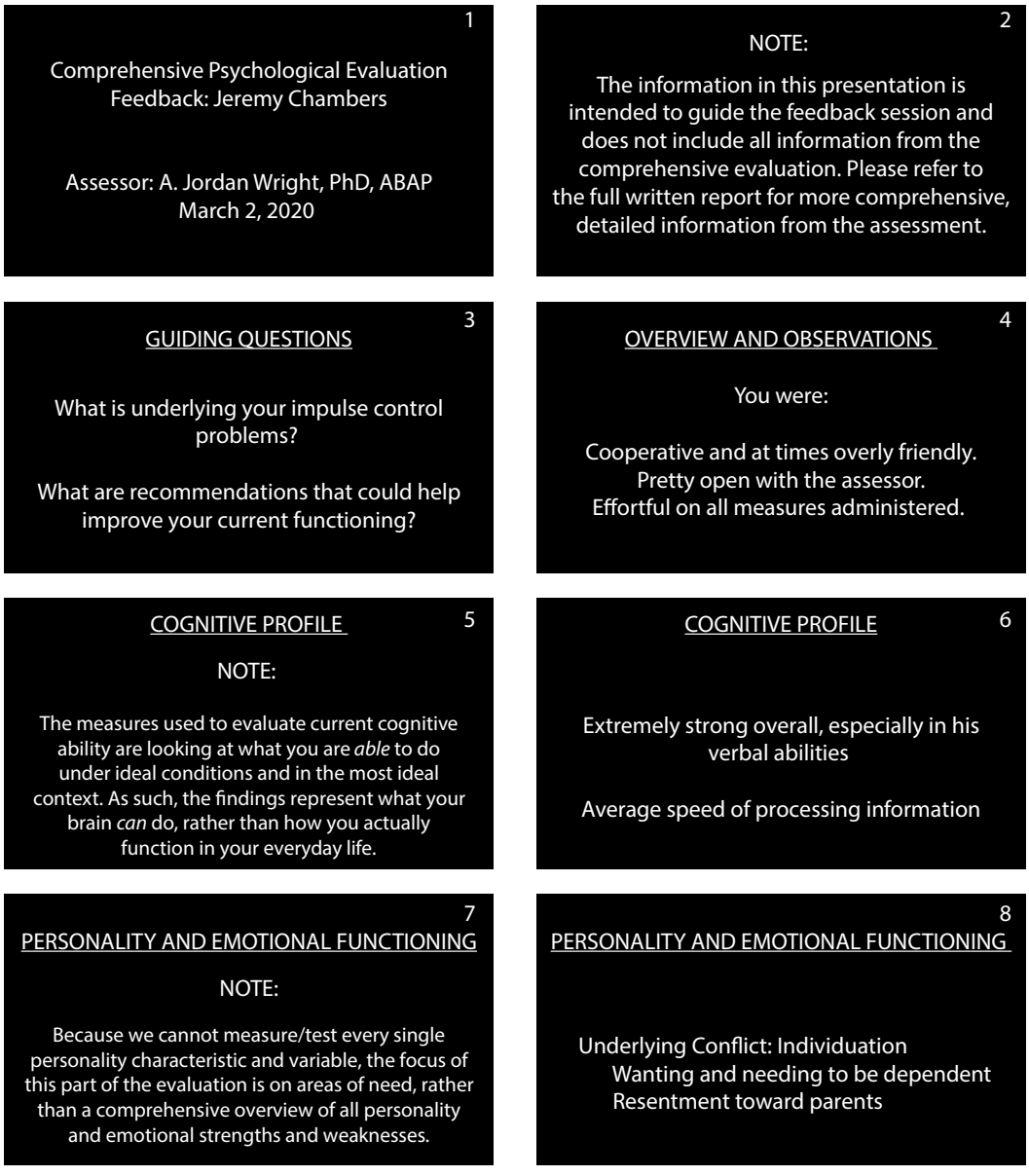
Feedback

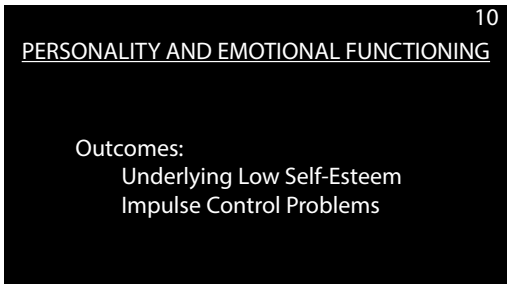
Preparation for Feedback

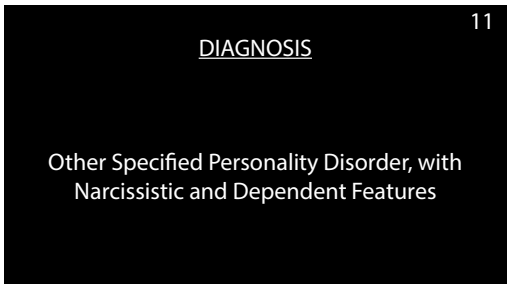
The feedback for Jeremy posed a specific problem, as it would necessarily have to occur well before the assessment report was completed. This was agreed on before the testing began so that feedback could be given before he returned to Chicago. During the feedback session the assessor and Jeremy could collaborate about the best way to proceed with recommendations, such that he can be connected with a therapist in Chicago as quickly as possible and the assessor can get a copy of the report to the therapist, as well as to Jeremy. For the feedback session, however, a feedback presentation was created.

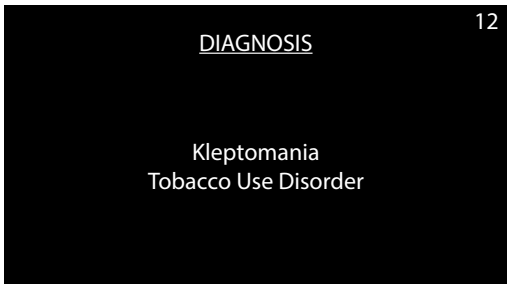
In this case, the feedback presentation serves the purpose of having something to guide the session in the absence of an actual report (which would need to be finalized later on). It includes a brief summary of cognitive functioning, personality and emotional functioning, diagnosis, and recommendations. Including the diagnosis was a judgment call on the assessor's part, and it was decided that it would not harm Jeremy significantly for him to see it written and that he would likely not have a strong negative reaction to it. It certainly could be argued that it would be better not to include the diagnosis, but the assessor made the judgment call to include it for the feedback session.

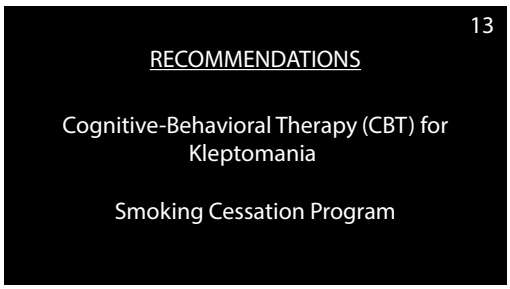
Again, the major considerations when deciding exactly how to give feedback to Jeremy were (a) his level of cognitive and intellectual functioning, (b) his level of insight, and (c) the specific type and amount of information that needed to be relayed to him. Regarding his intellectual capacity, he exhibited no deficit in any area and even displayed a strength in verbal ability. Regarding his level of insight, it is unclear how much insight he has. He seems willing to address the stealing behaviors pretty readily, but he did not report much concern with his interpersonal functioning. It will be extremely important to gauge how the session is going as these themes are discussed. As always, ultimately, the flow of the feedback session will take its pace both from the assessor and from Jeremy, as the assessor will constantly check in with his reactions and feelings about the feedback presented. Taken altogether, there are no compelling reasons that he could not eventually see the report in its entirety. For the feedback session, though, only the presentation was possible.











Feedback Session

Jeremy arrived on time for his feedback session, which occurred the day after his final testing session. Luckily, the assessor had time to analyze the data, at least preliminarily, the evening before; had he not, he would have postponed the feedback session. He again arrived with his mother, and as he came into the session alone he asked if he "should" bring his mother into the feedback session. The assessor, as they both sat down in the office, decided to process for a moment why Jeremy would or would not want his mother present for the feedback. Before any feedback was given about his individuation process or mixed dependent and resentful feelings about his family, this theme was played out in the room. Jeremy reported that his mother had "come all this way for me" and that she "deserves" to receive the feedback from the assessment. However, when asked if there were any "cons" to having his mother present during the feedback session, he stated, "Well, I'm an adult, so I guess I don't really need her." After speaking for a few minutes about whether to include his mother, the assessor suggested that he give Jeremy the feedback alone first; then, Jeremy could decide whether he wanted to bring his mother into the session to receive the feedback from both himself and the assessor. So the feedback session continued with Jeremy alone.

Following the structure of the feedback presentation, the assessor restated why Jeremy had originally presented for an assessment (mostly the impulse control problems) and explained how the session would be organized. Specifically, the assessor told Jeremy that the feedback would be separated into cognitive functioning, personality and emotional functioning, and the diagnosis and recommendations. Once it was clear that Jeremy was oriented to the session, the assessor reasserted that some of the information in the presentation was written out in brief terms and would need a bit of explanation.

The beginning of the feedback was extremely easy to give, as Jeremy was functioning extremely well cognitively. His slightly lower processing speed was contextualized by the possible reasons for psychomotor slowing, including anxiety, "emotional stuff," and personality characteristics. However, the assessor emphasized the fact that his processing speed was not weak compared with others, so there was no evidence of any cognitive difficulty whatsoever.

By far the bulk of the session focused on the first emotional theme—his deep conflict between dependence on and wanting adult independence from his family. The assessor presented this theme as a developmental task that everybody goes through at some point in their life, turning from dependence on family to independence and "individuation" from them. He clearly had a reaction when reading this theme, and the assessor decided to stop the feedback and check in with Jeremy about what he was thinking and feeling. This was the first time he showed any real difficulty in looking the assessor in the eye, as he stated that his mother had "been through so much" and was "so important" to him. When pressed on why he was then having a strong reaction, he hesitantly reported that there were times when he felt "smothered." The assessor empathized with these mixed feelings and again normalized them as natural developmentally. Almost suddenly, Jeremy laughed, looked at the assessor, and said, "Good thing I didn't bring her in here for this!" Making a joke at this point when he was confronted with deep emotions would be used later in the session to illustrate his control over social situations and over himself and his emotions.

The next two themes were presented as highly related to his problematic individuation process. When discussing his weak identity, he looked at the assessor and asked whether the assessor thought that was why he wanted to be a youth minister. Rather than answering this question, the assessor simply remarked that this was an interesting observation on Jeremy's part and used it as an opportunity for a "preview" of the recommendation for exploratory psychotherapy, encouraging him to take up that exact question with a therapist.

Control over social situations and over himself, though he had not "conceptualized it that way," also resonated with him—and the example of his joking earlier when faced with difficult emotions was employed to illustrate the point. He discussed knowing "exactly how to play it" in different social situations, so that he could elicit a favorable response from others. He asserted that this "works for me," and the assessor (thinking now that the motivational interviewing component of his recommendations makes a great deal of sense, given Jeremy's current lack of understanding of this as a problem at all that needs changing) discussed briefly how genuineness and vulnerability lead to deep and lasting relationships. He emphasized the different skills necessary for making friends (social skills) and keeping friends (the capacity for closeness).

In discussing his underlying low self-esteem, Jeremy reported that although he does not like people to know how bad he feels about himself, at times he actually does want them to know. Not in a joking way, he commented how amazing it was that the tests could pick that up because he works hard not to let people know that he does not feel good about himself. This was related back to his overcontrol of social situations and tied to the discussion about deepening relationships (and gaining support) through genuineness.

The final theme did not cause much reaction. Clearly, his impulse control problems were his overt reason for wanting the assessment originally. He did state that it was "interesting" to think about where his impulse control problems are coming from (as they were presented as outcomes of the other themes).

When discussing the diagnoses, the assessor first explained what diagnoses really are—descriptions of clusters of symptoms that get in the way of a person's functioning. When Jeremy saw *kleptomania* in the presentation, he clearly had a reaction to it, seemingly not because he did not agree with it or understand why he qualified but because he reported it was the first time anyone had used that term. Having the term applied to him was then processed a bit, such that he was encouraged to discuss what it meant to him to be diagnosed with kleptomania. He had already admitted that his stealing behaviors were a problem, but having it diagnosed as "an illness" brought up feelings in him that he was not sure about. In fact, when probed, he could not even identify whether the feelings were generally positive or negative. He said, "They just feel weird." At this point, the assessor decided

to stay with this rather than move on, to see whether Jeremy could identify what he might be feeling and encouraging him to consider that he may even be feeling different and conflicting emotions. Eventually, Jeremy was able to identify slightly ambivalent feelings about his behavior being marked as an illness, though overriding his ambivalence was some hope that he could get help for the behavior.

Once the assessor was satisfied that Jeremy had processed this first diagnosis adequately (at least for the limited amount of time allowed in a feedback session), he presented the tobacco use disorder diagnosis, which was much easier for Jeremy to hear.

The final, and perhaps most difficult, diagnosis to present to Jeremy was the personality disorder. The assessor first explained what a personality disorder is, emphasizing that personality disorders are generally concerned with an individual's style of interacting with themselves (like identity and self-esteem), others, and the world around them that are getting in the way of succeeding in life entirely. This point was restated several times in several different ways, such that the personality disorder was presented as a maladaptive style of dealing with himself and other people. "Oh, I've got one of those!" was his response, relating to his problematic self-functioning and over-controlling nature in interpersonal interactions. This exclamation seemed less of an "aha moment" and more of a somewhat-joking-but-somewhat-protective stance, seeing clearly in the presentation that he was indeed diagnosed with a personality disorder. The terminology of the *otherwise specified* was explained to him as clearly as possible. Before he and the assessor were able to process his reaction to this diagnosis in depth, he quietly said, "I guess I need some help, then." First, the assessor offered significant positive reinforcement for this comment, noting that it is not easy for anyone to admit they need help, and especially not out loud and in the presence of another person. The comment then steered the session toward the recommendations.

The discussion of recommendations focused more on the prognosis when it comes to treating what he is dealing with. The assessor assured Jeremy that now that he has accepted that he wants help, especially for his stealing behaviors, psychotherapy can be extremely effective at helping with issues of dealing with emotions, controlling his behaviors, helping him develop his identity more clearly, and dealing with others better. He asked where he could find an appropriate therapist, and the assessor assured Jeremy that he would help him find a good referral; he asked if the therapist in Chicago would be "as good as you," somewhat jokingly. Although another example of ingratiating and overly controlled social behavior, the assessor chose in this moment simply to chuckle with Jeremy and move on. At this point, the session switched to a discussion about giving feedback to Jeremy's mother, who was still in the waiting room.

Again, Jeremy presented his ambivalence about sharing the feedback with his mother, listing both pros and cons to doing so. In the end, he asked if he could be the one to give the feedback to his mother, "in my own words," while the assessor observed and answered any questions that arose. This process seemed like an excellent way not only to give his mother the feedback but also to solidify Jeremy's understanding of the feedback and ensure that there was no miscommunication about it. Jeremy's feedback to his mother was almost identical to the feedback he had received from the assessor, and the assessor rarely even needed to speak in the rest of the session. The assessor asked whether either had any questions at the end, which they did not, and they thanked the assessor and left, asking him to send the report to them as soon as it was ready. At this point, Jeremy scheduled a phone call with the assessor for three weeks from that day to discuss the report and the referral. Having sent the report and referral information, that phone call confirmed that he had already contacted the therapist, sent the report to her, and scheduled a first appointment.

Summary

Jeremy Chambers's assessment, while a bit unusual in its time constraint, is a good example of how psychological assessment can add to clinical impressions. It would have been obvious to most mental health professionals

that he suffered from kleptomania. If this were the primary presenting problem in a clinical intake, a behavioral therapy may have been recommended to stop the compulsive behavior. However, what underlies his compulsion to steal, and especially all of the interpersonal difficulties and problems with identity and individuation, were not as apparent from simply interviewing. Jeremy struggles in many areas of his life. His occupational functioning is clearly compromised by his stealing, but his social functioning is also impaired, which may have been overshadowed by the more salient problem of stealing and getting fired from jobs. At a 6-month check-in, Jeremy's therapist told the assessor that he was "making progress" in therapy on two core issues: his individuation and his identity development. He had not stolen since the assessment, though this likely was in part because he had not taken a retail job where it would have been easier for him to do so.

CHAPTER 10

An Adolescent Girl With Test Anxiety

Audrey Cheng was a 16-year-old Asian American (Chinese American) girl who came in for an evaluation because she was having daily "panic attacks" in school (and it turns out at home as well). Her private school actually recommended that she see a psychiatrist and begin medication, but Audrey's mother, a nurse who works in a neonatal intensive care unit (NICU) with multiple social workers, decided to bring her in for a full assessment before "jumping into medicating her." So she reached out and scheduled an appointment for the clinical interview to begin the assessment process.

The Clinical Interview

The first appointment for the clinical interview included both Audrey and her mother. As always, how the clinical interview is structured should be carefully considered. Because Audrey is an older adolescent, she should have a great deal of information to add to the clinical interview. Additionally, the referral question (in the initial contact with Audrey's mother) highlighted panic attacks; although the notion of ego-syntonic versus ego-dystonic symptoms and traits is quite dated and perhaps overly psychoanalytic (stemming from Freud, 1914), it can be useful for making some decisions. That is, whether the presenting complaints are ego-dystonic (foreign to who the person is, symptoms they are likely to want to get rid of or fix, such as anxiety or sadness) or ego-syntonic (more aligned with who a person sees themselves, such as their way of relating to others or their style of coping) can inform how to structure a clinical interview. In this case, Audrey's panic attacks are most likely ego-dystonic, in that she knows they are not good, does not like them, and wants to get rid of them. It is very likely that both she and her mother will have similar views on them, so it should be generally fine to do the interview together. In cases in which the presenting complaints are more ego-syntonic, this might not be the case. For example, if Audrey's complaint related to her relationship with her parents and her parents felt Audrey's way of relating was aggressive and entitled, but Audrey felt her parents were unfair and uncaring (thus, her style might seem to her more related to their characters than her own), then the clinical interview may benefit from occurring separately (both because of the ego-syntonic nature of her symptoms and because of some likely conflicting opinions about what is going on between her and her parents).

Thus, the clinical interview was scheduled for Audrey and her mother. They were both extremely pleasant from the very beginning, having no questions throughout the consent and assent process, readily signing the forms, and eagerly wanting to engage in the clinical interview. For this assessment, a semistructured clinical interview was used to collect the background and contextual information. The interview is organized into overall domains (e.g., presenting problem, cognitive complaints, mood complaints, developmental history, medical history), with broad questions to start and more specific follow-up questions about specific symptoms as needed.

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The assessor prefaced the process by clarifying that he would be asking many questions, and they would be generally for whoever wanted to answer them. The assessor let them both know that he was going to ask them lots of questions—some broad and some very specific and some that may not apply to Audrey because they are the same questions he asks everybody.

Presenting Problem: OK, so what questions do you want answered with this assessment?

It became clear quite early in the clinical interview that, although both Audrey and her mother were eager and open throughout the process, they were quite quiet, brief and pointed in their responses, and did not elaborate much. Both Audrey and her mother were completely fluent in English, though her mother was from China and they spoke Chinese at home. Whether cultural, related to their personalities, or something else (like nervousness), neither one elaborated freely throughout the clinical interview. Audrey's mother began by restating what she had said on the phone originally: that Audrey gets very anxious at school and her teachers have recommended she try medication. She reported that single sentence and then stopped. The assessor asked Audrey if she could elaborate on the anxiety she experiences at school, and she added a few sentences. She explained that she experiences "panic attacks" every day at school and at home. Again, the assessor had to prompt for more details, focusing on what exactly she experiences during these panic attacks.

Audrey explained that she has both "small panic attacks" and "big panic attacks." The smaller ones generally relate to "inconsequential circumstances" (e.g., running out of shampoo) and result in her having "a lot of thoughts in my head at once that I can't control that then turn physical." She explained that she feels heaviness in her chest, "fidgetiness" in her hands, and often stomachaches. During the bigger panic attacks—which she said happen over bigger things like high-stakes tests (like the ACT and SAT), performing well in school, thinking about college, and her social life—she experiences shallow and rapid breathing, pounding in her heart and chest, sweating, trembling, dizziness, sometimes choking for air, and most often a dread of losing control and "going nuts." She said that she recently had one of these panic attacks at home, and she said she "found myself trying to calm down by digging my nails into my arm, to the point that I was bleeding." Her mother added that during this panic attack she went to her and hugged her extremely tightly and rocked her in her arms for about 20 minutes until she was able to breathe normally and ultimately calm down. Audrey said that that panic attack was related to a friend not yet responding to an invitation to her birthday party. (The friend responded a day later saying that she would in fact be coming to the party.)

The assessor asked for another example, and Audrey discussed a situation at school the prior week when a teacher called on her in class to answer a question. Even though she knew the answer, she became so nervous that she experienced one of her "big" panic attacks. She said she went to the school counselor's office and took about an hour to calm down and be able to breathe normally. She said that her therapist had taught her some breathing and distraction techniques, but they often do not work for her in the moment even when she tries them.

Audrey's mother added that they are especially worried about Audrey's anxiety and its effect on testing. She has to take the SAT or ACT soon, and it is already causing stress. She said Audrey is in a school that "does not really give tests," so they do not have firsthand experience or evidence about what will happen during a high-stakes test like the SAT or ACT. However, it is concerning to them both that Audrey is already nervous about the test. Audrey said, "I don't want to have a breakdown and just tank the test because of it."

History of Presenting Problem: How long have these panic attacks been going on?

Audrey's mother said that Audrey was anxious and depressed in middle school, but it was not until high school that she started experiencing "the full-blown panic attacks." The assessor first confirmed that this was the case with Audrey and then asked them to follow up about the depression. Audrey's mother said that Audrey had struggled with low self-esteem beginning again in middle school. She said that Audrey has periods during which she

is extremely tired and fatigued because she does not sleep well at all, seems "slow" in everything she does, cannot get things done or pay attention well, and just "does not want to do anything." The assessor asked Audrey about these "periods," and she said she usually loves to paint but that she does not want to do even that during these times. The assessor asked her specifically about suicidality, and she said she had thought about what it might be like if she were dead but denied any intent to actually harm herself seriously. The assessor asked about the timing of these "periods"; Audrey's mother said the first time was sometime in middle school for about a month, and Audrey said that she has periods like this ("when I don't even want to get out of bed") about twice a year for about a month each. She said, "That's why I first got into therapy." The assessor said they would revisit the topic of her therapy a bit later in the clinical interview.

Cognitive Status Complaints: Let's talk about your cognitive functioning. How are your attention and concentration generally?

Although the semistructured clinical interview usually starts with a broader questioning of a topic (like cognitive functioning in general), to get an idea of what is most salient to the client the assessor decided to skip straight to the specific questions in this case because he already had some information about attention problems (and especially because it seems somewhat variable depending on if she is in a depressive episode or not). Audrey said that her attention is usually "very good," and she gets "really good grades," except for when she is depressed and cannot focus on anything. She similarly reported that all other cognitive functions are generally intact, including memory, language comprehension, word finding, and visuospatial functioning. She denied hallucinations and delusions, but she did report that her decision-making abilities are "not great—I have analysis paralysis." When asked to explain what she meant by this, Audrey said that she tends to overthink things and analyze situations so much that she finds herself not being able to make decisions or solve problems in her life. Her mother simply added, "Absolutely."

Emotional Status Complaints: OK, so what's your mood like at the moment?

Audrey said that over the past week or so she felt her energy lowering, and she was worried she might be getting into one of her "depressed phases" again. She said that her therapist told her she was "dysthymic" because she was always so pessimistic and hopeless. However, she said she does not generally feel sad. The assessor asked her about her sleep currently, and she said that she has started taking melatonin, and that seems to help her. She said that she had been so anxious over the past week that she had found herself needing to "press my hands together and my legs together just to feel less pain." The assessor asked one more time about suicidal ideation, and Audrey said she had not really thought about killing herself "for a while."

Family Context and History: OK, tell me about your family.

Audrey's mother said that Audrey was an only child and that she and Audrey's father had divorced about a year ago. She said that Audrey sees her father, who is an engineering professor at a university, about twice a week but that she lives full-time with her. The assessor asked Audrey what the breakup between her parents was like for her, and she simply shrugged and said, "It's fine." Her mother said that she did not seem to have a difficult time with it.

The assessor asked Audrey about her relationship with her parents, and Audrey said that she had a "great" relationship with her mother and an "awkward" relationship with her father. When asked why it was awkward, Audrey said, "He was pretty hard on me as a kid." Audrey's mother elaborated that Audrey's father had high academic expectations for Audrey, "as many Chinese parents do," and that he was "impatient" with any difficulties or anxieties Audrey had related to academics. The assessor asked specifically if there were any punishing or abusive behaviors, and both Audrey and her mother denied any intimidation, physical punishment, or other potentially abusive behaviors. They said that he just got very disappointed and frustrated with her. They also reported that since

Audrey started therapy (in middle school), her therapist had taught her father to be more patient and less frustrated with her. They both denied any other family difficulties or major family events that have had an impact on her.

Educational History: So speaking of academics, tell me about your school performance.

Audrey's mother said that Audrey was "an excellent student," getting all As since elementary school. She said that she works hard and, "even when she's struggling," she makes sure to put in extra time and effort to maintain her good grades. Audrey said that it was sometimes difficult—"when I get into one of my blah periods"—to motivate to get her schoolwork done, but her mother is "extremely supportive" and helps make sure she stays focused on doing well.

Developmental and Medical History: Turning to you, Mom, were there any problems with your pregnancy, her birth, or her development?

Audrey's mother said that there were no problems with pregnancy, birth and delivery, or any aspect of her developmental milestones. When asked, she also reported that Audrey is not and has never been seriously sick with any medical illness and has never had any head injuries, blackouts, or loss of consciousness, all which Audrey confirmed. When asked, Audrey's mother also denied any major medical problems in their family, except for Audrey's father struggling with a history of some depression.

Psychiatric History: OK, tell me about your history in therapy.

Audrey's mother said that Audrey started therapy in eighth grade, after about a year of "really struggling" with her anxiety and depression. She has been in treatment with the same therapist since then (about 3 years), and they both reported that her therapist has not given her a "formal diagnosis, just anxiety and depression stuff." Audrey said that the therapy has been helpful, especially related to getting her father to be "less hard on me" but also to learning some strategies to cope better. Audrey's mother said she has not seen a psychiatrist and has not been prescribed any psychiatric medications.

Substance Use History: Any history of using alcohol or any other drugs?

Audrey said that she has used alcohol, but "not much, 'cause I don't really like it." She said that she has only ever used alcohol with friends, never alone. She also said that she smokes marijuana "a few times a week." She said specifically that she "[tries] to do it with people" but that she also does it alone. She said it helps her deal with her anxiety, "and it just feels good." She and her mother both reported that her smoking marijuana has not interfered in her life in any way, either academic or social.

Legal History: Do any of you have any involvement in the legal or court system?

Audrey's mother said that their family has never had any involvement in the legal or court system, noting that "even our divorce was quick and easy."

Social History and Context: Tell me about your social life.

Audrey said that she does have some friends, but that she is "not great at meeting people—I get so nervous." She said that she has one close friend currently but that she does not share too much with her because "I don't think she really gets me." She said she likes being with people, but she finds it "easier" just to be on her own. When the assessor asked her to explain what she meant by this, she said that she gets "so in my head" when she is around other people, she finds it easier and "more comfortable" to stay alone. She said she had had some "bad experiences" with some friends, and when she described them they seemed like very typical adolescent experiences with friends.

Psychosexual History and Context: Tell me about your sexual identity.

Audrey said, "I think I'm bisexual, but I'm not sure." She said that she is not currently sexually active and has never been, so she "cannot be sure" about her sexual identity. She denied any history of sexual abuse or trauma. When asked about her experience of figuring out her sexual identity, she said that it "does not bother me much right now," stating that she is focused on school and getting into a good college "much more than figuring that stuff out." Although an unclear sexual identity for many can be extremely stressful, Audrey genuinely did not seem to be worried about it; she said that she did not think her parents or any of her friends would react negatively "if I was queer," so she said she would probably "figure it all out in college."

Cultural Evaluation: Tell me about your culture and identity.

Audrey's mother said, "We are Chinese—she is also American, but we are very Chinese." The assessor asked Audrey to clarify what it was like for her to be both "very Chinese" and American, and Audrey talked briefly about "all the expectations put on me" because they are Chinese. She reiterated how hard her father was on her related to academics even though she has done consistently well throughout school. She added, though, that she feels "really comfortable" being both Chinese and American. She said that she thinks being a minority student will give her an advantage for getting into college ("even though lots of Asian kids are really smart"), but she also said she values the "work ethic my parents gave me." She said that "sometimes what gives me hope is that I can work hard and do well."

Audrey said that she and her family are not religious or spiritual at all, and she said, "I guess I'm agnostic?" in a questioning tone. She said she has no immediate intention of exploring any religion or spirituality.

Current Stressors: So I know we've covered this pretty extensively, but I just want to summarize. What are your biggest stresses in life at the moment?

Audrey, very tersely, said, "school, tests, college, and social stuff." Because the assessor had pretty thorough information on each of these different stressors, he decided not to ask for any clarification.

Current Medications: Other than melatonin, are there any other medications you're on right now?

Audrey said that she was not on any other medications currently.

Summary: Is there anything you think I've missed or should know about you that I haven't covered?

Audrey and her mother thought for a moment, and both stated that they could not think of anything else at the moment. The assessor encouraged both of them to let him know if something "popped up" in their minds, throughout the entire assessment process, that they think he should know about Audrey. This concluded the clinical interview, and the assessor thanked them for being so open. They scheduled the next appointment and left.

Mental Status Evaluation

Appearance and Behavior

Audrey was on time for all her appointments, and her mother accompanied her each time (even though at her age she could have come unaccompanied). Her appearance was unremarkable—she was appropriately dressed and groomed. She showed no problems with her gross motor functioning, coordination, posture, gait, or balance. She also did not exhibit any problems with her fine motor functioning, except that she fidgeted with her hands noticeably during most tasks that did not require the use of her hands (such as Verbal subtests of the Wechsler Adult Intelligence Scale, 4th Edition [WAIS-IV]). She was extremely well related throughout the process, making good eye contact, being cooperative and friendly with the assessor.

Speech and Language

Audrey's speech and language were unremarkable. She exhibited appropriate volume, articulation, vocabulary, grammar, and rate.

Mood and Affect

Audrey reported feeling "low energy," and her affect was generally aligned with this. She did not smile too often, and her facial expression generally looked a bit bored or fatigued. She reported anxiety, though she did not exhibit any overt signs of anxiety (other than fidgeting with her hands) during the testing process.

Thought Process and Content

Audrey's thoughts as articulated in sessions were goal directed, logical, and free from problems like tangential, circumstantial, magical, or overly concrete thinking. She did not exhibit any overt difficulties understanding what was going on or instructions given to her, even on complex cognitive tasks, and she denied hallucinations and any delusional or magical thoughts. She reported significant anxious and depressive ideation, including worthlessness and low self-esteem, helplessness, and hopelessness, and she reported some past passive suicidal ideation, but she denied current ideation and any past or present intent.

Cognition

Audrey was alert and engaged throughout the assessment. Her memory seemed intact, and she had no difficulties maintaining attention on tasks that lasted longer than a few minutes.

Prefrontal Functioning

Audrey reported no problems with Audrey's judgment, planning, and impulse control, and each of these seemed generally adequate during the assessment process and she exhibited no overt signs of impulsivity. She did report difficulties with decision making and problem solving, related to overthinking ("analysis paralysis").

Hypothesis Building

Now that the clinical assessment (the clinical and collateral interviews and the mental status evaluation) has been completed, the information gathered can be used to create hypotheses for what might be going on for Audrey.

Identify Impairments

Clearly, Audrey has multiple areas of difficulty she is struggling with. She is clearly struggling with significant symptoms of anxiety (including panic attacks but also other anxious symptoms) and depression. She does not seem to be struggling academically at all; however, there are some odd aspects in this case to consider. Specifically, she is having significant self-reported nervousness about taking the SAT or ACT (high-stakes exams). Typically, accommodations for these exams are difficult to get, especially if a student does not have a history of academic difficulties and specific testing accommodations. However, Audrey goes to a school that does not use tests, so there was no way for her to have had testing accommodations previously. As such, whether her anxiety (or other issues) significantly negatively impacts her test-taking ability is unknown; it may or may not be an impairment in functioning. We will have to explore this to determine if there is an issue and need to address the anxiety and depressive symptoms in our hypothesis building and test selection.

Enumerate Possible Causes

The first major task regarding understanding what is going on with Audrey is really about differential diagnosis of her anxiety and depressive symptoms. Certainly she exhibits symptoms consistent with multiple disorders, and we cannot give her all of them. Therefore, we will need to use the data from the interview and measures administered to determine which diagnosis or diagnoses are most appropriate in this case. Multiple anxiety disorders could be appropriate: generalized anxiety disorder (GAD), panic disorder, and social anxiety disorder seem especially applicable in this case. Related to her social anxiety, it is possible that her symptoms may align with avoidant personality disorder, though she is still quite young to be considered to have a personality disorder.

Audrey's depressive symptoms similarly require consideration for which diagnosis is most appropriate. Her therapist reportedly believes her symptoms most closely align with persistent depressive disorder (dysthymia), though the episodic and severe nature of her periods of depression seems to align better with major depressive disorder (MDD). Differentiating between the two will again require careful consideration of the symptoms that emerged from the clinical interview and that will emerge from the tests.

Finally, we want to ensure that there are no specific difficulties related to her test-taking abilities. The two major hypotheses of what could potentially cause difficulties in test taking are an other specified anxiety disorder (that is, diagnosable test anxiety) and a specific learning disorder. While she clearly does not exhibit the type of learning disorder that overtly affects her learning or performance in classes (such as dyslexia), whether she has specific difficulties on tests is a big question mark because she is in an environment that has not offered her the opportunity to find out.

As always, we will consider that the presenting problems have an etiology in (a) substance use and (b) a medical condition. Although Audrey admitted to using marijuana, it really seems as though she uses it to self-medicate her anxiety symptoms (meaning the anxiety predated the marijuana use); additionally, Audrey and her mother specifically denied her marijuana use having any negative effects on her functioning. Further, she denied other substance use (other than occasional alcohol use). As such, it is unlikely that her impairments are due to substance use (though it is possible her marijuana use does actually contribute to or reinforce some problems). Additionally, Audrey and her mother denied any medical issues, and her symptoms do not seem specifically consistent with a medical etiology (though things like thyroid conditions can mimic mental illnesses like depression). However, based on the information we have, we will continue to assess the psychological processes that likely underlie her problems.

Selecting Tests

Beginning with the academic hypothesis posited for Audrey, we need to develop a battery of cognitive and academic tests to understand her general intellectual ability and her academic skills. Although not a specific hypothesis of what is likely impairing her functioning, it may also be useful to understand her attention and executive functioning. To understand her overall intellectual ability, if we want to use a Wechsler scale, we have a choice to make between the Wechsler Intelligence Scale for Children, 5th Edition (WISC-V) and the WAIS-IV. As she is extremely high functioning academically (getting consistently excellent grades in a private school in New York City), we are likely more concerned with ceiling effects of the WISC-V than floor effects of the WAIS-IV. That is, we expect that she will do generally quite well on the Wechsler scale compared with others her age, so we will use the WAIS-IV (which has by definition harder items on it). As part of this overall understanding, as always, the Bender Visual-Motor Gestalt Test, 2nd Edition (Bender-2) will add some other basic cognitive skills, including fine motor skills, visual–perceptual ability, and short-term visual memory. To assess her academic functioning, two academic achievement tests will be used: a broad achievement test that will evaluate reading, writing, and mathematics skills (the Wechsler Individual Achievement Test, 3rd Edition [WIAT-III]) and a reading test that has some specific similarities to the SAT or ACT test (Erwin & Millikin, 1980; the Nelson-Denny Reading Test [NDRT]). While of course the conditions of an individual assessment (and implications for performance) are

quite different, most testing accommodation requests for the ACT or SAT require the use of the NDRT, and the types of questions and test format are somewhat similar. As such, adding the NDRT can help us discover whether Audrey may have specific difficulties in taking this kind of standardized test.

Although not entirely necessary, because the assessor had the time and flexibility to add some measures, he decided to gain an understanding of Audrey's attention and executive functioning. To screen for specific problems in these areas, we can add a Conners' Continuous Performance Test, 3rd Edition (CPT-3), with additional tests to measure other aspects of executive functioning: the Delis-Kaplan Executive Function System Trail Making Test (D-KEFS Trails) and the Wisconsin Card Sorting Test, Computer Version Fourth Edition (WCST-IV). Additional subtests of the D-KEFS can always be added to better understand different aspects of executive functioning, if needed, though we are not expecting to have any difficulties in these areas.

For the remaining emotional and behavioral hypotheses (differentially diagnosing the anxiety and depressive disorders), we can build a battery of tests to evaluate them all, as most of the broad-based emotional and behavioral measures for adolescents will include information relevant to all of them. For this age, we can enlist a combination of reporters, including Audrey, her mother, and her teachers. For self-report, we can use multiple measures to evaluate her emotional functioning in slightly different ways. These include the Minnesota Multiphasic Personality Inventory-Adolescent-Restructured Form (MMPI-A-RF), the Personality Assessment Inventory–Adolescent (PAI-A), and the Behavior Assessment System for Children, 3rd Edition–Self-Report of Personality, Adolescent (BASC-3 SRP-A). Under certain circumstances, we could certainly pare this down and not use all three, and each has advantages and disadvantages. However, with the luxury of time and resources, we will err on the side of collecting more data from her.

Although it is likely that Audrey's self-report will clarify her anxiety and depressive diagnoses quite well to strengthen our confidence in conclusions drawn, we want to make sure we include both additional informants and additional methods. The Behavior Assessment System for Children, 3rd Edition (BASC-3) provides information across multiple domains of functioning (including signs of depression, anxiety, and attention and school problems) from not just the self but also parent and teacher perspectives. The BASC-3 should help us confirm the exact nature of Audrey's symptoms, across contexts (school and home), from the triangulated perspectives of others in her life. To build in evidence from alternative test methods, we will include the Rorschach Performance Assessment System (R-PAS) and the Roberts-2 (the second edition of the Roberts Apperception Test for Children).

The R-PAS may or may not provide useful information in this case, as it does have some variables with evidence to support their representation of anxiety and helplessness, among some other somewhat emotional constructs (Mihura, Meyer, Dumitrascu, & Bombel, 2013). The actual psychometric properties of the Roberts-2 are generally quite debated (e.g., Bell & Nagle, 1999; Dupree & Prevatt, 2003; Malberg, Rosenberg, & Malone, 2017; Roberts & Gruber, 2005; Smith, 2007), and we will certainly not make any clinical or diagnostic decisions based on information that emerges from the measure. However, the information that can be elicited from a storytelling task like the Roberts-2 may add some nuance to our understanding of some symptoms. For example, if an adolescent is depressed, many measures will tell that story quite clearly—they will reveal clusters of symptoms aligned with other adolescents who are depressed. However, they may not give specific nuance into the individual adolescent's particular experience of depression. For example, their depression could be characterized by one or any combination of factors like hopelessness, low self-esteem and worthlessness, helplessness, loneliness, sadness, or many other types of experience. A storytelling technique like the Roberts-2 may (or certainly may not) provide a bit of nuance to better understand a child or adolescent's experience. We will, of course, use the data that emerge from the Roberts-2 extremely cautiously and conservatively.

Thus, our assessment's battery of tests will consist of

- Bender-2
- WAIS-IV
- CPT-3

- D-KEFS Trails
- WCST-IV
- WIAT-III
- NDRT
- BASC-3 (self, parent, and teacher reports)
- MMPI-A-RF
- PAI-A
- R-PAS
- Roberts-2

Accumulating the Data

Table 10.1 shows the results from each individual cognitive and academic measure administered. Much of the data is exactly what would be expected of a highly intelligent adolescent struggling with some depression. On the WAIS-IV, Audrey showed great strengths compared with others her age across all areas of functioning (Full Scale IQ [FSIQ] of 98, 87th percentile), except for processing speed (the WAIS-IV Processing Speed Index was an 83, 13th percentile; the Number–Letter Sequencing on the D-KEFS Trails was a 7, 16th percentile). Her WAIS-IV Verbal Comprehension Index, one of our strongest predictors of academic performance, was a 130 and fell within the 98th percentile. Her measures of attention and executive functioning were generally unimpaired. Notably, though, her measures of fluency (speed of reading and doing basic mathematics) were extremely low, much lower than would be expected of a young woman performing so well at a rigorous private school. Her pencil-and-paper math fluency was below average (WIAT-III Math Fluency was a 74, in the 4th percentile), as was her reading on a pencil-and-paper test (Reading Rate on the NDRT was an 85, 14th percentile).

TABLE 10.1 **AUDREY'S COGNITIVE DATA**

Test	Index or scale	Classification
WAIS-IV	Full Scale IQ	High average
	Verbal Comprehension Index	Very superior
	Perceptual Reasoning Index	Average
	Working Memory Index	Very superior
	Processing Speed Index	Low average
	Cancellation Subtest	Average
Bender-2	Copy	High average
	Recall	Average
	Motor	Unimpaired
	Perception	Unimpaired
CPT-3	Detectability	Good performance
	Omissions	Good performance
	Commissions	Average
	Hit Reaction Time Standard Deviation	Average
	Variability	Good performance
	Hit Reaction Time Block Change	Average
	Omissions by Block Change	No significant increase
	Commissions by Block Change	No significant increase

(Continued)

TABLE 10.1 (*CONTINUED*)

Test	Index or scale	Classification
D-KEFS Trails	Visual Scanning	High average
	Number Sequencing	Average
	Letter Sequencing	Low average
	Number–Letter Switching	High average
	Motor Speed	High average
WCST-IV	Total Errors	Average
	Perseverative Errors	Average
	Nonperseverative Errors	Average
WIAT-III	Oral Language Composite	Average
	Listening Comprehension	Average
	Oral Expression	High average
	Reading Composite	Superior
	Written Expression Composite	Very superior
	Mathematics Composite	Superior
	Math Fluency Composite	Below average
NDRT	General Reading Ability	Very superior
	Vocabulary	Very superior
	Comprehension	Very superior
	Reading Rate	Low average

One way to build the argument for how she is likely to function on an exam and whether or not she is likely to benefit from extended time is to compare her actual academic abilities with her speed and fluency of accomplishing those abilities. Table 10.2 shows reorganized data to compare ability and speed (not just with academic information but also with general cognitive information just to see if the pattern is consistent). It becomes clear from looking at the data in this table that there is a pretty stark contrast between her abilities and her speed.

Table 10.3 shows the data that emerged from Audrey's personality, emotional, and behavioral measures. As always, the order of measures and methods presented is not extremely important, but those measures that have

TABLE 10.2 **AUDREY'S ORGANIZED SKILLS AND FLUENCY-RELATED DATA**

Test: / **Theme:**	**WAIS-IV**	**D-KEFS Trails**	**WIAT-III**	**NDRT**
Verbal and academic ability	Very superior Verbal Comprehension Index	High average processing accuracy (Visual Scanning, Switching)	Extremely strong academic abilities (Reading, Writing, and Math)	Extremely strong reading ability (including vocabulary and comprehension)
Fluency	Low average Processing Speed Index	Low average to average processing speed (Number–Letter Sequencing)	Below average math fluency	Low average reading rate

stronger empirical evidence are listed first (the broad-based self-report measures), followed by the performance-based measures (R-PAS and Roberts-2), and finally the information that emerged from the clinical interview. As always, not every piece of information that emerged from the clinical interview can be included in the data table, but a small number of nuggets that seemed especially salient or important have been included, remembering that self-report in a clinical and collateral interview setting is another method used in an integrative, multimethod assessment.

TABLE 10.3 **ACCUMULATION OF AUDREY'S DATA**

MMPI-A-RF
Demoralization—negative self-view and negative emotions
Low positive emotions
High dysfunctional negative emotions
Some somatic symptoms—malaise and gastrointestinal problems
Self-doubt and inefficacy
Ruminates and worries
PAI-A
Anxiety, especially cognitive and physiological
Depression, especially cognitive and affective
Emotional instability
Negative interpersonal relationships
BASC-3 Self-Report of Personality
Anxiety
Depression
Social stress
Low self-esteem
Poor interpersonal relationships
Poor coping
Test anxiety
BASC-3 Parent Rating Scales
Anxiety
Depression
Withdrawal from others
Poor coping
Poor emotional self-control
Tendency to react negatively quite easily
BASC-3 Teacher Rating Scales
Anxiety
Depression
Withdrawal from others
Poor coping
Tendency to react negatively quite easily

(Continued)

TABLE 10.3 (*CONTINUED*)

R-PAS

Helplessness
Somewhat distorted understanding of others
Inadequate coping skills

Roberts-2

General emotional distress
Poor strategies for coping with difficult situations
Difficulty understanding others' motivations
Feeling misunderstood by others
Stress about socializing

Clinical interview and behavioral observation data

Anxiety—intrusive thoughts, fidgetiness, stomachaches
Panic attacks—shortness of breath, pounding heart, sweating, trembling, dizziness, choking, and fear of losing control and "going nuts"
Nervous about SAT and ACT (in a school that does not give tests, so no experience with high-stakes testing)
Depressive episodes—low self-esteem, loss of interest in nearly all activities for most of the day every day, sleep problems, fatigue, psychomotor slowing, poor attention
Passive suicidal ideation
"Analysis paralysis"—overthinks situations to the point that she cannot make decisions or solve problems
Father was "impatient" with any difficulties academically or related to anxiety
Smokes marijuana multiple times a week—to deal with her anxiety
Gets nervous meeting new people
Does not feel her best friend "gets" her
Gets "so in my head" around others—easier to withdraw and isolate
Unclear sexual identity
Pressure—"expectations put on me" because of Chinese culture

Identifying Themes

We will begin identifying themes with Audrey's data using the seven traditional psychological themes: self, others, thinking, feeling, behavior, coping, and context. As always, any piece of data that logically could fit into more than one theme will be labeled as such, and we will figure out later where it best belongs. The preliminary themes for Audrey's data are presented in Table 10.4.

Organizing the Data

Audrey's reorganized data are presented in Table 10.5. When the data are reorganized and examined within themes, some of them become clearer and more specific, whereas others need to be reorganized. For example, the coping and others themes are pretty clear—they describe a girl with difficulties coping effectively with life and who tends to isolate and withdraw from others (both things that are not surprising, given the clinical interview). Some of the other themes clearly need some reorganizing, though. And there are multiple pieces of data that were placed in multiple themes, so these will need to be explored as well (though hopefully some may reconcile themselves when some of the themes are reorganized).

TABLE 10.4 **IDENTIFYING AUDREY'S THEMES**

Themes	
	MMPI-A-RF
Feeling	Demoralization—negative self-view and negative emotions
Feeling	Low positive emotions
Feeling	High dysfunctional negative emotions
Feeling	Some somatic symptoms—malaise and gastrointestinal problems
Self	Self-doubt and inefficacy
Thinking	Ruminates and worries
	PAI-A
Thinking and Feeling	Anxiety—especially cognitive and physiological
Thinking and Feeling	Depression—especially cognitive and affective
Feeling	Emotional instability
Others	Negative interpersonal relationships
	BASC-3 SRP
Feeling	Anxiety
Feeling	Depression
Others	Social stress
Self	Low self-esteem
Others	Poor interpersonal relationships
Coping	Poor coping
Feeling	Test anxiety
	BASC-3 PRS
Feeling	Anxiety
Feeling	Depression
Others	Withdrawal from others
Coping	Poor coping
Feeling	Poor emotional self-control
Feeling and Coping	Tendency to react negatively quite easily
	BASC-3 TRS
Feeling	Anxiety
Feeling	Depression
Others	Withdrawal from others
Coping	Poor coping
Feeling and Coping	Tendency to react negatively quite easily
	R-PAS
Feeling	Helplessness
Others	Somewhat distorted understanding of others
Coping	Inadequate coping skills

(Continued)

TABLE 10.4 (*CONTINUED*)

Themes	
	Roberts-2
Feeling	General emotional distress
Coping	Poor strategies for coping with difficult situations
Others	Difficulty understanding others' motivations
Others and Context	Feeling misunderstood by others
Others	Stress about socializing
	Clinical interview and behavioral observations data
Thinking and Feeling	Anxiety—intrusive thoughts, fidgetiness, stomachaches
Feeling	Panic attacks—shortness of breath, pounding heart, sweating, trembling, dizziness, choking, and fear of losing control and "going nuts"
Thinking	Nervous about SAT and ACT (in a school that does not give tests, so no experience with high-stakes testing)
Feeling	Depressive episodes—low self-esteem, loss of interest in nearly all activities for most of the day every day, sleep problems, fatigue, psychomotor slowing, poor attention
Thinking	Passive suicidal ideation
Thinking	"Analysis paralysis"—overthinks situations to the point that she cannot make decisions or solve problems
Context	Father was "impatient" with any difficulties academically or related to anxiety
Behavior and Coping	Smokes marijuana multiple times a week—to deal with her anxiety
Others	Gets nervous meeting new people
Others	Does not feel her best friend "gets" her
Others	Gets "so in my head" around others—easier to withdraw and isolate
Self	Unclear sexual identity
Context	Pressure—"expectations put on me" because of Chinese culture

Finalizing Themes

Audrey's data need some clarifying and rearranging from their current form, for multiple reasons. First, there are clearly separate anxiety and depression themes (mechanisms) at play with her. Second, there are a lot of nuggets that are spread across multiple themes. It is best, though, to start with the easiest tasks—to scan themes across tests, determine which ones "hang together" quite well and tell a clear story about Audrey, and rename those themes accordingly (to make the theme names more qualitatively descriptive). In Audrey's case, looking across measures, there are two themes that emerge as relatively cohesive in their current state. The first is the coping theme. Across informants and across methods, the data paint a clear picture of a young woman who does not have adequate skills to cope with her life. At the same time, we know we need to get rid of the behavior theme, as it only has a single piece of data in it (which happens to be in multiple themes). The fact that Audrey smokes marijuana to cope aligns quite well with the theme of poor coping abilities, so we can maintain it in coping and get rid of the behavior theme entirely. naming this theme, we have multiple options. to keep it simple and understandable, the theme will be called problems coping.

The second theme that seems to be telling a coherent story about Audrey in its current form is the others theme. This theme includes several stages in the process of her interpersonal difficulties: difficulty understanding others, feeling misunderstood, social stress and nervousness, and ultimately both withdrawal and negative or poor

TABLE 10.5 **AUDREY'S ORGANIZED DATA**

Test: Theme:	MMPI-A-RF	PAI-A	BASC-3 SRP	BASC-3 PRS	BASC-3 TRS	R-PAS	Roberts-2	Interview and Behavioral Observations
Feeling	Demoralization—negative self-view and negative emotions	Anxiety—especially cognitive and physiological	Anxiety	Anxiety	Anxiety	Helplessness	General emotional distress	Anxiety—intrusive thoughts, fidgetiness, stomachaches
	Low positive emotions	Depression-especially cognitive and affective	Depression	Depression	Depression			Panic attacks—shortness of breath, pounding heart, sweating, trembling, dizziness, choking, and fear of losing control and "going nuts"
	High dysfunctional negative emotions	Emotional instability	Test anxiety	Poor emotional self-control	Tendency to react negatively quite easily			Depressive episodes—low self-esteem, loss of interest in nearly all activities for most of the day every day, sleep problems, fatigue, psychomotor slowing, poor attention
	Some somatic symptoms—malaise and gastrointestinal problems			Tendency to react negatively quite easily				
Self	Self-doubt and inefficacy		Low self-esteem					Unclear sexual identity
Thinking	Ruminates and worries	Anxiety-especially cognitive and physiological						Anxiety—intrusive thoughts, fidgetiness, stomachaches
		Depression—especially cognitive and affective						Nervous about SAT and ACT (in a school that does not give tests, so no experience with high-stakes testing)
								Passive suicidal ideation

(Continued)

TABLE 10.5 (*CONTINUED*)

Test: Theme:	MMPI-A-RF	PAI-A	BASC-3 SRP	BASC-3 PRS	BASC-3 TRS	R-PAS	Roberts-2	Interview and Behavioral Observations
								"Analysis paralysis"—overthinks situations to the point that she cannot make decisions or solve problems
Others		Negative interpersonal relationships	Social stress	Withdrawal from others	Withdrawal from others	Somewhat distorted understanding of others	Difficulty understanding others' motivations	Gets nervous meeting new people
			Poor interpersonal relationships				Feeling misunderstood by others	Does not feel her best friend "gets" her
							Stress about socializing	Gets "so in my head" around others—easier to withdraw and isolate
Coping			Poor coping	Poor coping	Poor coping	Inadequate coping skills	Poor strategies for coping with difficult situations	Smokes marijuana multiple times a week—to deal with her anxiety
				Tendency to react negatively quite easily	Tendency to react negatively quite easily			
Context							Feeling misunderstood by others	Does not feel her best friend "gets" her
								Father was "impatient" with any difficulties academically or related to anxiety
								Pressure—"expectations put on me" because of Chinese culture
Behavior								Smokes marijuana multiple times a week—to deal with her anxiety

relationships. These could be separated into multiple themes, or they can hang together as a single theme related to her difficulties interacting with others. As always, there are two things to consider when making this decision. First, there is no right or wrong answer—whatever is explainable and defensible in the report and feedback, as long as it will make sense to the audience, is acceptable. Second, each theme must have data that converge across methods, reporters, and measures. That is, if we split it up into multiple themes, we need to be very confident that there are enough data in each of the new themes that they can hold together as strong, clear themes. In Audrey's case, we could separate the theme into social stress (which would include not just the anxiety but also the reasons for it—her poor understanding of others and feeling misunderstood by them) as the process and withdrawal or negative relationships as the outcome. However, in this case (somewhat arbitrarily), we will keep all these data together in a single theme and call it social difficulties. This will allow us to explain the mechanisms and outcomes in the narrative but to focus on the fact that, overall, she has some significant social problems.

The next step, now that we have solidified two themes and deleted one, is to scan and determine if there are other themes that do not have enough data, across informants and methods, to sustain themselves. One theme that stands out as having very little solid data is the context theme. It is important to note that many of our standard measures often do not include much information about context (too many, for example, do not include specific cultural variables to help explain difficulties). So there are times when a context theme can have very little data, but it can be important enough information to include as a theme anyway. For example, if a child's parents are actively getting divorced, it may seem to be affecting them significantly, but that effect does not emerge on test measures (because most are not equipped to elicit such information). Even though the data are only from the interview, it may be important to include that stressor as its own theme. In this case, we need to decide if the contextual information (all from the interview and the psychometrically weak Roberts-2) is important enough to retain as a theme or if these data can be redistributed. For Audrey, the contextual information has to do with feeling misunderstood by others (these data fit nicely in the new social difficulties theme) and pressure she has experienced (from her father and from cultural expectations). While this pressure contextualizes a great deal for Audrey, it seems very much tied to her anxiety. Since we know we will likely ultimately end up with an anxiety theme, it probably makes the most sense to redistribute these data into the soon-to-be-anxiety theme and delete the context theme entirely.

The other theme that has some cross-measure data (but not actually cross method or cross-informant) is the self theme. The self theme is also interesting, as it makes sense that most data about how one feels about themselves should actually come from self-report. That is, we would not actually expect robust data about self-esteem to come from a teacher (though a teacher can certainly note overt behaviors that signify problems with self-esteem). That being said, we again have a decision to make. We can retain this theme as a low self-esteem theme (and tie her unclear sexual identity into this, though that is making a big assumption about the effect of her sexual identity development on her self-esteem), or we can redistribute these data into what we know will end up being some sort of depression theme. As always, there are pros and cons to either decision, and neither one is right or wrong. In this case, because there are only really two self-esteem nuggets (and both from self-report inventories), we will redistribute them into the soon-to-be-depression theme and get rid of the self theme altogether.

The next step is to look at the feeling and thinking themes, knowing full well that we are going to reorganize them into anxiety and depression themes. When we do so, many of the data are absolutely clear about where they fit. For example, the MMPI-A-RF high dysfunctional negative emotions nugget relates to problematic anxiety and irritability, so it will end up in the anxiety theme. The MMPI-A-RF low positive emotions will end up in depression, as will the demoralization. Many of the measures simply revealed significant amounts of anxiety and depression, so distributing these data is easy. We have already decided to redistribute the pressures (from context) into the anxiety theme and the low self-esteem (from self) into the depression theme. Reorganizing like this takes care of a lot of the data nuggets that were assigned to multiple themes. What are left are some of the more physiological and somatic symptoms. In this case, there are data related to malaise and data related to gastrointestinal

distress. The malaise data align well with the depression theme, and the gastrointestinal data align well with the anxiety theme. We now have several robust themes that relate directly to Audrey's experience.

Finally, we need to consider any "leftover" data from our reorganization process. In this case, a few nuggets do not seem to fit easily and cleanly into our new themes. First, there are data related to poor emotional self-control and a tendency to react negatively quite easily (all from the BASC-3 parent and teacher reports). These data could certainly be related to her depressive symptoms, as irritability and reactivity are highly linked phenotypically with depression in adolescence (e.g., Stringaris, Zavos, Leibenluft, Maughan, & Eley, 2012). However, in this case, although linked with depression, these data seem to be more clearly describing her difficulties coping effectively with situations and her own emotional experience. As such, we will redistribute these data nuggets into the poor coping theme. What is left is the single piece of data about Audrey not being entirely clear on her own sexual identity, which emerged from the clinical interview. Remember that, when she discussed it, she was quite open (even in front of her mother) about it, and she explicitly stated that her sexual identity development was not specifically salient (and certainly not anxiety provoking) for her at the moment. Knowing that it will be in the report in the background information section, we have to decide whether to shoehorn it into one of our themes or to leave it out of our interpretation section. In this case, given the fact that it does not seem core, central, or particularly problematic for Audrey, we will actually just delete this piece of data from our conceptualization. Again, it will be noted in the report, in the background information, so we are not ignoring it entirely—this is important to remember. Table 10.6 presents Audrey's reorganized (and straightforward-ized) data.

Conceptualizing

Remembering that the task at this point is to try to create a logical narrative among the themes, applying psychological theory, so that it presents a coherent story, we have to connect the following themes:

- anxiety
- depression
- social difficulties
- problems coping

Before deciding on the most logical way to fit all these themes together, we will first consider some of the model templates presented in Chapter 4. There are multiple reasons we will be considering only a few models: the diathesis–stress model and a developmental mismatch model. First, the interpersonal circumplex model is much more useful in adult assessments, when personality is more "formed." Second, there are so few themes (just four) that there are not that many different, logical ways to put them together.

Diathesis–Stress Model

In applying the diathesis–stress model of conceptualization, we must try to divide the themes into (1) traits inherent within Audrey that she likely developed at a younger age and that she "brings to the picture" (diatheses), (2) external issues that affect her functioning (stressors), and (3) states that are more situational or transient (outcomes). It is important to categorize each of our themes into these three types. As always, the more convincing these categorizations are, the more likely Audrey and her mother are to accept the recommendations given.

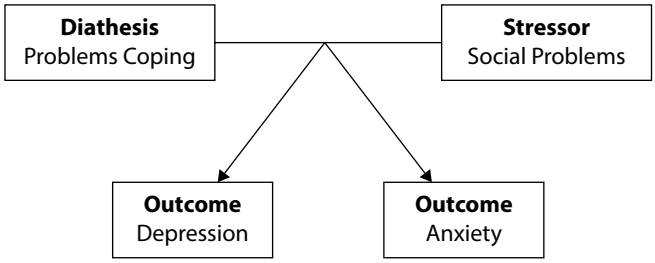
For Audrey, there are so few themes, it is relatively easy to organize them within this framework. If we consider both anxiety and depression more symptom-like states (as opposed to traits), then they are outcomes. Problems coping can be considered more core to an individual, as she should have developed skills to cope with life (and her emotions) at a much earlier age. That leaves us with her social problems. Although we combined both process

TABLE 10.6 **AUDREY'S REORGANIZED DATA**

Test: Theme:	MMPI-A-RF	PAI-A	BASC-3 SRP	BASC-3 PRS	BASC-3 TRS	R-PAS	Roberts-2	Interview and Behavioral Observations
Anxiety	High dysfunctional negative emotions	Anxiety—especially cognitive and physiological	Anxiety	Anxiety	Anxiety			Anxiety—intrusive thoughts, fidgetiness, stomachaches
	Some somatic symptoms—(malaise and) gastrointestinal problems		Test anxiety					Panic attacks—shortness of breath, pounding heart, sweating, trembling, dizziness, choking, and fear of losing control and "going nuts"
	Ruminates and worries							Nervous about SAT and ACT (in a school that does not give tests, so no experience with high-stakes testing)
								"Analysis paralysis"—overthinks situations to the point that she cannot make decisions or solve problems
								Father was "impatient" with any difficulties academically or related to anxiety
								Pressure—"expectations put on me" because of Chinese culture
Depression	Demoralization—negative self-view and negative emotions	Depression-especially cognitive and affective	Depression	Depression	Depression	Helplessness	General emotional distress	Depressive episodes—low self-esteem, loss of interest in nearly all activities for most of the day every day, sleep problems, fatigue, psychomotor slowing, poor attention

Test: Theme:	MMPI-A-RF	PAI-A	BASC-3 SRP	BASC-3 PRS	BASC-3 TRS	R-PAS	Roberts-2	Interview and Behavioral Observations
	Low positive emotions		Low self-esteem					Passive suicidal ideation
	Some somatic symptoms—malaise (and gastrointestinal problems)							
	Self-doubt and inefficacy							
Social Difficulties		Negative interpersonal relationships	Social stress	Withdrawal from others	Withdrawal from others	Somewhat distorted understanding of others	Difficulty understanding others' motivations	Gets nervous meeting new people
			Poor interpersonal relationships				Feeling misunderstood by others	Does not feel her best friend "gets" her
							Stress about socializing	Gets "so in my head" around others—easier to withdraw and isolate
Problems coping		Emotional instability	Poor coping	Poor coping	Poor coping	Inadequate coping skills	Poor strategies for coping with difficult situations	Smokes marijuana multiple times a week—to deal with her anxiety
				Poor emotional self-control	Tendency to react negatively quite easily			
				Tendency to react negatively quite easily				

FIGURE 10.1 **DIATHESIS–STRESS MODEL FOR AUDREY**



issues and outcomes into the social problems theme, we can consider her social difficulties overall as a stressor, especially given that peer socialization and friendships are a primary context that can be extremely protective or risky for youth mental health problems (e.g., Erdley & Day, 2017; van Harmelen et al., 2017).

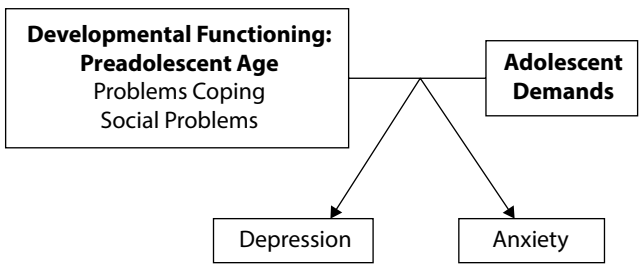
The resulting diathesis–stress model for Audrey is shown in Figure 10.1. When considering the viability of this model, we have to decide whether the model makes intuitive sense with the three categorized parts. That is, would the diathesis posed, combined with the external stressor, likely cause the outcomes? *A girl who has insufficient skills to cope with her life and faced with significant social difficulties will likely develop anxiety and depressive symptoms*. This model seems not only arguable but also actually relatively intuitive. The fact that this model is so straightforward and yet so comprehensive serves as a strength, as Audrey and her mother would likely understand it relatively easily. However, it may be too straightforward. Especially given what we know about our social problems theme, which has combined process and outcome, this conceptualization may actually just be too reductive.

Developmental Mismatch Model

The developmental model for Audrey may be useful to consider, as adolescence comes with very specific and extremely stressful demands. At this point in her development, she should have developed adequate coping skills and social skills to navigate her social and emotional worlds. However, these two areas are somewhat underdeveloped for her. Thus, what characterizes Audrey's current developmental functioning are more preadolescent levels of coping skills and socialization. Her developmental level of demands, obviously, are adolescent in nature, though we do not have any specific themes that illustrate this (her gender identity development certainly suggests this, as does the reality of her navigating adolescence and 11th grade). The anxiety and depression themes, similar to the diathesis–stress model, would be considered outcomes.

Audrey's developmental model is shown in Figure 10.2. While this model still makes a great deal of intuitive sense, there is a major benefit to conceptualizing Audrey's functioning in this way. Instead of explaining her skills

FIGURE 10.2 **DEVELOPMENTAL MISMATCH MODEL FOR AUDREY**



deficits as problematic and static (i.e., as a diathesis), this way of conceptualizing implies the capacity for her to develop these skills (which, while they are lagging behind developmentally, are skills that everyone gains at some point). This may provide a slightly more hopeful lens to her and her mother. However, this conceptualization (similar to the diathesis–stress model) may still be too linear and reductive, as certainly her depression and anxiety also contribute back toward her social difficulties.

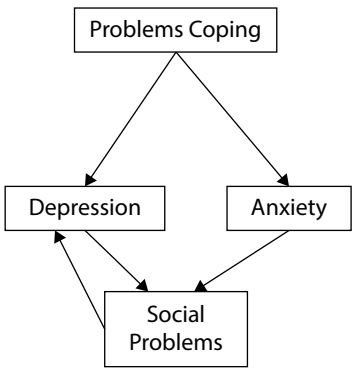
Complex Model

The diathesis–stress model and the developmental model seem to fit Audrey well; however, both are maybe too simplistic. One of the benefits of having so few themes is that we can tell a slightly more complex and nuanced story without overwhelming the client or our audience. Thinking about these four themes in a slightly more complex way may lead to a more logical way to link several of them, as well as to explain some reciprocal, reinforcing relationships between some of them. We can retain some of the logic of the previously considered models and use it for the complex model. Specifically, for Audrey, her difficulties coping with the world, situations, and her own emotions can certainly be considered an underlying trait that contributes significantly to the development of problems in her life. Specifically, her difficulties coping with the world have contributed to her developing depressive and anxious symptoms. The interaction between her problems coping and the world and context she lives in is implied in this model. That is, in a diathesis–stress framework, her problems coping (diathesis) interact with her everyday life (stressor), including socializing, pressure to perform academically, upcoming high-stakes tests, and college admission (all the major stressors she identified during the clinical interview). The stressor in this model is implied, though, rather than made explicit (though it could be).

Given what is known about the reciprocal relationship between social problems (especially withdrawal and avoidance) and depression in adolescence (e.g., Danneel, et al., 2019; Platt, Kadosh, & Lau, 2013), we can educate Audrey and her mother about this relationship. That is, depression (and in Audrey's case certainly her anxiety, as well) contributes to avoidance and withdrawal from others, but social difficulties (including low perceived support from others, conflict, rejection, and loneliness) also reinforces depressive thoughts and feelings. While we cannot necessarily tease apart the chicken-and-egg dynamic of depression, anxiety, and social problems in Audrey's case, the most important thing for Audrey to know is the reinforcing cycle of these difficulties. The resulting complex model for Audrey is shown in Figure 10.3.

This model explains Audrey's difficulties well. *Her insufficient skills in coping with her world, life, and emotions have contributed to her developing symptoms of anxiety and depression. Her emotional distress (anxiety and depression) have contributed to social difficulties, which reinforce her depressive thoughts and feelings.* Although this model is not necessarily

FIGURE 10.3 **COMPLEX MODEL FOR AUDREY**



more "valid" than any of the others, it is certainly still easy to explain but adds a bit more nuance and education, based on what we know from the psychology literature about mechanisms in adolescent internalizing disorders.

Report Writing

Before the report can be written, the final step of determining diagnosis and recommendations must be addressed. The first and probably easiest diagnostic question to answer is about Audrey's academic functioning. We need to keep two things in mind when thinking about her academic functioning. First, she came in with a specific question about how she is likely to perform on high-stakes exams that are coming up (both based on her cognitive–academic profile and based on anxiety). Second, she performs extremely well in a very rigorous academic environment, but one in which she has not had to take tests or exams. When looking at her data, it is clear that she is extremely smart and extremely skilled academically. However, her data tell a story of someone who has all the knowledge and ability but may not do as well on timed or "speeded" exams. The speeded nature of exams like the SAT and ACT may actually be rather problematic in understanding a student's actual abilities and ultimate likelihood of academic success (e.g., Perez, 2002), so Audrey will likely be at a disadvantage on these tests. Between that fact and the significant discrepancy between her abilities and her fluency–speed scores on tests, we can justify diagnosing her with specific learning disorders in math and reading. While these will justify asking for more time on the SAT or ACT, we will also need to explain very clearly in feedback what these disorders do and do not mean, as they may sound surprising given her excellent academic performance in school.

The more complicated decisions focus on the differential diagnoses of her anxiety and depression profiles. Beginning with the depressive symptoms, despite the fact that her therapist reportedly discussed dysthymia with her, her symptomatic profile is much more consistent with major depressive disorder (MDD). Specifically, the episodic nature of her symptoms, as well as their severity (including suicidal ideation), is more aligned with MDD than dysthymia. Further, her reported symptom profile meets clear criteria, so that decision is relatively easy.

Audrey's anxiety profile is a bit more complicated. There are certainly a number of different anxious and panic symptoms. She could meet criteria for generalized anxiety disorder (GAD), but this also may not capture exactly what is going on with her. Specifically, she does have some anxiety about her academic performance, but it seems to drive her to excel academically rather than impairing her functioning in any way. Her actual anxieties, ones that cause difficulty in her life, are more centered on socialization and on the tests she is about to take. Separately, she certainly suffers from panic attacks.

The panic attacks seem clearly to meet criteria for panic disorder. That is, not only do her episodic symptoms meet the actual criteria for panic attacks, but the additional criteria for panic disorder—concern or worry about the panic attacks and their consequences, primarily, and changing behavior to avoid them, secondarily in Audrey's case—are also certainly present for her. The "leftover" anxiety symptoms are really about socialization and the tests she is about to take, though it is unclear just how much this anxiety is affecting her; it is impossible to know how much test anxiety affects her because she has not taken any tests. In this case, it seems to make sense to add the diagnosis of other specified anxiety disorder, with social and test-related anxiety. The latter (test related) will further justify the requests for additional time accommodations on the SAT or ACT, and the former (social) illustrates an area of real clinical need for her.

With regard to recommendations that emerge from these diagnoses, as well as the conceptualization and her characteristics in general, we will recommend several educational accommodations and several interventions for Audrey. Specifically, we have built a strong case that (due to both her learning disorders and her test-related anxiety) Audrey requires additional time on exams to demonstrate her actual knowledge and abilities. Although she is in a school that does not give tests, it is important to be explicit about her needing extra time on tests, even in school, just in case at some point she needs this. If she has to take a test at school at some point,

she could potentially transfer (though it is unlikely), and, perhaps most importantly, she will very likely end up at a university that does use tests and exams as one method of academic evaluation. She will benefit from extra time in all of these circumstances, so it is important to be explicit about that. She also requires extra time on the ACT or SAT (whichever she decides to take). We will recommend time-and-a-half; this is simply because her fluency, while much lower than her actual academic ability, is not so egregiously low that it would qualify her for double time. If she or her mother felt strongly about requesting double time, we could alter this and make the request, even though it is unlikely to be granted. An additional testing accommodation that we will recommend is that she be able to take exams in a room separate from her peers to mitigate her test-related anxiety. It is highly likely that observing peers speeding through the exam while she struggles (especially with speed) will increase her anxiety. As such, a separate room gives her a better shot of demonstrating her actual abilities.

For her depressive, anxious, and panic disorders, the evidence base behind effective treatment aligns relatively well. Both for adolescents and adults, the treatment that overlaps for each of these disorders with strong research evidence is cognitive behavioral therapy (CBT), combined with psychopharmacological treatment. Because this is a diagnosis-driven intervention recommendation, we need to make sure there are no conceptualization-based or client characteristic-based reasons that CBT would be contraindicated. For example, we need to determine if Audrey is likely ready to change her symptoms, understands that she needs help, and is likely to accept suggestions. Because the answer to each of these is generally yes, CBT continues to be the treatment of choice and will likely be successful. It should be noted that the assessor was unsure of what kind of treatment Audrey was actually engaging in with her current therapist, so it was unclear how amenable to this recommendation her therapist would be. Regardless, the assessor felt it was the most ethical recommendation to explicitly suggest CBT. As always, even though there is evidence that a combination of therapeutic intervention and medication tends to benefit clients the most, the assessor as a psychologist does not recommend medication. Instead, we include a recommendation that Audrey and her mother consult with a psychiatrist to determine the potential benefits of psychiatric medication.

Confidential Psychological Assessment Report

Identifying Information

Name:	Audrey Cheng	**Date of report:**	2/28/20
Sex:	Female	**Assessor:**	A. Jordan Wright, PhD
Age:	16		
Date of birth:	1/1/04	**Dates of**	1/21/20; 1/25/20;
Ethnicity:	Asian American	**assessment:**	2/11/20; 2/13/20

Referral Source and Questions

The client's school reportedly recommended that the client see a psychiatrist to consider medication for daily panic attacks she is experiencing at school. Her mother decided to bring her in for a comprehensive assessment instead to understand what is underlying her difficulties and to make recommendations for the best way to support the client (including whether psychiatric medication should be considered).

Measures Administered

- Clinical interview
- Collateral Interview with Mother
- Bender Visual-Motor Gestalt Test, 2nd Edition (Bender-2)
- Wechsler Adult Intelligence Scale, 4th Edition (WAIS-IV)
- Conners' Continuous Performance Test, Third Edition (CPT-3)
- Delis-Kaplan Executive Function System, Trail Making Test (D-KEFS Trails)
- Wisconsin Card Sorting Test, Computer Version Fourth Edition (WCST-IV)
- Wechsler Individual Achievement Test, 3rd Edition (WIAT-III)
- Nelson-Denny Reading Test (NDRT)
- Minnesota Multiphasic Personality Inventory-Adolescent-Restructured Form (MMPI-A-RF)
- Personality Assessment Inventory-Adolescent (PAI-A)
- Behavior Assessment System for Children, 3rd Edition (BASC-3)
  - Self-Report of Personality-Adolescent (SRP)
  - Parent Rating Scales-Adolescent (PRS)
  - Teacher Rating Scales-Adolescent (TRS)
- Rorschach Performance Assessment System (R-PAS)
- Roberts Apperception Test for Children and Adolescents, 2nd Edition (Roberts-2)

Client Description

Audrey Cheng is a 16-year-old, Chinese American girl who is currently in 11th grade at a private school in New York City. She was cooperative and friendly throughout the assessment, making appropriate eye contact and engaging well with the assessor. She engaged with tasks appropriately and seemed to make effortful attempts on all tests administered.

Presenting Problem and Its History

The client and her mother reported that the client struggles with a significant amount of anxiety. Specifically, she struggles with general symptoms of anxiety, including thoughts she cannot control, fidgetiness in her hands, and ultimately stomachaches. She reported that her anxiety comes in multiple contexts, including most notably about school and tests and also related to socializing with peers. She described one aspect of her anxiety being related to "analysis paralysis," which she described as overthinking and overanalyzing situations to the point of not being able to make a decision or solve a problem. She reported that she is currently experiencing a great deal of anxiety related to taking either the SAT or ACT, especially as her current school does not give tests, so she does not know how well she will be able to handle the experience.

In addition to these general symptoms of anxiety, the client and her mother also described the client experiencing significant panic attacks. Specifically, she experiences sudden onsets of shortness of breath, pounding heart, sweating, trembling, dizziness, choking for air, and fear of losing control of herself and "going nuts." These occur more than once a week. The client described a few recent panic attacks, each with difficulty being able to calm down and breathe normally. During one, she tried to calm herself by digging her nails into her arm, to the point that she was bleeding, and ultimately her mother held her tightly and rocked her for 20 minutes until she was calm. During another, she reported that it took her an hour in the school counselor's office to be able to breathe normally, after being asked by a teacher to answer a question that she knew the correct answer to.

In addition to her anxiety and panic symptoms, the client discussed struggling with a history of depressive symptoms. Specifically, she and her mother reported periods of several weeks during which she does not want to get out of bed, is not interested in doing anything (including painting, which she loves), and struggles with sleep,

fatigue, slowness, low self-esteem, and attention. She reported that she has thought about what it would be like if she were dead, but she denied ever having actual intent to harm or kill herself.

The client and her mother reported that her anxiety, panic, and depressive symptoms all began in middle school, about 4 years ago. They reported that her anxiety has been relatively constant throughout, that her panic attacks have become more frequent and severe, and that her periods of depression are occasional, about twice a year.

Relevant Background Information

The client is an only child who currently lives full-time with her mother. Her parents divorced about a year ago, and she sees her father about twice a week. The client reported that she has a "great" relationship with her mother and an "awkward" relationship with her father, who was "impatient" and "hard" on her throughout her childhood, especially related to academics. She is in 11th grade at a private school in New York City; she reported having excellent grades and no history of academic difficulties. She reported that she has a somewhat limited friend group, partly because she gets nervous meeting new people and partly because she finds it "easier" to be alone because of the anxiety she experiences in social situations. She reported that she has a best friend; however, she does not feel fully understood by her, so she does not share much with her. The client reported that she may be bisexual, though she is unclear about her sexual identity at this point. She is not currently sexually active, and she reported no anxiety or stress about figuring her sexual identity out at this point. Similarly, she reported feeling comfortable being both Chinese and American culturally, valuing her work ethic but also struggling with "all the expectations put on me" because of their Chinese culture.

The client and her mother reported that the client has been in therapy for about the past 3 years, primarily in response to her depressive and anxious symptoms in middle school. They reported that her therapist has not formally diagnosed the client, except with anxiety and depression. The client's mother reported that the client's father has also struggled with depression, but she denied any other major medical or psychiatric illnesses in their family. The client has never seen a psychiatrist and has not been prescribed any psychiatric medication. However, she is currently taking melatonin to help her sleep.

The client's mother reported no difficulties with her pregnancy with the client or with her birth and delivery. She reported that the client met all developmental milestones (e.g., crawling, walking, talking, potty training) on time and appropriately, and the client has had no major medical illnesses, currently or in the past. The client reported drinking alcohol only occasionally, not liking the effect it has on her. However, she also reported using marijuana multiple times per week, primarily to reduce her anxiety and feel better. She denied use of any other substances.

Behavioral Observations

The client engaged fully in each task administered. She exhibited some fidgeting with her fingers during multiple tasks that did not require the use of her hands. Otherwise, her behaviors during the assessment were unremarkable.

Mental Status Evaluation

The client was appropriately dressed and groomed for her appointments, where she showed up on time, accompanied by her mother. She was cooperative and friendly with the assessor throughout, making appropriate eye contact throughout the evaluation and attempting to answer questions directly and clearly. She seemed to persist and give full effort on all activities. She exhibited some psychomotor abnormalities, including some agitation at moments (especially fidgeting with her hands during tasks that did not require use of her hands). Her speech included a full range of voice, and her language was specific and goal directed. Her mood was reportedly "low energy," and her affect was generally mood congruent and appropriate to the situation. Her thought process was clear and goal directed, and her thought content was currently free of delusions. She reported some anxious and

depressive ideation, including some hopelessness and pessimism. The client denied hallucinations and aggressive and homicidal ideation. She reported some passive suicidal ideation, but she denied intent to harm herself. Her attention and concentration were adequate throughout, and her memory functioning appeared intact. Her insight and judgment were adequate.

Overall Interpretation of Test Findings

Cognitive and Academic Functioning

General Cognitive Ability

The client was administered several measures to assess her current cognitive functioning. It should be noted that these measures evaluate her cognitive ability under ideal conditions and in the most ideal context; as such, they represent her cognitive ability rather than how she actually functions in her daily life.

The client's overall performance across her multiple domains of cognitive functioning was generally strong compared with others her age, with some variation. Her greatest strength is in her verbal abilities, including her ability to manipulate verbal information and communicate in complex and sophisticated ways. She exhibited some weakness in her nonverbal reasoning abilities (though they were average compared with others her age) and the speed with which she processes information and performs tasks, which is slow for her age.

Fine Motor Skill. The client's control over her fine motor functioning is intact. On a measure assessing her ability to control her fine motor functioning deliberately and carefully, the client exhibited unimpaired fine motor accuracy (Bender-2 Motor Subtest, 51st–100th percentile). Her speed of controlling her fine motor movement is also good for her age (D-KEFS Trails Motor Speed, 84th percentile).

Visual–Spatial Perception and Reasoning. On measures of visual perceptual ability, including nonverbal reasoning, visuospatial aptitude, and induction and planning skills on tasks involving nonverbal stimuli such as designs, pictures, and puzzles, the client performed within the average range compared to others her age (WAIS-IV Perceptual Reasoning Index, 50th percentile). She exhibited no difficulties in her visual perceptual abilities, from her basic visual perceptual skills (Bender-2 Perception Subtest, 26th–100th percentile) to her more complex visual reasoning on nonverbal puzzles, which was also generally average compared with others her age (WAIS-IV Visual Puzzles, 37th percentile; WAIS-IV Matrix Reasoning, 63rd percentile).

Visual–Motor Integration. The client's ability to integrate her visual understanding with her motor coordination is similarly average to high average. On a task requiring her to copy complex drawings as precisely as possible without time restraint, which requires perceptual ability and the coordination between that ability and fine motor control, she performed in the high average range compared to others her age (Bender-2 Copy, 81st percentile). On a task requiring her to use blocks to recreate complex designs presented to her within a time limit, the client performed in the average range compared with others her age (WAIS-IV Block Design, 50th percentile). It should be noted that this task requires both visual–motor integration abilities and speed, as it is timed, which (as will be noted below) is not a strength for her. Her integration of her visual–perceptual skills with her fine motor skills is average to high average.

Nonverbal Memory. The client's short-term visual memory, which was assessed only briefly using a visual memory task, was strong for her age. She exhibited high average ability to remember visual information presented to her immediate afterward (Bender-2 Recall, 63rd percentile). She exhibited no difficulty with learning or remembering nonverbal information.

Language. On measures of verbal ability, including verbal comprehension, ease of use of verbal skills, verbal knowledge, and the ability to express herself clearly and completely, the client's performance fell within the very superior range compared with others her age (WAIS-IV Verbal Comprehension Index, 98th percentile), representing one of her greatest cognitive strengths. Her ability to express herself clearly is extremely strong for her age

(WAIS-IV Vocabulary, 95th percentile), as is her general fund of verbal knowledge (WAIS-IV Information, 98th percentile). Her abstract understanding of language and use of words in complex and abstract ways is also extremely strong (WAIS-IV Similarities, 91st percentile). Her ability to understand and use language effectively is extremely strong for her age.

Processing Speed. The client's ability to focus attention and quickly scan, discriminate between, and respond to visual information within a time limit (knowing she was timed) was generally low average compared with others her age (WAIS-IV Processing Speed Index, 19th percentile; D-KEFS Trails Number–Letter Sequencing, 16th percentile). Even though this is low average compared with others, compared with her overall functioning her speed of processing information and performing tasks represents a significant weakness for her.

Executive Functioning. The client completed several tasks that evaluate executive functions, such as attention, working memory, impulse control, adapting to changing conditions, and monitoring herself in her strategies. Her performance on these tasks was unimpaired.

Selective Attention. The client's selective attention, the ability to focus on one thing when there are distractions present and quickly determine correct (relevant) versus incorrect (irrelevant) stimuli, is unimpaired. On very brief tasks of selective attention and speed, she performed generally adequately (D-KEFS Trails Visual Scanning, 84th percentile; WAIS-IV Cancellation, 63rd percentile). Moreover, on a much more boring task that lasted an extended period of time, the client's ability to focus when distractions were present was extremely good (CPT-3 Omissions, 25th percentile [better than 75% of same-aged peers]; CPT-3 Detectability, 14th percentile [better than 86% of peers]; CPT-3 Variability, 18th percentile [better than 82% of peers]). As such, she has good ability to control her attention and focus when distractions are present.

Sustained Attention. The client's ability to sustain her attention across time once engaged in a task (even a boring, tedious one) emerged as similarly unimpaired. Specifically, on a boring task that continued for an extended period of time, her response time to stimuli stayed generally constant throughout (CPT-3 HRT Block Change, 34th percentile [better than 66% of same-aged peers]), and she did not become significantly more inaccurate as the task progressed (CPT-3 Omissions by Block Change, $p > .10$; CPT-3 Commissions by Block Change, $p > .10$). On another task that required her to hold rules in her head for how to respond, she showed no difficulty maintaining her attention to keep the rules in her head as the task progressed (WCST-IV Nonperseverative Errors, 50th percentile). Once engaged in a task, even a boring one, she is able to maintain her attention adequately.

Verbal Working Memory. On tasks that assessed her ability to concentrate, learn new information, hold it in short term memory, and manipulate that information to produce some result or reasoning outcome, the client's performance fell within the very superior range of functioning compared with others her age (WAIS-IV Working Memory Index, 98th percentile), representing another area of extreme strength for her. She is able to work with verbal information in her mind extremely well.

Impulse Control and Related Functions. On a task evaluating her ability to control her basic cognitive impulses, requiring her to respond to stimuli in the opposite way than her impulses would guide her, she exhibited good ability to control her behavior (CPT-3 Commissions, 32nd percentile [better than 68% of same-aged peers]). Her ability to control her impulses and apply a new strategy that was given to her to a task was also unimpaired (D-KEFS Trails Number–Letter Switching, 63rd percentile). On another task that required her to control her impulses, self-monitor, and adapt to feedback in the moment, her performance was also unimpaired, falling within the average range compared with same-aged peers (WCST-IV Perseverative Errors, 58th percentile). Her cognitive abilities to control her impulses and her other mental functions are completely intact.

Academic Achievement

The client's academic achievement was evaluated and compared with a general national normative group, not necessarily to peers in her current school or class setting.

The client's academic performance revealed unimpaired academic oral language use and extremely strong ability in reading, writing, and mathematics. However, she exhibited weakness in the speed with which she performs academic operations, including reading and mathematics.

Academic Oral Language. The client's overall use of language for academic endeavors is average (WIAT-III Oral Language, 73rd percentile). Specifically, her attention to and understanding of information that is presented to her aloud is average for her grade level (WIAT-III Listening Comprehension, 63rd percentile). Her ability to express academic ideas clearly and completely, however, is stronger, falling in the high average range for her level of education (WIAT-III Oral Expression, 88th percentile). She did not exhibit any problems with her academic use of oral language.

Reading. The client exhibited extremely strong academic achievement in reading for her education level (WIAT-III Total Reading, 95th percentile; NDRT General Reading Ability, › 99th percentile), except for weakness in the speed at which she reads. She displayed good ability related to basic reading skills, including adequate understanding of phonetics (WIAT-III Pseudoword Decoding, 73rd percentile) and strong ability to read actual words by recognition (WIAT-III Word Reading, 84th percentile). Similarly, she exhibited extremely strong understanding of vocabulary (NDRT Vocabulary, › 99th percentile). These skills have set the foundation for extremely strong reading comprehension, which is very superior compared with same-grade peers (WIAT-III Reading Comprehension, 99.5th percentile; NDRT Comprehension, 98th percentile). However, her speed of reading is a significant weakness compared to her strong reading abilities (NDRT Reading Rate, 14th percentile; WIAT-III Oral Reading Rate, 19th percentile), though she is quite accurate when she reads (WIAT-III Oral Reading Accuracy, 91st percentile). Her general reading ability is extremely strong, though her rate of reading is a significant weakness for her.

Writing. The client's overall writing abilities similarly emerged as extremely strong for her educational level (WIAT-III Written Expression, 98th percentile). Her basic ability to spell words is extremely strong (WIAT-III Spelling, 98th percentile), as is her ability to construct meaningful and complex sentences (WIAT-III Sentence Composition, 92nd percentile). These skills have built a foundation for very good ability to express herself clearly in an essay format (WIAT-III Essay Composition, 88th percentile). Her ability to communicate in writing is extremely strong for her grade level.

Mathematics. Similar to her reading abilities, the client's overall math abilities are extremely strong compared with others at her educational level (WIAT-III Mathematics, 97th percentile), except for some weakness in the speed at which she performs math. Her knowledge of basic mathematical concepts is superior compared with others at her grade level (WIAT-III Math Problem Solving, 96th percentile), as is her ability to solve progressively difficult actual math problems with paper and pencil when given unlimited time (WIAT-III Numerical Operations, 96th percentile). However, her speed of solving simple addition, subtraction, and multiplication problems within a time limit is below average for her grade level (WIAT-III Math Fluency, 4th percentile). Her mathematical abilities are extremely strong, except for her significant slowness in performing mathematical operations.

Cognitive and Academic Summary

The client's overall cognitive abilities are extremely strong for her age, with specific strengths in her verbal abilities. She exhibited some personal weakness in her speed of processing information and performing tasks, though. Her lower speed of processing information has translated to her academic abilities; while her actual abilities are extremely strong for her level of education, she performs academic operations (including reading and math) significantly more slowly than others at her grade level.

Emotional and Behavioral Functioning

The client, her mother, and her teacher were administered several measures to assess her current emotional and behavioral functioning. It should be noted that the focus of these measures is on areas of need, rather than a comprehensive overview of all of her emotional and behavioral strengths and weaknesses. As such, this section will necessarily focus on areas of her functioning that need support.

The assessment revealed that the client struggles with her underlying emotional states, which render her unable to effectively and consistently cope with her everyday experiences. As a result, she has developed significant symptoms of both anxiety and depression, which in turn contribute to social difficulties (which then serve to reinforce her depression).

Problems Coping. The client's underlying emotional states are strong, rapidly shifting, overwhelming, and ultimately make it difficult for her to cope with everyday life problems effectively and consistently. The client's emotional states are overwhelming and reactive, and she has a difficult time controlling them (BASC-3 PRS; BASC-3 TRS; PAI-A). Included in her emotional overwhelm, she tends to react quickly and overly negatively to situations (BASC-3 PRS; BASC-3 TRS). As a result, she does a poor job coping consistently and effectively with even minor stressors (BASC-3 SRP; BASC-3 PRS; BASC-3 TRS; R-PAS; Roberts-2). Her difficulties coping can explain why she uses marijuana to better cope with her anxiety.

Anxiety. One result of her poor coping is a significant amount of anxiety. The client struggles with a significant amount of anxiety (BASC-3 SRP; BASC-3 PRS; BASC-3 TRS; PAI-A; MMPI-A-RF). Specifically, this anxiety is primarily related to worry, rumination, and intrusive thoughts (PAI-A; MMPI-A-RF), including what she thinks of as "analysis paralysis," overthinking things so much that she cannot make decisions or solve problems. Additionally, her anxiety does contribute to physiological symptoms, such as gastrointestinal distress (PAI-A; MMPI-A-RF), which she experiences as stomachaches. Specifically, she exhibits a high amount of test anxiety (BASC-3 SRP), which will negatively affect her performance on high-stakes exams; she is particularly already nervous about taking the SAT or ACT, especially given that her current school does not give tests, so she has very little experience with them. In addition to her more general and test-specific anxiety, she does experience specific panic attacks, including shortness of breath, pounding heart, sweating, trembling, dizziness, choking for air, and a fear of losing control and "going nuts." Although her anxiety likely comes from many sources, it is important to note that her father's history of "impatience" with her related to academics and anxiety as well as the high "expectations" placed on her because of her Chinese culture, can serve to reinforce anxious thinking and feelings.

Depression. In addition to anxiety, the client's poor coping also leads to significant depressive symptoms. The client struggles with a number of depressive symptoms (BASC-3 SRP; BASC-3 PRS; BASC-3 TRS; PAI-A; MMPI-A-RF; Roberts-2). Specifically, she has negative, ruminative thoughts, pessimism about the future, and some helplessness (PAI-A; MMPI-A-RF; R-PAS) as well as a great deal of low self-esteem (BASC-3 SRP; MMPI-A-RF). In addition to her thoughts, she struggles with depressed mood, including general malaise and low energy, sadness, and crying (PAI-A; MMPI-A-RF). Her depression has manifested as a loss of interest in nearly all activities, sleep problems, fatigue, slowed movement, and poor attention.

Social Difficulties. The client's difficulties coping, anxiety, and depression all contribute to significant difficulties in interacting with others, which then reinforce her depressive symptoms. Specifically, some of her anxiety revolves around social stress (BASC-3 SRP; Roberts-2), and she reported that she gets quite anxious around others and nervous meeting new people. Her anxiety and especially depressive symptoms contribute to her tendency to withdraw from and avoid interacting with others (BASC-3 PRS; BASC-3 TRS), which she said is "easier" than dealing with her anxiety in social situations. Also contributing to her avoidance of others is some difficulties understanding why others behave the way they do (R-PAS; Roberts-2). She ultimately does not have many or fulfilling relationships with others (PAI-A; BASC-3 SRP) and feels misunderstood by others (Roberts-2), all which can serve to reinforce her self-doubts and sadness.

Summary

Audrey Cheng is a 16-year-old, Chinese American girl who is currently in 11th grade at a private school in New York City. She presented with multiple difficulties, including significant symptoms of anxiety (including anxious thoughts, nervousness, stomachaches, and panic attacks) and depression (including periods of loss of interest in activities, poor sleep, fatigue, low self-esteem, slowness, and attention problems). She reported specific anxiety about upcoming high-stakes exams (the SAT or ACT), especially because her current school does not give

tests and she fears her anxiety will impair her ability to perform well on them. She engaged with tasks appropriately and seemed to make effortful attempts on all tests administered.

Cognitively, the client's overall abilities are extremely strong for her age, with specific strengths in her verbal abilities. She exhibited some personal weakness in her speed of processing information and performing tasks, though. Her lower speed of processing information has translated to her academic abilities: whereas her actual abilities are extremely strong for her level of education, she performs academic operations (including reading and math) significantly more slowly than others at her grade level.

Emotionally, the client struggles with her underlying emotional states, which render her unable to effectively and consistently cope with her everyday experiences. As a result, she has developed significant symptoms of both anxiety and depression, which in turn contribute to social difficulties (which then serve to reinforce her depression).

Diagnostic Impression

Currently, the client meets criteria for other specified anxiety disorder, with social and test-related anxiety (*DSM-5* code 300.09; *ICD-10* code F41.8). Specifically, the client struggles with significant anxious symptoms, including some social anxiety and significant test-related anxiety, that negatively impact her functioning. She finds it difficult to control her anxiety symptoms, and at times she avoids situations (such as social) that may elicit them.

The client also meets criteria for panic disorder (*DSM-5* code 300.01; *ICD-10* code F41.0). Specifically, she experiences panic attacks, which include shortness of breath, sweating, trembling, dizziness, a pounding heart, and fear of losing control and "going nuts." She worries persistently about getting these panic attacks and avoids some situations in order to prevent them (such as socializing).

Further, the client meets criteria for major depressive disorder (*DSM-5* code 296.20; *ICD-10* code F33.9). Specifically, she exhibits significant depressive symptoms, including loss of interest in almost all activities for most of the day, nearly every day for certain periods; low self-esteem, sleep problems, loss of energy, psychomotor slowing, and attention problems. She also experiences some passive suicidal ideation (though she denied actual suicidality or intent to harm herself). She has experienced these depressive episodes occasionally for the past few years.

Finally, the client meets criteria for specific learning disorders, with impairment in reading (*DSM-5* code 315.00; *ICD-10* code F81.0) and mathematics (*DSM-5* code 315.1; *ICD-10* code F81.2). Specifically, while her reading, writing, and math skills are extremely strong, she has difficulties with her fluency–speed across academic tasks.

Recommendations

1. The client should share the results of this evaluation with both her school and any treatment providers.
2. The client should receive specific educational accommodations to maximize her academic potential, given her learning disorders. Specifically,
   a. She should be afforded extra time on all examinations (time-and-a-half) within the context of school classes, when and if they are given in the future.
3. The client should receive specific testing accommodations to perform to her potential, given her learning disorders and anxiety. Specifically,
   a. She should be afforded extra time on all standardized examinations (time-and-a-half).
   b. She should be allowed to take exams in a room separate from peers to decrease her anxiety.
4. The client should continue in her psychotherapeutic treatment. Specifically, CBT can address her depressive, anxious, and panic symptoms.
5. The client should consider consulting with a psychiatrist to discuss the potential benefits of psychiatric medication.

_____ _____

A. Jordan Wright, PhD Date

New York State Licensed Psychologist

Feedback

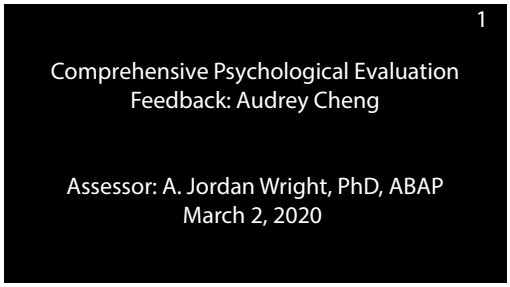
Preparation for Feedback

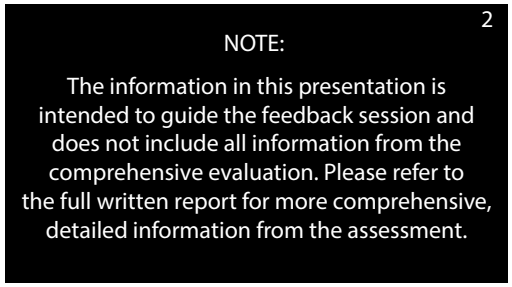
When considering exactly what feedback to give and how to give it to Audrey and her mother, there seemed to be no reason not to give all feedback to both of them together. There was nothing in the assessment that would likely be contentious, that might cause some conflict between them, or which one should hear differently (or a different amount of) than the other. As such, the assessor scheduled the feedback session with both Audrey and her mother together.

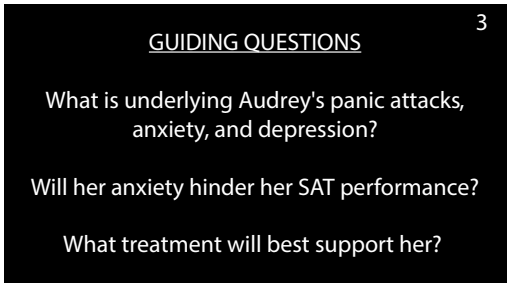
As usual, the assessor decided to give the feedback verbally and with the presentation before giving Audrey and her mother the actual report. He wanted to ensure that they understood every piece of the feedback and had an opportunity to ask questions or discuss reactions, without the distraction of needing to look at a lengthy report. The plan was to discuss the cognitive and academic feedback first and then to discuss the emotional and behavioral functioning, with plenty of time for reactions and questions.

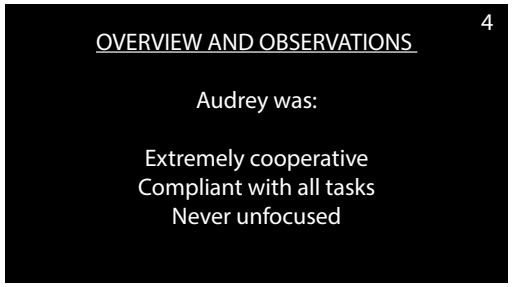
Feedback Presentation

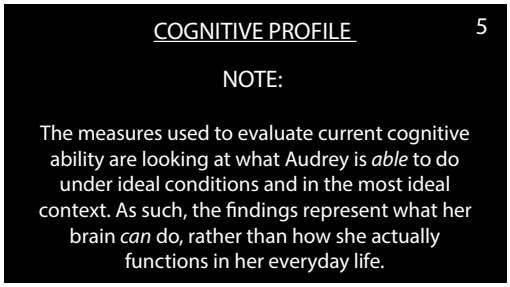
The assessor decided to create a feedback presentation for the case to organize and guide the feedback session.

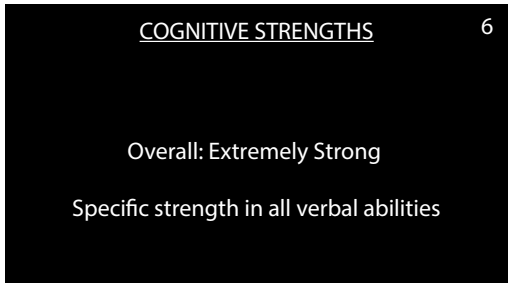












7

COGNITIVE VULNERABILITIES

Speed of processing information and performing functions

8

ACADEMIC STRENGTHS

Extremely strong Reading, Writing, and Mathematics abilities

9

ACADEMIC VULNERABILITIES

Speed of reading and doing math

10

DIAGNOSIS (part 1)

Specific Learning Disorders, with Impairment in Reading and Math

11

PERSONALITY & EMOTIONAL FUNCTIONING

NOTE:

Because we cannot measure/test every single emotional and behavioral characteristic and variable, the focus of this part of the evaluation is on areas of need, rather than a comprehensive overview of all emotional and behavioral strengths and weaknesses.

12

EMOTIONAL DIFFICULTIES

Problems regulating emotions and coping
Anxiety
Depression
Social Difficulties

13

DIAGNOSIS (part 2)

Panic Disorder

Other Specified Anxiety Disorder, with Social and Test-Related Anxiety

Major Depressive Disorder

14

RECOMMENDATIONS

School and Testing Accommodations:

Time-and-a-half
Testing in own room

15

RECOMMENDATIONS

Cognitive-Behavioral Therapy
(depressive, anxious, and panic symptoms)

16

RECOMMENDATIONS

Consulting with a Psychiatrist

Feedback Session

Audrey and her mother came in for their feedback session on time and reportedly eager to get feedback. As always, the assessor oriented them to how the feedback session would flow, letting them know that they could stop the assessor at any point if they had questions or reactions to anything being said. He emphasized the point that there would be two parts to the feedback—one focusing on Audrey's cognitive and academic functioning and the other focusing on her emotional functioning. They were encouraged to let the assessor know whenever anything did not align with their own thoughts or feelings. They had no questions at this point, so the assessor moved on to the cognitive and academic feedback.

The feedback began with a reiteration of the guiding questions and a summary of observations, focused on just how cooperative and focused Audrey was throughout the process. The cognitive and academic feedback to Audrey and her mother, which followed next, was generally quite easy to give, as it was very much aligned with how they both viewed Audrey's functioning, for the most part. It is important not to underestimate how powerful it can be to tell a smart person that they are smart—Audrey's affect brightened immediately when she heard how well she had performed across the board on her cognitive and academic skills tests. The assessor braced her and her mother for the "less good" news to come, that her speed of performing tasks on tests, especially ones similar to the SAT or ACT, was much slower than would be expected. The assessor emphasized a few things. First, he differentiated her actual abilities from her speed of performing. Second, he contextualized speed of performing academic tasks in a test-like format is not necessarily very predictive of anything other than not finishing tests. And third, even though her speed on testing was slower than would be expected, it was not grossly impaired in any way; it was weak, both for her and compared with others, but it was not extremely weak. Finally, he emphasized that her slow speed of performing tasks on tests like these could at least in part be attributable to her lack of experience taking tests; she simply has not been trained to perform these types of tasks quickly.

The assessor offered all these "cushioning" statements preventively, expecting that Audrey (or her mother) may have a negative reaction to her slow speed of performing academic tasks. However, it may not have been necessary. Audrey did not seem at all bothered by the findings (or even surprised); this could in part be because the assessor contextualized it so much, or she might just not necessarily have had a problem with them. Either way, neither Audrey nor her mother seemed at all upset or confused. The next task was for the assessor to use the information just presented to justify the first diagnosis, the learning disorders. Again, the assessor reiterated that part of the job of this report is to build "a case" for her to receive some accommodations on the SAT or ACT, and it is a hard case to build given that she has never had any accommodations before and has not struggled academically. He explained that the specific learning disorder diagnosis encompasses all different types of learning disabilities, and he clarified exactly what was meant by it in Audrey's case (the focus on speed and fluency). Again, Audrey and her mother did not seem to have a noticeable reaction to this diagnosis. The assessor asked if they had any questions, and they responded that they did not, and so the session moved forward.

What followed was perhaps one of the easiest feedback sessions the assessor had ever conducted, likely (again) because not much of what emerged was surprising. Both Audrey and her mother knew very well that Audrey struggled with coping with the world and with anxiety, depression, and socializing. Labeling them diagnostically was not groundbreaking for either one of them, though when looking at the slide with the set of three emotional diagnoses (panic disorder; other specified anxiety disorder, with social and test-related anxiety; and major depressive disorder), Audrey's mother did specifically ask if they should consider medication (calling back to one of the original purposes of the assessment). The assessor said he would address that question specifically very soon, and he went on to present the three sets of recommendations: accommodations, therapeutic intervention, and consulting with a psychiatrist.

Throughout the entire session, Audrey and her mother both nodded along, asked very few questions, seemed not to have any difficulty with any of the findings, and generally remained quiet. On the last slide, which presented the recommendation to consult with a psychiatrist, the assessor worked hard to elicit a reaction from either of them. He asked specifically what it was like for them to get this feedback. Audrey did not change her affect when she said, "Well, I guess I need meds. I want to try and see if they make things better." The assessor reiterated what a big decision medication was to make. He underscored that the decision of whether to take medication would always be theirs to make, even if they do go consult with a psychiatrist, as long as Audrey is not a danger to herself or anyone else. They nodded along, and the assessor reiterated the major findings and recommendations, putting them in the context of her taking the SAT or ACT as well as her more general functioning. He restated that because of her slow speed of performing on tests and her anxiety, she should get extra time and be able to take the test in a room separate from others. And because of her depression, anxiety, and panic, she should make sure that the therapy she receives is CBT and should consult with a psychiatrist. Audrey and her mother thanked the assessor, shook his hand, and left.

Of note, the assessor reached out after the session to offer to fill out any paperwork for the SAT or ACT that was necessary to request accommodation. Additionally, he offered to provide a slightly revised report that would be more appropriate and targeted for use by the test companies (providing less information about her emotional functioning, except as relevant to test-taking). Audrey's mother accepted these offers, and Audrey was ultimately granted time-and-a-half on the SAT (and was subsequently accepted into an Ivy League school for college). Her mother also reported that Audrey was taking antidepressant medication, had switched therapists (her original therapist did not feel competent to provide her CBT), and had significantly improved both emotionally and socially.

Summary

Audrey's assessment was not necessarily one that provided dramatic or groundbreaking information to Audrey or her mother, but it did serve some important purposes. First, it provided Audrey an opportunity to find out how she is likely to perform on standardized exams, given that she is at a school that does not use tests or exams in any way in their curriculum. This uncovered a potential problem that Audrey and her mother were not even aware of—the fact that her speed and fluency of performing academic tasks on tests is quite slow, despite her being extremely smart and having a great deal of academic knowledge and skill. Knowing this (and having it in writing in a formal evaluation) helped get her accommodation that likely played a significant part of her success on the SAT. Second, the assessment provided her with concrete and formal diagnoses, which came with specific treatment recommendations. Although Audrey's school had initially recommended medication for Audrey, it is likely that both she and her mother took the recommendation more seriously coming from the results of a comprehensive assessment. Both the accommodations and the interventions that came from the assessment seem to have improved Audrey's life significantly, even if not dramatically unexpected.

CHAPTER 11

An Aggressive Boy

Christopher Santiago was a 6-year-old Latino boy who was referred by his school for an assessment for several reasons. He was in a first-grade class in a public elementary school, but he was struggling with reading. Additionally, he was acting out behaviorally in class, inappropriately disrupting the class at least two times per school day. The purpose of the assessment was to evaluate why he might be having difficulties reading and why he was acting out in school.

The Clinical Interview

The first appointment for the clinical interview was made for Christopher's parents alone. Given the boy's age, the assessor felt that it would be most beneficial to hear about his difficulties without his being present. The second clinical interview occurred on another day of assessment, and it included meeting with Christopher alone to discuss any difficulties at school or at home and meeting with Christopher and his parents together to observe their family interaction. A brief third interview occurred on the phone with Christopher's current teacher.

Christopher's mother came on time for the first session, though his father was about 20 minutes late. His mother was dressed casually in a dress, appropriate for the session. She was an attractive Latina woman in her early 30s who smiled freely and was extremely polite, and she apologized profusely for her husband's tardiness. When his father arrived, they exchanged a very noticeable nonverbal exchange: she glared at him angrily and breathed loudly and deeply, he raised his eyebrows somewhat apologetically, and she rolled her eyes. He was dressed in work attire, wearing a button-down shirt and slacks. He was also attractive and in his early 30s, and he apologized for being late.

As usual, the sections that follow are not categorized into biopsychological evaluation and psychosocial evaluation because the flow of the clinical interview did not follow that structure. The subsections present the clinical interview as closely as possible to the way it actually unfolded, rather than artificially grouping sections of information that did not present themselves sequentially. That is, the presentation mirrors the way the clinical interview happened chronologically, along with the overarching questions the assessor asked Christopher's parents, Christopher, and his teacher. Clarifications were occasionally necessary throughout the interview, but those questions and comments are not presented here. The assessor engaged both parents in the consent process (going slightly more quickly through it with Christopher's father, as he came late, but engaging him nonetheless) and then began the clinical interview, which was conducted as a more unstructured process in this case.

Conducting Psychological Assessment, First Edition. A. Jordan Wright.

Presenting Problem: So, can you tell me what's going on with Christopher?

Christopher's mother began speaking, answering the question almost as though defending Christopher. She stated that he has always been "a good kid" and that he never had difficulties in school or with his behavior before the last few months of the previous school year. In his kindergarten class, for most of the year, he had been attentive and cooperative, and he had never had academic difficulties. At home, he has always behaved—she said they had a loving family and have never had any difficulties. After some time of this kind of reporting, the assessor interjected, "So some of that has changed?"

"Well," she responded, "his teacher is concerned." She went on to report that his teacher had discussed with them a noticeable problem with Christopher's reading ability, which was reportedly lagging behind others in his class. She said that his kindergarten teacher had said something similar in their final meeting last year, but that the teacher "wasn't too concerned." She also said that in the past 8 or so months Christopher had been misbehaving at school and at home. As she said this, she glanced at her husband. The assessor asked both of them to describe what she meant by "misbehaving." His mother began by stating that Christopher does not listen to his father, throwing "tantrums" whenever he asks him to do anything, even if it is very minor and inconsequential. At this point, the assessor chose to stop his mother from going on to ask his father about this behavior. "Just what she said—anything I ask him to do sets him off." He went on to report that they have a "relatively good relationship," that as long as he is not requesting anything, Christopher is very loving and warm with him. His father reportedly reads him bedtime stories every night, a ritual that Christopher loves and cannot get to sleep without. "But when I ask him to do anything, he gets aggressive, hitting me, screaming, and crying."

His mother reported that this misbehavior happens occasionally with her as well and has begun happening at school. She reported that he apparently disrupts the classroom with outbursts several times during the day, though he is able to be calmed down by his teacher—"she's very good." Again glancing at her husband, his mother stated that they do not understand why there has been such a change in Christopher's behavior.

History of Presenting Problem, Developmental History, and Educational History: So you said that this is a pretty big change in his behavior, huh?

Both Christopher's mother and father adamantly stated that he had been "a model child" before about 8 months ago, when these behavioral problems began. He had reportedly been "a good sleeper" as a baby, generally crying only when hungry or in need of a diaper change. He met all of his developmental milestones on time; he was a curious child who crawled and walked easily, and toilet training had gone smoothly. He was a verbal child, and his parents had read to him every night since he was a baby.

Christopher's mother reported some difficulty with his first day of kindergarten, when he did not want his mother to leave the classroom. "But after the first day, he loved it and had no problem going from then on." In kindergarten, he had excelled academically, with no reported difficulties from his teacher in his reading (or other academic areas) or in his behavior for most of the year, until the final few months, when he had some reading difficulties and several instances of acting out in class. When he went into the first grade, he changed teachers (as all the children in his school do), but both parents felt that his first-grade teacher was excellent and warm.

Family History: Okay, I want to ask some more general information so I can learn about Christopher. Can you tell me more about your family?

Again, Christopher's mother answered the question. She reported that Christopher is the only child in the family, and he had been born about 6 years after she and her husband married. She was "a stay-at-home mom," after having worked for the first 6 years of their marriage as a teacher's assistant in a school. However, she had been

taking night classes for the past 3 years to get a nursing degree. Her husband reported that he works as a customer service representative in a bank. He added that their schedule "works well" because he comes home and can be with Christopher while she goes to school, which is why he reads Christopher his bedtime stories each night. Both agreed that it was good that Christopher was never without one of them when he was at home each day.

Suspecting from their interaction that something may be going on between the couple, the assessor asked more specific details about their relationship, beginning with how they met. They reported that they had met in high school; they were both part of a very small group of students who had been born in Puerto Rico but had moved to New York as younger children. They dated "on and off" for several years before getting married around the time they were 21 years old. Having Christopher was planned and expected, and they had agreed that his mother would stay at home and raise him during his early childhood. There was a long, somewhat awkward pause, during which they glanced at each other knowingly. The assessor wondered aloud if there were something more they were not yet telling him.

Christopher's mother stated that they both loved Christopher very much and that they felt they were very good parents. She reported, though, that they were having difficulties in their own relationship, but that they were "working hard to keep it from Christopher." They were fighting often, sometimes about money and sometimes about "petty, inconsequential things," but they were careful never to fight when Christopher was home. Generally, they fought in the morning after Christopher left for school, and occasionally they fought "quietly" after he had gone to bed and his mother had come home from school. Both parents were looking down toward their laps, not making eye contact with the assessor, and his father reported that they were starting to think about whether their marriage "works." Their greatest fear was, if they decided to divorce, how to handle telling Christopher. They both quickly reassured the assessor, both looking at him for the first time during this section of the interview, that the other was a good parent and that they would share custody and be friendly with each other while raising Christopher. The assessor empathized with the difficulty of their situation and validated their commitment to their son.

Medical and Psychiatric History and Family Medical and Psychiatric History: Now, I want to switch gears a bit and ask you some specific questions about Christopher, if that's okay.

Christopher's parents looked somewhat relieved not to have to talk about their own marital difficulties, and they said they were happy to answer questions about Christopher. The assessor asked about medical and psychiatric history, and both parents denied any history of serious medical problems and any history of any form of psychiatric or psychotherapeutic treatment. They stated that they had "had it easy" with Christopher from the beginning.

The assessor asked, "Okay, what about the two of you and the rest of your families? Any medical or psychiatric problems?" Both denied any major medical problems or psychiatric history. His mother reported that her grandfather had died of heart disease but that nobody else had had any major medical problems in her family. His father reported that he thought his own mother may have been depressed when she moved from Puerto Rico but that she had not been diagnosed or received treatment. About 4 years ago, she and his father (Christopher's paternal grandfather) had moved back to Puerto Rico, and he said that she seemed "much happier there."

Alcohol and Substance Abuse History: Any history of alcohol or drug abuse in your family?

Both parents denied using any substances, except for his father having "an occasional beer" with friends. They said they did not want Christopher exposed to such things in the home, so they did not even keep alcohol in their house or refrigerator. Christopher's father reported that he had had a great uncle in Puerto Rico who had "drunk himself to death," so they "just want[ed] to be safe" and not expose Christopher to alcohol or any other drugs.

Social History: OK, tell me about Christopher's social life.

Both parents seemed to brighten in their demeanor at this question. His mother reported that he had many friends, some from the neighborhood, some children of their own friends, and some from school. "He's very popular—even his teacher says so." They reported that Christopher both attends and hosts sleepovers with friends, and he has a best friend, Jonathon. They had been best friends since about the second week of kindergarten, and even though they had been placed in different first grade classrooms, they had remained best friends, always sitting together at lunch and playing together at recess. Christopher's parents said they liked Jonathon, "a good kid," and his parents, and they were happy that Christopher had so many friends in school.

Psychosexual History and Criminal and Legal History: Here are some questions I ask everybody. Does Christopher have any history of physical or sexual abuse or any other involvement with the law?

Both parents denied any history of abuse and legal involvement, both for Christopher and themselves. His father asked, almost incredulously, whether any 6-year-old the assessor had assessed had been in trouble with the law. The assessor explained that if any child had, it would be important for him to know to understand the child or family entirely.

Multicultural Evaluation: So, you're both from Puerto Rico. Was it difficult adjusting to New York?

Both parents looked at the assessor a bit confused, perhaps wondering why he was asking about their acculturation (as opposed to something about Christopher), but they answered anyway. Both reported that what really helped them acculturate was the small community of Puerto Ricans they lived near in New York, as well as the small group of Puerto Rican children in school. Although they spoke only Spanish at home growing up, both had chosen to speak only English in school and with each other—their home now was a monolingual English-speaking home—to help them "fit in" better in non–Puerto Rican America. They both reported that Christopher's school was very diverse and "open" to different races. His mother noted that Jonathon, Christopher's best friend, was Black, and that his other friends were "all different colors."

Session 2

Christopher came in with his parents for the second session, and it began with all three of them in the room together with the assessor. Christopher was a small, athletic child with a very bright smile and had very little difficulty engaging the assessor, a complete stranger. He was dressed casually in jeans and a T-shirt and played with the foam basketball and hoop in the room almost immediately after being introduced to the assessor. Both his parents played with him, lovingly, as they chatted casually with the assessor. After some play time, the family sat with the assessor and explained to Christopher why he was there, and the assessor explained what the sessions would entail. The assessor then asked Christopher if it would be okay to meet with him alone, without his parents, and he shrugged and said, "Sure."

Presenting Problem: So, tell me about school.

The assessor decided to do the clinical interview while playing foam basketball with Christopher in the office. They maintained a good, casual conversation while shooting baskets, dribbling the ball ineffectively (foam balls do not dribble well), and running around the office. Christopher said that school was "good" and that he liked his teacher. He said that some of it was "hard," though, stating that sometimes he did not understand what was

going on in class. When asked for details, Christopher was not able to explain, and he became more energetic in his basketball playing. "I hear you have a lot of friends." To this, Christopher smiled widely and started talking about his best friend, Jonathon, who is "awesome." He talked about several "pretend games" they play, usually being wizards who can turn any bad thing that happens into a good thing.

"And how's everything going at home?" Christopher stopped running around for a moment, as if thinking about the question, then said, "Okay, I guess." When the assessor asked, "You guess?" Christopher said that he wished his parents would see him more. When asked what he meant by this, Christopher shrugged and went back to playing basketball. The assessor asked how he feels when his parents do not see him enough, and he reported that he gets "sad like them." Again, he was unable (or unwilling) to elaborate what he meant by this. He did deny that he ever considered hurting himself. They continued to play basketball for a bit, and then they began doing some testing.

Collateral Interview With Teacher

Christopher's parents signed a release form for the assessor to speak with Christopher's teacher. When they were able to speak on the phone, the assessor asked her to discuss Christopher's functioning at school.

Presenting Problem: Tell me about Christopher at school.

Christopher's first-grade teacher spoke openly about Christopher. She reported that, overall, he was an extremely well-behaved child. She was very good friends and close colleagues with his kindergarten teacher. She knew he had had some difficulties toward the end of the previous school year, but she had expected him to "catch up" in the first grade. Only a few weeks after beginning, however, he began to have some of the same difficulties in class that had been reported by his kindergarten teacher. He had been an average student in kindergarten, and moving him into a bilingual English–Spanish classroom in the first grade was meant to improve his academic performance. At this point, the assessor clarified with the teacher that, in his first-grade classroom (but not his kindergarten class) half of the day was taught in English and half was taught in Spanish, which she confirmed as correct. She reported that many of the Latinx children in the school were placed on a bilingual track, and almost all of them performed better in these bilingual classes than in their previous monolingual English classes.

She continued to report almost identically what Christopher's parents had reported: that when he became frustrated in class he tended to misbehave, not listening to her instructions, occasionally throwing a book or pushing a chair over in a tantrum. She also confirmed that she was able to calm him down relatively easily and get him "back on track." She also reported that his reading ability did not seem to be improving in class as much as his peers'. She was not sure whether that was because of a learning disability or "something else," but there was something interfering with his reading skill. She then offered to speak again if the assessor felt he needed any more information, and they hung up.

A Pause in the Assessment

After this collateral interview, even though no formal testing had been done yet, the assessor called Christopher's parents to confirm that they were aware that he was in a bilingual classroom. They reported that it may have been mentioned but that they had not realized it. The assessor again confirmed that they spoke only English at home, and he recommended, even before the testing, that they work with his school to have him transferred to a monolingual English-speaking classroom as soon as possible.

Mental Status Evaluation

Appearance and Behavior

Christopher was well groomed and casually and appropriately dressed for all sessions. He was a small, athletic 6-year-old boy with a bright smile and a friendly demeanor. He had no difficulty engaging the assessor or adapting to the testing situation.

Speech and Language

Christopher was open and articulate, and his speech was generally goal directed and logical, except for a few times when he would speak rapidly and tangentially about his friends. He spoke fluent, grammatically correct English with no defining accent. He had no difficulties with receptive language (in English), understanding all the directions on all of the tests administered.

Mood and Affect

Christopher was reportedly and observed to be happy throughout most of the assessment. There were several times he reported that he would become "sad," and his facial expression and demeanor were congruent with this feeling. Generally, this would occur when discussing his parents and their "unhappiness."

Thought Process and Content

Christopher's thought process seemed clear and logical, free of hallucinations and delusions. He became slightly tangential when discussing his friends, telling the assessor long stories about games that he would play with them. His thought content was free of suicidal and homicidal ideation, and he did not report any anxiety.

Cognition

Christopher was alert and engaged throughout the assessment. His attention, concentration, and memory seemed intact.

Prefrontal Functioning

Christopher exhibited good planning and judgment. His impulse control was adequate, except when he at times got carried away with the energetic games played in session, when he would become overly excited and impulsive.

Hypothesis Building

Now that the clinical assessment (the clinical and collateral interviews and the mental status evaluation) has been completed, the information gathered can be used to create hypotheses for what might be going on for Christopher.

Identify Impairments

Christopher has two major impairments in functioning, which seem separate but may be related. First, he is struggling academically. Although it seems obvious that a child who does not speak Spanish should not be in a bilingual, English–Spanish classroom, he is having significant trouble reading, even in English, his primary language. Thus, his academic difficulty seems as though it might be related to some sort of cognitive or learning

difficulty. Second, he is acting out behaviorally, both in school and at home. This behavior has emerged only recently and is markedly different from the way his parents reported that he "usually is."

Enumerate Possible Causes

Thinking first about Christopher's academic difficulties, there are a few major reasons he might be struggling with reading. The obvious first major hypothesis is a specific learning disorder, with impairment in reading. If he is exhibiting reading difficulties at a level substantially below what would be expected for his age and are not accounted for by an intellectual disability, another mental or neurological disorder, or inadequate educational instruction, he will qualify for this specific learning disorder. The criteria for the reading disorder, however, reveal two other hypotheses. The null hypothesis—that in actuality nothing is inherently wrong with Christopher academically—is an actually realistic option in this case given that he is in a clearly inappropriate learning environment (a bilingual classroom). However, there still may be reading difficulties above and beyond this classroom problem.

The second additional hypothesis revealed by the criteria of the learning disorder is the possibility that he simply has low cognitive functioning and would not actually be expected to read at a higher level. This hypothesis creates two possible diagnoses—borderline intellectual functioning and intellectual developmental disorder (intellectual disability). He does not seem to have any of the markers of a more general cognitive disorder that would impair his reading ability, such as a communication disorder, so these seem like the most likely diagnostic possibilities. However, as is the case with all academic problems, a final hypothesis could be that his emotional and behavioral functioning is interfering with his learning. That is, if his acting out during school is impeding his attending to lessons and taking in the information taught, then he simply would not grow academically at the same rate as his peers who pay attention. Based on his teacher's report, however, his acting out in class does not seem to be to such a severe degree that he is missing a significant chunk of lessons.

His acting-out behavior, both at home and in school, which is a marked change from previous behavior, may have several explanations diagnostically. While they may be signs of an oppositional defiant disorder (ODD), this diagnosis would be the choice of last resort, to be chosen only if it is determined that the acting-out behavior is not secondary to any other problems. These "other problems" that the acting-out behavior could be secondary to are generally related to emotional difficulties. That is, it is widely accepted that emotional problems in children often manifest as behavioral problems. Therefore, both anxiety and depressive disorders should be included as possibilities. Included in these anxiety and depressive disorders would be an adjustment disorder. At his present age, he is really adjusting to many different identifiable stressors, though the symptoms would have to be clearly linked to one of these transitions or changes to qualify for an adjustment disorder diagnosis.

You should always consider (a) that the presenting problems have an etiology in substance use and (b) that the presenting problems have an etiology in a medical condition. For Christopher, there seems to be little possibility that either of these is the case. At 6 years old, it is extremely unlikely that he is using any substances without his parents' knowledge, and they denied any use, so it is unlikely that his symptoms are attributable to substance use. Additionally, he recently had a full physical exam that revealed no evidence of any medical problems. Accordingly, it will be assumed that the symptoms are primarily psychological in nature.

Selecting Tests

Because there are several cognitive hypotheses in question, test selection should include a larger battery of cognitive tests than some of the other assessments presented previously that were primarily emotional. To understand Christopher's academic difficulties, the first step is to understand his overall intellectual ability, which can be measured with the Wechsler Intelligence Scale for Children, 5th Edition (WISC-V). As part of this overall understanding, as always, the Bender Visual-Motor Gestalt Test, 2nd Edition (Bender-2) will add some other basic cognitive

skills, including fine motor skills, visual–perceptual ability, and short-term visual memory. Importantly, though, we must also understand his academic achievement functioning in general, as well as his reading ability more specifically. To assess his general academic functioning, a broad achievement test will be used—the Wechsler Individual Achievement Test, 3rd Edition (WIAT-III). For a more specific assessment of his reading functioning, including exactly how it may be impaired, the Gray Diagnostic Reading Tests, 2nd Edition (GDRT-2) can be used. This test provides measures of decoding separate from measures of comprehension, which will help identify where in the developmental process of reading ability he is having difficulty (if he has, in fact, a reading disorder). Additional reading tests (e.g., tests for reading fluency) could be added if the results from these tests are inconclusive.

For the emotional and behavioral assessment, because of his age, a broad-based collateral-report measure will be used, which his parents and teacher fill out separately—the Behavior Assessment System for Children, 3rd Edition (BASC-3). This measure includes both clinical and adaptive scales on both behavioral and emotional constructs, and it allows for report of functioning across different contexts (home and school). It should give an excellent overview of any specific difficulties, from inattention, to somatization, to the anxiety and depressive information that will be important for the hypotheses generated previously. Additionally, the BASC-3 will offer a quantified report of Christopher's aggression and conduct problems. An additional parent-report measure of his functioning will be included, the Personality Inventory for Children, 2nd Edition (PIC-2), simply because it also has some subscales that focus on family dysfunction, including conflict among family members and parent maladjustment, which is not captured well on the BASC-3. Because of his age, there are very few evidence-supported emotional and behavioral measure that can be given directly to him. To add a different method to the battery, though, we will include the Rorschach Performance Assessment System (R-PAS), which is imperfect (especially with younger children) but can offer additional information when combined with the BASC-3 and PIC-2. Another imperfect but potentially useful measure is the Roberts Apperception Test for Children and Adolescents, 2nd Edition (Roberts-2), a projective storytelling measure. While there is limited evidence to its utility, the stimulus cards portray scenes with children and others (peers and adults); while there is no concern about Christopher's social world, using some cards that portray parents and children in interaction may shed some light on how he views his family life. Again, though, with its limited evidence-support, we will use this measure cautiously.

Thus, our assessment's battery of tests will consist of

- Bender-2
- WISC-V
- WIAT-III
- GDRT-2
- BASC-3 (parent and teacher reports)
- PIC-2
- R-PAS
- Roberts-2

Accumulating the Data

Table 11.1 shows the results from each individual measure administered. On the WISC-V, Christopher performed within the average range as compared with others his age overall (full Scale IQ [FSIQ] of 100, 50th percentile). All of his indices were average, including his verbal comprehension index, which was a 99 and fell within the 47th percentile. His performance on the Bender-2 was also average across all of the subtests. This already rules out borderline intellectual functioning and intellectual developmental disorder from our hypotheses, as he exhibited no deficits in any area of cognitive functioning measured.

TABLE 11.1 **ACCUMULATION OF CHRISTOPHER'S DATA**

BASC-3 Parent Rating Scales

Nervousness and anxiety
Sadness
Poor adaptability
Conduct problems
Difficulty overcoming stress and adversity

BASC-3 Teacher Rating Scales

Some conduct problems
Some nervousness and anxiety
Sadness
Learning problems
Quickly irritable and difficulty maintaining self-control when faced with adversity
Difficulty overcoming stress and adversity

PIC-2

Some poor academic achievement
Some disruptive behavior
Conflict among family members
Fear and worry
Depression

R-PAS

Limited psychological resources to cope with the world
Vigilance and sensitivity to external cues
Takes in too much information
Some anxious ideation that is outside of his control
Pessimistic ideation
Dependency needs not being met
Some oppositionality
Environmental sensitivity
Interpersonal closeness needs not being met

Roberts-2

Resentment at not being attended to
Focus on parental discord
Attuned to others
Feeling neglected
Anxiety about not being able to take care of himself
Acting out when confused about emotions
Sadness and loneliness

Clinical interview and behavioral observation data

Tantrums at home
Misbehaving in school
Wanting his parents to see him more
Gets sad at times
Aware that his parents are unhappy

His performance on the WIAT-III and the GDRT-2 was varied. On the WIAT-III, his reading index was in the low average range for his grade level (in the 12th percentile), with his greatest weaknesses appearing on the early reading skills and pseudoword decoding subtests (both in the 6th percentile). His mathematics, writing, and academic oral language indices were all average. On the GDRT-2, his general reading composite fell within the low average range (18th percentile) compared with others his age. Interestingly, his comprehension composite was average (27th percentile), while his decoding composite was below average (6th percentile). It became clear that he was reading words by recognition rather than by decoding them phonetically. Thus, he was reading at a significantly lower level than would be expected for his age, especially given his average IQ (including average verbal comprehension ability). His comprehension of what was read (revealing that his word recognition while reading was somewhat effective) was adequate for his age.

Identifying Themes

Although we could begin to address some of the already emergent themes (such as emotional distress), we will begin identifying themes with Christopher's data using the seven traditional psychological themes: self, others, thinking, feeling, behavior, coping, and context. The preliminary themes for Christopher's data are presented in Table 11.2.

Organizing the Data

Christopher's reorganized data are presented in Table 11.3. When the data are reorganized and examined within themes, some of the themes become clearer and more specific, whereas others need to be reorganized. For example, the behavior theme is relatively straightforward; this is describing a child who is acting out behaviorally in an oppositional way (which will be no surprise to anyone reading the report, as it is one of the major concerns presented during the clinical interview). Similarly, the coping theme tells the story of a boy with limited ability to cope with his current life stressors. However, there are some pieces of data that need to be reconciled, as they are divided between more than one theme. Additionally, some of the themes could do with some reorganizing.

Finalizing Themes

A few things need to happen to finalize Christopher's themes. The first, and easiest, is deciding where data that were previously categorized into multiple themes best fit. For example, there is a data point from the PIC-2, "Fear and worry," that was categorized both within feeling (fear) and thinking (worry). From reading across both the feeling and thinking themes, this nugget seems to best fit within the feeling theme, along with all the other evidence of anxiety. The "Resentment at not being attended to" from the Roberts-2 similarly seems to fit one of its two proposed themes better than the other; rather than focus on the resentment (a feeling), it seems to fit best within the context theme, which has other data related to him not feeling as if he is being taken care of enough. The third data nugget that straddles two themes is slightly different. The BASC-3 TRS "Quickly irritable and difficulty maintaining self-control when faced with adversity" actually seems to have two real components to it: becoming irritable quickly (which relates to difficulty coping with circumstances) and difficulty maintaining self-control (which relates to behavioral acting out). As such, we will split the data point in two and leave each component part where it fits best.

The next problem we have to contend with is the fact that the others data simply is not enough to sustain a full theme. You could not have a theme in a report using that single data point from that single measure. As such, we have to decide if and where it fits best in another theme. From scanning the data, it actually seems to fit well within the thinking theme, where the "Attuned to. . ." aspect aligns quite well with the taking in of a great deal of contextual information.

TABLE 11.2 **IDENTIFYING CHRISTOPHER'S THEMES**

Themes	
	BASC-3 Parent Rating Scales
Feeling	Nervousness and anxiety
Feeling	Sadness
Coping	Poor adaptability
Behavior	Conduct problems
Coping	Difficulty overcoming stress and adversity
	BASC-3 Teacher Rating Scales
Behavior	Some conduct problems
Feeling	Some nervousness and anxiety
Feeling	Sadness
Thinking	Learning problems
Coping and Behavior	Quickly irritable and difficulty maintaining self-control when faced with adversity
Coping	Difficulty overcoming stress and adversity
	PIC-2
Thinking	Some poor academic achievement
Behavior	Some disruptive behavior
Context	Conflict among family members
Feeling and Thinking	Fear and worry
Feeling	Depression
	R-PAS
Coping	Limited psychological resources to cope with the world
Thinking	Vigilance and sensitivity to external cues
Thinking	Takes in too much information
Thinking	Some anxious ideation that is outside of his control
Thinking	Pessimistic ideation
Context	Dependency needs not being met
Behavior	Some oppositionality
Thinking	Environmental sensitivity
Context	Interpersonal closeness needs not being met
	Roberts-2
Feeling and Context	Resentment at not being attended to
Context	Focus on parental discord
Others	Attuned to others
Context	Feeling neglected
Feeling	Anxiety about not being able to take care of himself
Behavior	Acting out when confused about emotions
Feeling	Sadness and loneliness
	Behavioral observations and other data
Behavior	Tantrums at home
Behavior	Misbehaving in school
Context	Wanting his parents to see him more
Feeling	Gets sad at times
Context	Aware that his parents are unhappy

TABLE 11.3 **CHRISTOPHER'S ORGANIZED DATA**

Test: Theme:	BASC-3 PRS	BASC-3 TRS	PIC-2	R-PAS	Roberts-2	Interview and Behavioral Observations
Feeling	Nervousness and anxiety	Some nervousness and anxiety	Fear and worry		Resentment at not being attended to	Gets sad at times
	Sadness	Sadness	Depression		Anxiety about not being able to take care of himself	
					Sadness and loneliness	
Coping	Poor adaptability	Quickly irritable and difficulty maintaining self-control when faced with adversity		Limited psychological resources to cope with the world		
	Difficulty overcoming stress and adversity	Difficulty overcoming stress and adversity				
Behavior	Conduct problems	Some conduct problems	Some disruptive behavior	Some oppositionality	Acting out when confused about emotions	Tantrums at home
		Quickly irritable and difficulty maintaining self-control when faced with adversity				Misbehaving in school
Thinking		Learning problems	Some poor academic achievement	Vigilance and sensitivity to external cues		
			Fear and worry	Takes in too much information		
				Some anxious ideation that is outside of his control		
				Pessimistic ideation		
				Environmental sensitivity		
Context			Conflict among family members	Dependency needs not being met	Resentment at not being attended to	Wanting his parents to see him more

TABLE 11.3 (*CONTINUED*)

Test: Theme:	BASC-3 PRS	BASC-3 TRS	PIC-2	R-PAS	Roberts-2	Interview and Behavioral Observations
				Interpersonal closeness needs not being met	Focus on parental discord	Aware that his parents are unhappy
					Feeling neglected	
Others					Attuned to others	

Additionally, we have a decision to make about the feeling theme. After we move the "Pessimistic ideation" and "Anxious ideation" data points from the thinking to the feeling theme, where it fits much better, we have enough data across measures to support separate themes of anxiety and sadness (which is often a better label for a theme than depression, since that means different things to different people, including mental health professionals). If the data showed a strong difference in magnitude between the two (anxiety and sadness), which would then inform treatment recommendations, then we might choose to separate these. However, with quite a bit of scholarship focused on the underlying and overarching similarities in general distress disorders (e.g., Watson, 2005), we may want to simply conceptualize this theme as emotional distress. So, at this point, Table 11.4 presents what we currently have.

The final decisions to be made are what stories are being told by the thinking and context themes, which are less straightforward than the other three, which were easily renamed to reflect the data included within them. For the thinking theme, we have some difficulties with academics emerging from the BASC-3 TRS and the PIC-2, though these data may not be extremely useful in the context of this evaluation, where we already know there are academic difficulties. So we may decide to ignore those data (knowing that the academic difficulties are already firmly established, both in the clinical assessment and the cognitive and academic assessment), and focus on the rest of the data. From the rest of the data, although not the strongest theme, we can say confidently that he is more aware of his context and surroundings than his parents seem to think. In fact, we have a piece of data in the context theme from the interview with Christopher about him being aware that his parents are unhappy (despite the fact that they reported specifically working hard to hide that fact from him). So, we may choose to move that data nugget to strengthen this theme and rename it high awareness or highly aware.

The context theme, then, is our final section to contend with. Again, reading across all the data, it tells a pretty clear story of a child whose dependency needs are not being met. However, how we frame this for a report and feedback that will be given to parents is important. One consideration is whether we think that Christopher is in some way being (actually) neglected, such as not receiving daily care, food, education, or affection from his parents. If we believe so, then we may be a bit stronger in our language of how to label this theme. If, on the other hand, we feel that he is not actually being neglected, but that perhaps he is the type of child who has more dependency and affection needs than some other children, such that he requires even more effortful parental affection, then we may focus the theme name more on him (rather than on his parents). In this case, there is no real evidence that he is being neglected in any way, and his parents seem affectionate and responsive to him (based on the observation of the family together). Thus, we may simply call this theme unmet needs or something similar. As such, our final themes with data are presented in Table 11.5.

TABLE 11.4 **CHRISTOPHER'S REORGANIZED DATA**

Test: Theme:	BASC-3 PRS	BASC-3 TRS	PIC-2	R-PAS	Roberts-2	Interview and Behavioral Observations
Emotional distress	Nervousness and anxiety	Some nervousness and anxiety	Fear and worry	Pessimistic ideation	~~Resentment at not being attended to~~	Gets sad at times
	Sadness	Sadness	Depression	Some anxious ideation that is outside of his control	Anxiety about not being able to take care of himself	
					Sadness and loneliness	
Poor coping	Poor adaptability	Quickly irritable ~~and difficulty maintaining self-control when faced with adversity~~		Limited psychological resources to cope with the world		
	Difficulty overcoming stress and adversity	Difficulty overcoming stress and adversity				
Acting-out behavior	Conduct problems	Some conduct problems	Some disruptive behavior	Some oppositionality	Acting out when confused about emotions	Tantrums at home
		~~Quickly irritable and~~ difficulty maintaining self-control when faced with adversity				Misbehaving in school
Thinking		Learning problems	Some poor academic achievement	Vigilance and sensitivity to external cues	Attuned to others	
			~~Fear and worry~~	Takes in too much information		
				Environmental sensitivity		
Context			Conflict among family members	Dependency needs not being met	Resentment at not being attended to	Wanting his parents to see him more

TABLE 11.4 (*CONTINUED*)

Test: Theme:	BASC-3 PRS	BASC-3 TRS	PIC-2	R-PAS	Roberts-2	Interview and Behavioral Observations
				Interpersonal closeness needs not being met	Focus on parental discord	Aware that his parents are unhappy
					Feeling neglected	

TABLE 11.5 CHRISTOPHER'S FINALIZED DATA

Test: Theme:	BASC-3 PRS	BASC-3 TRS	PIC-2	R-PAS	Roberts-2	Interview and Behavioral Observations
Emotional distress	Nervousness and anxiety	Some nervousness and anxiety	Fear and worry	Some anxious ideation that is outside of his control	~~Resentment at not being attended to~~	Gets sad at times
	Sadness	Sadness	Depression	Pessimistic ideation	Anxiety about not being able to take care of himself	
					Sadness and loneliness	
Poor coping	Poor adaptability	Quickly irritable ~~and difficulty maintaining self-control when faced with adversity~~		Limited psychological resources to cope with the world		
	Difficulty overcoming stress and adversity	Difficulty overcoming stress and adversity				
Acting-out behavior	Conduct problems	Some conduct problems	Some disruptive behavior	Some oppositionality	Acting out when confused about emotions	Tantrums at home
		~~Quickly irritable and~~ difficulty maintaining self-control when faced with adversity				Misbehaving in school

(Continued)

TABLE 11.5 (*CONTINUED*)

Test: / Theme:	BASC-3 PRS	BASC-3 TRS	PIC-2	R-PAS	Roberts-2	Interview and Behavioral Observations
High awareness		Learning problems	Some poor academic achievement	Vigilance and sensitivity to external cues	Attuned to others	Aware that his parents are unhappy
			~~Fear and worry~~	Takes in too much information		
				Environmental sensitivity		
Unmet needs			Conflict among family members	Dependency needs not being met	Resentment at not being attended to	Wanting his parents to see him more
				Interpersonal closeness needs not being met	Focus on parental discord	~~Aware that his parents are unhappy~~
					Feeling neglected	

Conceptualizing

Remembering that the task at this point is to try to create a logical narrative among the themes, applying psychological theory, so that it presents a coherent story, we have to connect the following themes:

- emotional distress
- poor coping
- acting out behavior
- high awareness
- unmet needs

Before deciding on the most logical way to fit all these themes together, we will first consider some of the model templates presented in Chapter 4: a diathesis–stress model, a developmental mismatch model, and a common function model for conceptualization.

Diathesis–Stress Model

In applying the diathesis–stress model of conceptualization, we must try to divide the themes into (1) traits inherent within Christopher that he likely developed at an even earlier age and that he "brings to the picture" (diatheses), (2) external issues that affect his functioning (stressors), and (3) states that are more situational or transient (outcomes). It is important to categorize each of our five themes into these three types. As always, the more convincing these categorizations are, the more likely Christopher's parents are to accept the recommendations given.

For Christopher, this model is relatively straightforward and intuitive. There are several themes that are easily outcomes, as they are generally not seen as inherent to an individual and their personality. Two seem more like personality characteristics, and one that seems clearly related to the impact of external forces on him. Beginning with this external theme, it seems clear that the fact that he has unmet needs is related to his external environment. At his age, these needs likely stem from his parents and secondarily from his teachers, school, and peers. The fact that he has environmental needs that are not being met can easily be argued as an external stressor.

Two themes generally not thought of as core to who an individual is in their personality or character are emotional distress and acting out. The assessor could easily argue that these are outcomes of other, more underlying, dynamics occurring within Christopher. While someone may be born with some kind of (perhaps genetic) predisposition for depression, very few people believe that a child can be born inherently sad. Other factors must play a part in creating this sadness. Especially with Christopher, the changes in his emotional and behavioral functioning (i.e., the fact that several years before he did not seem to be anxious, sad, or acting out) are also good clues that these themes may not be inherent to who he is as a person and that they are not likely diatheses.

However, the remaining two themes—his high awareness of what goes on around him and his vulnerability or lack of ability to cope with difficult things on his own—do seem to be more characteristic of who Christopher is as a person. These seem to be more related to his overall personality and defensive structure than to his current emotional or situational functioning. The diathesis–stress model for Christopher is shown in Figure 11.1.

When considering the viability of this model, we have to decide whether the model makes intuitive sense with the three categorized parts. That is, would the diathesis posed, combined with the external stressor, likely cause the outcomes? A boy who is highly vulnerable to becoming overwhelmed and who is acutely aware of what is happening around him, when he feels that his needs are not being met (and his parents are preoccupied with their own problems), could develop emotional symptoms such as anxiety and depression, and he could begin acting out behaviorally. This model seems to be arguable and relatively intuitive. The fact that this model is so straightforward yet so comprehensive serves as a strength, as Christopher's parents would likely understand it relatively easily.

Developmental Mismatch Model

The developmental model for Christopher is extremely interesting to think about, as he is only 6 years old. Along a developmental spectrum, he should be beginning to struggle with the task of taking initiative and leadership, according to Erikson's model of psychosocial development, as well as separation and individuation from his parents. According to Margaret Mahler and her colleagues (Mahler, Pine, & Bergman, 2000), he should feel that his parents offer a safe "home base," but he should also feel comfortable exploring his new social world at school, separate from them. What characterizes his current developmental functioning, however, are his lack of independent coping resources (his vulnerability) and his acute awareness of the world around him. These

FIGURE 11.1 **DIATHESIS–STRESS MODEL FOR CHRISTOPHER**

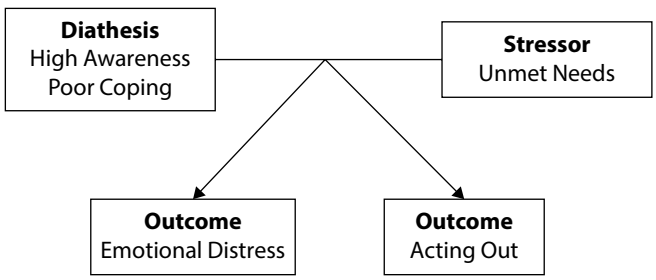
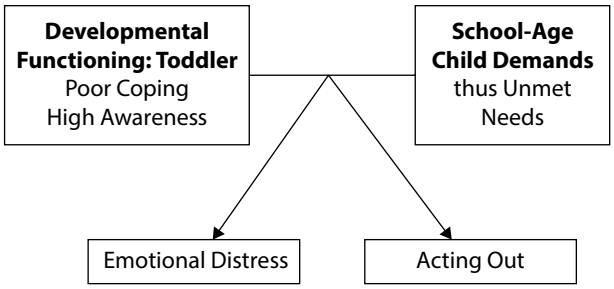


FIGURE 11.2 **DEVELOPMENTAL MISMATCH MODEL FOR CHRISTOPHER**



characteristics seem more like those of a toddler, who still needs their parents to help them cope with the world around them and is learning everything for the first time, taking in as much information as possible from the world around them, than a school-aged child. Accordingly, Christopher's developmental functioning and his real-world demands are not on the same developmental level, and this would likely cause problems.

Interestingly, although this is conceptualized differently, the model is almost identical to the diathesis–stress model for Christopher. Christopher's developmental model is shown in Figure 11.2.

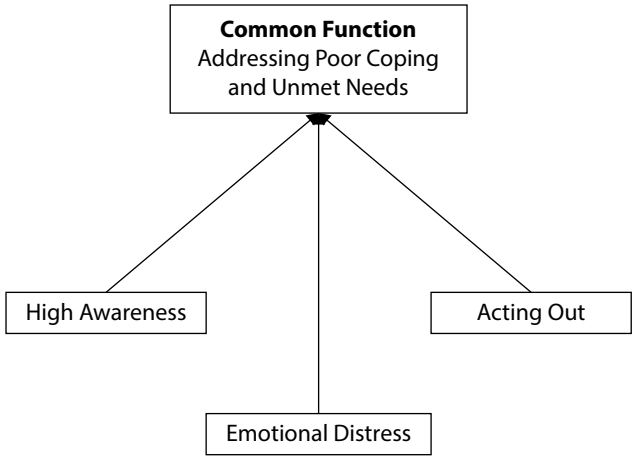
This model (still) makes intuitive sense, in general. There are two major benefits to conceptualizing Christopher in this way. First, rather than characterizing his difficulties coping (and to a lesser extent his high awareness) as some sort of weakness or problem, this model situates these traits along a developmental continuum, representing very normal behavior that is lagging slightly behind where it should be at this point. Second, this developmental model of his emotional and behavioral functioning could end up tying in well with any academic or cognitive delays he may have. Knowing that he is having difficulties in reading, but not in his cognitive or verbal ability overall, this reading difficulty could similarly be conceptualized as a normal but delayed developmental and academic process. The major drawback of this model, however, is that it would require a great deal of explanation of normal development for it to make sense to Christopher's parents. It may, in the end, just be too complex to be useful to the family.

Common Function Model

The common function model, as always, requires all of the themes to align such that they are serving a common purpose, which is generally embodied in one or two of the themes. The first step is to understand what common function Christopher would organize his defenses around addressing. That is, what are his basic underlying needs, which the other themes serve to address? In Christopher's case, it seems that what he really needs to cope with are his general difficulties coping with the world effectively and his unmet needs. If addressing these two problems is the common function, our model will need to argue that all the other themes are serving the purpose of coping with them.

His high awareness of his environment could certainly be argued to be a coping mechanism for his coping deficits and unmet needs, as he is vigilant to any potential difficulties around him. His acting-out behavior, as well, may serve the purpose of putting attention on the fact that he needs extra support. His emotional distress, however, seems less like defensive or coping mechanisms to deal with his coping deficits; they seem more like outcomes of his poor coping and unmet needs. In fact, a more logical model, rather than this common function model, might be a common cause model, in which the arrows come down from the common cause of the unmet needs and problems coping to lead to the outcomes of high awareness, acting out, and emotional distress. This model may be easier to argue than one in which each of the themes serves the common purpose of coping with

FIGURE 11.3 **COMMON FUNCTION MODEL FOR CHRISTOPHER**



poor adaptability and unmet needs. Although it does not make intuitive sense, the common function model for Christopher is shown in Figure 11..3.

This model could be argued, but it would be difficult to explain how emotional distress are helping Christopher address his poor coping and unmet needs. Consequently, the assessor would likely abandon this option pretty quickly.

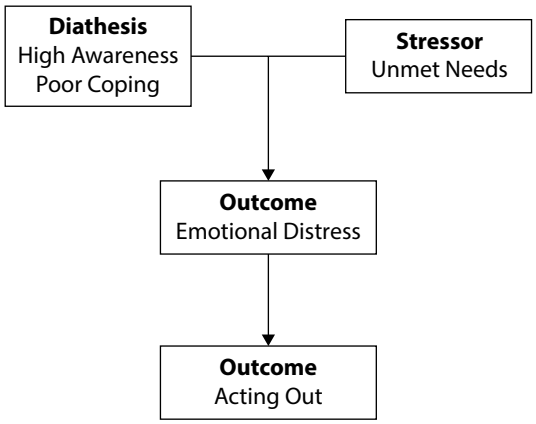
Complex Model

Both the diathesis–stress model and the developmental model seem to fit Christopher well. Either could be used for the final report. However, thinking about the themes in a slightly more complex way may lead to a more logical way to link several of them. While there would likely be no difficulty explaining how his diathesis (high awareness and poor coping) and stressor (unmet needs) together lead to emotional distress, their direct link to Christopher's acting-out behavior may make slightly less sense. Additionally, knowing that in childhood acting-out behavior is often secondary to emotional difficulties, it may make more sense to explain the acting-out behaviors as a result of his emotional distress, as a way he expresses his emotional discomfort.

This formulation represents only a slight modification of the diathesis–stress model, but conceptually it may be an important one, especially when it comes to diagnosis. Explaining to Christopher's parents that acting-out behaviors are often the result of emotional distress means that a diagnosis of anxiety and depression would explain the behavior, rather than needing a separate diagnosis for it. If the theme were on the same level as the anxiety and depression, it would make more sense that it is a second, equal outcome, and it may warrant its own diagnosis (something like oppositional defiant disorder). However, with this slight shift in the model, the assessor is including some psychoeducation to the parents about how anxiety and depression present in childhood. The complex model for Christopher is shown in Figure 11.4.

This model explains Christopher's difficulties well. Because he has insufficient coping mechanisms to deal with the world as effectively as he should, and because he is highly aware of his surroundings, especially his parents' marital difficulties and unhappiness, combined with not having all of his emotional needs met by his parents (perhaps also as a result of their own marital difficulties), he has developed some emotional distress, which manifests as symptoms of both anxiety and sadness. These contribute to some acting-out behaviors, as that is often how emotional difficulties are expressed in children. Although this model is not necessarily more "valid" than any of the others, it is certainly easier to write up and argue than some of the previous models.

FIGURE 11.4 **COMPLEX MODEL FOR CHRISTOPHER**



Report Writing

Before the report can be written, the final step of determining diagnosis and recommendations must be addressed. Beginning with Christopher's academic difficulties, the determination must be made whether he has (a) a reading disorder, (b) borderline intellectual functioning, (c) intellectual developmental disorder, or (d) no cognitive or academic diagnosis (because he is in an inappropriate bilingual classroom or his behavior problems have interfered with his attending to classroom lessons). Based on his average WISC-V results, both borderline intellectual functioning and intellectual developmental disorder are easily ruled out.

The determination of whether he has a reading disorder is slightly more difficult. The test results certainly suggest that his reading ability is lagging behind what is expected for his age. However, whether the reason for this lag is some sort of reading disorder or is related to his inappropriate classroom placement is less clear. The major evidence that helps make this determination is the fact that the actual difficulty Christopher is having in reading is in his capability to understand phonemes, decode words, and read phonetically. He is reading primarily via word recognition, which is working for him somewhat but will ultimately not work, as vocabulary becomes more difficult with higher level reading. However, these are skills that should have been mastered in kindergarten (when he was in an appropriate, monolingual English classroom).

Because many school systems currently use a response to intervention (RTI) model to determine learning disabilities, this complicates the diagnostic matter further. That is, many school districts require a low level of intervention for academic (in this case reading) problems, to see if a child's performance improves before determining if they need a higher level of intervention. Because his difficulties are in basic skills—phonetic mastery—that should have been mastered last year (when he was in a monolingual English classroom), we can err on the side of assigning him a learning disorder with impairment in reading to help ensure that he gets some additional intervention. He would certainly benefit from work with a reading specialist to help his phonetic reading skills. However, we will also recommend retesting after a period of intervention to see if his basic reading skills have improved.

As for his acting-out behaviors at school and at home, the testing data suggest that ODD, which should be diagnosed only when the acting-out behaviors cannot be attributed to any other reason or disorder, is not an appropriate diagnosis for Christopher, inasmuch as his behavior seems to stem from anxious and depressed feelings. It is clear that these symptoms are impairing his functioning and that they warrant a diagnosis. Thus, the major decision is how to diagnose these anxious and depressed feelings (which will encompass the acting-out behaviors as well)—an adjustment disorder, some type of anxiety disorder, or a depressive disorder.

Currently, there does not seem to be a concrete, identifiable stressor that triggered these symptoms (although the onset of his parents' marital difficulties likely contributed significantly). That is, if the behavioral (and emotional) difficulties had clearly begun after an identifiable stressor, such as beginning first grade in the bilingual classroom, then an adjustment disorder would be appropriate. However, because they began midway through kindergarten, and his parents and teacher could not identify any concrete transition or change to which he began adjusting at that point, an adjustment disorder can be ruled out. When the symptoms that were reported by his parents and his teacher and that emerged from testing data are considered, Christopher does not meet full criteria for any anxiety disorder or for major depressive disorder; he has no sleep or appetite difficulties and no reported concentration problems, fatigue, or thoughts of death. However, his depressive and anxious feelings are impacting him significantly, so a final diagnosis needs to encompass his sadness, his anxious feelings, and his acting-out behaviors. One way of encompassing these symptoms into a single disorder is through the use of a mixed anxiety-depressive disorder (Möller, Bandelow, Volz, Barnikol, Seifritz, & Kasper, 2016). Because this diagnosis is not in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*, the two possible ways to code it are as an other specified anxiety disorder, with depressive symptoms or as an other specified depressive disorder, with anxious distress. Both clearly represent a disorder that does not meet full criteria for another anxiety or mood disorder but comes with both anxious and depressive symptoms that are significantly affecting the person's functioning. In this case, we can choose the other specified depressive disorder, with anxious distress, simply because the anxious and depressive symptoms seem about equal in terms of evidence and intensity, with perhaps a bit more acknowledgment of the sadness, which was self-reported (while anxiety was not).

The diagnosis will also include a note that Christopher's parents' marital discord is likely having a very significant, detrimental effect on him. The *DSM-5* has a V-code (other conditions that may be a focus of clinical attention) for a child being significantly affected by their parents' marital discord.

Confidential Psychological Assessment Report

Identifying Information

Name:	Christopher Santiago	**Date of report:**	2/28/20
Sex:	Male	**Assessor:**	A. Jordan Wright, PhD
Age:	6		
Date of birth:	1/1/14	**Dates of**	1/21/20; 1/25/20;
Ethnicity:	Latino	**assessment:**	2/11/20; 2/13/20

Referral Source and Questions

The client was referred by his school to assess both his academic and behavioral functioning. Specifically, the school and his parents want to know what is underlying his difficulties with reading and his acting out behaviorally both in school and at home.

Measures Administered

- Clinical interview
- Collateral interview with mother and father
- Collateral interview with teacher

- Bender Visual-Motor Gestalt Test, 2nd Edition (Bender-2)
- Wechsler Intelligence Scale for Children, 5th Edition (WISC-V)
- Wechsler Individual Achievement Test, 3rd Edition (WIAT-III)
- Gray Diagnostic Reading Tests, 2nd Edition (GDRT-2)
- Behavior Assessment System for Children, 3rd Edition (BASC-3)
  - Parent Rating Scales—Child (PRS)
  - Teacher Rating Scales—Child (TRS)
- Personality Inventory for Children, 2nd Edition (PIC-2)
- Rorschach Performance Assessment System (R-PAS)
- Roberts Apperception Test for Children and Adolescents, 2nd Edition (Roberts-2)

Client Description

Christopher Santiago is a 6-year-old, Latino boy of somewhat small stature and athletic build for his age. He was well groomed and dressed casually and appropriately. He has a bright smile and a friendly demeanor, and he was extremely cooperative with the assessor throughout the assessment process. He seemed to make effortful attempts on all tests administered.

Presenting Problem and Its History

The client's parents and teacher reported that the client is having some difficulty with reading, not making as much progress as his peers in first grade. His reading ability was generally average last year in kindergarten until a few months before the end of the school year, when he began to exhibit some difficulties. This year, in first grade, he has reportedly not learned at the same rate as his peers. He has difficulty reading words and progressing through reading passages in class. He was reportedly an average student a year ago in his kindergarten class for most of the year, and this year he moved from a monolingual, English-speaking classroom to a bilingual English–Spanish first grade class, despite the fact that he does not speak Spanish (his home is monolingual English speaking).

Additionally, the client's parents and teacher reported that he is acting out behaviorally in school and at home. Reportedly, he has "tantrums" whenever his father asks him to do anything and sometimes with his mother and when he is frustrated at school. These tantrums include screaming, crying, and occasional aggressive behavior like hitting and throwing things. Both at school and at home, he is able to be calmed down from these tantrums and refocused. His parents reported that he has no history of acting-out behaviors prior to about 8 months ago. His tantrums reportedly began a few months before finishing kindergarten. They have been consistent since that time (about four months prior to this evaluation), occurring about two times per day in school and almost daily at home, especially with his father. Other than beginning first grade, there were no other clear or notable changes or transitions in his life prior to the beginning of the acting-out behaviors.

The client reported that at times he becomes sad, especially when he feels his parents do not see him enough, but he denied any thoughts of harming himself.

Relevant Background Information

The client is the only child in his family, and his parents have been married for about 12 years. His mother is attending nursing school at night, and his father works as a customer service representative at a bank. They reported an open and loving relationship with their son, including reading to him nightly as he goes to bed. They also reported, however, that they are having marital difficulties, to the point of considering divorce. They reported working hard to hide their marital problems from the client, confining their fights to times when he is at school or asleep. At the time of this report, they had not yet made a decision whether to divorce.

Other than with reading, the client performs academically adequately in school, and he has many friends, including a best friend he has had for about 1 1/2 years. He is reportedly popular among his peers, and he socializes often, both in and out of school. He has no history of abuse and no legal problems. He is one of several Latino children in his very diverse school, and he socializes freely with most of the other children.

The client's parents reported no difficulties during his mother's pregnancy with him. He reportedly had an easy temperament as a baby, crying only when hungry or in need of a diaper change and being easily consoled. He slept well throughout his infancy. He met all developmental milestones (e.g., crawling, walking, talking) on time and easily, including relatively easy toilet training. His parents reported no major medical or psychiatric problems in their own or the client's history, and none of the family members have ever received psychiatric treatment. The client's paternal grandmother had reportedly been depressed, but she had never been diagnosed or treated. No other family psychiatric history was reported. The client's parents denied any use of alcohol or drugs by the client or themselves.

Behavioral Observations

The client was extremely friendly and cooperative throughout testing. He gave effortful attempts on all tests administered. At times he became "bored" with some of the tests, so games were used as incentives to continue with the tasks at hand. He seemed to enjoy competitive games, but his mood was not highly affected by his winning or losing; he seemed to enjoy playing the games with the assessor, regardless of who won.

Mental Status Evaluation

The client was casually and appropriately dressed, well groomed, and extremely cooperative and friendly throughout the testing process, maintaining appropriate eye contact throughout. His motor activity was within normal limits. He disclosed information freely, except when asked to elaborate on anything negative he had reported, when he generally shrugged his shoulders and said, "I don't know." Both his receptive and expressive language ability were extremely good. His mood and affect were both happy, though he reported and exhibited some sadness at times. His thought process was generally goal directed, and his thought content was free of hallucinations, delusions, and suicidal and homicidal ideation. His memory seemed within normal limits, and his attention and concentration were adequate. His judgment and planning were good, and his impulse control was adequate, except when he got overly excited while playing an energetic game in sessions.

Overall Interpretation of Test Findings

Cognitive and Academic Functioning

General Cognitive Ability

The client was administered several measures to assess his current cognitive functioning. It should be noted that these measures evaluate his cognitive ability under ideal conditions and in the most ideal context; as such, they represent his cognitive ability rather than how he actually functions in his daily life.

In general, the client's overall cognitive ability is average for his age. His functioning across all of the assessed cognitive domains, including his verbal comprehension, which is especially important to his ability to function in school and learn reading and writing, was consistently average compared to his same-age peers. There were no indications of any specific significant strengths or weaknesses within his average overall functioning; notably, there were no areas of deficit or weakness.

Fine Motor Skill. On a measure assessing his ability to control his fine motor functioning deliberately and carefully, the client exhibited no difficulties in his fine motor control (Bender-2 Motor subtest, 51st–100th percentile). His control of his movement is not currently impaired.

Visual–Spatial Perception and Reasoning. On measures of visual perceptual ability, including nonverbal reasoning, visuospatial aptitude, and induction and planning skills on tasks involving nonverbal stimuli such as designs, pictures, and puzzles, the client performed within the average range compared to others his age (WISC-V Visual–Spatial Index, 61st percentile). Specifically, he showed no difficulty in his basic abilities with visual perception (Bender-2 Perception subtest, 51st–100th percentile) or in his more complex nonverbal reasoning skills (WISC-V Visual Puzzles, 63rd percentile).

Visual–Motor Integration. In addition to his adequate fine motor and visual perceptual abilities, his ability to coordinate and integrate his visual perception with his fine motor functioning is average for his age. On a task requiring him to copy complex drawings as precisely as possible without time restraint, which requires visual perceptual ability and the coordination between that ability and fine motor skills, he performed in the average range compared to others his age (Bender-2 Copy, 66th percentile). On a task requiring him to use blocks to recreate complex designs presented to him within a time limit, the client also performed in the average range for his age (WISC-V Block Design, 37th percentile). His ability to integrate his visual perception abilities with his fine motor skills is average.

Nonverbal Memory. The client's short-term visual memory, which was assessed only briefly using a visual memory task, was also average for his age. He exhibited average ability to remember visual information presented to him immediate afterward (Bender-2 Recall, 55th percentile). He exhibited no difficulty with learning or remembering nonverbal information.

Processing Speed. The client's speed of processing visual information and performing nonverbal tasks within a time limit (knowing he was being timed) is also generally average for his age (WISC-V Processing Speed Index, 50th percentile). He is able to work at a speed that is comparable with others his age when he focuses and puts effort into doing so.

Language. On measures of verbal ability, including verbal comprehension, ease of use of verbal skills, verbal knowledge, and the ability to express himself clearly and completely (all in English), the client's performance also fell within the average range compared to others his age (WISC-V Verbal Comprehension Index, 47th percentile). His ability to express himself clearly is average for his age (WISC-V Vocabulary, 63rd percentile), as is his abstract understanding of language and use of words in complex and abstract ways (WISC-V Similarities, 37th percentile). His average language ability is a good predictor of how he should be performing academically in general.

Fluid Reasoning. The client's ability to understand underlying conceptual relationships between things and solve novel types of problems using reasoning is also average compared to others his age (WISC-V Fluid Reasoning Index, 50th percentile). He exhibited no difficulties related to his ability to think abstractly about underlying concepts and patterns of information.

Working Memory. On tasks assessing his ability to concentrate, learn new information, hold it in short-term memory, and manipulate that information to produce some result or reasoning outcome, the client's performance also fell within the average range for his age (WISC-V Working Memory Index, 50th percentile). His ability to hold onto and manipulate information in his head is average both for verbal information (WISC-V Digit Span, 50th percentile) and for nonverbal information (WISC-V Picture Span, 50th percentile).

Academic Achievement

The client's academic achievement was evaluated and compared with a general national normative group, not necessarily to peers in his current school or class setting.

The client's academic performance revealed average achievement in his academic oral language use (such as listening to instructions), mathematics, and writing. However, he exhibited some weakness in reading, especially in the basic reading skills required as a foundation for adequate reading, such as phonetic reading ability.

Academic Oral Language. The client's academic oral language abilities are average for his grade level (WIAT-III Oral Language, 47th percentile). His ability to understand and make sense of language presented to him aloud is average for his grade level (WIAT-III Listening Comprehension, 50th percentile), as is his ability to express academic information clearly and completely (WIAT-III Oral Expression, 53rd percentile).

Reading. The client exhibited low average overall achievement in reading for his grade level (WIAT-III Total Reading, 12th percentile; GDRT-2 General Reading Composite, 18th percentile); however, there was some variation in his reading abilities. Specifically, he exhibited significant difficulties related to basic, early reading skills, including phonetic awareness and chunking (WIAT-III Early Reading Skills, 6th percentile) and ability to use phonetics to decode words (WIAT-III Pseudoword Decoding, 6th percentile; GDRT-2 Decoding Composite, 6th percentile), both falling below average for his grade level. However, his actual word reading by recognition and speed and ease of reading fluently are stronger, falling in the average range for his grade level (WIAT-III Word Reading, 25th percentile; WIAT-III Oral Reading Fluency, 25th percentile). Interestingly, the more complex task of understanding what he reads (comprehension) was also low average to average for his level of education (GDRT-2 Reading Comprehension Composite, 18th percentile; WIAT-III Reading Comprehension, 34th percentile). Although he has difficulty with the basics of understanding phonemes and decoding words, he has compensated well through word recognition in general.

Writing. The client's writing abilities are in the average range compared with the written expression ability of others at his grade level (WIAT-III Written Expression, 34th percentile). The client's speed and ease of alphabet writing is average (WIAT-III Alphabet Writing Fluency, 50th percentile), as is his spelling (WIAT-III Spelling, 25th percentile) and ability to construct meaningful, grammatical sentences in writing (WIAT-III Sentence Composition, 50th percentile).

Mathematics. Similar to his writing abilities, the client's overall math abilities are average for his grade level (WIAT-III Mathematics, 63rd percentile). Specifically, his speed, ease, and accuracy of performing basic arithmetic are adequate (WIAT-III Math Fluency, 50th percentile). Similarly, he exhibited average knowledge of mathematical concepts (WIAT-III Math Problem Solving, 63rd percentile) and actual ability to solve progressively more difficult actual math problems with pencil and paper when given unlimited time (WIAT-III Numerical Operations, 63rd percentile). He exhibited no difficulties in mathematics.

Cognitive and Academic Summary

The client's overall, general cognitive ability is average. On tests of academic performance, he performed as expected, in the average range for his grade level, on measures of mathematics, writing, and oral language ability. However, he showed some weakness in his reading ability, specifically in his basic understanding of phonetics and use of them to decode words.

Emotional and Behavioral Functioning

The client and his parents and teacher were administered several measures to assess his current emotional and behavioral functioning. It should be noted that the focus of these measures is on areas of need rather than a comprehensive overview of all of his emotional and behavioral strengths and weaknesses. As such, this section will necessarily focus on areas of his functioning that need support.

The client's assessment revealed that he is a child who is both highly vulnerable to becoming overwhelmed, as he does not have the adequate resources to cope with the stressors of his life on his own, and highly attuned to and aware of what is happening in his environment. Specifically, he is currently highly aware of his parents' marital difficulties, which have contributed to the client's high needs for attention and care not being addressed well enough by them. Together, his difficulties coping, high awareness, and unmet needs have contributed to some emotional distress, including both feelings of anxiety and feelings of sadness. As is common with children

experiencing emotional difficulties, his sadness and anxiety are exhibiting themselves as acting-out behaviors both in school and at home.

Underdeveloped Coping Skills. The client is extremely vulnerable to becoming overwhelmed by stresses in his life, because he does not have the coping skills necessary to effectively manage them. The client has limited psychological resources to cope with the world (R-PAS), which manifests in him having difficulty overcoming stress and adversity (BASC-3 PRS; BASC-3 TRS). This difficulty emerges at times when there are changes in what is expected, such as routine, and disappointment (BASC-3 PRS), in addition to him at times becoming very quickly irritable (BASC-3 TRS). His underdeveloped coping skills mean that he needs to rely more on his parents, peers, and teachers than most other children his age to help him cope with stress.

High Awareness. The client is highly attuned to what goes on around him, maintaining a great awareness of those around him (more so than others likely realize). He is highly attuned to others, focused on and sensitive to what they do to a greater degree than many others his age (R-PAS; Roberts-2). He may be taking in too much information from the outside world, in fact, more than he is able to effectively handle (R-PAS). An example of his high awareness is his reported awareness that his parents are unhappy, a fact they reported they are working hard to hide from him. It should be noted that, related to his underdeveloped coping abilities, he is highly affected by what is going on in his environment and what he is highly attuned to (R-PAS).

Unmet Needs. Although his parents are caring and loving toward him, the client feels that his needs for security, attention, and support (which are higher than many other children his age, because of his underdeveloped coping skills) are not being met by them. He feels somewhat neglected (Roberts-2), specifically that his needs for closeness and support are not fully being met (R-PAS). This relates to him reporting that he wishes his parents would see him more. It should be noted that he is building some resentful feelings about his parents not quite meeting his needs (Roberts-2). It is very likely that the conflict between his parents (PIC-2) is contributing to them not attending to him as much as he needs them to.

Emotional Distress. The combination of him having underdeveloped coping skills, high awareness of what is going on around him, and some unmet needs for support and closeness has contributed to him having developed some emotional distress, including symptoms of both anxiety and sadness. The client struggles with some nervousness, fear, and anxiety that is outside his control (BASC-3 PRS; BASC-3 TRS; PIC-2; R-PAS), including worried thoughts about him not being able to take care of himself (Roberts-2). Additionally, he struggles with sadness (BASC-3 PRS; BASC-3 TRS; Roberts-2), pessimistic thinking (PIC-2; R-PAS), and some loneliness (Roberts-2). He also reported that he gets sad at times, though he did not discuss his anxiety.

Acting-Out Behaviors. Quite common for children who are experiencing emotional distress, his sadness and anxiety exhibit themselves in acting-out and oppositional behaviors both at school and at home. As was made clear in the clinical interviews, the client struggles to maintain control over his behaviors at school and at home (BASC-3 PRS; BASC-3 TRS; PIC-2; R-PAS; Roberts-2). He is especially bad at maintaining control over his behaviors when he is faced with adversity or confused about his emotions (BASC-3 TRS; Roberts-2), which can lead to tantrums, meltdowns, and general oppositional behavior.

Summary

Christopher Santiago is a 6-year-old, Latino male who currently lives with his parents. He was referred for psychological assessment to assess what is underlying his reading difficulties and his recent behavioral acting out at school and at home. He is currently in a bilingual Spanish–English classroom, though he does not speak any Spanish. Additionally, his parents are having marital difficulties, which they are trying to keep hidden from the client.

Cognitively, he is currently functioning within the average range compared with others his age in his overall ability, including his verbal abilities in English. On tests of academic performance, he performed as expected, in the average range for his grade level, on measures of mathematics, writing, and oral language ability. However, he showed some weakness in his reading ability, specifically in his basic understanding of phonetics and use of them to decode words.

Emotionally, he is highly vulnerable to becoming overwhelmed, as he does not have the adequate resources to cope with the stressors of his life on his own, and highly attuned to and aware of what is happening in his environment. Specifically, he is currently highly aware of his parents' marital difficulties, which have contributed to the client's high needs for attention and care not being addressed well enough by them. Together, his difficulties coping, high awareness, and unmet needs have contributed to some emotional distress, including both feelings of anxiety and feelings of sadness. As is common with children experiencing emotional difficulties, his sadness and anxiety are exhibiting themselves as acting-out behaviors both in school and at home.

Diagnostic Impression

Currently, the client meets criteria for a specific learning disorder, with impairment in reading (*DSM-5* code 315.00; *ICD-10* code F81.0). Specifically, his basic reading skills (e.g., understanding phonemes, applying phonetics to decoding words) are weak for his age and education level. While he is currently compensating by reading words by sight (rather than decoding them), and he is understanding what he reads adequately, as reading tasks become more sophisticated and harder, he will need the foundational skills and will not be able to rely on his compensatory techniques. His reading difficulties are likely exacerbated by the fact that he is in an inappropriate classroom setting (a bilingual English–Spanish class).

Additionally, the client currently meets criteria for a mixed anxiety-depressive disorder, which is categorized as an other specified depressive disorder, with anxious distress (*DSM-5* code 311; *ICD-10* code F32.8). Specifically, while he does not meet criteria for a full anxiety disorder or depressive disorder, he has a mixture of anxious and depressed symptoms that are significantly impairing his functioning, leading him to act out behaviorally in oppositional and impulsive ways at home and at school.

It should be noted that another area that should be a focus of clinical attention is child affected by parental relationship distress (*DSM-5* code V61.29; *ICD-10* code Z62.898). His parents' unhappiness and family discord can contribute significantly to his emotional distress.

Recommendations

1. The client's parents should discuss the results of this assessment with his school and any potential treatment providers.
2. The client should be placed in a monolingual English-speaking classroom as soon as possible.
3. The client should be afforded some educational accommodations and interventions at school. Specifically, he should be referred to a reading specialist or special education teacher support service (SETSS) to remediate his phonetic reading skills (this should be considered Tier 2 RTI intervention). More exposure and practice in decoding words and carefully sounding them out should help improve his reading ability relatively rapidly. He should receive individual reading remediation at least three times per week.
4. The client's parents should provide him (either through school or independently) with counseling services. Specifically, a CBT orientation that includes components of behavioral parent training (BPT) and other family involvement can help the client build more and more effective coping skills and help his parents provide necessary supports to him.
5. The client should be reevaluated in 6 months, before the beginning of his next academic year, to determine if the reading intervention has helped him develop the necessary basic reading skills to continue to progress in general education in second grade.

_____ _____

A. Jordan Wright, PhD
New York State Licensed Psychologist

Date

Multiple recommendations emerge from the conclusions (and diagnoses) drawn from this evaluation. The first two recommendations are the most straightforward: the client's parents should discuss the results of the evaluation with the school, and he should be moved to a monolingual English-speaking classroom immediately (in fact, he was even before the feedback session or report were given, based on the immediate recommendation in the middle of the assessment process).

The cognitive and academic assessment has built a strong argument for him to receive targeted, specific remediation in his basic reading skills, which should be provided by his school. Because even his basic reading skills are not that far below average, but also because the school year is half over and he is not developing in reading as he should, a medium "dosage" of three times per week is recommended (if his basic reading scores were much lower, a higher "dosage" of five times per week would have been recommended; if it were the beginning of the school year, a lower "dosage" of once weekly might have been recommended). Because of the RTI mindset of schools, the remediation is considered part of this process, and it is recommended that he be re-assessed before entering second grade.

The other recommendation that emerges from the conclusions and emotional diagnosis is some sort of psychotherapeutic treatment, which can help Christopher gain coping skills and also get more support from his parents (especially given their marital difficulties). When considering depression, anxiety, and acting out behaviors, the evidence-based treatments range from CBT (for depression) to family-based CBT (for anxiety) to behavioral parent training (BPT; for disruptive behaviors). A MATCH-ADTC (Chorpita & Weisz, 2009) approach may also be beneficial, to focus on specific symptomatic aspects of Christopher's presentation. Couple counseling would likely benefit Christopher's parents as well, even if only to navigate a separation effectively (it should be noted that you have the option to make this recommendation in the feedback session but leave it out of the report, which is what happened in this case).

Feedback

Preparation for Feedback

When considering exactly what feedback to give and how to give it to Christopher's parents, perhaps the most important consideration is the fact that his parents are likely not expecting to hear that their marital problems are impacting Christopher significantly, especially given that they think he is unaware of them. Additionally, care must be taken not to shame his parents and make them feel that any problems are entirely their fault. This is extremely important, because by almost all accounts, they are very good parents. Their lack of transparency with their son, who happens to be overly perceptive of his surroundings and does not cope with uncertainty or change that well, must be addressed, however.

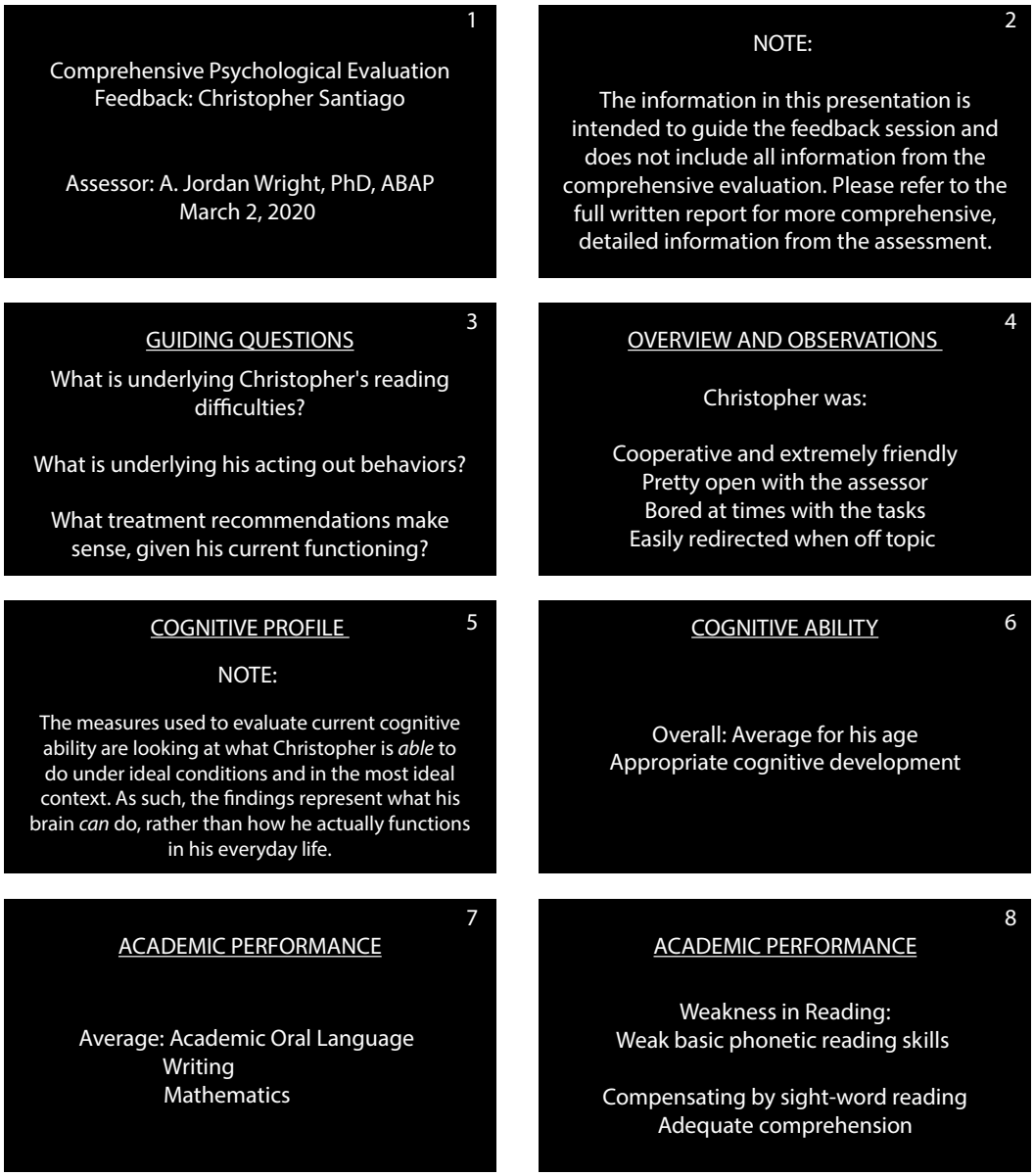
The major considerations when deciding exactly how to give feedback to Christopher's parents were (a) the level of cognitive and intellectual functioning of his parents, (b) their level of insight, and (c) the specific type and amount of information that had to be relayed to them. With a 6-year-old child, the assessor decided to give feedback to the parents alone and then to bring Christopher in to receive some very abridged feedback in front of his parents. Regarding their intellectual capacity, Christopher's parents were bright and articulate, so they could be given the entire report as is, without needing to create a summary sheet. Regarding their level of insight, as discussed previously, they seemed relatively unaware of Christopher's emotional state and their impact on it. The amount of feedback to give them must be driven both by the report itself and constant reevaluation of how they are responding to the feedback, as some of it may be difficult for them to hear. Ultimately, the assessor

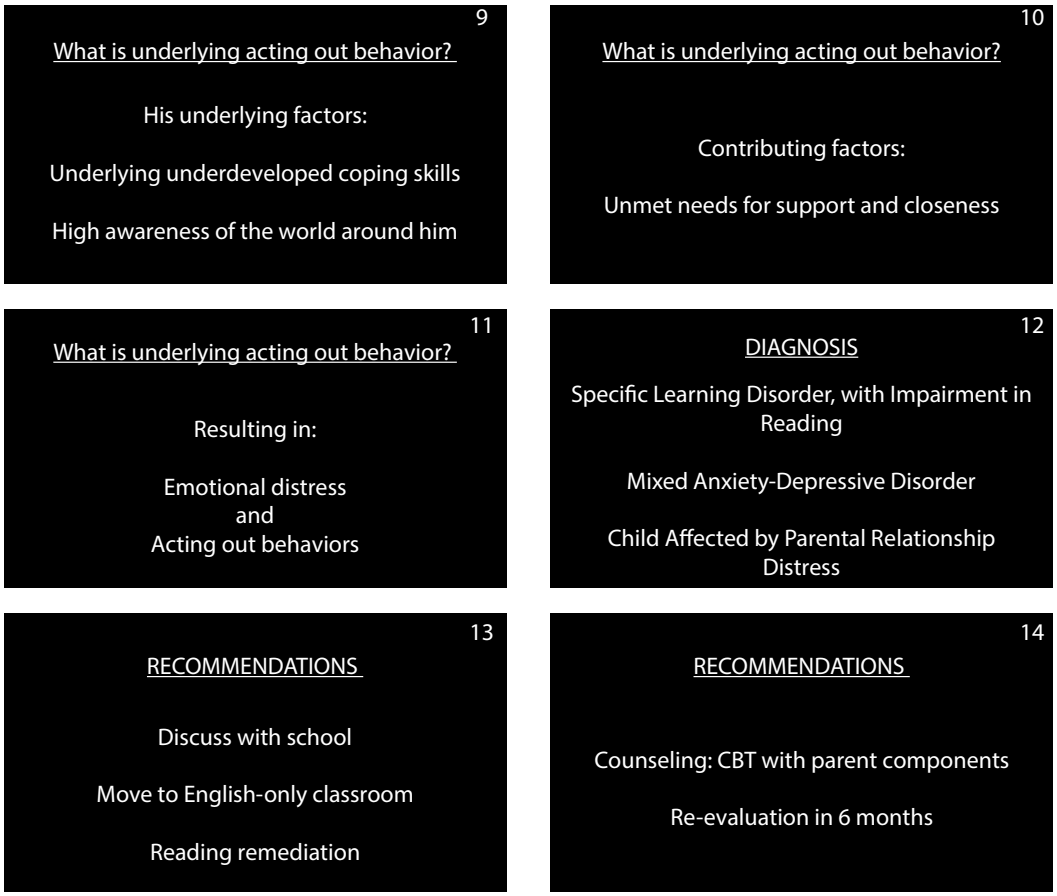
was confident that Christopher's parents would take the recommendations, because their primary concern was their son's well-being.

The assessor also decided to give the feedback verbally before giving Christopher's parents the actual report. He wanted to ensure that they understood every piece of the feedback and had an opportunity to ask questions or discuss reactions, without the distraction of needing to look at a lengthy report. The plan was to discuss the cognitive and academic feedback first and then to discuss the emotional functioning, with plenty of time for reactions and questions.

Feedback Presentation

The assessor decided to create a feedback presentation for the case to organize and guide the feedback session.





Feedback Session

Christopher and his parents came in for their feedback session, and a colleague played with Christopher in another room while the assessor gave feedback to his parents. As always, the assessor oriented them to how the feedback session would flow, letting them know that they could stop the assessor at any point if they had questions or reactions to anything being said. He emphasized the point that there would be two parts to the feedback—one focusing on Christopher's academic functioning and the other focusing on his acting-out behavior. They were encouraged to let the assessor know whenever anything did not align with their own thoughts or feelings. They had no questions at this point, so the assessor moved on to the cognitive and academic feedback.

The cognitive feedback, although a major focus of the assessment and the current feedback session, was relatively straightforward to give. The parents had already been encouraged to have Christopher transferred from his bilingual English–Spanish class to a monolingual English-speaking classroom, which had been successfully done the week before. The assessor explained that there were no deficits or weaknesses in his overall cognitive ability and that he was developing appropriately cognitively, which they seemed happy to hear.

He also reported that, as anticipated, Christopher's reading ability was somewhat lower than would be expected. He explained that at least part of this weakness is likely due to the fact that he was in an inappropriate classroom. He explained in detail, however, how when Christopher reads words correctly his comprehension is unimpaired but that Christopher had significant difficulty decoding words into their component parts (i.e., reading them phonetically) to read them. He explained that this is a skill he should have learned and mastered last year in

kindergarten, which for some reason he did not. He further explained that work with a reading specialist or SETSS on phonetic decoding would be extremely helpful and would likely lead to marked improvement relatively quickly. They had no questions, other than asking where they could find a reading specialist. The assessor told them that Christopher's school should have one on staff to provide this service, but if for any reason they had questions (or wanted to pursue it independently from school) they were welcome to reach back out for additional support.

The rest of the session focused on the emotional and behavioral functioning section of the feedback. The assessor began by explaining that the first part of the feedback was about some of Christopher's more core characteristics, the "type of child" he is. He began by stating that Christopher has a great number of strengths, including extremely good social skills, good self-esteem, and a loving family. He then reported that, based on the assessment, Christopher has some difficulty coping with and adapting to changes in the world around him and in his life. This feedback elicited some reaction from his parents, who then reported that he had always had difficulty with change. They told a story about moving into a new apartment when he was 3 years old and how he had cried for about a week about it. His mother stated that she thought he had gotten better at adapting because of his relatively smooth transition to school in kindergarten. They seemed a bit apologetic for not mentioning some of these things earlier in the process, and they understood that Christopher's gaining coping skills was a process and that he might be better than he was before but still has some growing to do.

The second aspect of his underlying states that emerged was his extremely acute awareness of what was going on around him in his environment and with his parents. His parents looked at each other cautiously, and then his father said somewhat quietly, "He knows about us, doesn't he?" The conversation then turned to the next theme—the fact that he has needs that are unmet by his parents. Rather than simply reporting this theme, however, the assessor asked Christopher's parents how they imagined it might affect Christopher to know about their marital difficulties but not to be told about them as though they might not actually exist. His mother said "confusing," and his father said "frightening and unsettling." The assessor validated their insights and empathized with the difficult position they were in. He assured them that no parents want their children to know about marital difficulties. He also repeated that Christopher's seeing it but the family's not discussing it could be confusing, frightening, and unsettling, using their words. He then specified that with Christopher, it was causing some emotional distress, specifically some sadness and anxiety.

The focus of the session then moved to the fact that, in childhood, emotional distress is often manifested as behavior problems. The assessor explained that Christopher's acting out at home and at school was his way of expressing his emotional difficulties. Both his parents listened quietly while nodding their heads slightly. When he asked if this feedback made sense, they both confirmed that it made sense and clearly explained what was going on with Christopher. His mother then asked what they should do about it, if and how they should talk to him about their marital problems. The assessor then made the recommendation to them to consider couple's counseling (which he made a point to tell them was not in the report, but he wanted to recommend it anyway). He explained that couple's counseling could be helpful in several ways, and even if they decided to divorce it could help them do so in the most beneficial way possible for Christopher.

The assessor noted that while the couple's counseling could help them work through some of their difficulties as a couple, individual therapy (with a family component) could be useful for Christopher as well to improve his coping skills. Interestingly, Christopher's parents had a conversation, almost as if the assessor were not present, about beginning couple's counseling. They discussed how it could work logistically, with their schedules, and how it could benefit all three of them, and they decided to try it. They again asked about resources, this time for individual counseling for Christopher. The assessor again recommended that they discuss with their school first and, if they needed an outside referral, to get back into contact with him.

The assessor then gave them a copy of the report and led them quickly through it, encouraging them to read it in its entirety when they got home and let him know whether they had any questions about it. They thanked the assessor and began to get up to leave, but the assessor reminded them that he wanted to give Christopher some feedback as well so that he did not think he did all that testing for no reason. Christopher's father left to get Christopher and brought him back into the room.

When Christopher was in the room with his parents, he first gave the assessor a high five (a ritual at the beginning of each of his testing sessions). The assessor explained that he wanted to let Christopher know what had come out of all the "puzzles and things" they had been doing. The way he framed it, though, was organized around the recommendations rather than the problems. He began by telling Christopher that he thought he should get some extra help with reading, as he knew his current struggles could be "kind of frustrating for you." The assessor said that his parents would work with school to find "someone nice" to help him practice. He seemed happy about this. Next, the assessor said that he was going to find someone to help him with his emotions, which he knows "sometimes suck."

Christopher then looked at his parents, both of whom had an encouraging look on their faces. His mother added that they wanted to make sure they were doing everything they could so that he knew how much they loved him. He responded by jumping into her lap and letting her hug him. His father scooted his chair so that it was touching his wife's chair and he could put his hand on Christopher, too. The assessor asked Christopher if he had any questions.

Christopher seemed too involved in the family hug to respond to the assessor, but the assessor wanted to make sure that his parents heard the language he was using to explain therapy to Christopher so that they could repeat it when they needed to. As they got up to leave, thanking the assessor, Christopher ran full speed into the assessor's leg, throwing his arms around it in a tight hug. He looked up at the assessor with a wide smile and then he giggled and ran out of the room. Then his parents shook the assessor's hand and left.

Summary

In addition to some straightforward reading problems, Christopher's case uncovered two major areas that needed to be addressed in his life: his inappropriate placement in a bilingual classroom and the parental secret of their marital difficulties. From a family systems perspective, Christopher was charged with keeping this family secret, though the information was likely confusing, as he may not know whether to trust his own observation (that there was a problem) or his parents (who were hiding it). All this converges to cause problems for Christopher. The way he was expressing his emotional difficulties was by acting out behaviorally, which in many ways is lucky. Had he not saliently had difficulties (i.e., had he just hidden any unhappiness or emotional difficulty inside), he might not have been referred for services. He could have stored up these negative feelings for much longer until they became dangerous. Luckily, his acting out was noticed and addressed relatively early so that the negative feelings could be dealt with before they grew. Although his parents felt some guilt about contributing to their son's difficulties, their care and concern for him would ultimately lead them to find some extra support to make sure he was doing well.

CHAPTER 12

An Adolescent Girl With School Problems

Francesca Palomi was a 14-year-old White girl who was referred by her pediatrician for an assessment for several reasons. In making the referral, the pediatrician noted that Francesca had some cognitive and behavioral difficulties, that she had completed an organizational skills group in an outpatient clinic recently and was on multiple medications, and that despite this she was struggling in school.

The Clinical Interview

The first appointment for the clinical interview was made for both Francesca and her parents. At her age, she should be able to contribute significantly to a clinical interview, and especially because the presenting problem appeared to be academic, it is likely that she and her parents would agree about different aspects of the problem itself. As such, the strategy was for the assessor to use a semistructured clinical interview with Francesca and her parents together and then to ask her parents to leave the room and follow up with some additional questions for Francesca alone. This strategy often works well with adolescents to help them feel aligned with and connected to the assessor rather than like their parents are on a team with the assessor against the adolescent. The plan was to follow up with her parents about any necessary information by phone. This would avoid the illusion that he parents would be told whatever she said right after she was seen alone.

The family was about 20 minutes late to the first session. Francesca's mother apologized and said that they left home late and then had to stop and buy Francesca a snack because she asked for one. It should be noted that the planned session was only an hour and a half (to do consents/assent and the clinical interview), so a snack did not seem entirely necessary. They were all appropriately and casually dressed and generally friendly, though Francesca was quiet and generally looked bored and even rolled her eyes at some points throughout the initial interview—even during the consent process. Although she was asked for assent (she was asked specifically to sign the form), she was visibly irritated and said that it was not her choice to come in for an evaluation, "but I guess I'll just sign." At this point her mother sighed loudly and her father put his hand on her mother's leg, seemingly to calm her down or acknowledge her frustration and support her. It became clear during the consent process that there was significant family tension and that it may have been better to interview her parents alone and then interview Francesca alone on a separate day. However, because they were all already present for the session, the assessor forged ahead with all of them, with a plan to meet with Francesca alone for the second half of the session (or for as long as possible).

For this assessment, a semistructured clinical interview was used to collect the background and contextual information. The interview is organized into overall domains (e.g., presenting problem, cognitive complaints,

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mood complaints, developmental history, medical history), with broad questions to start and more specific follow-up questions about specific symptoms as needed. The assessor prefaced the process by clarifying that he would be asking many questions directed generally at whoever wanted to answer them. Francesca should not feel specific pressure to speak in front of her parents if she did not want to. The overarching structure of the interview follows, without every specific question included. As always, the assessor let the family know that he was going to ask them lots of questions—some broad and some very specific and some that may not apply to Francesca because they are the same questions he asks everybody.

Presenting Problem: Alright, so what do each of you want out of this assessment? What questions do you want answered?

The family was silent for a few moments, seemingly unsure who would respond. After a brief silence, though, Francesca's mother said that Francesca has "severe problems" paying attention and following directions at home and at school. She said that Francesca goes to a Catholic school, and they are quite strict and have high expectations for appropriate behavior in school. She said that teachers have reached out to her and Francesca's father to let them know that Francesca often plays with things at her desk instead of focusing on lessons, gets up and wanders around during class when she is not supposed to, and generally does not follow instructions well. She began to talk about Francesca's behavior at home, but the assessor interrupted (apologizing) to pause her and ask Francesca if what her mother was reporting was accurate.

Francesca shrugged, and everyone sat in silence for a bit, looking at her. Her mother said her name in an exasperated voice, but the assessor said it was ok if Francesca did not want to talk at the moment. Her mother continued that Francesca exhibits the same behaviors at home and in church (mass), which they attend twice a week. Her mother said that she fidgets during mass in ways that are inappropriate and significantly different and worse "than anyone else her age." She also stated that Francesca needs instructions given to her multiple times for her to be able to implement them; she said that "very often" if she hears instructions only one time she adamantly insists that she was never told. Her mother glanced at Francesca and added that she believes that Francesca is being honest when she says this, rather than just trying to get out of doing what she was asked to do. Her mother then began to discuss additional problems with Francesca acting out behaviorally, but again the assessor interrupted her, apologizing, and asked her about Francesca's history of difficulties with attention and fidgetiness.

Francesca's mother reported that teachers in kindergarten had told her about several problems, including focus, hyperactivity, and difficulty learning letters appropriately. She said they suggested getting an evaluation for a learning disability, but they "never got around to it." Now Francesca is in eight grade and not doing very well academically and has struggled academically consistently throughout school, somehow managing to "muddle by." Francesca shrugged again.

Francesca's mother then returned to the additional problems she was about to discuss earlier in the session. She said that Francesca has been "trantruming" since she was a toddler—that she is oppositional, breaks rules, and "tantrums" both at school and at home and has throughout her schooling. She said that Francesca is "needy" and sensitive, interrupting any attention given to her siblings, even when it is extremely disruptive (such as at bedtime). She said that Francesca's behaviors are very obvious to her because she has a sister 1 year younger who is "very calm." She said that she was evaluated by her pediatrician about 3 years ago and medicated for her difficult behavior, addressing both attention deficit hyperactivity disorder (ADHD) and anxiety and depression. Her mother added that since she was diagnosed with anxiety and depression, Francesca has "used it as an excuse to be a nightmare." Francesca, with her arms crossed, sat stoically, eyes cast downward all through these descriptions.

The assessor decided at this point to shift the session to the more specific symptom evaluation in the semistructured interview because he was getting less comfortable with the way Francesca's mother was talking about her in front of her.

Cognitive Status Complaints: OK, let's talk a little more about your thinking. You seem to have some problems with your attention and concentration. Can you tell me more about that?

Francesca shrugged and said that everything her mother had said is true: She has problems paying attention and does not mean to be rude to her mother or teachers, but sometimes she "can't help it." The assessor asked her and her parents then about her memory, language comprehension, word finding, visuospatial skill, problem solving, and decision-making. Her mother answered most of the questions, basically reporting no difficulties "when she hears things." They both denied any problems with hallucinations and delusions.

Emotional Status Complaints: So that's your thinking. Let's talk about feelings. Tell me about your mood in general.

Again, the family sat in silence, looking at Francesca to answer. And again, Francesca shrugged. Her mother and father both reported that she "seems angry all the time." They discussed her "storming" into her room and slamming her door often, getting into arguments with them and her teachers, and rolling her eyes a lot at them even when she was not angry. Her father discussed how he is unsure whether her problems with getting homework done are about her disorganization or about how she is "so angry that she just can't get stuff done." Throughout this, Francesca looked down at her lap. Rather than ask for more examples of her anger in front of her, the assessor assured her parents he understood that she has some anger and asked if there were any other issues with her mood, like anxiety or signs of depression such as helplessness, hopelessness, or low self-esteem. Francesca's parents said, "Who could ever know? We just see the angry." The assessor asked Francesca directly, but she did not respond. So he decided he would ask her later when they were talking without her parents present.

The assessor continued with the semistructured interview, asking about Francesca's sleep, appetite, energy level, hobbies, symptoms of mania and hypomania, and any suicidal ideation. They denied problems in all these areas, and Francesca even spoke up to deny any thoughts of harming or killing herself.

Family Context and History: Tell me about your family.

The client's mother said that they have seven children; three are adults and do not live at home, and Francesca is the oldest of those living at home. She has a sister a year younger, "who is so calm," and a brother and sister who are twins and are 7 years old. She said that Francesca is closest with her younger sister and that they have a "pretty good" relationship, though she said her sister has a difficult time "dealing with Francesca's moodiness." She said that Francesca physically and verbally fights a great deal with her younger twin siblings, especially "when she feels they are getting more attention than she is." The assessor glanced at Francesca, who was still looking at her lap.

The assessor asked for more details about Francesca's fighting with her younger siblings, especially about the physical fighting (to see if anyone was in potential danger of serious harm). Her mother said that "it never gets too out of hand" but that Francesca will often shove the twins or wrestle with them when she is upset. Francesca is obviously much bigger than her young siblings, "but she never really hurts them." She also said that Francesca

fights with her older siblings a great deal, and one of them has even stopped coming home to visit because she "can't deal with" Francesca's behavior.

The assessor asked some specific details about the family like marital history and quality of their relationship to ensure that he understood the family structure. All seven children were theirs together. Francesca's father said that the relationship he and his wife had was generally good but that at times it was strained "because of the stress of behavior around the house," clearly referring to Francesca. They denied any significant family changes or events that could have some major effect on Francesca and her development.

Developmental History: OK, were there any problems or complications with your pregnancy or the Francesca's birth?

Francesca's mother said that she had no problems with pregnancy or with delivery of Francesca, which was "pretty easy." She said that Francesca met all her developmental milestones appropriately and on time but that she had low muscle tone and received occupational therapy as a toddler because of it. She also said Francesca needed speech therapy in kindergarten because others had some difficulty understanding her speech clearly. However, she said Francesca was very resistant to going to speech therapy, and her pediatrician discovered that she had fluid in her middle ear. She received an ear tube, and her speech development caught up quickly.

Medical History: Any other medical problems, either now or in the past?

Francesca's parents quickly and easily responded that there were no other medical problems, and her father added that they make sure to take her for a physical every year because of "almost missing" the problem with fluid in her ears (and misattributing her articulation problems to a speech and language disorder). They also reported that she had never had any head injuries or lost consciousness.

Educational History: OK, let's switch to school. Tell me about academic performance.

Francesca's mother started by saying that Francesca's school performance "could be much, much better." She said again that Francesca goes to a Catholic school, and she said that she gets a great deal of attention there. A "learning specialist" sees her five times a week to work with her individually and to give her quite a few accommodations, but she "still usually gets grades in the 60s and 70s." The assessor asked for details about the accommodations she currently receives at school, and her mom said that Francesca gets extra time on exams, breaks during testing, revised and simplified test directions, and occasional prompts during tests and assignments from teachers to remain on task. Francesca added that she also gets to take tests in a room separate from everyone else. The assessor asked how she got all these accommodations, and her mother shrugged (looking a lot like Francesca when she did) and said, "I guess they just know she has some sort of extra needs." The assessor confirmed that she had never been formally tested or diagnosed for a learning disability, but the school added the accommodations because she was struggling so significantly.

The assessor continued the educational context and history section of the semistructured interview by asking about whether Francesca had ever repeated a grade or qualified for special education, both which her mother denied. Her father added that he is very unsure whether her academic problems are "real" or a result of her problems with behavior and attention in school.

Family Medical History: Are there any major medical or psychiatric problems in your family?

Francesca's parents both said that there were no medical problems in their family but that both sets of their parents (Francesca's grandparents) had been depressed in the past. They added that one of Francesca's older

siblings has significant anxiety and goes to therapy and takes medication for it. They denied any other major problems, though.

Psychiatric History: OK, tell me about your history in therapy.

Francesca's mother said that Francesca had been in play therapy when she was very young, but none of the family could remember even roughly when that was, except that it was "before preschool." She said that she was unsure how long it lasted; eventually Francesca refused to continue going, so it ended. She said that when Francesca was in second or third grade, a teacher at school suggested behavior charts for all of the children in the home, but Francesca got so upset by seeing her younger siblings progressing on their charts that she ripped them up.

Francesca's mother repeated that their pediatrician had diagnosed Francesca with ADHD, anxiety, and depression about 3 years ago and initially prescribed her Prozac and Ritalin. Francesca refused to continue on the Prozac quickly after beginning it because of gastrointestinal problems, and her pediatrician prescribed her Wellbutrin, which she currently takes. Additionally, over the past 3 years her pediatrician has altered her ADHD medication from Ritalin to Strattera to Adderall to (currently) Vyvanse, reportedly because none of them was "fixing her" enough to be able to be still and focus at school. Other than her play therapy as a young child, she has not engaged in any other form of counseling or psychotherapy.

Substance Use History: Any history of using alcohol or any other drugs?

Francesca's mom said that they do not know of Francesca ever having used alcohol, nicotine, or any other drugs, and she and her husband looked hopefully over at Francesca. Francesca groaned and said in an irritated tone, "You know I don't do any of that shit!"

Legal History: Do any of you have any involvement in the legal or court system?

Francesca's parents looked a tad confused, and the assessor had to list off a few examples of being involved in lawsuits, being arrested or convicted of crimes, and being involved in custody battles. They said that nobody in their family had ever been involved in anything illegal or in any court cases.

Social History and Context: Tell me about your social life.

Francesca spoke for the first time at length, saying that she does not really have friends because her three best friends from the past few years have been talking about her behind her back and they have all been fighting. She said she does not really "get along with" other kids in her grade but that she has an easier time with younger children. Her mother agreed with her, saying that she gets along well with friends of her 7-year-old siblings, and she said that Francesca's teacher said that Francesca hangs out with younger kids at school as well. Francesca again spoke up and repeated that she does not really have friends.

The assessor asked and all three denied any history of sexual trauma or abuse, and Francesca said that she was not sexually active: she said, "I don't even have friends!" and smirked a bit, the first sign of positive affect she had displayed throughout the interview.

Cultural Evaluation: Tell me about your culture and identity.

Francesca looked at the assessor and eventually shrugged, and her mother rolled her eyes and said that they are Catholic and very involved in their church. They attend mass multiple times a week, and Francesca's father teaches Sunday school. "Other than that," she said, "we're just a normal White family."

Current Stressors: So what are your biggest stressors in life at the moment?

Francesca's father said that their biggest family stress is Francesca, and the assessor jumped in quickly to stop him from elaborating for two reasons. First, it was already clear that Francesca was difficult for her family and was having a tough time. Second, the assessor did not feel that Francesca needed to hear yet again that she is a bad kid. So the assessor said, "OK, but anything else?" Francesca's father and mother said that they did not have any other major stresses; when the assessor asked Francesca specifically, she shrugged.

Individual Clinical Interview

At this point, with the semistructured interview completed, the assessor asked Francesca's parents to leave the room so that he could continue the interview with Francesca alone.

Presenting Problem Revisited: OK, so I heard what your mom had to say about what's going on. Do you have anything to add? And do you think what she said accurately reflects what's going on with you?

With Francesca now alone with the assessor and without her parents, she opened up and spoke much more freely. She reported that she gets in trouble at school because she is disorganized and often leaves her homework at home (or forgets that she had the homework to begin with and did not do it). Additionally, she said that she is angry a lot and that "it doesn't take much to set me off." But she also said she is anxious about school and does not feel happy very often. She also acknowledged that she has very little patience for her younger siblings (the 7-year-old twins) "who get whatever they want, whenever they want it" and shared that she also fights with them.

The assessor followed up on multiple areas to verify the information that had been provided previously, and Francesca confirmed that most of it was accurate, including her having few friends and "no interest in a boyfriend." She said that she does not like church because "it makes me feel worse about myself." When asked to clarify, she said that she has trouble behaving the way others behave in church, and everyone there makes her feel ashamed of herself for her behavior and "not being good enough."

Current Stressors: I heard from your parents, but what are your biggest stressors in life at the moment?

Francesca said that "it sucks" not having friends and getting into fights with girls she thought were her friends. She discussed getting into arguments with lots of different peers, reiterating that she does not get along with others her age. She also said, "I suck at school," and that she would like to be doing better. She also said that it is difficult for her not having anyone to talk to about her problems, which the assessor empathized with and noted for later, as this may signify an openness and willingness to engage in some sort of counseling or psychotherapy.

Mental Status Evaluation

Appearance and Behavior

Francesca was late for every session, and each time her mother explained the reason as Francesca wanting to stop to get something on the way and her mother allowing it. Francesca was appropriately dressed and groomed throughout the process, and she was markedly different in her relatedness with the assessor when her parents were present and when they were not. When her parents were present, she made minimal eye contact, spoke very little, and appeared sullen. When she was alone with the assessor, she was much more appropriately engaged, elaborated on ideas, spoke openly, and kept conversation going well. She exhibited noticeable fidgeting behaviors

throughout the testing process like tapping her feet, twirling a pen, and tapping her fingers on the desk, even during tasks that required concentration.

Speech and Language

Francesca's speech and language were unremarkable. When her parents were present, she often spoke in sarcastic (passive-aggressive) tones, but when alone with the assessor she had appropriate volume, articulation, vocabulary, grammar, and rate.

Mood and Affect

Francesca reported feeling happy only infrequently, and her affect was very much aligned with this—very infrequently smiling or exhibiting positive affect. She reported some anxiety, irritability, and angry feelings, though these were not observed during the testing process except for her impatience with and resulting passive-aggressive behavior toward her parents. Otherwise, her affect was somewhat constricted.

Thought Process and Content

Francesca's thoughts as articulated in sessions were goal directed, logical, and free from problems like tangential, circumstantial, magical, or overly concrete thinking. She did not exhibit any overt difficulties understanding what was going on or instructions given to her, even on complex cognitive tasks, and she denied hallucinations and any delusional or magical thoughts. She reported significant depressive ideation, including worthlessness and low self-esteem, helplessness, and hopelessness, but she denied any suicidal ideation.

Cognition

Francesca was alert and engaged throughout the assessment. Her memory seemed intact, though she had some difficulties maintaining attention on tasks that lasted longer than a few minutes. With prompting, she was able to refocus her attention on tasks in the moment, though.

Prefrontal Functioning

Francesca and her parents reported significant problems with Francesca's judgment, planning, and impulse control, though they were generally adequate during the assessment process. She exhibited no overt signs of impulsivity, though she was noticeably fidgety during most of the process.

Hypothesis Building

Now that the clinical assessment (the clinical and collateral interviews and the mental status evaluation) has been completed, the information gathered can be used to create hypotheses for what might be going on for Francesca.

Identify Impairments

Clearly, Francesca is struggling in multiple areas of difficulty. First, she is obviously having difficulties with her attention, executive functioning, and academics. These issues, even though they were presented as the primary purpose of the assessment, are only one set of impairments. She also has difficulty in her emotional functioning (especially with what seems to be a great deal of depressive symptoms), her behavioral functioning (including oppositional behaviors), and her social functioning. Additionally, some family dynamics are certainly problematic.

As these are all intertwined impairments in her functioning, we will need to make sure to account for all of them when we develop hypotheses and ultimately select tests.

Enumerate Possible Causes

First, we can focus on Francesca's cognitive and academic functioning. There seems to be a great deal of evidence for problems in her attentional and executive functioning systems—and a previous pediatrician diagnosis of ADHD—so we can easily include ADHD as a hypothesis. Academically, certainly her problems with attention and behavior seem to be negatively impacting her actual ability to do her schoolwork, but there may also be actual problems with learning and academic achievement (which can often frustrate children and adolescents and feed behavioral and emotional problems), which would signify specific learning disorders. Whenever a child is struggling academically, even if educators or parents attribute this to defiance, attention problems, or other factors, a learning disability should be assessed and ruled out.

Francesca's emotional turmoil also already seems extreme (even for an adolescent), based only on the clinical assessment. She is struggling with low self-esteem, irritability, problems with anger, and other depressive symptoms as well as some anxiety. Having previously being diagnosed with both depression and anxiety (again, by her pediatrician) and medicated for them, we will of course consider the presence of both mood and anxiety disorders. These may include any combination of disorders, and all will be considered when conceptualizing the case.

Francesca's social difficulties seem very much tied to her other problems, and the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)* and *International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10)* do not include any diagnoses to explain only social difficulties in the way she is experiencing them. So we then move to her other behaviors. Her fidgeting is certainly aligned with ADHD, and her impulse control problems and tantrums could be tied to ADHD as well or could signify the presence of either oppositional defiant disorder (ODD) or intermittent explosive disorder. With the possible exception of some physical aggression toward her younger siblings, her reported behaviors do not seem severe enough to warrant a hypothesis of conduct disorder (CD), but any testing for the other disruptive behavior disorders will necessarily evaluate CD as well.

Finally, although problems within the family dynamic are obvious, the degree of these problems is less clear at this point. The *DSM-5* does not have specific disorders for truly problematic family systems or interactions, but it does include within the section on "Other Conditions That May Be a Focus of Clinical Attention" the possibilities of including both parent–child relational problem and sibling relational problem. These are important for many reasons, and it should be noted that Francesca may be both a driving factor in problematic family dynamics and a reciprocal target of family problems. That is, problematic family dynamics are complicated, with reciprocal relationships between parenting behaviors and child behaviors ultimately feeding into self-sustaining, problematic systems and patterns (e.g., Tiberio, Capaldi, Kerr, Bertrand, Pears, & Owens, 2016).

As always, we will consider (a) that the presenting problems have an etiology in substance use and (b) that the presenting problems have an etiology in a medical condition. Although Francesca adamantly denied any substance use, the level of irritability does raise some red flags. However, her patterns of behavior, especially having developed many years ago, seem to indicate less acute onset and focal problems. This is the same for a medical condition, in addition to the fact that she has yearly physicals and no major medical issues have emerged. As such, we will continue to assess the psychological processes that likely underlie her problems.

Selecting Tests

Beginning with the cognitive hypotheses posited for Francesca, we need to develop a battery of cognitive tests to understand her general intellectual ability, her attention and executive functioning, and her academic skills.

To understand her overall intellectual ability, we will use the Wechsler Intelligence Scale for Children, 5th Edition (WISC-V). As part of this overall understanding, as always, the Bender Visual-Motor Gestalt Test, 2nd Edition (Bender-2) will add some other basic cognitive skills, including fine motor skills, visual–perceptual ability, and short-term visual memory. In this case, to understand her attention, we will add a Conners' Continuous Performance Test, 3rd Edition (CPT-3), with other tests to measure other aspects of executive functioning: the Delis-Kaplan Executive Function System Trail Making Test (D-KEFS Trails) and the Wisconsin Card Sorting Test, Computer Version Fourth Edition (WCST-IV). Additional subtests of the D-KEFS can always be added to better understand different aspects of executive functioning, if needed. To assess her general academic functioning, a broad achievement test will be used—the Wechsler Individual Achievement Test, 3rd Edition (WIAT-III). Again, other academic measures can be added to clarify and add nuance to any difficulties that emerge from the broader achievement test, as needed. However, this cognitive battery should give a solid snapshot of her current cognitive and academic abilities.

Although this battery provides a picture of her current intellectual, cognitive, attentional, executive functioning, and academic abilities, we need to add an assessment of her actual, everyday (typical) functioning. Often, this comparison between what an individual is able to do and how they actually do in their real life is extremely important for understanding what is going on with them. For Francesca, we can use the parent, teacher, and self-reports of the Comprehensive Executive Function Inventory (CEFI), which will provide normative comparisons of her actual behaviors related to maintaining attention, controlling her impulses, regulating her emotional reactions, and engaging her other executive functions (like planning, organizing, and multitasking) in her everyday life.

For the remaining emotional and behavioral hypotheses (e.g., depression, anxiety, ODD, intermittent explosive disorder), we can build a single battery of tests to evaluate them all since most of the broad-based emotional and behavioral measures for adolescents will include information relevant to each of them. For this age, we can enlist a combination of reporters, including Francesca, her parents, and her teachers. For self-report, we can use multiple measures to evaluate her emotional functioning in slightly different ways. These include the Minnesota Multiphasic Personality Inventory-Adolescent-Restructured Form (MMPI-A-RF), the Personality Assessment Inventory-Adolescent (PAI-A), and the Millon Adolescent Clinical Inventory (MACI). Under certain circumstances, we could certainly pare this down and not use all three, and each has advantages and disadvantages. However, with the luxury of time and resources, we will err on the side of collecting more data from her. In fact, because of her "tantrums" and irritability, we will add a more specific measure of emotion regulation to better understand whether her emotional experiences are comparatively typical for adolescents (who of course experience significant emotional turmoil) or if it is outside the norm. For this, the Difficulties of Emotion Regulation Scale (DERS) has been shown to add useful information for adolescents (e.g., Weinberg & Klonsky, 2009).

To build evidence across reporters, we will also add measures that enlist Francesca's parents and teachers to report on her behaviors and functioning from their perspective. The Behavior Assessment System for Children, 3rd Edition (BASC-3) provides information across multiple domains of functioning (including signs of depression, anxiety, attention problems, hyperactivity, and oppositional behavior) from self, parent, and teacher perspectives. Because of the potentially problematic family dynamics, we will add two other measures. While the Personality Inventory for Children, 2nd Edition (PIC-2; a parent-report measure) has many scales that overlap and are redundant with the BASC-3 parent report, some scales related to family conflict and parental adjustment can be useful. The BASC-3 and PIC-2 have the added benefit of providing information on everyday attentional and hyperactive and impulsive behaviors, which will inform the ADHD hypothesis along with the CEFI. Additionally, while most of these measures include information about the family dynamic and parent–child relationship, in this case it will be useful to use a specific measure of Francesca and her parents' and siblings' dynamics,

so we will add the parent and self-report forms of the Parent Adolescent Relationship Questionnaire (PARQ), which has been shown to be very useful in understanding potentially problematic dynamics in the parent–adolescent relationship (e.g., Robin, Koepke, Moye, & Gerhardstein, 2009).

Finally, because our current assessment thus far is so heavily reliant on self- and other-report measures, to round out the thinking, emotional, and behavioral assessment we can use the Rorschach Performance Assessment System (R-PAS) to add a performance-based measure of functioning. The R-PAS is especially useful in understanding how individuals perceive and think in more ambiguous situations (which adolescents certainly face all the time), so it can help inform the ADHD hypothesis and add some information for the other hypotheses.

Thus, our assessment's battery of tests will consist of

- Bender-2
- WISC-V
- D-KEFS Trails
- CPT-3
- WCST-IV
- WIAT-III
- BASC-3 (self-, parent, and teacher reports)
- PIC-2
- CEFI (self-, parent, and teacher reports)
- MMPI-A-RF
- PAI-A
- MACI
- R-PAS
- PARQ
- DERS

Accumulating the Data

Table 12.1 shows the results from each performance-based cognitive and academic measure administered. On the WISC-V, Francesca performed within the average range compared with others her age overall (Full Scale IQ [FSIQ] of 98, 45th percentile). Most of her indices were average, including her verbal comprehension index, which was a 98 and fell within the 45th percentile. She showed strength in her Fluid Reasoning Index (112, 79th percentile) and especially her visual working memory (Picture Span was 14, 91st percentile). Her measures of attention and executive functioning, though, were significantly worse.

Focusing on the more interesting data in the cognitive testing, we can organize all the results that relate to ADHD-like pathology, including selective and sustained attention, working memory, impulse control, and cognitive control (which includes impulse control plus other executive functioning abilities). If we organize those findings to look across measures, we see a picture of pretty problematic executive functioning, including attention. Table 12.2 shows reorganized data for different aspects of executive functioning.

Table 12.3 shows the data that emerged from Francesca's personality, emotional, and behavioral measures. As always, the order of measures and methods presented is not extremely important, but measures that are broader and have stronger empirical evidence are listed first (the broad-based self-report measures), followed by the broad-based performance measure (R-PAS), and finally the measures that tap into more specific aspects of her functioning (such as the CEFI and DERS). There was so much overlap between parent and teacher report on the BASC-3 and on all three CEFI raters that they were collapsed into one table for ease even

TABLE 12.1 **FRANCESCA'S COGNITIVE DATA**

Test	Index or scale	Classification
WISC-V	Full Scale IQ	Average
	Verbal Comprehension Index	Average
	Visual Spatial Index	Average
	Fluid Reasoning Index	High average
	Working Memory Index	High average
	Processing Speed Index	Average
	Cancellation Subtest	Below average
Bender-2	Copy	High average
	Recall	High average
	Motor	Unimpaired
	Perception	Unimpaired
D-KEFS Trails	Visual Scanning	Below average
	Number Sequencing	Average
	Letter Sequencing	Average
	Number–Letter Switching	Low average
	Motor Speed	Below average
CPT-3 (first trial)	Detectability	Elevated
	Omissions	Slightly elevated
	Commissions	Elevated
	HRT SD	Very elevated
	Variability	Elevated
	HRT Block Change	Elevated
	Omissions by Block Change	Significant increase
	Commissions by Block Change	Significant increase
CPT-3 (second trial)	Detectability	Elevated
	Omissions	Elevated
	Commissions	Elevated
	HRT Standard Deviation	Elevated
	Variability	Very elevated
	Hit Reaction Time Block Change	Elevated
	Omissions by Block Change	Significant increase
	Commissions by Block Change	Significant increase
WCST-IV	Total Errors	Average
	Perseverative Errors	High average
	Nonperseverative Errors	Low average
WIAT-III	Oral Language Composite	Average
	Listening Comprehension	Low average
	Oral Expression	Average
	Reading Composite	Average
	Written Expression Composite	Average
	Mathematics Composite	Average
	Math Fluency Composite	Average

TABLE 12.2 **FRANCESCA'S ORGANIZED EXECUTIVE FUNCTIONING–RELATED DATA**

Test: / Theme:	WISC-V	D-KEFS Trails	CPT-3	WCST-IV	WIAT-III
Selective attention	Poor selective attention (Cancellation subtest)	Poor selective attention (Visual Scanning)	Poor attention (Detectability, Omissions, HRT SD, Variability)		Weak attention (Listening Comprehension)
Sustained attention			Poor sustained attention (HRT Block Change, Omissions by Block Change, Commissions by Block Change)	Weak sustained attention (Nonperseverative Errors)	Weak attention (Listening Comprehension)
Working memory	High average working memory (Working Memory Index), though stronger for visual than verbal				
Impulse control and related functions		Low average impulse control and applying new strategies (Number-Letter Switching)	Poor impulse control (Commission Errors)	High average impulse control, self-monitoring, and adapting to feedback (Perseverative Errors)	

TABLE 12.3 **ACCUMULATION OF FRANCESCA'S DATA**

MMPI-A-RF

Dysfunctional negative emotions (depressive and anxious)
Self-demeaning
Feels persecuted
Somatization-headaches
Attention problems
Stress and anxiety
Prone to anger
Negative attitudes toward school
Aggressiveness

PAI-A

Somatization
Anxiety (lots)
Phobias
Cognitive signs of depression (rumination)
Irritability
Unstable emotions
Low self-esteem
Negative relationships

MACI

Family discord problems
Self-devaluation
Peer insecurity
Impulsivity
Some anxiety
Depressive feelings (pessimistic)
Interpersonally abrasive
Resentful and angry
Defiant and cocky
Impatience
Alternates between passive-aggressiveness (disrespect) and impulsive anger
Expects the worst from relationships/others
Low tolerance for frustration

BASC-3 Self-Report of Personality

Negative attitudes toward school and teachers
Anxiety
Depression
Somatic and health-related concerns
Attention problems
Hyperactivity
Low self-esteem
Low self-reliance

(Continued)

TABLE 12.3 (*CONTINUED*)

Problematic interpersonal patterns
Anger

BASC-3 Parent and Teacher Rating Scales[a]

Anxiety
Depression
Somatic and health-related concerns
Attention problems
Hyperactivity
Problematic interpersonal patterns
Anger
Difficulty adapting to change and disappointment
Poor social skills
Very poor executive functioning—problem solving (disorganized and haphazard)
Very poor executive functioning—attentional control
Very poor executive functioning—behavioral control
Very poor executive functioning-emotional control
Defiant

PIC-2

Attentional problems
Academic difficulties
Disruptive behavior
Hyperactivity
Impulsiveness
Noncompliance
Family conflict
Anxiety
Depression
Peer conflict

R-PAS

Very complex thinker—can get disorganized
Anxious rumination
Uncomfortable with emotions and emotionally stimulating information
Some confusion
Sees self as damaged or flawed
Significant problems with understanding other people accurately
Lots of need to be supported by others
Expects aggressiveness from others

CEFI[b]

Attention problems
Emotion regulation problems
Impulse control problems
Planning, organization, and working memory problems

TABLE 12.3 (*CONTINUED*)

PARQ
Problems with communication between parents and adolescent
Parent–child arguments about school
Sibling conflict
Parents believe that adolescents should behave flawlessly
Believes parents are unfair
DERS
Problems with goal-directed behavior when upset
Impulsive and out of control when upset
Weak skills for changing mood when upset
Clinical interview and behavioral observation data
"Severe problems" paying attention and following direction at home and at school
Gets up and wanders around during class when not supposed to
Fidgets during church
Needs instructions given to her multiple times
Has "tantrums"
Oppositional and breaks rules
"Seems angry all the time"
Fights with 7-year-old siblings
Difficulty getting along with others in her grade
Does not have friends
Disorganized with homework and remembering to do it or bring it back to school
Anxious in school
Does not feel happy often
Church makes her "feel worse about [herself]"
Feels that she "suck[s] at school"

[a] The parent and teacher BASC-3 results were extremely similar and thus were collapsed into a single set of evidence.

[b] The self, parent, and teacher CEFI results all revealed the same problems, and thus were collapsed into a single set of evidence.

though they are listed separately in the report. The final set of data nuggets listed are from the clinical interview and observations. Only a small number of nuggets that seemed especially salient or important are shown in the data table since not every piece of information that emerged from the clinical interview can be included. (Self-report in a clinical and collateral interview setting is another method used in an integrative, multimethod assessment.)

Identifying Themes

We will begin identifying themes with Francesca's data using the seven traditional psychological themes: self, others, thinking, feeling, behavior, coping, and context. As always, any piece of data that logically could fit into more than one theme will be labeled as such, and we will figure out later where it best belongs. The preliminary themes for Francesca's data are presented in Table 12.4.

TABLE 12.4 **IDENTIFYING FRANCESCA'S THEMES**

Themes	
	MMPI-A-RF
Feeling	Dysfunctional negative emotions (depressive and anxious)
Self	Self-demeaning
Feeling	Feels persecuted
Feeling	Somatization (headaches)
Thinking	Attention problems
Feeling	Stress and anxiety
Feeling	Prone to anger
Context	Negative attitudes toward school
Others	Aggressiveness
	PAI-A
Feeling	Somatization
Feeling	Anxiety (lots)
Feeling	Phobias
Thinking	Cognitive signs of depression (rumination)
Feeling	Irritability
Feeling	Unstable emotions
Self	Low self-esteem
Others	Negative relationships
	MACI
Context	Family discord problems
Self	Self-devaluation
Others	Peer insecurity
Behavior	Impulsivity
Feeling	Some anxiety
Feeling	Depressive feelings (pessimistic)
Others	Interpersonally abrasive
Feeling	Resentful and angry
Behavior	Defiant and cocky
Behavior	Impatience
Others and Feeling	Alternates between passive-aggressiveness (disrespect) and impulsive anger
Others	Expects the worst from relationships and others
Coping	Low tolerance for frustration
	BASC-3 SRP
Context	Negative attitudes toward school and teachers
Feeling	Anxiety
Feeling	Depression
Feeling	Somatic and health-related concerns
Thinking	Attention problems

TABLE 12.4 (*CONTINUED*)

Themes	
Behavior	Hyperactivity
Self	Low self-esteem
Self	Low self-reliance
Others	Problematic interpersonal patterns
Feeling	Anger
	BASC-3 PRS/TRS
Feeling	Anxiety
Feeling	Depression
Feeling	Somatic and health-related concerns
Thinking	Attention problems
Behavior	Hyperactivity
Others	Problematic interpersonal patterns
Feeling	Anger
Coping	Difficulty adapting to change and disappointment
Others	Poor social skills
Thinking	Very poor executive functioning—problem solving (disorganized and haphazard)
Thinking	Very poor executive functioning—attentional control
Behavior	Very poor executive functioning—behavioral control (impulsive)
Feeling	Very poor executive functioning—emotional control
Behavior	Defiant
	PIC-2
Thinking	Attentional problems
Context	Academic difficulties
Behavior	Disruptive behavior
Behavior	Hyperactivity
Behavior	Impulsiveness
Behavior	Noncompliance
Context	Family conflict
Feeling	Anxiety
Feeling	Depression
Others	Peer conflict
	R-PAS
Thinking	Very complex thinker—can get disorganized
Thinking	Anxious rumination
Feeling	Uncomfortable with emotions and emotionally stimulating information
Thinking	Some confusion
Self	Sees self as damaged/flawed
Others	Significant problems with understanding other people accurately
Coping and Others	Lots of need to be supported by others

(Continued)

TABLE 12.4 (*CONTINUED*)

Themes	
Others	Expects aggressiveness from others
	CEFI
Thinking	Attention problems
Feeling	Emotion regulation problems
Behavior	Impulse control problems
Thinking	Planning, organization, and working memory problems
	PARQ
Context	Problems with communication between parents and adolescent
Context	Parent–child arguments about school
Context	Sibling conflict
Context	Parents believe that adolescents should behave flawlessly
Context	Believes parents are unfair
	DERS
Feeling	Problems with goal-directed behavior when upset
Behavior	Impulsive and out of control when upset
Coping	Weak skills for changing mood when upset
	Clinical interview and behavioral observations data
Thinking	"Severe problems" paying attention and following direction at home and at school
Behavior	Gets up and wanders around during class when not supposed to
Behavior	Fidgets during church
Thinking	Needs instructions given to her multiple times
Behavior	Has "tantrums"
Behavior	Oppositional and breaks rules
Feeling	"Seems angry all the time"
Others and Context	Fights with 7-year-old siblings
Others	Difficulty getting along with others in her grade
Others	Does not have friends
Thinking	Disorganized with homework and remembering to do it or bring it back to school
Feeling	Anxious in school
Feeling	Does not feel happy often
Self	Church makes her "feel worse about [herself]"
Self	Feels that she "suck[s] at school"

Organizing the Data

Francesca's reorganized data are presented in Table 12.5. When the data are reorganized and examined within themes, some of the themes become clearer and more specific, whereas others need to be reorganized. For example, the self theme is extremely clear—it describes an adolescent with significant struggles with self-esteem. Similarly, the coping theme describes a girl with ineffective skills for coping with the stressors of her life. However, some pieces of data need to be reconciled because they are divided among more than one theme. Additionally, some of the themes could do with some reorganizing.

TABLE 12.5 **FRANCESCA'S ORGANIZED DATA**

Test: / Theme:	MMPI-A-RF	PAI-A	MACI	BASC-3	PIC-2	R-PAS	CEFI	PARQ	DERS	Interview and Behavioral Observations
Feeling	Dysfunctional negative emotions (depressive and anxious)	Somatization	Some anxiety	Anxiety	Anxiety	Uncomfortable with emotions and emotionally stimulating information	Emotion regulation problems		Problems with goal-directed behavior when upset	"Seems angry all the time"
	Feels persecuted	Anxiety (lots)	Depressive feelings-pessimistic	Depression	Depression					Anxious in school
	Somatization (headaches)	Phobias	Resentful and angry	Somatic and health-related concerns						Does not feel happy often
	Stress and anxiety	Irritability	Alternates between passive-aggressiveness (disrespect) and impulsive anger	Anger						
	Prone to anger	Unstable emotions		Very poor executive functioning—emotional control						
Self	Self-demeaning	Low self-esteem	Self-d evaluation	Low self-esteem		Sees self as damaged and flawed				Church makes her "feel worse about [herself]"
				Low self-reliance						Feels that she "suck[s] at school"

(Continued)

TABLE 12.5 (*CONTINUED*)

Test: Theme:	MMPI-A-RF	PAI-A	MACI	BASC-3	PIC-2	R-PAS	CEFI	PARQ	DERS	Interview and Behavioral Observations
Thinking	Attention problems	Cognitive signs of depression (rumination)		Attention problems	Attentional problems	Very complex thinker—can get disorganized	Attention problems			"Severe problems" paying attention and following direction at home and at school
				Very poor executive functioning—problem solving (disorganized and haphazard)		Anxious rumination	Planning, organization, and working memory problems			Needs instructions given to her multiple times
				Very poor executive functioning—attentional control		Some confusion				Disorganized with homework and remembering to do it or bring it back to school
Context	Negative attitudes toward school		Family discord problems	Negative attitudes toward school and teachers	Academic difficulties			Problems with communication between parents and adolescent		Fights with 7-year-old siblings
					Family conflict			Parent–child arguments about school		
								Sibling conflict		
								Parents believe that adolescents should behave flawlessly		

								Believes parents are unfair		
Others	Aggressiveness	Negative relationships	Peer insecurity	Problematic interpersonal patterns	Peer conflict	Significant problems with understanding other people accurately				Fights with 7-year-old siblings
			Interpersonally abrasive	Poor social skills		Lots of need to be supported by others				Difficulty getting along with others in her grade
			Alternates between passive-aggressiveness (disrespect) and impulsive anger			Expects aggressiveness from others				Does not have friends
			Expects the worst from relationships and others							
Behavior			Impulsivity	Hyperactivity	Disruptive behavior		Impulse control problems		Impulsive and out of control when upset	Gets up and wanders around during class when not supposed to
			Defiant and cocky	Very poor executive functioning—behavioral control (impulsive)	Hyperactivity					Fidgets during church
			Impatience	Defiant	Impulsiveness					Has “tantrums”
					Noncompliance					Oppositional and breaks rules
Coping			Low tolerance for frustration	Difficulty adapting to change and disappointment		Lots of need to be supported by others			Weak skills for changing mood when upset	

Finalizing Themes

We need to understand a great deal of data before Francesca's themes can be finalized. First, we can determine if some themes already nicely work as they are. Reading across the data, three themes emerge as relatively consistent, straightforward, and cohesive: self, context, and coping. Each has enough data across measures to sustain itself, and each tells a clear story. The self theme can easily be relabeled low self-esteem since every nugget of data within the theme consistently supports Francesca's struggle with self-esteem (regardless of how she presents in the moment during the assessment). The context theme includes conflict and discord in both the family and school context. Although these could be separated, it is likely more useful to keep together and is thus labeled as such. Finally, the coping theme presents a girl with insufficient skills to deal effectively with her current stresses, so it can be labeled as insufficient coping skills. As a final step here, we must decide what to do with the shared piece of R-PAS data between the coping and others themes. After looking at the large amount of data in the others theme, the fact that she needs more support than most others her age actually seems to align more closely with her inadequate coping capacities—so we will keep it with coping and remove it from the others theme.

In moving on to the more complex themes, we can separate all the feeling data that emerged about Francesca into emotional content (i.e., her actual feelings) and emotional process (i.e., how she experiences and engages with her feelings). When we do this, a clear theme of emotional distress is revealed, showing stress, anxiety, depression, and somatic symptoms. As is often the case, we have a decision to make about whether to group all the emotional distress data together in a single theme or to separate them out into three symptom categories: anxious, depressive, and somatization. Two major factors support keeping them collapsed as a single theme: (a) the sheer number of themes we have and will need to contend with when we conceptualize; and (b) the body of research highlighting the underlying and overarching similarities in general distress disorders (e.g., Watson, 2005). As such, we will decide in this case to keep them lumped together.

In addition to the emotional distress, though, are quite a few data about anger and resentment toward others, which are of course related to distress but are also significantly different and unique to her emotional experience. Extracting an anger and resentment theme leaves data about emotional dysregulation, which can be relabeled as problems with regulating emotions. (This avoids use of the term *dysregulation*, which is unnecessarily wordy.) This emotional dysregulation theme is fine as it is now, but the emotional distress theme will be strengthened by adding to it a few pieces of data that are cognitive symptoms of emotional distress, including cognitive signs of depression from the PAI-A and anxious rumination from the R-PAS. Although these are more cognitive than emotional, they align so closely with the concept of distress that they will fit better in this theme than in the thinking theme.

Once thinking data more related to emotional distress are removed from the thinking theme, it begins to be more clearly a theme related to poor attention with a bit of confusion and other problems with executive functioning thrown in. Knowing that Francesca's cognitive testing results were extremely consistent with an ADHD diagnosis helps in constructing this as a problems with regulating thinking theme, heavily focused on attention but including the other issues. Basically, her mind's ability to maintain control over itself is weak.

Next we look at the behavior data. Similar to the logic of the thinking theme, quite a few nuggets include hyperactivity and impulsivity, which points to a problems with regulating behavior theme. However, some data in the behavior theme do not quite fit neatly into hyperactivity and impulsivity (which of course will be useful diagnostically later). What are left are evidence of noncompliant, disruptive, and defiant behaviors, enough across tests to sustain their own theme. This is especially useful given that a great deal was reported in the collateral interview with her mother about her defiance (and her mother feeling

she uses anxiety and depression as an excuse to act out behaviorally). While these could be conceptualized as part of the impulsive behaviors, they are also qualitatively different from impulsivity, and separating them out reduces the likelihood that her ADHD can be used as an excuse to be defiant. Thus, we end up with an additional theme of acting-out behaviors. The "tantrums" in the behavior theme reported by Francesca's parents could fit into acting out or problems with behavioral control, but they seem more aligned with her problems controlling her emotions. Therefore, we can move that piece of data to the problems regulating emotions theme.

Finally, we have the others data to contend with. One way to look at interpersonal data is to separate out the internal, underlying nuggets and the external (behavioral) and consequence nuggets. Alternatively, we could think about the internal and behavioral nuggets together and the ultimate social and interpersonal consequences separately. The three separate issues can also be evaluated independently, such that there are three interpersonal themes: (a) the underlying, internal states related to interpersonal functioning; (b) the social and interpersonal behaviors; and (c) the ultimate consequences. In this case, not many nuggets across measures explain the internal states, so they are combined with the interpersonal behaviors into an overarching theme of poor social skills, which relates to difficulty accurately understanding others, expecting the worst from them, and being outwardly abrasive toward them. Because of the aggressive nature of this theme (which is a behavior as opposed to the underlying anger and resentment), the MACI finding that she is alternately passive-aggressive and aggressive can be moved here to more fully add nuance to her interpersonal behaviors. The theme that is left with the rest of the data relates clearly to interpersonal conflict, including negative relationships and problematic interpersonal patterns. Finally, while her fights with her younger siblings certainly align with her problematic interpersonal patterns, they seem to fit better within the formerly context theme of school and family problems, so we can move it there. Table 12.6 presents the final, reorganized data for Francesca.

Conceptualizing

Remembering that the task at this point is to try to create a logical narrative among the themes, applying psychological theory so that it presents a coherent story, we have to connect the following themes:

- emotional distress
- problems regulating emotions
- anger and resentment
- low self-esteem
- problems regulating thinking
- school and family problems
- poor social skills
- interpersonal conflict
- problems regulating behavior
- acting-out behaviors
- insufficient coping skills

Because there are so many themes, one way of making the process more manageable is to figure out if some of them can be grouped into a single overarching construct in some way. In this case, especially knowing that Francesca's cognitive testing is extremely consistent with underlying ADHD pathology, we can group the problems regulating emotions, thinking, and behavior into a single theme labeled problems with self-regulation,

TABLE 12.6 **FRANCESCA'S REORGANIZED DATA**

Test: / Theme:	MMPI-A-RF	PAI-A	MACI	BASC-3	PIC-2	R-PAS	CEFI	PARQ	DERS	Interview and Behavioral Observations
Emotional distress	Dysfunctional negative emotions (depressive and anxious)	Somatization	Some anxiety	Anxiety	Anxiety	Anxious rumination				Anxious in school
	Somatization (headaches)	Anxiety (lots)	Depressive feelings (pessimistic)	Depression	Depression					Does not feel happy often
	Stress and anxiety	Phobias		Somatic and health-related concerns						
		Cognitive signs of depression (rumination)								
Problems regulating emotions		Unstable emotions		Very poor executive functioning—emotional control		Uncomfortable with emotions and emotionally stimulating information	Emotion regulation problems		Problems with goal-directed behavior when upset	Has "tantrums"
Anger and resentment	Feels persecuted	Irritability	Resentful and angry	Anger						"Seems angry all the time"
	Prone to anger									
Low self-esteem	Self-demeaning	Low self-esteem	Self-devaluation	Low self-esteem		Sees self as damaged and flawed				Church makes her "feel worse about [herself]"
				Low self-reliance						Feels that she "suck[s] at school"

Problems regulating thinking	Attention problems			Attention problems	Attentional problems	Very complex thinker—can get disorganized	Attention problems			"Severe problems" paying attention and following direction at home and at school
				Very poor executive functioning—problem solving (disorganized and haphazard)		Some confusion	Planning, organization, and working memory problems			Needs instructions given to her multiple times
				Very poor executive functioning—attentional control						Disorganized with homework and remembering to do it or bring it back to school
School and family problems	Negative a ttitudes toward school		Family discord problems	Negative attitudes toward school and teachers	Academic difficulties			Problems with communication between parents and adolescent		Fights with 7-year-old siblings
					Family conflict			Parent-child arguments about school		
								Sibling conflict		

(Continued)

Test: Theme:	MMPI-A-RF	PAI-A	MACI	BASC-3	PIC-2	R-PAS	CEFI	PARQ	DERS	Interview and Behavioral Observations
								Parents believe that adolescents should behave flawlessly		
								Believes parents are unfair		
Poor social skills	Aggressiveness		Peer insecurity	Poor social skills		Significant problems with understanding other people accurately				Difficulty getting along with others in her grade
			Interpersonally abrasive			Expects aggressiveness from others				
			Expects the worst from relationships and others							
			Alternates between passive-aggressiveness (disrespect) and impulsive anger							

Interpersonal conflict		Negative relationships		Problematic interpersonal patterns	Peer conflict					Does not have friends
Problems regulating behavior			Impulsivity	Hyperactivity	Hyperactivity		Impulse control problems		Impulsive and out of control when upset	Gets up and wanders around during class when not supposed to
			Impatience	Very poor executive functioning—behavioral control (impulsive)	Impulsiveness					Fidgets during church
Acting-out behaviors			Defiant and cocky	Defiant	Disruptive behavior					Oppositional and breaks rules
					Non compliance					
Insufficient coping skills			Low tolerance for frustration	Difficulty adapting to change and disappointment		Lots of need to be supported by others			Weak skills for changing mood when upset	

simply for the purposes of conceptualizing. Thus, our final list of themes to connect (still many, but slightly more manageable) are:

- emotional distress
- problems with self-regulation
- anger and resentment
- low self-esteem
- school and family problems
- poor social skills
- interpersonal conflict
- acting-out behaviors
- insufficient coping skills

Before deciding on the most logical way to fit all these themes together, we will first consider some of the model templates presented in Chapter 4: a diathesis–stress model and a developmental mismatch model. The interpersonal circumplex model is much more useful in adult assessments, when personality is more "formed," and the common function model may be useful. However, there are so many themes that it is difficult to organize under the heading of a single function in a coherent way.

Diathesis–Stress Model

In applying the diathesis–stress model of conceptualization, we must try to divide the themes into (1) traits inherent within Francesca that she likely developed at a younger age and that she "brings to the picture" (diatheses), (2) external issues that affect her functioning (stressors), and (3) states that are more situational or transient (outcomes). It is important to categorize each of our (now) nine themes into these three types. As always, the more convincing these categorizations are, the more likely Francesca and her parents are to accept the recommendations given.

For Francesca, even though there are a lot of themes, this model is actually relatively straightforward and intuitive. Several themes are easily outcomes since they are generally not seen as inherent to an individual and their personality, and one theme seems clearly related to the impact of external forces on her. Even though she is a big contributor to the difficulties she is having at school and at home, these are also contexts within which she is developing, so these school and family problems are a major external stressor on her.

Three of the themes are generally not considered core to who an individual is in their personality or character: emotional distress, acting out, and interpersonal conflict. The assessor could easily argue that these are outcomes of other, more underlying, dynamics occurring within Francesca. Even though Francesca has reportedly been difficult in her behavior (acting out) from early on, these are still symptoms of deeper underlying difficulties. Additionally, while she may have genetic predisposition toward emotional distress (depression, anxiety), it is generally widely believed that the development of an emotional disorder requires a complex interaction between genetic and environmental influences (e.g., Rutter, 2003) and even specifically between genetics and parent–adolescent relationship (Brouillard, Brendgen, Vitaro, Dionne, & Boivin, 2018), so emotional distress is usually considered an outcome.

The remaining themes are not as clear-cut and need to be categorized as either part of the diathesis or outcomes. In this case, one way of distinguishing between the remaining themes is those that are general skills that she should have developed by this point in her live versus thoughts, feelings, and behaviors she is currently enacting. If we consider skills deficits all part of the diathesis, it would categorize insufficient coping skills, poor social

skills, and problems with self-regulation (poor self-management skills) all together. Remaining would be low self-esteem (which at times can be considered part of a diathesis, and in other circumstances be an outcome) and feelings of anger and resentment as outcomes. The diathesis–stress model for Francesca is shown in Figure 12.1.

When considering the viability of this model, we have to decide whether the model makes intuitive sense with the three categorized parts. That is, would the diathesis posed, combined with the external stressor, likely cause the outcomes? *A girl who has insufficient skills to cope with her life, interact effectively with others, and regulate her thoughts, feelings, and behaviors, when in environments of family and school difficulties, can develop low self-esteem, anger and resentment toward others, and emotional distress and act out behaviorally and be in conflict with others.* Although quite wordy when placed in a single sentence this way, it is certainly arguable that an adolescent with these skills deficits, within stressful home and school environments, could develop these problems. This model seems not only arguable but also relatively intuitive. That this model is so straightforward yet so comprehensive serves as a strength, as Francesca and her parents would likely understand it relatively easily.

Developmental Mismatch Model

The developmental model for Francesca may be useful to consider, as adolescence comes with very specific and extremely stressful demands. Her adolescence, in particular, will require a great deal of resilience within the context of her very stressful home and school lives. Along a developmental spectrum, she should be developing her identity by considering possible selves to decide who she wants to be in the world (e.g., Dunkel & Anthis, 2001). This task, however, would be built on a foundation of having successfully navigated and reconciled many other areas of development beforehand. Notably, she should have developed adequate coping skills and social skills by this point in her life (and in fact much earlier). Additionally, research has shown that the development of self-regulation (regulating emotions, thoughts, and behaviors), while it continues to strengthen throughout development, largely happens at the early elementary school age (Thompson, 2009). Thus, what characterizes Francesca's current developmental functioning are her elementary school age skills of coping, socializing, and self-regulating. Her developmental level of demands obviously are adolescent in nature, with difficulties to navigate at home and at school. The rest of the themes would be considered outcomes. Interestingly, although conceptualized differently, this model is exactly the same as diathesis–stress model for Francesca and is shown in Figure 12.2.

FIGURE 12.1 **DIATHESIS–STRESS MODEL FOR FRANCESCA**

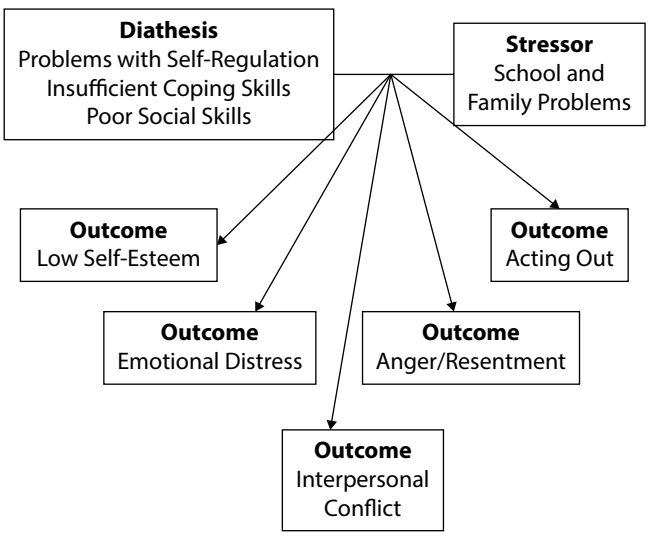
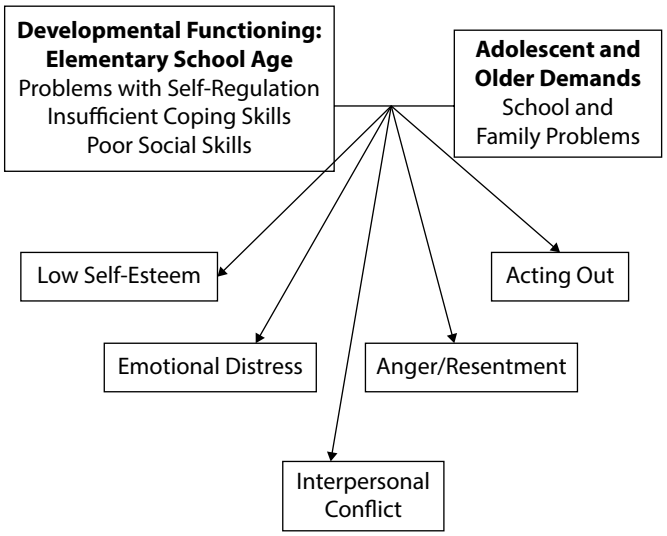


FIGURE 12.2 **DEVELOPMENTAL MISMATCH MODEL FOR FRANCESCA**



While this model still makes a great deal of intuitive sense, there is a major benefit to conceptualizing Francesca's functioning in this way. Instead of explaining her skills deficits as problematic and static (i.e., as a diathesis), this way of conceptualizing implies the capacity for her to develop these skills (which, while they are lagging behind developmentally, are skills that everyone gains at some point). This may provide a slightly more hopeful lens to her and her parents.

Complex Model

The diathesis–stress model and the developmental model seem to fit Francesca well. Either could be used for the final report. However, thinking about the themes in a slightly more complex way may lead to a more logical way to link several of them. This is especially true because some of the outcomes are very likely to influence one another. Some of the outcomes are internal states (low self-esteem, emotional distress, and anger and resentment), and some are behaviors (acting out and interpersonal conflict). Also, although the diathesis (or the developmental level of functioning) and her current stressors certainly contribute to the behaviors, it is also likely that her current internal states do as well. For example, it is relatively common for depression to manifest in adolescence as irritable and hostile (acting-out) behavior (Parker & Roy, 2001). Similarly, anger and resentment can certainly lead to aggressive and antisocial behavior (Fives, Kong, Fuller, & DiGiuseppe, 2011). Thus, we can create three layers to our model: in the top layer, the diathesis–stress and developmental mismatch models are the most underlying factors; the middle layer contains the internal states that stem from the underlying problems; and on the bottom are behaviors stemming from all the underlying traits and internal states.

Although this approach is straightforward, with each layer contributing to all the themes in the layer below it, would certainly make sense that more nuanced interactions are at play between the themes. The addition of lots of arrows can make the picture seem overly complex and confusing, but it is easier to explain in narrative form and also includes some really important aspects not captured by the previous models. For example, Francesca's core, underlying traits (her skills deficits in coping, socializing, and self-regulating) not only interact with her school and family problems but also contribute *to* them. This is important for Francesca and her family to understand; these contexts act as stressors in her life but are also more stressful for her because of how she has interacted with them problematically. Additionally, while the interaction between her core, underlying traits and her stressors certainly adds to her problematic internal states (low self-esteem, emotional distress, and anger

and resentment), her poor social skills also contribute to her interpersonal conflict behaviors, and her problems regulating her impulsive behaviors also contribute to her acting-out behaviors, as do her anger and resentment toward others. The complex model for Francesca is shown in Figure 12.3.

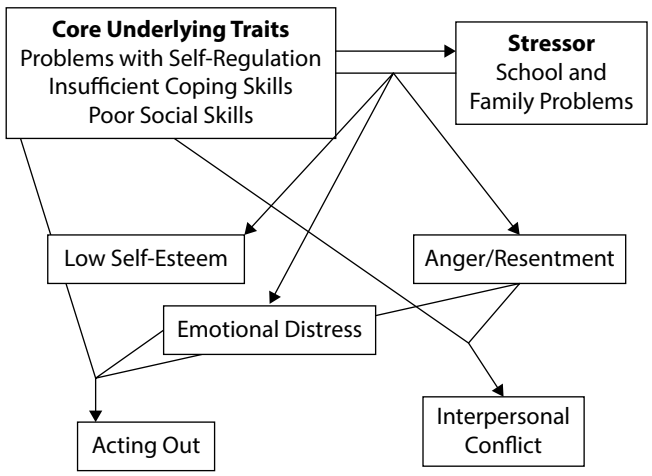
This model explains Francesca's difficulties well. *Her insufficient skills in regulating her thoughts, feelings, and behaviors, as well as in coping and interacting with others, have contributed to difficulties within her family and at school. Because of her underlying difficulties, combined with the stress of these problematic environments, she has developed low self-esteem, emotional distress, and anger and resentment toward others. Additionally, her emotional distress and anger and resentment, combined with her problems coping and difficulties controlling her behavior, have contributed to her acting out behaviorally. Her poor social skills, problems regulating her behaviors, and anger and resentment toward others have also contributed to behaviors that lead to interpersonal conflict.* Although this model is not necessarily more valid than any of the others, it is certainly easier to write up and argue than some of the previous models.

Report Writing

Before the report can be written, the final step of determining diagnosis and recommendations must be addressed. We will begin with Francesca's cognitive and academic profile. Her average (on-grade) performance across reading, writing, and mathematics on the WIAT-III generally rules out the presence of a learning disorder (despite her low grades at school) and indicates that something else is interfering with her performance in school. Her cognitive profile of weak attention and executive functioning ability (as measured by optimal-functioning, performance-based measures), combined with her actual problematic attention and executive functioning behaviors (as measured by typical-functioning, self- and other-report measures and reflected in her problems with self-regulation) strongly support a diagnosis of ADHD, combined presentation. That is, across contexts, she has problems both in attention (selective, sustained, and other executive functions) and in her ability to control her behaviors (both hyperactive, including fidgeting and leaving her seat in class, and impulsive). This ADHD hypothesis is strongly supported by the assessment evidence.

Emotionally and behaviorally, Francesca presents with a number of different problems that are negatively impacting her functioning. We need one or more diagnoses to account for both emotional difficulties (some anxiety and lots of depression, low self-esteem, and anger) and behavioral problems (acting-out and aggressive

FIGURE 12.3 **COMPLEX MODEL FOR FRANCESCA**



behaviors). While we could diagnose two separate disorders (such as depression and oppositional defiant disorder), the diagnosis of disruptive mood dysregulation disorder (DMDD) captures the angry outbursts, irritability, and underlying depressive qualities (characterized in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition [DSM-5]* as a depressive disorder) that is present in Francesca's case. Although there is some controversy around whether DMDD is a useful diagnostic classification for children and adolescents with irritability and depression (e.g., Bruno et al., 2019; Lochman et al., 2015), it seems to be associated with youth who may have both depressive and behavioral (acting-out) symptoms that result in significantly higher school and relationship difficulties than others with depression or ODD (Benarous, Renaud, Breton, Cohen, Labelle, & Guilé, 2020). This accounts for the bulk of Francesca's difficulties, except that her family relational problems are so significant that they should be addressed in treatment somehow. Thus, the diagnoses of parent–child relational problem and sibling relational problem will also be given to her, which increases the likelihood that the family will take this aspect of Francesca's difficulties seriously and focus on it in treatment.

With regard to recommendations and conceptualization that emerge from these diagnoses, we will recommend several accommodations in school and several interventions for Francesca and her family. Specifically, Francesca would benefit from a self-contained, special education classroom with educators better equipped to address her ADHD and her emotional and behavioral problems. This is of course unlikely to happen at the Catholic school she currently attends, and having a conversation with her parents about switching schools (either to a public school with a self-contained special education class or to a different nonpublic school with specialized services) may not be easy. A general Catholic school, however, is very unlikely equipped to address Francesca's educational needs. In case her school does feel that it can meet her needs, specific recommendations will be included to guide her advocates there in accommodating her needs.

Interventions for her ADHD should include both continuing current pharmacological treatment (though it will be strongly recommended that she be seen by a psychiatrist rather than her pediatrician) and adding nonpharmacological interventions, such as executive function coaching. However, these will be presented after the recommended therapeutic treatments for her DMDD, as those symptoms are somewhat more serious and need more immediate attention.

For her DMDD, as it is a newer diagnosis, there is not a great deal of evidence of treatment efficacy. Some evidence has shown effectiveness of different medications, including antidepressants, psychostimulants, antipsychotics, and even mood stabilizers in the treatment of DMDD (Bruno et al., 2019). For nonmedication treatments, there is some early evidence supporting dialectical behavioral therapy (DBT) adapted for children (Bruno et al., 2019). However, this may not be accessible to Francesca and her parents, given how specialized it is. Additionally, it has been applied to pre-adolescents, but not to those in Francesca's age group, though it is very likely that it would not be harmful for her to have better skills. Therefore, even though it will be included, the primary psychotherapeutic recommendation will be for cognitive behavioral therapy (which has support for emotional disorders and anger in youth generally; García-Escalera, Chorot, Valiente, Reales, & Sandín, 2016; Reinecke, Ryan, & DuBois, 1998; Sukhodolsky, Kassinove, & Gorman, 2004), with some information on the Unified Protocol for the Treatment of Emotional Disorders in Youth (UP-Y; Ehrenreich, Buzzella, Trosper, Bennett, Wright, & Barlow, 2008; Trosper, Buzzella, Bennett, & Ehrenreich, 2009). Knowing the landscape of access to treatment Francesca and her family will have, CBT is likely the most realistic recommendation to make.

Finally, given the relational problems within the family, both between Francesca and her parents and between Francesca and her siblings, family therapy will be recommended. It is likely that family therapy will not only address problematic family dynamics but (sneakily) also likely Francesca's problematic strategies for trying to gain attention from her parents and negotiate difficulties with her siblings. That is, Francesca's behavior should improve by addressing family patterns. This way, her problematic dynamics, feelings, and behaviors are being addressed from multiple perspectives: medication, individual treatment (and hopefully skills development), and family therapy.

Confidential Psychological Assessment Report

Identifying Information

Name:	Francesca Palomi	**Date of report:**	2/28/20
Sex:	Female	**Assessor:**	A. Jordan Wright, PhD
Age:	14		
Date of birth:	1/1/06	**Dates of**	1/21/20; 1/25/20;
Ethnicity:	White	**assessment:**	2/11/20; 2/13/20

Referral Source and Questions

The client was referred by her pediatrician to assess difficulties she is having both at home and especially in school. Although she is on several psychiatric medications and has completed an organizational skills group, she continues to struggle with attention, organization, and planning, which negatively affects her schoolwork. Additionally, she has behavioral difficulties at home and at school. The present evaluation was requested to assess what is likely underlying her cognitive, emotional, and behavioral problems at school and at home.

Measures Administered

- Clinical interview
- Collateral interview with mother
- Bender Visual-Motor Gestalt Test, 2nd Edition (Bender-2)
- Wechsler Intelligence Scale for Children, 5th Edition (WISC-V)
- Delis-Kaplan Executive Function System, Trail Making Test (D-KEFS Trails)
- Conners' Continuous Performance Test, Third Edition (CPT-3)—administered twice
- Wisconsin Card Sorting Test, Computer Version Fourth Edition (WCST-IV)
- Wechsler Individual Achievement Test, 3rd Edition (WIAT-III)
- Minnesota Multiphasic Personality Inventory-Adolescent-Restructured Form (MMPI-A-RF)
- Personality Assessment Inventory—Adolescent (PAI-A)
- Millon Adolescent Clinical Inventory (MACI)
- Behavior Assessment System for Children, 3rd Edition (BASC-3)
  - Self-Report of Personality-Adolescent (SRP)
  - Parent Rating Scales-Adolescent (PRS)
  - Teacher Rating Scales-Adolescent (TRS)
- Personality Inventory for Children, 2nd Edition (PIC-2)
- Comprehensive Executive Function Inventory (CEFI)
  - Self-Report Form (SF)
  - Parent Rating Form (PF)
  - Teacher Rating Form (TF)
- Rorschach Performance Assessment System (R-PAS)
- Parent Adolescent Relationship Questionnaire (PARQ)
- Difficulties in Emotion Regulation Scale (DERS)

Client Description

Francesca Palomi is a 14-year-old White girl who is currently in the eighth grade at a Catholic school in New York City. She was somewhat guarded in discussions when her parents were present, but she was much more cooperative and made better eye contact when they were not. She engaged with tasks appropriately, but she had some difficulty persisting on longer tasks. She was able to be refocused by the assessor, though. She was generally cooperative and seemed to make effortful attempts on all tests administered.

Presenting Problem and Its History

The client's mother reported that the client's ability to pay attention and follow directions at home and at school is both inconsistent and problematic. She further reported that she and the client's father have received calls from school because the client plays with things at her desk instead of focusing on lessons, gets up and wanders around during class when she is not supposed to, and generally has difficulty following instructions appropriately. The client also reported that she has difficulty organizing herself to remember to do her homework, and even when she does she sometimes accidentally leaves it at home. Her mother also reported that the client has difficulty with instructions, "very often" not even hearing them if they are only given once and needing them repeated multiple times for her to implement them at home and school. Her mother reported that there have been signs of problems focusing and being hyperactive since the client was in kindergarten. She also reported that her school suggested an evaluation for a learning disability in kindergarten because the client had difficulty learning letters appropriately, but they did not follow through with this recommendation. She further reported that the client receives many accommodations in school, but that her grades are still poor.

Additionally, the client's mother reported that the client has exhibited behavioral difficulties, including being oppositional, breaking rules, and "tantruming" since she was a toddler. These behavioral problems are reportedly present both at home and at school. At home, she reportedly fights both physically and verbally with her 7-year-old siblings (brother and sister). At school, she reportedly has temper tantrums and significant difficulties getting along with peers. The client's mother reported that the client "seems angry all the time" and is moody and irritable. She reported that, about 3 years ago the client was evaluated by her pediatrician, was diagnosed with ADHD, anxiety, and depression, and was prescribed medications for these disorders. However, she reported that the client continues to have emotional and behavioral difficulties at home and at school.

Relevant Background Information

The client is the middle child of seven in her family, with three older siblings (who are grown and do not live at home) and three younger siblings (one sister who is 1 year younger and twin brother and sister who are 7 years old). She and her parents reported that she has a strained relationship with both her parents and most of her siblings, though she has a better relationship with her 13-year-old sister. Her parents reported that the client is verbally and physically aggressive with her 7-year-old siblings and verbally aggressive with her older siblings, to the point that one of her older siblings does not come home anymore because of the client's behavior.

The client's mother reported that the client is struggling significantly academically in school, despite receiving significant supports including a learning specialist five times a week, extra time on exams, breaks during testing, revised and simplified directions, testing in a room separate from others, and occasional prompts from teachers during assignments and tests to remain on task. She receives these accommodations from school despite not having been formally evaluated for or diagnosed with a learning disability. Her grades are reportedly in the 60s and 70s across academic subjects. The client also reported that she does not currently have significant friendships or social support, has difficulty getting along with peers her age, and recently lost her three best friends

because of fighting. The client's family identifies as Catholic; her father teaches Sunday school, and they go to mass multiple times a week. However, the client's mother reported that the client has problematic behaviors in church (especially fidgeting), and the client reported that church makes her feel bad about herself and ashamed of her behavior.

The client's parents reported no difficulties during pregnancy and birth of the client. She met all developmental milestones (e.g., crawling, walking, talking) on time and appropriately, though she had low muscle tone as a toddler and received occupational therapy. Additionally, in kindergarten the client had problems with speech articulation and received speech therapy; however, her pediatrician discovered fluid in her ear and put in an ear tube, at which point her speech articulation developed rapidly and caught up with peers. Her parents reported no major medical or psychiatric problems in their own or the client's history, but they reported some history of depression and anxiety in their own families, including the client's older sister having an anxiety disorder and the client's grandparents suffering from depression. The client and her parents denied any use of alcohol or drugs by the client or anyone else in her family.

The client engaged in play therapy when she was very young (before preschool age), but she reportedly refused to continue in it after a while. In second or third grade, a teacher recommended behavior charts for the client and her siblings in the home, but the client reportedly got so upset that her siblings were progressing and she was not that she ripped them up. The client was diagnosed with ADHD, anxiety, and depression by her pediatrician about 3 years ago, and she has been on multiple medications since then. Although she began on Ritalin (for ADHD) and Prozac (for anxiety and depression), they tried multiple other medications; currently, she is taking Vyvanse (for ADHD) and Wellbutrin (for anxiety and depression). However, the client's parents reported that these medications do not seem to be helping her significantly, as she continues to have emotional, behavioral, and school-related problems. The client has reportedly not engaged in any other form of counseling or psychotherapy.

Behavioral Observations

The client was noticeably guarded in her interactions with the assessor when her parents were present, including limited conversation and extremely limited eye contact. However, when her parents were not present, she was much more engaged with the assessor, speaking openly, engaging in reciprocal conversation, elaborating on ideas, and making more appropriate eye contact. She exhibited notable fidgeting behaviors throughout the testing process, including tapping her feet on the floor and fingers on the desk and twirling a pen repeatedly. Several times during somewhat longer tasks she had difficulty persisting, but she was able to be redirected by the assessor to reengage in the tasks.

Mental Status Evaluation

The client was casually and appropriately dressed, well groomed, and generally cooperative and friendly throughout the testing process, maintaining appropriate eye contact when her parents were not present, but noticeably guarded when they were. She exhibited hyperactive fine motor activity, including fidgeting, tapping her feet, twirling a pen, and tapping her fingers on the desk constantly throughout testing. She disclosed information freely and seemingly openly with the assessor. Both her receptive and expressive language ability were within normal limits. Her mood was reported as anxious, irritable, and angry (with very little positive emotion), and her affect was somewhat constricted but appropriate to her mood and the situation. Her thought process was goal directed and logical, and her thought content was free of hallucinations, delusions, and current suicidal and homicidal ideation. Her memory seemed within normal limits, and she exhibited some difficulties maintaining attention on tasks that lasted more than a few minutes, though she was able to be redirected back to the tasks. She and her parents reported significant problems with her judgment, planning, and impulse control, but they were all adequate throughout the testing process.

Overall Interpretation of Test Findings

Cognitive and Academic Functioning

General Cognitive Ability

The client was administered several measures to assess her current cognitive functioning. It should be noted that these measures evaluate her cognitive ability under ideal conditions and in the most ideal context; as such, they represent her cognitive ability rather than how she actually functions in her daily life.

In general, the client's overall cognitive ability is generally average or better for her age, with specific strengths in her ability to solve novel visual–spatial problems, identify patterns in visual puzzles, and hold visual information in her mind and manipulate it. She exhibited significant weaknesses in her attention, other executive functions, and her fine motor speed.

Fine Motor Skill. On a measure assessing her ability to control her fine motor functioning deliberately and carefully, the client exhibited unimpaired fine motor accuracy (Bender-2 Motor subtest, 51st–100th percentile). However, her speed of controlling her fine motor movement is extremely weak for her age (D-KEFS Trails Motor Speed, 2nd percentile).

Visual–Spatial Perception and Reasoning. On measures of visual perceptual ability, including nonverbal reasoning, visuospatial aptitude, and induction and planning skills on tasks involving nonverbal stimuli such as designs, pictures, and puzzles, the client performed within the average range compared with others her age (WISC-V Visual Spatial Index, 42nd percentile). She exhibited no difficulties in her visual perceptual abilities, from her basic visual perceptual skills (Bender-2 Perception subtest, 25th–100th percentile) to her more complex visual reasoning on nonverbal puzzles, which was also average compared with others her age (WISC-V Visual Puzzles, 63rd percentile).

Visual–Motor Integration. The client exhibited generally strong ability to integrate her visual understanding with her motor coordination compared with others her age. The client exhibited high average ability to copy increasingly complex shapes in an untimed period (Bender-2 Copy, 75th percentile). On a task requiring her to use blocks to recreate complex designs presented to her within a time limit, though, the client performed in the average range of functioning compared to others her age (WISC-V Block Design, 25th percentile). It should be noted that the latter task required both visual–motor integration and motor speed, which is not a strength for her. As such, her actual visual–motor integration ability appears to be intact and good.

Nonverbal Memory. The client's short-term visual memory, which was assessed only briefly using a visual memory task, was strong for her age. She exhibited high average ability to remember visual information presented to her immediate afterward (Bender-2 Recall, 75th percentile). She exhibited no difficulty with learning or remembering nonverbal information.

Processing Speed. The client's ability to focus attention and quickly scan, discriminate between, and respond to visual information with a time limit was in the average range compared with others her age (WISC-V Processing Speed Index, 37th percentile). On tasks that required her to quickly scan and find targets among distractors, she exhibited no difficulties compared with others her age (WISC-V Symbol Search, 37th percentile; D-KEFS Trails Combined Letter–Number Sequencing, 63rd percentile). On tasks that required her to identify and draw designs quickly, the speed of her performance was also adequate compared with others her age (WISC-V Coding, 25th percentile; Bender-2 Copy Time, 27th percentile), though not a strength. Overall, the client's speed of processing information is adequate, though not a strength for her.

Language. On measures of verbal ability, including verbal comprehension, ease of use of verbal skills, verbal knowledge, and the ability to express herself clearly and completely, the client's performance fell within the average range compared with same-aged peers (WISC-V Verbal Comprehension Index, 45th percentile). Her ability to

express herself clearly and precisely verbally is average compared with others her age (WISC-V Vocabulary, 63rd percentile), as is her abstract understanding of language and use of words in complex and abstract ways (WISC-V Similarities, 25th percentile).

Fluid Reasoning. On tasks assessing the client's ability to infer relationships between different pieces of information and spot patterns on problems that use very little prior knowledge, she performed in the high average range compared with same-aged peers (WISC-V Fluid Reasoning Index, 79th percentile), constituting a significant strength for her. She is particularly strong at identifying patterns in nonverbal puzzles (WISC-V Matrix Reasoning, 91st percentile).

Executive Functioning. The client completed several tasks that evaluate executive functions, such as attention, working memory, impulse control, adapting to changing conditions, and monitoring herself in her strategies. Her performance on these tasks was problematic, especially related to attention and impulsivity.

Selective Attention. The client exhibited significant difficulties in her selective attention, the ability to weed out essential versus nonessential information, quickly determine correct versus incorrect stimuli, and focus her attention when distractions are present. Specifically, she had difficulty focusing when distractions were present on short tasks that were somewhat engaging (WISC-V Cancellation, 5th percentile; D-KEFS Trails Visual Scanning, 5th percentile) and on tasks that were longer and more boring and tedious (CPT-3 Detectability, 88th percentile and 91st percentile; CPT-3 Omissions, 73rd percentile and 86th percentile; CPT-3 HRT SD, 98th percentile and 97th percentile). Her difficulties with focusing when distractions are present are likely to impair her ability to listen and pay attention appropriately to instruction provided aloud (WIAT-III Listening Comprehension, 10th percentile).

Sustained Attention. The client's sustained attention, the ability to concentrate and keep vigilant on a boring task that continues for an extended period of time, is also problematic compared with others her age. On a boring task that lasted an extended period of time, she had difficulty maintaining her attention over time. Specifically, the time it took her to respond to stimuli increased significantly as the task progressed (CPT-3 HRT Block Change, 95th percentile and 94th percentile), and she became more inattentive (CPT-3 Omissions by Block Change, $p < .10$) and more impulsive (CPT-3 Commissions by Block Change, $p < .10$) as the task progressed. On another task that required her to hold rules in her head for how to respond, she showed some difficulty maintaining her attention to keep the rules in her head as the task progressed (WCST-IV Nonperseverative Errors, 12th percentile). Her problems sustaining her attention are also likely to contribute to her difficulties attending to instructions provided aloud (WIAT-III Listening Comprehension, 10th percentile).

Working Memory. On tasks that assessed her ability to learn and memorize new information, hold it in short term memory, concentrate, and manipulate that information to produce some result or reasoning outcome, the client's performance fell within the high average range of functioning compared with others her age (WISC-V Working Memory Index, 75th percentile). Her skills in attending to and manipulating information were much stronger for nonverbal information (WISC-V Picture Span, 91st percentile) than for verbal information (WISC-V Digit Span, 37th percentile), though her performance was average for verbal information.

Impulse Control and Related Functions. The client's control over her impulses is somewhat variable. On a task measuring the client's cognitive ability to control her impulses and respond to stimuli in the opposite way than her impulses would want her to, she performed poorly (CPT-3 Commissions, 84th percentile and 86th percentile). On a task that required her to control her impulses and to change her strategy midway through the task, she performed in the low average range (D-KEFS Trails Number–Letter Switching, 16th percentile). However, on another task that required her to control her impulses, self-monitor, and adapt to feedback in the moment, her performance fell within the high average range compared with same-aged peers (WCST-IV Perseverative Errors, 86th percentile), showing no difficulties. It should be noted that these latter two tasks are significantly shorter than the first one. Her basic cognitive ability to control her impulses is variable, with some ability to maintain control on brief tasks but significant difficulty over longer periods of time.

Academic Achievement

The client's academic achievement was evaluated and compared with a general national normative group, not necessarily with peers in her current school or class setting.

The client's academic performance revealed generally average achievement in her academic oral language use, reading, and mathematics and writing ability strength. The only weakness that emerged was her ability to attend to and respond to academic information presented aloud to her.

Academic Oral Language. Although her overall use of language for academic endeavors is generally average (WIAT-III Oral Language, 27th percentile), she exhibited some variability in her skills. Specifically, her ability to express academic ideas clearly and completely is average for her level of education (WIAT-III Oral Expression, 61st percentile). However, her attention to and understanding of information that is presented to her aloud is weak for her grade level (WIAT-III Listening Comprehension, 10th percentile). This weakness will make following directions and learning material presented aloud more difficult for her.

Reading. The client exhibited average achievement in reading for her grade level (WIAT-III Total Reading, 61st percentile). She showed average to high average basic reading skills, including her understanding of phonetics (WIAT-III Pseudoword Decoding, 53rd percentile) and ability to read actual words by recognition (WIAT-III Word Reading, 84th percentile). Further, her ease, speed, and accuracy of reading aloud is average (Oral Reading Fluency, 61st percentile). These abilities have built the foundation for adequate ability with reading comprehension, which was also average compared with same-grade peers (WIAT-III Reading Comprehension, 45th percentile).

Writing. The client's overall writing abilities are high average compared with others at her grade level (WIAT-III Written Expression, 86th percentile), representing a significant strength for her; however, it should be noted that her strength is in more basic writing skills rather than more advanced written expression. The client's spelling ability is superior (WIAT-III Spelling, 94th percentile). Her ability to construct grammatical and meaningful sentences is average compared with others at her educational level (WIAT-III Sentence Composition, 70th percentile), as is her ability to express herself clearly in an essay (WIAT-III Essay Composition 68th percentile). As such, her basic writing skills are strong, and her more advanced writing skills are average for her grade level.

Mathematics. The client's overall math abilities are average for her grade level (WIAT-III Mathematics, 27th percentile). Specifically, her speed, ease, and accuracy of performing basic arithmetic are adequate (WIAT-III Math Fluency, 25th percentile). Similarly, she exhibited average knowledge of mathematical concepts (WIAT-III Math Problem Solving, 47th percentile) and actual ability to solve progressively more difficult actual math problems with pencil and paper when given unlimited time (WIAT-III Numerical Operations, 25th percentile). She exhibited no significant difficulties in mathematics.

Cognitive and Academic Summary

Overall, the client is generally functioning in the average or better range across different domains of cognitive ability for her age, with specific strength in nonverbal or visual reasoning. However, she does have deficits in her attentional and executive functioning abilities and weakness in her fine motor speed. Her academic ability is generally adequate for her grade level in reading, writing, and mathematics, but she exhibited some difficulty in paying attention and responding appropriately to material presented to her aloud.

Emotional and Behavioral Functioning

The client and her parents and teacher were administered several measures to assess her current emotional and behavioral functioning. It should be noted that the focus of these measures is on areas of need rather than a comprehensive overview of all of her emotional and behavioral strengths and weaknesses. As such, this section will necessarily focus on areas of her functioning that need support.

The assessment revealed that the client has significant difficulties controlling her own psychological functioning, including her emotions (which are erratic and overwhelming to her), her thinking (including confusion and problems with attention), and her behaviors (which are both hyperactive and impulsive). Additionally, she has poorly developed skills for coping with the everyday demands of her life and for interacting appropriately and effectively with others. All these underlying problems have contributed to, as well as been worsened by, problems at school and within her family. As a result, she has developed a negative view of herself (including low self-esteem) and of other people (including anger and resentment) and is currently experiencing significant emotional distress, including symptoms of both anxiety and depression. As is common for individuals struggling with underlying anger, resentment, depression, and impulse control problems, she is acting out behaviorally and being generally uncooperative and defiant toward authority. As a result of her poor control over herself, her underlying anger toward others, and her weak social skills, she also experiences significant conflict with others.

Problems With Self-Control. The client displays a number of problems with executive functioning, including difficulty maintaining control over her emotions, her thinking, and her behaviors.

Problems Controlling Her Emotional States. The client has difficulty regulating her emotions effectively. Specifically, the client has difficulty maintaining control over her emotions (CEFI SR, PR, & TR; BASC-3 PRS & TRS; PAI-A). She is quite uncomfortable with her emotions, which can overwhelm her (R-PAS), and she has significant difficulty accomplishing things when she is emotional or upset (DERS).

Problems Controlling Her Thinking. The client also has difficulty adequately regulating her thinking and cognitive processes at home and at school. Consistent with her cognitive testing, she has significant attention difficulties (MMPI-A-RF; BASC-3 SRP, PRS, & TRS; CEFI SR, PR, & TR; PIC-2). One contributor to her weak attention is that her thought processes can be somewhat disorganized and confused (BASC-3 PRS & TRS; R-PAS; CEFI SR, PR, & TR). While she can think in complex ways (R-PAS), she can become disorganized and distracted.

Problems Controlling Her Behaviors. The client also has difficulty regulating her behaviors at home and at school, exhibiting both hyperactive and impulsive behaviors. She has significant difficulty relaxing and sitting still for extended periods of time (BASC-3 SRP, PRS, & TRS; PIC-2), which occurs both at home and at school. Further, she is impulsive, including signs of both impatience and recklessness in her behaviors (MACI; BASC-3 PRS & TRS; CEFI SR, PR, & TR). She is especially impulsive and out of control of her behaviors when she is emotionally upset (DERS).

Insufficient Coping Skills. The client has significant difficulty coping effectively with the everyday demands of her life. Specifically, she has a low tolerance for frustration and becomes upset easily (MACI). She also has difficulty adapting to disappointment and setbacks (BASC-3 PRS & TRS). Once she is upset, she also has great difficulty changing her mood or soothing herself in healthy ways (DERS). As such, she has a higher need than most others her age for support from others (R-PAS).

Poor Social Skills. In addition to having not developed adequate coping skills, she has also not yet developed adequate skills for interacting with others effectively. At her core, she does not realistically and accurately understand other people (R-PAS), expecting the worst from them, including for them to be aggressive toward her (MACI; R-PAS). This has led to significant insecurity in how she thinks about interacting with others (MACI). In addition

to not understanding others accurately, she has poor skills for interacting and is significantly callous, abrasive, and either passive-aggressive or aggressive even when the situation does not call for her to be so (MMPI-A-RF; MACI; BASC-3 PRS & TRS).

Family and School Problems. The client experiences significant problems at home and at school, which she contributes to and which contribute to her current difficulties. She experiences a significant amount of conflict in the home within her family (which, again, she contributes to and which contributes to her currently experienced distress; MACI; PIC-2; PARQ). Specifically, there are significant problems in communication between the client and her parents, with her believing her parents are unfair and her parents believing (somewhat unrealistically) that she should behave in much more desirable ways (PARQ). Additionally, there are significant conflicts between the client and her siblings (PARQ). Also, she experiences some significant academic difficulties (PIC-2), which have contributed to her developing a negative attitude in general toward both her school and her teachers (MMPI-A-RF; BASC-3 SRP). These school difficulties contribute to arguments between the client and her parents (PARQ). Without adequate skills to cope with these problems—as well as difficulties controlling her emotions, thinking, and behaviors—she has developed some problems with how she views herself, with anger and resentment toward others, and with current emotional distress.

Low Self-Esteem. Though the client works hard to come across to others as confident and assertive, she has strong underlying feelings of insecurity about herself. She struggles with significant low self-esteem, viewing herself as deeply flawed and devaluing even personal accomplishments (MMPI-A-RF; MACI; BASC-3 SRP; R-PAS). Some of her view of herself as weak and ineffective are likely related to her academic difficulties and to the feeling that she cannot effectively rely on herself to accomplish things (BASC-3 SRP).

Anger and Resentment. She has developed a negative view of both herself and others and struggles with significant underlying anger and resentment toward others. Related to her expectation that others will be aggressive toward her and let her down, she has become bitter and resentful and feels generally persecuted by others in her life (MMPI-A-RF; MACI). This makes her both irritable toward others (PAI-A) and prone to easily become angry, even with very little or no provoking (MMPI-A-RF; MACI; BASC-3 SRP, PRS, & TRS).

Emotional Distress. In addition to her negative view of herself and others, she has developed and is currently experiencing significant emotional distress. Currently, she has significant amounts of anxiety, including specific fears, an overfocus on anxiety-producing thoughts, and poorly managed stress (MMPI-A-RF; PAI-A; MACI; BASC-3 SRP, PRS, & TRS; PIC-2; R-PAS). Additionally, she is experiencing a significant amount of negative (depressive) emotions, including pessimism and general sadness (MMPI-A-RF; MACI; MMPI-A-RF; BASC-3 SRP, PRS, & TRS; PIC-2). Because she is uncomfortable with her often overwhelming emotional states, she also experiences some of her emotional distress more as physical symptoms, like headaches (MMPI-A-RF; PAI-A; BASC-3 SRP, PRS, & TRS).

Acting-Out Behaviors. Not uncommon for individuals struggling with underlying anger, resentment, depression, and impulse control problems, one way the client attempts to cope with her world is by acting out behaviorally and being generally uncooperative and defiant. Currently, she is exhibiting behaviors across contexts that are uncooperative, noncompliant, and generally defiant toward authority (MACI; BASC-3 PRS & TRS; PIC-2). These behaviors have become significantly disruptive (PIC-2).

Interpersonal Conflict. One result of her poor control over herself, her underlying anger toward others, and her weak social skills is significant conflict with others. She has a significant problem with conflict with peers, including negative relationships with others (PAI-A; BASC-3 SRP, PRS, & TRS; PIC-2). It should be noted that conflict with others will reinforce her expectations that others will be aggressive toward her or let her down.

Summary

Francesca Palomi is a 14-year-old, White girl who is currently in the eighth grade at a Catholic school in New York City. She was referred for psychological assessment to assess what is underlying her problems with attention, executive functioning, and emotional and behavioral functioning at both home and school. She reportedly has difficulties with focus and following instructions, requiring them to be repeated multiple times for her to be able to implement them appropriately. Her problems seem to be negatively affecting her academic performance in

school. Additionally, she reportedly has significant problems with oppositional, rule-breaking, and temper tantrum behaviors, again both at home and at school.

Cognitively, the client is generally functioning in the average or better range across different domains of cognitive ability for her age, with specific strength in nonverbal and visual reasoning. However, she does have deficits in her attentional and executive functioning abilities and weakness in her fine motor speed. Her academic ability is generally adequate for her grade level in reading, writing, and mathematics, but she exhibited some difficulty in paying attention and responding appropriately to material presented to her aloud.

Emotionally, the client has significant difficulties controlling her own psychological functioning, including her emotions (which are erratic and overwhelming to her), her thinking (including confusion and problems with attention), and her behaviors (which are both hyperactive and impulsive). Additionally, she has poorly developed skills for coping with the everyday demands of her life, as well as for interacting appropriately and effectively with others. All these underlying problems have contributed to, as well as been worsened by, problems at school and within her family. As a result, she has developed a negative view of herself (including low self-esteem) and of other people (including anger and resentment), as well as currently experiencing significant emotional distress, including symptoms of both anxiety and depression. As is common for individuals struggling with underlying anger, resentment, depression, and impulse control problems, she is acting out behaviorally and being generally uncooperative and defiant toward authority. Additionally, as a result of her poor control over herself, her underlying anger toward others, and her weak social skills, she experiences significant conflict with others.

Diagnostic Impression

Currently, the client meets criteria for attention deficit hyperactivity disorder (*DSM-5* code 314.01; *ICD-10* code F90.2), combined presentation. Specifically, she exhibits significant difficulties both related to attention and to hyperactivity and impulsivity, and these problems manifest across contexts. They are causing significant impairment in her functioning.

Further, the client meets criteria for disruptive mood dysregulation disorder (*DSM-5* code 296.99*; ICD-10* code F34.8). Specifically, she exhibits difficulties in regulating her mood, with severe anger outbursts, reactions to events that are bigger than expected, and frequent irritability present in multiple contexts.

Finally, the client is struggling with issues related to relationships within her family, including parent-child relational problems (*DSM-5* code V61.20; *ICD-10* code Z62.820) and sibling relational problems (*DSM-5* code V61.8; *ICD-10* code Z62.891). Her negative relationships and interactions with both her parents and her siblings are problematic, both in reinforcing her own negative self-evaluation and emotional states and in discomfort for other family members.

Recommendations

1. The client's parents should discuss the results of this report with the school staff and with her mental health service providers.
2. The client should be in an educational environment that is specifically tailored to provide academic services to students with learning (ADHD) and emotional (DMDD) challenges. This environment should be a self-contained, special education classroom with specially trained teachers (in special education). The client should be accommodated in the following specific ways:
   - Lesson outlines should be provided to her whenever possible so that she knows what to expect and when.
   - Daily schedules should be written and posted or given to her so that she can refer to them often.
   - The client should be given consistent and regular times during the day when she can take a break and release pent-up motor energy. This may include running "errands" for the teacher.
   - Checklists should be used whenever possible, both for daily tasks (school to-dos) and for assignments with multiple components.
   - Assignments and exams with multistep instructions should be broken down into clear, step-by-step directions to successful completion. Steps should be numbered and sequenced in the most efficient and

logical way to successful completion possible. When possible, these steps should be presented only a few at a time.
- On worksheets, assignments, and exams, whenever possible, key points and words should be highlighted, underlined, or bolded.
- On assignments and exams, whenever possible, a teacher should check in with the client to ensure her understanding of all the directions.
- Teachers should adopt strategies to ensure that the client first understands concepts (what she hears in class, what she has read) and then has a plan to complete any assignments. These plans should be clear, step by step, and written down whenever possible.
- Teachers should offer written instructions, even when verbal instructions are clear, to ensure understanding.
- Teachers should reward on-task, positive behaviors and be cognizant of not punishing, highlighting, or giving attention to minor disruptive behaviors to avoid inadvertently reinforcing undesired behaviors.
- The client requires several testing accommodations, including extended time (1.5 times the amount of normally allotted time on exam sections), breaks within and between tests (at least 5 minutes of break for every 30 minutes of work completed), and the ability to take tests in a separate, quiet room alone.

3. To address her problems regulating her thoughts, behaviors, and especially her emotions, the client should engage in individual CBT. If possible, the therapist may include components from the Unified Protocol for the treatment of emotional disorders in youth (UP-Y). CBT has been shown to help stabilize routines, increase family supports, and help youth monitor and cope with emotions, with the ultimate results of reducing aggression, improving self-esteem, and increasing the ability to understand the links between one's emotions and behaviors. Alternatively, if possible, DBT has been shown to be effective in the treatment of DMDD as well.
4. An executive function coach, learning specialist, or cognitive therapist can help her control her thinking in a more structured, effective way. Strategies can include practicing breaking down directions in a very careful, orderly way, with methodical plans to follow through with them; creating and maintaining habits for better organizing herself (e.g., checklists, calendars); staying on task for longer periods of time; and evaluating the truth of any conclusions she may jump to about situations.
5. To address problematic dynamics within the family system, the family should consider engaging in family therapy. This can help the client learn more effective and prosocial ways to feel heard and seen within the family system and to establish better patterns of interacting to ensure that the needs of each family member are being met.
6. The client should continue to be seen and monitored by a psychiatrist, as psychiatric medication has been shown to be effective in the treatment of both ADHD and DMDD. Special attention should be paid to the differential treatment of DMDD from just depression and anxiety.

_____ _____

A. Jordan Wright, PhD
New York State Licensed Psychologist

Date

Feedback

Preparation for Feedback

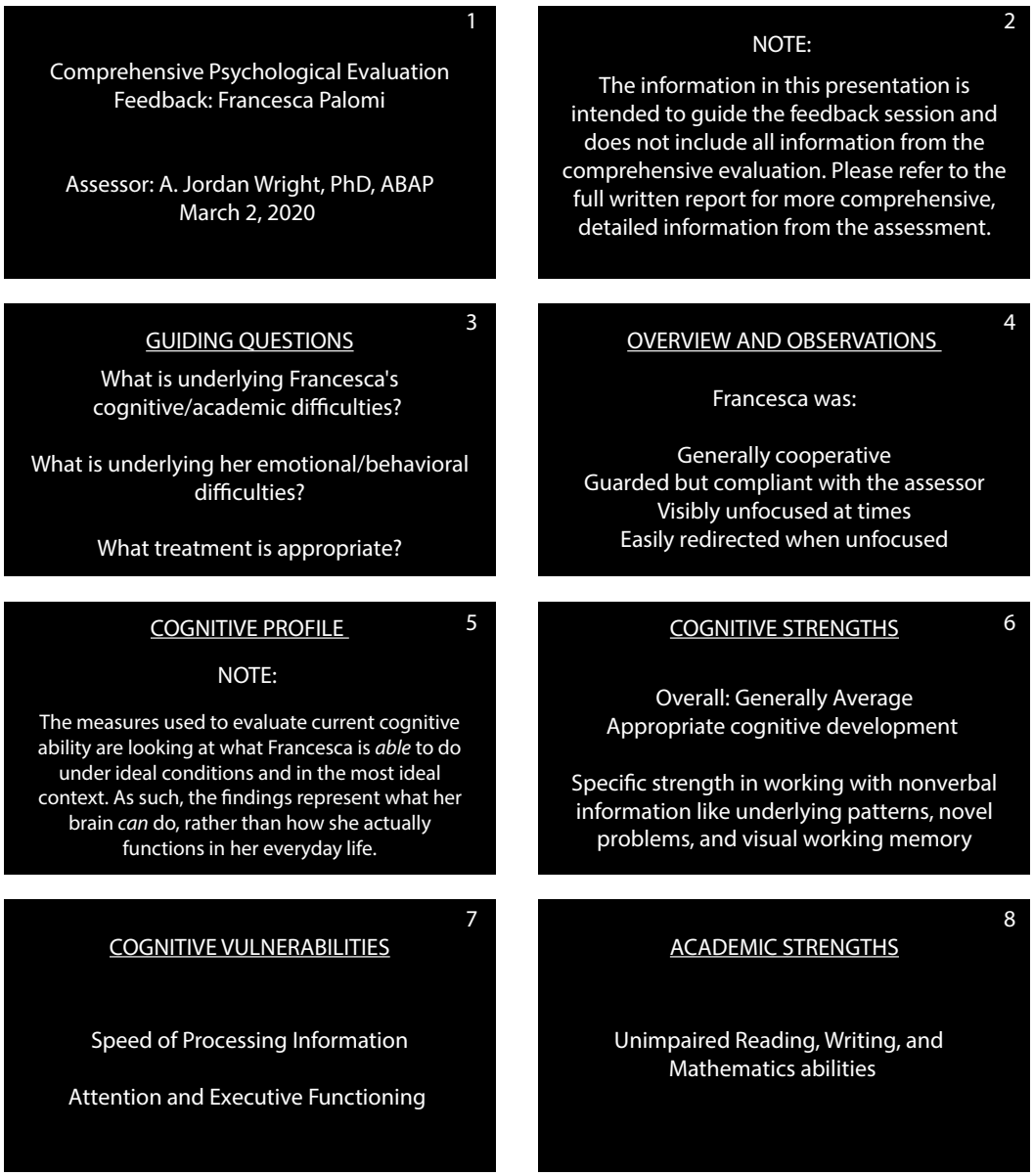
When considering exactly what feedback to give and how to give it to Francesca and her parents, the trickiest part is deciding whether to give feedback to Francesca alone, her parents alone, all together, or in some other configuration (such as with her alone first, then with her and her parents). Especially given the problematic relational dynamics at play between Francesca and her parents, care needs to be taken. In this case, it was decided

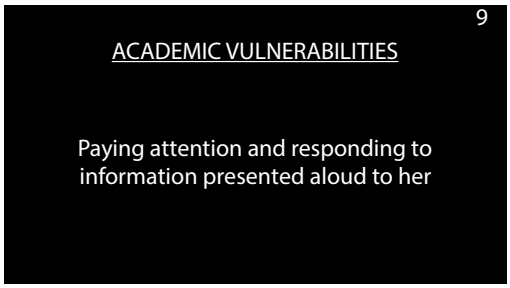
that the assessor would first schedule and give feedback to Francesca's parents, and then a separate session would be set up to give feedback to Francesca with her parents present. The full feedback presentation would be used for the session with her parents, and most of it (changing the third person to the second person [she/her to you/your] and without the diagnosis) would be used in the sessions with her and with all three together.

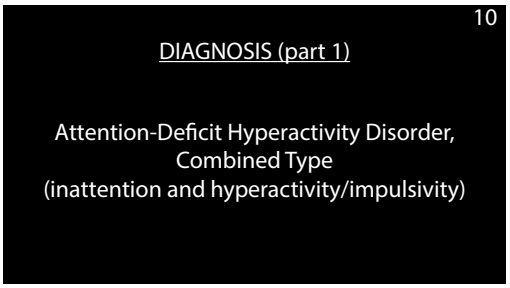
As usual, the assessor decided to give the feedback verbally and with the presentation before giving Francesca's parents the actual report. He wanted to ensure that they understood every piece of the feedback and had an opportunity to ask questions or discuss reactions, without the distraction of needing to look at a lengthy report. The plan was to discuss the cognitive and academic feedback first and then the emotional and behavioral functioning, with plenty of time for reactions and questions.

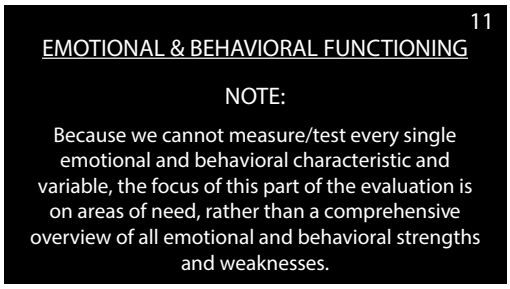
Feedback Presentation

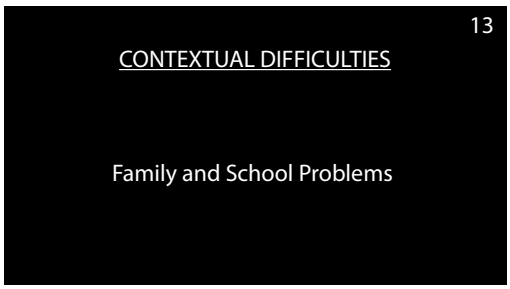
The assessor decided to create a feedback presentation for the case to organize and guide the feedback session.

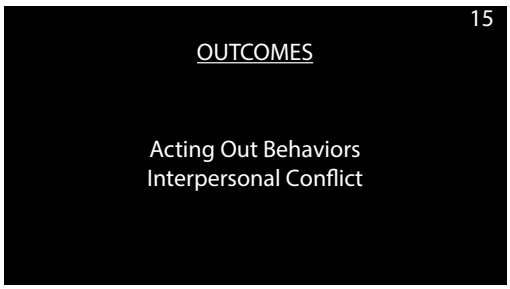


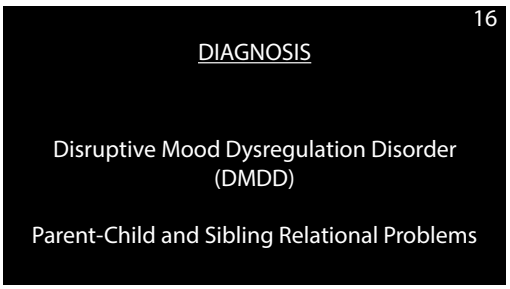


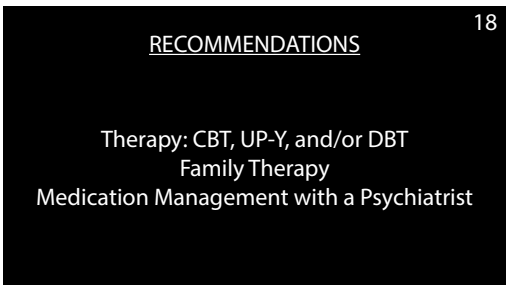












Parent-Only Feedback Session

Francesca's parents came in for their feedback session on time. (This was the first time they had been on time for a session and the only one they had not had Francesca with them.) As always, the assessor oriented them to

how the feedback session would flow, letting them know that they could stop the assessor at any point if they had questions or reactions to anything being said. He emphasized that there would be two parts to the feedback—one focusing on Francesca's cognitive and academic functioning and the other focusing on her behavior. They were encouraged to let the assessor know whenever anything did not align with their own thoughts or feelings. They had no questions at this point, so the assessor moved on to the cognitive and academic feedback.

The initial cognitive feedback, which focused mostly on Francesca's ADHD symptoms, was relatively straightforward, and her parents did not seem surprised by any of it. They said that she already had the ADHD diagnosis, and they were definitely aware of her problems with both attention and organization. The assessor explained what *executive functioning* meant in this context, and they said that they knew Francesca had problems in "every single one of those things." Even before moving to the academic assessment, the assessor told them that this is what ADHD looks like (jumping ahead to diagnosis).

The academic feedback was a bit tougher for Francesca's parents to understand. Contrary to her significantly struggling with her grades at school, she did not exhibit any actual deficit in her reading, writing, or math abilities compared with others at her grade level. This finding took some explanation, especially the differences between this type of testing and all the different kinds of work and evaluation she has to do at school across the same academic subjects. For example, her reading comprehension emerged as unimpaired, but her English grades in school are not based just on her ability to understand what she reads. She has to follow through on all assignments to read what she is supposed to; she has to engage in class discussions about readings she was supposed to have done; she has to complete assignments like essays and papers on readings she was supposed to have done; and she has to take tests based on reading she was supposed to have done. Explaining it this way, her father said, "So if she hasn't done the reading she was supposed to have done, she'll tank all of that." The assessor confirmed this and explained that this means she has no specific language-based learning disability but that her ADHD symptoms significantly "get in the way" of her being able to succeed academically.

He moved to the next slide that presented the one academic problem that emerged, again consistent with her ADHD (and extremely consistent with what her parents experience with her at home): her difficulties attending to and responding to information (like directions and instructions) presented aloud to her. The assessor then presented the overall diagnosis for her cognitive and academic functioning, reemphasizing how her ADHD symptoms, while they obviously affect her general functioning at home and school, also affect her academic functioning.

The next part of the session focused on Francesca's emotional and behavioral functioning, with the general goal of helping them understand what is underlying Francesca's behavioral problems. The assessor began with the problems with self-regulation that are highly characteristic of individuals with ADHD. Her parents said that they understood all these but had not heard them presented this way before. They talked about Francesca's problems "controlling herself," in terms of her emotions and behaviors, and they said that it was helpful to think of these things as aligned with her problems "controlling her attention." Similarly, they had no questions or concerns related to Francesca's weak coping skills and poor social skills. They said these are things that are "very much who she is."

Following this was a more difficult section, as it focused on some of the family dynamics (in addition to school) that are problematic for Francesca. In this section, the assessor made sure to emphasize that Francesca's core, underlying problems contribute significantly to family difficulties; in fact, he spent a good amount of time empathizing with how difficult it must be to be a good parent to her. He did then, however, discuss how all the problems within the family (and at school) serve as stressors for her, interacting with her core traits to contribute to some significant problems. Her mother looked sad, and her father asked how they should be better parents to Francesca. The assessor said that one of the recommendations would be for family therapy to help Francesca and the whole family interact more effectively. Her mother, looking down at her lap, said that they "probably all need

that." The assessor reassured them both that family therapy can be extremely effective at "fixing families that need a little help." They seemed reassured and asked to keep going.

The next part of the process focused on what happens to Francesca "internally" because of her core problematic traits and her stressful contexts. While her parents were all too aware of her anger and resentment, they were less aware of the dynamics of her depressive symptoms, including her low self-esteem, sadness, and pessimism. At this point, the assessor decided to do a bit of psychoeducation and discuss how at times depression can manifest in children and adolescents more like acting out and irritability. He moved ahead in the presentation to discuss how the way she "shows" her emotional distress is in her angry outbursts, her oppositionalism, and her aggressive and antisocial behaviors. They seemed genuinely surprised that there was a link between Francesca's negative behaviors and her being depressed and sad.

To address this surprise reaction, the assessor moved forward in the presentation to reveal the diagnosis of DMDD, which he took time to explain. Because of the relative lack of literature on DMDD, much of the description to them was focused on it encapsulating Francesca's emotion dysregulation and irritability, tying her internal emotional discord to her outward behaviors. He followed with the formal diagnoses of parent–child and sibling relational problems and then proceeded to the recommendations, which needed very little explanation except for offering help finding the appropriate kinds of therapy for Francesca since the listing of therapeutic orientations was understandably so unfamiliar to them. The assessor also emphasized the importance of seeing a psychiatrist rather than their pediatrician for medication management. He pointed out that psychiatrists specialize entirely in this area, whereas pediatricians "have to be experts in a whole lot of different things." They said they understood and looked forward to Francesca hearing the feedback as well.

Francesca's Feedback Session

Francesca and her parents came back on a separate day to receive feedback, and Francesca first came into the session alone. She seemed genuinely happy to see the assessor, showing more positive affect than she had throughout the entire rest of the assessment process. She said she was excited to get the feedback, "'cause I just wanna get better." The assessor took her through mostly the same process that he took her parents through, with all the same explanations. She had similar reactions to her parents, especially about the areas that were more obvious, like the ADHD cognitive symptoms, the core underlying traits that also align with ADHD, and the problematic behaviors. Similar to her parents, she was surprised that she did not have any actual academic difficulties. In contrast to her parents, though, she was not at all surprised by the findings of low self-esteem, depression, and anger. During this part of the feedback, she looked down at her lap (the same way she did throughout most of the clinical interview with her parents present). The assessor worked hard to normalize the development of depressed states when she struggles with everything she faces—the problems controlling herself and coping with the world and her really stressful problems within her family and at school. He also emphasized that these things can be helped, both with medication (which she is already taking) and with specific kinds of therapy.

The forward trajectory of the feedback session stopped at this point when Francesca looked up at the assessor, with a hopeful look in her eye, and asked about therapy. He recalled her comment early on in the process that she did not have anyone to talk to about her problems, and the assessor emphasized that a counselor could be there for her to talk to and to teach her concrete skills like how to regulate her emotions better, raise her self-esteem, and express herself in better ways to her peers, siblings, and parents. "I want that," was all she said in response, but she continued making appropriate eye contact with the assessor. He rushed through the recommendations, as he had already mostly said them already, and Francesca asked if the assessor could tell her parents she needs therapy. They went and got her parents to reiterate the feedback that the assessor gave to Francesca in front of all of them.

The final part of the feedback session was a very abbreviated review of the struggles Francesca was facing. The assessor basically said that she has ADHD, problems in her relationships with her parents and siblings, and some emotional difficulties that need help. He then spent most of this section focusing on the recommendations, highlighting (again) seeing a psychiatrist, engaging in family therapy, and getting Francesca a counselor who can help her gain skills in multiple areas that will help her. Although none of the family members asked questions or raised concerns during this section, Francesca watched the assessor intently as he gave the feedback, and afterward she was the first to thank him before they all left.

Following feedback, the assessor contacted Francesca's parents to follow up and provide some specific recommendations for places they could engage with for psychiatry, family therapy, and counseling for Francesca. He ended up finding an adolescent DBT program that was accessible to the family, so he recommended starting there. They had already engaged in family therapy and had an appointment with a pediatric psychiatrist, and they were in the process of finding a more appropriate school setting for Francesca. They were encouraged to reach out to the assessor at any point if they needed anything, including other referrals, consultation with their new providers, or anything else.

Summary

What was supposed to be a straightforward ADHD evaluation turned out to be an adolescent with significant needs. Francesca had not only ADHD but also some emotional and behavioral problems that affected her significantly across multiple domains of functioning (including social, family, academic). Her parents needed significant support to understand not only her difficulties but also how to be adequate parents to her. Different children with different temperaments and different personalities and emotional and behavioral functioning require different kinds of parents. Especially in a family with seven children, this can be a difficult concept for parents to understand. By highlighting the impact of Francesca's behaviors on the family and the interactions between the family dynamic and Francesca's underlying problems, the family is kept focused on understanding that they, too, are contributing to the problems Francesca is exhibiting. It is very easy to identify her as the problem, and in some ways she absolutely is a significant difficulty within the family. However, the assessment was successful at convincing them to get her help they previously had not (a psychiatrist and specific therapy) and to engage in family therapy to help correct some of their problematic dynamics.

References

Akhtar, S., & Thomson, J. A. (1982). Overview: Narcissistic personality disorder. *American Journal of Psychiatry, 139*(1), 12–20.

Alcántara, C., & Gone, J. P. (2014). Multicultural issues in the clinical interview and diagnostic process. In F. T. L. Leong (Ed.), *APA handbook of multicultural psychology* (pp. 153–163). Washington, DC: American Psychological Association Press.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Publishers.

American Psychological Association Division 12. (n.d.). *Treatment target: Borderline personality disorder: Psychological treatments*. Retrieved January 11, 2020, from hpps://div12.org/diagnosis/borderline-personality-disorder/

Axelrod, B. N., Fichtenberg, N. L., Millis, S. R., & Wertheimer, J. C. (2006). Detecting incomplete effort with digit span from the Wechsler Adult Intelligence Scale—Third Edition. *Clinical Neuropsychologist*, *20*(3), 513–523.

Barlow, D. H., Allen, L. B., & Choate, M. L. (2016). Toward a unified treatment for emotional disorders. *Behavior Therapy, 47*(6), 838–853.

Bateman, A. W. (2012). Interpersonal psychotherapy for borderline personality disorder. *Clinical Psychology & Psychotherapy*, *19*(2), 124–133.

Bell, N. L., & Nagle, R. J. (1999). Interpretive issues with the Roberts Apperception Test for Children: Limitations of the standardization group. *Psychology in the Schools*, *36*(4), 277–283.

Bellak, L., & Abrams, D. M. (1997). *The Thematic Apperception Test, the Children's Apperception Test, and the Senior Apperception Technique in clinical use* (6th ed.). Needham Heights, MA: Allyn & Bacon.

Benarous, X., Renaud, J., Breton, J. J., Cohen, D., Labelle, R., & Guilé, J. M. (2020). Are youths with disruptive mood dysregulation disorder different from youths with major depressive disorder or persistent depressive disorder? *Journal of Affective Disorders, 265*, 207–215.

Ben-Porath, Y. S. (2012). *Interpreting the MMPI-2-RF*. Minneapolis, MN: University of Minnesota Press.

Blais, M. A., & Hopwood, C. J. (2017). Model-based approaches for teaching and practicing personality assessment. *Journal of Personality Assessment, 99*(2), 136–145.

Blais, M., & Smith, S. (2014). Improving the integration process in psychological assessment: Data organization and report writing. In R. Archer & S. Smith (Eds.), *Personality assessment* (pp. 405–439). New York, NY: Routledge.

Bornstein, R. F. (2017). Evidence-based psychological assessment. *Journal of Personality Assessment, 99*(4), 435–445.

Blumenthal, S., Wood, H., & Williams, A. (2018). *Assessing risk: A relational approach*. New York, NY: Routledge.

Briere, J. (2000). *Inventory of Altered Self-Capacities professional manual*. Odessa, FL: Psychological Assessment Resources.

Brouillard, C., Brendgen, M., Vitaro, F., Dionne, G., & Boivin, M. (2018). Links between the mother–adolescent and father–adolescent relationships and adolescent depression: A genetically informed study. *Journal of Clinical Child & Adolescent Psychology*, *47*(sup1), S397–S408.

Bruno, A., Celebre, L., Torre, G., Pandolfo, G., Mento, C., Cedro, C., . . . & Muscatello, M. R. A. (2019). Focus on disruptive mood dysregulation disorder: A review of the literature. *Psychiatry Research, 279*, 323–330.

Cain, N. M., Pincus, A. L., & Ansell, E. B. (2008). Narcissism at the crossroads: Phenotypic description of pathological narcissism across clinical theory, social/personality psychology, and psychiatric diagnosis. *Clinical Psychology Review, 28*(4), 638–656.

Campbell, J. C., & Messing, J. T. (Eds.). (2017). *Assessing dangerousness: Domestic violence offenders and child abusers* (3rd ed.). New York, NY: Springer Publishing Company.

Chaplin, T. M., Klein, M. R., Cole, P. M., & Turpyn, C. C. (2017). Developmental change in emotion expression in frustrating situations: The roles of context and gender. *Infant and Child Development*, *26*(6), e2028.

Conducting Psychological Assessment, First Edition. A. Jordan Wright.

Chorpita, B. F., & Weisz, J. R. (2009). *Modular approach to therapy for children with anxiety, depression, trauma, or conduct problems (MATCH-ADTC)*. Satellite Beach, FL: PracticeWise, LLC.

Cohen, B. M., Hammer, J. S., & Singer, S. (1988). The Diagnostic Drawing Series: A systematic approach to art therapy evaluation and research. *Arts in Psychotherapy, 15*(1), 11–21.

Cole, P. M., & Jacobs, A. E. (2018). From children's expressive control to emotion regulation: Looking back, looking ahead. *European Journal of Developmental Psychology, 15*(6), 658-677.

Cotrena, C., Branco, L. D., Shansis, F. M., & Fonseca, R. P. (2016). Executive function impairments in depression and bipolar disorder: Association with functional impairment and quality of life. *Journal of Affective Disorders*, *190*, 744–753.

Danneel, S., Bijttebier, P., Bastin, M., Colpin, H., Van den Noortgate, W., Van Leeuwen, K., . . . & Goossens, L. (2019). Loneliness, social anxiety, and depressive symptoms in adolescence: Examining their distinctiveness through factor analysis. *Journal of Child and Family Studies*, *28*(5), 1326–1336.

Downey, G., & Coyne, J. C. (1990). Children of depressed parents: An integrative review. *Psychological Bulletin, 108*, 50–76.

Dunkel, C. S., & Anthis, K. S. (2001). The role of possible selves in identity formation: A short-term longitudinal study. *Journal of Adolescence*, *24*(6), 765–776.

Dupree, J. L., & Prevatt, F. (2003). Projective storytelling techniques. In C. R. Reynolds & R. W. Kamphaus (Eds.), *Handbook of psychological and educational assessment of children: Personality, behavior, and context* (pp. 66–90). New York, NY: Guilford Press.

Ehrenreich, J. T., Buzzella, B. A., Trosper, S. E., Bennett, S. M., Wright, L. R., & Barlow, D. H. (2008). *The unified protocol for treatment of emotional disorders in adolescents*. Unpublished manuscript, Boston University.

Erdley, C. A., & Day, H. J. (2017). Friendship in childhood and adolescence. In M. Hojjat & A. Moyer (Eds.), *The psychology of friendship* (pp. 3–19). New York, NY: Oxford University Press.

Erikson, E. H. (1963). *Childhood and society* (2nd ed.). New York, NY: Norton.

Erwin, T. D., & Millikin, J. L. (1980). The relationship of the Nelson-Denny Reading Test to the Scholastic Aptitude Verbal Tests. *Measurement and Evaluation in Guidance*, *13*(3), 169–171.

Feher, E., VandeCreek, L., & Teglasi, H. (1983). The problem of art quality in the use of the Human Figure Drawing Test. *Journal of Clinical Psychology, 39*, 268–275.

Finn, S. E. (2007). *In our clients' shoes: Theory and techniques of Therapeutic Assessment*. New York, NY: Routledge.

First, M. B. (2013). *DSM-5 handbook of differential diagnosis*. Washington, DC: American Psychiatric Publishers.

Fives, C. J., Kong, G., Fuller, J. R., & DiGiuseppe, R. (2011). Anger, aggression, and irrational beliefs in adolescents. *Cognitive Therapy and Research*, *35*(3), 199–208.

Freud, A. (1963). The concept of developmental lines. *Psychoanalytic Study of the Child*, *18*(1), 245–265.

Freud, S. (1914). On narcissism: An introduction. In J. Strachey et al. (Trans.), *The standard edition of the complete psychological works of Sigmund Freud, Volume XIV* (pp. 67–102). London, UK: Hogarth Press.

Fuller, G. B., Parmelee, W. M., & Carroll, J. L. (1982). Performance of delinquent and nondelinquent high school boys on the Rotter Incomplete Sentence Blank. *Journal of Personality Assessment, 46*, 506–510.

García-Escalera, J., Chorot, P., Valiente, R. M., Reales, J. M., & Sandín, B. (2016). Efficacy of transdiagnostic cognitive-behavioral therapy for anxiety and depression in adults, children and adolescents: A meta-analysis. *Revista de Psicopatología y Psicología Clínica*, *21*(3), 147–175.

Gardner, J. M. (1967). The adjustment of drug addicts as measured by the Sentence Completion Test. *Journal of Projective Techniques & Personality Assessment, 31*, 28–29.

Grossman, S. D., & Amendolace, B. (2017). *Essentials of MCMI-IV assessment*. Hoboken, NJ: John Wiley & Sons.

Groth-Marnat, G., & Wright, A. J. (2016). *Handbook of psychological assessment* (6th ed.). Hoboken, NJ: Wiley.

Gualtieri, C. T., & Johnson, L. G. (2005). ADHD: Is objective diagnosis possible? *Psychiatry (Edgmont), 2*(11), 44–53.

Haak, R. A. (1990). Using the sentence completion to assess emotional disturbance. In C. F. Reynolds & R. W. Kamphaus (Eds.), *Handbook of psychological and educational assessment of children: Personality, behavior and context* (pp. 147–167). New York, NY: Guilford Press.

Hammen, C., Burge, D., Burney, E., & Adrian, C. (1990). Longitudinal study of diagnoses in children of women with unipolar and bipolar affective disorder. *Archives of General Psychiatry, 47*, 1112–1117.

Hammer, E. F. (1997). *Advances in projective drawing interpretation*. Springfield, IL: Charles C. Thomas.

Hays, P. A. (2001). *Addressing cultural complexities in practice: A framework for clinicians and counselors*. Washington, DC: American Psychological Association.

Høglend, P. (1999). Psychotherapy research: New findings and implications for training and practice. *Journal of Psychotherapy Practice and Research, 8*(4), 257–263.

Horowitz, M. (1989). Clinical phenomenology of narcissistic pathology. *Psychiatric Clinics of North America, 12*, 553–570.

Jobes, D. A. (2016). *Managing suicidal risk: A collaborative approach* (2nd ed.). New York, NY: Guilford Press.

Kernberg, O. (1975). *Borderline conditions and pathological narcissism*. New York, NY: Jason Aronson.

Khan, A., Faucett, J., Lichtenberg, P., Kirsch, I., & Brown, W. A. (2012). A systematic review of comparative efficacy of treatments and controls for depression. *PLoS One*, *7*(7), e41778.

Killian, G. A., & Campbell, B. (1987). House–Tree–Person technique. In D. Keyser & R. Sweetland (Eds.), *Test critiques compendium* (pp. 206–221). Kansas City, MO: Test Corporation of America.

Kochanska, G., Coy. K. C., & Murray, K. T. (2001). The development of self-regulation in the first four years of life. *Child Development, 72*, 1091–1111.

Kuhn, D., Langer, J., Kohlberg, L., & Haan, N. S. (1977). The development of formal operations in logical and moral judgment. *Genetic Psychology Monographs, 95,* 97–188.

Lah, M. I. (1989). Sentence completion tests. In C. S. Newmark (Ed.), *Major psychological assessment instruments, 2* (pp. 133–163). Boston, MA: Allyn & Bacon.

Leary, T. (1957). *Interpersonal diagnosis of personality*. New York, NY: Ronald Press.

Lehman, E. B., & Levy, E. I. (1971). Discrepancies in estimates of children's intelligence: WISC and human figure drawings. *Journal of Clinical Psychology, 27*(1), 74–76.

Lezak, M. D., Howieson, D. B., Bigler, E. D., & Tranel, D. (2020). *Neuropsychological assessment* (5th ed.). New York, NY: Oxford University Press.

Linehan, M. M. (2015). *DBT skills training manual*. New York, NY: Guilford Publications.

Lochman, J. E., Evans, S. C., Burke, J. D., Roberts, M. C., Fite, P. J., Reed, G. M., . . . & Elena Garralda, M. (2015). An empirically based alternative to *DSM-5*'s disruptive mood dysregulation disorder for ICD-11. *World Psychiatry*, *14*(1), 30–33.

Luft, J., & Ingham, H. (1955). The Johari Window, a graphic model of interpersonal awareness. *Proceedings of the Western Training Laboratory in Group Development, 246*. Los Angeles, CA: University of California, Los Angeles.

MacKinnon, R. A., Michels, R., & Buckley, P. J. (2015). *The psychiatric interview in clinical practice* (3rd ed.). Washington, DC: American Psychiatric Publishing.

Malberg, N., Rosenberg, L., & Malone, J. C. (2017). Emerging personality patterns and difficulties in childhood. In V. Lingiardi & N. McWilliams (Eds.), *Psychodynamic diagnostic manual, second edition: PDM-2* (pp. 501–539). New York, NY: Guilford Press.

Marcia, J. E. (1966). Development and validation of ego identity status. *Journal of Personality and Social Psychology, 3*(5), 551–558.

Marshall, P., Hoelzle, J., & Nikolas, M. (2019). Diagnosing attention-deficit/hyperactivity disorder (ADHD) in young adults: A qualitative review of the utility of assessment measures and recommendations for improving the diagnostic process. *Clinical Neuropsychologist*, 1–34.

Mayer, J. D. (1998). A systems framework for the field personality. *Psychological Inquiry: An International Journal for the Advancement of Psychological Theory, 9*(2), 118–144.

Mayer, J. D. (2005). A tale of two visions: Can a new view of personality help integrate psychology? *American Psychologist, 60*(4), 294–307.

McConaughy, S. H. (2013). *Clinical interviews for children and adolescents: Assessment to intervention* (2nd ed.). New York, NY: Guilford Press.

McGill, R. J., Dombrowski, S. C., & Canivez, G. L. (2018). Cognitive profile analysis in school psychology: History, issues, and continued concerns. *Journal of School Psychology, 71,* 108–121.

Meyer, G. J., Erard, R. E., Erdberg, P., Mihura, J. L., & Viglione, D. J. (2011). *Rorschach Performance Assessment System: Administration, coding, interpretation, and technical manual*. Toledo, OH: Rorschach Performance Assessment Systems, LLC.

Meyer, G. J. (2004). The reliability and validity of the Rorschach and Thematic Apperception Test (TAT) compared to other psychological and medical procedures: An analysis of systematically gathered evidence. In M. J. Hilsenroth & D. L. Segal (Eds.), *Comprehensive handbook of psychological assessment, 2: Personality assessment* (pp. 315–342). Hoboken, NJ: Wiley.

Mihura, J. L., Meyer, G. J., Dumitrascu, N., & Bombel, G. (2013). The validity of individual Rorschach variables: Systematic reviews and meta-analyses of the comprehensive system. *Psychological Bulletin*, *139*(3), 548–605.

Möller, H. J., Bandelow, B., Volz, H. P., Barnikol, U. B., Seifritz, E., & Kasper, S. (2016). The relevance of "mixed anxiety and depression" as a diagnostic category in clinical practice. *European Archives of Psychiatry and Clinical Neuroscience, 266*(8), 725–736.

Morey, L. C. (1996). *An interpretive guide to the Personality Assessment Inventory (PAI)*. Odessa, FL: Psychological Assessment Resources, Inc.

Mullins-Sweatt, S. N., Hopwood, C. J., Chmielewski, M., Meyer, N. A., Min, J., Helle, A. C., & Walgren, M. D. (2019). Treatment of personality pathology through the lens of the hierarchical taxonomy of psychopathology: Developing a research agenda. *Personality and Mental Health*. Retrieved on January 25, 2020 from https://onlinelibrary.wiley.com/doi/full/10.1002/pmh.1464

Nikolas, M. A., Marshall, P., & Hoelzle, J. B. (2019). The role of neurocognitive tests in the assessment of adult attention-deficit/hyperactivity disorder. *Psychological Assessment, 31*(5), 685–698.

O'Bryant, S. E., Engel, L. R., Kleiner, J. S., Vasterling, J. J., & Black, F. W. (2007). Test of Memory Malingering (TOMM) trial 1 as a screening measure for insufficient effort. *Clinical Neuropsychologist*, *21*(3), 511–521.

Olbrich, S., Jahn, I., & Stengler, K. (2019). Exposure and response prevention therapy augmented with Naltrexone in kleptomania: A controlled case study using galvanic skin response for monitoring. *Behavioural and Cognitive Psychotherapy, 47*(5), 622–627.

Parker, G., & Roy, K. (2001). Adolescent depression: A review. *Australian & New Zealand Journal of Psychiatry*, *35*(5), 572–580.

Perez, C. (2002). Different tests, same flaws: Examining the SAT I, SAT II, and ACT. *Journal of College Admission*, *177*, 20–25.

Piaget, J. (1972). *The psychology of the child*. New York, NY: Basic Books.

Piotrowski, C. (1984). The status of projective techniques: Or, "wishing won't make it go away." *Journal of Clinical Psychology, 40*, 1495–1502.

Piotrowski, C. (2015). Projective techniques usage worldwide: A review of applied settings 1995–2015. *Journal of the Indian Academy of Applied Psychology, 41*(3), 9–19.

Platt, B., Kadosh, K. C., & Lau, J. Y. (2013). The role of peer rejection in adolescent depression. *Depression and Anxiety*, *30*(9), 809–821.

Raskin, R., Novacek, J., & Hogan, R. (1991). Narcissism, self-esteem, and defensive self-enhancement. *Journal of Personality 59*(1), 19–38.

Reinecke, M. A., Ryan, N. E., & DuBois, D. L. (1998). Cognitive-behavioral therapy of depression and depressive symptoms during adolescence: A review and meta-analysis. *In Database of Abstracts of Reviews of Effects (DARE): Quality-assessed reviews [Internet]*. Centre for Reviews and Dissemination (UK).

Rhodewalt, F., & Morf, C. C. (1998). On self-aggrandizement and anger: A temporal analysis of narcissism and affective reactions to success and failure. *Journal of Personality and Social Psychology, 74*, 672–685.

Ripoll, L. H. (2013). Psychopharmacologic treatment of borderline personality disorder. *Dialogues in Clinical Neuroscience, 15*(2), 213–224.

Roberts, G. E., & Gruber, C. (2005). *Roberts-2: Manual*. Torrance, CA: Western Psychological Services.

Robin, A. L., Koepke, T., Moye, A., & Gerhardstein, R. (2009). Assessment of the parent–adolescent relationship in teens with ADHD. *ADHD Report*, *17*(5), 1–6.

Rotter, J. B., Lah, M. I., & Rafferty, J. E. (1992). *Rotter Incomplete Sentences Blank* (2nd ed.). New York, NY: Psychological Corporation.

Rutter, M. (2003). Commentary: Nature–nurture interplay in emotional disorders. *Journal of Child Psychology and Psychiatry*, *44*(7), 934–944.

Sattler, J. M. (2018). *Assessment of children: Cognitive foundations and applications* (6th ed.). San Diego, CA: Jerome M. Sattler Publisher.

Shields, G. S., Moons, W. G., Tewell, C. A., & Yonelinas, A. P. (2016). The effect of negative affect on cognition: Anxiety, not anger, impairs executive function. *Emotion*, *16*(6), 792–797.

Silverman, L. K. (1997). The construct of asynchronous development. *Peabody Journal of Education, 72*(3&4), 36–58.

Skowron, E. A., & Schmitt, T. A. (2003). Assessing interpersonal fusion: Reliability and validity of a new DSI Fusion with Others Subscale. *Journal of Marital and Family Therapy*, *29*, 209–222.

Smith, S. R. (2007). Performance-based assessment in schools. *Journal of Psychoeducational Assessment, 25*(3), 248–256.

Sommers-Flanagan, J., & Heck, N. C. (Eds.). (2013). The initial interview with diverse populations [Special Issue]. *Journal of Contemporary Psychotherapy, 43*(1).

Sommers-Flanagan, J., & Sommers-Flanagan, R. (2017). *Clinical interviewing* (6th ed.). Hoboken, NJ: Wiley.

Strauss, E., Sherman, E. M. S., & Spreen, O. (2006) *A compendium of neuropsychological tests: Administration, norms, and commentary* (3rd ed.). New York, NY: Oxford University Press.

Stringaris, A., Zavos, H., Leibenluft, E., Maughan, B., & Eley, T. C. (2012). Adolescent irritability: Phenotypic associations and genetic links with depressed mood. *American Journal of Psychiatry*, *169*(1), 47–54.

Sukhodolsky, D. G., Kassinove, H., & Gorman, B. S. (2004). Cognitive-behavioral therapy for anger in children and adolescents: A meta-analysis. *Aggression and Violent Behavior*, *9*(3), 247–269.

Sullivan, H. S. (1970). *The psychiatric interview*. New York, NY: Norton.

Suzuki, L. A., Ponterotto, J. G., & Meller, P. J. (2008). *Handbook of multicultural assessment: Clinical, psychological, and educational applications* (3rd ed.). San Francisco, CA: Jossey-Bass.

Thompson, R. A. (2009). Doing what doesn't come naturally: The development of self-regulation. *Zero to Three*, *30*(2), 33–39.

Tiberio, S. S., Capaldi, D. M., Kerr, D. C., Bertrand, M., Pears, K. C., & Owen, L. (2016). Parenting and the development of effortful control from early childhood to early adolescence: A transactional developmental model. *Development and Psychopathology*, *28*(3), 837–853.

Trosper, S. E., Buzzella, B. A., Bennett, S. M., & Ehrenreich, J. T. (2009). Emotion regulation in youth with emotional disorders: Implications for a unified treatment approach. *Clinical Child and Family Psychology Review*, *12*(3), 234–254.

Tuerlinckx, F., De Boeck, P., & Lens, W. (2002). Measuring needs with the Thematic Apperception Test: A psychometric study. *Journal of Personality and Social Psychology, 82*(3), 448–461.

van Harmelen, A. L., Gibson, J. L., St. Clair, M. C., Owens, M., Brodbeck, J., Dunn, V., . . . & Goodyer, I. M. (2016). Friendships and family support reduce subsequent depressive symptoms in at-risk adolescents. *PloS One, 11*(5), e0153715.

van Harmelen, A. L., Kievit, R. A., Ioannidis, K., Neufeld, S., Jones, P. B., Bullmore, E., . . . & NSPN Consortium. (2017). Adolescent friendships predict later resilient functioning across psychosocial domains in a healthy community cohort. *Psychological Medicine*, *47*(13), 2312–2322.

Walsh, W. B., Savickas, M. L., & Hartung, P. J. (2013). *Handbook of vocational psychology: Theory, research, and practice* (4th ed.). New York, NY: Routledge.

Wanderer, Z. W. (1969). Validity of clinical judgments based on human figure drawings. *Journal of Consulting and Clinical Psychology, 33*(2), 143–150.

Watson, D. (2005). Rethinking the mood and anxiety disorders: A quantitative hierarchical model for *DSM-V*. *Journal of Abnormal Psychology, 114*(4), 522–536.

Weinberg, A., & Klonsky, E. D. (2009). Measurement of emotion dysregulation in adolescents. *Psychological Assessment, 21*(4), 616–621.

Weiner, I. B. (1966). *Psychodiagnosis in schizophrenia*. Hillsdale, NJ: Lawrence Erlbaum.

Weiner, I. B., & Greene, R. L. (2017). *Handbook of personality assessment* (2nd ed.). Hoboken, NJ: Wiley.

Weissman, M. M., Wickramaratne, P., Nomura, Y., Warner, V., Pilowsky, D., & Verdeli, H. (2006). Offspring of depressed parents: 20 years later. *American Journal of Psychiatry, 163*, 1001–1008.

Westen, D. (1995). *Social Cognition and Object Relations Scale: Q-Sort for projective stories (SCORS-Q)*. Unpublished manuscript, Department of Psychiatry, Cambridge Hospital and Harvard Medical School, Cambridge, MA.

Wiggins, J. S. (1982). Circumplex models of interpersonal behavior in clinical psychology. In P. C. Kendall & J. N. Butcher (Eds.), *Handbook of research methods in clinical psychology* (pp. 183–221). New York, NY: Wiley.

Winter, D. G., & Stewart, A. J. (1977). Power motive reliability as a function of retest instructions. *Journal of Consulting and Clinical Psychology*, *45*, 436–440.

Wood, C., & Hays, D. G. (2013). *A counselor's guide to career assessment instruments* (6th ed.). Broken Arrow, OK: National Career Development Association.

Wolfe, P. L., Millis, S. R., Hanks, R., Fichtenberg, N., Larrabee, G. J., & Sweet, J. J. (2010). Effort indicators within the California Verbal Learning Test-II (CVLT-II). *Clinical Neuropsychologist, 24*(1), 153–168.

World Health Organization. (2004). *ICD-10: International statistical classification of diseases and related health problems* (10th ed.). Geneva: World Health Organization.

Wright, A. J. (Ed.) (2019). *Essentials of psychological assessment supervision*. Hoboken, NJ: Wiley Publishers.

Yama, M. F. (1990). The usefulness of human figure drawings as an index of overall adjustment. *Journal of Personality Assessment, 54*(1–2), 78–86.

Zhang, Z., Huang, R., & Liu, D. (2018). Kleptomania: Recent advances in symptoms, etiology and treatment. *Current Medical Science, 38*(5), 937–940.

Zubin, J., & Spring, B. (1977). Vulnerability: A new view of schizophrenia. *Journal of Abnormal Psychology, 86*, 103–126.

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