PSY 557
Jim Graham

Why Assessment?
- Assessment is a way to get a great deal of information in a short amount of time
- The information is very specific rather than general
- The information is (generally) quantitative in nature rather than qualitative
- The information is (generally) standardized

Purposes of Assessment
- Assessing client problems, identifying, conceptualizing, and defining the client problems and strengths
- Selecting and implementing effective interventions, identifying barriers to intervention
- Providing answers to specific referral questions
- To provide a standardized method of measuring counseling outcome or change over time

All of these purposes can be accomplished without assessment, though including formal assessment strengthens each of these.

Formal assessment is an adjunct, not a replacement, for clinical judgment.

Process of Assessment
- Identify the purpose of the assessment
  - Referral questions
  - Meeting with client
- Select instruments
  - Acceptable psychometric properties
  - Appropriate for client, counselor, and setting
- Administer instruments
  - Do not deviate from standardized administrations

Score instruments
- Again, stick to procedure!

Interpreting scores
- Think of this like research:
  - Look at the data, and generate multiple explanations for the data
  - For each possible explanation, consider what other evidence you might expect to find.
  - Rule-out explanations that don’t fit all available data
  - Explanations supported by multiple sources of information are preferable
Process of Assessment

- Answer referral questions
- Frame interpretation in light of referral questions
- Provide appropriate feedback to the client

Minimum Competencies

1. Avoid errors in scoring and recording
2. Do not answer examinee’s questions in greater detail than permitted by the test manual
3. See that examinees follow instructions so that test scores are accurate
4. Keep testing materials secure
5. Refrain from coaching or training individuals or groups on test items (as this misrepresents the person’s abilities)

6. Use settings for testing that allow for optimum performance
7. Establish rapport with examinees
8. Be willing to give feedback to test takers in counseling situations
9. Do not assume that the norm for one group automatically applies to another group
10. Do not label people with derogatory terms on the basis of test scores that lack perfect validity

Evaluating Measures

- What does the test attempt to measure?
- What is the construct/s being measured, including subscales?
- Number of items and item format

- How are scores created?
  - How is it administered/scored?
  - Intended population?
  - Standard scores? Norm referenced? Criterion referenced?

- Does it tend to measure things with little error?
  - Reliability of scores (including subscales).
  - Test/Retest, Inter-rater, Cronbach’s alpha

- Does it measure what it’s supposed to measure?
  - Validity of Scores (Construct (Convergent/Discriminant), Content, Predictive, etc.)
Evaluating Measures

- With what population has the measure been evaluated?
- For what counseling applications is the measure appropriate?
- For what research applications is the measure appropriate?

Does the intended use match one of the above?

Actuarial vs. Clinical Decisions

- Clinical – information is integrated in clinician’s head;
- Actuarial (statistical) – decision guided solely by empirically established relations between data and the condition of interest

What would you use to determine recidivism risk for violent offenders?

Law School Applicants – what do you use?

- UGPA
- Mean GPA from applicant’s college
- LSAT
- Mean LSAT from applicant’s college

Law School Applicants – what do you use?

- MMPI Goldberg Rule: 3 – 2 if < 45, neurotic (Lie paranoia, schizophrenia, hysteria, psychasthenia)
  - Average judge: 62% correct
  - Best Judge: 67%
  - Goldberg rule: 70%
  - Lots of practice – still not as good.
  - Clinician using Goldberg results – still not as good

50 variables decreased to 12: psychopathy, elementary school adjustment, age at time of offense, separation from parents when younger than 16, failure on previous conditional release, nonviolent offense history, marital status, schizophrenia, most serious injury of victim, alcohol abuse score, gender of victim

Weighted and summed, gives probability of violence over next 7 to 10 years
Meehl (1954) 19/20 studies, actuarial is better

How we make decisions:
- What are the important factors to consider?
- And what factors are extraneous?
- How much weight should be given to the factors?

Why actuarial is better
- Actuarial always comes to the same conclusion for a set of data (reliable)
- Factors are weighted based on actual contribution to prediction
- People develop false beliefs, actuarial prediction does not
- Requires no training – Blasphemy!

What are ways we can improve clinical judgment?

- Clinicians have access to more information:
  - Clinical is even worse if clinicians have more information than actuarial;
  - Too much information is actually part of the problem!
- Clinicians have familiarity with setting:
  - Clinical is even worse if data come from same setting as clinician
- Exceptions:
  - What to do – look for rare events not included in the actuarial formula
  - When left to their own devices, clinicians see too many exceptions

Diagnosis: Clinical is ok for diagnosing, not good at all for predicting future

- Base Rate: Clinical is better if clinicians know the base rate
- Expertise: Clinical is better if clinicians are experts

Initial Interview

- During an initial interview, your goals are to:
  - Begin development of a therapeutic relationship
  - Establish the purpose of the assessment and the referring questions that will drive the assessment
  - Gain necessary background information

Information Gathered:
- Demographic information
- Presenting concerns
- Physical Appearance
- Present functioning
- Health and medical history, current status
- Past counseling/assessment history
- Family information
- Social/Developmental History
- Educational/Occupational History
Initial Interview

- Generally, initial interviews will tend towards the structured/semi-structured side of things (rather than unstructured).
- Common “first session” assessments:
  - Mental Status Examination (formally used to screen for delirium)
  - Alcohol Screening (CAGE)
  - Suicide Screening (SAD PERSONAS)

CAGE
- Cut back – ever felt the need to cut back on your drinking?
- Annoyed – Do people annoy you by criticizing your drinking?
- Guilty – Ever feel bad or guilty about your drinking?
- Eye opener – Ever have a drink first thing when you wake up to steady your nerves or get rid of a hangover?

SAD PERSONAS
- Sex
- Age
- Depression
- Previous attempt
- Ethanol abuse
- Rational thought loss
- Social supports lacking
- Organized plan
- No spouse/primary support person
- Access to lethal means
- Sickness
- One point for each, can fail as a predictive instrument

Assessment questions:
- Describe the referral questions as you understand them
- Ask for input/modification on questions
- Example referral questions:
  - What is the source of my (insert problem here)?
  - How does my (insert problem here) affect my (insert life domain here)?
  - What counseling approaches are likely to meet with the most success? What counseling approaches are likely to be the most difficult?
  - What might I expect to happen in (insert situation here)

Self-Report Tests

- Generally, these tests are paper-and-pencil measures
- Not always completed by the person being rated
  - Includes observer ratings (parent report, teacher report, etc.)
- Self report measures exist for nearly everything you could imagine

Finding self-report tests:
- Colleagues
- MMY
- Testing catalogs
- Books with summaries of measures
  - Measures for Clinical Practice
  - Handbook of Family Measurement Techniques
  - Positive Psychological Assessment
**Self-Report Tests**

- **Administration**
  - Generally, this involved reading a set of short instructions to clients, and ensuring that they understand the procedures.
  - Be careful of pressure-sensitive materials (don’t write on top of a stack of papers).
  - The response to any one item generally doesn’t matter so much, rather the overall pattern of responses matters.

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**SCL-90-R**

- **Symptom Checklist 90 – Revised**
  - Designed to measure “psychological symptom patterns”
  - 9 subscales (symptom areas)
  - 3 “global” scales
  - **Items**
    - 90 items
    - 5 point-response scale from “Not at all” to “Extremely”
    - 12 to 15 minutes to complete

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**Administration**

- Introduce the test –
  - Example: “This is a test that will let us know more about your problems. This is a list of problems people sometimes have. Please read each one carefully, and blacken the circle that best describes how much that problem has distressed or bothered you during the past 7 days, including today. Blacken the circle for only one number for each problem, and do not skip any items. If you change your mind, erase your first mark carefully.
  - After this, give the client time alone, but be available in case they have questions.

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**SCL-90-R**

- **Uses:**
  - Ages 13+
  - 4 different samples (separate male and female):
    - Community (nonpatients)
    - Adolescent nonpatients
    - Psychiatric inpatients
    - Psychiatric outpatients
  - Due to the “past 7 days”, it can be used as a one-time assessment, or a repeated measure of change.

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**Scoring**

- Uses scoring templates (separate one for each subscale) and a scoring sheet + profile.

- **Subscales**
  - Align the black rectangles
  - Sum the responses shown in the window (enter in 1st column)
  - Count the # of completed items (enter in 2nd column)
  - Divide sum by # for subscale raw-score

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**Scoring**

- **GSI**
  - Score the “additional items”
  - Sum all of the subscale + additional item columns
  - Divide sum by # for GSI raw score

- **PST**
  - Count the number of non-zero responses

- **PSDI**
  - Divide total sum by # of non-zero responses
**Scoring**

- Use Norms in manual to convert raw scores to standard scores.
- Standard Scores are $t$-scores ($\text{mean}=50, \text{sd}=10$).
- Profile forms, including percentiles, are also available.
  - Percentiles use the normal distribution.
  - On Excel: $=\text{NORMDIST}(x, \text{mean}, \text{sd}, \text{true})$.
  - If $x=64$, $=\text{NORMDIST}(64, 50, 10, \text{true})$.

**Scales**

- **Somatization (SOM)**
  - Perceptions of bodily dysfunction (GI problems, cardiovascular problems, pain, etc.).
  - Includes some somatic equivalents of anxiety.
- **Obsessive-Compulsive (O-C)**
  - Thoughts, impulses, and actions that are unremittent and unwanted.
  - Also includes problems with cognitive performance (inattention, etc.).

**Scales**

- **Interpersonal Sensitivity (I-S)**
  - Feelings of inadequacy and inferiority, particularly when compared to others, self-doubt, self-depreciation.
  - Uncomfortable during social interactions.
  - Very self-conscious, expect negative outcomes from social interactions.
- **Depression (DEP)**
  - Dysphoric mood, withdrawal, lack of motivation, hopelessness,
  - Cognitive and somatic correlates of depression.
- **Anxiety (ANX)**
  - Nervousness, tension, panic attacks, etc.
  - Also includes some somatic components of anxiety.

**Scales**

- **Hostility (HOS)**
  - Thoughts, feelings and actions associated with anger.
  - Aggression, irritability, rage, resentment.
- **Phobic Anxiety (PHOB)**
  - Persistent fear response to a specific trigger, that is irrational or disproportionate and leads to escape behavior.
  - Focuses on disruptive manifestations of anxiety (similar to agoraphobia).

**Scales**

- **Paranoid Ideation (PAR)**
  - Projective thought, hostility, grandiosity, centrality, fear of loss and autonomy, delusions.
- **Psychoticism (PSY)**
  - Withdrawn, isolated schizoid lifestyle.
  - Symptoms of schizophrenia: hallucinations, thought control.
  - Set up as a continuum, from mild interpersonal alienation to dramatic psychosis.

**Global Indices**

- **Global Severity Index (GSI)**
  - Best single indicator of the current level or depth of the disorder.
  - Good summary measure.
- **Positive Symptom Total (PST)**
  - A measure of symptom breadth, irrespective of severity.
- **Positive Symptom Distress Index (PSDI)**
  - A measure of symptom intensity (depth).
  - The average level of distress for the symptoms that were endorsed.
Interpreting Scores

- Consider the Global Indices – T of 60 is higher than 84% of the normative sample, 70 is higher than 98%
- Defining a positive psychiatric “case” with the nonpatient sample (Norm B)
  - If GSI ≥ 63 or
  - At least two subscales ≥ 63

Interpreting Scores

- Subscale interpretation.
  - There are no guidelines set forth by the manual.
  - Think of each problem area on a continuum in the normal population:
    - A T of 60 or above is associated with “moderate” problems in an area
    - A T of 65 or greater is often referred to as “clinically significant”
    - A T score of 70 or greater is clinically significant, and also “severe”

Interpreting

- Identify the central problems
  - What are the highest subscale scores?
  - Give these the most weight in interpretation
  - Consider the less severe problem areas in light of the central problem.
  - Consider how the data relate to the self-report of the client and other ancillary information

Interpretation Exercises

- High PAR – what counseling issues might you want to consider?
  - Effective approaches?
  - Ineffective approaches?
- How would a high PAR + high I-S differ from a high PAR + high HOS?
- High PAR + high HOS + high PSY?
BASC-2

- Behavior Assessment System for Children
  - Designed to evaluate the behavior and self-perceptions of 2-25 year olds
  - Two rating scales (teachers and parents)
  - Self-report scale
  - Structured Developmental History
  - Student Observation System
- Items
  - 100 to 160 items, depending on form
  - 4 point-response scale: Never, Sometimes, Often, Always
  - 10 to 15 minutes to complete

Administration

- Introduce the test –
  - Example: “I am evaluating ___ and would appreciate your help. I would like to know how ___ behaves (at home, in your class) in order to help him/her. This form takes 10 to 15 minutes to complete. Please read the instructions on the form, and respond to all of the items. Let me know if you have any questions. I appreciate your help.”
- After this, give the respondent time alone, but be available in case they have questions.

BASC-2

- Uses:
  - Ages 2-25; primarily school-aged
  - Teacher and Parent rating scales
    - Preschool (2-5)
    - Child (6-11)
    - Adolescent (12-21)
  - Self Report
    - Child (8-11)
    - Adolescent (12 to 21)
    - College (18 to 25)
  - Responses are as they relate to the “past several months”

Scoring

- Computerized scoring (see handout)
- When entering scores, each keystroke advances the cursor to the next item.
- You are given the option to re-enter the data to check for errors
- Several different norm options:
  - General (combined or separate sex)
  - Clinical (combined or separate sex)
  - LD Clinical (combined or separate sex)
  - ADHD Clinical (combined or separate sex)
- The scoring and report is automatically generated.

Scales

- The available scales are different, based on the age and type of form used.
- Behavioral Symptoms Index
  - Atypicality (Odd or strange behaviors)
  - Withdrawal
  - Aggression
  - Hyperactivity
  - Depression
  - Attention Problems
- Externalizing Problems
  - Aggression
  - Hyperactivity
  - Conduct Problems
- Internalizing Problems
  - Anxiety
  - Depression
  - Somatization
- School Problems
  - Learning Problems
  - Attention Problems
Scales

- Adaptive Skills
- Activities of Daily Living
- Adaptability (ability to adjust to changes in routine, shift from task to task, etc.)
- Functional Communication
- Leadership
- Social Skills
- Study Skills

Interpreting Scores

- Clinical Scales
  - 60-69 “At Risk”
  - 70+ “Clinically Significant”
- Adaptive Scales
  - 31-40 “At Risk”
  - 30 or less “Clinically Significant”

Interpreting

- Start with the BSI & Adaptive Skills
- Interpret the Indices
- Modify the interpretation with the individual subscales
- Identify the central issues
  - Consider the less severe problem areas in light of the central problem.
  - Consider how the data relate to the self-report of the client and other ancillary information

Personality Testing

- Personality tests attempt to measure:
  - Relatively stable traits
  - That predict how an individual will behave across a wide variety of situations
  - As such, personality traits are quite useful for a variety of assessment situations.

Personality Testing

- Outside of MA Counseling scope of practice:
  - Minnesota Multiphasic Personality Test (MMPI-2)
  - A very widely used and well-researched measure
  - Millon Clinical Multiaxial Inventory – III (MCMI-III)
  - Focus on Axis 2, reputation as being overpathologizing
  - Rorschach Inkblot Test
  - Projective test, typically uses the Exner System
Myers-Briggs Type Indicator
- Used a lot in I/O, many problems
  - Introversion/Extroversion
  - Sensing/iNtuition
  - Feeling/Thinking
  - Judging/Perceiving

NEO-PI-R
- Many personality theorists are interested in determining the basic components of personality;
  - Most of them have converged on a five-factor solution
    - Openness
    - Conscientiousness
    - Extraversion
    - Agreeableness
    - Neuroticism

NEO PI R
- Revised NEO Personality Inventory
  - Designed as a measure of normal personality
  - 240 Items
  - 5-point Likert scales (SD to SA)
  - Balanced + and – items
  - Level B Qualification
  - Self and observer report versions
  - Shorter version, FFI (Five Factor Index)

NEO PI R
- 5 Domain Scales (OCEAN)
  - Each Domain Scale has 6 Facet Scales
  - Administration
    - Uses a pressure-sensitive self-scoring form
    - Takes 30 to 40 minutes to complete
    - Ages 17 and up
      - College age norms
      - Adult norms

NEO PI R
- Scoring
  - Tear open self-report form.
  - Sum up each row to obtain the facet scale raw scores
  - Sum up each appropriate facet scale to obtain the domain scores
  - Transfer scores to Normative forms, circle appropriate raw scores
  - Determine T-scores, write at top
  - Percentiles are available in back of manual

Interpretation of Scores
- 66+ Very High
- 56-65 High
- 45-55 Average
- 35-44 Low
- 34- Very Low
Neuroticism

- Tendency to experience psychological distress and negative emotion;
- Very common in psychopathology, where the relevant question is typically what form it takes (e.g., anxiety or depression);
- Low neuroticism does not equal greater positive emotion, just lower negative emotion

<table>
<thead>
<tr>
<th></th>
<th>High</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>N1: Anxiety</td>
<td>prone to worry, nervous</td>
<td>calm and relaxed</td>
</tr>
<tr>
<td>N2: Angry Hostility</td>
<td>easily frustrated and expression of anger (expression is agreeableness)</td>
<td>easygoing</td>
</tr>
<tr>
<td>N3: Depression</td>
<td>guilt, sadness, hopelessness, Shame</td>
<td>infrequent sadness (not cheerfulness)</td>
</tr>
<tr>
<td>N4: Self-Consciousness</td>
<td>sensitive to ridicule, embarrassment</td>
<td>less bothered in social situations (not necessarily good social skills)</td>
</tr>
<tr>
<td>N5: Impulsiveness</td>
<td>inability to control cravings and urges</td>
<td>easy to resist temptations and high frustration tolerance</td>
</tr>
<tr>
<td>N6: Vulnerability</td>
<td>unable to cope with stress, panicking in emergencies</td>
<td>capable of handling difficult situations</td>
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Extroversion

- Different from Jung’s conceptualization (MBTI)
- Sociability, preference for groups
- Experience of positive emotion

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>E1: Warmth</td>
<td>Affectionate, friendly, like people, easy attachments</td>
<td>Formal, reserved, distant (not hostile)</td>
</tr>
<tr>
<td>E2: Gregariousness</td>
<td>Preference for other's company, more the merrier</td>
<td>Don't avoid contact, but don't seek out other's company</td>
</tr>
<tr>
<td>E3: Assertiveness</td>
<td>Dominant, forceful, socially ascendant, leaders</td>
<td>Stay in background and let others do the talking</td>
</tr>
<tr>
<td>E4: Activity</td>
<td>Rapid tempos, high energy, fast-paced, busy</td>
<td>Leisurely and relaxed (usually not sluggish and lazy)</td>
</tr>
<tr>
<td>E5: Excitement-Seeking</td>
<td>Crave excitement and stimulation, like bright colors and loud noise, sensation seeking</td>
<td>Little need for thrills</td>
</tr>
<tr>
<td>E6: Positive Emotions</td>
<td>Joy, happiness, love; laugh easily and often</td>
<td>Less exuberant and high spirited</td>
</tr>
</tbody>
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Openness

- **Openness to Experience**
- Nondogmatic attitudes and values (not particularly associated with mental health, just determines the defenses – intellectualization versus suppression/denial)

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>O1: Fantasy</td>
<td>Vivid fantasy life, complex inner worlds, daydreaming, creativity</td>
</tr>
<tr>
<td>O2: Aesthetics</td>
<td>Appreciate art and beauty, moved by poetry, music (this doesn't mean good taste!)</td>
</tr>
<tr>
<td>O3: Feelings</td>
<td>Open to and valuing of own emotional life, experience more intense emotions</td>
</tr>
<tr>
<td>O4: Actions</td>
<td>Tries new things, eats new food, prefer variety</td>
</tr>
<tr>
<td>O5: Ideas</td>
<td>Intellectual curiosity, consider new ideas, enjoy philosophical arguments and brain-teasers</td>
</tr>
<tr>
<td>O6: Values</td>
<td>Ready to reexamine social, political, and religious values</td>
</tr>
</tbody>
</table>

Openness

- **High**: Imaginative, sensitivity to art and beauty, intellectual curiosity, rich and complex emotional life, behaviorally flexible, Willing to entertain novel beliefs and attitudes
- **Low**: Prefer familiar over novel, muted emotional responses, narrower scope of interests, generally socially and politically conservative, not authoritarian (that's low agreeableness)

Agreeableness

- **High**: Altruistic, sympathetic to others, eager to help others, expects others will be helpful in return; Tend to be more popular, but less willing to defend their own independent viewpoint.
- **Low**: Disagreeable, egocentric, skeptical of other’s intentions, competitive rather than cooperative

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>A1: Trust</td>
<td>Believe that others are honest and well-intentioned</td>
</tr>
<tr>
<td>A2: Straight-forwardness</td>
<td>Frank, sincere, ingenious</td>
</tr>
<tr>
<td>A3: Altruism</td>
<td>Generous, concerned for other's welfare, willing to help</td>
</tr>
<tr>
<td>A4: Compliance</td>
<td>Reaction to IP conflict: defers to others, inhibits aggression, forgives &amp; forgets</td>
</tr>
<tr>
<td>A5: Modesty</td>
<td>Humble, self-effacing (not low self-esteem)</td>
</tr>
<tr>
<td>A6: Tender-Mindedness</td>
<td>Moved by other's needs, emphasize the human side of social policies</td>
</tr>
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Conscientiousness

- The active process of planning, organizing, and carrying out tasks
- Used to be called “character”, aka “Will to Achieve”

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</tr>
</thead>
<tbody>
<tr>
<td>C1: Competence</td>
<td>Feel well-prepared to deal with life; capable, prudent, effective; high self-esteem, internal locus of control</td>
<td>Lower opinion of abilities; feel unprepared and inept; low self-esteem, external locus of control</td>
</tr>
<tr>
<td>C2: Order</td>
<td>Neat, tidy, well-organized (OCD?)</td>
<td>Unmethodical, unable to get organized</td>
</tr>
<tr>
<td>C3: Dutifulness</td>
<td>Adhere to ethical principles, fulfill moral obligations</td>
<td>More casual, undependable, unreliable</td>
</tr>
<tr>
<td>C4: Achievement</td>
<td>High aspirations, work hard to achieve goals, diligent, sense of purpose, workaholics</td>
<td>Laid-back, not driven to succeed, aimless, often content with low achievement</td>
</tr>
<tr>
<td>C5: Self-Discipline</td>
<td>High ability to begin tasks and see them through despite boredom and distractions</td>
<td>Procrastinate, easily discouraged, not impulsive, just unable to motivate</td>
</tr>
<tr>
<td>C6: Deliberation</td>
<td>Cautious, deliberate, tend to think before acting</td>
<td>Hurry, act without considering consequences, spontaneous, can make snap decisions</td>
</tr>
</tbody>
</table>

NEO Interpretive Strategy

- **Affect**: Describe the person’s emotional life? Types of emotions experienced, value of emotions, etc.
- **Behavior**: How does the individual behave? Problem behaviors? Substance abuse, etc.?
- **Cognition**: What attitudes, beliefs, and values does the person hold? How do they see the world?

**Conscientiousness**

- **High**: Purposeful, strong-willed, and determined. Associated with academic and occupational achievement; scrupulous, punctual, reliable, also fastidiousness, compulsive neatness, or workaholic behavior
- **Low**: Not lacking in moral principles, but less exacting in applying them, more lackadaisical in working toward goals, more hedonistic

**NEO Interpretive Strategy**

- **Interpersonal**: How does the person relate to others? What are their relationships like?
- **Reaction to Stress**: How does the person respond to problems? How are they likely to cope with stress? How do they respond to adversity?
- Other areas may be dictated by referral questions (counseling issues, etc.)
NEO Interpretive Strategy

- Work through each scale, inserting the interpretive statements into the appropriate subheadings
- It’s less important to use the exact perfect category, and more important to tell a story that makes sense
  - E.g. – Information from someone with a low A1 (trust) could go into Interpersonal or Cognitive; wherever it paints the clearest picture

NEO Interpretive Strategy

- Indicate which findings are stronger than others
- Once you’ve completed the scale interpretation, look within each domain and determine how the components relate to one another.
- Try writing a paragraph for each area, tying the information together.
- Also provide an overall summary, drawing connections between the areas and describing how they interrelate.

Therapeutic Assessment

- The process of assessment influences the client.
  - Assessment is part of the process of meaning-making
  - Existing problems and strengths can take on new meaning in light of the information gained by the assessment

TA Session 1

- Discuss goals of assessment
  - Generated by:
    - The client
    - The referring body
    - You
  - As the assessor, you are the expert at helping frame questions in a manner that can be addressed by assessment
  - For the client to be invested in the accuracy of the results, the goals should be transparent and open to modification

TA Session 1

- Gain relevant background information
  - Conduct a file review before the initial meeting
  - Attempt to predict some referral questions, and determine what information is necessary ahead of time.
- Describe the assessment process
  - General information about how to approach test-taking, etc.

http://online.wsj.com/article/SB122211987961064719.html?mod=Vhoofront#project%3DPERSONALITY08%26articleTabs%3DInteractive
### Testing Sessions

- Introduce each test, describing what it is intended to measure.
- Generally, tests are best completed in the office.
- If necessary to take some materials home, give careful instructions on how to complete the tests.
  - Ensure that the materials are returned!

### Integrated Report

- Identifying Information (include dates of evaluation)
- Reason for Referral or Referral Questions
- Tests Administered (and who completed them)
- Behavioral Observations
  - How did they approach test-taking?
  - Frustration tolerance? Self depreciating comments? Answered quickly or slowly?
  - Include a validity statement

### Integrated Report

- Background Information
- Reports of Individual Tests:
  - Describe the test
  - Present results
  - Interpret results
- Summary
  - Briefly restate results of tests if necessary
  - Tie the pieces together to present an integrated picture of the individual

### Integrated Report

- Diagnosis, if relevant
- Answers to referral questions and/or recommendations (generally best presented by question)

### Couple Assessment

- Individual measures can be administered to each member of the couple.
- Some measures (e.g., NEO) allow people to rate one another.
- Profiles can be plotted against one another to look for areas of agreement/discrepancy
  - \( 1+1 = 3 \)
<table>
<thead>
<tr>
<th>Marital Satisfaction Inventory</th>
<th>MSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>150 T/F items</td>
<td>Inconsistency</td>
</tr>
<tr>
<td>25 minutes to complete</td>
<td>Validity scale that looks at similarity of responses across 20 item pairs</td>
</tr>
<tr>
<td>Identifies the nature and extent of relationship distress in couples considering or beginning conjoint therapy</td>
<td>Conventionalization</td>
</tr>
<tr>
<td>Covers a broad range of problem areas</td>
<td>Tendency to distort appraisal of relationship in a socially desirable manner</td>
</tr>
<tr>
<td>Interpreted as “Good” “Possible Problem” and “Problem”</td>
<td>Global Distress</td>
</tr>
<tr>
<td></td>
<td>Overall dissatisfaction with the relationship</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MSI</th>
<th>MSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affective Communication</td>
<td>Disagreement about Finances</td>
</tr>
<tr>
<td>Dissatisfaction with amount of affection and understanding communicated by one’s partner, Lack of affection &amp; support, lack of understanding and mutual disclosure of feelings</td>
<td>Discord re: the management of finances</td>
</tr>
<tr>
<td>Problem-Solving Communication</td>
<td>Sexual Dissatisfaction</td>
</tr>
<tr>
<td>Ineffectiveness in resolving differences, poor problem-solving skills</td>
<td>Dissatisfaction with the frequency and quality of intercourse and sexual activity</td>
</tr>
<tr>
<td>Aggression</td>
<td>Role Orientation</td>
</tr>
<tr>
<td>Level of intimidation and aggression experienced by the respondent from their partner</td>
<td>Traditional vs. nontraditional views of gender roles in relationships and parenting</td>
</tr>
<tr>
<td>Time Together</td>
<td>Family History of Distress</td>
</tr>
<tr>
<td>Lack of shared leisure activity, lack of shared interests</td>
<td>Disruptions of relationships in respondent's family of origin</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MSI</th>
<th>Family Assessment Measure III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissatisfaction with Children</td>
<td>Quantitative assessment of family strengths and weaknesses, using the process model of family functioning</td>
</tr>
<tr>
<td>Dissatisfaction over relationship between parents and children</td>
<td>Grade 5 and up reading level</td>
</tr>
<tr>
<td>Conflict over Child Rearing</td>
<td>Many different forms and methods of use:</td>
</tr>
<tr>
<td>Extent of conflict between partners over childrearing practices</td>
<td>General – a person rates the overall family</td>
</tr>
<tr>
<td></td>
<td>Self-rating – a person rates themselves</td>
</tr>
<tr>
<td></td>
<td>Dyadic Relationship Scale – a person rates their relationship with another family member</td>
</tr>
<tr>
<td></td>
<td>1+1+1 = 12 (3+3+6)</td>
</tr>
</tbody>
</table>
FAM-III

- Task Accomplishment
  - Basic tasks consistently completed, flexible (even under stress), task ID shared by family members
  - Failure of some basic tasks, inflexible; minor stresses result in crisis
- Role Performance
  - Roles are well-integrated; people know what is expected of them, flexible roles
  - Poor agreement over roles, inability to adapt to changes
- Communication
  - Clear, direct communication; sufficient information, receiver is open to messages
  - Insufficient communication, clarification not sought

FAM-III

- Affective Expression
  - Full range of expressed affect, with correct intensity
  - Inhibition (or overly intense) emotional expression
- Involvement
  - Empathic involvement; supportive, nurturant; concern promotes autonomous functioning
  - No involvement, or extreme & symbiotic; insecure
- Control
  - Patterns of influence lead to some spontaneity, yet predictable; control attempts are constructive and educational
  - Control is either rigid or chaotic; overt power struggles
- Values & Norms
  - Family’s value system are consistent with larger culture; rules are consistent
  - Family’s value system result in confusion; implicit and explicit rules contradict

FAM-III

- Only in General rating form:
  - Overall Rating
  - Social Desirability
  - Defensiveness