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Introduction to the Handbook of Clinical Assessment and Diagnosis

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OVERVIEW

This handbook provides up-to-date summaries and applied recommendations for psychological assessment and diagnosis. The comprehensive compilation of chapters written by experts in their respective fields should guide graduate-level teaching/training and research as well as serve as an update on assessment for behavioral health service providers. Each chapter presents major theoretical, empirical, methodological, and practical approaches used in psychological assessment and diagnosis across different assessment methods, varied psychological disorders/presentations, and unique assessment settings. As will be seen when reading the chapters, a major theme for empirically based assessment is that test users must “read well beyond the manual” to decide whether to use and how to interpret any psychological test or measure (Holden & Fekken, Chapter 23, this volume, p. 322).

We believe this handbook will appeal to three primary audiences. The first is academicians, including professors/instructors and graduate students completing training in psychological assessment. The chapters provide updated and empirically supported recommendations consistent with the competency-based training model of the American Psychological Association (2006). The chapters include valuable coverage of foundational assessment topics as well as more advanced training in the application of assessment skills in clinical practice. However, the handbook should also be valuable to professional psychologists (and related mental health professionals) by providing a current, updated coverage of assessment topics, consistent with ethical practice guidelines. Finally, researchers of applied psychological assessment as well as those who wish to include clinically meaningful measures in their research should benefit from this comprehensive handbook.

STRUCTURE OF THE HANDBOOK

Part I of the handbook (Chapters 2 through 9) outlines major issues that cross all psychological assessment

methods, settings, and disorders. Chapter 2 provides coverage of contemporary psychometric topics relevant to both researchers and clinicians who conduct assessments. Chapter 3 provides a conceptual and empirical presentation of multicultural assessment issues, which are critical to test development and test interpretation/use. Chapter 4 discusses common ethical issues that arise in psychological assessment. Chapter 5 presents information on contemporary diagnosis, including review of the most common approaches as well as presentation of new approaches and their empirical bases. Chapter 6 presents a critical topic often neglected in existing assessment tests: noncredible responding and performance and the importance of taking validity of patient/participant response into account when interpreting assessment results in both clinical and research contexts. Chapter 7 focuses on empirical review of a new assessment technology with growing use in both research and clinical settings: ambulatory assessment, which serves as a foundational example of our intent to consider technological advances in the field of psychological assessment across methods, diagnoses, and settings. Chapter 8 considers a key development in the integration of psychological assessment and intervention, the Therapeutic Assessment (e.g., Finn, 2007) approach, providing practical recommendations for the delivery of assessment feedback and also its use as an intervention in its own right. Chapter 9 reviews critical elements of the psychological report. In each of the chapters in Part I, the authors provide interpretive and practical recommendations and discuss frequent misuses or misunderstandings of the assessment methods/approaches presented.

Part II of the handbook (Chapters 10 through 20) covers specific assessment methods, including interviewing; use of collateral reports; intellectual assessment; achievement assessment; vocational assessment; neuropsychological assessment; omnibus personality and psychopathology instruments, including the Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF; Ben-Porath & Tellegen, 2008), the Personality Assessment Inventory (PAI; Morey, 2007), and the Millon Clinical

Multiaxial Inventory-IV (MCMI-IV; Millon et al., 2015); the psychometric status of various specific-construct self-report instruments (e.g., Beck Depression Inventory [Beck, Steer, & Brown, 1996]; Depression, Anxiety, Stress Scales [Lovibond & Lovibond, 1993]); and performance-based instruments (e.g., Rorschach Inkblot Method [Rorschach, 1942]; Thematic Apperception Test [Murray, 1943]). Within each chapter, the authors discuss psychometrics of the tests and measures they review and offer practical recommendations for their selection and use. In addition, when making recommendations to the reader, the authors take into consideration diversity issues and research findings on the use of psychological instruments in diverse populations. Further, authors also review the degree to which the instruments of focus assess for non-credible report/responding. Finally, the authors present any upcoming technologies and assessment advances in their area of focus and critically consider the degree to which they are ready to be implemented in clinical assessment practice or research.

Part III of the handbook (Chapters 20 through 31) covers various forms of psychopathology and cognitive dysfunctions commonly encountered in clinical practice (or as areas of research focus) across the life span, including neurodevelopmental disorders, disruptive behavior disorders, depression, anxiety, trauma, psychosis, eating disorders, substance use disorders, personality disorders, dementia, and traumatic brain injury. Within each chapter, the authors provide a contemporary, evidence-based conceptualization of the constructs and disorders of focus. In addition, all authors consider the cross-cutting issues (as reviewed in Part I), including a critical psychometric review of instruments presented, use of the instruments in diverse populations, consideration of noncredible presentation/report in assessment of the respective construct/disorder, and unique ethical and practical issues. Finally, if there are emerging techniques and technologies unique to the assessment of their construct/disorder of focus, those are also critically examined.

Part IV, the final section of the handbook (Chapters 32 through 35), consists of chapters covering assessment in four particularly unique clinical settings – integrated primary care, forensic practice, neuropsychological settings, and school-based assessment – which often warrant special procedural considerations beyond what would be expected in “typical” assessments conducted in mental health settings. Within these chapters, the authors continue to consider the critical assessment issues presented in Part I by addressing general assessment considerations unique to their setting, cultural/diversity issues specific to their setting, consideration of the importance of assessment for noncredible presentation/report in their setting, psychometrics of any tests and measures unique to their setting, unique ethical/practical issues in the setting of focus, and presentation of any emerging techniques and technologies unique to their setting.

WHAT IS A GOOD CLINICAL PSYCHOLOGICAL ASSESSMENT?

Cross-Cutting Handbook Themes

One of the holistic goals for this handbook is to provide resources necessary to gain a comprehensive understanding of what constitutes a good clinical assessment. In this introductory chapter, we provide guidance on some broad and important domains that go into such evaluations and how the chapters that follow broadly reflect on them.

The referral question. The key consideration up front for any assessment is the reason the person is being seen. In a general mental health assessment, the patient will often be self-referred or referred by a general practitioner or psychiatrist for the purpose of determining a diagnosis and/or obtaining treatment recommendations. But there are several settings in which standard recommendations presented throughout various chapters might not always apply. Part IV of the handbook covers four unique types of settings: primary care (Chapter 32), forensic (Chapter 33), neuropsychology (Chapter 34), and school (Chapter 35) (but see also Chapter 14 for the vocational counseling context), in which special considerations in light of referral are often necessary to structure the evaluation. For instance, Zapf, Beltrani, and Reed (Chapter 33) note that, in many forensic evaluations, the person being evaluated is not the actual client, which has significant implications for informed consent and confidentiality but also the structure of the evaluation itself. More generally, psychologists who conduct psychological assessments in any setting should be aware of the many ethical issues (see Chapter 4) that pertain specifically to assessment prior to starting an evaluation.

Another setting in which the referral question (and thus approach to assessment) is quite unique is when quick treatment decisions must be made in the primary care setting (Chapter 32) or in crisis management (e.g., risk for self-harm). Psychometric issues with screening instruments are discussed in Chapter 2. The use of screening measures in clinical practice and the differences between screening and comprehensive assessment are discussed in Chapters 13, 19, 23, 25, 29, 31, and 32.

Sources of information/methodology. Psychological assessments are often tailored to individual referral questions and various chapters raise a number of different issues relevant to both the assessment for specific mental disorders and the broader areas of functioning (e.g., intelligence [Chapter 12], achievement (Chapter 13), neurocognitive [Chapters 15, 31, 34], and vocational [Chapter 14]). Virtually all psychological assessments will require a good clinical interview (Chapter 10) and many chapters discuss specific structured interviews for different types of mental disorders (Chapters 5, 10, 22–29). Structured clinical interviews can be particularly important if a specific

diagnostic decision must be made (e.g., post-traumatic stress disorder [PTSD] for an insurance claim) and reliability of decision-making is a key issue.

Furthermore, across the parts and chapters, readers will find comprehensive coverage of self-report instruments commonly used in both clinical and research settings as well as instruments that are relatively unique to assessment of specific disorders/constructs or in specific assessment settings. These can be useful for obtaining corroborating quantitative information about an individual's standing on a construct of interest; if the assessment is ultimately for treatment, such measures can also be used to track outcome. Readers will also find comprehensive coverage of cognitive tests commonly used in both clinical and research settings (e.g., Chapters 12, 13, 15, 21, 30, 31, 32, 34, 35). Finally, collateral reports (see Chapters 11, 21, 22, 33) can be useful in many assessments, particularly in cases in which individuals might not have sufficient ability to self-report (e.g., children) or have motivation to present themselves in an accurate light; Achenbach, Ivanova, and Rescorla (Chapter 11) provide useful guidance on how to integrate information across various methods and measures in assessment.

Another major theme that emerges across the chapters herein is the importance of the overall assessment progress beyond the use of specific tests or measures/methods. For example, in several chapters (Chapters 8, 10, 14, 21, 25–28), the importance of a good working relationship with the person being assessed is emphasized. In Chapters 8, 10, and 14, the importance of assessment for beginning the therapeutic process is also emphasized. Further, Chapter 13 reminds readers of the importance of careful administration and scoring to the overall assessment process. Finally, regardless of the assessment circumstances, a basic risk assessment for harm to self or others is always imperative (Chapters 23, 27, 33).

Differential diagnosis. Mental health evaluations frequently require an element of differential diagnosis to guide formulation, treatment recommendations, and goal-setting (e.g., Sellbom, Marion, & Bagby, 2013). It is therefore important that a clinician undertaking a psychological assessment is aware of both contemporary thinking about psychopathology generally (see Chapter 5) and current models of common mental health problems as they select the most appropriate assessment tools to evaluate competing hypotheses. Indeed, an entire section (Part III: Assessment and Diagnosis of Specific Mental Disorders) is devoted to the evaluation of assessment methods and tests for common forms of psychopathology, including depression, anxiety and obsessive-compulsive disorders, PTSD, psychosis and bipolar disorders, eating disorders, substance use disorders, and personality disorders in adulthood as well as autism spectrum disorders, attention-deficit/hyperactivity disorder (ADHD), and other disruptive behavior disorders in childhood. Particularly impressive is that most of these chapter authors provide summative and evaluative lists of measures

for each, so readers can compare which instruments seem to have the best psychometric support for what purpose and with what population.

It is important to keep in mind, however, that single-construct measures (both interviews and self-report inventories) are often limited to that construct only and do not measure noncredible responding. In many circumstances, the diagnostic picture might be more opaque. The inclusion of established omnibus inventories that assess for a range of constructs, such as the MMPI-2-RF (Chapter 16), PAI (Chapter 17), MCMI-IV (Chapter 18), or performance-based methods (e.g., the Rorschach Inkblot Method; Chapter 20), might be particularly useful to assist the clinician with a broader picture for both diagnostic decision-making and broader clinical formulation.

Noncredible responding. Many individuals undergoing psychological evaluations have an incentive to misrepresent themselves. Such responding can be intentional or unintentional but nevertheless will affect the ultimate clinical formulation if undetected and if not considered when interpreting test results. This issue is so critical to clinical practice that we have devoted a whole chapter to it (Chapter 6). Readers will also see the growing understanding of the importance of considering noncredible report and behavior in interpreting both self-report and cognitive test results, including areas in which these measures have been well developed, as well as domains where much more work is needed to develop and use such measures. Of course, it is important that readers be aware that *any* report (i.e., self- [both interview and questionnaire] and informant reports) is potentially vulnerable to noncredible responding. Although in extreme cases noncredible reporting might invalidate an entire assessment (e.g., feigning mental illness during a criminal responsibility evaluation), in many mental health evaluations it can also serve as useful information in understanding clients (e.g., extreme symptom exaggeration as an indication of an extremely negativistic perceptual style or significant minimization of obvious problems as an extreme tendency toward social desirability across contexts). In any instance, clinicians should be careful not to interpret either self-report or collateral measures or performance on tests as valid if invalidity measures, or other indicators, suggest caution in interpretation.

Clinical formulation. Every good psychological assessment ultimately needs a formulation of some kind on which any opinions and/or recommendations are ultimately based (e.g., Chapters 8, 9, 10, 18, 25, 26, 27, 34). Such a formulation is often based on a particular theoretical perspective (e.g., Eells, 2007), such as a cognitive behavioral model (e.g., Persons, 2008) or psychodynamic perspective (e.g., McWilliams, 1999), especially if treatment recommendations follow. But it is not required, and sometimes not even appropriate, given the referral

question at hand. For instance, judges would likely not care about competency to stand trial being formulated from a cognitive behavioral therapy (CBT) or any particular theoretical perspective; it is a capacity-based question. Individuals undergoing neuropsychological evaluations are best formulated from a biopsychosocial perspective (see Chapters 14, 31, and 34) that emphasizes the contributions of brain processes, sociocultural influences, and individual difference factors in patient presentation and interpretation of test results.

We do not advocate for a particular theoretical perspective here and it would be far beyond the scope of this chapter, or even the handbook, to do so. Rather, we make some broader recommendations for formulations that readers might want to keep in mind. First, we believe it is a good idea that *any* clinical formulation considers a developmentally informed biopsychosocial approach at minimum (Campbell & Rohrbaugh, 2006; Suhr, 2015; see also Chapters 14, 31, 32, and 34). Thus, regardless of theoretical perspective, humans are influenced by their biology, psychological processes, and external circumstances in a dynamic fashion throughout their development. These should all be emphasized in any clinical formulation. Furthermore, chapter authors also remind readers that assessment data should speak to issues beyond specific symptoms and maladaptive traits, such as assessing for evidence of functional impairment (Chapters 15, 21, 22, 25, and 31–35), measuring contextual factors that may maintain/exacerbate presenting problems or be protective (Chapters 13, 17, 22, and 27), and assessment of comorbidities (Chapters 21, 24, and 25). In fact, a major theme emerging from the chapters is that assessment should capture the unique presentation for each person (see Chapter 22 as a particularly good example), given the heterogeneity of presentations for individuals with any given psychological diagnosis.

Considerations of diversity issues. It is critical that clinicians consider a range of multicultural and other diverse characteristics about their clients undergoing assessments. Although this field continues to be woefully understudied with respect to the great number of diversity issues to which clinicians need to be attuned (e.g., LGBTQIA+, physical disability, diversity within nonmajority cultures), progress has been made in the multicultural domain. In Chapter 3, Leong, Lui, and Kalibatseva discuss important threats to cultural validity in assessment practice, educate the readers broadly on how to address these threats, and also provide indications of best practices. But this handbook goes beyond one important chapter. Indeed, throughout almost every chapter, the need to continue to address the validity of both self-report measures and cognitive tests in diverse populations is emphasized. In recent decades, much work has been done in this area, as presented in the chapters herein, which present data on translations of tests for different languages and cultures, statistical analysis for bias in test interpretation, and norms for diverse populations. However, the reader will

recognize across the chapters that more work is clearly needed and hopefully the information presented in the chapters can serve as a good starting point to inspiring more research in this important area of assessment.

Treatment implications/recommendations. For many clinical assessments, the goal is to both generate a broad understanding about the implications of the assessment findings for treatment and articulate specific recommendations. Depending on context, therapeutic goal-setting could be considered at this stage as well. Various treatment implications are considered across many chapters, including guiding treatment decisions (Chapters 5, 8, 17, 18, 22, 25, 31, 32, 34), identifying patient characteristics likely to affect therapeutic alliance (Chapters 13, 17, 22, 23, 26), predicting treatment outcome (Chapters 17, 24), and tracking treatment outcome over time (Chapters 2, 13, 23, 24, 25, 26, 32, 34). A thorough assessment of stages of change (Prochaska and DiClemente, 1983) as a treatment-choice determinant can be useful in many contexts (see Chapter 28). Moreover, specific treatment recommendations should naturally flow from the conceptual formulation and should consider the type of treatment (if any), including modality (e.g., individual, group, family), and whether referral to a psychiatrist for psychotropic medications would be warranted. In more rare circumstances, individuals undergoing assessments might require acute care and/or be heavily monitored for risk to self and/or others.

Report writing. Most psychological assessments culminate in a psychological report and we have a chapter dedicated to this topic (Chapter 9); report writing is also discussed in Chapter 33, which specifically covers forensic settings. Chapter 9 provides a recommended structure of a psychological report (see Table 9.2), which includes a biographical sketch of the report author, identifying information and referral question, sources of information, informed consent, presenting problem(s) and symptoms(s) and/or background situation, psychosocial background, mental status and behavioral observations, evidence-based psychological tests, clinical interview results, case formulation, recommendations, and summary and conclusions. Not surprisingly, these sections map onto our own recommendations on what constitutes a good psychological evaluation. Furthermore, Zapf et al. (Chapter 33) remind us that reports in the forensic context differ in important ways from those conducted in a therapeutic context, in that the sources, methodology, and reporting of findings are directly tailored to addressing a particular psycho-legal question for the Court.

FUTURE DIRECTIONS OF CLINICAL ASSESSMENT

Virtually all chapters provide directions for future developments for their particular area. One of the areas we asked chapter authors to consider in their respective areas of expertise was technological advancements; and, while some chapters (e.g., Chapter 7 on ambulatory

assessment) specifically highlighted a general method moving the whole field forward in this regard, many authors discussed other technological advances that either have some preliminary support or are important future directions for the field. For example, some authors (Chapters 19, 29) discuss the potential benefits of computer adaptive testing (CAT) in both symptom and personality trait assessment, which is possible given the increasing emphasis on using item response theory (IRT; see Chapter 2) in scale construction. CAT provides for the potential benefit of significant time savings in assessment and increased precision of scores given reliance on latent modeling techniques. We note, though, that the CAT concept in personality assessment has been a target for quite some time (e.g., Forbey & Ben-Porath, 2007; Roper, Ben-Porath, & Butcher, 1991) and we hope for future investment in this important area. Similarly, in the context of achievement testing (Chapter 13), authors highlight information and computer technology (ICE), which represents a digital method for the administration, scoring, and interpretation of educational achievement testing. Finally, some chapter authors (Chapters 8, 24) call for consideration of virtual reality in the context of therapeutic assessment, building on important gains in the treatment for particular disorders (e.g., exposure disorder for phobia; see Powers & Emmelkamp, 2008). Other chapters consider the implementation of today's technology (internet, smartphone, video-chat capabilities) for the assessment context, such as the use of smartphones to gather ambulatory data (Chapter 14) and telepsychology (Chapter 34).

In sum, we believe that further development of assessment methods to reach geographically or otherwise physically disadvantaged individuals through various computer and internet-based technology is a very important direction for the field. We hope that psychological assessment scholars continue to innovate and bring some of our more archaic techniques into the twenty-first century. We hope that such innovation will not come at the cost of careful psychometric validation for these instruments, which is critical in aiding assessors in determining what measures/tests are most valid for a particular person in a particular setting to answer a particular assessment question.

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