Week 1 — 4 Pillars of Assessment

SLO1: Explain commonly used psychological assessment instruments, their theoretical foundations and make basic interpretations of results

"Assessment" vs testing, why does it matter? An assessment is the method used to gain information/understanding to answer a clinical question. Applications span cognitive, academic, language, memory, problem-solving, personality, coping, and social abilities. A **Good assessment** → good formulation/diagnosis → effective treatment; poor assessment contaminates downstream decisions.

Norm-referenced tests	Questionnaires/scales/suverys
(e.g., ability): standardised, normed; compare to population; follow manuals strictly, interpret relative standing. You want to understand how the single value fits within the whole group.	dimensional scores; check psychometrics and norms; don't equate screens with diagnoses. Self-reports no need for a clinical professional to administer. The main psychometrics are validity and reliability. A higher score will indicate a construct (personality, well-being state) **They do not diagnose**
Observations	**Interviews**
in-session/naturalistic; multiple informants; quantify where possible. Corroborative → existing supporting evidence Primary → direct observation Qualitative → description of behaviours Quantitative → how many specific behaviours	structured ↔ semi-structured; multi-informant; integrates qualitative detail. Structured → pre-determined set of questions, follow a guideline that provides organised answers Semi-structured → combo of set & open-ended questions with more room for raw, unbiased discussions

Why assessment is difficult (and how to respond)

Clients tell **stories**, interventions target **symptoms**; presentations overlap; comorbidity is common. Use multiple methods/sources and a plan tied to the referral question.

Symptoms exist on a **continuum**; categorical thresholds are imperfect—so pair screens/scales with clinical judgment. You may have a client with a previously diagnosed Major Depressive Disorder (MDD), another cilent with Persistent Depressive Disorder (PDD), but both show up when their symptoms are most intense. Yet… they both have nearly identical depressive symptoms.

Assessment as a process… and most likely a loop

Presenting symptoms → Assessment → Diagnosis & formulation → Treatment & **re-assessment** (reporting). Keep it iterative and hypothesis-driven. When things don't work out, you go back to square one again.

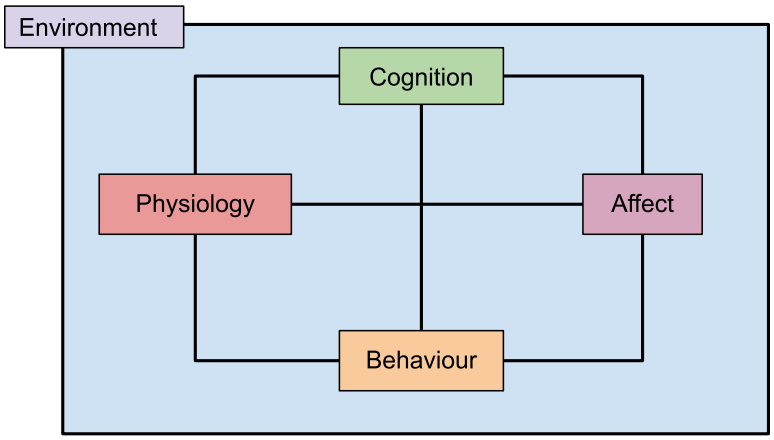
Intake OSCE (8-step micro-checklist): Referral goal → consent/limits → open narrative → risk triage → 5-factor map → measures (justify) → collaterals/observation → summary & next steps.

Readings

Cohen et al., Ch.1: testing & assessment history; standardisation and validity as an "argument from evidence"; testing proliferated from Binet to WWI/II uses.
Love (2018) Diagnostic dilemma: don't over-rely on labels; use formulation; be aware of base rates & confirmatory bias (reading activity flagged in slides).

Week 2 — Clinical Assessment w/ Cognitive Behavioural Framework & Interviewing

☆ CB 5-factor model



Cognitions ↔ Emotions ↔ Behaviours ↔ Physical symptoms ↔ Environment; any factor can influence others. Use the model to **guide interview, formulation, and treatment**.

☆ CB Interviewing w/ some prompts

1. Presenting Problem → surface & main
2. History → medical, family, lifestyle
3. Problem Analysis independent ↔ dependent
    a. Cognitions, emotions, behaviour, biology ↑
    b. Context (environmental), triggers, modulating variables ⤴better/worse? environmental, interpersonal
    c. Maintaining/ perpetuating factors (short- vs long-term consequences; avoidance/safety behaviours)

Goal: to understand what issues are going on currently & what has led them to this service

1. Initial account & rapport “what brings you to therapy?”
2. Description of symptoms
    a. Daily? Weekly? Monthly? Is it random?
    b. Frequency → intensity of the symptoms. Is it barely noticeable? Or consistenly painful
    c. Impairment → how is it effecting their daily life?
    d. Distress → how much distress is it causing them?

Worked on mapping. Situation: going to tutorial → Thought: “They’ll think I’m boring” → Emotion: anxious → Physiology: hot/shaky → Behaviour: avoid/silent. Use this to target **maintaining loops**.
Interview structure (practical scaffold). Engagement & agenda → presenting problem & history → detailed 5-factor enquiry → functional links → goals → homework plan → summary & check understanding.

Readings (Fenn & Byrne, 2013)
Guided discovery & **Socratic questioning** (e.g., “What else could we assume?”) are core stance/skills.
Agenda-setting each session; **homework** extends learning; CBT is **structured & time-limited** (typ. 5–20 sessions for non-comorbid anxiety/depression).
Behavioural experiments test predictions & reduce safety behaviours; BA uses scheduling/graded tasks with **pleasure/mastery ratings**.

Week 3 — Clinical Assessment w/ Measures & Psychometrics (Scales & Screeners)

Families of measures (know when to use what)

Generic Symptom Scales	Disorder-specific scales
Broad constructs; severity & change monitoring Broad focus on clinical features/symptoms E.g., global anxiety, self-esteem, or body image. The most common form of survey in clinical psychology. **Assume clinical symptoms = continuous construct** Norms may be available, but not always. Sometimes, qualitative descriptors are available, but not always. Applications: Treatment efficacy (i.e., before vs. after). – Building the client's symptom profile. Can be used together with interviews - Depression, Anxiety and Stress Scales (DASS; Lovibond & Lovibond, 1995) - Kessler Psychological Distress Scale (K10; Kessler et al., 2002).	Map more closely to diagnostic features. Focus on pre-defined diagnostic symptoms. Disorder defines scale. **Assume clinical symptoms = continuous construct** Norms may be available, but not always. Sometimes qualitative descriptors are available, but not always. Applications: Treatment efficacy (i.e., before vs. after). Building the client's symptom profile. These can also be used together with interviews - Beck Depression Inventory (BDI; Beck et al., 1996) - Patient Health Questionnaire (PHQ; Kroenke et al., 2001) 10
Diagnostic Screens	**Behavioural checklist**
Group membership yes/no; require follow-up interview Does this person have a disorder? Yes or No? Some disorder-specific symptom scales are used as diagnostic Screener. These can also be used in interviews and be apart of research studies in clinical samples. - Mood Disorder Questionnaire (MDQ; Hirschfeld et al., 2000) - Social Phobia Screener (SOPHS; Batterham et al., 2017) -	Focus on behaviour > cognition and/or affect May be a generic or disorder-specific symptom measure, or diagnostic screen. Commonly involves multi-informant responses. It can help to overcome limitations of the client's self-reports. Applications: Investigations among children (e.g., < 12 years); Assessing neurocognitive or neurodevelopmental disorders - Child Behaviour Checklist (CBCL; Achenbach & Rescorla, 2001). - Checklist for Autism in Toddlers (CHAT; Baron-Cohen et al., 2000)

Psychometric essentials

- **Reliability** (internal, test–retest, inter-rater); **Validity** (content, criterion, construct with factor structure & expected correlations); **SEMs/Confidence Intervals**. (Wk1–3 overview)
- **Cut-offs**: sensitivity vs specificity trade-off; choose based on **decision cost** (false positives vs misses).
- **Norms**: relevance of the standardisation sample; interpret with percentiles/stanines; avoid raw-score only reporting.

Common pitfalls (marker-friendly to mention). Treating screens as diagnostic, ignoring language/culture effects; giving scores without **bands/CIs**; using tools with weak psychometrics for the target population.