CHAPTER 1

The Initial Clinical Assessment: Clinical Interviewing and Hypothesis Building

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

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

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

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

The Clinical Interview

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

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

TABLE 1.1 **COMPONENTS OF THE CLINICAL INTERVIEW**

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

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

Consent

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

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

Referral Questions

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

The Case of David: Referral Questions

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

Presenting Problem and Its History

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

Presenting Problem

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

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

History of Presenting Problem

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

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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.