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

The first important step is to figure out in what way the individual’s functioning is impaired; this is most often the *presenting problem* or the *referral question*. The issues reported by either (a) the individual himself or herself or (b) whoever referred him or her for the assessment are most often at least part of what is impaired in or is impairing his or her functioning. However, most often, what is reported at first (the “presenting problem”) is only part of what is actually disturbing the individual or is merely the result of something else that he or she is not even aware of. Practitioners should be both open to the original presenting complaint and ready to consider the possibility of impediments the individual is not aware of. 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 can 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: (1) the presenting problem (and its history), (2) a symptomatic evaluation, and (3) a psychosocial evaluation. The summary chart that follows (Table 1.1) may help you make sure you collect all the relevant information you need to form a complete picture of how the individual views himself or herself. This sheet 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 hold 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 will feel better about an assessment session that is relaxed and will be more likely to be open and disclose more information.

Presenting Problem and Its History

The first component of the clinical interview, the presenting problem, is related to the issues that constitute the reason for the assessment, as well as the history of these issues. Clients can come in for many reasons, from specific functional impairment to subjective distress. For example, clients

<table>
<thead>
<tr>
<th>TABLE 1.1</th>
<th>COMPONENTS OF THE CLINICAL INTERVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenting Problem and History of Presenting Problem</td>
<td>Includes assessment of dangerousness to self/others</td>
</tr>
<tr>
<td>Symptomatic Evaluation</td>
<td>Psychosocial Evaluation</td>
</tr>
<tr>
<td>Developmental history</td>
<td>Family history</td>
</tr>
<tr>
<td>Psychiatric history</td>
<td>Educational/vocational history</td>
</tr>
<tr>
<td>Alcohol/substance abuse history</td>
<td>Criminal/legal history</td>
</tr>
<tr>
<td>Medical history</td>
<td>Social history</td>
</tr>
<tr>
<td>Family medical and psychiatric history</td>
<td>Psychosexual history</td>
</tr>
<tr>
<td></td>
<td>Multicultural evaluation</td>
</tr>
</tbody>
</table>
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, but 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 part of the presenting problem.

**Presenting Problem**
The presenting problem includes whatever complaint the individual identifies as the reason for the assessment. An assessment 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. 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 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 his or her presenting problem, some areas you may consider asking specifically about are presented in Table 1.2.

Not all of 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. The Case of David (p. 18) will illustrate how the clinical interview can unfold.

**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

---

### Table 1.2
**Components of Assessing the Presenting Problem**

#### Current stressors

**Cognitive status complaints**
- Attention/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/aggressive ideation**
- Ideation
- Intent
- Plan
- Means
David is a 23-year-old Hispanic client who comes in because of academic difficulty in college, requesting an evaluation for a learning disorder or possible attention-deficit/hyperactivity disorder. While this is all the information given at the time of referral, 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, and depending on the information you receive, you may have to 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 he seems to be struggling in other areas of his life as well. He reports that he has difficulty paying attention to tasks that involve reading and writing. He also reports, however, that he has been struggling with depression for the past three years, when “everything fell apart.” Although he was able to report on what was happening three years ago, it is 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. In order to get more specific, you may have to ask about specific aspects of depression, including appetite, sleep, motivation, energy level, and so forth. 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 in to 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 hurting yourself 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 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 in addition to that of the individual being assessed. Consulting with the prior clinician not only provides potentially rich data and cross-verification but also provides the individual you are assessing with a sense of continuity and coherence to the his or her ongoing assessment and care.

**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. 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 may want to start there and ask about what was going on for him three years ago when he first became depressed. 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. You might begin by asking David what happened three years ago.

When asked what happened three years ago, David reports that his girlfriend, his “high school sweetheart,” broke up with him. He reported that she (Continued)
had been cheating on him when they went to separate colleges, but he did not find out until she told him while 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 reports that he had to take some time off from his studies and he had 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 or not 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 or not 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, 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 passing, though barely so.

**Symptomatic Evaluation**

The second component (though there is no reason it needs to come in this order during an actual interview) of the clinical interview is a symptomatic evaluation. 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. Assessors should ask specific questions about symptoms related to different psychiatric diagnoses, as well as observe them during the clinical interview and the entire assessment. Similar to medical interviews, in order to fully understand what is going on for a client, an assessor must inquire about family history, medical history, and substance use history.

**Developmental History**

The assessment of developmental history can be seen as a crossover between the symptomatic evaluation and the 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 pregnancy of the individual’s mother, as well as during labor and delivery. Following these medical questions, you should ask about significant events during infancy and childhood, including developmental milestones (such as lateness in achieving developmental milestones like sitting up, crawling, walking, talking, and toileting). Also included should be any childhood behavioral problems, significant accidents, and traumas. Some basic information it is generally useful to assess during the assessment of developmental history is shown in Table 1.3.

### Table 1.3

**Components of Assessing Developmental History**

<table>
<thead>
<tr>
<th>Problems during pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems around birth/delivery</td>
</tr>
<tr>
<td>Developmental milestones</td>
</tr>
<tr>
<td>Sitting up</td>
</tr>
<tr>
<td>Crawling</td>
</tr>
<tr>
<td>Walking</td>
</tr>
<tr>
<td>Speaking</td>
</tr>
<tr>
<td>Toileting</td>
</tr>
<tr>
<td>Socialization</td>
</tr>
</tbody>
</table>
Psychiatric History
The history of psychiatric symptoms and treatments is extremely important for understanding the actual course of the individual's problems. You should be sure to collect information on any past hospitalizations, past harm or threat of harm to self or others, and any psychotropic medications taken in the past. If there were previous treatments, you should obtain a release of information to get the records of these treatments or, at the very least, to speak with the previous treating clinicians. This is especially important when there have been previous hospitalizations or a history of medication, because these can be markers of a more serious psychiatric condition.
Any history of psychiatric diagnosis

Any history of psychiatric treatment, including
Type of professional seen
Reason for treatment
Dates of treatment
Frequency of visits
Duration of treatment
Outcome of treatment

Any history of psychiatric medication

Reviewing these previous records and speaking to previous treating clinicians serves the goal of obtaining as much information and data as possible in order to provide 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 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 or not 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/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 his or her symptoms, even in what he or she considers to be low doses. Included in the assessment of alcohol and other substance
use should be the type(s) of substance, 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 his or her use of substances has caused any type of impact, positive or negative, on his or her 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.

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 medications taken currently or in the past. Medical history and status can significantly affect current psychological functioning. If any medications are currently being taken, make sure to note for how long they

---

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 he was medicated at that time, but he does not remember with what medication. He cannot even remember when in his childhood this occurred, though it happened before he was 8 years old.

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 a month for medication management. When you ask more about the treatment, he tells you that it is “something like cognitive-behavior treatment” and that it has been very helpful for him. Although he still struggles with depression, he says he “functions better” than he did before. He says he has never been to another mental health professional before.
### Table 1.5 Components of Assessing Alcohol/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

---

**The Case of David: Alcohol/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 on alcohol “frequently.” When words like this arise in this context, it is important to find out more specifically what he means, as the word “frequently” may mean something different to him than it does to you. 

*(Continued)*
Specifying, he said he drank every day and got drunk at least every other day, if not more often. By 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 denies any problems before then, that he can remember. He says 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.

have been taken, for what they were prescribed, 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 changes in the presenting problem and 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 as well as his or her level of awareness of health status. The important components to consider when assessing medical history are listed in Table 1.6.
David denies any major medical problems, currently or in the past. 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, “I've always been healthy as a horse—well, except for all the drugs, I guess,” and laughs. Although some assessors may feel differently, you may want to, at that moment, recommend to him that he go for a physical exam, just 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 and Psychiatric 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 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 problems—either current or past—in a different light. It may be especially important to point out to the client that psychiatric illnesses are often undiagnosed (e.g., 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.

**Psychosocial Evaluation**

Whereas the symptomatic evaluation helps to clarify the content of the individual’s current functioning, including symptomatology, the psychosocial evaluation is designed to examine the context of 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 caregiver 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 he or she is married or has a significant partner, you should get a description of the relationship,
**TABLE 1.7**

**COMPONENTS OF ASSESSING FAMILY HISTORY**

**Family of origin structure**
- Primary caregiver(s), including quality of relationship
- Siblings, including quality of relationship
- Significant family events

**Current family status/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 disclosed that he was raised as the only child of his mother and he had never known 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 said he thinks his father is in Chile, but he is not sure, and he 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 ask specifically about their relationship as he was growing up and now, but 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.

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/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. 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/occupational history are listed in Table 1.8.

<table>
<thead>
<tr>
<th>Table 1.8</th>
<th>Components of Assessing Educational/Vocational History</th>
</tr>
</thead>
</table>

**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/emotional problems in school
- General grades

**Vocational 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
For David, the educational/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 he found it “easy to do.”

**Criminal/Legal History**

You should note any history of legal problems. It is absolutely necessary to assess past legal involvement, including whether or not 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 design the testing battery to assess those traits specifically. This portion of the assessment is especially important if the individual indicated during the symptomatic evaluation that he or she has the potential to harm himself or herself or others, in that this risk, in combination with a criminal history, may be magnified. Areas to consider when assessing legal history are listed in Table 1.9.

**Table 1.9**

**COMPONENTS OF ASSESSING CRIMINAL/LEGAL HISTORY**

<table>
<thead>
<tr>
<th><strong>Current criminal/legal involvement</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Probation/parole</td>
</tr>
<tr>
<td>Lawsuits</td>
</tr>
<tr>
<td>Impact of current legal involvement on day-to-day life</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Past criminal/legal involvement</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Probation/parole</td>
</tr>
<tr>
<td>Lawsuits</td>
</tr>
<tr>
<td>Impact of past legal involvement on day-to-day life</td>
</tr>
</tbody>
</table>
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.

**Social History**

A history of socialization should be evaluated, including current number of friends and the quality of these 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 or not the individual has a best friend may prove important information later in the assessment process, as well. It is also extremely important to note any history of interpersonal difficulties. For example, because a diagnosis on Axis II almost invariably includes interpersonal impairment, a history of difficulty in the interpersonal domain may prove diagnostically important. Any current significant relationships, if not described in the family history section, may be described in detail here, again including their length and quality. The areas to consider when assessing social history are listed in Table 1.10.

**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.

---

**The Case of David: Criminal/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 1.10: Components of Assessing Social History

<table>
<thead>
<tr>
<th>Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current social support system</td>
</tr>
<tr>
<td>Best friend(s)</td>
</tr>
<tr>
<td>Current romantic relationship</td>
</tr>
<tr>
<td>Social history</td>
</tr>
<tr>
<td>History of interpersonal difficulties</td>
</tr>
<tr>
<td>History of romantic relationships</td>
</tr>
</tbody>
</table>

### 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, and it was at this point that he met his high school girlfriend, 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 whom he keeps in touch with. 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, as well as 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, but 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.”
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 not only increase the person’s comfort while being assessed, but will also increase the likelihood that he or she 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 asking what he or she watches on television. Also, try to avoid judgmental terms and covert meanings—use language that is plain and honest (e.g., when asking a woman about her onset of puberty, ask around what age she got her first period, rather than asking when her “special visitor” first arrived). Some areas that may be relevant in this part of the interview are listed in Table 1.11.

**Multicultural Evaluation**

It is impossible to understand an individual without understanding the cultural environment in which he or she is functioning. For a more in-depth discussion on multicultural evaluation in clinical interviewing, see Suzuki, Ponterotto, and Meller (2008).
secondary languages and migration history, if there is one. It is important to evaluate the individual’s cultural, racial, and spiritual/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, as well as how he feels about these differing worlds and himself within them, may impact his current functioning considerably. It is important to note that even individuals who are part of the majority culture (White males, for example) 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 that he or she has fully acculturated at present, should also be evaluated. Information that can be included in this section of the interview, when applicable, is given in Table 1.12.

### Table 1.12

**Components of Conducting a Multicultural Evaluation**

<table>
<thead>
<tr>
<th>Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immigration history</td>
</tr>
<tr>
<td>When immigrated to current country</td>
</tr>
<tr>
<td>Length of time in current community</td>
</tr>
<tr>
<td>Acculturation issues</td>
</tr>
<tr>
<td>Cultural, racial, and ethnic identity</td>
</tr>
<tr>
<td>Spiritual and religious history and identity</td>
</tr>
<tr>
<td>Sexual identity</td>
</tr>
</tbody>
</table>

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 and 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,” even as he struggled with school, because he was fluent in two languages. His mother is Catholic, as is her entire family, most of whom are in Chile, and 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.
Mental Status Evaluation

While the client is a major source of information about what is going on with his or her 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. The MSE was designed as a method for identifying, in particular, individual characteristics that may seem 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.

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

<table>
<thead>
<tr>
<th>TABLE 1.13</th>
<th>COMPONENTS OF THE MENTAL STATUS EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Status Evaluation</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Appearance and behavior</strong></td>
<td></td>
</tr>
<tr>
<td>Grooming</td>
<td></td>
</tr>
<tr>
<td>Motor activity</td>
<td></td>
</tr>
<tr>
<td>Relatedness</td>
<td></td>
</tr>
<tr>
<td><strong>Speech and language</strong></td>
<td></td>
</tr>
<tr>
<td>Speech patterns</td>
<td></td>
</tr>
<tr>
<td>Receptive language</td>
<td></td>
</tr>
<tr>
<td>Expressive language</td>
<td></td>
</tr>
<tr>
<td><strong>Thought process and content</strong></td>
<td></td>
</tr>
<tr>
<td>Goal-directed thinking</td>
<td></td>
</tr>
<tr>
<td>Hallucinations and delusions</td>
<td></td>
</tr>
<tr>
<td>Depressive and anxious ideation</td>
<td></td>
</tr>
<tr>
<td>Suicidality and homicidality</td>
<td></td>
</tr>
<tr>
<td><strong>Cognition</strong></td>
<td></td>
</tr>
<tr>
<td>Attention and concentration</td>
<td></td>
</tr>
<tr>
<td>Memory</td>
<td></td>
</tr>
<tr>
<td><strong>Prefrontal functioning</strong></td>
<td></td>
</tr>
<tr>
<td>Judgment</td>
<td></td>
</tr>
<tr>
<td>Planning and impulse control</td>
<td></td>
</tr>
<tr>
<td>Insight</td>
<td></td>
</tr>
</tbody>
</table>

For a more in-depth discussion on the mental status evaluation, see J. Sommers-Flanagan and Sommers-Flanagan, 2002.
(i.e., how adequate his or her hygiene is), but also the level of motor activity (e.g., psychomotor retardation or hyperactivity) and coordination (fine and gross motor functioning) displayed. Behavior refers both to any abnormal or repetitive behaviors, such as constant shifting or throat-clearing, and to the individual’s relatedness toward you, including cooperativeness, friendliness, guardedness, and 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 several things, including 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, as 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 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, “clues,” as to some possibilities of 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 may on the one hand relate to her desperation to get her children back, but on the other hand may reveal some sort of narcissistic or histrionic presentation.

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 pervasive developmental
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 him or her 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 he or she will be able to comprehend the test instructions. Similarly, if an individual’s vocabulary is so limited that he or she cannot make his or her 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 (a) receptive and (b) expressive elements. Receptive language refers to language comprehension; you should note whether the person seems to understand all that you are saying and whether he or she requires you to repeat questions, comments, and instructions. Expressive language refers to the individual’s actual use of language to make his or her 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 (e.g., the figure weights subtest of the WAIS-IV 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 would certainly impair interpersonal relationships, educational and occupational functioning, and so forth—but it 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 utilizes the Test of Nonverbal Intelligence, 3rd Edition (TONI-3), a language-free intelligence measure, for example. 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 him or her, and the ultimate “picture” of the client should make sense in connection with this receptive language difficulty.

Consider also 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 himself or herself. Affect refers to the observed emotional state of the individual, such as what his or her 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 (a) appropriate to the situation and (b) appropriate to 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, the possible stigma of mental illness, or even fears of being diagnosed
as depressed. Not only will this incongruence be additional data for the assessment, but it can help inform you to be slightly more gentle 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 his or her 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 ex-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
conducting psychological assessment

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 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 man who is going through a divorce and whose soon-to-be ex-wife has hired a private investigator may not be delusional in thinking he is being followed. There is actually evidence that his belief may be true (e.g., seeing the same man in the same car everywhere he 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 symptomatic 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 “hates 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 his or her 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 woman does not remember seemingly important details of her 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 her functioning. Moreover, if a person cannot concentrate on the questions you are asking in the interview, it is likely that his or her 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 for the child. Frustrating or angering the person who will help decide whether you get your child back 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 he or she controls 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 he or she has difficulties and needs support or help, (b) that he or she plays a part in his or her 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 high 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 low 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 he or she plays in his or her 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 also to have what could be considered preadolescent-level functioning in other domains, including extremely naïve judgment and difficulty delaying gratification.
### FORM FOR RECORDING MENTAL STATUS EVALUATION DATA

**Mental Status Evaluation**

<table>
<thead>
<tr>
<th>Appearance:</th>
<th>_____________________</th>
<th>Grooming:</th>
<th>_____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor activity:</td>
<td>_____________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Coordination:**

- **Gross motor:** [ ]
- **Stance/posture:** [ ]
- **Gait:** [ ]
- **Balance:** [ ]
- **Fine motor:** [ ]

**Abnormal movements/repetitive behaviors:** [ ]

**Relatedness (circle):**

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Uncooperative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cooperative</td>
<td>Hostile</td>
</tr>
<tr>
<td></td>
<td>Relaxed</td>
<td>Guarded</td>
</tr>
<tr>
<td></td>
<td>Friendly</td>
<td>Seductive</td>
</tr>
<tr>
<td></td>
<td>Good eye contact</td>
<td>Poor eye contact</td>
</tr>
</tbody>
</table>

**Speech/Language (circle):**

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Nasal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Expressive:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Volume:</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>Pitch:</td>
<td>Monotone</td>
</tr>
<tr>
<td></td>
<td>Quality of voice:</td>
<td>Hoarse</td>
</tr>
<tr>
<td></td>
<td>Articulation:</td>
<td>Normal</td>
</tr>
<tr>
<td></td>
<td>Rhythm:</td>
<td>Clutter</td>
</tr>
<tr>
<td></td>
<td>Rate:</td>
<td>Slow</td>
</tr>
</tbody>
</table>

(Continued)
<table>
<thead>
<tr>
<th>Vocabulary/Grammar</th>
<th>Age appropriate:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>IQ appropriate:</td>
<td>Yes</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Idiomatic (slang):</td>
<td>Yes</td>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

Comments: ______________________________________________________________
__________________________________________________________________________

**Affect/Mood** (circle):

Affect: **Normal**  
- Range: Expressive/Good range
- Type: 
  - Appropriate to situation

**Abnormal**  
- Range: 
  - Flat
  - Constricted
  - Labile
- Type: 
  - Angry
  - Irritable
  - Sad
- Appropriate to situation

Mood: **Euthymic**  
- Happy

**Abnormal**  
- Range: 
  - Elevated
  - Depressed
  - Angry
  - Mild
  - Moderate
  - Severe
- Type: 
  - Mild
  - Moderate
  - Severe
- Appropriate to situation

Congruent: Yes  
- Inappropriate to situation

Comments: ______________________________________________________________
__________________________________________________________________________

**Thought Process** (circle):

**Normal**  
- Goal directed
- Logical
- Abstract reasoning

**Abnormal**  
- Tangential
- Circumstantial
- Magical thinking
- Concrete thinking
- Flight of ideas
- Slow thinking
- Rapid thinking
- Loose associations

Comments: ______________________________________________________________
__________________________________________________________________________
<table>
<thead>
<tr>
<th>Thought Content (circle):</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hallucinations</td>
<td>Not present</td>
<td>Not present</td>
</tr>
<tr>
<td>Auditory</td>
<td>Paranoid</td>
<td></td>
</tr>
<tr>
<td>Visual</td>
<td>Grandiose</td>
<td></td>
</tr>
<tr>
<td>Olfactory</td>
<td>Body image</td>
<td></td>
</tr>
<tr>
<td>Tactile</td>
<td>Ideas of reference</td>
<td></td>
</tr>
<tr>
<td>Mood incongruent</td>
<td>Mood incongruent</td>
<td></td>
</tr>
<tr>
<td>Mood congruent</td>
<td>Mood congruent</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>_____________</td>
<td></td>
</tr>
</tbody>
</table>

**Depressive Ideation**
- Not present
- Worthlessness
- Excessive guilt
- Self reproach
- Low self-esteem
- Helplessness
- Hopelessness

<table>
<thead>
<tr>
<th>Suicidality</th>
<th>Aggressiveness</th>
<th>Homicidality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not present</td>
<td>Not present</td>
<td>Not present</td>
</tr>
<tr>
<td>Ideation</td>
<td>Ideation</td>
<td>Ideation</td>
</tr>
<tr>
<td>Plan</td>
<td>Plan</td>
<td>Plan</td>
</tr>
<tr>
<td>Intent</td>
<td>Intent</td>
<td>Intent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments:</th>
<th>____________________________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>____________________________________________________________</td>
</tr>
<tr>
<td></td>
<td>____________________________________________________________</td>
</tr>
</tbody>
</table>

**Attention and Concentration (circle):**

<table>
<thead>
<tr>
<th>Comments:</th>
<th>____________________________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>____________________________________________________________</td>
</tr>
<tr>
<td></td>
<td>____________________________________________________________</td>
</tr>
</tbody>
</table>

**Memory (circle):**

<table>
<thead>
<tr>
<th>Comments:</th>
<th>____________________________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>____________________________________________________________</td>
</tr>
<tr>
<td></td>
<td>____________________________________________________________</td>
</tr>
</tbody>
</table>

*(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: ______________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Hypothesis Building

Once data have been gathered through completion of the clinical inter-
view, the collection of background information from other sources (e.g.,
from the person who referred the individual, from other collateral sources,
from medical records, etc.), 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-IV-TR perspective, consult the *DSM-IV-TR Handbook for Differential Diagnosis* (First, Frances, & Pincus, 2002), which includes a list of symptoms with all their likely diagnostic causes. That being said, a DSM-IV-TR perspective is only one of many perspectives.

Also important is a thorough knowledge of cognitive, personality, and emotional functioning from whichever theoretical perspective you subscribe to. The process of generating hypotheses for what is impairing 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 the likely 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 himself or herself or by someone else, for difficulties in functioning, as well as the clinical interview, which usually reveals significant 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, and has reported 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

---

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.
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 while 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.

As with any assessment, there are two hypotheses that must be ruled out across the board. The first is a substance-related 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 abuse 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 records (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 Axis II and 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 that others are conspiring against her). This list of possibilities is hardly exhaustive (for example, Asperger’s Disorder 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 in order 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 himself or herself or from someone else who referred the person for the assessment, clues as to what may be happening will begin to emerge during your first encounter. This is merely the beginning. The bulk of information about the person comes from (a) the clinical interview and (b) 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 (medical records, consulting previous treating clinicians, etc.), the clinical interview, and your own clinical observations and mental status evaluation, the next task is to consolidate the data into coherent themes 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 psychodiagnosics and personality and emotional 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.