Syllabus
PSY-R8305 - Intervention: Diagnostic Interviewing
Clinical Psychology Year-in-Residence

Residency Description
PSY-R8305 - Intervention: Diagnostic Interviewing (non-credit). This face-to-face residency course is focused on diagnostic interviewing and use of the current versions of the DSM and the ICD. Learners examine trust and relationship building as a foundation for gathering the information needed to formulate diagnostic impressions and identify differential diagnoses. Learners also engage in case discussions, role-plays, and group exercises with particular attention given to methods of gathering client information and communicating diagnostic conclusions.

This residency course is associated with PSY8220, Advanced Psychopathology.

The following courses prepare students for this residency:
- PSY8220 Advanced Psychopathology
- PSY8310 Theories of Psychotherapy
- PSY-R8302 Intervention: Building Effective Relationships

This residency helps prepare students for the following courses:
- PSY8316 Evidence-Based Practice in Psychology
- PSY-R8306 Intervention: Case Formulation
- PSY-R8307 Intervention: Treatment Planning
- PSY-R8308 Intervention: Crisis Intervention and Risk Management
- PSY-R8314 Intervention: The Practice of Psychotherapy
- PSY-R8315 Practicum Readiness Evaluation
- PSY-R8316 Residency Capstone: Preparing for Practicum
Residency Objectives
By successfully completing this course, students will have demonstrated their ability to:
1. Gather client information through structured, semi-structured, and unstructured diagnostic interviews while appropriately maintaining rapport, focus, pacing and interview transitions. GOC 1.1.1, 1.1.2, 1.3.1, 4.1.1, 4.1.2
2. Gather client information through prior records, and understand what information is important and how to access and incorporate it with information gathered through the diagnostic interview. GOC 4.1.3, 4.2.1, 4.2.2
3. Formulate clinically useful and accurate DSM 5/ ICD 9 diagnostic impressions and differential diagnoses based upon information gathered. GOC 4.2.1, 4.2.2
4. Confidently present diagnostic information orally to client-surrogates and other professionals. GOC 1.2.2, 1.2.3, 4.2.1, 4.2.2
5. Demonstrate insight into, understanding of, and the ability to respond effectively to ethical concerns raised during diagnostic interviewing and the psychological diagnosis of clients. GOC 1.2.2, 1.2.3, 1.3.2, 2.1.1, 2.1.2, 3.2.2, 3.3.4
6. Demonstrate insight into, understanding of, and the ability to respond effectively to diversity and individual-difference issues as they arise in diagnostic interviewing and the psychological diagnosis of clients. GOC 1.2.2, 1.2.3, 1.3.2, 3.1.1, 3.2.1, 3.2.2, 3.3.1, 3.3.3
7. Apply professional competencies associated with successful training and practice of psychology. GOC 1.3.1, 1.3.2, 1.3.3, 1.3.4, 1.3.5

Course Materials
- Diagnostic and Statistical Manual of Mental Disorders, 5th Ed. (DSM 5). Washington, DC, American Psychiatric Association, 2013. (Brought by student)
- Various Handouts (Including: the Diagnostic Method in American Psychology, role plays and case studies). (provided electronically and at residency)
- Bibliography (provided electronically)
doi:10.1521/psyc.2008.71.2.93


Course Requirements
1. Full attendance throughout the residency.
2. Participation in all learning activities.
3. Completed outcome documentation.

Personal Disclosure
To provide the best learning experience, the residencies encourage students to participate in experiential exercises and discussion topics that may include disclosure of information that is personal. Students are asked to use their best judgment to determine what is appropriate involvement and disclosure. Students are always welcome to decline to share. Also, to provide the most conducive learning environment, we request that you keep confidential all the personal material that is shared in the residencies.

Americans with Disabilities Act
Students with an ADA disability on file with Capella University should communicate with the Director of Residency Training and the faculty instructor prior to the beginning of this residency about any accommodations needed to allow the student to demonstrate competence in skills of this residency.

Course Schedule and Learning Activities
Day 1

1 hour 45 min Welcome and Introductions:
Orientation. In a combination of mini-lecture and large group discussions, students and Instructor will process important issues; discuss objectives, goals and learning activities of this seminar, and remaining material from previous seminars. The Instructor will present a brief lecture covering theories, principles, and concepts, and how theoretical orientation impacts diagnostics and knowledge competencies that give the context for the practice proficiencies taught in this Seminar. The use of the DSM 5 in the diagnostic process will be a primary focus of the weekend. Instructor will review the DSM 5 cross-cutting instruments and assessments.
Residency Objectives 1, 2, 3, 5, 6, 7

1 hour Introduction to the DSM 5 Assessment Measures
(A) Students and instructor will review and become familiar with the DSM 5 Assessment Measures. Students will also review the Diagnostic Features and Differential Diagnosis sections of the DSM 5.
(B) Faculty led discussion and demonstration. Instructor will conduct a diagnostic interview incorporating the use of the DSM 5 Assessment Measures.
(C) Students will work in large group to develop and demonstrate competence in basic diagnostic interviewing skills and in managing the dynamics inherent in developing and maintaining diagnostic interviewing relationships while gathering necessary psychological diagnostic and historical information. Opportunity will be provided for students demonstrate diagnostic interviewing skills, and to receive group feedback. Students will be evaluated and provided feedback by both the student-observers and the Instructor.
Residency Objectives 1, 2, 3, 7

1 hour 30 min Developing skill in the use of the DSM 5 Assessment Measures. Initial observation and practice:

(A) Students will observe and participate in diagnostic interviews in role-plays of various psychopathologies from data-gathering to the development of differential diagnoses. Role plays and case studies supplied by the instructor will provide an opportunity to discuss specific uses of the DSM 5 instruments and assessments in diagnosis. Diversity, individual-differences, and ethical concerns will be highlighted.
(B) Faculty led discussion and demonstration. Role plays and faculty and student fishbowl demonstrations.
(C) Students will work in large and small groups to develop and demonstrate competence in basic DSM 5 diagnostic interviewing skills and in developing differential diagnoses. Competence in managing dynamics for developing and maintaining diagnostic interviewing relationships while gathering necessary psychological diagnostic and historical information will also be developed. Ethical and diversity issues will be discussed. Students will be evaluated and provided feedback by both the student-observers and the Instructor.
Residency Objectives 1, 2, 3, 5, 6, 7
2 hours 30 min  

Initial Individual Practice exercises: Clinical Interviewing, data-gathering and the DSM 5.

A) Working in dyads, students will operate as interviewer and interviewee while practicing diagnostic role plays or utilizing case studies supplied by instructor. The Instructor will evaluate clinical proficiency. Discussions and demonstrations will grow from interview and diagnostic issues raised during the role-plays.
B) Faculty and student fishbowl demonstrations, as needed.
C) Students will work in dyads to develop and demonstrate competence in basic diagnostic interviewing skills and in developing differential diagnoses with the DSM 5. Competence in managing dynamics for developing and maintaining diagnostic interviewing relationships while gathering necessary psychological diagnostic and historical information will also be fostered. Diversity, individual-differences, and ethical concerns will be highlighted along with the role of theoretical orientation. Each student will operate as interviewer and interviewee, and will be evaluated and provided feedback by both the student-participants and the Instructor.

Residency Objectives 1, 2, 3, 5, 6, 7

Day 2

1 hour 30 min  

Introduction to Semi-structured and Unstructured Clinical Diagnostic Interviewing Techniques, Theoretical orientation, and DSM 5 / ICD 9 Coding:

(A) Students and instructor will discuss the clinical, ethical, and diversity issues raised by the diagnostic interview process in comparison with unstructured and semi-structured methods. The standard method in American diagnostic practice will focus a discussion and mini-lecture related to a variety of diagnostic clinical interview and mental status evaluation formats. Important historical data sources will be discussed, including medical, social, family, employment, educational and psychological histories. Instructor will provide a mini-lecture on clinical interviews and mental status exams and their relationship to theoretical orientations, and will share handouts detailing these activities. Diagnostic coding with the DSM 5/ICD 9 system will be the focus of these processes.
B) Role plays and faculty and student fishbowl demonstrations, as needed.
C) Students will work in triads, one being an interviewer, one an interviewee, and one the observer. Each student rotates through each role. Unstructured and semi-structured diagnostic interviewing techniques, management of relationship dynamics, and DSM 5/ICD 9 diagnostics will be practiced by all students using case studies provided by the instructor, and evaluated by both the student-observer and the Instructor.

Residency Objectives 1, 2, 3, 5, 6, 7

1 hour 30 min  

Focus on the DSM 5 and Differential Diagnosis:

(A) Students and instructor will discuss clinical, ethical, and diversity issues related to psychodiagnostics and the complexities of diagnostic interviewing and choosing appropriate differential diagnoses. A discussion of theoretical orientation will focus diagnostic issues. Initial communication of results will be discussed. Role plays & case studies provided by instructor will help students maintain client rapport while focusing diagnostic interviewing skills on the differential diagnostic process.
B) Role plays and faculty and student fishbowl demonstrations, as needed.
C) Students will continue working in triads. Case studies will be used to generate DSM 5/ICD 9 diagnoses. The students' primary focus will be on
development of appropriate differential diagnoses and how to communicate them. Students will choose structured, unstructured and semi-structured techniques, the differences of which will form the basis for the class discussion. Students will be evaluated by the student-observer and by the Instructor.

Residency Objectives 1, 2, 3, 5, 6, 7

2 hours

Diagnostic Interviewing: Role Plays utilizing the DSM 5 symptom measures and/or unstructured or semi-structured interviewing processes for psychodiagnostics:
(A) Students and instructor will discuss clinical, ethical, and diversity issues related to psychodiagnostics, the complexities of diagnostic interviewing, impact of theoretical orientation, and choosing appropriate differential diagnoses. Further issues of sharing interview results with clients and other professionals will be discussed. Continued work with instructor-supplied role-plays and/or case studies will help students maintain client rapport while focusing interviewing skills on the differential diagnostic process. Handouts of mental status exams and clinical interview data-gathering forms will be used along with symptom measures to demonstrate how to use structured formats in unstructured and semi-structured ways.
(B) Role plays and faculty and student fishbowl demonstrations, as needed.
(C) Students will continue working in triads with each student rotating through each role. Interviewing skills, maintenance of rapport, DSM 5/ICD 9 diagnostics, and management of treatment relationship dynamics will be practiced by all students. The primary focus will be development of appropriate differential diagnoses via structured, semi-structured and unstructured interview techniques and beginning effective communication of those diagnostic issues to clients and other professionals. Students will be evaluated by the student-observers and by the Instructor.

Residency Objectives 1, 2, 3, 4, 5, 6, 7

1 hour 45 min

Focus on diagnostic interviewing, using the DSM 5 for differential diagnoses while providing culturally and individually-sensitive psychodiagnostic feedback:
(A) Students and instructor will discuss clinical, ethical, and diversity issues related to psychodiagnostics and the complexities of diagnostic interviewing and the provision of diagnostic feedback to clients and other professionals. Students will practice providing diagnostic feedback to clients and other professionals.
Role plays and case studies will help students maintain client rapport while focusing diagnostic interviewing skills on the differential diagnostic process as it transitions to case conceptualization and treatment planning. Students will provide culturally and individually sensitive diagnostic feedback to clients and other professionals.

(B) Role plays and faculty and student fishbowl demonstrations, as needed.
(C) Students will continue working on supplied role-plays in triads with each student rotating through each role. Interviewing skills, maintenance of rapport, DSM 5/ICD 9 diagnostics, and management of treatment relationship dynamics will be practiced by all students while the primary focus will be development of appropriate differential diagnoses. Students will provide feedback to role-play clients regarding differential diagnostics. Students will be evaluated by the student-observer and by the Instructor.

Residency Objectives 1, 2, 3, 4, 5, 6, 7

1 hour 15 min Diagnostic Interviewing --- Bringing it all together: From interview to differential diagnosis to treatment implications.

(A) Students and instructor will discuss clinical, ethical, and diversity issues related to psychodiagnostics and the complexities of diagnostic interviewing and the provision of feedback to client on psychodiagnostic, basic case conceptualization, and emerging treatment implications. Students will practice providing feedback to clients and other professionals on psychodiagnostic and treatment issues. Role plays will help students maintain client rapport while focusing diagnostic interviewing skills on the differential diagnostic process and understanding case conceptualization and treatment implications. Students will provide culturally and individually sensitive diagnostic feedback to clients and other professionals along with tentative case conceptualizations and basic treatment planning issues.

(B) Faculty and student fishbowl demonstrations, as needed.
(C) Students will continue working with supplied role plays/case studies in triads. Interviewing skills, maintenance of rapport, DSM 5 / ICD 9 diagnostics, management of treatment relationship dynamics, provision of culturally and individually-sensitive feedback will be practiced by all students. The primary focus will be development of appropriate differential diagnoses and sensitive communication of those diagnoses as they relate to client treatment needs. Students will be evaluated by student-observers and by the Instructor.

Residency Objectives 1, 2, 3, 4, 5, 6, 7

Day 3

1 hour Diagnostic Interview Review: Final Role-Plays and Discussions of Diagnostic issues:
(A) Students and instructor will discuss clinical, ethical, and diversity issues related to the complexities of diagnostic interviewing and the provision of feedback to client on psychodiagnosics and emerging case conceptualization and treatment implications. More work with supplied role-plays and case studies will consolidate learning from this weekend, and will evolve from student perceptions of needed areas of practice.

(B) Role play and faculty and student fishbowl demonstrations.

(C) Interviewing skills, maintenance of rapport, use of the DSM 5 cross-cutting and symptom severity measures, management of relationship dynamics, DSM/ICD diagnosis, and the provision of diagnostic feedback to role-play clients and professionals will be practiced by all students. The primary focus will continue to be development of appropriate differential diagnoses. Students will practice providing feedback to role-play clients regarding differential diagnostics, beginning case conceptualizations, and potential treatment implications. Students will be evaluated by student-observers and by the Instructor.  

**Residency Objectives 1, 2, 3, 4, 5, 7**

1 hour 45 min

**Weekend Tie-up discussion with individual and group feedback:** Instructor will provide individual feedback to students on skills development with recommendations for further development. Students also provide feedback to instructor.

This last group focus on diagnostic interviewing will seek to resolve student questions regarding diagnostic interviewing, theoretical orientation, beginning case conceptualization and treatment issues. It will also provide direction for skill development prior to the subsequent WiR on Case Conceptualization.

Bibliography readings for the Case Conceptualization weekend will be assigned and discussed. Following this 60-minute tie-up and summary discussion the instructor will meet briefly with each student individually in feedback sessions regarding the student’s weekend’s performance and further training needs. Meanwhile students working independently in a group will have 45-minutes to develop individual plans for further learning of diagnostic skills outside of the WiR. A subsequent brief student-faculty discussion will clarify individual and group goals for strengthening these skills.

**Residency Objectives 1, 2, 3, 4, 5, 6, 7**

1 hour

**Completion activities.**

Completion of student self-assessment and program evaluation materials. Attendance logs signed. Case conceptualization resources will be disseminated and students reminded about the Grand Rounds and reading list requirements to be completed for the September Weekend-in-Residence.

**Residency Objectives 4, 5, 6, 7**
# STUDENT SKILLS RATING FORMS

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Bibliography for PSY-R8305, PSY-R8306 & PSY-R8307

Prior to the YiR (PSY-R8305, PSY-R8306), read one of the original sources below from each one of the theoretical orientation groups (Psychodynamic, Cognitive-Behavioral, or Existential) and be prepared to discuss and apply concepts from this major theoretical orientation in your August residency course.

In addition to the resources provided, you may also utilize textbooks and supplemental readings on these theories in order to prepare yourself for the WiR discussions and activities.

PSYCHOANALYSIS/PSYCHODYNAMIC


COGNITIVE-BEHAVIORAL


**EXISTENTIAL/HUMANISTIC**


**Supplemental Bibliography for PSY- 8305, PSY-R8306 & PSY-R8307**

**TEXTBOOKS & ARTICLES COVERING SEVERAL THEORIES**
Ablon, J. Stuart; Levy, Raymond A. & Katzenstein, Tai. (Psychotherapy Research Program, Massachusetts General Hospital, Newton, MA) Beyond brand names of psychotherapy: Identifying empirically supported change processes.


SULLIVANIAN/RELATIONSHIP


CHILDREN’S THERAPY

Grand Rounds Presentation

As part of each Intervention Week in Residence (WIR), you will be asked to make a group presentation in pairs. Each group will focus on a different theoretical orientation (CBT, Psychodynamic or Humanistic/Existential). Each theoretical orientation should be represented each weekend. The first step is to pick a partner and then decide which theoretical orientation your group will be representing. Be sure to send your proposed partner and theoretical emphasis to your instructor at least 2 weeks prior to the intervention WIR. The instructor will assign a theoretical orientation to your group if not all the orientations are represented. Over the course of the year, you should present from each theoretical orientation at least once and use a different partner for each presentation. We will briefly discuss the presentations at the beginning of the WIR.

Prior to the weekend, you should have prepared your presentation. This presentation should meet the following characteristics:

- 15-20 total minutes including discussion
- Provide an overview of the theory, applying it to the weekend’s topic (5 minutes)
- Describe how this theory is applied to a specific case example (5 minutes)
- Discussion (5-10 minutes)
- Include reference list from refereed journals for distribution for each weekend

Presentations will be a part of the following weekends:

- Intervention: Diagnostic Interviewing
- Intervention: Case Presentation
- Intervention: Treatment Planning
- Intervention: Case Formulation
- Crisis Intervention and Risk Assessment
- Practice of Psychotherapy
- Residency Capstone: Supervision, Consultation, and Advocacy
**The standard method in American diagnostic practice** follows these steps, not necessarily in order:

**Step 1:** Gather a complete list of all recognized symptoms and signs, and assemble them in related groupings.

**Step 2:** Find out the duration and severity of each of the presenting signs and symptoms.

**Step 3:** Identify the stressors (including life changes, transitions, and so on) in the client's life that coincide with the duration of the symptoms identified in Steps 1 and 2.

**Step 4:** Form a tentative hypothesis as to the nature of the disorder, based on the information gathered in these first three steps.

**Step 5:** Begin gathering histories. There are at least five histories that must be taken at this phase of the process: medical history, family history, academic or vocational history, psychiatric history (any previous bouts of mental disorder or treatment), and social history (friendships, dating, sexual, et cetera). Each of the histories provides information that will support or undermine your initial tentative hypothesis. For instance, if the tentative hypothesis is that the client has a depressive disorder of some sort, the family history shows that numerous relatives have suffered from depression, and the psychiatric history shows that the client has had bouts of depression earlier in life, this information strengthens the initial hypothesis.

If information gathered during the histories phase weakens your original hypothesis, the new information should be formulated into new tentative hypotheses. In the example above, if the histories showed no previous depression, but the medical history indicated that the client suffers from diabetes, a new tentative hypothesis might be that the client has diabetes-induced depressive symptoms. Further exploration could then be made to confirm or disconfirm this diagnostic hypothesis.

As you can see, this is a process of gathering information to form, confirm, or disprove hypotheses about what is wrong and what can be treated. As you know, the model of the scientist-practitioner calls for always forming both hypotheses and alternative hypotheses. The diagnostic procedure continues with two more steps:

**Step 6:** Use assessment instruments appropriate to the situation. Often, a general inventory such as the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) is useful as an indicator of areas of concern, and can solidify the clinical judgment based on the interview. However, no assessment instrument can replace a well-done clinical interview, and should never be the sole basis for a diagnosis.

**Step 7:** Obtain collateral information when it is possible and ethical to do so (this is especially important in forensic diagnosis). Collateral information comes from sources other than the client's self-report, such as parents' reports, interviews with employers or teachers, previous medical or psychological records, employment records, and so on. In the therapy arena, this level of information is not usually sought because of confidentiality concerns. However, if an adequate and accurate diagnosis cannot be made without collateral information, clients will often give permission for it to be obtained if they are well informed about its purposes and can discuss their concerns directly. It is never ethical to seek collateral information without full and informed consent, and releases of information in accordance with your state or provincial law,
from the client.

References
Diagnostic Rules and Principles

1. The rule of parsimony: The clinician seeks the single most elegant, economical, and efficient diagnosis that accounts for all the available data. If a single diagnosis is insufficient, seek the fewest number that best explain the symptoms.

2. The rule of diagnostic hierarchy: The most severe diagnoses that could account for the symptoms must be ruled out in descending order.

3. The rule of chronology: The disorder that is present the longest will tend to have priority if it can account for the current symptoms.

4. The rule of safety: When the diagnostic picture is unclear, the “safest” diagnosis is the diagnosis that ranks highest for treatability, positive outcome and prognosis, and the least serious pathology and social stigma.

5. The principle of percentages: Between two or more diagnostic options, consideration is given to the diagnosis that is more frequently found in the population from which the client is drawn.

6. The principle of the best data: Suggests that the relative decision making influence of the data should be based on the validity, reliability, objectivity, and longitudinal nature of the data.

7. The rule of history: Recognizes that historical data, if collected accurately, is more valuable than cross sectional data. Patients with strikingly different diagnoses can appear quite similar if information is based only on a single observation in time.

8. The rule of signs vs. symptoms: Symptoms (what your patient complains of) may be distorted by either YOUR interpretation or the CLIENT’S interpretation. But, signs (what you observe or measure about the patient) are subject only to the inaccuracies of your own interpretation.

9. The principle of objective vs. subjective: This principle reminds us to be wary of any diagnosis based on intuition or hunches and not on empirical and measurable data.

10. The rule of crisis: This rule reminds us that data obtained in a crisis situation are suspect. While it may reveal valuable clinical insights, it offers little in the way of understanding day-to-day behavior of the client. Thus, relying too heavily on crisis-generated data can distort the assessment.
Diagnostic Don’ts
Limitations and Pitfalls in the Diagnostic Process

1. *Failure to acknowledge one’s limitations*

2. *Not recognizing the limitations of the data:* Data must be valid, reliable, pertinent, objective and complete. A diagnosis is only as accurate as the data from which it is obtained.

3. *Jumping to conclusions:* Intuition and first impressions, although helpful when developing hypotheses, are not objective data and can lead to dangerous process of taking shortcuts in the interview.

4. *Self-fulfilling prophecies:* Thinking that a client has a particular diagnostic or psychosocial problem and not being open to other considerations can lead the interviewer to “find” data that supports the clinician’s impressions and to minimize or ignore the competing data.

5. *Stereotyping:* Unsupported assumptions about race, culture, gender, age, sexual orientation and diagnostic category can lead to judgment errors. Great heterogeneity exists among persons with the same diagnosis. “Textbook cases only exist in textbooks.”

6. *Failure to use multiple sources of data:* The more complex the diagnostic scenario, the more important is the presence of objective data obtained from multiple sources such as tests, structured interviews, collateral data, checklists, and historical records.

7. *Not administering a mental status exam:* Unless the clinician is aware of any and all cognitive difficulties being experienced by the client, it is highly likely that a diagnostic error will occur. Clinicians should commit to memory the components and procedures for conducting the MSE.

8. *Asking too many closed ended questions.*

9. *Not allowing for silence.*

10. *Inadequate listening and attending by the interviewer* (secondary to their own thoughts, feelings, fatigue, etc.).

11. *Failure to establish rapport.*
Guidelines for Effective Diagnostic Interviews

1. Prepare for the initial interview: Carefully review the referral before the initial meeting and any other available data. Clients are understandably annoyed if they are repeatedly asked the same information by different healthcare providers. Also, re-familiarize yourself with the diagnostic areas most likely to be relevant to the client’s referral question.

2. Determine the purpose of the interview: Ask yourself: What do I want to accomplish in this hour? Is it making a diagnosis, answering a specific question (is this patient suicidal i.e.) initiating psychotherapy, or all three?

3. Clarify the purpose and parameters of the interview to the client: Present the rationale to the patient for the interview and make sure you have a shared agenda. Monumental misunderstandings can occur when the clinician and patient are not “on the same page.”

4. Conceptualize the interview as a collaborative enterprise: Interestingly, the word *diagnosis* is derived from the Latin *assidere*, which means to “sit beside.”

5. Truly hear what the interviewee has to say: Let patients tell their “story” in their own words, without interruption or value judgments. The importance of listening can’t be over-emphasized.

6. Use structured interviews: If not intimately familiar with diagnostic categories and data, consider using structured interviews to enhance diagnostic reliability and validity. I.E. Structured Clinical Interview for the DSM-IV (SCID).

7. Encourage the client to describe complaints in concrete behavioral terms and give concrete examples: Clients who describe their problems in terms of vague concepts (“nerves, crazy, blue, confused” etc.) are presenting unreliable data. Ask clients to give examples, be concrete in terms of physical and psychological signs, and consider the three dimensions of problematic behavior: frequency (how often?), duration (how long?), and intensity (how severe?).

8. Complement the interview with other assessment methods: Validity of interview is often enhanced by psychological testing, behavioral or situational observations, and family/collateral reports.

9. Identify the antecedents and consequences of problem behaviors: Note any variables that precede the problem and either maintain, strengthen, or weaken the target behaviors. Similarly, attempt to identify both internal and external events that strengthen or weaken the problem. What are the consequences in the domains of affective, somatic, behavioral, cognitive, and relational?
10. Differentiate between skill and motivation: Skill refers to a behavior within the client’s repertoire of abilities. Motivation refers to the emotional state that initiates such abilities. Is a client’s inability to perform a task related to skill set or motivational deficit?

11. Obtain a base rate of behaviors: Be aware of data to allow comparisons and contrasts between clients from similar diagnostic groups and communities. This will improve clinical accuracy and acumen.

12. Avoid expectations and biases: “We see what we expect to see.” We tend to search for supporting evidence for our expectations and to minimize or exclude that data which is contrary to our notions about this client or problem.

13. Use a confirmation/disconfirmation strategy: What evidence exists in this client, from interview and other sources, to support or exclude the provisional diagnosis? What data can we hunt down that will confirm or disconfirm a diagnosis? MUST know the DSM criteria for major categories and how to elicit this information from the client.

14. Be aware of the “fundamental attribution error:” This error occurs when the clinician attributes the client’s disorder to intrapsychic factors without due consideration to environmental, situational, or circumstantial variables. Attention to Axis IV factors will help prevent this.

15. Delay reaching final decisions while the interview is being conducted: To reduce your susceptibility to bias, reserve your final diagnostic decisions until after the interview is terminated.

16. Consider the alternatives: After generating an initial impression, make yourself think about any competing diagnoses or play the “devil’s advocate” position and consider how a cunning peer might challenge your final diagnostic decision and make sure you can substantiate your impressions.

17. Provide a proper termination: Don’t stop abruptly, the termination of the session should provide a seamless transition from information gathering to departure. Consider any final broad questions (i.e. “Is there anything else that you think is relevant that I’ve not asked you about?”) as well as offering the opportunity for the client to ask you questions.
Steps to Developing a Case Formulation
Based on: Mumma (1998), Persons (1989), and Tompkins (1999)

1. Develop a comprehensive problem list: To include both stated problems by the client as well as those assessed by the psychologist. Would include any difficulties related to: generalized levels of distress, sense of well being, specific signs and symptoms of psychopathology, risk of harm to self/others, physical health issues, family/interpersonal issues, work/school issues, and goals stated by collaterals.

2. Determine the nature of each problem: What is the origin of the problem? What are the current precipitants of the problem? What are the consequences of the problem?

3. Identify patterns among the problems: What are the connections and themes among the problems?

4. Develop a working hypothesis to explain the problems: The clinician brings together all the information obtained about the patient in an attempt to develop an organized, comprehensive picture and explanation of the patient’s problems. What is the most parsimonious of all hypotheses generated?

5. Validate and refine the hypothesis: The therapist must test out the hypothesis before final acceptance of case formulation and subsequent development of a treatment plan. How do you know if the refined hypothesis has high degree of accuracy? A) The hypothesis accounts for all identified problems B) The antecedents and triggers are easily understood in light of the hypothesis C) Hypothesis based predictions are accurate D) The patient agrees with the hypothesis. E) Treatment based on the hypothesis is successful.

6. Test and revise the hypothesis during treatment: Represents a form of continuous quality improvement (CQI) during the treatment. Case formulations are never cast in stone.


CASE STUDY: Strange behaviors in a teenager with developmental disorder

James is a 15-year old boy, the second of three children, with a long history of unusual and delayed development. His parents bring him for evaluation because of a worsening in his behavioral functioning. Over the 2 years before this evaluation, James has become progressively more rigid and inflexible, and his insistence on elaborate routines causes much difficulty. He has no real friends and displays a number of idiosyncrasies. He repeats certain phrases from television over and over and displays a fascination with bits of string and lint. He has collected considerable quantities of these items, which he insists on carrying with him. Any attempt to divert him from this unusual interest leads to agitation with periods of body rocking or head banging.

Upon examination, James exhibits an unusual pattern of social relatedness – making eye contact infrequently and seeming relatively uninterested in social interaction. He does not use facial expressions, gestures, or body posture to regulate the interaction and lacks emotional reciprocity. His parents report that he has great trouble sustaining a conversation and is interested in discussing only certain television programs and his string collection. His language is stereotyped and repetitive with a monotonic quality. His parents also report that he exhibits some stereotyped behaviors when excited and tends to adhere to various nonfunctional routines (e.g., he always walks around a chair three times before sitting in it, a practice observed by the clinician during the evaluation). His affective range is highly constricted, and his insight and judgment are poor. No evidence of delusions, hallucinations, or other psychotic phenomena are observed.

James was born to a working-class family after a normal pregnancy, labor, and delivery. According to his mother, as an infant he was undemanding and relatively placid and seemed “different” from the first weeks of his life. In contrast to his two siblings, James seemed much less interested in social interaction. Motor milestones occurred at the expected times, but language development was significantly delayed. There was some concern that James might be deaf, but a hearing test indicated apparently normal hearing. Although initially reassured by their pediatrician that James was a “late talker”, his parents continued to be concerned and, when he was 36 months old, they sought additional evaluations. On examination, James exhibited scattered developmental skills with severe delay in language and language-mediated cognitive skills, but with some motor and nonverbal cognitive abilities close to age level. James said only a few single words that were used for requests for food rather than for social contact. He was unable to follow simple requests and had marked difficulties with tasks that involved imitation. James was particularly intolerant of change. For example, he insisted that his parents follow exactly the same complicated routine at bedtime each night and became extremely agitated if any change in the usual pattern occurred. He was also very sensitive to the inanimate environment so that, although he often seemed almost completely oblivious to his mother’s voice, he would panic when he heard the vacuum cleaner. His play involved simple object manipulation with considerable perseveration. A comprehensive medical evaluation revealed a normal electroencephalogram and computed tomography scan. Genetic screening and
chromosome analysis were normal as well. Family history consisted of a much less severe speech-language delay in his older brother.

**DIAGNOSIS:**
CASE STUDY:

Ms. J, a 65-year old widow of 2 years, visits her medical doctor because of increasing fatigue, lethargy, and depression that have developed over the past 6 months. These symptoms began gradually, but over the past month have worsened to the point that she is having trouble getting out of bed in the morning, quit her volunteer job at the local hospital, and stopped a number of her usual social activities at church. She does not seem to have any motivation, and it has become a chore to perform even the most basic activities of daily living, such as cooking and housekeeping. Ms. J reports that she has been sleeping too much (sometimes 10-12 hours per day) and has gained weight (15 pounds over the past month) because of inactivity. She also complains of diffuse aches and pains, difficulty staying warm, and a range of other physical discomforts. Other family members have recently remarked about how tired and fatigued she looks. Ms. J’s daughter is very concerned because her mother has dropped out of so many activities that she formerly enjoyed and does not even show much interest in spending time with her two young grandchildren, to whom she has always been devoted. Ms. J is very upset about feeling so tired all the time. She reports that she is frequently tearful and is beginning to feel that she is a burden on the daughter with whom she lives. Most of the household chores that she used to help with now fall on her daughter, who also cares for her two small children and husband. Ms. J says she has started wondering whether she wouldn’t be better off dead so that “I wouldn’t be a burden on everyone.” Ms. J reports that her concentration has worsened over the past couple of months, that she frequently misplaces things, and that she even has difficulty following the plot of television programs.

Ms. J has no history of depression, excessive alcohol use, or problems with memory before 6 months ago. She has never been hospitalized for psychotic problems, nor is there any family history of such problems. She has seen a mental health professional only once for a short period of psychotherapy following the death of her husband. She says that she thinks of her husband often and continues to miss him because they were very happily married for 48 years and had a satisfying and fulfilling relationship. Ms. J says that she has just begun to feel some relief from that loss when this feeling of fatigue and “the blues” started. She has also experienced a number of new physical health problems since her husband’s death and has been diagnosed with both diabetes and hypertension within the past year. Ms. J is currently taking glyburide 5 mg/day for diabetes and hydrochlorothiazide 50mg/day for hypertension. Over the past 6 months, she has also experienced worsening constipation for which she takes a stool softener (documsate sodium 100 mg) twice a day and occasionally gives herself an enema to obtain relief.

During the initial interview, Ms. J appears tired, listless, and older than her stated age. She describes her mood as depressed and discouraged. She says this is because she is so tired and can’t do the things she used to be able to do. Her affect is somewhat constricted and depressed, but her eye contact is good and she realties well to the therapist. Her speech is slowed but spontaneous and friendly in tone. Her thought processes are goal directed and logical. Her thought content is characterized by ruminations about her fatigue and difficulty with usual activities, but no hallucinations or delusions are present.
DIAGNOSIS:
CASE STUDY:
MS. D., a 55-year-old business executive, has previously had several relatively brief (up to 1 month) episodes of depression. These episodes each followed a psychosocial stressor but remitted after cognitive behavior psychotherapy without any need for medication or hospitalization. The current depression also began in the context of a possible business reversal, but, unlike the previous depressions, it did not improve as business did. Instead, the depression gradually deepened and became more severe and pervasive. Within 6 weeks, the patient became unable to work. She spent her day lying in bed facing a blank wall.

Upon evaluation, the patient reports that she is usually able to fall asleep easily; she often awakens in the early morning hours and paces and becomes very agitated. She says that, although she does not feel very good during the day, the worst time for her is shortly before sunrise, when she sometimes feels like killing herself. Ms. D appears dehydrated and reports that she has lost between 15 and 20 pounds. (Physical and laboratory testing revealed no significant abnormalities.) Her face shows no emotion, and she states convincingly that she finds nothing pleasurable and she has even lost her sense of humor, which has always been a mainstay for her. She says that even when her grandchildren arrived on a visit she was able to summon up only a temporary smile. She quickly returned to feeling blank and empty and didn’t have the energy to play with the children as she always had in the past. The patient describes feeling overwhelming guilt but does not have bizarre delusional beliefs. She says that she feels like a failure at work and as a wife and grandmother and is constantly apologizing to everyone for not getting better. She feels that she is letting people down and that the business will collapse without her.

Ms. D describes her overall mood as feeling dead inside. Although she has experienced depression before, she says it was never anything like this, not even when she lost her mother to whom she was very close. She says it is very difficult to describe her feelings and that she has an emotional ache that is “horrible beyond words”.

DIAGNOSIS:
**CASE STUDY:**
Mr. A. a 28-year-old unmarried accountant, seeks consultation because “I feel I am going nowhere with my life.” Problems with his career and girlfriend have been escalating and are causing him increasing distress. Mr. A recently received a critical job review. Although he is reliable and his work accurate, his productivity is low, his management skills are poor, and he has conflicts with is boss over minor issues.

The patient’s fiancée recently postponed their wedding date. She said that, although she respects and loves him, she is ambivalent because on so many occasions he tends to be remote and critical and he is often uninterested in sex.

Mr. A describes himself as a pessimist who has difficulty experiencing pleasure or happiness. He says that as far back as he can remember he has always been aware of an undercurrent of hopelessness, feeling that his life is hard and not worth living. Mr. A grew up in a suburban community and attended public schools. His mother is a quiet person, periodically “moody,” remote, and depressed. Shortly after the birth of Mr. A’s sister, 3 years his junior, his mother became very depresse3d and was hospitalized. She responded well to ECT and had no further psychiatric care. Mr. A’s father, now deceased, was successful in business but was also overbearing, critical, and intimidating and drank to excess. Mr. A says he respected him but never felt they were close.

The patient did well academically in high school and college. He participated in some social activities but was shy and was considered gloomy and not fun to be with by most of his classmates.

In college, Mr. A benefited from counseling after breaking up with his first girlfriend. During this time an internist gave him amitriptyline for migraine headaches, which provided good relief from both the headaches and the feelings of hopelessness. In retrospect, he feels that this was a very good period of his life. He began a new job and relationship, functioned well, and almost seemed to enjoy life. However, when he discontinued the medication after 3 months, he seemed to slip slowly and insidiously back into his previous state of pessimism and hopelessness.

Although he is usually depressed, he has had depressive episodes that met criteria for a Major Depressive Disorder: He has never been suicidal or had prominent suicidal ideation and has not experienced significant problems with weight loss, insomnia, or psychomotor activity. For months at time, however, Mr. A’s energy levels are diminished and his ability to concentrate impaired. He views himself negatively, feeling he has little to offer. He is always surprised when others like and respect him. When he is depressed, his sex drive is reduced and he has difficulty maintaining an erection, which frightens him.

Mr. A has periods when he withdraws from friends and social activities, but with effort he always goes to work. Some weekends, he stays in bed in a state of profound inertia. In the past, he would sometimes drink excessively but now has only an occasional glass of wine. He does not recall ever having periods of excessive energy or elation. Mr. A says the he recognizes his strong need to please others, to obtain approval, and to avoid conflicts. He feels extremely
anxious when forced to deal directly with a hostile situation. He takes pride in his acknowledged perfectionistic traits.

Mr. A appears early for his appointment, is conservatively dressed, and initially appears outgoing and affable. As the interview progresses, however, he becomes tearful as he discusses his problems and acknowledges his depressed mood. There is no evidence of a thought disorder or of hallucinations or delusions. His insight is impaired by his tendency to deny and repress emotionally laden material. His judgment is intact, as are his orientation and recent memory. His intelligence appears to be high-average.

**DIAGNOSIS:**
**CASE STUDY:**
Mr. D is a 24-year old, single, unemployed college dropout who was admitted to the hospital 3 weeks after he painted everything in sight black and white, including his room, his furniture, his clothes, and himself. He was responding to a persistent male voice that told him that his behavior would somehow solve the race problem in America and bring peace to his family.

Mr. D has been hospitalized on at least five previous occasions during the past 5 years, each time for 4-6 weeks. Each hospitalization was due to an exacerbation of his illness with some combination of command hallucinations, strange behavior, and persecutory delusions. He has always responded fairly well to treatment with antipsychotics but hates to take medication because it makes him feel “even deader than dead”. Between hospitalizations, he is likely to take medication irregularly or not at all and to miss more outpatient appointments than he keeps.

Mr. D is the fourth of five children in an extremely close-knit, guilt-provoking, and argumentative family. His mother has been hospitalized twice for hallucinations and persecutory delusions but now functions reasonably well without medications. She believes that she knows better than the doctors what is best for her son. Her other children have left the family apartment and Ms. D has become increasingly attached to and dependent on “the only kid I have left”. Mr. D responds to his mother’s ministrations with annoyance and avoidance but, when they are not forthcoming, also becomes annoyed.

Mr. D spends most of his time in the apartment doing yoga and reading about Jungian archetypes and social oppression. He sleeps all day and stays up most of every night and, except when hospitalized, rarely talks to anyone outside his immediate family circle. He is afraid to go outside, especially during the day, because he believes that strangers on the street are talking to each other about him and are able to control his thoughts and actions. He is convinced that the transmission of thought commands requires solar energy and that he is safer at night. He also believes that a “right-wing, neo-Nazi” group is attempting to ruin his reputation by spreading rumors that he is one-eighth Jewish.

As usual, Mr. D responds well to antipsychotic medication during his hospitalization. He remains convinced of his delusions, but in a low-key way, and can to some extent be argued out of them. He is also able to talk to staff with less suspicion and greater coherence than when he was admitted, and his behavior is no longer overtly bizarre. He seems ready for discharge.

**DIAGNOSIS:**
CASE STUDY:

Ms. S, a 26 year-old married woman is referred to the psychologist by her gynecologist, Dr. G. The physician reports that she is “off work, depressed, suicidal, stumbling around at home on all kinds of medications, and has no active gynecological disease.” Dr. G says that she, the gynecologist, has “had it” with both her and her mother who have “just worn me out, always complaining about something and phoning me day and night.” Besides, “they never pay their bills.” The patient is a member of a locally prominent but erratic family. She has been divorced once and married for the second time 2 years before this evaluation; she has no children.

Ms. S has difficulty walking into the office, bracing herself on the walls and furniture at times but at other times fully supporting herself. She never actually falls. She relates that this sometimes happens to her without warning. She complains, “I am horribly depressed and just want to end it all. I also want to get off all these medications.” She reports that she has had many health problems since she was a young teenager. She has seen literally hundreds of doctors but has never found one who has really helped her. She has been seeing her gynecologist for dysmenorrhea, which she says began virtually at menarche. She describes severe cramping (for which she takes Empirin with codeine) and “gushing blood” for 7 or 8 days each menstrual period. She also says that her menstrual periods are very irregular. However, she has never been anemic, and extensive gynecological workups Havre not identified any pathology. She takes Fiorinal for “migraine” headaches (which “last for days”). In fact, she reports that she is having a migraine at the time of the interview, although she does not seem to be bothered by light or noise. She also reports having frequent chest pains that convince her she is about to have a heart attack, but numerous electrocardiograms have been negative. She reports that she has “asthma” for which she was once “resuscitated” and that she gets short of breath when “emotionally excited”. Although she says that she suffers from “rheumatoid arthritis” and often has pain in “all of my joints” that makes it very difficult to get out of bed, there is no evidence of joint deformities and she is not under a doctor’s care for her condition. She also reports problems with nausea and vomiting, a bloated feeling, and sometimes “going for days without being able to keep any food down.” However, several gastrointestinal workups have never identified a specific illness and she appears to be well nourished. Her neurological examination was within normal limits.

Ms. S reports that she has been depressed “for ears” but that it has been worse in the past “few months” since she began having problems at work. She is a political appointee and feels that people are jealous of her and deliberately harass her. She appears distraught but not really sad. She states that she is depressed “all day, every day”, has little or no interest in anything, never feels like eating (but has not lost weight), goes “for days” without sleeping unless she uses a hypnotic drug, has no energy, can’t concentrate, is a worthless person, and sometimes contemplates suicide (but does not have any specific plan). She describes her “wonderful” husband of 2 years as her only “bright spot” and says he is “fully supportive in every way”. Although she initially maintains that there are absolutely no problems in her marriages, she later admits that she usually has pain during sexual intercourse that has prevented relations for several months at a time.

Ms. S was prescribed an antidepressant by her gynecologist (but only takes it “when I really need it”), a benzodiazepine for insomnia (which she has been taking “full dose” every night “for months”), and another benzodiazepine for anxiety (which she takes “to the limit”). She denies current or past use of alcohol or nonprescribed drugs. Although never previously referred to a therapist/psychologist/psychiatrist for
depression, she has taken several antidepressants and sedative hypnotics prescribed by other physicians over the years. She states that the medications only made her feel worse.

Her only previous psychiatric contact was 3 years earlier when she was hospitalized for 4 days for a "psychosis". She recalled that people’s faces would “melt away and re-form into monsters.” She described it as a “difficult period.” She reports that she was treated with “some horrible drug called Haldol,” which she was to have continued after discharge. She never filled the prescription and her “psychotic” symptoms did not recur.

Review of Ms. S’s extensive medical records reveals a history of many physical complaints that have been inconsistently reported. Migraine headaches and asthma were mentioned as diagnostic possibilities, but there was a great deal of disagreement from physician to physician. A diagnosis of rheumatoid arthritis or of another connective tissue disease was not supported by laboratory evaluations.

**DIAGNOSIS:**