Psychological Case Report Guidelines

Assessment and Measurement Report

Master and Doctor of Psychology (Clinical Psychology)

Please note that this document outlines the requirements for the Psychological Assessment and Measurement Case Reports in the Master and Doctor of Psychology (Clinical Psychology) placement units, excluding unit CLN560 Supervised Clinical Placement AB. Click here to access the specific CLN560 Psychological Report Guidelines on my.CMI here. Students undertaking a Psychological Treatment Case Report need to refer to the appropriate guidelines on my.CMI.

Students should refer to the Placement Handbook for more information about the number and type of case reports required in each placement unit.

Overview

Complete a 3000-word assessment and measurement psychological case reports (approximately 5-7 single spaced pages). One report is based on a referral question where cognitive functioning is primary in the presentation, and another where personality, emotional and behavioural functioning is primary.

Where students have satisfactorily completed an assessment based psychological report in a first-year placement (cognitive functioning as primary), then this would satisfy the current case report requirement for this area of functioning in second year (placement units CLN662-663).

In completing assessments students should aim to take a comprehensive approach, integrating multi-method assessment data in addition to psychological testing as gathered throughout the various phases of the assessment.

Supervision of Assessments

Assessments need to be planned for and completed working closely with supervisors, including gaining supervisor approval to utilise psychological tests as selected. Drafts of reports are shared with supervisors for formative feedback but please be aware that supervisors are not required to review multiple drafts.

Supervisors will assess the final report within Sonia as either satisfactory or not yet satisfactory and make this recommendation to the placement coordinator. Where the report is marked as unsatisfactory students will be required to make changes and resubmit. Students whose Psychological Case Report does not pass on the second attempt may result a progress concern, unit failure or requirement to complete an additional report.

Students should note details of case report activity in logbooks including the date/s of client and non-client related activity related to the completion of the case report requirement along with any reflections including in response to supervision.

Deidentification

Please ensure you deidentify the case reports. Refer to the Guide to De-Identifying Placement Assessments on my.CMI. Please deidentify all client details when transmitting the reports electronically to the supervisor. We recommend you also password protect the document to safeguard against any interception and provide this password verbally to the supervisor and not by the same means of report transmission (email).

Report Writing

Keep in mind that the case report is fundamentally meant to communicate and document the assessment and the person being assessed rather than to overemphasize psychological test findings. Students should aim to write an engaging and integrative way, avoiding unnecessary use of jargon or subheadings apart the main bolded headings below.

Guidelines on Test Selection

Test selection decisions for this requirement should be guided by recognized test selection criteria as well as test familiarity and competency with tests gained in coursework. Test selection criteria

See Appendix 1 below for specific guidelines on test selection.

Providing feedback

The assessment process should include providing feedback of your evaluation to whoever your client is, the individual you are assessing in most circumstances taking into consideration of a range factors (e.g. structuring the session, considering what will be most helpful, developmental considerations for children, disclosing diagnosis etc.). These factors should be reviewed and planned for in supervision prior to providing feedback.

Assessment and Measurement Case Report Format

- **Referral Reason and Question (s):** Clearly state and clarify the reason for the referral (the question/s the report will answer or the initial hypothesis to be considered). The referrer for example may have had a specific diagnostic question to answer, but following the initial interview, the client and/or assessor may add concerns or questions to be addressed in the evaluation. Questions may need to be refined and negotiated so they are realistic and can adequately addressed within the scope of the assessment.

- **Assessment Methods:** List in order of dates administered or completed (next to the method) and all methods undertaken including client interview, collateral interview (including who was interviewed and relationship with client), review of records, tests administered.

  Write the formal name of tests administered in their entirety, followed in parenthesis by the abbreviation that you plan to use throughout the report, for example, Weschler Intelligence Scale for Children, 5th Edition (WISC-V), Personality Assessment Inventory (PAI). It is important to note that the inclusion of all procedures helps to emphasize the significance of non-test data to the final opinions and impressions.

- **Presenting Problem and Its History:** This section is related to the issues that constitute the reason for the assessment or whatever complaint the client identifies as the reason for the assessment including an evaluation of harm to self and other (i.e., risk).
    - Provide a detailed history surrounding the problem including when the problem began (initial onset); if there was a precipitating event or events; how continuous or intermittent the problem has been (i.e., its course), including when and how the problem got worse or better since the difficulty began, it's intensity and duration and also, it's functional or life impact. Previous attempts to solve or cope with the problem should be reported along with previous assessment and treatment episodes.
    - The content for this section will flow from data collected in (a) the referral (b) clinical interviewing (c) behavioural observations and mental status (c) collateral interviews and records. As required, the presenting problem may need to be reassessed and clarified in subsequent interviews/contacts given that a clear presenting issue and its history may not be forthcoming in initial client self-reports (i.e., client's may be vague, defensive, lack awareness etc.).
- **Relevant Background Information:** This section may be known as a "case history" and contextualizes the referral questions, presenting problems, conclusions and recommendations. Provide succinct and relevant background (i.e., relevant to answering the referral question(s) and reporting on aspects of functioning).

  Subheadings can be used but be aware that writing under multiple subheadings can become tedious for the writer and the reader.

  Avoid a detailed summary of every aspect of history gathered in earlier phases of the assessment (when gathering information on all possible hypotheses). Not all background will be relevant. If data is available via extensive clinical/ collateral interviews and consulting records, students will likely have more information than is useful for the purpose of the report.

  A key task is to convey the most relevant information which could be reported in a series of paragraphs in a chronological narrative or "story" within a biopsychosocial framework. The terms used can vary depending on the purpose and type of report. Refer to the table below and report on areas as background information is relevant and known:

Biopsychological	Psychosocial
• Developmental History • Psychiatric History • Alcohol and Substance use History • Medical History • Family Medical, Psychiatric, and Substance Use History	• Family History • Educational and Vocational History • Social History • Criminal and Legal History • Cultural Evaluation

- **Behavioural Observations:** This includes a summary of behavioural observations related to the client's functioning taken throughout the entire evaluation, from each session if there was more than one. This data may provide information relevant to the evaluation itself and include any remarkable test session behaviour that would also be included elsewhere in the report. Provide at least some information on how well the individual related to you throughout the assessment (e.g., openness and comfort disclosing personal information, general cooperativeness etc.). Support observations related to the client's functioning with concrete, behavioural evidence (e.g., "seemed guarded during the interview as evidenced by short brief replies to questions").

- **Mental State Examination**: Provide a concise MSE (paragraph or so), covering the six major areas (1) appearance and behaviour (2) speech and language (3) mood and affect (4) thought processes and content (5) cognition; and (6) insight and judgement. Utilise correct terminology as this section of the report is generally aimed toward other mental health professionals, and hence, it's acceptable to use technical language (e.g. "his affect was mood incongruent and inappropriate to the situation"). Across domains note specific and concrete examples which signal atypical functioning.

- **Interpretative Summary of Test Results:** Introduce this section by providing a description of the test(s) or measures chosen, along with a rationale for selection in relation to the referral question (s) and hypotheses formed.

  Generally, this section should be organized in a clear and logical way, under relevant constructs or domains measured by the test(s). The interpretive summary should clearly convey to the reader which findings are noteworthy and of greatest significance for the client and referral question(s), with less remarkable or incidental results briefly summarized.

  Extensive use of tables and descriptive interpretations of how the client performs on each component of the test should be avoided (as required refer to tables containing test findings within an appendix section).

- **Clinical Impression:** Integrate all assessment data (without introducing any new data), to synthesize and formulate final conclusions drawn in specific answer to the referral question(s). The clinical impression should offer a deeper and more accurate understanding of the client. Based on sufficient evidence from all data gathered, offer a justification for DSM-5-TR diagnosis & differential diagnosis or identify clear areas for clinical attention and focus for treatment If a provisional or no diagnosis is offered.

- **Recommendations:** These should align with evidence-based literature and flow from the clinical impression and conclusions (i.e., so the reader can see why the recommendations are being made). Consider client preferences and characteristics that may impact on treatment success. Recommendations should be practical and specific, listed in order of priority and identify referral sites, resources, individuals and/or clinics that can assist the client in carrying out those recommendations.

- **Feedback:** This section should include what feedback of the assessment was provided to the client (e.g., referral questions answered, recommendations discussed, diagnosis disclosed or not), factors

considered when delivering the feedback (e.g., developmental considerations, client's mental state and capacity to understand feedback), and the client's understanding and response to feedback (e.g. any therapeutic value). This section should also facilitate appropriate follow-up care and a smoother transition for other providers who may work with the client.

- **Reflection:** Critically, comment on how the multi-method approach utilized in the assessment enhanced the accuracy, validity, and utility the assessment. Reflect on personal reactions, challenges, or learnings encountered in completing the assessment and comment on how these may be used to further develop assessment competency.

Resources:

The following text (available electronically through the CMI library) provides chapter material relevant to completing the case report including guidance on test selection criteria (p. 10-23), the phases of clinical assessment (p.32-37), and in-depth information on the psychological report as it relates to relevant research, guidelines, format and sample reports (Chp. 15). Groth-Marnat & A.J. Wright. *Handbook of psychological assessment* (6th ed.). Wiley

Further references and resources including sample psychological reports to guide the completion of the case report are available on the Clinical Psychology Placements Canvas Page.

Appendix 1: Guidelines on Test Selection

Cognitive functioning:

- These should be a widely used, standardized, performance-based measure of one or more core domains of cognitive functioning namely general cognitive functioning such as WPPSI/WISC/ WIAT, or measures such as the WRAML, RBANS, WMS assessing neuropsychological statues in domains such as executive functioning, attention, short- and long-term memory, and language.
- Symptom or disorder focused self-report measures (either broad based or targeted) related to cognitive functioning (such as the Connors, BRIEF) are not sufficient unless they are used alongside other standardized, performance-based measures.
- Complex diagnostic assessments that make use of specific testing procedures requiring advanced training (such as the ADOS for neurodevelopmental disorders) are not appropriate Tests designed to analyse academic achievement or support a learning disability diagnosis (such as the WIAT) are not sufficient unless combined with a standardized measure of intelligence.
- Tests designed to analyse academic achievement or adaptive behaviour to support a learning disability or intellectual development disorder diagnostic determinations (e.g., WIAT, Vineland) are not sufficient unless combined with a standardized measure of intelligence.

Personality, emotional and behavioural functioning:

- Personality assessment should include an established standardised, broad- based self-report measure of personality and psychopathology (clinical syndromes), which include validity scales. Examples include the PAI and MMPI, or others that measure clinical personality patterns and emotional adjustment such MCMI. Alternatively, other emerging measures such as the PID-5 may be considered when indicated.
- Due caution needs to be given in regard to any consideration to administer personality-based assessments to children and adolescents. Comprehensive measures designed to assess behavioral and emotional adjustment in young people (ABAS, Achenbach CBCL) may be used as an alternative in particular settings (e.g. school-based assessments). Once again, the validity, reliability and clinical utility of these tools would guide selection as with any other.
- If a measure of normal personality functioning is used (such as a measure of the big five personality constructs, (e.g., NEO-PI, Catell 16 PF), students should do so in relation to the specific referral question, the personality-based issue under consideration, with a clear view for how the results can be used to enhance clinical utility.
- Briefer symptom-focused instruments whether they be single construct or syndrome specific (e.g., BDI-II, STAI, Y-BOCS, TSI for trauma), or those that assess the current level of a variety of symptoms (e.g. SLC-90-R), are not sufficient unless they are used alongside comprehensive broad-based tools.

- The use of a recognised structured Interview (such as the SCID) would not qualify as psychological test but would appropriately be used for diagnostic interviewing purposes alongside a standardized, broad-based measure.
- Questionnaires that have been developed in conjunction with specific models of psychological treatment for adults, those that are used to assess and formulate within that same model (e.g., Young Schema Inventory for Schema Therapy), are not designed specifically for the assessment of personality/emotional functioning. Such tools, however, may be appropriate to utilize in intervention/treatment reports or in combination with a standardized broad-based measure of personality/psychopathology (e.g., PAI).