

## CH. 5. CULTURAL FACTORS INFLUENCING THE SELECTION, USE, AND INTERPRETATION OF PSYCHIATRIC MEASURES pdf

### 1: Handbook of Psychiatric Measures : A. John Rush :

*Addresses limitations in the use of measures including ethnic, cultural, and socioeconomic factors that influence their interpretation Use of this special resource is further enhanced by a CD-ROM containing the full text of more than of these measuresâ€”an invaluable aid for reference and clinical decision-making.*

Such information is obtained through a variety of methods and measures, with relevant sources determined by the specific purposes of the evaluation. Sources of information may include Records e. Agreements across multiple measures and sources, as well as discrepant information, enable the creation of a more comprehensive understanding of the individual being assessed, ultimately leading to more accurate and appropriate clinical conclusions e. The clinical interview remains the foundation of many psychological and neuropsychological assessments. In addition, the interview element of the assessment process allows for behavioral observations that may be useful in describing the client, as well as discerning the convergence with known diagnoses. Based on the information and observations gained in the interview, assessment instruments may be selected, corroborative informants identified, and other historical records recognized that may aid the clinician in reaching a diagnosis. Conceptually, clinical interviewing explores the presenting complaint s i. An important piece of the assessment process and the focus of this report, psychological testing consists of the administration of one or more standardized procedures under particular environmental conditions e. Assessments, then, serve to respond to questions through the use of tests and other procedures. It is important to note that the selection of appropriate tests requires an understanding of the specific circumstances of the individual being assessed, falling under the purview of clinical judgment. For this reason, the committee refrains from recommending the use of any specific test in this report. Any reference to a specific test is to provide an illustrative example, and should not be interpreted as an endorsement by the committee for use in any specific situation; such a determination is best left to a qualified assessor familiar with the specific circumstances surrounding the assessment. To respond to questions regarding the use of psychological tests for the assessment of the presence and severity of disability due to mental disorders, this chapter provides an introductory review of psychological testing. The chapter is divided into three sections: Where possible an effort has been made to address the context of disability determination; however, the chapter is primarily an introduction to psychological testing. The ensuing discussion lays out some of the distinctions among such tests; however, it is important to note that there is no one correct cataloging of the types of tests because the different categorizations often overlap. Psychological tests can be categorized by the very nature of the behavior they assess what they measure , their administration, their scoring, and how they are used. Figure illustrates the types of psychological measures as described in this report. Components of psychological assessment. Performance validity tests do not measure cognition, but are used in conjunction with performance-based cognitive tests to examine whether the examinee is exerting sufficient effort to perform well and responding more The Nature of Psychological Measures One of the most common distinctions made among tests relates to whether they are measures of typical behavior often non-cognitive measures versus tests of maximal performance often cognitive tests Cronbach, , A measure of typical behavior asks those completing the instrument to describe what they would commonly do in a given situation. Measures of typical behavior, such as personality, interests, values, and attitudes, may be referred to as non-cognitive measures. A test of maximal performance, obviously enough, asks people to answer questions and solve problems as well as they possibly can. Because tests of maximal performance typically involve cognitive performance, they are often referred to as cognitive tests. Most intelligence and other ability tests would be considered cognitive tests; they can also be known as ability tests, but this would be a more limited category. Non-cognitive measures rarely have correct answers per se, although in some cases e. It is through these two lensesâ€”non-cognitive measures and cognitive testsâ€”that the committee examines psychological testing for the purpose of disability evaluation in this report. One distinction among non-cognitive measures is whether

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the stimuli composing the measure are structured or unstructured. A structured personality measure, for example, may ask people true-or-false questions about whether they engage in various activities or not. Those are highly structured questions. On the other hand, in administering some commonly used personality measures, the examiner provides an unstructured projective stimulus such as an inkblot or a picture. The test-taker is requested to describe what they see or imagine the inkblot or picture to be describing. The premise of these projective measures is that when presented with ambiguous stimuli an individual will project his or her underlying and unconscious motivations and attitudes. The scoring of these latter measures is often more complex than it is for structured measures. There is great variety in cognitive tests and what they measure, thus requiring a lengthier explanation. Cognitive tests are often separated into tests of ability and tests of achievement; however, this distinction is not as clear-cut as some would portray it. Both types of tests involve learning. Both kinds of tests involve what the test-taker has learned and can do. Conversely, one can also have a vocabulary test based on words one learns only in an academic setting. Intelligence tests are so prevalent in many clinical psychology and neuropsychology situations that we also consider them as neuropsychological measures. Some abilities are measured using subtests from intelligence tests; for example, certain working memory tests would be a common example of an intelligence subtest that is used singly as well. There are also standalone tests of many kinds of specialized abilities. Some ability tests are broken into verbal and performance tests. Verbal tests, obviously enough, use language to ask questions and demonstrate answers. Performance tests on the other hand minimize the use of language; they can involve solving problems that do not involve language. They may involve manipulating objects, tracing mazes, placing pictures in the proper order, and finishing patterns, for example. This distinction is most commonly used in the case of intelligence tests, but can be used in other ability tests as well. Performance tests are also sometimes used when the test-taker lacks competence in the language of the testing. Many of these tests assess visual spatial tasks. Historically, nonverbal measures were given as intelligence tests for non-English speaking soldiers in the United States as early as World War I. These tests continue to be used in educational and clinical settings given their reduced language component. Different cognitive tests are also considered to be speeded tests versus power tests. A truly speeded test is one that everyone could get every question correct if they had enough time. Some tests of clerical skills are exactly like this; they may have two lists of paired numbers, for example, where some pairings contain two identical numbers and other pairings are different. The test-taker simply circles the pairings that are identical. Pure power tests are measures in which the only factor influencing performance is how much the test-taker knows or can do. A true power test is one where all test-takers have enough time to do their best; the only question is what they can do. Obviously, few tests are either purely speeded or purely power tests. Most have some combination of both. For example, a testing company may use a rule of thumb that 90 percent of test-takers should complete 90 percent of the questions; however, it should also be clear that the purpose of the testing affects rules of thumb such as this. Few teachers would wish to have many students unable to complete the tests that they take in classes, for example. When test-takers have disabilities that affect their ability to respond to questions quickly, some measures provide extra time, depending upon their purpose and the nature of the characteristics being assessed. Questions on both achievement and ability tests can involve either recognition or free-response in answering. In educational and intelligence tests, recognition tests typically include multiple-choice questions where one can look for the correct answer among the options, recognize it as correct, and select it as the correct answer. One must recall or solve the question without choosing from among alternative responses. This distinction also holds for some non-cognitive tests, but the latter distinction is discussed later in this section because it focuses not on recognition but selections. For example, a recognition question on a non-cognitive test might ask someone whether they would rather go ice skating or to a movie; a free recall question would ask the respondent what they like to do for enjoyment. Cognitive tests of various types can be considered as process or product tests. Take, for example, mathematics tests in school. In some instances, only getting the correct answer leads to a correct response. In other cases, teachers may give partial credit when a student performs the proper

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operations but does not get the correct answer. Similarly, psychologists and clinical neuropsychologists often observe not only whether a person solves problems correctly i. Test Administration One of the most important distinctions relates to whether tests are group administered or are individually administered by a psychologist, physician, or technician. Tests that traditionally were group administered were paper-and-pencil measures. Often for these measures, the test-taker received both a test booklet and an answer sheet and was required, unless he or she had certain disabilities, to mark his or her responses on the answer sheet. In recent decades, some tests are administered using technology i. There may be some adaptive qualities to tests administered by computer, although not all computer-administered tests are adaptive technology-administered tests are further discussed below. An individually administered measure is typically provided to the test-taker by a psychologist, physician, or technician. More faith is often provided to the individually administered measure, because the trained professional administering the test can make judgments during the testing that affect the administration, scoring, and other observations related to the test. Tests can be administered in an adaptive or linear fashion, whether by computer or individual administrator. A linear test is one in which questions are administered one after another in a pre-arranged order. Typically, if the test-taker is answering the first questions correctly or in accordance with preset or expected response algorithms, for example, the next questions are still more difficult until the level appropriate for the examinee performance is best reached or the test is completed. If one does not answer the first questions correctly or as typically expected in the case of a non-cognitive measure, then easier questions would generally be presented to the test-taker. Tests can be administered in written keyboard or paper-and-pencil fashion, orally, using an assistive device most typically for individuals with motor disabilities , or in performance format, as previously noted. It is generally difficult to administer oral or performance tests in a group situation; however, some electronic media are making it possible to administer such tests without human examiners. Another distinction among measures relates to who the respondent is. In most cases, the test-taker him- or herself is the respondent to any questions posed by the psychologist or physician. In the case of a young child, many individuals with autism, or an individual, for example, who has lost language ability, the examiner may need to ask others who know the individual parents, teachers, spouses, family members how they behave and to describe their personality, typical behaviors, and so on. Scoring Differences Tests are categorized as objectively scored, subjectively scored, or in some instances, both. An objectively scored instrument is one where the correct answers are counted and they either are, or they are converted to, the final scoring. Such tests may be scored manually or using optical scanning machines, computerized software, software used by other electronic media, or even templates keys that are placed over answer sheets where a person counts the number of correct answers. Sometimes subjective scores may include both quantitative and qualitative summaries or narrative descriptions of the performance of an individual. Scores on tests are often considered to be norm-referenced or normative or criterion-referenced. Norm-referenced cognitive measures such as college and graduate school admissions measures inform the test-takers where they stand relative to others in the distribution. For example, an applicant to a college may learn that she is at the 60th percentile, meaning that she has scored better than 60 percent of those taking the test and less well than 40 percent of the same norm group. Likewise, most if not all intelligence tests are norm-referenced, and most other ability tests are as well. In recent years there has been more of a call for criterion-referenced tests, especially in education Hambleton and Pitoniak, High school graduation tests, licensure tests, and other tests that decide whether test-takers have met minimal competency requirements are examples of criterion-referenced measures.

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### 2: 6: Diagnostic Rating Scales and Psychiatric Instruments | Clinical Gate

*Cultural factors influencing the selection, use, and interpretation of psychiatric measures --Ch. 6. Diagnostic interviews for adults -- Ch. 7. General psychiatric symptoms measures -- Ch. 8.*

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### 3: Chapter 5: Identifying Market Opportunities Through Marketing Information Systems And Research

*cultural factors influencing the selection, use, and interpretation of psychiatric measures* section ii: general measures (non--disorder specific) chapter 5. DIAGNOSTIC MEASURES FOR ADULTS Chapter 6. GENERAL PSYCHIATRIC SYMPTOMS MEASURES Chapter 7.

In their report, the subcommittee recommended that the conceptual model of psychological abilities required for work, as currently used by SSA through the MRFC assessment, be revised to redress shortcomings and be based on scientific evidence. The subcommittee identified four major categories of psychological functioning essential to work: Each of these functional domains would also be relevant areas of assessment in children applying for disability support. As indicated below, there are standardized measures that have been well normed and validated for pediatric populations. Interpretation of test results in children is more challenging, as it must take into account the likelihood of developmental progress and response to any interventions. Thus, the permanency of cognitive impairments identified in childhood is more difficult to ascertain in a single evaluation. Page Share Cite Suggested Citation: Psychological Testing in the Service of Disability Determination. The National Academies Press. It was beyond the scope of this committee and report to identify and describe each available standardized measure; thus, only a few commonly used tests are provided as examples for each domain. The choice of examples should not be seen as an attempt by the committee to identify or prescribe tests that should be used to assess these domains within the context of disability determinations. For a more comprehensive list and review of cognitive tests, readers are referred to the comprehensive textbooks, Neuropsychological Assessment Lezak et al. Intellectual disability affects functioning in three domains: Language and Communication The domain of language and communication focuses on receptive and expressive language abilities, including the ability to understand spoken or written language, communicate thoughts, and follow directions American Psychiatric Association, ; OIDAP, The mental functions of language include reception of language i. Abilities related to communication include receiving and producing messages spoken, nonverbal, written, or formal sign language , carrying on a conversation starting, sustaining, and ending a conversation with one or many people or discussion starting, sustaining, and ending an examination of a matter, with arguments for or against, with one or more people , and use of communication devices and techniques telecommunications devices, writing machines WHO, In a survey of historical governmental and scholarly data, Ruben found that communication disorders were generally associated with higher rates of unemployment, lower social class, and lower income. A wide variety of tests are available to assess language abilities; some prominent examples include the Boston Naming Test Kaplan et al. Learning and Memory This domain refers to abilities to register and store new information e. However, it is important to note that semantic, autobiographical, and implicit memory are generally preserved in all but the most severe forms of neurocognitive dysfunction American Psychiatric Association, ; OIDAP, Attention and Vigilance Attention and vigilance refers to the ability to sustain focus of attention in an environment with ordinary distractions OIDAP, Normal functioning in this domain includes the ability to sustain, shift, divide, and share attention WHO, Persons with impairments in this domain may have difficulty attending to complex input, holding new information in mind, and performing mental calculations. They may also exhibit increased difficulty attending in the presence of multiple stimuli, be easily distracted by external stimuli, need more time than previously to complete normal tasks, and tend to be more error prone American Psychiatric Association, Tests for deficits in attention and vigilance include a variety of continuous performance tests e. This domain reflects mental efficiency and is central to many cognitive functions NIH, n. Executive Functioning Executive functioning is generally used as an overarching term encompassing many complex cognitive processes such as planning, prioritizing, organizing, decision making, task switching, responding to feedback and error correction, overriding habits and inhibition, and mental flexibility American Psychiatric Association, ; Elliott, ; OIDAP, Patients with such impairments will often have difficulty

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completing complex, multistage projects or resuming a task that has been interrupted American Psychiatric Association, Because executive functioning refers to a variety of processes, it is difficult or impossible to assess executive functioning with a single measure. The majority of cognitive tests have normative data from groups of people who mirror the broad demographic characteristics of the population of the United States based on census data. As a result, the normative data for most measures reflect the racial, ethnic, socioeconomic, and educational attainment of the population majorities. Unfortunately, that means that there are some individuals for whom these normative data are not clearly and specifically applicable. This does not mean that testing should not be done with these individuals, but rather that careful consideration of normative limitations should be made in interpretation of results. Selection of appropriate measures and assessment of applicability of normative data vary depending on the purpose of the evaluation. Clearly, each of these purposes could be relevant for SSA disability determinations. However, each of these instances requires different interpretation and application of normative data. Unfortunately, it is rare that an individual has a formal assessment of his or her premorbid cognitive functioning. Thus, comparison of the postinjury performance to demographically matched normative data provides the best comparison to assess a change in functioning Freedman and Manly, ; Heaton et al. In many instances, this type of data is provided in alternative normative data sets rather than the published population-based norms provided by the test publisher. In this situation, use of otherwise appropriate standardized and psychometrically sound performance-based or cognitive tests is appropriate. To make this determination, the most appropriate comparison group for any individual would be other individuals who are currently completing the expected vocational tasks without limitations or disability Freedman and Manly, Unfortunately, there are few standardized measures of skills necessary to complete specific vocational tasks and, therefore, also no vocational-specific normative data at this time. Until such specific vocational functioning measures exist and are readily available for use in disability determinations, objective assessment of cognitive skills that are presumed to underlie specific functions will be Page Share Cite Suggested Citation: Despite limitations in normative data as outlined in Freedman and Manly , formal psychometric assessment can be completed with individuals of various ethnic, racial, gender, educational, and functional backgrounds. Use of appropriate standardized measures by appropriately qualified evaluators as outlined in the following sections further mitigates the impact of normative limitations. Interpretation requires assigning some meaning to the standardized score within the individual context of the specific test-taker. There are several methods or levels of interpretation that can be used, and a combination of all is necessary to fully consider and understand the results of any evaluation Lezak et al. This section is meant to provide a brief overview; although a full discussion of all approaches and nuances of interpretation is beyond the scope of this report, interested readers are referred to various textbooks e. One example of an interpretative approach would be that a performance within one standard deviation of the mean would be considered broadly average. Performances one to two standard deviations below the mean are considered mildly impaired, and those two or more standard deviations below the mean typically are interpreted as being at least moderately impaired. This type of comparison allows for identification of a pattern of strengths and weaknesses. However, if there is significant variability in performances across domains, then a specific pattern of impairment may be indicated. Profile Analysis When significant variability in performances across functional domains is assessed, it is necessary to consider whether or not the pattern of functioning is consistent with a known cognitive profile. That is, does the individual demonstrate a pattern of impairment that makes sense or can be reliably explained by a known neurobehavioral syndrome or neurological disorder. For example, an adult who has sustained isolated injury to the temporal lobe of the left hemisphere would be expected to demonstrate some degree of impairment on some measures of language and verbal memory, but to demonstrate relatively intact performances on measures of visual-spatial skills. This pattern of performance reflects a cognitive profile consistent with a known neurological injury. Conversely, a claimant who demonstrates impairment on all measures after sustaining a brief concussion would be demonstrating a profile of impairment that is inconsistent with research data indicating full cognitive recovery

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within days in most individuals who have sustained a concussion McCrea et al. Interpreting Poor Cognitive Test Performance Regardless of the level of interpretation, it is important for any evaluator to keep in mind that poor performance on a set of cognitive or neuropsychological measures does not always mean that an individual is truly impaired in that area of functioning. In instances of inconsistent or unexpected profiles of performance, a thorough interpretation of the psychometric data requires use of additional information. To answer the latter question, administration of performance validity tests PVTs as part of the cognitive or neuropsychological evaluation battery can be helpful. Interpretation of PVT data must be undertaken carefully. Particular attention must be paid to the limitations of the normative data available for each PVT to date. As such, a simple interindividual interpretation of PVT testing results is not acceptable or valid. Rather, consideration of intraindividual patterns of performance on various cognitive measures is an essential component of PVT interpretation. PVTs will be discussed in greater detail later in this chapter. Qualifications for Administering Tests Given the need for the use of standardized procedures, any person administering cognitive or neuropsychological measures must be well trained in standardized administration protocols. He or she should possess the interpersonal skills necessary to build rapport with the individual being tested in order to foster cooperation and maximal effort during testing. Additionally, individuals administering testing should understand important psychometric properties, including validity and reliability, as well as factors that could emerge during testing to place either at risk as described in Chapter 3. Many doctoral-level psychologists are well trained in test administration. In general, psychologists from clinical, counseling, school, or educational graduate psychology programs receive training in psychological test administration. However, the functional domains of emphasis in most of these programs include intellectual functioning, academic achievement, aptitude, emotional functioning, and behavioral functioning APA, Neuropsychologists are clinical psychologists trained in the science of brain-behavior relationships. The clinical neuropsychologist specializes in the application of assessment and intervention principles based on the scientific study of human behavior across the lifespan as it relates to normal and abnormal functioning of the central nervous system. HNS, That is, a neuropsychologist is trained to evaluate functioning within specific cognitive domains that may be affected or altered by injury to or disease of the brain or central nervous system. For example, a claimant applying for disability due to enduring attention or memory dysfunction secondary to a TBI would be most appropriately evaluated by a neuropsychologist. They do not practice independently, but rather work under the close supervision and direction of doctoral-level clinical psychologists. Qualifications for Interpreting Test Results Interpretation of testing results requires a higher degree of clinical training than administration alone. Most doctoral-level clinical psychologists who have been trained in psychometric test administration are also trained in test interpretation. As stated in the existing SSA n. The reason for the evaluation, or more specifically, the type of claim of impairment, may suggest a need for a specific type of qualification of the individual performing and especially interpreting the evaluation. As stated in existing SSA n. More specifically, clinical neuropsychologists have been trained to interpret more complex and comprehensive cognitive or neuropsychological batteries that could include assessment of specific cognitive functions, such as attention, processing speed, executive functioning, language, visual-spatial skills, or memory. The standardization of neuropsychological tests allows for comparability across test administrations. As discussed in detail in Chapter 2 , a number of studies have examined potential for malingering when there is a financial incentive for appearing impaired, suggesting anywhere from 19 to 68 percent of SSA disability applicants may be performing below their capability on cognitive tests or inaccurately reporting their symptoms Chafetz, ; Chafetz et al. However, an individual may put forth less than optimal effort due to a variety of factors other than malingering, such as pain, fatigue, medication use, and psychiatric symptomatology Lezak et al.

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### 4: Handbook of psychiatric measures ( edition) | Open Library

*Considerations in choosing, using, and interpreting measures for health care systems Ch. 5. Cultural factors influencing the selection, use, and interpretation of psychiatric measures.*

Performance validity tests do not measure cognition, but are used in conjunction with performance-based cognitive tests to examine whether the examinee is exerting sufficient effort to perform well and responding to the best of his or her capability. Similarly, symptom validity tests do not measure non-cognitive status, but are used to examine whether a person is providing an accurate report of his or her actual symptom experience. Because cognitive tests frequently are performance based and non-cognitive measures generally involve self-report, performance validity tests and symptom validity tests are shown as being associated with these types of tests. The scoring of these latter measures is often more complex than it is for structured measures. There is great variety in cognitive tests and what they measure, thus requiring a lengthier explanation. Cognitive tests are often separated into tests of ability and tests of achievement; however, this distinction is not as clear-cut as some would portray it. Both types of tests involve learning. Both kinds of tests involve what the test-taker has learned and can do. Psychological Testing in the Service of Disability Determination. The National Academies Press. Conversely, one can also have a vocabulary test based on words one learns only in an academic setting. Intelligence tests are so prevalent in many clinical psychology and neuropsychology situations that we also consider them as neuropsychological measures. Some abilities are measured using subtests from intelligence tests; for example, certain working memory tests would be a common example of an intelligence subtest that is used singly as well. There are also standalone tests of many kinds of specialized abilities. Some ability tests are broken into verbal and performance tests. Verbal tests, obviously enough, use language to ask questions and demonstrate answers. Performance tests on the other hand minimize the use of language; they can involve solving problems that do not involve language. They may involve manipulating objects, tracing mazes, placing pictures in the proper order, and finishing patterns, for example. This distinction is most commonly used in the case of intelligence tests, but can be used in other ability tests as well. Performance tests are also sometimes used when the test-taker lacks competence in the language of the testing. Many of these tests assess visual spatial tasks. Historically, nonverbal measures were given as intelligence tests for non-English speaking soldiers in the United States as early as World War I. These tests continue to be used in educational and clinical settings given their reduced language component. Different cognitive tests are also considered to be speeded tests versus power tests. A truly speeded test is one that everyone could get every question correct if they had enough time. Some tests of clerical skills are exactly like this; they may have two lists of paired numbers, for example, where some pairings contain two identical numbers and other pairings are different. The test-taker simply circles the pairings that are identical. Pure power tests are measures in which the only factor influencing performance is how much the test-taker knows or can do. A true power test is one where all test-takers have enough time to do their best; the only question is what they can do. Obviously, few tests are either purely speeded or purely power tests. Most have some combination of both. For example, a testing company may use a rule of thumb that 90 percent of test-takers should complete 90 percent of the questions; however, it should also be clear that the purpose of the testing affects rules of thumb such as this. Few teachers would wish to have many students unable to complete the tests that they take in classes, for example. When test-takers have disabilities that affect their ability to respond to questions quickly, some measures provide extra time, depending upon their purpose and the nature of the characteristics being assessed. Page 92 Share Cite Suggested Citation: In educational and intelligence tests, recognition tests typically include multiple-choice questions where one can look for the correct answer among the options, recognize it as correct, and select it as the correct answer. One must recall or solve the question without choosing from among alternative responses. This distinction also holds for some non-cognitive tests, but the latter distinction is discussed later in this section because it focuses not on recognition but selections.

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Often for these measures, the test-taker received both a test booklet and an answer sheet and was required, unless he or she had certain disabilities, to mark his or her responses on the answer sheet. In recent decades, some tests are administered using technology i. There may be some adaptive qualities to tests administered by computer, although not all computer-administered tests are adaptive technology-administered tests are further discussed below. An individually administered measure is typically provided to the test-taker by a psychologist, physician, or technician. More faith is often provided to the individually administered measure, because the trained professional administering the test can make judgments during the testing that affect the administration, scoring, and other observations related to the test. Tests can be administered in an adaptive or linear fashion, whether by computer or individual administrator. A linear test is one in which questions are administered one after another in a pre-arranged order. Typically, if the test-taker is answering the first questions correctly or in accordance with preset or expected response algorithms, for example, the next questions are still more difficult until the level appropriate for the examinee performance is best reached or the test is completed. If one does not answer the first questions correctly or as typically expected in the case of a non-cognitive measure, then easier questions would generally be presented to the test-taker. Tests can be administered in written keyboard or paper-and-pencil fashion, orally, using an assistive device most typically for individuals with motor disabilities , or in performance format, as previously noted. It is generally difficult to administer oral or performance tests in a group situation; however, some electronic media are making it possible to administer such tests without human examiners. 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Sometimes subjective scores may include both quantitative and qualitative summaries or narrative descriptions of the performance of an individual. Scores on tests are often considered to be norm-referenced or normative or criterion-referenced. Norm-referenced cognitive measures such as college and graduate school admissions measures inform the test-takers where they stand relative to others in the distribution. For example, an applicant to a college may learn that she is at the 60th percentile, meaning that she has scored better than 60 percent of those taking the test and less well than 40 percent of the same norm group. Likewise, most if not all intelligence tests are norm-referenced, and most other ability tests are as well. Page 94 Share Cite Suggested Citation: High school graduation tests, licensure tests, and other tests that decide whether test-takers have met minimal competency requirements are examples of criterion-referenced measures. Test Content As noted previously, the most important distinction among most psychological tests is whether they are assessing cognitive versus non-cognitive qualities. In clinical psychological and neuropsychological settings such as are the concern of

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this volume, the most common cognitive tests are intelligence tests, other clinical neuropsychological measures, and performance validity measures. Many tests used by clinical neuropsychologists, psychiatrists, technicians, or others assess specific types of functioning, such as memory or problem solving. Performance validity measures are typically short assessments and are sometimes interspersed among components of other assessments that help the psychologist determine whether the examinee is exerting sufficient effort to perform well and responding to the best of his or her ability. Most common non-cognitive measures in clinical psychology and neuropsychology settings are personality measures and symptom validity measures. Some personality tests, such as the Minnesota Multiphasic Personality Inventory MMPI , assess the degree to which someone expresses behaviors that are seen as atypical in relation to the norming sample. Symptom validity measures are scales, like performance validity measures, that may be interspersed throughout a longer assessment to examine whether a person is portraying him- or herself in an honest and truthful manner. Somewhere between these two types of tests—cognitive and non-cognitive—are various measures of adaptive functioning that often include both cognitive and non-cognitive components. Page 95 Share Cite Suggested Citation:

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### 5: DSM-5 Conceptual Changes: Innovations, Limitations and Clinical Implications

*Handbook of Psychiatric Measures - www.enganchecubano.com chapter 4. cultural factors influencing the selection, use, and interpretation of psychiatric measures section ii: general measures (non-disorder specific) chapter 5. diagnostic measures for adults chapter 6. general psychiatric symptoms measures chapter 7. mental health status.*

The male and female split will then be in proportion to the age groupings, according to the actual population percentages. So the final quota sample will be according to sex and age. Suppose a seller of tractors wishes to measure a population with respect to the percentage. Generally, then, for percentages, the sample size may be calculated using: Analytical techniques for researching international market: Besides the usual descriptive data analysis methods, there are a number of other techniques which can be used in analysing market potential. Statistics can be obtained from in country sources. Describe the relationship between demand for goods and changes in income. This could, for example, show what could happen to the demand for basic agricultural products, if income rises. In theory, it should decline. If Zimbabwe, for example, introduces a new form of tobacco drying, it is likely the other tobacco producing countries around it will do the same. One of these methods is analogy. There are two ways of using this technique, one is by cross sectional comparison, the other by time series analysis. Cross sectional analysis assumes that a factor which correlates with demand in country A could be translated to country B. Time analysis is a similar technique but adds the time dimension, very similar to the estimate of the stage in the international life cycle. One USA chemical company found that soup consumption was the only reliable index forecasting sales in Asia. There are limitations to the analysis. These include whether the two countries can really be compared, whether technical or social developments have led to a leapfrogging of the product under consideration, and whether the difference between potential and actual demand which could depend on other factors like price, adaptability etc. Comparative analysis, say between countries on intracompany, intercompany, national - subnational markets can be useful for estimating potential demand. It is not unreasonable, say, to compare Zambia and Tanzania. Computer packages exist to cluster similarities and differences between countries which may show factors which could be common and therefore potential markets. Such packages include multidimensional or clustering techniques. MFIs indirectly measure potential demand, using variables that either intuition or statistical analysis suggest can be closely correlated with the potential demand for the product under review. Variables should be restricted to those which relate to product demand and these may be GNP, net national income or total population. In assessing the demand for coffee appliances, for example, an index which includes coffee drinkers and type of coffee consumed would be useful. A very useful and powerful tool. The procedure selects the independent variable that accounts for the most variance in the dependent variable, then the variable that accounts for the remaining variance etc. Often multiple regression is needed as a single variable will not do. Predictions are often made on market demand for products based on what would happen if GNP were increased. As seen earlier, an increase in GNP could be good for luxury or durable goods but not basic commodities. However, high GNP per capita, may be a good predictor of, say, exotic high value horticultural produce, out of season produce or technological advanced agricultural machinery. Location of research facility It is always a burning question as to where to locate the research, in-country or "at home". In general the more "distant" the country, the better it is to locate the research in-country. Surveillance techniques could, on the other hand, be mainly conducted at home. The following case shows what happened to the Tanzanian sisal industry due, in part, to the lack of a global intelligence facility. Basically, it failed to take account of the shrink in demand for sisal fibre in Western Europe. Many sisal mills were being dosed because of the fact that they were old and labour intensive hence uneconomic, and the: Sisal was brought into Tanzania by a German Agronomist, Dr. Richard Hingdorf in and the first estates were established in Tanga and Morogoro regions. British and Asians, although a number of Germans re-acquired their estates from onwards. Production was around - tonnes per annum. Since then production has stagnated at around 30 - 33 tonnes per annum. Needless to say Tanzania has long since

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ceased to be the number one world producer and its export earnings fallen well behind that of coffee, cotton tea, tobacco and cashewnuts. The decline in sisal production came in two stages, an initial stage up to and then onwards. Both internal and external factors account for the decline. In the second stage liquidity problems affected production. However, the external factors in the two periods had the most significant effect and show clearly the consequences of an ill prepared intelligence system. In the initial stage up to Tanzania experienced declining world prices of sisal fibre and the introduction of a substitute, cheap synthetic fibre -polypropylene twines. These factors led to low investment in replanting, leaf transport facilities and factory machines at the estate level. An inability to pick up these changes in demand by the intelligence system was a major player in the industry collapse. However, there is a ray of hope with a new swing worldwide to more "greener" and more environmentally friendly products. Tanzania sisal could make a comeback. These are as follows: Many of these facets apply more to developing than developed countries. However using a variety of methods, outlined in the section, a lot of them can be ingeniously overcome. Whilst the gathering of information in the international context is fraught with difficulties, without it the marketer would be planning in the dark. The two most important modes of scanning are surveillance and search, each giving data of a general or specific kind, invaluable to the strategy formulation process. In all decisions whether to obtain data or not, costs versus benefits have to be considered carefully. Chapter Summary Such is the uncertainty surrounding doing business globally, that without some form of intelligence system, organisations will most certainly founder. Whether the organisation obtains information itself or through the help of outside agencies, it must first determine the purpose for which the information is to be used, then how it is to be collected and analysed, taking into account cost and time considerations. It is often cheaper and less time consuming to use already available published data, but this can be too general, dated and not in the form required. In this case primary data collection may be required, involving decisions on the research design, method of data collection, sample type, and size and method of analysis. Collecting intelligence data internationally can be fraught with hidden dangers including lack of access to respondents and misinterpretation due to cultural differences.

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### 6: Handbook of psychiatric measures - JH Libraries

*Ch. 4 Cultural Factors Influencing the Selection, Use, and Interpretation of Psychiatric Measures / Maritza Rubio-Stipec / Ian Canino / Madelyn Hsiao-Rei Hicks / Ming T. Tsuang Sect. II General Measures (Non-Disorder Specific).*

Gintner The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition DSM-5 includes numerous alterations to specific disorders, as well as fundamental conceptual and organizational changes. The purpose of this article is to review three fundamental conceptual changes in DSM For each change, potential benefits and shortcomings are discussed in terms of innovation, limitations and clinical implications. Considering this scope of influence, the release of its latest edition, DSM-5 American Psychiatric Association [APA], , has garnered considerable interest among professionals, patient advocacy groups and the public alike Paris, The strength of this reactionâ€”both positive and negativeâ€”reflects the scope of change. The purpose of this article is to review three of these fundamental conceptual changes: For each of these innovations, three questions will be addressed. First, what was the basis for introducing the change as an innovation to the manual? Here the rationale and potential contribution of the change will be discussed. Special attention will be paid to issues such as enhanced diagnostic accuracy, coverage and clinical utility. Second, does the innovation have any potential drawbacks or limitations? For example, to what extent could the innovation contribute to over or underdiagnosis, limit access to treatment, or pose some harm like increased stigmatization? Third, what are the practical consequences of the innovation relative to how clinical mental health counselors provide care for their clients? This section considers the impact on day-to-day practice and how the diagnostic process itself may be transformed. The conclusion section ties these three threads of innovations together and discusses implications for mental health practice in the 21st century. As part of the United Nations Charter, countries around the world have agreed to use the ICD codes to report mortality, morbidity and other health information so that uniform statistics can be compiled. The DSM and ICD classifications of mental disorders have a number of similarities, but also have important differences. Both are descriptive classifications that categorize mental disorders based upon a constellation or syndrome of symptoms and signs. Signs, on the other hand, are observable client behaviors such as crying, rapid speech, and flat affect. The names and diagnostic descriptions for many of the mental disorders in the ICD are similar to those in the DSM, a consequence of collaboration over the years and a shared empirical pool from which both have drawn. Despite these similarities, there are significant disparities. First, DSM criteria are very specific and detailed, while the ICD relies more on prototype descriptions with less detailed criteria and minimal background information to guide the diagnostic process First, ; Paris, ; Stein et al. The ICD, on the other hand, has always employed a nonaxial system that simply lists medical disorders, mental disorders, and other health conditions. These differences in complexity reflect the constituencies that each manual is designed to serve: A third discrepancy is that the names and descriptions for many disorders differ, which at times reflects marked conceptual differences First, As another example, the definition of the type of trauma that qualifies for post-traumatic stress disorder PTSD is much broader in ICD allowing for events that are exceptionally threatening or catastrophic than in DSM-IV-TR requiring that the event must be associated with actual or threatened death, serious injury, or threat to the physical integrity. These ICD-DSM disparities have led to difficulties comparing research results, collecting health statistics, communicating diagnostic information and reaching similar diagnostic decisions APA, ; First, ; Widiger, Like conversing in two different languages, the diagnosis has often been lost in translation. Innovation From the outset of the DSM-5 development process there was a concerted effort to address these disparities. The goal was to find ways of harmonizing structural, conceptual and disorder-specific differences. The most significant impact of the harmonizing effort is the discontinuation of the multiaxial system in DSM Unlike the GAF, however, this rating is not required and serves only as an ancillary tool. In this example, borderline personality disorder is a secondary diagnosis. The V code is noted because it is an important area to target in the treatment plan. There were three major reasons for abandoning

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the multi-axial system. First, health professionals in general medicine found it difficult to use because it was so different from the ICD format Kupfer et al. Second, the multi-axial system contributed to the idea that mental disorders were qualitatively different from medical disorders, a dated dualistic distinction between mind and body APA, ; Kupfer et al. Third, research had shown that distinctions between Axes I and II were artificial and did not reflect that these axes actually overlapped considerably Lilienfeld et al. Thus, the multi-axial system seemed to create artificial distinctions that did not seem valid Lilienfeld et al. The ICD, on the other hand, offered a more simplified system that allowed a diverse group of health professionals to code disorders using a similar format. Substantial harmonization of the manuals, however, will happen in the future. Limitations Despite the potential contribution of this harmonization, there are three major drawbacks to consider. First, the loss of the multi-axial system may compromise the richness of the diagnostic assessment. In a sense, the multi-axial system was holistic in that it provided a way of noting prominent psychiatric conditions, maladaptive personality functioning, medical conditions, relevant stressors and environmental problems, and overall functioning. What will prompt clinicians to consider these important domains remains unclear. However, these tasks are not required in the diagnostic workup and, if history is any guide, will probably be underutilized. This risks a reductionistic conceptualization of mind as simply brain. The direction in which the diagnostic train is heading is clear. The question is whether the track can be altered to one that is more balanced and biopsychosocial. The ICD codes that have been selected often do not map well onto these disorders. As another example, binge eating disorder was added to DSM-5 to recognize individuals who had a pattern of maladaptive bingeing episodes, but did not have the compensatory behaviors e. The ICD code selected for this disorder was, nevertheless, bulimia nervosa. Because ICD is updated annually, it may be that more appropriate codes will be made available in future years. Thus, while ICD-DSM consilience has occurred, at least to this point, it has been superficial and restricted to the non-axial formatting of the diagnosis. Clearly, it may enhance the curb appeal of DSM-5 to the medical community, but the real interior renovation is yet to occur, awaiting ICD Clinical Implications The demise of the multi-axial system means that mental health counselors must be more intentionally biopsychosocial in their diagnostic assessments. More meat can be put on the bare-bones non-axial system by systematically assessing these biological, psychological and sociocultural factors. This can be accomplished by always assessing whether any important contextual factors can be noted using the V codes, which will be termed Z codes when ICD goes into effect. While these measures are not part of the formal diagnosis, they can be noted in the chart and inform treatment planning. Many insurance companies require a multi-axial diagnosis. The GAF score was often used to justify level of care. At the time of this writing, it is not clear what insurance companies will do with these modifications. The decision here will be important. What insurance companies require, for better or worse, often has profound impact on what clinicians do and the kind of clinical care they deliver. Clinicians make a yes-no decision about whether or not an individual has a disorder, based upon the particular criteria. First, comorbidity is common and there is some question as to whether comorbid conditions such as depression and anxiety are distinct or are really different expressions of some shared underlying dysfunction Lilienfeld et al. This is problematic because NOS is not particularly informative in terms of describing the condition or making decisions about treatments. Finally, a categorical system assumes that each disorder is homogenous and that disorder occurs at the particular cut point. There is no recognition of subthreshold symptoms, and there is the assumption that those who do fulfill the criteria are qualitatively similar. In this sense, categorical assignment loses potentially useful clinical information about the condition and about what treatment strategies might be indicated. Innovation DSM-5 attempts to address this issue by introducing dimensionality to supplement the categorical approach APA, While categories indicate differences in kind, dimensions describe variations in degree Lilienfeld et al. From this perspective, mental disorders are considered to lie on a continuum, like blood pressure. Theoretically, the spectrum can run from optimal functioning to significant impairment. Markers of morbidity or adverse outcome determine where on the spectrum the cut point for disorder is drawn. This dimensionality allows for more fine-grained determination of not only severity or impairment, but also

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improvement or deterioration. Dimensionality is incorporated into DSM-5 in three general ways. First, DSM-5 has added several formal spectrum disorders, which combine highly related disorders. Another spectrum disorder is substance use disorder, which blends the former categories of abuse and dependence. The somatic spectrum is captured by somatic symptoms disorder, which merges what was formerly somatization disorder, pain disorder and undifferentiated somatoform disorder. For each of these spectrum disorders, DSM-5 provides a severity rating as well as other specifiers to note degree of impairment and complicating features. A second way that dimensionality is infused into DSM-5 is that severity ratings and an expanded list of specifiers have been placed within the existing categories. In a sense, DSM-5 tries to dimensionalize the category. While this was done to some extent in previous editions, DSM-5 broadens this effort throughout the manual. For example, a number of new specifiers were added to describe mood episodes such as anxious distress presence of comorbid anxiety, mixed features presence of symptoms from the opposite mood pole, and peripartum onset onset of symptoms sometime during pregnancy through one month post-delivery. For example, severity ratings are an important consideration in deciding whether to use psychotherapy or medication for the treatment of major depressive disorder APA. A third way that dimensionality is being promoted in DSM-5 is through the availability of a variety of online assessment measures APA. These are rating scales that fall into three general categories. First, there are disorder-specific measures that correspond closely to the diagnostic criteria. These measures could be used to buttress the more clinical assessment that relies on the diagnostic criteria. Measures are available for a range of disorders including depression, many of the anxiety disorders, PTSD, acute stress disorder and dissociative symptoms. Versions are available for adults as well as children aged 11 and older. Most of these are self-completed but some are clinician-rated. A third type of measure is referred to as cross-cutting symptom measures CCSM. Similar to a broadband assessment of bodily systems in medicine, these measures assess common psychiatric symptoms that may present across diagnostic boundaries and may be clinically significant to note in the overall treatment plan. Level 1 CCSM is a brief survey of 13 domains of symptoms. A more in-depth Level 2 assessment measure is available for a domain that indicates a significantly high rating. These measures can be reproduced and used freely by researchers and clinicians and can be downloaded at <http://www.psychiatry.org/pubs/tools>. Use of these types of measure is hoped to add surplus information that can aid diagnosis, case monitoring and treatment planning.

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