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DEPARTMENT OF STUDIES AND RESEARCH IN PSYCHOLOGY

M.Sc PSYCHOLOGY THIRD SEMESTER

COURSE-15 : EXPERIMENTAL PSYCHOLOGY PRACTICAL-III

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COURSE-15

EXPERIMENTAL PSYCHOLOGY PRACTICAL –III

INTRODUCTION

Dear students,

This course Experimental Psychology –Practical III is mainly designed to cater to the needs of the knowledge required for a clinical assessment in Psychology. Various Psychological tests and other Psychological assessment instruments and procedures are used extensively for research purposes in Psychology. At the same time Psychological assessments are used in various areas like clinical setting, research , educational field, vocational selection. Psychologists are observers, investigators, and explorers of human behavior. Psychological tests are used for assessment, analysis of behavior of an individual or a group, for further modification based on the knowledge obtained from assessment. Psychological testing provides valuable data in applied areas such as educational and employment selection and placement. Psychodiagnosis and treatment planning and also in any situation that involves making decisions about people, programs and procedures. Psychological assessment is utilized in several applied contexts like educational, occupational, clinical, health, legal and environmental.

In clinical setting, Clinical Psychologists usually spend more time on treatment, consultation, research, teaching and other activities. Clinical assessment is done for the purposes of identifying and diagnosing disorders of behavior and cognition for the planning of treatments or other intervention programmes. It may be in mental hospitals, private offices, administration sectors, medical centers , schools custodial institutions and forensic settings. Clinical Psychologists are called on to conduct Psychological evaluations in mental health settings for the purposes of diagnosis, treatment and residential placement, in medical setting as an aid in planning and evaluating the effectiveness of Psychotherapy and Chemotherapy, in educational settings as an aid in various settings to conduct evaluations required by law.

The general goals of Clinical assessment is to provide an accurate description of the patient's (client's) problems to determine what interpersonal and environmental factors precipitated and are sustaining the problem and to make predictions concerning outcomes with and without intervention. It also includes case study.

Being said the importance of Clinical Assessment and its applications, this Course Experimental Psychology-Practical –III for the IIIrd Semester M.Sc Psychology students provides a knowledge and understanding about Clinical Assessment and various practicals utilized in this aspect. It is very much important for a student of Psychology to understand, learn, master these practical for assessment purposes. Each practical provides you an insight into the area of behavioural assessment in a particular direction. This practical course consists of a detailed information and introduction towards clinical assessment. It explains case study, the process, steps to be conducted. Further eight different practicals are provided by mastering those you will get an underastanding of assessment, observation, analysis of the behavior. By studying this course you will be gaining knowledge about clinical assessment, administration of these Psychological tests and the ability to analyze the behavior with the help of these practical.

Wishing you All the Best

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INTRODUCTION TO PSYCHOLOGICAL ASSESSMENT

In the present day scenario, Psychological testing has created an important influence on the lives and careers of people throughout the world. It has become a very important necessity in all areas of life whether it is for screening purposes, diagnose, research, selection, interviews etc. Whenever any information is needed to help people make decisions about an individual to assist them in selecting their actions for educational or occupational purposes, one or the other Psychological tests are being utilized in this situation. Psychological assessments are usually extensively used in schools, psychological clinics, industry, civil, military services for diagnostic evaluation, selection, placement, promotion purposes. In hospitals, clinics, Mental hospitals assessment is done for identification of psychological symptoms, diagnosis, for planning treatment, intervention etc.

In recent years psychological assessment has gained very much importance. Due to the development of thousands of tests in all the categories like intelligence, memory, Emotional intelligence, scholastic abilities, aptitude testing, interest, motivation, adjustment, personality and all sorts of clinical assessments like case history, Mental status examination, Psychological testing's for various psychological disorders, it has been utilized. As the psychological testing and assessment has gained the utmost importance it has given rise for the professional individuals who can do the as
sessment and provide the necessary help, guidance required for those who come for testing. Hence, psychological testing has become a profession.

Role of a Psychologist in assessment

In psychological assessment, a psychologist evaluates the competencies and the limitations of an individual, and reports them in an objective and helpful manner. Psychological tests have certain core principles in the assessment. They are:

- Tests are samples of behaviour
- Tests should have reliability and validity
- Tests results are interpreted with reference to the individual's age, culture, background.

Psychological assessment is very useful and powerful. The Psychologist who does the assessment should have the skill, knowledge and the training required to administer, interpret the test. A Good Psychologist is the one who can administer the test in the specified manner, interpret and analyze the results objectively and prepare a report, communicating very carefully and cautiously in the presentation language.

Ethics in Psychological Assessment

In psychological assessment there are certain ethical rules which a Psychologist needs to follow in their profession. Ethics refers to the correct rules of conduct necessary when carrying out a psychological assessment. The psychologist needs to remember that they have a duty to respect the rights and dignity of the test taker. This means that the psychologist who is doing assessment must abide by certain moral principles and rules of conduct. The American Psychological Association (APA) and the American Personnel and Guidance Association (APGA) have given the ethical codes pertaining to the test administration. The codes cover test administration, standardization, reliability, and validity.

According to these Ethics the evaluation and diagnosis should be conducted only in a professional context by trained, competent Psychologists using appropriate tests. An application of scientific procedures in designing and selecting tests and techniques that is appropriate for specified populations, judicious, interpretation, of test results, careful use of test scoring and interpretation which should be clear but careful explanation of assessment findings. The psychological assessors must be able to make sound ethical judgements by being sensitive to the needs of examinees, as well as the need of the organizations in which they practice and of society as a whole. While administering the test the tester must keep in mind the following code of conduct. That is they should obtain informed consent, they should be given a brief understanding about the test, protection, of participants, deception should be avoided, high importance for confidentiality, about the individual's test scores and other personal information. Following these codes and adhering to these codes and standards helps ensure that psychological tests and other psychometric instruments and procedures are used by qualified persons in a sensible and sensitive manner.

REFERENCES: 1. Lewis R. Aiken (2000) Psychological Testing and Assessment 10th Edition, Allyn and Bacon, Inc.

2. Anastasi, A & Urbina(1997)Psychological Testing (7th Edition)Upper Saddle River, NJ: Prentice Hall.

CLINICAL ASSESSMENT

INTRODUCTION:

We would readily agree that in order to solve a problem it is necessary (if not sufficient) to "diagnose" it correctly. Whether we are considering a person in distress, or nations in conflict, the route to solutions starts with knowledge of the problem's nature and causes. Diagnosis is necessary for mental health intervention. It is an inevitable part of the clinical process, whether or not special procedures are involved. Diagnosis often involves a systematic study of the patient through the use of specially designed interviews, tests, and observations. Diagnosis serves the clinician's constant need to make decisions about his patient. He must decide whether and how the problem can be treated, what might occur if no intervention took place or if there were particular changes in the patent's life circumstances.

Some judgments required of clinicians are momentous-should a patient be admitted to a hospital or released from one? Should an accused murder be tried for homicide or acquired for "reasons of insanity"? Should a child with a learning problem be transferred to a special school or can remedial work be done in the present setting? Other decisions have constantly to be made in the ongoing work of psychotherapy, such as; is the patient ready to explore a particular problem area? Is that area central or peripheral to his neurotic conflict? Should therapy hours be increased or therapy terminated? The variety of judgments clinicians must make is virtually limitless. "Clinical assessment is the process by which clinicians gain understanding of the patient necessary for making informed decisions. Another meaning of clinical assessment is a way of diagnosing and planning treatment for patient that involves evaluating someone in order to figure out what is wrong.

Diagnosis is thus both inevitable and necessary. The task of the clinician is to describe the patient's personality structure and dynamics, his assets as well as failings, the demands on him and his coping resources. Holt (1968) has described as "characterological diagnosis" rather than "symptomatic diagnosis".

For this reason, the term "clinical assessment" seems preferable to others in common use, such as psychodiagnosis, "diagnostic psychological testing" or "psychiatric evaluation".

"Diagnosis" is the act of specifying a psychiatric nosological label. "Psychological assessment" (or evaluations or measurement) or 'Personality assessment" are overly broad.

Concept and methods have been shared and interchanged between clinical assessment and psychological measurement in general. Measures developed in the context of general psychology as well as differential psychology have contributed much to clinical testing. The perceptual demonstrations of Gestalt organizational principle became basis of Bender's (1938) famous test for organic brain damage. Word association tests developed originally for discovering conflict areas in an individual have been widely used in the study of verbal association. For purpose of clinical assessment, many procedures were developed for the study of abilities, intelligence, or personality traits have found wide applicability in clinical psychology. Contrariwise, the Rorschach test and other projective techniques developed in the clinical framework have been widely utilized in the study of personality processes in well-functioning people.

Clinical assessment describes any act by which the clinicians gains information of value about his patient. It may include only measures of a specific variable, using a well-validated test, or it may involve a full-scale effort to construct a "working image or model of the person". The unique qualities of clinical assessment bring it most into with the psychometric tradition in psychology. Many procedures are used, tapping multiple levels of functioning in historical as well as contemporaneous perspective. The clinician conceptualizes the unique questions to be answered, the techniques to use, and finally has to integrate the many findings into a coherent whole. At all stages, clinical judgments and inference are required and the effectiveness of the assessment depends on the skill and wisdom of the clinician. Hence, clinical assessment is and probably will remain as much art as science, though grounded in disciplined thinking and knowledge.

Historical Aspects of assessment concepts

The model of clinical assessment described here has its roots in two related bodies of work that of Henry A and Murray and his colleagues of the Harward Psychological clinic and that of David Rapport and his coworkers at the Meaninger Clinic. Though differing in important regards both exemplified intensive clinical assessments using many methods to assess multiple facets and levels of functioning, where findings could be combined through skilled clinical inference into a theoretically consistent model of the person.

From the 1930 to the 1950, the Harward Clinical psychologists studied intensively small groups of people usually normal and often students. Their intent was to understand the individual human life, where possible over extended periods of time and as holistically as

possible. They were concerned to discover the sources of creative and adaptive personality functioning rather than centering on pathological trends. Although generating their own theory of personality (H.A Murray, 1938; 1959), their thinking was influenced by the convergence of the dynamic psychologists of Freud and Jung, the emphasis on integrative and holistic functioning of organisimic theorists, and Allport's stress on individuality and uniqueness of the human personality.

By the time of World War II, clinicians were excited by the then new concepts and methods of psychodiagnosis, and devoted great effort to perfecting and practicing diagnostic skills.

PURPOSE OF CLINICAL ASSESSMENT

The purpose of assessment is, "understanding the whole person". Under any circumstances, many assessors and many techniques, can only attempt to approximate full understanding of a person in all his individuality and complexity. The very intricacies of the human personality cannot be assessed. The limitations in our techniques, time, and skill, limit the reach of assessment. More realisitity, we are guided by a conceptual framework, within personality functioning in order to construct a model of the particular person, from which hypothesis can be derived and tested as to how and why he acts, thinks, and feels as he does, particular variables such has abilities, needs, skills and the like are studied, both in a comparative framework, to see how the individual compares with others, and in personalistic framework, to discover how the variables interrelate in the functioning of the individual himself.

In actual clinical situations, the aims and methods of assessment are determined in fair measure by the needs of clinical decision- making expressed in "referral questions", the questions "How anxious is this patient?" is relatively straight forward. The focus of assessment increasingly broadens as additional questions are added: "And under what circumstances is the patient likely to become more or less anxious?" 'When threatened what defense mechanisms came into play? How? 'Is the patient able to carry on the normal requirements of his job under such conditions?" "To finally" 'And what kind of person is he anyway? "As Levy (1963) noted, the issues which draw most on the interpretative skills of the clinicians are 'unbounded' questions, those more familiar to psychometric measurement are 'bounded' questions.

TYPES OF ASSESSMENT TECHNIQUES

There are four ways one can gain information about another person:

1. Ask the person himself.
2. Ask someone who know the person.
3. Observe the person as he behaves naturally.
4. Observe the person in standardized test situation.

The different techniques used in formal clinical assessment depend on one or another, sometimes combinations, of these modes of information gathering.

1. ASK THE PERSON HIMSELF

The interview is the backbone of clinical assessment. It involves putting questions to the patients to which if he can and will, gives direct replies. Most obvious are those which seek specific facts, such as age, number of siblings, place of birth, social status and the like. However, even is addressing personal needs and characteristics, the intent and relevance of the question is usually clear, though it may be more or less specific. Thus, we ask "Are you anxious when you approach the boss for a raise?" or more generally "Do you feel inadequate with the older and more powerful people? Or even more general "Tell me about situations in which you feel inadequate and anxious". In the normal process of clinical interviewing, the flow of statement and response is relatively free, as the interviewer follows the patients into areas which concern him. But interview may be more structured, following a more or less specific line of questions. One type of personality inventory is essentially a structured interview in written form. Other techniques which approximate the structured interview involves list of adjectives from which patients choose those most characteristic of them or statements which are to be sorted along a similar dimension. Interviews and personality inventories often involve questions the patient reveals rather than describes himself in his responses. Interview provides opportunity for observing nonverbal behavior. The patient is not only describing himself but living and acting in the situation, revealing characteristic behaviors. From the clinician's stand point, the disparity between the patient's assertions (I' am at ease in any social situation") and his visible behavior (Shy, tremulous voice, sweaty palms, fidgeting) provides important information about personality trends. Overall, however, the interview

and related self-descriptive techniques for the patient to characterize himself and his views of relevant others and of his world, in his own terms.

2. ASK SOME ONE WHO KNOWS THE PERSON

Friends, parents, spouse or partner, teachers, colleagues and employers, who know a great deal about a person in various settings, are potentially rich sources of information. A major concern is confidentiality in the clinical relationship, but second reason lies in the wish to understand the patient's problems. The treatment of children, grossly psychotic patients, the aged and neurologically damaged required interviews with persons who can describe the patient's behavior, personality characteristics, development, and so forth. Similarly, in assessment studies of normal subjects, systematic information is often sought from friends, peers and others. Where clinical assessment occurs after a period of psychotherapy, or after termination to assess change, the therapist himself becomes an "informant" in the manner of a friend as teacher, through his knowledge of the patient.

3. OBSERVE THE PERSON AS HE BEHAVES NATURALLY

For better understanding, direct observations of the patient in critical life situations would obviously be desirable, but under most circumstances they are unobtainable. Full clinical assessment may involve a "home visit" by a staff member who can report on observations of the physical environment and something of the spontaneous interplay among family members, but even though obtained in the same the information is primarily based on quasi-clinical interviews. With hospitalized patients, nurses and other staff members have ample opportunity to observe the patients in the "life situations" and their judgments in clinical assessment. Similarly, the behaviors of the patient in clinic, while in the waiting room, or with receptionist, provide same but limited observational data. In assessment studies of normal subjects, psychologists have been ingenious in developing quasi-natural conditions (in effect, situational tests) for observing subjects. In genius techniques have been used; for example, So skin (1966) had subjects carry miniature radio transmitters with them so that naturally occurring social interplay could be recorded and studied. The psychology, generally as well as in clinical assessment, psychologists remain committed to experimental and test measures.

4. OBSERVE THE PERSONS IN STANDARDIZED TEST SITUATIONS

Whatever their limitations, tests of numerous sorts remain the major instruments of assessment for clinicians as well as other psychologists. They represent the unique contribution of the psychologists, both as behavioral scientists and in clinical practice. The principle qualities of tests are:

1. Observations can be made under standard conditions.
2. Observations can be done when needed.
3. Observations can be done in ways that reduces subjective bias.
4. Observations can be done so that quantitative measures (of varying type and precision) can describe psychological functions.
5. Observations can be done in ways that different individual can be compared.

STAGES IN THE ASSESSMENT PROCESS

Sandberg and Tyler (1962) described the course of clinical assessment as a flow through four major stages;

1. **Preparation:** The clinician learns about the patients problems, 'negotiates' the referral questions and plans further steps in assessment.
2. **Input**: The data about the patient and his situations are collected.
3. **Processing**: The material collected is organized, analyzed and interpreted.
4. **Output**: The resulting study of the person is communicated and decisions as to further clinical actions made.

REFERENCES: 1. Lewis R. Aiken (2000) Psychological Testing and Assessment 10th Edition, Allyn and Bacon, Inc.

2. Anastasi. A & Urbina(1997)Psychological Testing (7th Edition)Upper Saddle River, NJ: Prentice Hall.

CASE STUDY

OUTLINE FOR A CASE STUDY

The following outline suggests the major areas, and some of the specific questions, which should be considered in a clinical case study.

I. Present status

A. **Adaptations** are the major tasks in the patient's life (work, school, family) and how well is he functioning? Does he seem to be at or below optimum?

B. Symptomatic behaviors

1. From the patient's standpoint, "What is troubling him? What are his "presenting symptoms"?
2. As viewed by concerned others, family or co-workers what deviant or disturbed behavior does the patient show? What bothers them?
3. From the perspective of the assessing clinician, what evidence is there of psychological disturbance? Are there thought disorders or failure of reality testing? Are negative emotions overly strong uncontrollable or painful? Anxiety? Depression? Are distressing conflicts visible? Obsessive thoughts? Specific dysfunctions. e.g., failures of memory, inapt problem-solving, concrete thinking?

C. **Motivation for clinical care and preconceptions about mental health**: What the patient expect will it happen in the clinic? Why did he come? What is the hoped for the out come? Symptom relief? More effective functioning Personality change? Change in distressing external conditions? What does being a 'patient' mean to him? How does he view mental illness, mental health? Is he psychologically minded?

D. Appearance and behavior in clinic

Is he anxious? Guarded? Trusting, un co-operative and resistant?

II. The manifest personality

A. Biological features

Is the patient healthy? What is his medical history? Physical appearance? If required appropriate medical examinations and tests are done.

B. Temperament

Is the patient energetic, lethargic, and active? Are emotions intense, controlled impulsive? Is life zestful? Do negative or positive emotions dominate? Are emotions appropriated to his age and life circumstances? Is he graceful or clumsy? Are gestures tense, open, and compulsive?

C. Manifest personality traits

How might the patient describe himself? How might others who know him well describe him?

D. Interpersonal behavior

How does the patient appear to others? What is his "stimulus value?" Is he liked, respected, trusted? What are his primary relationships? What kind of friends does he have, and how many? Is he isolated, gregarious? A joiner?

III. PERSONALITY DYNAMICS AND STRUCTURE

A. Motives and affects

What are his major conscious and unconscious motives? How are they related? Where do they conflict? What are the sources of characteristic affects? To what are anxiety, hostile feelings, guilt, and shame related? What gives pleasure? What are has fantasies and wishes, concealed as well as revealed?

B. Moral principles, social values, and attitudes

What are the major precepts by which the patient lives? Is his conscience stern, rigid, corruptible, and nonexistent? Are there mature ideals, flexibly held, or childlike imperatives?

C. Ego functions and identity

1. **Ego strength**.

Is the behavior self-initiated and internally controlled? Are impulses modulated? Does he work toward goals? Preserve objectivity and perspective?

2. **Defenses and coping mechanism**.

What are the salient defenses? Are they paralleled by effective, positive coping mechanisms?

3. **Thought organization, cognitive controls, and styles**.

What are characteristic ways the subject approaches cognitive problems (by reducing or perhaps increasing complexity)? Can he tolerate ambiguity? Does he scan broadly or focus narrowly? Delay appropriately before decision?

4. Intelligence, abilities, competencies

What are the patient's skills, talents, hobbies and vocational competencies and his intellectual resources?

5. **Identity and self-concept**

How does the patient view himself? What kind of person does he see himself to be? What are his aspirations? How much self-esteem does he have? On what does it rest?

IV Social determinants and current life situations

A. Group memberships and roles.

To what social groups does the patient belong? Which of these are most important in defining his social identity; which serve as "reference group?" Are social and personal identities congruent? Does the patient feel that he shares class characteristics with others?

B. Family

What are the relationships between patient and spouse, parents or children? How does the present family system work? Is it like or unlike that of 'family of origin?'

C. Education and work

School and work history: Is the patient satisfied with his work achievements, income, conditions of work? Is leisure available? How is it used? Hobbies?

D. Social ecology

In what kind of community (physical and social) does the patient live? Is it "home" or alien? Does he identify his welfare with community goals? Does he participate in community affairs work for community improvement? Is the environment crowded, noisy safe, ugly? Does he commute or live close to work? Are desired facilities available?

V. Major stresses and coping potential

What are the major stresses in the patient's current life? Do they consist of social problems, realistically beyond his control, e.g., unemployment, poverty? Are there excessive demands in his job or school situation, intense competition, long hours, and too heavy workload? Do strain result from interpersonal, marital or love relationships? To what extent can be person reduce or avoid stress though his own efforts? What personality or social resources are available to him?

VI. Personality Development

Here the question is 'How did this personality come to be'? The answer necessarily involves analysis of early life experiences relationships to significant others, parents and peers. The critical identifications throughout life and major learning experiences. The history and sequence of social and interpersonal influences on the person of particular importance is the way in which the patient coped with successive developmental tasks. What alternatives were available to the subject? How did he deal with new experiences and challenges? Did he hold to safe and established modes of behavior? Could he take on new roles?

VII Formation of the Case

a. Synthetic interpretation of the personality

How can the person be conceived and understood? What are the major themes-descriptive dynamic, structural and genetic-which allow us to describe a "whole person?" within this context, how can the patient's psychological disturbance be understood? What functions do his symptoms have in the economy of the personality, how do they prevent greater disintegration of psychological distress (primary gain)? Is there evidence that the patient is gaining further reward from his pathology (Secondary gain)?

b. Overall diagnostic impression (if necessary)

In terms of standard nomenclature, what should the patient's, conditions be called? What others psychiatric diagnoses have to be considered (differential diagnosis)?

c. Specific dysfunctions

In terms of the many specific psychological functions which can be assessed, in which realms does the patient function adequately and in which are there evidences of malfunctions? For example, are there speech problems, memory deficit, impaired abstract thinking intense neurotic drives, etc., which can be separately described without regard for formal diagnosis?

VIII Recommendations and predictions

A. Desired outcomes

What qualities of the person and or his situations requires change if the patient is to function in a more effective and comfortable way?

What are his major growth needs which could provide goals for therapeutic interventions?

B. Possible interventions

1. **Environmental and social**: Can the patient's life conditions be changed in ways to reduce stress and facilitate growth? For example change of home living conditions, taking leave form school, new job etc., Can counseling be done with relevant others. e.g. parents or friends, who might change their impact on the patient? Might new social activities be of benefit, perhaps in conjunction with people with similar problems?

2. **Psychotherapy**, Might psychotherapy be helpful? Of what sort with what kind of therapist, for how to what goals? Should it be individual?

3. O**ther therapeutic interventions**. Is hospitalization necessary? Are drugs required? Which one's? For what purpose? What idiosyncratic psychological effects to drugs might be predicted for this patient? Electroshock or other somatic therapies? Is

treatment needed for ancillary conditions, e.g., hearing loss, speech defect, reading disability.

C. Course of the future life

Following intervention (and/or without any) what predictions can be made about the patient's future life history? Extrapolating from his present character structure and life situation what intensifications and or reduction in his problems might be expected ? Are any events in the offing (e.g. leaving school, marriage, birth of a child) which might have predictable consequences? What kind of psychological or social interventions might be needed in the future?

As drawn up, this outline is intended to guide case study before systematic clinical interventions. At later points, such case analysis would include material which emerged during the course of psychotherapy, description of hospital behavior, and follow-up studies. Case studies reporting the entire sequence of clinical encounters, as well as the full assessment of the patient's personality, would necessarily include more categories. Correspondingly, the final section on recommendations and predictions would be oriented to the future beyond the clinical process.

REFERENCES: 1. Lewis R.Aiken (2000) Psychological Testing and Assessment 10th Edition, Allyn and Bacon, Inc.

2. Anastasi,A & Urbina(1997)Psychological Testing (7th Edition)Upper Saddle River,NJ: Prentice Hall.

GENERAL RULES FOR PSYCHOLOGY PRACTICALS

1. Always begin the experiment only after you have understood the problem, the procedure and the instructions. It is very essential that the purpose of the experiment and the reasons for each step in the procedure should be clearly understood.
2. The procedure should be strictly followed. The results will get affected if the procedure is not followed strictly. The students should clearly understand that the instructions to the subject is an essential part in the Psychological experiments. Slight variations in the instructions may lead to large variations in the results obtained and it may mislead the interpretations.
3. Students should not look upon the experiments as a competition with other members of the group. The student should understand that the variations in the ability, sensitivity, aptitude, personality is normal. It is the task of Psychology to find these differences.
4. As an experimenter, always be objective. Record whatever you observe. Do not express surprise or at what the subject does. Do not show any emotional expressions when the subject is taking the experiments. Always remember that the Psychology Experiments do study the individual differences and human behaviour as it is. Objectivity is essential. Always discuss and interpret only after the completion of the experiments and after the scores and results are obtained.
5. Always record the results as it is obtained. Reliable observation is very important characteristic in this scientific method of Experimentation.
6. Always get acquainted with the experiments before administering it on the subject. Complete knowledge on administration, procedure, scoring, interpretation is very essential for the experimenter.
7. In a number of experiments the stimulus material should be concealed from exposure till the appropriate moment arrives.
8. After the experiment is conducted the results should be recorded in the prescribed manner.

REFERENCES: B. Kuppuswamy(1954) Elementary Experiments in Psychology. Oxford University Press.

PRACTICAL – 1

CLINICAL ANALYSIS QUESTIONNAIRE (CAQ)

Assessor: **Date:**

Assesse: **Time:**

INTRODUCTION:

The concept of personality is a major topic of study in Psychology. The personality varies from individual to individual. The personality varies from individual to individual. We see a wide variety of differences in the personality makeup of an individual. The personality of an individual is determined by various factors. The factors like, heredity, environment, socioeconomic status, nature, nurture, biological, physiological, psychological, spiritual and many more factors. As these factors influence upon the individual's personality an individual's personality comprises of numerous qualities which in turn makes him unique. As the personality of an individual consists of these multifaceted dimensions, the psychologists have conducted numerous studies and research upon understanding personality and they have put forward personality theories. The theories of personality like Eyesenck's biological trait theory, Gordon Allport's personality theory, George Kelly's personal construct theory, Carl Roger's person centered theory, Cattell's factor analytical trait theory are the major one's.

To assess the personality of an individual Psychologists developed different types of personality assessment techniques. The major one's are projective tests, inventories and questionnaires.

In this practical, we are going to discuss in detail the personality assessment developed by Cattell, i.e., Clinical Analysis Questionnaire (CAQ). This questionnaire is one of the major classical assessment techniques of personality of an individual.

Background and Description of the CAQ

In the 1960's Cattell and his coworkers undertook a programmatic series of researches to merge two important avenues of development in personality assessment:

1. Measurement of pathologically important syndromes and deviant behavior patterns as determined by clinical observations.

2. Measurement of traits identified and consistently replicated by factor-analytic experimentation on normal adults.

After much research (Cattell & B Jersted 1967, Cattell & Bolton, 1969, Delheees and Cattell 1970, Cattell, 1973) the Clinical Analysis Questionnaire (CAQ) was developed as a single instrument that would simultaneously measure normal and pathological trait levels and provide a full, multidimensional profile of the individual. The test has 28 scales, 16 of which are the normal personality traits previously included in the 16 PF, seven of which measure various primary manifestations of depression and five of which were developed to measure factor-analytically identified traits that were discovered in the MMPI item pool. Consequently, the CAQ combines evidence of pathology along with information's on personality structure itself. It serves both diagnostic and treatment-planning functions simultaneously.

Bjerstedt (1967) identified and replicated seven distinct though correlated primary depression components. Each factor reflected different aspects of clinical depression. One, for example, involved somatic complaints such as gastrointestinal disorders, headaches and sleep disturbances. Another centered around guilt and worthlessness and excessive self-criticism. All seven were found to be distinct from those previously established personality factors included in the 16 PF.

PROBLEM: To assess the personality of the subject by administering Clinical Analysis Questionnaire.

MATERIALS: 1. Clinical Analysis Questionnaire (Part-I and Part-II)
2. Answer sheet
3. Stencil for scoring
4. CAQ Manual
5. Writing materials

PLAN: CAQ(Part-I and Part-II)is administered to the subject, after answering the questionnaire, scoring is done with the help of stencil keys and manual.

PROCEDURE: CAQ (Part-I and Part-II)is provided to the subject and responses are taken. The test booklet with clear instructions on the cover page is given and the subject is asked to sit comfortably and read the instructions and then answer the questions.

ADMINISTERING: The examiner needs one test booklet for each individual to be tested. There will be cases within certain patient populations, when use of an answer sheet is not possible. In these cases the examinee may respond in the test booklet and an assistant can transfer these to the answer sheet later.

Since it is an objective test, the CAQ can be easily administered by an assistant or a nurse, however, it is the responsibility of the psychologist, psychiatrist, physician or other qualified mental health professional under whose direction the testing is taking place to see that assistants are trained to administer the test properly, to establish the necessary rapport and to answer any questions that the examinee might raise.

The instructions for the CAQ are printed on the first page of the test booklet. In Part I of CAQ for each question there are three responses. The subject has to select response which is suitable for him/her. Usually the in between responses belong to uncertain category, hence the subject is instructed to avoid these responses as much possible.

CAQ can be administered to a single individual or to a large group at a given time. This questionnaire is to be used for above 16 years of age group. There is no time limit to give responses for this questionnaire, but the subject is requested to complete this questionnaire as fast as possible. Usually giving response to this questionnaire may take around 2 hours, in case of the individuals who are suffering from anxiety and depression may require more than 2 hours of time duration.

After the examinee has completed the test, Scan answer sheet or booklet quickly to be sure that all questions have been answered and that only one answer is given for each question. It is surprising how frequently an examinee will forget an item here or there, and this can have some serious effects on the scores derived from the test, particularly if the test is scored by hand.

SCORING: Score the CAQ answer sheet by hand; this can be accomplished in a relatively short time by use of two plastic keys, one for each side of the answer sheet. Detailed instructions are printed on the keys. Be sure that the key is lined up carefully on the left and bottom edges of the answer sheet, start with the key for Part – I, noting that the answer sheet must be turned upside down before lining up the key. The raw score can be entered on the answer sheet in the boxes that are located to the right. When finished with Part – I turn the answer sheet over and use the second scoring key to obtain the scores on Part – II side 2 of the answer sheet is not turned upside down for scoring.

If some items have been inadvertently omitted by the examinee, a full score can be computed from a partial scales score. Simply multiply the partial score by the number of items in the full scale (8 for part I, 12 for Part-II), divide by the number of items completed, and round to the nearest whole numbers. For example, an examinee who completed only six items on Factor A and had partial score of 9 would receive a full-scale score of 12 by this method. The obtained raw scores are converted into sten scores. Based on the sten scores the results are interpreted.

CONSTRUCTION OF THE TEST

The CAQ has 272 items, 128 in part I of the test, which covers the normal personality structure, and 144 in part II of the test, which covers the depression and pathological traits. The division of the test booklet into two parts was intended to make the test more convenient to administer, particularly with clinical patients who might not be able to maintain the necessary concentration for extended periods. Each part can be completed separately, though the interval between administrations should not be excessive.

For Part – I of the CAQ, the principal source of items was Form A of the 16 PF, Half the items in part – I are identified with Form – A items, another 10% are slightly modified from the way they appear is 16 PF another 20% of the items are drawn from other forms (B.C and D) of the 16PF, the final 20% consisted of previously unpublished items or those so change from existing 16 PF items.

Part – II items were not taken from any previously published source. The initial pool was developed on the basis of reported clinical symptomology. Each of the items in the questionnaire has three choices from which the examinee may select an answer. Generally,

the middle response is an “in between” or “uncertain” category, and instructions urge examinees not to use this category very frequently.

The CAQ can be administered to a single individual or to a large group at one time. It was designed for use with adults and will normally be used with individuals 16 years or older. There is no strict time limit imposed. It will generally require no more than two hours of time, but is the case of severely depressed patients it may require much longer.

CAQ-Part-I: It consists of 16 personality traits. About these personality traits a brief introduction is given below:

TRAITS MEASURED BY THE CAQ.

NORMAL PERSOANLITY TRAITS

A: WARMTH

Individuals who score high on this are usually found to be more warmhearted, personable and easy to get along with. It indicates that they like to give presents and would, if given the choice, rather sell than develop an invention. They are frequently more successful and more satisfied in occupations where interpersonal contact is a critical feature, such as sales positions. High-scoring individuals prefer to adapt to other people’s schedules rather than require other people to adapt to their schedules. They are also more likely to share their feelings with others. Occupational, social workers have been found to score significantly above average on this scale as have some groups of business executives, especially those of middle, rather than upper-level management, artists and research scientists, who are typically more oriented to things and ideas than to people, tend to score significantly below average on this scale.

B. INTELLIGENCE

This is not strictly personality trait but has become an integral part of the 16 PF profile and was retained here in the CAQ. It is a measure of general ability. Sten scores of 1-3 interpreted as indicating that the individual is probably less intelligent than average. A sten score of 8, which as noted earlier, should be interpreted as a range of 8-10, indicates the individual is above average.

C. EMOTIONAL STABILITY

Higher anxiety is generally reflected in lower score on Factor C. The individual's level on Factor C may be taken as an index of the individual's stress tolerance. The higher the score on 'C' the more resources, the individual has available to meet the challenges of the day.

High-scoring individuals are generally able to reach personal goal without particular difficulty. They do not seem to be easily distracted when working on something. They frequently report general satisfaction with the way they have their lives.

E. DOMINANCE

High scoring individuals are generally more self-assertive, aggressive and competitive. They describe themselves as forceful and generally are very direct in their relations with other people, frequently telling them exactly what they think of them. They like to put their own ideas into practice and enjoy having things their own way.

F. IMPULSIVITY

This is the second of our important extraversion primaries in the CAQ. Individuals who score high on this trait are generally happy to luck lively and enthusiastic. They indicate that they prefer popular to classical music. They admit to having more friends than most people. They enjoy parties, shows, and jobs that offer change, variety, and travel.

G. CONFORMITY

Individuals who score high on this trait tend to be more persistent more respectful of authority, and more conforming to the standards of the group.

H. BOLDNESS

High –scoring individuals on Factor H are typically adventurous, bold and energetic.

I. SENSITIVITY

Trait descriptions associated with high scores on this dimension include tender-minded, dependent, over protected, fidgety, clinging and insecure. High-scoring individuals report that they enjoy sentimental music. They prefer to use reason rather than force in getting things done. They prefer English to Math in school, their sense of direction is poor.

L. SUSPICIOUSNESS

Trait descriptions associated with high scores on this dimensions include suspecting, jealous, dogmatic, critical and irritable. High-scoring individuals include the notions that they do not forget mistakes easily. They say that their parents were strict and demanding. They are bothered about what others say behind their backs and they tend to be critical of other people's work.

M. IMAGINATION

This is the 'absent minded professors' factor among the 16 normal traits included in the CAQ. High scoring individuals are frequently unconventional and are typically concerned about everyday matters. They tend to forget trivial things, not interested in mechanical things. They do not enjoy hearing details of an accident. Their parents were above average in intellectual interests.

N. SHREWDNESS

High-scoring individuals prefer being around 'polished', sophisticated people, their feelings are not easily swayed, they are polite and diplomatic about handling other people, prefer to keep problems to themselves.

O. INSECURITY

High-scoring individuals tend to be worried, guilty, moody, and depressed quite often elevated scores are very common in clinical disorders of all types.

Q_1. RADICALISM

Individuals with high scores tend to be analytic liberal and innovative, feel that society should throughout traditions, trust logic rather than feelings, prefer to break with established ways of doing things.

Q_2. SELF –SUFFICIENCY

People who score high prefer to be alone, do not need the support of groups, prefer to work alone rather than with committees and problem-solve better alone than in groups. Higher scores appear to be related to success in school, particularly at the upper educational levels, but are negatively related to number of job promotions (Cattell -1972).

Q_3. SELF-DISCIPLINE

High-scoring individuals generally have strong control over their emotional life and behavior in general. At the extreme upper levels, individuals may become excessively compulsive and difficult to be around. They prefer to get their thoughts organized before speaking up, they keep their room neat and organized, do not leave things to chance.

Q_4. TENSION

This is one of the principle contributions to the anxiety and major medical risk factor. As Cattell has pointed out, higher scores are associated with frustrated motivation.

CAQ-Part-II: It consists of 12 clinical personality traits. A brief description about these traits is given below:

THE CLINICAL FACTORS

D_1. HYPOCONDRIASIS

High scoring individuals are depressed and preoccupied with bodily dysfunctions. Many of the complaints are non-specific. For example, high-scoring people feel that thus 'nerves are going to pieces that their health is worse than others, they feel sluggish and the health is generally run down. This is one of the major contributors to the depression factor indications that play a role in depression for women than men. Female neurotics and schizophrenics tend to score higher than males on this dimension.

D_2. SUICIDAL DEPRESSION

The item content centers on thoughts of self-destruction. High-scoring individuals are disgusted with life, life has become empty and meaningless, and they entertain thoughts of death as a viable alternative to this present hopeless situation. Scores on D_2 are very high in diagnosed Schizophrenics and depressive, but not in anxiety neurotics.

D_3. AGITATION

High scoring individuals say they would like adventurous jobs in which they have to speak up and take charge, they crave excitement. Beneath the surface there may be something of a 'death wish' which could explain this restless love of adventures and risk.

D_4. ANXIOUS DEPRESSION

High-scoring individuals are clumsy and shaky in handling things. They dream a lot about frightening events, they lack self-confidence, seldom speak out and say what they think, are confused and unable to cope with sudden demands, and are subject to disturbing dreams. It represents aspects of depression which can be incapacitated and profoundly disturbing. Scores are high in neurotics, alcoholics and nonparanoid, schizophrenics.

D_5. LOW ENERGY DEPRESSION

Some other primary depression factors have fatigue as a secondary symptom, but here low energy is central to the pattern.

D_6. GUILT AND RESENTMENT

This is the aspect of depression associated with a sense of having committed the unpardonable and experienced the sense of utter worthlessness. High-scoring individuals are troubled by what they have done wrong during the day, are self-critical and inclined to blame themselves when anything goes wrong. Nightmares, in which desertion by others is the central theme, are frequent.

D_7. BOREDOM AND WITHDRAWAL

This dimension is characterized by two main features a feeling that life is too pointless and silly to care at all and a tendency to avoid people. High scoring individuals feel too depressed and useless to want to interact with other people, are happier alone away from people. The highest-scoring group tends to be schizophrenics, narcotic abusers.

Pa. PARANOIA

There are reports of suspicion, sense of injustices and persecution, jealousy with respect to others, some cynicism about human nature and a fear of being poisoned.

Pp. PSYCHOPATHIC DEVIATION

High-scoring individuals are generally less inhibited than the average person, both by physical danger or pain and by the criticism of society.

Sc. SCHIZOPHRENIA

High-scoring individuals have difficulty getting their ideas into words, have strange impulses, and feel that the world is unsympathetic and that they are rejected and pushed around by people. They see themselves as being of little importance to others, have memory lapses, have feelings of unreality and hallucinatory experiences.

As. PSYCHASCHENIA

It is characterized by obsessional types of behavior over which the individual reports little self-control. These include counting objects unnecessarily and idea and phrase that run through their mind which are unimportant things. There is also a suggestion of phobic patterns here as well.

Ps. PSYCHOLOGICAL INADEQUACY

High-scoring individuals describe themselves as no good for anything. Reality distortions occur in the area of factual self-worth. Individuals who elevate on this scale think of themselves as doomed or condemned. This suggests the "Learned helplessness" pattern that Beck (1967) has described.

SECOND-ORDER FACTORS

In addition to the 28 primary scales that are obtained directly from the CAQ answer sheet, it is possible to calculate secondary or second-order scores. Such as extraversion, anxiety, etc., by combining the primary scale scores in specific ways.

Second order factors do not supply new information about the examinee over and above that contained in the primary scores. But, they do serve to organize the primary scores information in useful ways for purpose of test interpretation.

PRECAUTIONS: 1.The assesse is requested to attempt all questions honestly.

2. The assesse is requested to go through the instructions and follow the example given.
3. The procedure should be strictly followed by the assesse.
4. Though there is no time limit, the assesse has to give responses as fast as possible.

DISCUSSION

CAQ is the major personality questionnaire which measures the individual's normal and clinical personality traits. This measure 16 normal personality traits and 12 clinical personality traits accurately. This questionnaire provides comprehensive analytical information about 28 personality traits of an individual.

NORMS

Normative scores used with the CAQ are called stens (i.e., standard –ten scores), stens have a mean of 5.5 in the reference populations, a standard deviation of 2 and range between 1 and 10.

Table 1 (for females) and Table 2 (for males) give the principal norm table for the CAQ. The reference group selected here is a sample of normal (i.e., non clinical) adults. On certain scales of the CAQ the raw score differences between men and women despite efforts to reduce them at the item selection level, are of sufficient magnitude that a combined norm table would generally result in a bimodal distributions of standard scores. As a result, the separate sex norm tables are the ones most likely to be used in general practice.

SUPPLEMENTARY NORM TABLES

Appendix 'A' contains additional norm tables that the test user may wish to consider. Here we have provided special norms for college students, convicts, certain important clinical groups, and unisex tables for normal adults. In certain settings these conversion tables may prove to be more useful than those presented in table '1' and '2'

USING THE NORMS TABLES

In the design of the CAQ all of the items that are part of the factor B (intelligence) scale were grouped together at the end of Part – I. The test authors felt that in many clinical cases there would be much more reliable evidence on intellectual functioning available from other tests, and that Factor 'B' items would dispensed with. Moreover, in contrast with the items that precede them, these eight items do have a correct answer. The test authors felt this change in task might need to be more clearly spelled out for patient populations. However, in this test Factor 'B' is kept in its usual places as the second element of the 16PF profile. Consequently, it is extremely important that the individual doing the scoring if the test is scored by hand-keep this in mind and enter the norm table or profile sheet appropriately.

To use table 1 or 2 find the raw score interval which includes the examinee's obtained raw scores and read its sten equivalent at the top of the table. For example, assume that an adult female had obtained the following raw scores on Part – I of the CAQ:5. 5,8,9,9,3,6,11,10,12,6,7,9,10,10,6: These convert by use of table 1 to stens of 2,4,4,6,6,1,5,6,6,7,4,5,6,7 6,5. Once you have obtained the sten score for part-I go on and do the same for the 12 raw scores in part-II.

Note in particular that the intelligence scale (Factor B) has only 9 point range (0-8) and when Factor B raw scores are converted to stens, the upper most sten range disappears. The value of 8 is given in these tables as the topmost intelligence sten, but is strictly to be interpreted as a sten of 8 to 10.

INDIVIDUAL TABLE: This Table indicates the Personality Scores and Interpretation of the results of the subject in CAQ Part I

SL. No	**Personality Factors**	**Raw Scores**	**Sten Scores**	**Interpretation**
1	A. Warmth			
2	B. Intelligence			
3	C. Emotional Stability			
4	E - Dominance			
5	F. Impulsivity			
6	G. Conformity			
7	H. Boldness			
8	I. Sensitivity			
9	L. Suspiciousness			
10	M. Imagination			
11	N. Shrewdness			
12	O. Insecurity			
13	Q_1 Radicalism			
14	Q_2 Self Sufficiency			
15	Q_3 Self Discipline			
16	Q_4 Tension			

This Table indicates the Personality Scores and Interpretation of the results of the subject in CAQ Part II (Clinical Factor)

SL. No	**Personality Factors**	**Raw Scores**	**Sten Scores**	**Interpretation**
1	D_1 Hypochondriacs			
2	D_2 Suicidal Depression			
3	D_3 Agitation			
4	D_4 Anxious Depression			
5	D_5 Low Energy depression			
6	D_6Guilt and Resentment			
7	D_7 Boredom and Withdrawal			
8	Pa. Paranoia			
9	Pp. Psychopathic Deviation			
10	Sc. Schizophrenia			
11	As. Psychaschenia			
12	Ps. Psychological Inadequacy			

INDIVIDUAL RESULTS: Individual results are discussed and interpreted**.**

APPLICATIONAL VALUE: CAQ is used for personality Assessment in various fields like education sector, industry and clinical assessments**.**

CLINICAL USES: 1. CAQ Part-I and Part-II is used to analyze the normal and clinical personality traits of the individual.

2. CAQ Part I and Part II gives several relevant clues to the diagnosticians.

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PRACTICAL NO - 2

ASSESSMENT OF PSYCHOLOGICAL HEALTH USING GENERAL HEALTH QUESTIONNAIRE (GHQ) BY DAVID GOLDBERG

Assessor : **Date:**

Assessee : **Time:**

INTRODUCTION:

The psychological health is as much important as the physical health for an individual. In our day to day life as we come cross physical illness, its symptoms, in the same manner we all face one or the other psychological problems or disturbances and we find some symptoms of those disturbances in our behavior. It is important to identify and recognize these symptoms, so that we can take care of our health. In this aspect, GHQ is one of important questionnaire which helps to identify any signs & symptoms which may affect our health.

Individuals face lots of psychological tension, stress, anxiety, and fear in their life. These psychological problems lead to certain physical illnesses. There is an inseparable interconnection between our mind and body. Health psychology focuses on this aspect and from the studies and researches conducted in Health psychology it is clearly evident that the psychological problems may lead to psychophysiogical illnesses and psychosomatic illnesses. And it may be seen in the disorders like hypertension, insomnia, eating disorder peptic ulcers, migraine headache etc.

To understand, identify, recognize & diagnose these symptoms in psychology, the psychologist have developed a number of inventories, questionnaires like, Anxiety scales, depression scales, adjustment assessment, stress scale, etc.

General Health Questionnaire (GHQ) is one of the most useful questionnaire which can be used for screening purposes. An identification of the problem and symptoms is very much important in psychology for diagnosis, counseling purposes and for psychothereapy. In this regard GHQ serves as a very useful Questionnaire David Goldberg has developed this questionnaire. A simple one to administer, but most reliable questionnaire.

There is a need for a simple neuroticism scale recognized in all psychiatric circles. It is useful, not only for clinical work in screening and assessing the progress of treatment but has a larger utility in clinical psychiatric research. Neuroticism, though a widely accepted and clinically useful concept, is rather difficult to define. Most of the clinicians regard is a propensity inborn or acquired to have maladjusted pattern of behavior during time of stress. Accordingly a test which claims to measure neuroticism in this country should be such that it measures symptoms which are actually perceived by our patients and are recognized by our doctors.

In neurotic illness in India where insight and ego strength is retained, disturbances are expressed more through physical complaints rather than emotional and psychological complaints. The presence and severity of psychological symptoms can be assessed through the GHQ. The General Health Questionnaire (GHQ) is screening device for identifying minor psychiatric disorders in the general population and within community or non-psychiatric clinical settings such as primary care or general medical out-patients.

Scale GHQ is a 28 items questionnaire, which is modified version of General Health Questionnaire of Goldberg and Hillier (1972). It is translated into 38 different languages. It is suitable for all ages from adolescent upwards, not for children, it assess the respondent's current state and asks if that differs from his/her usual state. It is sensitive to short-term psychiatric disorder but not long standing attributes of the respondent.

The self-administered questionnaire focuses on two major areas;

- The inability to carry out normal functions.
- The appearance of new and distressing phenomena.

Scale of General Health Questionnaire consists of four sub-sets. They are:

a. somatic symptoms
b. Anxiety and insomnia
c. Social dysfunctions
d. Severe depression

It is available in the following versions.

- GHQ – 60 : The fully detailed 60 items Questionnaire
- GHQ – 30 : a short form without items relating to physical illness.

- GHQ – 28 : a 28 items scale version – assesses somatic symptoms Anxiety, insomnia, social dysfunctions and severe Depression
- GHQ -12: a quick, reliable and sensitive short form ideal for research Studies.

It is a quick and easy method to identify 'possible psychiatric cases'. As a screening device, it gives reliable information at the first stage screening process. Emphasis is on 'here and now' subjects are asked to respond to the questions in terms of their present and recent complaints, not those that they had in the past. Even in Indian conditions, General Health Questionnaire has proved to be reliable and valid tool in population surveys.

PROBLEM: To assess presence of psychological health morbidity in the subject using General Health Questionnaire.

PLAN: Administer the GHQ and find out the total score of the subject and interpret with reference to the norms.

MATERIALS: 1. General Health Questionnaire (GHQ)
2. Manual and scoring key
3. Writing materials.

PROCEDURE: The subject is seated comfortably and given a copy of GHQ which is self-administering. The instructions are given to the subject. The questionnaire is usually completed in10 to 15 minutes of time. After the subject completes the questionnaire the experimenter scores the responses under the four problem areas.

INSTRUCTIONS: "I would like to know if you had any medical complaint and how your health has been in general areas the past few weeks, mark the questions simply by putting a tick mark (√) before the answer which you think most applies to you. Remember that I want to know about present and recent complaints and not those that you had in the past. It is important that you try and answer all the questions.

PRECAUTIONS: 1. The subject is asked to give honest responses.
2. Responses should be given for all the questions.

ANALYSIS OF RESULTS:

1. A Score of Zero is given to the first two answers and scores of one is given to the remaining two answers.
2. The number of items identified by the subject is found out. Add the raw scores in all the four dimensions.
3. Individuals with a total score of 5 and above are considered to be possible cases of psychological morbidity.

INDIVIDUAL TABLE:

Table indicating the scores obtained by the subject and the interpretation in General Health Questionnaire

Name	Somatic symptoms	Anxiety Insomnia	Social Dysfunction	Severe Depression	Total

INDIVIDUAL RESULT: The individual's result is discussed and interpretation is done.

GROUP TABLE: Table indicating the scores obtained by the group and its interpretation in General Health Questionnaire.

Subjects	Somatic symptoms	Anxiety Insomnia	Social Dysfunction	Severe Depression	Total

GROUP RESULTS: The group result is being discussed and interpretation is done.

DISCUSSION:

The aim of the questionnaire is to assess the presence of psychological morbidity in the subject using GHQ. Result is being discussed on the basis of score.

CONCLUSION:

Based on the subject scores it is indicated whether psychological morbidity is present or not.

High score indicates the psychological interventions as on modified versions of GHQ by Goldberg & Hiller.

APPLICATIONAL VALUE:

1 The self-administered questionnaire is an ideal screening device for identifying non-psychotic and minor psychiatric disorder to help inform further interventions.
2 GHQ is available in four different versions enabling researchers and clinicians to select the version most appropriate to their individual requirements.
3 For researchers intending to set up their own localize validation studies the GHQ user's guide provides guidance and advice.
4 It can be used with illiterate, unsophisticated population.
5 Medically oriented, hence more acceptable to the patient's population.
6 It has high discriminatory power to separate the psychiatric population from the normal group.

REFERENCES:

* www.g-assesment.co.uk/productsd/general-health
* www.statics solutions.com/general-health-questionnaire-ghq/
* GHQ manual

QUESTIONNAIRE:

The General Health Questionnaire GHQ – 28 David Goldberg

PRACTICAL NO - 3

ASSESSMENT OF DEPRESSION USING BECK DEPRESSION INVENTORY (BDI)

Assessor: **Date:**

Assesses: **Time:**

INTRODUCTION

Psychodiagnosis is the process of examining a person from a psychological viewpoint to determine the nature and extent of a mental or behavioural disorder, A psychodiganostician has to observe, conduct interviews and use psychological tests for the patient to determine the presence or absence of certain psychological and physical symptoms. The diagnostician will compare the patients symptoms with the standard descriptions of abnormal behavior to determine in which category of disorders the patient fits. Finally, in this process the psychiatric classification of the patient is assigned as specified in the Diagnostic and Statistical Manual of Mental Disorders – IV. After the diagnosis of the disorder, a prognosis, or prediction of probable outcome is done.

Beck depression Inventory (BDI) is a 21 – item self-reporting questionnaire for evaluating the severity of depression in normal and psychiatric populations. This test is developed by Beck in1961 BDI was originally developed to provide a quantitative assessment of the intensity of depression. It reflects the depth of depression, it monitors the changes overtime and provides an objective measure for judging improvement and effectiveness of treatment methods.

Depression is a common and growing problem in many modern societies, it is passing sadness or grief, an illness that affects the body as well as the mind. It may cause an individual to feel sad, anxious, irritable, hopeless, helpless shameful excessively aligned and even suicidal (NIMH, 2007).

The National Institute of Mental Health (2009) finds depression is experienced differently by each individual. The severity, frequency and duration of symptoms vary depending on the individual and his or her particular illness. Symptoms include persistent sad, anxious or ‘empty feelings’ feelings of hopelessness and pessimism, feelings of guilt,

worthlessness and helplessness, irritability, restlessness and loss of interest in activities or hobbies which are pleasurable including sex. Other symptoms include fatigue and decreased energy, difficulty concentrating, remembering details and making decisions; insomnia, early morning wake fullness, or excessive sleeping overcoming or appetite loss; thoughts of suicide and suicide attempts and persistent aches or pain headache, cramps or digestive problems that do not ease even with treatment (NIMH-2009).

Depression is one of the major psychoses. It negatively affects the individual's feelings, thoughts and actions. The major symptoms of depression are: sadness, loss of interest, weight loss, change in appetite, insomnia, fatigue, feeling worthless, guilty feelings, affected cognitive activities like lack of concentration and inability to make decisions, thoughts of death and suicide. The individual suffering from depression in an effort to overcome depression may fall into smoking, alcoholism and drug addiction.

Hence it is important that the individual suffering from depression to be identified in the initial stages for the treatment purposes. Before, starting the treatment it is important to identify the severity and stages of depression. Scales, inventories, questionnaires, checklists have been developed. Beck depression inventory is one of the most reliable, appropriate and suitable one for the diagnosis purposes.

Types of Depression

Major depression: Severe symptoms that interfere with the ability to work, sleep, study, eat and enjoy life.

Persistent depressive disorder: A depressed mood that lasts for at least 2 years may have episodes of major depression along with periods of less or severe symptoms.

Some forms of depressions are slightly different or they develop under unique circumstances, they include;

- Psychotic depression
- Post partum depression
- Seasonal affective disorder (SAD)
- Bipolar disorder

Description of the test: The BDI is a self - administered 21 item self-report scale measuring supposed manifestations of depression. The BDI takes approximately 10 minutes to complete.

Reliability

Internal consistency for the BDI ranges form .73 to .92 with a mean of .86 (Beck, Steer and Garbin, 1988).

PROBLEM: To assess the individual's Depression using Beck Depression Inventory.

PLAN: To administer the BDI. Score the responses using norms on characteristic attitudes and symptoms of depression and based on score/responses are interpreted.

MATERIALS:

1. Beck Depression Inventory
2. Manual
3. Writing materials

PROCEDURE: The individual is seated comfortably in the well-lit room. The Beck Depression inventory is given to the individual and is instructed. The individual is given 10 minutes to complete the test, but is monitored to see that responses are given rapidly though, the individual will circle all the items within the time.

INSTRUCTIONS: There are 21 items self report scale given to you. On this inventory are groups of statements. Please read each group of statements carefully. Then select one statement in each group which best describes the way you have been feeling at the past six months and circle the number adjacent to the appropriate statement. Be sure to read all the statements in groups before making your choice and there is no time limit, but complete it within 10 minutes. Do not miss any item.

PRECAUTIONS:

1. Before starting the test make sure the individual has understood the test.
2. Though there is no right or wrong answer, encourage the individual to give honest answers, the first thing that comes to their mind.
3. Ensure that individuals do not leave any sentence unanswered.

ANALYSIS OF RESULTS:

i) With the help of score identify the level of depression, whether subject scored below 4 - possible denial of depression, faking good; this is below usual scores for normal.

ii) The subject scored over 40 - this is significantly above even severely depressed person, suggesting possible exaggerations of depression, possibly characteristic of histrionic or borderline personality disorders.

SCORING

Add up the score for each of the twenty-one questions and obtain the total. The highest score on each of the twenty one questions is three; the highest possible total for the whole test is sixty three. The lowest possible score for the whole test is zero. Only add one score per question (the highest rated if more than one is circled).

Total score levels of Depression

Below 4 = Possible denial of depression, faking good; this is below usual scores for normal.

05 – 09 = These ups and downs are considered normal.

10 – 18 = Mild to moderate depression.

19 – 29 = Moderate to severe depression

30 – 63 = Severe depression

Over – 40 = This is significantly above even severely depressed persons, suggesting possible exaggeration of depression; possibly characteristic of Histrionic or borderline personality disorders.

DISCUSSION: The aim of the test is to assess the individual's depression using BDI. The individual results depend on Raw score.

Points for Discussion:

1. Sadness	2. Pessimism
3. Sense of failure	4. Dissatisfaction
5. Guilt	6. Expectation of punishment
7. Dislike of self	8. Self Accusation
9. Suicidal ideation	10. Episodes of crying

11. Irritability 12. Social withdrawal
13. Indecisiveness 14.change in body image
15. Retardation 16. Insomnia
17. Fatigability 18. Loss of appetite
19. Loss of weight 20. Somatic preoccupation
21. Low level of energy.

INDIVIDUAL TABLE: Table indicating the raw scores obtained by the subject in Beck Depression Inventory.

Subject	Raw Score	Interpretation

INDIVIDUAL RESULT: Interpretation is done for the obtained scores and results are being discussed.

GROUP TABLE: Table indicating the raw scores obtained by the subjects in Beck Depression Inventory.

Subjects	Raw Score	Interpretation

GROUP RESULTS: Table indicating the raw scores obtained by the subjects in Beck Depression Inventory. Interpretation of the results is done on the basis of the raw scores obtained by the group.

CONCLUSION:

i) The individual and group results are being analyzed.
ii) There will be individual differences in the group.

APPLICATIONAL VALUE:

i) This test can be used in clinical settings, career counseling centre, hospitals.

ii) In clinical practice or research, whether the diagnosis is for therapeutic purposes, for detecting psychological origins of physical disorders.

iii) This test can used in many situations in educational settings.

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PRACTICAL NO - 4

ASSESSMENT OF FEAR USING FEAR QUESTIONNAIRE (FQ)

Assessor: **Date:**

Assesse: **Time:**

INTRODUCTION

Fear has been classified as an emotion by psychologists, it is a very basic human emotion. Emotions are complex mental and physical processes as emotions involve feelings which are mental or psychological components and bodily reactions which are physical reactions, thus feelings is an essential part of emotions. The simple feeling is purely psychological and does not involve bodily reactions and that is how fear which may or may not involve bodily reactions could be both a feeling and an emotion.

Fear could be both a feeling and an emotion yet fear as an entirely subjective or mental feeling component would be difficult to detect as it would not be accompanied by visible or noticeable physical reactions as in fear as an emotion. Fear could be defined as an externalized emotion or feeling which may or may not be accompanied by bodily reactions and fear could be conscious or unconscious.

Fear is an ancient human feeling that tells that we are in danger that we may have to fight whatever is before us to or flee the situation as quickly as possible. Major characteristics of fear is it is normal and it protects us from potential danger. In case, if fear is very intense and severs, then it becomes panic.

Fear is an emotional state which occurs in the presence of or anticipation of a dangerous or noxious stimulus. It is usually characterized by internal, subjective experience of extreme agitation, a desire to flee or to attack and by a variety of sympathetic reactions. Fear can be often differentiated from anxiety in one or two grounds. That is (i) fear is treated as involving specific objects or events while anxiety is regarded as a more general emotional state. (ii) fear is a reaction to a present danger, anxiety is to an anticipated or imagined one.

Fear is any strong emotional reaction involving subjective feelings of unpleasantness, agitation and desire to flee or hide, that is accompanied by sympathetic anxiety.

A psychology of fear would distinguish fear as an emotion and fear as a feeling, fear as conscious and fear as unconscious as well as fear with bodily reactions and fear without bodily reactions and fear is anxiety and fear is phobia. Fear could be characterized as general unconscious feelings of unpleasantness or could be more complex emotions such as anxiety and externalized fear. Fear could also be phobias which are persistent pathological fears directed towards specific objects and situations.

Fear as Emotions: Fear when accompanied by bodily reactions would signify strong emotional responses to a situation or an object or event, since fear is internalized, fear would naturally begin with a feeling or a subjective component. This means the individual would first "feel" afraid of the situation and then react to it. Such fear in which the individual is conscious of the emotions and reacts strongly to it is generally an emotional response and this sort of fear is thus manifested as in strong emotion.

Fear as Feeling: Fear could however be simply manifested as a subjective feeling, a sense of uneasiness or unconscious perceptions of some sort of danger or threat that may not evoke strong bodily reactions. Fear as feeling is thus unconsciously released in dreams, slips of tongue, lapses of attention etc.

Fear in anxiety: Fear as a feeling could also be the subjective basis of anxiety as when internalized and even unexplained anxiety has a general feeling of fear. Anxiety thus also begins with a fear but this could be largely unconscious, internalized and more generalized. But anxiety has distinct bodily reactions and that is how anxiety differs from fear as a feeling.

Fear in Phobias: Fear in Phobias consist of persistent pathological emotional responses towards specific objects or events. The differences between anxiety and phobia is that phobias are always externalized. Since phobias are compositions of emotions and strong reactions the reactions are expressed in exaggerated forms in phobias so individuals with phobias would react in extreme ways and could develop a state of panic especially due to the extreme and uncontrollable bodily reactions.

In therapeutic treatment of psychology, it will be necessary to understand the origin of fear and this could be done with neurological studies and studies of bodily reactions and mental states. Fear as simple feelings or complex emotional responses should be identified in specific situations and extensive fear could be studied in anxiety and phobia.

PROBLEM: To assess the individual's /subjects fear using Isaac Marks Fear questionnaire (FQ)

PLAN: To administer the Fear Questionnaire. Score the responses using norms on different areas of fear, like Agoraphobia, blood injury phobia and social phobia. And the responses are interpreted with the help of the manual.

MATERIALS: 1**.** Fear questionnaire (FQ) by Isaac Marks.
2. Scoring Key and Norms
3. Writing materials

PROCEDURE: The individual is seated comfortably in the well-lit room. The Fear questionnaire is given to the individual and is instructed. The individual is given sufficient time to complete the test but monitored to see that responses are given rapidly. Though there is no time limit the individuals are able to complete it in 10 minutes.

INSTRUCTIONS: There are 24 items in the questionnaire and '8' options. Choose a number from the scale to show how much you would avoid each of situations listed below because of fear or other unpleasant feelings. Then write the number you choose in the space opposite each situation.

PRECAUTIONS:

1. Before starting the test make sure the individual has understood the test.
2. There is no right or wrong answer; encourage the individual to give honest answers, the first thing that comes to their mind.
3. Ensure that individuals do not leave any sentence unanswered and kept confidential.

ANALYSIS OF THE RESULTS: Scoring is done under several headings and interpreted based on norms.

SCORING KEY: Four scores are obtained from the Fear Questionnaire

- Main Phobia Level of Avoidance : Item – 1 (Score range 0 to 8)
- Total phobia score : sum of items 2 to 16 (score range 0 to 120)
- Agoraphobia subscale (items 5,6,8,12 & 15) (score range 0 to 40)
- Blood injury phobia subscale (items 2,4,10,13 & 16) (score range 0 to 40)
- Social Phobia subscale (items 3,7,9,11 & 14) (score range 0 to 40)
- Global phobia Rating : Item 18 (score range 0 to 8)
- Associated Anxiety and Depression: Sum of items 19 to 24 (score range 0 to 40).

INDIVIDUAL TABLE:

The table indicating the scores obtained by the subject and its interpretation in Fear Questionnaire.

Name	**Agoraphobia**	**Blood injury**	**Social Phobia**	**Interpretations**

INDIVIDUAL RESULT: The results obtained by the individual is interpreted and discussed.

GROUP TABLE: The table indicating the scores obtained by the subjects and its interpretation in Fear Questionnaire.

Subjects	**Agoraphobia**	**Blood injury**	**Social Phobia**	**Interpretations**

GROUP RESULTS: The results obtained by the subjects is interpreted and discussed.

CONCLUSION: Based on the results conclusions are drawn.

APPLICATIONAL VALUE: It is useful in clinical and counseling setting and also it's helpful in non- industrial sectors.

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PRACTICAL NO-5

ASSESSMENT OF DEPRESSION, ANXIETY AND STRESS USING DASS-21 SCALES

Assessor: **Date:**

Assesses: **Time:**

INTRODUCTION

Depression is a mood state characterized by a sense of inadequacy, a feeling of dependency, a decrease in activity or reactivity, pessimism, sadness and related symptoms. depression is quite normal, relatively short lived and frequent. In some cases, depression may be a symptom of some other Psychological disorder, or sometimes itself can be a specific disorder. There are major types of depression like agitated, endogenous, exogeneous, neurotic, psychotic, reactive, unipolar, bipolar etc. In the individuals who are facing severe depression it is found that they have suicidal tendency. Comparatively to other mental disorders it is found that the suicidal tendency in depression is very high. According to the research data available the percentage of people suffering from depression is very high compared to other psychological disorders. Hence, it is of utmost importance to identify the individuals who are suffering from depression using relevant Psychological assessment for the identification and for further treatment for those individuals.

Anxiety is a Psychoneuroses disorder. Psychoneuroses are minor Psychological disorders characterized by inner struggles and discordant social relationships. Psychoneurotic symptoms are extremely varied. Some of the major frequent Psychological complaints are anxiety and depression. Anxiety states are marked by emotional overreaction. Symptoms may include diffused tension, general apprehension, feelings of insecurity, restlessness, insomnia, palpitations, excessive sweating, dizziness, trembling, upset stomach and vague fears concerning impending calamity. Anxiety and fear may even become sever and create enormous trouble for a person. Psychologists have developed a number of scales to understand the symptoms of anxiety.

Stress is the term used interchangeably to mention pressure, tension, unpleasant external forces or an emotional response. In actuality the term 'stress' means "a process by which a person both perceives and responds to events that are judged to be challenging or threatening. The term stress was coined by the Hungarian endocrinologist Hans Selye, who was working at the University of Montreal. Selye used the term as a way of organizing physiological responses to a variety of challenges. According to Selye the body reacts similarly to a variety of different stressor. Stress can be classified into two types : Eustress – the stress which is positive and beneficial to an individual and Distress- the stress that is harmful and damaging to an individual. Stress is usually caused by major life events, daily hassles, environmental factors like noise, crowding, natural disasters, etc. Job related factors like job loss, role ambiguity, shift work, gender discrimination, retirement etc. Sociocultural factors like poverty, socioeconomic status, etc. It is also created by various biological factors like hormones, chemical secretions, etc.

Stress creates tiredness, decreases immunity, increases blood pressure, body pain, and disturbances in digestive activities. Stress leads to a number of physiological and psychological disturbances. Stress leads to Psychosomatic illnesses like, hypertension, migraine headache, peptic ulcers, heart related problems, etc. Hence it is important to identify stress at the initial stages to prevent further damage.

This particular scale DASS is a very important scale to assess depression, anxiety and stress and to identify them so that necessary action can be taken.

The DASS is a set of three self report scales designed to measure the negative emotional states of depression, anxiety and stress. Each of the three DASS scales contains 14 items, divided into subscales of 2-5 items with similar content. The Depression scales assesses the dysphoria hopelessness, devaluation of life, self -deprecation, lack of interest/involvement, anhedonia and inertia. The Anxiety scales assess autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The stress scale is sensitive to levels of chronic non-specific arousal. It assesses difficulty relaxing, nervous arousal and being easily upset/agitated, irritable/over-reactive and impatient. Subjects are asked to use 4 point severity/frequency scales to rate the extent to which they have experienced each state over the past week. Scores for Depression, Anxiety and stress are calculated by summing the scores for the relevant items.

In addition to the basic 42 items questionnaire, a short version, the DASS-21, is available with 7 items per scale. Note also that an earlier version of the DASS scales was referred to as the self-analysis Questionnaire.

As the scales of the DASS have been shown to have high internal consistency and to yield meaningful discriminations in a variety of settings, they should meet the needs of both researchers and clinicians who wish to measure current state or change in state over time (e.g., in course of treatment) on the three dimensions of depression, anxiety and stress.

Characteristics of high scores on each DASS scale

Depression scale

- Self-disparaging
- dispirited gloomy, blue
- convinced that life has no meaning or value
- pessimistic about the future
- unable to experience enjoyment or satisfaction
- unable to become interested or involved
- slow, lacking in initiative

Anxiety scale

- apprehensive, panicky
- tremble, shaky
- aware of dryness of the mouth, breathing difficulty, pounding of the heart, sweatiness of the palms
- Worried about performance and possible loss of control.

Stress scales

- Over-aroused, tense
- Unable to relax
- Touchy, easily upset
- Irritable
- Easily startled
- Nervy, jumpy, fidgety

- Intolerant of interruption or delay

PROBLEM: To assess the Depression, anxiety and stress using DASS-21 scale.

MATERIALS:

i) DASS-21 by Fernando Gomez scale

ii) DASS-21 manual

iii) Writing material

PLAN: Administer the DASS scale. Score the responses using the key and interpret the score using the key and interpret the sore using DASS severity Ratings.

PROCEDURE: The individual is seated in comfortably in well equipped room and DASS-21 scale is given to the individual/subject and is instructed. The individual is given sufficient time to complete the test but is monitored to see that responses are given. There is no time limit but should be able to complete within 10 minutes, and answer each items as truthfully as possible.

PRECAUTIONS: 1. The subject is asked to go through the instructions carefully before giving responses.

2. The subject is instructed to give honest responses.

SCORING THE DASS: The scale to which each item belong is indicated by the letters 'D' (Depression), 'A' (Anxiety) and 'S' (Stress). For each scale (D, A & S) sum the scores for identified items. Because the DASS-21 is short form version of the DASS (the long Form has 42 items), the final score of each item groups.

INTERPRETING THE DASS: Once multiplied by '2' , each score can now be transferred to the DASS profile sheet, enabling comparison to be made between the three scales and also giving percentile rankings and severity labels.

DASS severity Ratings (Don't forget to multiply summed scores by X2)

Severity	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely severe	28 +	20+	34+

Note: High Scores on the DASS would certainly alert the clinician to a high level of distress in the patient and this would need to be explored further within the interview process.
Low scores on the DASS should not be a substitute for a comprehensive clinical interview.

INDIVIDUAL TABLE: Table indicating the raw scores obtained by the subject and its interpretation.

Name	Depression		Anxiety		Stress	
	Score	Interpretation	Score	Interpretation	Score	Interpretation

INDIVIDUAL RESULT: Based upon the responses the results are being interpreted and discussed.

GROUP TABLE: Table indicating the raw scores obtained by the group and its interpretation in the DASS

Subjects	Depression		Anxiety		Stress	
	Score	Interpretation	Score	Interpretation	Score	Interpretation

GROUP RESULTS: Based upon the responses given by the subjects in the group the results are being interpreted and discussed.

CONCLUSIONS: Based upon the results conclusions are drawn.

APPLICATIONAL VALUE: The principal value of the DASS in a clinical setting is to clarify the locus of emotional disturbances as part of the broader task of clinical assessment. The essential function of the DASS is to assess the severity of the core symptoms of depression, anxiety and stress. It must be recognized that clinically depressed, anxious or stressed persons.

REFERENCES:

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PRACTICAL NO - 6

ASSESSMENT OF ANXIETY USING SELF- ANALYSIS FORM (ASQ)

Assessor: **Date:**

Assesse: **Time**:

INTRODUCTION:

Our era has been called the "age of anxiety" and anxiety manifestations are certainly widespread. Anxiety is one of the major psychoneuroses. In day to day life every individual face anxiety for one or the other things. Hence, anxiety is a normal phenomenon, which is inevitable. When an individual becomes aware of the subjective knowledge about the situation creating anxiety and prepares oneself for the situation automatically anxiety wanes off. When an individual is facing anxiety situation it leads to a number of psychophysiological changes in the individual. The symptoms like chest pain, headache, sweating, trembling, tiredness, weakness, insomnia, body pains, increased palpitations can be seen physically at the same time as in psychological activities, the cognitive activities lower down in tis efficiency like attention, perception, thought process, decision making, logical thinking, memory and learning gets affected. From the researches it has been shown that the females face more anxiety comparatively to male.

The factors creating anxiety may be due to social factors, psychological factors like the confusion, conflicts in the unconscious part of the mind of an individual, environmental factors, it may be due to the hormonal imbalance, the variations in the chemical secretions and it may be caused due to any deficiencies found in central nervous system and autonomic nervous system.

An individual comes across anxiety in a variety of situations for ex: facing an exam, physical illness, when trying to reach a goal, facing new situations, challenging situations etc. in these situations only through psychological assessment it can be found whether the symptoms faced by the individual is due to anxiety. Through psychological assessment it can also be found whether the individual is facing mild, moderate or severs anxiety. In case, the individual is facing a severe anxiety, it will affect the individual's functioning physically and

psychologically which in turn reduces the capacity and efficiency of performance. Hence, it is very important to identify the level of anxiety the individual is facing so that proper treatment is given. Health Psychologists measure anxiety through Self-Report instruments or through Psychological and behavioural assessments. Self –report instruments include checklists and inventories. To cater to this need, a variety of anxiety scales have been developed in Psychological assessment. These scales are used in health sectors, professionals, academics, etc. In this context assessment of anxiety using Self-Analysis Form (ASQ) is an effective one for identification of anxiety.

In clinical practice of research, whether the diagnosis is for therapeutic purposes, for detecting psychological origins of physical disorders, or for analyzing stress reactions to internal disturbances, it is increasingly necessary to have standard and dependable measures of Anxiety. There are also many situations in educational and social psychology where accurate assessment of anxiety level is of prime importance.

It is of utmost importance that certain aspects of anxiety, stress, tension, frustration need to be understood and identified in the initial stages to avoid the negative consequences of these on the health on the individual. Health Psychology is defined as the educational, scientific and professional contribution of the discipline of Psychology to the promotion and maintenance of health, the prevention and treatment of illness, and the identification of etiological and diagnostic correlates of health, illness, and related dysfuntion. Certain of these factors are so strong that they may lead to psychosomatic illness like ulcers, migraine headaches, it also includes cardiovascular disorders, cancer and life threatening illnesses.

In clinical practice, anxiety has been measured by observation and interview. The average factor pattern coefficients from 14 percent studies and constitutes our best and most complete statement of the anxiety pattern in questionnaire responses at the present time.

Table

Trait	Primary Factor Depression	Average Loading in the Anxiety pattern
Q_4	Tense/Relaxed	80
O	Apprehensive/self-assured	78
C	Emotionally unstable/emotionally stable	66
		54
		43

L	Suspicious/Trusting	
Q_3	Uncontrolled/Self-controlled	
H	Venturesome/shy	-38
Q_1	Experimenting/conservative	-06
F	Happy-go lucky sober	-03
G	Conscientious/Expedient	-03
M	Imaginative/Practical	-03
B	More Intelligent/Less intelligent	-02
N	Shrewd/Naive	-02
A	Warm hearted/Reserved	01
Q_2	Group-adherent/self-sufficient	-01
E	Assertive/Nonassertive	00
I	Sensitive/tough-minded	00

* Based on more than 10,000 samples, see Catell (1973) for original data source

COMPONENTS OF THE ANXIETY SCORE

Component 'O': Apprehension

The person scoring high reports that he is unstable, unable to sleep through worrying, unequal to the challenges of daily life, and easily gets down hearted and remorseful. The original title Cattell proposed for this factor was Guilt proneness, but, as can be seen from the manifestation mentioned above, it is broader than guilt in its most specific sense.

Component Q_4: Tension

The most common interpretation of this component is that it represents general frustration level. Q_4 has one of the strongest demonstrated relationships with clinically judged depression; manifestations express the gamut of frustration responses from anger and pugnacity to anxiety and depression.

Component Q_3: Low Self -Control

Based on study of questionnaire items which have been shown to measure this components, the person scoring high shows little regard for socially approved character responses, lack of self-control and foresight, tends to be inconsiderate of others, and has little regard for his or her social reputation.

Component 'C': Emotional Instability

This factor is one of dynamic disintegration and immaturity as opposed to controlled, organized emotionality. Among questionnaire manifestation of the trait, we find that the high-scoring person is easily annoyed by things and people, is dissatisfied with the world situations, his family, the restrictions of life, and his own health, and he feels unable to cope with life. He shows generalized neurotic responses in the form of the phobias, psychosomatic disturbances, sleep disturbances and hysterical and obsession behavior.

Component 'L': Suspicion

Regarding questionnaire responses and biographical information, the individual scoring high on this component indicates that he comes from a parental home which he admired, and which had lively intellectual interests. He is contemptuous of the average, he is scrupulously correct in behavior, and is annoyed by people putting on superior airs. He/she is annoyed by a grater number of things than the average person uninfluenced by a views of prominent people and declines to be generous in giving information to others is a test situation.

In terms of criterion associations, group dynamics experiments demonstrate that the high-scoring individuals are considered unpopular, and groups which are generally high on this component are significantly less cohesive and low on morale Cattell and Stice (1953).

PROBLEM: To assess the presence of Anxiety level in the subject by administering ASQ.

PLAN: Administer the ASQ and find out the total score of the subject and interpret with reference to the norms.

MATERIALS: 1. Self Analysis Form
2. ASQ Manual
3. Writing Materials

PROCEDURE: The subject is seated comfortably and given a copy of ASQ which is self-administering. Environmental conditions should be adjusted to provide a comfortable testing setting. In order to establish good rapport and maximize the validity of the responses, the examiner should make introductory remarks appropriate to the situation. Contextual variables which may need to be considered in interpreting the results should be noted at this time.

After testing, these observations may be recorded directly on the booklet. Space has been provided for this purpose on one page to subject. Thus, whether an examinee seems visibly agitated or uncomfortable at the time of testing may influence our interpretation of the test score. An individual who takes four times longer than average to answer the questions may be over precise and examinee who finishes the test in a minute should be questioned.

Test instructions are printed on the front page of the ASQ booklet along with two example items. The test can be given either individually or to large groups. Refer to the test as the 'self analysis form' rather than as an anxiety test. Reinforce the printed instructions by using the examinee to be as frank as possible. In clinical setting remind the examinee of the confidentiality of test score. In research settings where personal identification of responses is unnecessary, emphasize the examinee's anonymity.

INSTRUCTIONS: Inside this booklet there is forty statements about how most people feel or think at one time or another. There is no right or wrong answers. Just pick the one that is really true for you and mark the a, b, or c answer. You will start with the two simple examples below.

For convenience, all answers are recorded directly on the test booklet. The test is untimed but typically requires only about 5 minutes for the examinee of average reading ability who is not excessively disturbed. Anyone taking an unusually long time should be reminded that the 'first response' to each question is what is needed.

There is no time limit but work as fast as you can. Please do not leave any items answered.

PRECAUTIONS: 1. Before the subject starts answering the statements make sure that he/she has understood what exactly they have to do.

2. The subject is not supposed to leave any statements unanswered.

3. There is no right or wrong answer but honest answer is important and will be appreciated.

4. Before starting the 'ASQ' build up rapport and confidence in the subject, so that he/she co-operate in answering the statements.

ANALYSIS OF RESULTS

1. Check by a glance that all questions have been answered.

2. Fit the Key (ASQ) over the answer boxes on the left hand page, centering A at the top of the page in the hole so marked and the right edge of the Key on the vertical line at the right side of the answer boxes.
3. And score the responses for anxiety and determine whether, he/she has 'Low Anxious' or high – anxious with the help of the Key and norms.

SCORING

Lay the scoring Key directly over the booklet, following the simple instructions printed on the Key itself. The scorer simply adds 2's or 1's for each answer, according to the numbers printed above the hole through which the answer appears. The higher score always means more anxiety. Three kinds of scores for the test may be obtained.

1. A single total anxiety score based on all 40 items. This is all that is recommended or needed in the majority of cases.
2. A breakdown into (a) an unrealized, covert anxiety, score, score A for the 20 items on the left-hand test page (b) an overt, symptomatic, conscious anxiety score, score B. for the 20 right –hand -page items. Scores A and B sum to the total score.
3. A breakdown of total anxiety into five personality components in anxiety.

INDIVIDUAL TABLE : Table indicating the results of the subject in Self- analysis form of anxiety and the interpretation of results.

Subject	'A' scale	'B' scale	Total score	Interpretations

INDIVIDUAL RESULTS: The individual results are being interpreted and discussed.

GROUP TABLE: Table indicating the results obtained by the group and its interpretation.

Subjects	'A' scale	'B' scale	Total score	Interpretations

GROUP RESULTS: The results obtained by the group are being interpreted and discussed.

CONCLUSIONS: As per the results obtained by the subject finally Conclusions should be drawn.

APPLICATIONAL VALUE:

i. In clinical practice or research, whether the diagnosis is for therapeutic purposes, for detecting psychological origins of physical disorders, or for analyzing stress reactions to internal disturbances, it is increasingly necessary to have standard and dependable measure of anxiety.

ii. It is useful in Educational settings and social psychology where accurate assessment of anxiety level is prime importance.

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PRACTICAL NO-7

MINI-MENTAL STATUS EXAMINATION (MMSE)

Assessor: **Date:**

Assesse: **Time:**

INTRODUCTION:

The mental status examination is a structured assessment of the patient's behavioural and cognitive functioning. It includes descriptions of the patient's appearance and general behavior, level of consciousness and attentiveness, motor and speech activity, mood and affect, thought and perception, attitude and insight. The reaction evoked in the examiner, and finally higher cognitive abilities. The specific cognitive functions of alertness, language, memory, constructional ability and abstract reasoning are the most clinically relevant.

Pinel (1801) one of the fathers of modern psychiatry, gave some advice to his contemporary colleagues, one could scarcely improve on this advice in the present day approach to mental status examination.

Mental Status Examination are conducted to obtain an in –depth information about a person's emotional state (affect and mood) intellectual and perceptual functioning (attention, concentration, memory, intelligence and judgement), style and content of thought processes and speech, level of insight into mental status and personality problems, psychomotor activity, as well as the person's general appearance, attitude and insight into his or her condition. Mental Status Examination is done with careful observations and detailed interview of the person information on family, culture, health history, legal history and the person's activities and thoughts may all be elicited. Once the assessment is done, data have been obtained and integrated, a report summarizing the findings concerning the person's strengths and weakness is prepared, recommendations for clinical, education, or vocational interventions may be made.

Levels of consciousness: The level of consciousness refers to the state of wakefulness of the patient and depends both on brainstem and cortical components. Levels are operationally defined by the strength of stimuli needed to elicit responses and scheme of Plum and Posner (1980) is widely accepted.

A normal level of consciousness is one in which the patient is able to respond to stimuli at the same lower level of strength as most people who are functioning without neurologic abnormality.

Clouded consciousness is a state of reduced awareness whose main deficit is one of inattention. Stimuli may be perceived at a conscious level but are easily ignored or misinterpreted.

Delirium is an acute or subacute (hours to days) onset of a grossly abnormal mental state often exhibiting fluctuating consciousness, disorientation, heightened irritability and hallucinations. It is often associated with toxic, infectious or metabolic disorders of the central nervous system.

Obtundation refers to moderate reduction in the patient's level of awareness such that stimuli of mild to moderate intensity fail to arouse; when arousal does occur, the patient is slow to respond.

Stupor may be defined as unresponsiveness to all but the most vigorous of stimuli. The patient quickly drifts back into a deep sleep-like state on cessation of the stimulation.

Coma is unarousable unresponsiveness. The most vigorous of noxious stimuli may or may not elicit reflex motor responses.

When examining patients with reduced levels of consciousness, noting the type of stimulus needed to arouse the patient and the degree to which the patient can respond when aroused is a useful way of recording the information.

APPEARANCE AND GENERAL BEHAVIOR: These variables give the examiner an overall impression of the patient. The patient's physical appearance (apparent vs stated age), grooming (immaculate/unkept) dress(subdued/riotous) posture (erect/kyphotic) and eye contact (direct/furtive) are all pertinent observations. Certain specific syndromes such as unilateral spatial neglect and the disinhibited behavior of the frontal lobe syndrome are readily appreciated through observation of behavior.

SPEECH AND MOTOR ACTIVITY: Listening to spontaneous speech as the patient relates answers to open ended question yields much useful information. One might discern problems in output or articulation such as the hypophonia of Parkinson's disease, the

halting speech of the patient with word finding difficulties, or the rapid and pressured speech of the manic or amphetamine – intoxicated patient. Overall motor activity should also be noted, including any tics or unusual mannerisms. Slowness and loss of spontaneity in movement may characterize a subcortical dementia or depression, while akathisia (motor restlessness) may be the harbinger of an extrapyramidal syndrome secondary to phenothiazine use.

AFFECT AND MOOD: Affect is the patient's immediate expression of emotions; mood refers to the more sustained emotional make up of the patient's personality. Patient's display a range of affect that may be described as broad restricted, liable or flat. Affect is inappropriate when there is no consonance between what the patient is experiencing or describing and the emotion, he/she is showing at the same time (example: laughing when relating the recent death of a loved one). Both affect and mood can be described as dysphoric (depression, anxiety, guilt) euthymic (normal) or euphoric (implying a pathologically elevated sense of well-being.)

Affect must be judged in context of the setting and those observations that have gone before. For example, the scaled looking patient with eyes wide open and perspiration beading out on the forehead is soon recognized as someone suffering from Parkinson's disease, when the paucity of motion and diminished eye blink are noted and the beads of perspiration turnout to be seborrhea.

THOUGHT AND PERCEPTION:

The inability to process information correctly is part of the definition of psychotic thinking. How the patient perceives and responds to stimuli is therefore a critical psychiatric assessment. Does the patient harbor realistic concerns or are these concerns elevated to the level of irrational fear? Is the patient responding in exaggerated fashion to actual events, or is there no discernible basis in reality for the patient's beliefs or behavior?

Patients may exhibit marked tendencies toward sanalization or may be troubled with intrusive thoughts and obsessive ideas. The more seriously ill the patient may exhibit overtly delusional thinking (a fixed, false belief not held by his cultural peers and persisting in the face of objective contradictory evidence), hallucinations (false sensory perceptions without real stimuli). Because patients often conceal these experiences, it is well to ask leading

questions, such as “Have you ever seen or heard things that other people could not see or hear? Likewise, it is necessary to interpret affirmative responses conservatively, as mistakenly hearing one’s name being called or experiencing hypnagogic hallucinations in the peri-sleep period, is within the realm of normal experience.

Of all portions of the mental status examination, the evaluation of a potential thought disorder is one of the most difficult and requires considerable experience. The primary core physician will frequently desire formal psychiatric consultation in patients exhibiting such disorders.

ATTITUDE AND INSIGHT:

The patient’s attitude is the emotional tone displayed toward the examiner, other individuals or his/her illness. It may convey a sense of hostility, anger, helplessness, pessimism, over dramatization, self-centeredness or passivity. Likewise, the patient’s attitude toward the illness is an important variable. Is the patient a help-rejecting complainer? Does the patient view the illness as a psychiatric or non-psychiatric? Does the patient look for improvement or is he or she is resigned to suffer in silence?

Patients attitude often changes through the course of the interview and it is important to note any such changes.

STRUCTURED EXAMINATION OF COGNITIVE ABILITIES

The preceding sections of the mental status examinations provide a Gestalt view of the patient and his illness. A structured examination of specific cognitive abilities is a more reductionist approach to the patient and pays careful attention to neuroanatomic correlates. Such testing logically follows a hierarchy ordering of cortical function with attention and memory being the most basic functions on which higher-ordered abilities of language, constructional ability and abstract thinking are layered.

ATTENTION

The testing of attention is a more refined consideration of the state of wakefulness than level of consciousness. An ideal test of attentiveness should ask concentration an simple task, placing minimal demand on language function, motor response or spatial conception. Reaction times are frequently slowed in patients who have diminished attentiveness. This

may become evident early in the course of examination and provide an important clue that examiner is dealing with decreased attentiveness. One test often recommended is the ability to listen to digit spans of increasing length and repeat them back to the examiner. Another is to have the patient listen to a digit span and then repeat it backward. Perhaps a better test is to have the patient listen to a string of letters in which one letter is repeated frequently but randomly and to tap each time that letter is heard, for example "please tap each time you hear the letter 'K'" T L K B M N Z K K T K G B H W K L T K …….The number of errors the patient makes is noted, another test might be to have the patient count the number of times a given letter appears on a page full of randomly ordered letters.

LANGUAGE

The left perisylvian cortex mediates most aspects of language functions in 99% of right –handed individuals and over half of the lefthanded individuals. Thus, an aphasia implies damages to the left hemisphere about 95%of the time. Basic examination of language function should include an assessment of spontaneous speech, comprehension of spoken commands, reading ability, reading comprehension, writing and repetition.

The assessment of spontaneous speech performed as the patient supplies answers to open-ended questions. In this evaluation one looks for disorders of articulation abnormalities of content, disorders of output and paraphrasic errors. Phonemic errors are mistakes in pronunciation, semantic errors are mistakes in the meaning of words, and neologisms are meaningless nonwords that have a specific meaning for the patient.

Repetition is tested by having the patient repeat sentences with several nouns and pronouns for example "That's what she said to them yesterday" and "No ifs, ands or buts. Sometime we should check the comprehension in several levels of responses. Word finding disability, reading, writing is tested by having sign his name generates spontaneous sentences, or describe an object in writing.

MEMORY

Memory disturbances are a common complaint and is often presenting symptom in the elderly. Memory can be grouped simplistically into three subunits: immediate recall, short term memory and long-term storage.

Short term memory in the most clinical patient is the most important to be tested. Short term retention requires that the patient process and store information so that he or she can move on to a second task. Short term memory may be tested by having the patient learn four unrelated objects or concepts, a short sentence or a five component name and address and then asking the patient to recall the information in 3 to 5 minutes after performing a second, unrelated mental task.

ORIENTATION largely reflects memory function questions such as "where are we right now? What city are we in? What is today's date? What time is it right now? Are pertinent questions.

Immediate recall can be tested once again by having the patient repeat digit spans, both forward and backward, long term memory can be tested by the patient's ability to recall remote personal or historic events (eg the naming of previous presidents, major wars, etc) or answer select questions from the WAIS information subtest. Obviously, in asking remote personal events, the physician must be privy to accurate information to judge the accuracy of the patient's response.

PROBLEM: To assess the mental status by using MMSE Format.

PLAN: Administer the MMSE and find out the total score of the client and interpret with the help of norms.

MATERIALS: 1. Mini-Mental status examination (MMSE)
2. Writing materials
3. Manual

PROCEDURE: The subject is seated comfortably and given a copy of MMSE and writing materials and the examiner will ask questions which are in MMSE, same time answer will be recorded in MMSE format or papers.

PRECAUTIONS: 1.Before administering the test establish a good rapport with the subject.

2. Instruct the subject to read the instructions carefully, understand and then give responses.

3. The procedure should be strictly followed by the subject.
4. Though there is no time limit, the subject has to give responses as fast as possible.

INDIVIDUAL TABLE: Table indicating the scores obtained in MMSE by the subject.

Name	Orientation	Registration	Attention Calculation	Recall	Language	Copying	Total

INDIVIDUAL RESULTS: The results obtained by the subject is totaled and it si interpreted.

GROUP TABLE: Table indicating the scores obtained by the subjects in MMSE.

Subjects	Orientation	Registration	Attention Calculation	Recall	Language	Copying	Total

GROUP RESULTS: The results obtained by the group is totaled and interpreted.

DISCUSSION: Depending upon the observation of the Assesse, responses are qualitatively discussed.

MMSE SCORING : 24-30: no cognitive impairment
18-23: mild cognitive impairment
0-17: severe cognitive impairment

APPLICATIONAL VALUE: MMSE is used mainly in health sector, police department, Military, educational setting, etc.

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PRACTICAL NO - 8

FUNCTIONAL BEHAVIOURAL ASSESSMENT

Assessor: **Date:**

Assessee: **Time:**

INTRODUCTION:

Psychological assessment is done for various purposes in Psychology. It is being utilized for research, educational purposes, clinical purposes, and in many other professions and contexts. Assessment is done to understand the cognitive abilities, skills, aptitude, interest etc, not only the strengths of an individual can be identified through psychological assessment but also the problematic area in an individual's personality, in the behaviour can also be identified through various psychological tests.

ASSESMENT IN EDUCATIONAL SETTING

In educational setting psychological assessment is done in educational institutions, schools, colleges to evaluate the knowledge accumulated by the students, their specific knowledge, skills etc. The skills like cognitive, psychomotor, social skills are being assessed as they are not only restricted to the learning but also for the individual in various walks of life. Psychological assessment in recent years has gained a very prominent importance in the educational field. It is being used to test the neuropsychological functioning, student competency, teacher competency and also for intervention programs.

A variety of tests belonging to different categories like neuropsychological assessment , intelligence tests, memory tests, language tests, visuospatial tests, psychomotor functioning, personality assessment etc are being used in educational settings. Neuropsychological abilities include sensation, motor speed and strength, perception, perceptual motor integration, language, attention, abstracting ability, flexibility of thoughts, orientation and memory.

Apart from these psychological assessment also serves to identify the problem behaviour , problem areas in the children, students in reference to the learning context. Diagnosing learning disabilities, problem behaviour has gained much importance in todays' situations. Identification of problem behaviour in children and students is very much important in the beginning stages itself as the identification would help to plan for the further

interventions and corrective measures of the problematic behaviour through counselling, guidance and psychotherapies.

Behavioural assessment is used for the purpose of behavioural analysis and further for the modification of behavior. The process of behavior modification is preceded by a functional analysis of the problem behavior. This analysis consists of an A-B-C sequence in which A stands for the antecedent conditions, B the problem behavior, C the consequence of that behavior. B is modified by controlling A and altering C. The antecedents and consequences of the target behavior may be overt, objectively observable conditions or covert mental events reported by the person whose behavior is to be modified

Behavioural assessment has multiple functions

1. Identification of target behaviours, alternative behaviours and causal variables.
2. Design of intervention strategies
3. Reevaluation of target and causal behaviours.

In behavioural assessment various procedures are used. It includes observations, interviews, checklists, rating scales and questionnaires. Sometimes even projective techniques are also used.

When a student's behavior disrupts classroom instructions, teachers often address the problem by manipulating events that follow the misbehavior (eg verbal reprimands, isolation, detention, and suspension). Experience has shown that this approach fails to teach the student acceptable replacement behaviours(i.e., behaviours that are expected and appropriate for the circumstances). The student may respond to the consequences for the moment, but in many instances, what has been absent is a method for determining "why" the student misbehaved in the first place. Today there is a good reason to believe that the success of classroom behavior interventions hinges on identifying the likely causes and purposes of problem behavior as well as finding ways to teach and promote appropriate replacement behaviours that serves the same "functions" as the inappropriate behaviours.

We know that inappropriate student behavior may have the same form (eg, Charles and James both talk to the teacher) but serve different functions (eg, Charles in seeking peer approval while James is attempting to control an aversive teacher pupil interaction).

Functional assessment helps educators to understand what functions the problem behavior serves for the student. This enables them to determine interventions that reduce or eliminate specific behavior that serves the same purpose or function for the student (eg, teaching Charles more acceptable ways to gain peer attention).

The logic behind a functional behavioural assessment is that practically all behavior occurs within a particular context and serves a specific purpose. Students learn to behave (or misbehave) in ways that satisfy a need or that result in a desired outcome. Identifying the purpose of problem behavior or more. Specifically, what the student "gains" "controls" or "avoids" through those behaviors can provide information that is essential to developing instructional strategies and supports to reduce or eliminate behaviours that interfere with successful classroom performance or participation.

FUNCTIONAL BEHAVIOURAL ASSESSMENT:

Functional Behavior Assessment is a tool asses the possible causes of behavior as well as a guide to the development of behavior intervention plans. According to Scott, Anderson, Spaulding (2008), FBA is a positive tool used for behavioral interventions for those students whose behavior impedes their learning (Scott, Anderson, Spaulding, 2008). Functional Behavior Assessment (FBA) uses a variety of techniques and strategies to diagnose the causes and to identify likely interventions to address problem behaviors, ultimately eliminating the problem behavior.

Functional behavior assessment is a first step in trying to understand why a learner with ASD may be engaging in interfering behaviors. The teachers/practitioners develop interventions to reduce the occurrence of the interfering behavior in question. Usually, teachers/practitioners use functional communication training (FCT), differential reinforcement, response interruption/redirection, extinction, and stimulus control/environmental modification to address these behaviors in learners with ASD.

Conducting a Functional Behavioral Assessment is a team effort. Individuals who are involved in improving or eliminating the students behavior. The range of individuals who can be involved are: school counselors, teachers, parents, and paraprofessionals. With the collaboration of each of these individuals a Behavior intervention plan (BIP) is created. In

most cases the Student Support Team is responsible for conducting an FBA, which include school psychologist, teachers, counselors, and paraprofessionals.

Conducting an FBA is generally considered to be a problem solving process that looks beyond the behavior itself. The focus when conducting an FBA is on identifying significant, pupil-specific social affective, cognitive and /or environmental factors associated with the occurrence (non-occurrence) of specific behaviours. This broader perspective offers a better understanding of the function or purpose behind student behavior. Intervention plans based on understanding of "why" a student misbehaves are extremely useful in addressing a wide range of problem behaviors. Keeping in mind that FBA is usually the first of a two-pronged approach to addressing student problem behavior. Conducting an FBA lays the foundation for developing a BIP (Basic information process). In reviewing existing data, the learner may determine that more information is needed before an effective plan can be designed.

An FBA is an approach that incorporates a variety of techniques and strategies to diagnose the causes and to identify likely interventions intended to address problem behaviours. In other words, the FBA looks beyond the demonstrated behavior and focuses instead upon identifying biological, social, affective and environmental factors that initiate, sustain or end the target behavior. This approach is important because it leads the observer beyond the "symptom" (the behavior) to the underlying motivation for it.

Conducting an FBA

It describes and defines the target behavior in specific, concrete terms.

It collects information on possible functions of the target behavior.

It uses direct and indirect measures of behavior.

Check accuracy of behavior measurement.

It categorizes behavior- Is it linked to a skill deficit or a performance deficit?

It analyzes information to form a hypothesis (conjecture or personal function).

It devises interventions and/or develop BIP.

PROBLEM: To assess the behavior of an individual using FBA.

MATERIALS: 1. FBA Format.

2. Writing materials

3. Manual

PROCEDURE: FBI is based on observation method. Therefore, to carefully and objectively observe the student's behavior in different settings and during different types of activities. Conduct interviews with parents, staff and caregivers may help pinpoint the specific characteristics of the behavior. It will take time minimum two to three weeks.

Steps to be followed in Functional Behavioural Assessment

Step 1. Establishing a Team : A multidisciplinary team is established to provide a variety of perspectives about the interfering behavior that a particular learner with Autistic Spectrum Disorder is exhibiting. Members of the team should include all individuals who have observed the interfering behavior demonstrated by the learner with ASD over an extended period of time in a variety of settings and conditions.

Step 2. Identifying the Interfering Behavior: The members of the multidisciplinary team identify the interfering behavior that will serve as the target of the assessment and intervention strategies. Interfering behaviors include disruptive or repetitive behaviors that interfere with optimal development, learning, and/or achievement. Team members identify the interfering behavior that is most problematic for the learner.

Step 3. Collecting Baseline Data: This step focuses on collecting data from multiple sources to better understand the interfering behavior prior to designing and implementing an intervention strategy. Data collection is important throughout the FBA process because it helps teachers/practitioners define the behavior, record what the learner is currently doing, and evaluate the outcomes of the intervention plan.

Step 4. Developing a Hypothesis Statement: This step involves developing a hypothesis statement that is based upon the assessment results and describes the behavior in sufficient detail. Analyzing assessment data helps team members identify patterns of behavior across time and environments. On many occasions, patterns of behavior and the possible reasons for the behaviors will be obvious; however, at other times, the behavior patterns may be subtle and difficult to identify.

Step 5. Testing the Hypothesis: An important step in the FBA process is to test the hypothesis to ensure that it is correct, as long as there is no risk of injury or damage. If the behavior involves risk of injury or damage, then proceed to Step 6.

Step 6. Developing Interventions: Teachers/practitioners conduct an FBA as a first step in trying to understand why a learner with ASD may be exhibiting an interfering behavior. As the function of the behavior becomes apparent, teachers/practitioners develop interventions to reduce the occurrence of the interfering behavior in question. Teachers/practitioners use specific evidence-based practices such as functional communication training (FCT), differential reinforcement, response interruption/redirection, extinction, and stimulus control/environmental modification to decrease the occurrence of the interfering behavior and increase the use of more appropriate replacement behaviors.

Step 7. Monitoring Intervention Effectiveness: In this step, teachers/practitioners regularly monitor learner behavior(s) to determine the effectiveness of the intervention.

INSTRUCTIONS: In these activities test observer/researcher describe and define the target behavior in specific, concrete terms. Collect information on possible functions of the target behavior, examiner/observer/researcher, uses direct and indirect measures of behavior, also check the accuracy of behavior -Is it linked to skill deficit or a performance deficit? Analyze information to form a hypothesis.

In assessing a student's behavior, it is also important to consider whether a particular response may relate to cultural differences or expectations. (Culture, ethnic background).

PRECAUTIONS: When conducting an FBA is on identifying significant, pupil-specific social, affective, cognitive and or environmental factors associated with the occurrence or non-occurrence of specific behaviours. Before conducting FBA take the parental consent.

ANALYSIS OF RESULTS: Analysis is done under several headings such as scatterplot, sample of interview and ABC observation. Based on data triangle chart analysis will be done.

DISCUSSION: Depending upon the responses given qualifiedly the results will be analysed.

APPLICATION VALUE: 1. FBA is used mainly in the educational setting for the assessment of student's behavior

2.In Mental health clinics it is used for assessment of the behaviour.

3. It is being used in special schools.

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