Psychological Testing and Clinical Diagnosis

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The use of valid and reliable psychological tests and assessments is not only foundational to the authority of the field of counseling, but it also serves as the bedrock to the relevance and effectiveness of treatment (Leppma & Jones, 2013). Clinical mental health counseling can look different from patient to patient, as effective treatment is typically tailored to each specific patient, but there is generally a treatment plan that includes an intended outcome of the treatment. This kind of direction should often be informed by a diagnosis. While a patient may enter a counselor's office with a preconceived notion of a diagnosis, and self-report accordingly, it falls on the expert opinion of the counselor to determine if such a diagnosis is accurate. A relatively common diagnose of a serious mental health disorder in the United States is bipolar disorder. According to the National Institute of Mental Health (n.d.), bipolar disorder affects an estimated 5.7 million adults; with serious symptoms, it is vital for a counselor to use valid and reliable tests and tools to diagnosis and treat patients.

Bipolar Disorder

Per the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013), bipolar disorder manifests in ways that are grouped into two corresponding diagnoses: Bipolar I Disorder and Bipolar II Disorder. The DSM also notes the existence of Cyclothymia, Other Specified Bipolar Disorder, Unspecified Bipolar Disorder, Bipolar Disorder Due to Another Medical Condition, and Substance/Medication-Induced Bipolar Disorder. However, these are beyond the scope of this writing; these exist to accommodate those individuals that do not meeting the criteria for Bipolar I and II and cyclothymia but still experience significant and abnormal mood changes. Bipolar I can be characterized by manic episodes, hypomanic episodes, and major depressive episodes; manic episodes last more than seven days or require hospitalization, hypomanic disorders last more than four days, and depressive episodes manifest over the course of two weeks. Bipolar II can be characterized by

hypomanic episodes lasting four days and depressive episodes manifesting over the course of two weeks. Bipolar II is differentiated from Bipolar I in that a person experiencing the former will not have experienced a manic episode, and any mood shifting takes place between the hypomanic and the depressive (American Psychiatric Association, 2013).

Tools and Tests

The diagnostic process can be complicated and nuanced, and it may start before any patient reveals their reason for seeking treatment. As Ball, et al., (2015) reveal, the diagnostic process can occur in any number of orders but generally begins once a patient faces a medical issue and decides to seek attention. From there, any fact-finding and information gathering proceeds. Ideally, the patient will arrive with, or provide access to, existing medical information that can be used to inform a diagnosis. Additionally, one form of information gathering, which can be considered a tool for practitioners, is observation. A patient may enter an office and disclose that they believe they are experiencing major depressive disorder. They report continued feelings of hopelessness, lethargy, and a lack of motivation that has manifested six times over the past two weeks. They believe this meets the diagnostic threshold for depression. However, as they self-report, they are extremely talkative, appear to be having racing thoughts, and communicate a strong urge to begin treatment and start establishing treatment goals.

While the patient, in their limited knowledge, assumes they have major depressive disorder, a practitioner can observe that bipolar I is a more likely, holistic diagnosis. Given this overlap, a practitioner may reference yet another important tool: the DSM and, specifically, the cross-cutting symptom measure. This is available in the DSM-5. Per this measure, a patient meets a threshold for further inquiry if they reach a mild or greater level for mania. From there, there are a few tests that a practitioner should consider using.

A common diagnostic tool to help screen for a large number of psychological disorders is the Adult Self-Report Inventory-4. It was designed to serve as a clinical guide. There is a

preliminary section comprised of questions relating to demographics, and the inventory itself is comprised of 136 questions across 20 diagnostic-related areas using a four-point scale (Cellucci & Doll, 2014). The test exhibits moderate to high levels of reliability, depending on the intended use of the test; the test is considered highly reliable, with several types of validity evidence provided (Cellucci & Doll, 2014). The test takes 15 to 20 minutes to complete, and can be purchased online for prices ranging from $62 to $143.

The most common diagnostic test for bipolar disorder is the Mood Disorder Questionnaire (MDQ) (Hirschfield, 2007). The MDQ is a self-report, single-page page inventory that can be filled out by a patient quickly and scored by a practitioner within minutes after that. Any trained medical staff can administer this questionnaire. It is a list of thirteen yes/no questions, limits inquiry based on the symptoms having presented in the same time period, and asks for a self-report of the symptoms manifesting with any problems (Hirschfeld, et al., 2010). The development committee of this assessment has made it available for free online and it takes five to ten minutes to complete. Fonseca-Pedrero, et al., (2016) found that this test is valid as a diagnostic tool and using it to identify and prevent bipolar disorder in high-risk individuals.

Another diagnostic test, which is listed in the cross-cutting symptom measure, is the Altman Self-Rating Mania Scale (ASRM). The ASRM is a self-reported diagnostic tool that uses a five-item scale (Altman, et al., 1997). It is a highly valid and reliable test (Altman, et a., 2001). It boasts substantial diagnostic power for such a small test; though it's only five questions long, it uses a four-point scale and covers five behavioral areas of concern related to mania. The test is published with instructions as an appendix item by Altman, et al., (1997) and is free to use with attribution; it takes no more than five minutes to complete.

One of the common tests utilized in counseling is a personality test. The personality test can inform a counselor of a patient's motivations, character, and traits. However, these tests cannot diagnose and should not guide treatment. As a tool to help inform the way in which a

counselor interacts with a patient, it may be effective. However, that is the extent to which the personality test should be considered in the case of a patient seeking treatment for bipolar disorder.

Conclusion

There is not shortage of demand in the field of clinical mental health counseling. As mental health continues to deteriorate in the United States, effective counselors and valid and reliable psychological tests and assessments will continue to be necessary (Cohen & Swerdlik, 2018). Many diagnoses rely on the self-reporting of patients. While necessary and collaborative, self-reporting should not be the only tool used to diagnose accurately and treat effectively. Psychological disorders, whether bipolar disorder, post traumatic stress disorder, schizophrenia, et cetera, all require an accurate diagnosis; there are many tests and tools that exist at the disposal of practitioners. It is on the patient to self-report accurately, but it is on the practitioner to test and assess accordingly.

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