

Directions for the Psychotherapy Assessment Checklist (PAC Forms)

The PAC Forms are a comprehensive set of questions that provide the therapist with a great deal of information about a patient in a highly condensed format. They can be filled out by the patient—generally in 30-40 minutes—prior to the first visit. The therapist can review the forms immediately before the first session to obtain a comprehensive picture of patient problem areas; an initial scan of the forms will take a practiced therapist 5 minutes or less, yet a comprehensive interview to gather all the information on the forms could take 4-6 hours or more. Because of the demands of managed care, many colleagues have needed such a tool and have found the PAC forms to be efficient and useful. For private practitioners, obtaining as much information as possible as soon as possible is particularly useful in short-term and time-limited treatments.

PAC Forms Do Not Give a Definitive Diagnosis

The PAC Forms provide preliminary information on many topics including the patient's severity of symptoms (anxiety, depression, suicidality, etc), level of functioning (occupational and interpersonal), medical problems, and the likelihood of Axis I or Axis II diagnoses. It is important to stress that **the forms do not provide a definitive DSM-IV diagnosis**, but streamline the process of diagnosis and evaluation by quickly directing the therapist to the areas of greatest concern.

These forms are based on instruments used in psychotherapy research. They are designed to be easily used in private practice to help the collect behavior-based data in a wide range of areas before, during, and after treatment, and by rating the patient's progress throughout treatment. Clinicians who wish to function as scientist-practitioners will find these forms very helpful.

This addendum includes a description of the forms and directions for their use. Our Web site, www.affectphobia.org, has the following related items:

- The 7-page Psychotherapy Assessment Checklist (PAC Forms) themselves
- A one-page Summary Form, which therapists can fill out with of salient information from the PAC Forms
- A sample cover letter which can be sent to the patient with the PAC Forms, after adapting it for your own use.

The PAC Forms consist of fill-in-the-blank questions and comprehensive diagnostic checklists covering a wide range of topics, in the following order:

Basic Demographic Data	Name, address, phone, age, sex, education, marital status, etc. are at the top of Page 1.
Presenting Problems	Patients' self-report of the problems they want help with, rated on a 1-10 point scale, are also on Page 1. Every 5-to-10 sessions, patients can be asked to re-rate the degree of severity of each problem. These ratings form the basis for ongoing evaluation of how much treatment is helping to resolve what brought the patient into psychotherapy, and we have found them to be the most valuable assessment in the entire battery. In the same section, the patient gives the reason for coming to therapy now, which can help assess the patient's stage of motivation (e.g., personal motivation, court-mandated treatment), and any precipitating events.
Axis III: Medical Problems	Number of doctor visits, medications, cigarettes/alcohol consumption, a checklist of medical problem areas, and a self-report rating of physical health are all on Page 1.
Axis IV: Life Stressors	Recent losses and checklist of possible problem areas are also on Page 1.
Axis V: Global Assessment of Functioning	Page 2 contains a comprehensive assessment of interpersonal and occupational functioning, both current (daily) and life-long. This section assesses a number of important areas, including use of daily time, best and worst periods in life, and rating of self-esteem and general well-being. These behavior-based items help in giving a 1-100 GAF rating.
Axis I Diagnoses	Pages 3 and 4 include screening questions for important diagnostic areas: major depression (MD), dysthymia (DYS), past major depression (PMD), mania (MN), past mania (PMN), delusional disorder (DEL), schizophrenia (SCH), alcohol abuse/dependence (ALC), drug abuse/dependence (DRG), panic disorder (PAN), obsessive compulsive disorder (OC), post-traumatic stress disorder (PTSD), agoraphobia (AGR), social phobia (SOC), simple phobia (PHB), generalized anxiety disorder (GAD), somatization/hypochondriasis (SM/HY), anorexia (ANO), bulimia (BUL), and attention deficit disorder (ADD). In addition, there are more complete diagnostic criteria for major depression, panic symptoms, and generalized anxiety symptoms.
Axis II Diagnoses	Pages 5-7 consist of screening questions for DSM-IV criteria (or research criteria) for the following personality disorders: <ul style="list-style-type: none"> • Cluster C: avoidant (AVD), dependent (DEP), obsessive-compulsive (OC), passive-aggressive (also known as negativistic, NEG), depressive (DPR), self-defeating (SDF) • Cluster A: paranoid (PAR), schizoid (SZD), schizotypal (STP) • Cluster B: histrionic (HIS), narcissistic (NAR), borderline (BOR), antisocial

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USE AND INTERPRETATION OF THE PAC FORMS

The PAC forms can be mailed to the patient with instructions to complete and bring them to the first session. Alternatively—particularly in clinic settings—the PAC forms can be given to the patient prior to the first session, as is done with medical checklists prior to the visit to the general practitioner.

PAC Forms Can Be Scanned Rapidly

Prior to the start of the initial session, the therapist can scan the information on the PAC Forms in 5 to 7 minutes, write down the key issues on the PAC Summary Form, and obtain an overview of the main problem areas that can help guide the initial evaluation.

The PAC forms follow the common medical checklist format (e.g., symptoms, health behaviors). Medical checklists do not generate diagnoses, but guide physicians in their assessment process. Like medical checklists, the Psychotherapy Assessment Checklist is simply a patient's **initial self-report of problem areas that alerts the therapist to areas needing further evaluation**; it is not a psychometrically validated instrument.

The PAC forms use the checklist format or “yes-or-no” answers with as many items as possible. A few questions ask for severity ratings of problems or open-ended answers. But for the most part, the therapist can scan the responses for presence or absence of a problem and gain a rapid overview of the patient's functioning and problems areas.

“Yes” Answers Must Be Confirmed to Achieve Diagnostic Accuracy

Yes-or-no questions, like any test, can potentially generate false positives and false negatives. False negative responses have been extremely low in frequency, about 1-3% in our experience. For this reason, “no” responses are considered valid unless contradictory information is presented during the interview, and follow-up questions are asked only when the response to an item is “yes.” A far more common problem, making self-report unreliable, is that patients tend to respond “yes” far too often. When evaluated according to more strict DSM criteria, we have found that generally about 20% of the “yes” responses are false positives. Obsessional patients will report a behavior that may have happened only once 20 years ago, which is generally not relevant or sufficient for diagnostic criteria; patients with an obsessional personality diagnosis can have a false-positive rate as high as 40%. For this reason, **each “yes” answer to a diagnostic criterion needs to be confirmed based on further questioning or ancillary history before a diagnosis can be reached with any degree of confidence.**

Self-Report Is Particularly Inaccurate in Certain Areas

It is important to keep in mind that self-report is particularly likely to be inaccurate in some areas, e.g. drug and alcohol use, so the therapist will need to be alert to information—both in the initial evaluation and throughout the therapy—which contradicts the responses on the PAC Forms. Domestic abuse is another such area, which is why the category “somewhat” was added to the screening question at the bottom of page 1. Also, while the form asks for the patient's self-assessment of level of functioning, the

therapist's clinical judgment is essential for a valid GAF rating; the patient's rating should be taken into consideration along with all other data on the form, and interview material.

The questions for the **Axis I major diagnoses** are patterned after the main screening questions in the *Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I)* (First et al, 1997). During the SCID interview, if a patient answers "yes" to one the screening questions, the interviewer must ask further questions; if the subject answers "no" to all the screening questions for a particular area, the interviewer moves on to the next area.

**Positive Screening
Questions Need
Further Assessment**

In the same way, if the patient answers "yes" to any of the Axis I screening questions, you will need to further assess this category using DSM-IV criteria. If the patient responds "no" answers to the screening questions can be accepted at face value, unless your clinical judgment suggests otherwise (e.g., if the patient says s/he is not depressed, but you observe sad mood, lack of sleep, etc.)

In this brief format, it is not possible to assess **all** of the Axis I diagnostic categories. Screening questions are included for only 18 major diagnostic categories (along with past episodes of major depression and mania), so you will need to be alert for other diagnoses (e. g., sleep disorders, adjustment disorders, factitious disorders, impulse disorders not elsewhere classified).

In addition to the screening questions for major disorders, there are questions representing more full criteria for the important areas diagnostic areas of major depression, panic attacks, and generalized anxiety symptoms. As always, "yes" answers should be explored more fully.

For the **Axis II personality disorder** questions, based on the SCID-II (First et al, 1997), the "yes" responses in the right hand column will signal the possibility of the presence of a diagnosis. More than 5 or 6 "yes" responses in one category **may** signal the presence of a disorder. With 3 or fewer "yes" responses in a category, one can be **relatively** secure that the patient does not meet criteria for that particular diagnosis. However, since patients may be reluctant to report some of the less flattering criteria, clinical judgment remains paramount.

A high number of "yes" responses signal that the therapist should reach for the DSM manual—or the SCID interview forms—and question the patient further to determine whether the behavior actually meets criteria for a diagnosis.

The "yes" responses cannot be accepted as accurate for diagnosis unless the behavior in question occurs in many different settings, has been occurring since childhood or adolescence (or at least for many years duration), and constitutes a serious problem for the patient ("persistent, pervasive, and problematic" according to DSM guidelines). The PAC Forms can save time by suggesting areas for further evaluation, but to make an accurate DSM

diagnosis, the clinician needs to consult the DSM criteria and follow up on the checklist responses, particularly the positive responses.

Although passive-aggressive (negativistic) personality disorder, depressive personality disorder, and self-defeating personality disorder—as noted in Chapter 11 of *Treating Affect Phobia*—are not formally included in DSM-IV, they have been proposed in that manual or elsewhere for further research, and the behaviors described in their criteria are helpful to track in Short-Term Dynamic Psychotherapy.

SUGGESTIONS FOR SCANNING THE PAC FORMS QUICKLY

Each therapist can synthesize the information on the PAC forms according to their own needs. Here is one way to scan the information that we have found helpful:

Page 1

Scan the Main Problems, Medical Problems, and Current Stressors, noting salient problems or questions on the PAC Summary form. Remember that report of alcohol consumption needs careful review.

Page 2

Briefly scan for the following:

- **Extremes in daily functioning:** e.g., not enough sleep/exercise, too much work, etc.
- **Lifelong perspective on best and worst periods:** i.e., quality of life during 5-year periods, lifelong.
- **Worst Time in Life:** Quickly read about the worst time to obtain a sense of the extremes in the patient's functioning. If a patient has been hospitalized or made a major suicide attempt, that is important to know up front. The answer to "who helped" will give you a sense of the person's relatedness—were they able to accept help or elicit caretaking behavior in others, etc.?
- **Shameful issues** should be noted and addressed later, at an appropriate time in treatment.
- **Best Time in Life:** This category gives a perspective on the strengths the patient has to bring to bear on facing problems. Note the reversed order in the response categories. Instead of "No Yes" it is "Yes No;" this is one of the few places on these forms where a "no" response indicates a problem area.
- **Self-Esteem and Satisfaction in Living:** Note negative responses for potential data in support of depression or suicidality (reported on page 3). Positive responses may indicate personal strengths.
- **Self-Assessment of Functioning:** This is one of the most subjective of the response categories, and should only be accepted as valid when all other data supports it.

Pages 3-7

Review the items in each diagnostic category quickly by scanning down the right hand column for "yes" responses. Checking these off on the PAC Summary Form can condense the salient problem information even more

quickly.

Axis I information on Pages 3 and 4

On Page 3, primarily look for presence of depression. Pay particular attention to the subset of depressive symptoms (especially hopelessness, thoughts of dying or suicide) to begin estimating severity. On page 4, scan for type of anxiety and severity by noting the report of anxiety symptoms under the categories PAN (Panic) and AGR (Agoraphobia).

Axis II information on Pages 4-7

Scan the diagnostic categories for the main “yes” responses and note the areas on the PAC Summary Sheet about which you will want to inquire further. On page 5, scan for Cluster C anxiety-laden personality style (avoidant, dependent, obsessive-compulsive, negativistic, depressive). On page 6, scan first for self-defeating or masochistic behaviors; then scan for Cluster A isolated, withdrawn behaviors (paranoid, schizoid, schizotypal). On page 7, (and beginning at the bottom of page 6), scan for the prevalence of Cluster B identity disturbance or impulse control problems (histrionic, narcissistic, borderline, antisocial). Most patients will check items across all three clusters. As noted above, it is important to consider which of the “yes” responses are valid.

The Axis II clusters which predominate can be enormously helpful in guiding the initial sessions in short-term dynamic treatment, because (as discussed in Chapter 3) Axis II criteria are the behavioral embodiments of defensive functioning. Axis II items must change if personality disorders are to be resolved. Items marked “yes” on this form alert you very quickly to the **type** of defensive functioning that will need further exploration. For example, the avoidant patient must come to feel comfortable in social situations (#4, AVD), the obsessive patient must begin throwing things away and tolerating imperfection (#17 & 20, OC), and the patient with borderline personality disorder must come to know what is wanted and not wanted for the self and others (#90-92, BOR). The items under “self-defeating” category—although no longer a category under consideration for Axis II—do contain behaviors that can often contribute to problems such as depression.

The total number of Axis II items that are present (not by self-report, but after being checked by interview) is a useful way to assess the degree of defensiveness of the patient, as covered in detail in Chapter 11 of *Treating Affect Phobia*. Briefly, there are a total of 113 items on the Axis II form. In outpatient work, we have rarely encountered a patient with more than 50 or 60 of those items present. Most of the patients in our short-term research program for personality disorders have 20-40 items that are “valid yes’s”. Patients with 40 or more items marked “yes” are generally highly defended, and need alliance building and/or motivation prior to or along with focusing on presenting problems. Well-adjusted patients often have roughly 5-10 items marked “yes,” as we all have some interpersonal conflicts.

TREATMENT GUIDED BY ASSESSMENT

As discussed in Chapters 3 and 11 of *Treating Affect Phobia*, treatment can vary according to the disorder in question and is also greatly assisted by information on the Axis II forms. For example:

- Many “yes” items in Cluster C together with a moderate or better level of functioning (GAF>50) can indicate that Short Term Psychotherapy may be a useful approach.
- Many “yes” items in Cluster A can signal that the patient may not have the capacity for a ready alliance with the therapist, which is essential for short-term exploratory treatment. Therefore, issues of trust and building capacity for relationships may need to be focused on initially.
- A predominance of “yes” items in Cluster B may signal some disturbance of identity or impulse control disorder, and may call for a therapy approach that initially builds defenses, builds coping skills and develops a more adaptive sense of self and others for the patient—rather than rapidly uncovering conflicts or confronting defenses.

References

- First, M., Spitzer, Gibbon, & Williams (1997), *The Structured Clinical Interview for the DSM-IV Axis I Disorders (SCID-I)*. American Psychiatric Publishing.
- First, M., Gibbon, Spitzer, Williams & Benjamin (1997), *The Structured Clinical Interview for the DSM-IV Axis II Disorders (SCID-II)*. American Psychiatric Publishing.
- McCullough, L., Kuhn, Andrews, Kaplan, Wolf, & Hurley (2003), *Treating Affect Phobia: a Manual for Short-Term Dynamic Psychotherapy*. Guilford Press.

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