Rapid-assessment instruments for practice

John L. Levitt and William J. Reid

Rapid-assessment instruments are brief standardized questionnaires that can be used to facilitate the clinical evaluation of the client and to monitor progress during intervention. In this article, their characteristics, functions, and adequacy of measurement are discussed, and selected instruments are briefly reviewed.

In clinical social work, increasing emphasis is being placed on the use of short-term treatment and contractual agreements between workers and clients and hence on early diagnosis. These trends, in turn, have created the need for the rapid assessment of clients' "conditions" (defined in this article as a class of responses such as behaviors and emotional states). At the same time, more attention is being given to practitioners' efforts to evaluate the outcomes of their cases. Thus, practitioners are being encouraged to study the effects of their practice through single-case designs.[1]

If social work practitioners are to make rapid assessments, an appropriate methodology must be developed. One approach is to use testing or measurement devices for examining and monitoring such conditions of clients as depression, lack of self-esteem, and marital dissatisfaction. These devices may be termed "rapid-assessment instruments" (RAIs). Long the province of psychologists, RAIs recently have been introduced into social work for the purposes of diagnosis and monitoring of treatment.[2] The aim of this article is to provide guidelines and suggest available resources for the use of RAIs as a particularly suitable form of assessment for direct practice.

CHARACTERISTICS

Information about clients' conditions may be collected either directly or indirectly. The direct method involves the observation of a client's behavior in natural settings; indirect methods include the perusal of archival data and interviews with a client and others. Indirect methods, particularly interviews with clients, are now predominant in clinical work.

As a data collection device, the interview is primarily a means of eliciting information directly from the client. Thus, an assessment tool that easily fits into the context of the interview and that systematically structures the client's self-report would be most useful for direct practice. The RAI is such a tool.

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A RAI consists of a standardized series of structured questions or statements designed to elicit information from a client about the client's condition. The form of the RAI is standard in that it does not change over time or from one situation to another. Essentially the same questions or statements are presented the same way each time a RAI is administered. Furthermore, RAIs provide the means for attaching a numerical value to a client's condition and for indicating the degree to which a client possesses that condition. This is accomplished by having the client estimate the frequency of occurrences of behavior or rate himself or herself on scales.

Several important features distinguish RAIs from other measures or tests.[3] In general, RAIs are short (no more than two pages), easy to administer by the client, and easy to complete. They often can be completed in less than fifteen minutes. In addition, directions for completing the instrument and the instrument itself are in simple, clear language that the client can easily understand. Thus RAIs can easily be fitted in a typical clinical interview without interfering unduly with the therapeutic process.

Another important characteristic of the RAI is that it can be scored in about five minutes in the presence of the client, without recourse to complex scoring procedures; ideally, it could be independently scored by the client when self-administered. A RAI lends itself to easy and quick interpretation in that interpretation is straightforward and does not require extensive knowledge of testing procedures or of a particular body of theory.

FUNCTIONS

RAIs serve three functions, which will be considered roughly in ascending order of importance. First, by providing a systematic "sweep" of a particular condition, they may reveal certain items of information (in the client's responses to particular questions) that may not emerge in the clinical interview. For example, a man whose depression appears to be only incidental to other problems may check on the Beck Depression Inventory (one of the selected RAIs discussed later) that he has "definite plans about committing suicide."[4] The client's response would naturally be taken up in the interview. In general, the client's responses to particular items can be used as a basis for exploring problems. Although RAIs are not designed to identify the causes of the client's problems, the client's patterns of response may offer clues to possible dynamic factors.

Second, the client's overall score may be used as an index of the degree of disturbance or deviation in a given condition. This function depends, however, on the availability of norms derived from large-scale testing of the instrument. Ideally, such testing should yield criteria ("clinical cutting scores") that relate scores above or below a certain level to degrees of severity in the condition being measured. Thus, a score of 30 on the Beck Depression Inventory would suggest a severe degree of depression. Such interpretations rest on statistical associations between the test scores and some form of criterion measure. In the case of the Beck Depression Inventory, for example, cutting scores were determined by comparing patients' scores with psychiatrists' ratings of the patients' depressions.

Third, all RAIs may be used over time in repeated measurements of clients' conditions and thus provide data about changes associated with social work services. Scores obtained from the instrument derive informational value primarily in relation to other scores as they vary or not over the course of contact with the client. In other words, a score of 33 provides information, in terms of other scores (25, 45, and so on), about whether the client's condition is improving or deteriorating.

Although RAIs may not obtain change data that could not be collected through typical interviewing methods, they collect information in a more systematic and structured manner. The practitioner is then assured that the same information is acquired in the same way each time, that it is standardized in terms of quantity and comparability, and that it is less vulnerable to the biases and expectancies of practitioners.

The structured format of the RAI is also less time consuming than other formats. For example, it might take from five to ten minutes to complete a RAI, but as long as an entire interview to gather the same information via a question-response-discussion format. Thus, when such information is collected quickly and accurately, the interview can be devoted to more therapeutic purposes.

The change data collected via a RAI can be used to evaluate the general efficacy of therapeutic interaction. By administering the instrument during the initial exploration interviews and then during the intervention sessions, a rough form of baseline-treatment or A-B design is created.[5] If a practitioner intervenes immediately in the client's condition, a B-type (treatment only) design is formed—one that still permits the practitioner and client to examine the progress of treatment. Suppose a client applied for help with feelings of anxiety. A Zung Self-Rating Anxiety Scale (described later) would be administered during the first two exploratory interviews and in every other session during intervention for sixteen weeks. The hypothetical results are presented in Figure 1.

In Figure 1 the results suggest that the client's self-reported anxiety decreased after intervention began. Even if one presumes that treatment started right away and that there was no baseline period, the results still suggest that the client's level of anxiety decreased as intervention proceeded. Thus, the client and practitioner could easily determine that the desired change occurred.

Determining desired (or undesired) changes does not, in itself, provide conclusive evidence about the effectiveness of treatment. Other factors, such as environmental events, could be responsible for positive changes or for canceling out the effects of intervention. Nevertheless, by informing the practitioner if the client's condition is improving, not changing, or deteriorating, RAIs can guide treatment planning. On the one hand, the

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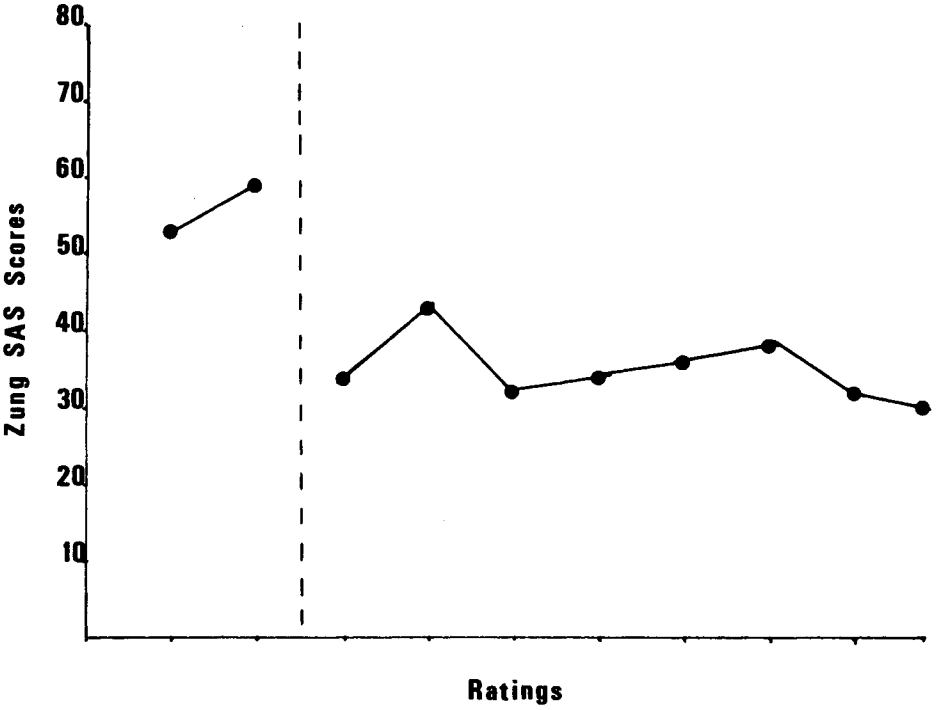
failure of desired change to occur can result in a reappraisal and possibly a revision of the approach to intervention. On the other hand, steady improvement in RAI scores can provide support for continuing previous efforts.

A RAI has two uses: (1) to measure change in a specific target of treatment or (2) to serve as an important indicator of change if intervention is successful. The previous case of the young man treated for anxiety (see Figure 1) illustrates the first of these two uses; a condition is identified as a major target of intervention, is treated, and is monitored by means of a RAI to see if change has occurred.

In the second use, the indicator may not be the direct target of change. In many cases, practitioners do not attempt to intervene in specific problem areas but rather in general personality, family, or environmental systems or structures. In such cases, changes in certain attitudes or behaviors are seen as indicators of changes in these larger units and can be measured by a RAI. An example of this use would be with a woman who sought help for feelings of sadness and hopelessness that seemed related to family problems. The practitioner involved her and her husband and children in family therapy. Although the target of intervention might be the family rather than the woman and her depression, a RAI might be useful in determining if actual changes in the woman's depression occurred with therapy. Indeed, if family therapy was generally efficacious, one would expect a lessening of her depression.

Because a RAI can serve these multiple functions in measuring change, the practitioner does not need to think that intervention is shaped by the particular method of data collection. For example, if the practitioner measures the treatment problem in terms of specific behaviors, he or she tends to think that the target of intervention should be the behaviors measured. For many practitioners, such an approach is egodystonic.[6] RAIs are relatively neutral instruments for measuring the degree or amount of a condition and do not tell the practitioner what should be changed or how the condition should be changed. Therefore, they can easily be introduced into most practice frameworks.

FIG. 1. Hypothetical Data Using a Rapid Assessment Instrument



ADMINISTRATION

Certain aspects of the administration of RAIs are important. If the RAI is administered during the first encounter with the client, the administration should take place before the interview begins or early in the interview. Otherwise, the instrument is likely to reflect the effects of the interview itself. If the client is self-administering the instrument on a regular basis, it should be completed at a specific time and at a specific place (for example, the client's home or place of work). This helps the client and practitioner rule out extraneous influences (such as time or setting) that may have a variable effect on the RAI scores.

Most of a client's problems arise outside the session and frequently long before it takes place. Indeed, many problems occur under a specific set of circumstances that can only be considered in the session through the client's reflection and self-report. For example, a client might feel depressed only at certain times of the day or in certain places. Because a RAI has a simple format and is portable, it can be used to evaluate the degree of a client's problem in the actual circumstances in which the problem is most troublesome to the client. Hence, if a client is most depressed on arriving home from work at 5:00 P.M., then, by having the client self-administer a depression inventory every other day at home at 5:00 P.M., one would be able to evaluate the problem more accurately than by having the client complete the inventory in a treatment session at 1:00 P.M. one day a week.

In addition, the practitioner needs to be aware of potential sources of bias in administration. The attitudes of practitioners or others in the setting produce "demand" characteristics that affect the way a client responds to the items of the instrument. For example, if a practitioner gives cues that the client should be improving, especially

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when the client is completing a RAI, then to meet the perceived "demands" of the situation, the client might complete the instrument differently than if such cues were not present. Hence, practitioners must be careful to refrain from revealing their hopes or expectations concerning a client's responses to the instrument.

Another type of bias arises when the client deliberately attempts to manage the impressions conveyed on the instrument. Indeed, clients can easily manipulate responses on a RAI because of its simplicity and the transparency of its objectives. Thus, if a RAI asks a mother to indicate if she dislikes her child, she may indicate what she feels to be the most socially desirable response even though that is not necessarily how she feels. Furthermore, if a practitioner or agency has some form of hold on the client, such as the client's coming for service under court order or to meet a school's "recommendation" to get help, then the client may deliberately manage the responses so it looks like he or she is improving or otherwise receiving benefit from the service provided.

There is no simple way to assure that such manipulation does not occur. However, by openly discussing the purposes of the instrument and by stressing the need for frankness, it is possible to decrease the likelihood of this form of bias.

RELIABILITY AND VALIDITY

The most important consideration in evaluating a RAI or any instrument is to determine its capacity to generate reliable, valid, and sensitive measurements. Unfortunately, neither the reliability nor validity of most RAIs has been adequately assessed or reported. For example, of the 166 behavior checklists, scales, tests, and inventories they examined, Walls et al. found attainable information on reliability or validity in only 20 percent.[7]

In general, "reliability" of a RAI refers to the consistency of obtained scores when the same individual completes the instrument at different points in time or when parallel or "split-half" versions of the same instrument are administered. Although respectable reliability coefficients are reported for many RAIs, certain cautions must be kept in mind. Stability of measurement on repeated administrations is one of the classic tests of the adequacy of an instrument; however, many conditions measured by RAIs—anxiety, for example—may be expected to show a good deal of variability even over short periods. Thus, reliability at retest may be difficult to obtain and evaluate.

If the interval between retesting is too short, stability over time may not be adequately tested, particularly since the client may remember previous responses on the typically brief RAI. If the interval is too long, time fluctuations in the condition may be measured and hence it may be difficult to assess the amount of stability obtained. The brevity of some RAIs may pose limitations for the usual split-half method of testing intra-instrument consistency. Moreover, since, as was noted before, a client's responses may be guided by the wish to create a general impression, high levels of correlation between different parts of the test may reflect global reactions in which the client responds to all items in a similar manner.

The "validity" of a RAI refers to the extent to which the instrument adequately measures the condition it was designed to measure. As might be expected, convincing evidence that a RAI is adequately measuring a given target condition has proved difficult to obtain. Since typical conditions—anxiety or depression—may have uncertain conceptual boundaries, it may not be simple to determine if the items of the instrument provide a reasonable sampling of the domain to be measured (content validity).

Empirical validation procedures, in which scores of an instrument are correlated with some criterion measure, are limited by the lack of "strong" criterion measures. For example, one commonly used criterion—ratings of clients by clinicians—has a number of well-known limitations, not the least of which is a frequently low level of interrater agreement. Moreover, the question of "valid for whom?" is usually an issue. Evidence of validity that is based on studies of young middle-class adults may not be applicable if the client is an elderly lower-class person.

SENSITIVITY

Although the "sensitivity" of an instrument—its ability to make fine discriminations—may be considered to be a part of validity, it is useful in the present context to regard it, as do Selltiz, Wrightsman, and Cook, as a separate aspect of the adequacy of an instrument.[8] To be used to maximum advantage, particularly in measuring change during the course of intervention, a RAI should be able to detect small fluctuations in a given condition. Since a RAI consists of a set of standard items designed to accommodate a range of situations, it may not be sensitive to the idiosyncracies and nuances of an individual case. For example, a client may not just be anxious with others in general; rather, the client may be anxious with certain types of persons, in certain situations, and so on. Subtle but important changes may arise that may not be tapped by the crude standard items that are found in most RAIs.

The foregoing reservations are designed to alert users to possible limitations of the RAI and not to discourage its use. One must keep in mind that data collected by means of the clinical interview also have measurement problems, possibly more serious, stemming from the biases of practitioners and clients and the lack of systematized data collection.

SELECTED RAIs

In this section, brief descriptions of several RAIs are presented. These examples, which meet the definition and criteria of RAIs presented in this article, were chosen because of their applicability to the clinical practice of social work. Before describing each RAI, it is important to mention several points. First, most of the instruments were developed for use with adults. Although the age at which adulthood begins is not often specified in the instrument, age 16 can be used as a rule of thumb.

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Second, whether reliability and validity studies were performed on the instrument will be noted. However, the extent and form of reliability and validity tests vary considerably. Prospective users of RAIs should examine the evidence for themselves.

Third, whether clinical cutting scores are available for each instrument will be indicated. However, some instruments have several cutting scores to distinguish among different degrees of severity. Again, available material on the use of the instrument should be thoroughly read before implementation.

Fourth, the instruments vary in the degree to which they have been used in actual research. Thus, an attempt will be made to indicate whether such usage has been extensive or limited.

Anxiety

Zung Self-Rating Anxiety Scale (SAS) is a twenty-item scale designed to be rated by adult clients. A comparable clinician-rated anxiety status inventory is also available.[9] Specifically, the SAS was designed to assess anxiety as a clinical disorder rather than as a state of feeling or mood. However, few reliability and validity studies are available, although information about correlations with clinical global impressions, the SAS, and other anxiety scales are in process. The SAS is part of the *ECDEU Assessment Manual* by Guy.[10] The manual, developed under the auspices of the National Institute of Mental Health, consists of tests recommended for use in evaluating the effects of psychotropic drugs.

State-Trait Anxiety Inventory (STAI) is a twenty-item instrument containing two scales—a state scale for measuring transitory, consciously felt anxiety and a trait scale for measuring general proneness to anxiety.[11] The scales may be administered either together or individually to subjects aged 11 years and older. Test-retest reliability and validity examinations have been performed on both scales with undergraduate college students. In addition, normative data have been obtained on college freshmen, college undergraduates, high school students, and neuropsychiatric and medical patients.

Correlations were obtained between the STAI and other personality tests given to undergraduates and hospitalized neuropsychiatric patients. However, no clinical cutting scores have been recommended. Furthermore, the authors' review of the use of the STAI with patient populations found that STAI state-scale ratings were uncorrelated with independent behavioral ratings of anxiety, although the ratings discriminated between normal and abnormal groups. This suggests that ratings may not accurately represent or perhaps may not be sensitive to behavioral ratings of anxiety.

Depression

The Beck Depression Inventory (BDI) is available in either a short form (thirteen items) or regular form (twenty-one items) and is meant to be administered to adults.[12] The BDI has been examined extensively in reliability and validity tests and in clinical research studies. The instrument is intended to measure depth of depression. It provides a score that represents both the number of categories of symptoms and the severity of the particular symptoms. Clinical cutting scores are available. The BDI is also part of the *ECDEU Assessment Manual.*[13]

Zung Self-Rating Depression Inventory (SDS) is a twenty-item scale for measuring the presence and severity of depression; reliability and validity studies have been performed.[14] Meant to be used with adults to assess states of clinical depression, the SDS has been extensively utilized in clinical and some cross-cultural studies. (A practitioner-rated form is also available.) A clinical cutting score is available, and the SDS is also part of the *ECDEU Assessment Manual*, referred to under the SAS and BDI.

Assertiveness

Rathus Assertiveness Schedule (RAS) is a thirty-item instrument for measuring the degree of assertiveness in adult clients.[15] Reliability and validity tests were performed on undergraduate college students. Recently, normative and factor analytic data have been made available.[16] No clinical cutting score is available, However, the RAS has been used in several studies of assertiveness.

Assertion Inventory (AI) is a forty-item instrument designed to measure the degree of social assertiveness in adults.[17] Although no clinical cutting score is available, reliability and validity tests have been performed on undergraduate college students and on women who participated in an assertion training program. The AI has also been used in clinical studies.

Social Interaction

Fear of Negative Evaluation (FNE) is a thirty-item scale designed to measure "apprehensions about others' evaluations, distress over negative evaluations, avoidance of evaluative situations, and the expectation that others would evaluate oneself negatively."[18]

Social Avoidance and Distress Scale (SAD) is a twenty-eight item scale designed to measure an individual's anxiety in social situations and to indicate potential areas of social avoidance.[19] Both the FNE and the SAD were intended for use with adults and have been tested for reliability and validity. Neither instrument has clinical cutting scores.

Marital Problems

Locke-Wallace Marital Adjustment Test is a fifteen-item scale designed to provide ratings of marital adjustment.[20] Originally designed for middle-class individuals, the instrument has been tested for reliability and validity. In addition, the instrument has been used extensively in clinical research. However, no cutting scores are available.

Marital Happiness Scale (MHS) is a nine-item scale developed to provide measures of reported marital happiness for areas considered inherent in most marriages. Originally developed to be a repeated measure in a clinical research study, MHS has not been reported to be subjected to tests of reliability and validity nor does it possess a cutting score. However, Azrin, Naster, and Jones suggest that the measure can be repeatedly used in evaluation and that it probably has some degree of validity based on its

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contiguous changes with experimental conditions.[21]

Dyadic Adjustment Scale (DAS) is a thirty-two-item scale that may be used to provide an overall measure of dyadic adjustment.[22] In addition, the larger scale may easily be broken down into four subscales: dyadic satisfaction (ten items), dyadic consensus (thirteen items), affectional expression (four items), and dyadic cohesion (five items). The DAS has been subjected to factor analytic, reliability, and validity tests, primarily on white working-class and middle-class individuals. However, it has not been used extensively in clinical research studies nor does it have a cutting score.

Clinical Measurement Package (CMP) contains seven scales, each of which comprises twenty-five items.[23] All scales have been tested for reliability and validity, although none has yet been extensively used in clinical studies. The seven scales all have the same cutting score and are scored and interpreted in essentially the same way. The seven scales and what they are intended to measure are as follows: (1) Generalized Contentment Scale (nonpsychotic depression), (2) Index of Self-Esteem (problems with self-concept), (3) Index of Marital Satisfaction (problems with marital relationships), (4) Index of Sexual Satisfaction (sexual problems), (5) Index of Parental Attitudes (parental problems with a specific child), (6) Child Attitude toward Mother (child's problems with the mother), and (7) Child Attitude toward Father (child's problems with the father).

Other RAIs

Several other potential RAIs, which will be described more briefly, are also available. If used at least before and after treatment, they may provide some evaluative information.

Cautela put together several behavior analysis forms that are useful in assessing and targeting various problem areas.[24] The forms that are especially suitable for social work are these: (1) Self-Rating Behavioral Scale, to determine which behaviors the client thinks he or she needs to learn to function more effectively (73 items), (2) Assertive Behavior Survey Schedule, to examine the rate and degree of assertiveness and the client's views of the consequences of his or her assertiveness (9 items), (3) Social Performance Survey Schedule, to examine the parameters that influence the subject's social performance (100 items), (4) Alcohol Questionnaire, to examine the client's and significant others' drinking habits, the client's motivation for drinking, and the client's motivation for wanting to stop drinking (17 items), and (5) Sexual Behavior Survey Schedules, separate forms for women and men that measure anxiety and pleasure and are used to assess various areas of sexual functioning (20 items each). Three other forms—Drug Questionnaire (21 items), Smoking Questionnaire (17 items), and Weight Questionnaire (29 items)—are similar to the Alcohol Questionnaire. They examine various aspects of the problem behaviors noted in their titles.

Wolpe and Lang developed the Fear Survey Schedule to assess various aspects of phobic and fear reactions.[25] The schedule has been used extensively in behavior therapy research and has been factor analyzed.

Stuart and associates have developed three assessment inventories for aspects of family, marital, and sexual functioning: Family Precounseling Inventory, Marital Precounseling Inventory, and Sexual Adjustment Inventory.[26] The three inventories were developed to be administered to the client either before or during the initial interview. In addition, all instruments contain some scales that indicate aspects of attitudes and behavioral functioning that might be used before and after evaluation.

CONCLUSION

In this article the authors explored the use of various short-form instruments that may be used to assess quickly a client's condition for the purposes of diagnosis and the evaluation of treatment. These instruments provide a simple, convenient, and relatively nonintrusive way of examining a client's condition. By using RAIs, practitioners should be able to incorporate an efficient standardized assessment format into their practice.

Having provided guidelines for their selection and use, noted their limitations, and presented selected examples, the authors would encourage practitioners to locate and use RAIs that meet their needs. However, the authors would advise practitioners to use RAIs only as an adjunct to the evaluation methods they already use and to examine carefully any prospective RAI for its suitability to the client's problem, the client's capabilities, and the practitioner's purposes. With these cautions taken into account, the use of RAIs should enhance the diagnostic and evaluative abilities of most forms of social treatment.

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