
Assessing Complexities in Anxiety Disorders: Consideration of Future Directions

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One of the earliest professional tasks mental health service providers are taught in their postgraduate education involves assessment. To take but one example, under the eligibility criteria for doctoral training programs established by the Committee on Accreditation from the American Psychological Association states the following requirement:

Diagnosing or defining problems through psychological assessment and measurement and formulating and implementing intervention strategies (including training in empirically supported procedures). To achieve this end, the students shall be exposed to at least the following areas: theories and methods of assessment and diagnosis; effective intervention; consultation and supervision; and evaluating the efficacy of interventions (p. 7; Guidelines and Principles; APA Office of Program Consultation and Accreditation, 2012).

The prominence of assessment in this statement suggests the centrality of this activity. Interestingly, while assessment is stressed in postgraduate education, many clinicians consider their primary evaluation tactic to be the clinical

interview. Indeed, one recent survey showed that structured interviews are routinely conducted by fewer than 15% of providers (Bruchmüller, Margraf, Suppiger, & Schneider, 2011) suggesting that most practitioners are ignoring a significant portion of their professional training when they enter the workforce. While many professionals fail to continue to rely on select aspects of their postgraduate training, this is a glaring inadequacy not only because of its centrality in graduate coursework but also because of well-established principles showing actuarial prediction of outcomes being superior to clinical judgment (Dawes, Faust, & Meehl, 1989).

To be fair, many clinicians use other assessment instruments to inform practice aside from structured interviews. These measures provide a means for determining specific targets for therapy as well as markers for charting improvement. With the advent of wider acceptance of empirically supported practices (Chambless & Ollendick, 2001), the specific instruments associated with efficacious treatment have become widely known as well. These measures often have the benefit of sound psychometric qualities, and in some instances provide specific cutoffs established using sophisticated methodologies such as receiver operating characteristic curves (ROC curves; Nunnally & Bernstein, 1994) or taxometric analyses (Waller & Meehl, 1998).

And, in the name of additional fairness, assessment procedures that are time consuming are frequently eschewed for simple economic reasons. Specifically, many insurance companies are

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reluctant to cover this aspect of practice or provide coverage that is well below that associated with other professional services. This confounding scenario is one important future policy direction that deserves attention. It is tantamount to seeking medical care for high blood pressure and the only assessment being the doctor inquiring as to whether one feels like their pressure is high.

Despite the aforementioned impediments to assessment, it is nonetheless a central feature of psychological practice. In the case of anxiety disorders, there exist a wealth of measures that specifically evaluate the presence and severity of many major presenting problems (for a compendium of measures, see Antony, Orsillo, & Roemer, 2001). The existence of well established and psychometrically sound assessment measures is a critical development for determining treatment outcomes. It is also critical for developing these very same efficacious treatment plans (Antony & Barlow, 2010).

However, it is also the case that many anxiety disorders are associated with relatively common complicating features. The accumulating evidence suggests that there are numerous instances where treatment recommendations vary as a function of specific complicating factors associated with different diagnoses. To take one example: Social Phobia has well-established cognitive-behavioral treatment protocols for both individual (Turk, Heimberg, & Magee, 2008) and group (Heimberg & Becker, 2002) formats. However, a large percentage of Social Phobia sufferers also abuse alcohol and other sedating substances. When this problem is present, treatment must also focus on problems of substance use and dependence either before, or concurrent to, treating Social Phobia (Randall, Book, Carrigan, & Thomas, 2008). Failure to attend to this important feature would increase the likelihood of poor treatment adherence and drop out given the demands of treatment for Social Phobia that is uncomplicated by substance abuse, such as exposure and other anxiety producing treatment challenges. This text has aimed to cover some of the major complicating features associated with anxiety disorders, and describe assessment strategies for the

complicating problems that might be less familiar to those who have developed the skills to treat uncomplicated presentations of the different conditions.

While complications associated with disorders are relatively common, there are also several assessment strategies that are familiar to clinicians in a general way, but less familiar as they specifically apply to anxiety disorders. For example, objective personality assessments such as the MMPI are well known, but the applicability to a diagnostic set such as anxiety disorders are not typically described as part of postgraduate education. Nonetheless, since measures such as these are routinely administered, it is essential to elucidate their utility in clinical practice with people with anxiety disorder. Indeed, sticking with the example of the MMPI, the chapter in this volume makes clear that while the measure is valid and well researched, the specific recommendations for interpretations in relation to anxiety disorder clients is far less clear.

Finally, there has been considerable interest in cognitive assessment in the anxiety disorders. Some of the interest stems from a research agenda promoted by funding agencies that stress the identification of neural mechanisms and correlated behavioral indicators that are specific to different psychopathology. While there are good questions as to how much value this research agenda has produced (see, for an example, Whiteside, Port, & Abramowitz, 2004), it has sparked great interest in understanding the relationship between basic cognitive processes such as attention, memory, judgment, and reasoning as it relates to anxiety disorders (Power & Dalgleish, 2008; Williams, Watts, MacLeod, & Mathews, 1997). This has begun to move beyond the research assessment arena into the treatment realm. Specifically, treatments aimed at training anxious clients in differential attention away from threatening stimuli have been piloted and show early promise (i.e., Najmi & Amir, 2010). With the advent of this approach to treatment, reliant as it is on automatic processes, it will be essential that providers have a solid set of assessment skills at their disposal to evaluate improvement.

It is our hope that this volume will alert readers to new approaches to assessment in anxiety disorders, highlight methods of evaluation for common complicating factors, and draw attention to limitations in the existing methodologies in order to promote additional research on the process. Through all of this, the connection between assessment and treatment has been emphasized, and it is also our hope that readers will develop a more fine-tuned set of therapeutic strategies to provide more individually tailored interventions for their anxious clients.

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