

Definition and Interview

A diagnostic interview is a data-gathering assessment whereby standardized cognitive instruments, behavioral checklists, rating scales, and interviews with individuals familiar with the client are used. It should be noted that it is common that observations from school personnel and parents (Barkley, 1990).

Two lists of criterion behavior subtypes in the DSM-IV. A dependent upon a menu list have to be present for a diagnosis and 6 of 9 criteria are to be met for hyperactivity/impulsivity. Behaviors include failing to pay close attention, sustaining attention in play activities, a seemingly inability to listen, and difficulty organizing tasks. Hyperactivity criterion often include fidgeting with hands or feet, leaving a seat in a classroom, talking incessantly, and running about excessively. Impulsivity criteria behaviors are often blurting out answers, difficulty waiting his or her turn, and interrupting others (APA, 2000, p. 86). It may be difficult for the person conducting the assessment to determine what is "often" when reacting to reports from others.

Although structured and semi-structured clinical interviews are available, Brown (2000) contended that many counselors utilize nonstandardized interviews. The Diagnostic Interview Schedule for Children (Shaffer, 1992) and the Semistructured Clinical Interview for Children and Adolescents (McConaughy, 1996) have been considered effective tools when reviewing technical data (Edwards, Schultz, & Long, 1995).

Parent and teacher interviews are important sources of information for the person conducting the assessment. Rating scales are available to collect this data. In addition to securing parent and teacher information behavior, rating scales such as the Behavior Assessment System for Children (BASC; Reynolds & Kamphaus, 1992), the Conners Rating Scales (1997), and the Child Behavior Checklist (Achenbach, 1991a, b) are good scales to assess for the problem and for adaptive behaviors. A detailed developmental history also is recommended. This history-taking will shed light upon the age of onset as well as any parental history of this disorder.

Another source of data collection can be secured from behavioral observations, such as classroom interactions. Brown (2000) indicated that these observations are useful in making interventions and recommendations.

Finally, psychological and psychoeducational assessments through the use of standardized instruments

are common approaches. These approaches usually include intelligence tests, achievement tests, and specific achievement batteries designed to assess for attention deficits.

This is a six page SAMPLE of Chapter 3 from the Arthur-Brende Study Supplement for the National Clinical Mental Health Counseling Examination.

Note that the actual Chapter 3 is 54 pages long. In addition, the Study Supplement contains 4 total chapters.

counseling and later diagnosed cause of employment abuse issues (Wadsworth & Wadsworth, 1997) for ADHD for adults individual to recall behaviors school years, because the childhood. Comorbidity also have another disorder at the end and Heckman (1976) social personality, anxiety, and adult studies when compared to children with ADHD.

Incidence

Greenhill (1998) indicated that ADHD in the United States is one of the most common childhood mental disorders. It is reported in the DSM-IV-TR that an estimated prevalence of attention-deficit hyperactivity/impulsivity is approximately 3% to 7% in school-age children (APA, 2000). Furthermore, an estimated 10% to 60% of children with ADHD continue to have the disorder as adults (Alpert et al., 1996). Barkley (1990) indicates that at least 50% of children with ADHD may develop mood disorders, particularly Bipolar spectrum disorders (Pavuluri MN et al., 2006). Hudziak et al. (1995) reports that it is estimated that 70% of the children diagnosed with ADHD are the sons and daughters of parents who have ADHD (inherited) or reveal symptoms of ADHD. Wadsworth and Harper (2007) report the estimated percentage of adults with ADHD is 4.7% worldwide.

Diagnostic Information

In U.S. society, children and adolescents suffer with increasing numbers of behavioral symptoms and problems with learning. The most frequently diagnosed condition, Attention Deficit Hyperactivity Disorder, may account for such difficulties most of the time. Typically beginning prior to age seven, symptoms appear more often in boys than girls and cause disruption in school and home. A developmentally inappropriate poor attention span and age-inappropriate features of hyperactivity and impulsivity characterize the disorder. It must be present for at least six months and interfere with academic or social functioning. The cause of such difficulties is frequently genetically based, although they have also been associated with child abuse and neglect. Children in institutions are frequently overactive and have poor attention spans, but such symptoms disappear when these factors are removed. Predisposing factors to ADHD may include the child's temperament, genetic-familial elements, and the demands of society to adhere

to a regimented way of behaving and performing. A low socio-economic standing does not seem to be a predisposing condition (Kaplan & Sadock, 1998).

Instrumentation

Assessment for ADHD usually involves a battery of instruments that are cognitive, behavioral, and syndrome-specific. Cognitive assessment using intelligence and achievement tests for ADHD tends to reflect upon deficits in attention, cognitive control, memory, and global intelligence. Loge, Staton, and Beatty (1990) found ADHD children to score lower than controls in Full Scale IQ, Information, Arithmetic, Digit Span, Block Design, and Coding on the WISC-R. Kaufman (1990) referred to the subtest deficits in arithmetic, coding, information, digit span, as the "ACID" profile frequently seen in children and adults with ADHD.

The following tests are considered to have good validity and reliability for such assessments:

1. Wechsler IQ test (WPPSI-R, WISC-III, WAIS-R; Wechsler, 1991)
2. WIAT or WIAT (Wechsler Individual Achievement Test; Wechsler, 1992)

Behavioral assessment provides important sources of information for the evaluator; however, behavioral reports are known to be frequently inaccurate. Accuracy is affected by social desirability, halo effects, parent exasperation, and leniency errors. A number of rating scales, frequently parent and teacher forms, are available to assess ADHD. Some of these are:

1. Disruptive Behavior Disorders Rating Scale (Pelham, Gnagy, Greenslade, & Milich, 1992)
2. Child Behavior Checklist (CBCL; Achenback & Edelbroch, 1986)
3. Impairment Rating Scale (Pelham et al., 1996)
4. Conners Rating Scale-Revised (Conners, 1997)

A final measure for data gathering is the Continuous Performance Test (CPT). This type of test assesses attention, impulsivity, and distractibility using letters or numbers projected on a screen (Guevremont, DuPaul, & Barkley, 1990). This is a state-of-the art test, since it records the child's actual performance, rather than the reports of observers. It is important to remember that children tend to act out rather than verbalize psychiatric disorders such as depression or anxiety. Thus, children may appear to have ADHD per observers, but may actually have another Axis I diagnosis. Careful assessment includes instruments to rule out other disorders that may mimic ADHD. A differential diagnosis is important when considering ADHD.

Adult ADHD: In assessing for adult ADHD there should be evidence of six symptoms related to hyperactivity or

inattention maladaptive behavior and present for at least six months. Comorbid Disorders associated with adult ADHD are: Oppositional defiant, conduct disorder, antisocial personality, substance abuse, learning, mood, and anxiety disorders (Spencer, Biederman & Wilens, 2004). Spencer, Biederman, Faraone et al. (2001) report that Tourette's syndrome and tic disorders are found in conjunction with ADHD.

Compared to children, adult assessment should focus more on cognitive deficiencies than overt behavior symptoms displayed by children (Weiss & Weiss, 2004). Woods et al. (2002) suggest assessing functional impairment by observing the adult's ability to respond to sustained and divided attention, verbal fluency, complex information-processing, response inhibition, and verbal list learning. Continuous Performance Tasks (CPT) are helpful to assess sustained attention and response control.

Treatment:

A combined intervention of medication and counseling is the preferred treatment for ADHD symptoms (Montano, 2004; Weiss & Weiss, 2004). The focus of psychotherapy or counseling is empowering the client to take personal responsibility for his or her own behavior and learning to recognize the relationship between difficulties managing behavior to difficulties with focusing and cognitive functioning.

Weiss and Weiss (2004) recommend the following activities to be a part of the treatment plan for adult ADHD.

- a. Education about ADHD
- b. Attention management training
- c. Behavioral management training
- d. Social skills training
- e. Stress management training
- f. Anger management training, and
- g. Problem-solving training

These authors caution counselors that insight therapies and non-directive therapies may not be as helpful as structured, directive therapies (medical, psychoeducation, behavioral intervention, cognitive restructuring, communication, social skills training, and family of origin exploration.)

Children:

ADHD is one of the most effectively treated childhood disorders. Goldstein (1994, 1996) recommends a multimodal, multidisciplinary, and long-term approach as treatment. He recommended parent counseling and training, client education, individual and group counseling, social skills training, psychopharmacological medication and school intervention. Treatment involves using behavioral and pharmacologic treatments. A

number of medications have been prescribed; however the stimulant Methylphenidate (Ritalin) has been the pharmacologic intervention first used most frequently in the past (with Adderall and Concerta also becoming quite commonly prescribed) with a response rate for children and adolescents reported to be 70% (Spencer, Biederman, Wilens, & Faraone, 1996, 1998).

ADHD symptoms occur in 6% to 9% of children in the United States. Physician visits by children with this disorder have been up 90% in response to a two-fold increase in this diagnosis being made over the past seven years. Although stimulants are used to treat the majority of children with ADHD, some disadvantages have been reported, such as the transitory nature of the effects, which cease when medication is not used, a failure rate of 30% to 40% and concerns about possible long-term safety (Rappley et al., 1999). Some professionals have been concerned about stimulants and have sought other treatments including Electroencephalogram (EEG) neurofeedback training, a novel treatment approach, which some researchers claim is both effective and more enduring (Kirk, 2000; Lubar, Swartwood, Swartwood, & O'Donnel, 1995).

A home-based (behavioral intervention) five-step plan, which also can be used in the office, is a recommended treatment for ADHD, as follows:

1. Conduct an assessment and psychoeducation
2. Attention training
3. Reinforcement techniques
4. Maintenance and implementation of the plan to new situations
5. Follow-up (Kronenberger & Meyer, 1996)

School-based behavioral interventions also have been effective. These programs involve antecedent management techniques, contingency management, and token economies. Cognitive-behavioral interventions have been effective in teaching children self-talk, self-monitoring, and problem-solving strategies.

Treatment: Adults

Spencer, Biederman, Wilens, and Faraone (1998) found in their studies that adults with ADHD were as responsive to the same or similar groups of stimulants as children and adolescents. Mattes, Boswell, and Oliver (1984) found the response rate for adults to be 25%. It is however, not uncommon for physicians to prescribe anti-depressant medications, including Atomoxetine (Strattera) rather than stimulants to treat for ADHD but find that patients with significant symptoms do not experience much improvement. Group counseling is recommended to encourage participants to share coping strategies and enhance socialization, thus reducing the stigma and isolation sometimes associated with ADHD.

Methylphenidate (Ritalin) - including the long acting form of Ritalin (Concerta) - and amphetamine - including the combination of dextroamphetamine and racemic amphetamine salts (Adderall) - are the most commonly prescribed medications for adults (Michelson, et al., 2003). When medications are prescribed and taken the counselor should monitor for any adverse affects such as insomnia, headache, and edginess for amphetamine compounds. For atomoxetine (Strattera) adverse affects may be gastrointestinal discomfort, more difficulty sleeping, sexual dysfunction in men (Michelson, et al., 2003), and mild increase in heart rate and blood pressure (Spencer, Biederman, Wilens, et al., 2003).

Monitoring

Self-reports and observations in overt behaviors are recommended. Bechen (2003) and Jackson and Farrugia (1997) provide a few examples suggesting that there be a reduction in:

- a. Lengthy pauses in a speech pattern (inattentive)
- b. Abrupt stop in speaking in the middle of a sentence
- c. Forgetting what they saying
- d. Wandering into places forgetting the reason for going to that place
- e. Requesting repeats of what was said to them or requested of them
- f. Staring into space rather than focus on a person.
- g. Interrupting others (impulsivity)
- h. Wanting things immediately (impulsivity)
- i. Not thinking about consequences (impulsivity)

Conduct Disorder

Definition and Interview

The DSM-IV-TR (APA, 2000) describes conduct disorder as a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated (p. 93). 15 specific criteria are divided into four categories: (a) aggression to people and animals, (b) destruction of property, (c) deceitfulness or theft, and (d) serious violation of rules (p. 94). This criteria list includes behaviors such as bullying, initiating physical fights, using a weapon to cause serious physical harm to others, perpetrating physically cruel acts on people and/or animals, stealing, running away from home, and deliberately destroying property. As in several other disorders, the child or adolescent's disturbance in behavior must include impairment in social, academic, or occupational functioning. The clinician also specifies whether the disorder is childhood-onset or adolescent-onset (no behavioral observations before age 10) and whether the behaviors are considered mild, moderate, or severe. At least 3 of the 15 criteria must be met within a 12-month time period. It also should be noted that Oppositional Defiant Disorder is closely related but less severe than conduct disorder. Conduct disorder also

overlaps and includes many symptoms of ADHD, suggesting a need for the clinician to assess the presence of attention and hyperactive symptoms. Finally, gender differences appear to be significant. The DSM-IV criteria indicates that males are more aggressive and confrontational compared with females, who tend to act out delinquency behaviors such as lying, truancy, running away, substance use, and prostitution (Frances & Ross, 1996).

In most cases, the assessment of children with Conduct Disorder can be difficult and confusing, because of parent and teacher misinformation, counselor countertransference, comorbidity, and confounding cultural and situational factors (Sommers-Flanagan & Sommers-Flanagan, 1998). According to Frick et al. (1994), children and adolescents with Conduct Disorder tend to have deceitful and manipulative behaviors. They minimize their difficulties, deny personal responsibility, and blame others for their social and academic difficulties. They cannot be trusted to provide accurate information about themselves on self-reporting instruments or structured interviews. However, during the data-gathering process, the interviewer can use these reports to highlight or reveal the client's capacity for lying and deceiving by comparing and validating the self-assessment data with other, more objective, information.

The parent and teacher observations as reported on paper-pencil forms, at best, are highly suspect. Reliability coefficients characteristically have been very low (Kazdin, 1995) because supervision of children has tended to be minimal so that many delinquent behaviors are concealed from adult awareness.

Counselor countertransference reactions can provide a clue during the assessment interview. On one hand, the interviewer may feel angry, rejecting, or retaliative during the interview (Willock, 1987). On the other hand, the inexperienced interviewer may overlook or minimize the client's destructive behaviors (Sommers-Flanagan & Sommers-Flanagan, 1993). Sommers-Flanagan and Sommers-Flanagan (1998) stipulate that comorbidity is commonly found with the following Conduct Disorders, as follows:

- a. Attention-Deficit/Hyperactivity (45%-70%) (Fergusson, Horwood, & Lloyd, 1991)
- b. Oppositional Defiant (84%-96%) (Hinshaw, Lahey, & Hart, 1993)
- c. Substance Abuse and Dependence Disorders (52%) (Frances & Ross, 1996; Meyers, Burket, & Otto, 1993)
- d. Depressive Disorders (15-35%); (Harrington, 1993)
- e. Anxiety Disorders (15%) (Cohen, Cohen, Kasn, Velez, Hartmark, Johnson, Rojas, Brook, & Streunig, 1993)

The therapist is cautioned not to make a diagnosis of Conduct Disorder too quickly, unless the behaviors are symptomatic of the underlying dysfunction and not a function or reaction to socio/cultural context or gender differences (APA, 1994). Sommers-Flanagan and Sommers-Flanagan (1998) suggest the following as a guide to the interview process for Conduct Disorder:

1. Be familiar with DSM-IV behavioral criteria.
2. Use multi-method, multi-rater, multi-setting assessment procedures.
3. Be familiar with the literature on differential diagnoses and develop checklists.
4. Obtain historical information before completing assessment interviews.
5. Rule out adverse family environments, social forces, and cultural circumstances.
6. Consult with colleagues.

The actual interview may take a combination of one of four forms: a) structured, b) unstructured, c) attachment-oriented, and d) morality-values-oriented (Sommers-Flanagan & Sommers-Flanagan, 1998).

The structured interview is frequently used to obtain the presence or absence of the 15 criteria of the DSM-IV-TR. According to Costello, Edelbrock, Dulcan, Kales, and Klavic (1984), this type of interview for Conduct Disorders has many limitations as well as low correlation coefficients. The structured interview is considered an effective method to obtain the developmental history (Sommers-Flanagan & Sommers-Flanagan, 1993; Tolan & Cohler, 1992). The interview is to be structured because clients with a conduct disorder are known to attempt to control the interview through the manner of presentation. Often the interviewer can expect the client to use threatening type behaviors (Yates, 1995). Answers to the developmental history are important to determine reactive or proactive aggressive behaviors of the client (Vitiello & Stoff, 1997).

The unstructured interview is useful in obtaining historical information such as antisocial or illegal behaviors. With this type of interview, the interviewer can not only observe how the client reports involvement with others but also use the information gained as a reliability measure.

The attachment-oriented interview, which can be useful for a variety of disorders, focuses on observing the opportunities and abilities the child or adolescent has with forming attachments. These attachments can be observed through the client-counselor interactions. According to Bradford and Lyddon (1994), one of four types usually is apparent. First, note whether the client is disrespectful of the interviewer. Second, assess the client's ability to form attachments by asking an open-ended question in which the child is to hypothesize, in a

given situation, with whom he or she would choose to be. Third, listen for themes such as harm-protection-safety, lack of intimacy-closeness, dependence-independence, and bad attitude information. Fourth, assess for morality and values through the use and involvement in simulations.

Incidence

The DSM-IV-TR (APA, 2000) indicates that conduct disorders are prevalent in the general population from less than 1% to more than 10% higher in males than females (p. 97).

Treatment

While developing a treatment plan, the clinician will want to keep in mind that individuals with a history of behaviors commensurate with Conduct Disorder generally have exhibited those behavioral patterns for a long time. Kazdin (1995) and APA (1994) pointed out that Conduct Disordered clients are typically resistant to treatment, especially outpatient therapy (Kazdin, 1996, 1998). Yates (1995) reported that during treatment adolescents with Conduct Disorder frequently exhibit transference issues because they feel threatened, manipulated, and will often seal off to the therapist or examiner. Some of these clients demonstrate improved behaviors if Axis I disorders such as ADHD, Anxiety Disorder or Mood Disorder can be treated (Bernstein, 1996; Biederman, Baldessarini, Wright, Keenan, & Faraone, 1993; Frances & Ross, 1996). Conduct Disorder treatment at home can be recommended for some if firm behavioral controls are maintained. Out-patient psychotherapy is most appropriate for some youth if they have a high level of ego integration (usually not the case), experience guilt, are capable of empathy, and can form relationships (Yates, 1995); for the very young (pre-and early school) if they have successfully been treated with cognitive-behavioral theory (social learning theory) (Kazdin, 1993). Research has indicated that children with severe conduct disorder problems may respond to long-term, highly structured residential treatment facilities that emphasize respect for authority and peer-monitored behavioral interventions. However, as these children move from early adolescence, the effectiveness of these treatments are diminished. Lastly, functional family therapy using behavioral, structural, strategic, and communication techniques are recommended for the entire family. Generally speaking, the earlier and more aggressive the interventions, the better the prognosis.

Instrumentation

Assessment for Conduct Disorder usually involves gathering data from the family, child, school, and community. One or two instruments will be listed for each source or area.

Individual

1. Minnesota Multiphasic Personality Inventory, Adolescent Form (MMPI-A; Butcher & Williams, 1992)
2. Adolescent Antisocial Behavior Checklist (Ostrov, Marohn, Offer, Curtiss, & Fexzko, 1980)
3. Child Behavior Check List (CBCL; Achenbach, 1992; Achenbach & Edelbrock, 1991a)

Parent, Teacher, Family Members

1. Dyadic Parent-Child Interaction Coding System (Eyberg & Robinson, 1983)
2. Family Intake Form (Horne & Sayger, 1990)
3. Genogram (McGoldrick & Gerson, 1985)
4. Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1978)
5. Teacher Report Form (Achenbach & Edelbrock, 1991)
6. Medical Records

Projective Instruments

1. Rorschach Inkblots (Exner, 1993)
2. Child Apperception Test (Murray, 1943)

Oppositional Defiant Disorder

Definition and Interview

“The essential feature of Oppositional Defiant Disorder is a recurrent pattern of negativistic, defiant, disobedient and hostile behavior toward authority figures that persists for at least six months ” (APA, 2000, p. 100). In addition, at least four of the following behaviors must be present: losing temper, arguing with adults, actively defying or refusing to comply with the requests or rules of adults, deliberately doing things that annoy other people, blaming others for his or her own mistakes, being or easily annoyed by others, being angry and resentful, and being spiteful or vindictive. The frequency and intensity of the behaviors must be greater than for those typically found in children of comparable age and development. The individual must experience impairment in social, academic, or occupational functioning. “The diagnosis is not made if criteria are met for Conduct Disorder, or if symptoms occur in conjunction with a Psychosis, Anti-Social Personality Disorder or Mood Disorder in an individual over 18 years ” (APA, 2000, p. 100).

This disorder is characterized by the client's deliberate intent to annoy, to be resistant, and to resist compromise. It is possible these defiant behaviors may not be apparent in the interview. Distinctive features are as follows: Oppositional Defiant clients have less-serious physical aggression than Conduct Disorder clients, behaviors are more evident at home than at school, and opposition is usually directed at known individuals.

Incidence

The incidence of Oppositional Defiant Disorder is reported to be in the range of 2% to 16% of the population (APA, 2000). The onset may occur as early as five to six years of age but can be apparent even in preschool children. However, it is more likely to surface in late or early adolescence. This behavior is more common in males than females, but by the teenage years there seem to be as many females as males.

Instrumentation

As with Conduct Disorder, Attention Deficit Hyperactivity Disorder and social phobias, behavioral checklists are available, including the following:

1. Child Behavior Checklist (CBCL; Achenback, 1991a)
2. Parent Report Form (Achenback, 1991b)

Delirium, Dementia & Cognitive Disorders

Disorders of cognition include Delirium, Dementia and Amnesic Disorders. These disorders are defined as being secondary to a general medical condition, use of substance or medication, or combination of the two. The American Psychiatric Association (2000) groups these mental disorders into three sections: a) Delirium, Dementia and Amnesic and other Cognitive Disorders; b) Mental Disorders Due to a General Medical Condition; and c) Substance-related Disorders (p. 135). Making a diagnosis of cognitive disorder is often more difficult in the elderly because it may be difficult to differentiate the normal vicissitudes of emotional and cognitive changes caused by aging from the abnormal cognitive functioning typical of mental disorders (Gintner, 1995).

Delirium

Definition and Interview

The APA (2000) defines Delirium as a disturbance in consciousness (i.e., reduced ability to focus, sustain, or shift attention) and disturbance in cognition affecting memory, orientation, language, or perception. Liability of mood (i.e., crying or irritability), and disorientation (for the correct year, month, day, or hour) are common. The disturbance has a rapid onset and may fluctuate with periods of normal mental functioning or may continue for days or weeks.

The causes of Delirium can be a general medical condition, substance use or withdrawal, multiple etiologies, and unspecified etiology. Delirium types commonly are referred to as central nervous system disorders (i.e., head trauma), metabolic disorders (i.e., hypoglycemia), cardiopulmonary disorders (i.e., respiratory failure), substance-induced (i.e., alcohol withdrawal) and systemic or central nervous system illnesses (i.e., encephalitis; APA, 1999). Reactions to medications or combinations of medications are not

uncommon sources of delirium in the elderly. Gintner (1995) outlines four steps or questions to follow during a differential interview for Delirium. Step 1 is to determine if the psychological symptoms are accompanied by any metabolic problem, such as fluctuating blood sugars found in poorly managed or previously undiagnosed diabetes. Step 2 is to determine if there is a worsening, chronic physical disorder such as a cardiovascular or respiratory problem causing diminished oxygenation of the brain. Step 3 is to determine if a prescription drug could be inducing the symptoms, and Step 4 is to determine what cognitive impairments are present.

Incidence

The prevalence of Delirium varies considerably when reviewing different populations. For example, the APA (2000) reported ranges for the hospitalized medically ill patients to be 10% to 30%, hospitalized elderly 10% to 15% on admission, and 10% to 40% may be diagnosed with Delirium while in the hospital. Typical Delirium symptoms resolve within 10 to 12 days, yet for some last up to six months. Elderly patients are likely to experience more prolonged symptoms. The prevalence in the general population is 0.4% in adults age 18 years and older and 1.1% in those ages 55 and older (APA, 2000).

Treatment

Delirium is considered a medical emergency with a high mortality rate if the client is not correctly referred for medical diagnosis and treatment. In most situations, the risk to clients with Delirium can be reduced if the condition is promptly diagnosed, treated, and managed in an orderly manner. This involves searching for the underlying cause, treating the condition, monitoring the client's safety, developing alliances, educating the client and family members regarding the illness, and providing for environmental and supportive interventions. Wise (1995) views Delirium treatment as reversing the reasons for Delirium and controlling the agitation which often accompanies the patient's confusion and paranoia. Treatment requires the presence of a physician to determine the cause of the Delirium and prescribe treatment, including pharmacological intervention if the patient is agitated. It is important that an individual suffering from a Delirium have exposure to reduced stimulation and be surrounded with familiar things and psychoeducation is recommended for the client and family members.

Instrumentation

Instruments to consider in assessing Delirium (APA, 1999):

1. Delirium Symptom Interview (DSI)
2. Confusion Assessment Method (CAM)
3. Delirium Scale (D scale)
4. Global Accessibility Rating Scale (GARS)
5. Saskatoon Delirium Checklist (SDC)