Guidelines on diagnostics case reports for the master's programme in Neuropsychology, clinical variant*

* These diagnostics guidelines have been drawn up for degree programmes at Maastricht University's Faculty of Psychology and Neuroscience in accordance with the psychodiagnostics case report guidelines for the Psychodiagnostics Basic Registration Certificate (*Basisaantekening Psychodiagnostiek*, abbreviated 'BAPD').

1. General

During the clinical internship, the student selects three case studies and elaborates them as described in section 3 of this document. Supervision consists of a minimum of 20 hours in total, spread out over multiple times and channels (phone calls, emails, Skype sessions, meetings) and meets the requirements set out in the regulations, and specifically in section 2 of this document.

2. Twenty hours of supervision

2.1 The choice of supervisor

As an intern enrolled at Maastricht University, the student will have two supervisors (mentors): one affiliated with the Faculty of Psychology and Neuroscience at Maastricht University and one who works in the institution where the student is doing their internship. The supervisor at the institution providing the internship is required to have demonstrable experience and training in psychodiagnostics, care needs assessment and treatment (for example, they are a qualified 'Healthcare Psychologist' (*gezondheidszorgpsycholoog*) or hold a similar postgraduate qualification).

The student must receive a minimum of 20 hours of supervision, consisting of individual supervision within the internship setting alongside group supervision in 'Clinical Supervision' meetings coordinated by Maastricht University before and during the internship. The supervision period is the same as the internship period.

It is not permitted to act as a supervisor if:

1. there is a family relationship, a personal relationship or an economic partnership between the supervisor and the student;

2. the supervisor is the student's employer or manager.

2.2 The supervisor's role and responsibilities

The supervisor at the institution providing the internship bears responsibility for supervising the student in their personal learning process within the context of the clinical internship. This concerns the development of a basic level of knowledge and skills in psychodiagnostics, care needs assessment and treatment.

This supervisor bears shared responsibility for compliance with the provisions set out in this document.

In the event of irregularities or deviations from the provisions of this document, the supervisor at the internship institution must inform the supervisor at Maastricht University within two months after this has first been established, notifying the student accordingly.

Both supervisors oversee the student during the preparation of the case reports required for the Neuropsychology master's programme at Maastricht University. This supervision will focus on the following aspects:

a. the structure and presentation of the report;
b. the quality of the case study in terms of its content;
c. the formal requirements relating to psychodiagnostics, care needs assessment and treatment that the case study report must meet, as described in this document.

At the start of the supervision period, the supervisor at the internship institution and the supervisor at Maastricht University draw up a supervision agreement together with the student. This supervision agreement forms part of the clinical internship contract. The supervision agreement must as a minimum include the following:

a. the work plan;
b. the duration of the supervision period;
c. the frequency and duration of the supervision meetings;
d. the method of reporting by the supervisee and the method of assessment to be employed by the supervisor.

At the end of the supervision period, both supervisors will issue an assessment.

The supervisor at the internship institution will evaluate the practical part of the clinical internship. A model for this is provided on Eleum, which should be regarded as a guide for discussion of the student's relative strengths and challenges. The assessment by the supervisor at Maastricht University focuses on the clinical activities report, the three case reports and the final mark. The assessment of the practical part of the internship by the supervisor at the internship institution will be taken into account in the final mark. Where the reports are concerned, the supervisor at the internship institution must provide a declaration stating that they pertain to real cases that were examined by the student independently (though under supervision) and were completed to a sufficient level of competence.

3. The three case reports

3.1 General

The three case reports must cover as broad a range as possible in terms of diagnostic issues and the psychodiagnostic tools used. At the time of submission the case reports may be no more than two years old. For more information about the requirements relating to the diversity of the case studies, see section 3.3 in particular.

Maastricht University uses these reports to test students' knowledge and skills in the field of general psychodiagnostics. No distinction is made between psychodiagnostics in a non-clinical setting and a clinical setting. For this reason, the same model is used for case study reports in both settings, and the components of the case study report are denoted by terms that apply in non-clinical and clinical settings alike. However, the explanations of the various components do differentiate between the terminology used in each setting.

The reports should be drawn up in line with the General Standard for Test Use (*Algemene Standaard Testgebruik*) (Dutch Association of Psychologists, 2010). However, in order to allow assessment of the diagnostic decision-making process, the reports must also meet other additional requirements (see sections 3.2 and 3.3). The case report must be written in such a way that it is clear how the conclusions and recommendations derived from the research findings relate to the diagnostic issues and hypotheses, and what further light a scientific-professional evaluation can shed. The components of the report reflect the steps taken when working through the diagnostic process. The report must demonstrate that the diagnostician has used information sources that are appropriate to the exercise of responsible practice (whether clinical or non-clinical). These sources of information comprise extant theoretical and empirical material in the relevant research area, the set of research tools available for diagnostic research in the relevant domain, an understanding of the error and bias inherent in subjective, unsubstantiated assessment and lines of reasoning, and the professional experiential knowledge that has been documented in guidelines, protocols and case studies. Considerations, choices and decisions should be explained with reference to the literature used. The report should also discuss the oral and written reports provided to clients and/or the principal and how these proceeded. In view of the requirements described above, these reports differ from the way real case reports are normally drawn up in practice. Each report must be no more than 7000 words (including raw scores and normtables, and works cited, but excluding the cover page; for the report itself a maximum of 5000 words is acceptable). The supervisor at Maastricht University will ask the student to clearly delineate and explain each choice made during the process and to substantiate them based on the scientific literature.

3.2 Components of the case report

The case report is made up of the following components:

1. Client data

2. Reason for referral

3. Intake

4. Design of the examination

5. Observations and impressions

6. Examination

7. Summary and comprehensive picture

8. Conclusions and recommendation

9. Evaluation

10. Ethics

11. Signatures of student and supervisor at the internship institution

12. Appendices

Below is a short description of the required content of each component. In the sections that follow, the specifics and framework of the diagnostic process are described in greater detail.

3.2.1 Client data

All personal data relevant to a case study, such as age, gender, family situation, employment/education, research setting and the referrer must be stated. If the diagnosis has been requested by an organisation, the client is an employee or potential employee, and the organisation, generally represented by a manager, director or HR adviser, is the referrer and principal. In this situation, the client is also a representative of the organisation/principal, so it is important to be mindful of the potential sensitivity of the data. Explicitly state that the data are being anonymised. Do not use the names of institutions and/or organisations (including the organisation requesting the assessment, if applicable). Remove or disguise information such as the names of family members, identifiable research data, birthdates, professions, place names, etc.

The Dutch Association of Psychologists (NIP) requires that all reports must mention the limited period of validity of any such report. The NIP applies a validity interval of two years.

3.2.2 Reason for referral or request for diagnosis

In a few sentences, indicate why the client referred themselves or was referred for diagnostics.

3.2.3 Intake

In a few sentences, summarise which information was already known prior to the start of the examination, including from referral letters, forwarded files and/or an intake conducted with the principal (by telephone or in person). Describe the perceived symptoms (i.e. the client's

subjective perspective of their current symptoms/problems), the development of the symptoms/problems over time, and relevant case history information or the view of the principal. The intake meeting concludes with the formulation of concrete care-oriented questions or other questions as based on the client's symptoms or view of the client/principal.

3.2.4 Design of the examination

For each care-oriented question / other question, specify the type of diagnostic question and type of examination, using the taxonomy in Table 1 in section 3.3.1 as a guide. Make sure there are at least three types of diagnostic questions across the total of the three case studies. Formulate a number of research questions and hypotheses based on the client/principal's symptoms or questions (for an exception to this, see 3.5). Reference must be made to scientific literature or to published case reports or experiential knowledge. State how the hypotheses or research questions are being investigated. Use tools such as questionnaires, tests, projective techniques, observations and interviews (see Table 2 in section 3.3.3), possibly in combination with a file analysis.

The research tools can vary in psychometric quality and relevance to the different domains. Use a minimum of two of the methods for each case study, and use all three of the methods at least once somewhere in the three case studies. State the criteria that must be met in order to arrive at a conclusion (i.e. the assessment criteria) for each hypothesis or research question. Where relevant, discuss the considerations underlying the decision to use (or not use) specific research tools. This is particularly relevant when using instruments of potentially limited psychometric benefit, or if the client's background (e.g. cultural background) diverges significantly from that for which the tool was originally intended or standardised.

3.2.5 Observations and impressions

Under 'impressions', describe your first impressions and observations regarding the client's presentation during the examination (such as appearance, eye contact and demeanour, description of symptoms and the feelings evoked in the examiner, and the client's responses to unintended interruptions to the examination context). Under 'observations', provide targeted observations relating to the way the client responded to the examination or test instructions and the manner in which the client carried out the assignments. Pay attention to not only the client's cognitive functioning, but also their affective and emotional reactions and – in performance tasks – their sensory and motor functioning. Only mention observations that are both noteworthy and relevant to addressing the diagnostic issue. It should be noted that both 'positive' and 'negative' features can be relevant to observations and impressions; the former category concerns phenomena whose presence is readily observable, while the latter concerns phenomena that are notable for their absence (for example, in the case of a person who self-reports as having serious memory issues, an unexpectedly strong ability to remember details from previous examinations).

When interpreting the results (Figure 1 in section 3.3), the extent to which observations and impressions either agree with or contradict the other findings of the examination must always be systematically evaluated. Wherever specific and/or more structured observation methods

are used to test (or help test) specific hypotheses, they should be treated as part of the examination method and described in the 'Examination' section (3.2.6).

3.2.6 Examination

For each research question and hypothesis, state the findings yielded by each research tool. Indicate how these observations will be factored in when interpreting the findings. Indicate to what extent the findings meet the predefined assessment criteria. State and substantiate which hypotheses will be accepted, rejected or require further research.

3.2.7 Summary and comprehensive picture

Start the summary by stating who has referred the client for diagnosis, followed by a brief summary of the findings from the intake meeting and the examination results. Then formulate a comprehensive picture linking the observations and examination results. Present this picture as an overarching interpretational framework, and refer to the academic sources used to substantiate the way different ideas have been integrated into the whole. Avoid unwarranted coherence by also mentioning anomalous data that do not fit into the picture.

3.2.8 Conclusions and recommendation

Based on the summary and comprehensive picture, formulate conclusions and make recommendations for interventions or possible further examination.

3.2.9 Evaluation

In this section, you are expected to provide insight into how you applied the diagnostic process in this case study and to identify your key learning moments. In other words, you are asked to take a bird's eye/overarching view of the case study. This includes reflecting on your personal learning process and performance during the different stages of the diagnostic process. Which parts or stages of the process went well? What did you find difficult and why? What insights did you come to? This could include professional and personal limitations and/or boundaries that you ran up against, for example in terms of expertise, working with the client system, intercultural aspects, dealing with and learning from feedback in supervision, the selection of research tools and interpreting the results, justifying or explaining the chosen methods, etc.

3.2.10 Ethics

In this section, you are expected to provide insight into how you dealt with ethical issues in this case study and to identify your key learning moments. Refer to different aspects of professional ethics and relate them to this case study, for example professional and scientific responsibility, equal treatment and openness towards the client, being clear about your role as diagnostician, respecting the client's right to privacy and confidentiality, and being mindful of the limitations of your own expertise and experience. To what extent did you act with respect for the client's autonomy, responsibility and equality, and how is this evidenced?

3.2.11 Signature of the student and the supervisor at the internship institution

The student and the supervisor at the internship institution must declare that the case reports pertain to real cases that were investigated by the student independently (though under supervision) and at the requisite level.

3.2.12 Appendices

You must always state which test results are needed to assess the interpretation process (i.e. standardised scores (deciles, percentiles, T-scores, IQs, confidence intervals, etc.)) and specify which standards have been used (if they deviate from the guidelines). This can be done in either an appendix or the report itself, as long as the interpretations and conclusions are transparent and verifiable for the reader. Use the APA guidelines when citing sources. A bibliography must be included as an appendix to the report.

3.3. Explanation of the different stages in the diagnostic process

Needless to say, the diagnostic process begins with registration and ends with a discussion of the recommendations. Between these beginning and end points, a process takes place in which, from the diagnostician's perspective, there are frequent switches between deliberation and action. The deliberation element concerns the formulation of hypotheses, the interpretation of data, choosing the appropriate research tools and integrating the findings. The action element consists of actually carrying out the activities as per the decisions made in the deliberation process. The general structure of the diagnostic process is outlined in the section describing the scope of the case report, which states the reason the person has been referred or self-referred for diagnostics (the start of the diagnostic process), followed by the sections on the 'intake meeting', 'study design', 'examination' (with the accompanying observations and impressions), 'summary and comprehensive picture' and 'conclusions and recommendation'. These headings represent the main stages in the diagnostic process (see Figure 1). If necessary, key stages can be repeated and the process, including the final conclusions, revisited based on the updated findings. The sub-stages making up these main stages have already been addressed implicitly in the description of the components of the case study report and will be discussed in detail subsequently. For the sake of completeness, the stages of the diagnostic process on which the case study report is based are presented here in Figure 1.

The stages of the diagnostic process can also be arranged by type within the basic methodological figure of the empirical cycle, consisting of the stages of observation, induction, deduction, testing and evaluation. The referral and intake meeting provide the starting material (observation) required to develop the examination design, with these first steps resulting in the choice of a theoretical and empirical framework (induction), based on which testable hypotheses are formulated (deduction). By carrying out the examination, hypotheses can be tested (testing), and the resulting findings are summarised and integrated within the context of the diagnostic issues (evaluation). It should be noted here that the diagnostic process cannot be approached as a by-the-book application of scientific research. Rather, it is about working in the spirit of the empirical cycle. Expectations should be stated

clearly, tested empirically and the findings critically evaluated in a process that is anchored as firmly as possible in the behavioural sciences and in the generic supporting disciplines developed in this domain such as research methodology, statistics, psychometrics and decision theory.

Further division into discrete disciplines takes place through the use of the available scientific tools, taking into account the nature of the diagnostic issue at hand. For example, an allocation assessment must be carried out according to the rules for allocation assessment and not, for example, those for identification research. For each of the types of assessment involved (identification, clarification, suggested intervention, selection, allocation) the diagnostician must use the appropriate theoretical, empirical and methodological knowledge. For example, the knowledge base on the range of classification systems for problem behaviour, and the tools which have been developed for this, forms a suitable part of identification diagnostics in clinical practice, but are not relevant to an allocation assessment that involves distributing students among different types of schools. In the diagnostics of identifying problem behaviour, the knowledge base consists of methods that have been developed to describe and classify problem behaviour based on fixed criteria (for example the classification of problem behaviour within the DSM system using targeted interviews). In allocation assessments involving students, the knowledge base consists of the variables demonstrated to have differential predictive validity, the prediction models used, and the set of tools that have been developed to conduct a valid assessment of the relevant variables.

Figure 1: Stages in the diagnostic process, according to the model used for case reports:

3.3.1 Care-oriented questions / other questions, types of diagnostic questions and types of examination

In a non-clinical setting, there do not tend to be care-oriented questions but rather questions asked by the principal, whether this be an individual or an organisation. The questions can pertain both to the organisation as a whole and to specific individuals, and relate to the normal growth and development of the client (individual or organisation). 'Care-oriented questions', on the other hand, refer to disturbed or problematic development or functioning. 'What is the best type of school for my child?' and 'Does this candidate meet the job requirements?' are examples of non-clinical questions. 'Does my child have dyslexia?' and 'Do I need therapy to solve my problems?' are examples of clinical care-oriented questions. When addressing such care-oriented or other questions, it is not only the content of the question that plays a role, but also the type of diagnostic question that is involved.

In terms of content, the care-oriented question 'Does my child have dyslexia?' pertains to the domain of reading and spelling, and in terms of the type of the diagnostic question, it can be classified as a request for the identification of a problem or disorder which therefore requires identification research. The care-oriented question 'What is the best type of school for my child?' can be classified as a request for allocation (in this case of the appropriate school type). The type of the diagnostic question makes clear what the objective of the research is.

The care-oriented question 'Does my child have dyslexia?' is an example of a standalone reason for seeking help. In practice, the research may be limited to such stand-alone contexts. More commonly however, there are multiple care-oriented questions / other questions. Such multiple questions relate to different types of diagnostic questions and the corresponding types of examination. Sometimes multiple care-oriented or other questions are actually introduced as such by the client or principal. The question 'Are there any tensions in the team that impact on production, and if yes, what can I do as a manager to reduce these tensions?' comprises, in succession, an identifying question ('Are there any tensions in the team?'), a clarifying question ('Do the tensions impact on production?') and a request for a suggested intervention ('What can be done to reduce these tensions?').

In other situations, the initial care-oriented or other question may appear to be standalone but, during the discussion, it becomes apparent that a number of other care-oriented or other questions are disguised behind this one question. A mother asking 'What's wrong with my child?' is an example of a standalone care-oriented question that corresponds with an underlying diagnostic question and examination type. During the intake meeting, it may then become apparent that the mother is worried about other things too, such as the impact of the parents' relationship issues on the child's development and the fact that the tensions in the family are beginning to be too much for her to cope with. It becomes apparent that she not only no longer knows the best way to help her child, but she is also unsure as to the best way to help herself. The identification question that formed the initial care-oriented question ('What's wrong with my child?') prompts the formulation of at least one clarifying question ('Do my/our relationship problems contribute to my child's problems?') and two requests for suggested intervention ('What is the best way to help my child?' and 'How can I be supported

in dealing with the tensions in my family?'). The examples of care-oriented or other questions in Table 1 have been classified according to the types of diagnostic question involved and the types of examination that can be undertaken. The care-oriented or other questions in Table 1 are standalone questions. They can therefore be classified into a single type of diagnostic question and corresponding examination type.

Table 1: Classification of care-oriented questions / other questions according to the types of diagnostic question involved and the types of examination that can be undertaken

Type of diagnostic question/ Examination	Care-oriented or other questions intended to promote growth (personal development/ career/ organisation)	Care-oriented or other questions relating to a disturbed or threatened personal development/career/company situation
identifying	- Are there any latent/beneath-the-surface conflicts in my team?	- Does my child have dyscalculia? - Does this child have an autism spectrum disorder?
clarifying	- This pupil is making progress more rapidly than we had anticipated. Is that because of the new teacher? - What tensions within the team impact on production?	- Are the child's fearful reactions outside the home the result of an insecure attachment to the parents? - According to the parents, the child is very withdrawn, but the teacher does not notice any difference between their child and other children. Why is this? - This person's performance has been very inconsistent lately. Nothing seems to have changed in the workplace, so is this related to the home situation? - Are this person's concentration problems the result of the accident he has had?
identifying a suggested intervention	- Are there any children in my class who require additional teaching material? - Which interventions are required or desirable to lift my team members to a higher level?	- Has this child with dyslexia been designated for intensive treatment?
selecting	- Which candidate(s) is/are most suitable for this position?	- Which client(s) in this institution will benefit most from this type of cognitive therapy?
allocating	- Can we entrust this person with a managerial position within this department? - Who is eligible for transfer to a different department?	- Which of the clients on the waiting list is next in line to be eligible for a short-term treatment?

3.3.2 Research questions and hypotheses

Research questions are those field-specific questions which relate to the client's care-oriented or other questions, plus questions which the diagnostician considers important based on their own experience and knowledge of the literature in conjunction with the data that has been collected up until that point. For example, in the case of a standalone care-oriented question such as 'Does my child have dyslexia?', the diagnostician may also consider it necessary to check for any additional or alternative learning or developmental problems (for example 'Does this child have a language problem?'). In this case, the research question is not 'Does this child have dyslexia?', but 'Does this child have dyslexia and/or other types of learning or developmental problems?'

An explanation of the research question is provided as part of the corresponding research hypothesis/hypotheses, with the diagnostician indicating the plausibility of the hypothesis in reference to the case study based on empirical, theoretical or experiential knowledge. In the above-mentioned example, the diagnostician might also suspect that there is a language development problem and may, therefore, formulate the following two research hypotheses. Hypothesis 1: According to the teacher, the child does not have any problems with arithmetic, but she does struggle with reading and spelling. Perhaps the child is dyslexic. Hypothesis 2: The case history shows that the child's language development started late and with difficulty. The child is able to keep up at school and is able to understand instructions, but has a limited vocabulary and speaks in simple sentences for her age. Perhaps she has an expressive language disorder.

What is characteristic for diagnostic research hypotheses is that they are generated inductively, based on individual client characteristics. This is the case in both clinical and non-clinical diagnostics for identifying and clarifying hypotheses, as well as those aimed at identifying a suggested intervention. For example, it may become apparent from an intake meeting with a principal that an employee has been making more mistakes since the work became more complex in nature. Based on the employee's qualities as stated in his CV, the following clarifying research hypothesis could be formulated. Hypothesis: This employee has started making more mistakes following the work having become more complex in nature due to a shifting of responsibilities and a reorganisation. The CV reveals that he completed junior general secondary education followed by a senior secondary vocational qualification, but his current position requires a higher level of professional education. It may be that too much is being asked of the employee at a cognitive level.

The situation is different in the case of selection or allocation, with clients being screened according to pre-defined criteria. Here, there is a research question, but no inductive hypothesis. In these cases, it does not make sense to use the term research hypothesis, and the diagnostician can restrict themselves to the research questions and the corresponding criteria.

3.3 Research tools: methods and domains

Table 2 classifies psychodiagnostic research tools according to method and domain. This classification can be considered to be a pragmatic one, as there is no single, commonly accepted taxonomy for psychodiagnostic tools. A distinction is made between three basic

methods (1. Performance tests, 2. Self-reporting, and 3. Assessment and observation), and a number of domains within each method.

In accordance with the Dutch Association of Psychologists' 'General Standard for the Use of Tests', psychodiagnostic tools can be used if the general conditions of 'quality' and 'relevance' are met. The quality of tools can be evidenced by their having been deemed sufficient by COTAN ('Commissie Testaangelegenheden Nederland', or Dutch Committee on Tests and Testing) or must be in some other way substantiated by the psychodiagnostician. The principle of relevance refers to the extent to which the choice of tools is likely to contribute to addressing the diagnostic issue. However, a number of additional rules apply where the application for a BAPD is concerned:

At least two methods must be used for each case study. Normally, each of the three methods must be used at least once during the course of the three case studies; however, in certain situations (extensive/structured) self-reporting is impossible or undesirable (for example because the client's age or mental age is too low). If this means less use can be made of this method, this must be explained in the Evaluation, and the consequences of missing out on this source of information must be reflected upon in greater detail. In these types of cases, it is recommended that the views of the client's relatives (i.e. educator, legal guardian etc.) of the client's perception of symptoms at least be included in the report.

Discuss and interpret the range of instruments that have been used, while being mindful of the specific pattern of strengths and weaknesses; for example, performance tests have different potentially disruptive factors (such as fatigue, fear of failure etc.) than those of the self-reporting method (social desirability, limited self-awareness etc.). The tools used also differ in terms of their reliability and validity; the stronger the material (in terms of psychometrics), the more reliable and authoritative the statements and/or conclusions can be. Findings from psychometrically strong material generally deserve a more central position in the deliberation process than those deriving from psychometrically weaker instruments.

As far as the use of domains is concerned, Table 2 is structured in such a way that, for each of the three methods, there is the freedom of choice to apply one or several domains depending on the issue under investigation and the specific diagnostic setting. For each method, the use of one domain can suffice, but the specific issues in a certain case study may necessitate the use of more than one domain. It is essential here that the use of tools must always be sufficiently comprehensive to be able to address the initial question.

Table 2: Testing methods and domains

Method	Domain	Examples*
1. Performance tests	Intelligence tests	WAIS, WISC, RAKIT, GIT, Raven, KAIT, etc.
	Neuropsychological assignments & functioning tests	TMT, Stroop, BADS, 15-W, CFR, etc.
	Motor research	MABC, KTK, MOT'97
	Didactic assignments	CITO, AVI, TVK, EMT, Klepel, DST-Nl, the 'PI dictee' spelling test, the Niveau-Test-Rekenen arithmetic test
	Organisational performance assignments	Digital in-tray exercises, Clues, Utopia, MCS, management simulations, Highlight, Zeezicht
2. Self-reporting	Symptom-oriented / Problem-oriented	SCL, BDI, YSR, PMT, DEX simulation, CFQ, CIS, SVL, VBBA, VOS, ASK, (work-related) sources of stress and energy
	Personality: a. overall b. specific aspects	 a. DAPP, MMPI, NPV, NEO, BIP, OPQ b. UCL, SIG, PMT
	Values and attitudes	BIT, ZKM, BZO, drivers questionnaire
	Family/system	NOSI (K), FRT
3. Assessment, observation and interpretation	Behavioural assessment (general)	a. informants: CBCL, TRF, SCHOBL-R, BRIEF, DEX questionnaire, VISK b. professional: ABC model
	Behavioural assessment Classification /Psychopathology (DSM-IV-TR criteria)	a. informants: AVL b. professional: structured or semi-structured interview (MINI, DIVA, SCID, Spek interview, CAS)
	Risk assessment	HCR, SVR, PCL-R, SAVRY
	Behavioural observation	Play observation (GORS), classroom observation, simulation/roleplay (In-Basket), negotiation/ evaluation/advice/coaching meetings, presentations, fact-finding, training / lessons, (strategic) writing assignments, ABC model
	Organisational assessment	BASAM, NIPG, MTO, WEB - Monitor.
	Projective material / Expression-based assignments	ZAT, TAT, ZALC, Rorschach, HTP, SIT, Dewey, PFT, family drawing (incl. the family represented as animals), etc.

*The assignments listed here are only examples; this table is not exhaustive. For a definition of the acronyms/abbreviations used, please see psychodiagnostic books and the COTAN ('Commissie Testaangelegenheden Nederland', or Dutch Committee for Tests and Testing) documentation.

3.3.4 Summary and comprehensive picture

The summary is a condensed version of information which has already been presented. The comprehensive picture extends beyond the summary. In the comprehensive picture, the various components of the information provided are related to each other and integrated into a concise case study formulation. With the comprehensive picture, the diagnostician essentially builds a theory of the individual case, involving not only the research findings in the strict sense, but all the information that is available about the client. The comprehensive picture is speculative inasmuch as the breadth of previously reported data will now be looked at as part of a whole that is the result of organisation and interpretation on the part of the diagnostician.

An example to illustrate the above: the diagnostician is tasked with assessing whether someone is able to resume their work after a burnout. This person's position involves signalling unexpected peaks and troughs in the demand for certain products, and making the necessary adjustments to delivery logistics. Following the request for assessment, the diagnostician checks with the principal what requirements the person must meet as part of the job description. In the intake meeting, the person's professional career and family situation are discussed with her, along with her own expectations in reference to her potential return to work. Based on the literature and practical experience, the diagnostician then formulates a number of research questions and hypotheses relating to this person's personality (emotional instability, extraversion) and cognitive capacities (intelligence). In the summary of the case study report, the data resulting from the intake meeting (job requirements, career and expectations of the individual, home situation) and the research findings (emotional instability, extraversion, intelligence) are briefly discussed. In the comprehensive picture, the implications of this information are interpreted, looking at how these different factors interrelate and impact upon each other. For example, the combination of unavoidable time pressure and hierarchical employer-employee relationships on the workfloor, previous experiences of failure, and unrealistic expectations about returning to work combined with a partner who is not very understanding, a low-to-average intelligence level and a high level of extraversion and emotional instability will lead to a different insight into the person's chances than in the case of a combination where the same person works in an environment where the time pressure can be easily adjusted, the relationships on the workfloor are more egalitarian and she can count on the support of an understanding partner. In both cases, the comprehensive picture will consist of an explanation of the consequences of the combination of conditions that have been found to be present for the person's performance. Where possible, these explanations will be substantiated by references to empirical research, theoretical insights, documented practical knowledge and the student's own practical experience.