CHAPTER 5

Planning the Evaluation and Rapport Building

Chapter Questions

- Why is it important to carefully plan an evaluation?
- What information is necessary for planning a focused clinical assessment?
- What are some of the important considerations in determining whether or not a child should be tested and who should do the testing?
- What is a scientific approach to testing?
- What is rapport and why is it more difficult to develop in the clinical assessment of children and adolescents than in many other clinical endeavors?
- How can informed consent be considered a rapport-building strategy?
- What are some of the important strategies that can aid in developing rapport with children and adolescents?

Non-specifics in Clinical Assessment

A recurrent theme in this text is that an assessor needs to have knowledge of several areas of basic research to appropriately select and interpret psychological tests for children and adolescents. In this chapter, we consider another area of competence crucial to clinical assessment that goes beyond knowing how to administer specific tests. It is rather difficult to discuss this competence in objective terms because it relates to difficult topics for research and, as a result, there is only limited objective data to guide this practice. Instead, much in this chapter is guided by clinical experience, not just our own experience, but the experience of other practicing

P.J. Frick et al., *Clinical Assessment of Child and Adolescent Personality and Behavior*,
DOI 10.1007/978-1-4419-0641-0_5, © Springer Science+Business Media, LLC 2010

psychologists who have written in this area.

This chapter deals with setting an appropriate context in which testing takes place. This is not simply the physical context of testing, but the activities of the assessor that allow the clinical assessment to achieve its goals. Many of the issues discussed involve clinical skills that are difficult to teach, but often require refinement based on practical experience in testing children and adolescents. However, an analogy can be made with the literature on psychotherapy. Many useful guides for practicing clinicians have been published that deal with the non-specifics of psychotherapy. The term non-specifics has been used to refer to several contextual factors, within which the psychotherapy techniques take place, such as the relationship between therapist and client or the process by which a therapist engages a client in a therapeutic setting (Karver, Handlesman, Fields, & Bickman, 2006). In this chapter, we attempt to deal with the non-specifics in the clinical assessment of children and adolescents.

One critical component of setting an appropriate context for an evaluation is careful planning. In the following section, we discuss a basic framework for designing clinical assessments for children and adolescents. Within this basic framework, however, evaluations must be tailored to the needs of the individual case. The critical developmental issues, the most relevant areas of adjustment to be assessed, and the most important elements of a child's or adolescent's environment will all vary from case to case. As a result, it is inappropriate to develop specific guidelines for designing evaluations. Instead, in this section we attempt to provide a framework for designing assessments that can be tailored to most assessment situations.

Clarifying the Referral Question

A crucial part of planning any evaluation is having enough information, prior to beginning the testing, to make at least some initial decisions on the structure and content of the assessment process. This is not to say that the assessment process should be so structured from the outset that changes after testing is underway are not possible. However, obtaining crucial information before the first testing session enhances the likelihood that one will provide a focused and appropriate assessment. Almost every testing agency, whether clinic, school, hospital, or private practitioner, has some established intake process that provides preliminary information on the child or adolescent being tested. There is no single best way to structure the intake procedure. However, there are some pieces of information that should be obtained routinely in any intake process, in addition to any basic information (e.g., name, address, phone number, insurance coverage) that is required by the agency.

Purpose of Testing

The most important piece of intake information for planning an evaluation is the intended purpose of the evaluation. A major flaw in many clinical assessments is a lack of focus. From the outset, an evaluation should have clearly specified goals and objectives. As discussed previously, it is erroneous to think in terms of an assessment technique or battery being valid or invalid. Results of the evaluation can be valid for *specific interpretations*. Therefore, what interpretations one anticipates making at the end of the evaluation should guide the selection of tests for the assess-

ment battery. For example, if an assessment is primarily intended to determine school placement, then the focus of the evaluation will not be to determine whether or not a psychiatric diagnosis is warranted, but to determine whether or not the child meets the eligibility requirements of the school system. The assessor may feel that more information is needed to make appropriate recommendations to meet a child's psychological and educational needs than is required by these criteria. However, enough information to determine the eligibility should be part of the assessment, if this is the primary referral question. In our experience, it is not uncommon for an otherwise sound and competently conducted evaluation to be useless for the specific purposes for which a child was referred.

There are many other examples showing how the intended use of the assessment information determines the measures to be used. This may be as broad as defining what areas need to be covered for a certain purpose (e.g., some residential treatment centers require a personality assessment prior to acceptance) to as specific as requiring certain tests (e.g., some school systems require specific tests to be given for special education placement). The assessor should not give a test that, in his or her professional judgment, is inappropriate for a particular use or is inappropriate for a particular client. However, if, at the time of referral, the intended use of the assessment is clarified and there is some question as to how appropriate certain requirements are for a given case, the assessor can attempt to address these issues before beginning the evaluation.

Often the person or agency referring a child or adolescent for testing is not sure how the test results will be used. Instead, the child is referred because the agency is unsure of the nature of a child's problem (or even whether there is a problem), and the referrer is unsure of what can be done to help the child. There are many variations on this theme, but, in essence, the goal of the assessment is to diagnose the source of a child's difficulty and to make treatment recommendations based on this diagnosis. In Chap. 3, we discussed many important issues in making diagnostic decisions. However, Martin (1988) provides a succinct and practical analysis of the specific goals involved in diagnosis. These are to (1) predict future behavior, (2) differentiate between abnormal and normal behavior, (3) make differential diagnoses, and (4) delineate individual differences in competencies and disabilities. Martin also provides some interesting recommendations for planning the evaluation to maximize the reliability of the diagnostic process. These are summarized in Box 5.1.

Description of Referral Problems

In addition to understanding the purpose of the testing referral, it is also important to obtain an initial description of the difficulties that a child is experiencing that led to the referral. One of the reasons that clinical assessments are so fascinating is that, if done right, the assessment is a type of scientific inquiry. Based on the intake information, the assessor should have some initial hypotheses for understanding a given case that will be tested during the evaluation. These hypotheses will guide the initial planning of the evaluation and initial test selection. As in any good scientific endeavor, we must be clear of the data that would support and those that would not support the various hypotheses. In contrast to many other scientific enterprises, however, the hypotheses can, and should, change during the investigation.

Box 5.1

Planning the Evaluation to Enhance Reliability

In our chapter on psychometric theory, we discussed reliability as a key concept in understanding the psychological measurement. Reliability is often considered as a property of individual tests. However, Martin (1988) discusses several issues in planning an assessment battery that can maximize the reliability of the information that is obtained. Key to Martin's approach is his conceptualization of four primary sources of error variance that can affect the reliability of measurement of children's social and emotional functioning:

(1) Temporal variance – changes in behavior over time
(2) Source or rater variance – differences in information due to characteristics of the informant
(3) Setting variance – differences due to different demand characteristics across settings
(4) Instrument variance – unreliability inherent in individual instruments

Martin uses the basic concept in measurement theory to describe how these sources of error variance can be controlled in an assessment. Specifically, the primary method of controlling error variance and increasing reliability is through *aggregation*. As the length of a test increases, the reliability of the scores increases. Thus, to control the temporal variance, repeated measurements on several occasions should be obtained. Similarly, to reduce source and setting variance, information should be obtained from multiple sources and across multiple settings. The implication of these psychometric considerations is the need for a comprehensive evaluation.

The final source of error variance in Martin's scheme is the *instrument variance*. Like the other sources of variance, aggregating information across instruments is a crucial method for increasing reliability. However, this is only the case if additional tests provide reliable information. If one adds unreliable tests to a battery, then aggregation actually *decreases* the reliability of the battery. Clinicians, who have a favorite test that they use in the batteries, will often justify their use of the test, even if it has been proven unreliable, by the statement "I only use it as one part of a more comprehensive battery." This is clearly better than using the test in isolation. However, adding a piece of unreliable information will only reduce the reliability of the aggregated information. In a separate publication, Martin (1982) gives the example of three umpires calling a baseball game. If one of the umpires is blind, his calls will only serve to reduce the reliability of the calls made by the entire umpiring team. The moral of the story: Aggregation only increases the reliability of the information obtained if the individual tests are selected to enhance reliability.

Source: Martin (1988). *Assessment of Personality and Behavior Problems Infancy through Adolescence*. New York: Guilford Press.

As data accumulate on a case and it becomes clear that initial impressions of a case were wrong, the assessor must revise the assessment accordingly. To employ this scientific approach to clinical assessment, enough preliminary information on a child's functioning must be obtained prior to starting the evaluation, so that initial hypotheses can be formed. A case example that utilizes this approach is provided in Box 5.2.

Box 5.2

A Scientific Approach to Clinical Assessment: A Case Example

Joshua is a 10-year-old boy who was referred to the outpatient psychiatry department of a large inner-city pediatric hospital for testing. The intake worker determined that Joshua was being referred by his parents because he was in danger of failing the fifth grade. According to the intake information, Joshua was having great difficulty paying attention in class and completing assignments. He was also described as being excessively fidgety and restless. The intake information indicated that these school problems were new this school year. He had been an A\B student in the four previous school grades, which made his current poor performance especially puzzling.

Based on this information, several initial hypotheses were formulated. It could be that similar problems were experienced in the past grades but they had just increased in severity in the fifth grade; in which case, dispositional causes were possible such as an attention deficit disorder and/or a learning disability. Alternatively, if this recent onset was supported in the evaluation (through interviewing parents about past school performance, obtaining school records, interviewing past teachers), it may be that Joshua had experienced or was experiencing some type of newly occurring stressor (e.g., parental divorce, sexual abuse) that was resulting in the deterioration in behavior. The evaluation was designed to test these initial hypotheses.

Interestingly, during the assessment of potential stressors, Joshua's mother reported that he had been involved in an automobile accident during the summer prior to entering the fifth grade. He had sustained a closed head injury and had lost consciousness for several minutes. He was released from the hospital with no noticeable effects of the injury. After obtaining this information, another hypothesis became possible. Joshua might have sustained neurological damage from the accident that was affecting his behavior. As a result, he was referred for a neurological exam, which uncovered neurological damage that seemed to be the most likely cause of his behavioral difficulties. Although the initial hypotheses were not correct, this illustrates how a scientific approach to hypothesis testing can be useful in structuring the assessment process.

Designing the Evaluation

We concluded Chap. 3 by providing several guidelines for clinical assessments of children that followed from research in developmental psychopathology. In this section, we take these research-based guidelines and use them to develop practical considerations in designing clinical assessments of children. Once again, these recommendations are designed to provide a generic framework that can be tailored to the needs of the individual case.

Developmental Considerations

From the discussion of developmental psychopathology provided in Chap. 3, it is clear that assessments of children's emotional and behavioral adjustment need to be sensitive to a number of important developmental issues. First, a basic tenet of developmental psychopathology is the importance of taking a "process-oriented" approach to conceptualizing children's adjustment. As a result, it is important that clinical assessments not only involve a standardized and comprehensive assessment of a child's

behavioral and emotional adjustment, but it is also important that they include an assessment of the developmental processes (e.g., temperamental tendencies, family context) that may be related to the child's current pattern of adjustment. This more comprehensive assessment requires that assessors maintain a current knowledge of the research related to the type of problems they encounter in their evaluations, so that they have an adequate understanding of the processes that may be involved in the development of these problems.

This research provides the assessor with some initial hypotheses regarding the problems that led to a child's referral for testing. Measures are selected so that these hypotheses can then be tested in the evaluation. For example, there is research to suggest that there are distinct subgroups of children with conduct problems, some of whom react very strongly to peer provocation and emotional stimuli, and some of whom show a lack of reactivity to emotional cues, leading them to ignore the potential consequences of their behavior on others (Frick, 2006). Solely assessing the child's level and severity of conduct problems and making a diagnosis of "Conduct Disorder," without assessing the child's affective and interpersonal style, would not allow one to distinguish between these different subgroups that may require different approaches to treatment (Frick & McMahon, 2008).

Secondly, it is important for the psychologist to consider the developmental stage of the child to be assessed in designing an assessment battery. For example, it is important, when selecting tests for a battery, to determine whether the tests provide good norm-referenced scores for the developmental stage of the child or adolescent being assessed. Because this is so important, a significant focus of the later chapters (which provide reviews of specific testing instruments) is on the description of the instruments' norm-referenced scores. It is evident from these reviews that the adequacy of these scores can vary across developmental stages (e.g., having a very limited normative sample for older adolescents). In addition to specific tests, some testing modalities may be more or less appropriate depending on the developmental level of the child. For example, in the chapter on structured interviews, we discuss research suggesting that the child self-report format on these interviews may be unreliable before age 9.

Determining the Relevant Psychological Domains

A fairly ubiquitous finding in research on childhood psychopathology is the high degree of overlap or comorbidity in problem behaviors (Jensen, 2003). That is, children with problems in one area of emotional or behavioral functioning are at high risk of having problems in other areas of emotional or behavioral functioning, as well as problems in social and cognitive arenas. In addition, a key assumption to a developmental approach to understanding children's adjustment is that all outcomes are influenced by multiple interacting processes. As a result, most evaluations of children and adolescents must be fairly comprehensive to ensure that all areas that could be relevant to treatment planning are assessed. In planning an evaluation, one should consider the most likely comorbidities associated with the referral problem and the most likely factors that can lead to such problems, and design the evaluation to provide an adequate assessment of these areas. From the referral information, one may also gather some clues as to how intensive the assessment of these potentially important domains should be.

For example, consider a referral of a 7-year-old boy who is having significant problems of being disorganized, being very impulsive, and having difficulty staying in

his seat. An initial hypothesis may be that the child has attention-deficit hyperactivity disorder (ADHD), and an evaluation is designed to test this hypothesis and to test the many different processes (e.g., poor executive functioning) that could lead to this disorder (see Chap. 17). In addition, from research on ADHD one knows that approximately 30% of children with the disorder have a co-occurring learning disability (Frick & Kimonis, 2008). Therefore, one needs to determine how this comorbidity can be assessed. However, in the initial intake, the child's mother states that her son has no real problems academically, other than losing his assignments frequently, and, in fact, he has only made two B's on his report cards since entering school. Based on this piece of information, one may decide not to conduct an intensive evaluation of a potential learning disability unless, during the course of the evaluation, some evidence of learning problems is discovered.

Screening of Important Contexts

Research has indicated that children's behavior is strongly influenced by factors in their psychosocial environment. Therefore, an important consideration in planning an evaluation is determining the aspects of a child's environment being assessed (e.g., teaching styles of specific teachers, affective tone of family interactions) and the assessment methodology (e.g., naturalistic observations, behavior rating scales). However, the relevance of context will vary from child to child. The intake information should provide enough information so that an evaluation can be planned, in which (1) informants from each of a child's relevant contexts provide information on the child's functioning and (2) the contexts that seem to have the most impact on a child's functioning can be assessed in greater detail.

One of the most influential contexts for the majority of children is the family. A chapter in this text (Chap. 12) is devoted to the assessment of a child's family environment. However, what constitutes a family for a child is becoming increasingly diverse, and the intake can yield some preliminary information on the family structure (e.g., marital status of parents, degree of contact with non-resident parents, other adult caretakers in the home) that provides the assessor with some clues as to the best method of structuring an evaluation of the family context.

Practical Considerations in Designing an Evaluation

In an important clinical endeavor like psychological testing that can have important consequences for a child, one does not like to consider mundane factors such as time and expense in designing the evaluation. Clearly, these factors should not outweigh what is in the best interest of the child being tested. However, sometimes these factors are unavoidable and often expediency is in the best interest of the child. For example, an adolescent who has an impending court date for a juvenile offense may need to have an evaluation completed before this date to help in determining the most appropriate placement and the most appropriate services. One should take care not to be so influenced by expediency that treatment decisions are misguided by poor assessment results. But one must consider what can be meaningfully obtained within the available time frame, and possibly make as part of the outcome of the evaluation a recommendation for the additional testing that might be beneficial as time allows.

How much to weigh cost and time constraints will vary from case to case. However, we feel that one should ask the following two questions in designing any evaluation:

1. What is the essential information needed to answer the referral question(s)?
2. What is the most economical means of obtaining this essential information without compromising the usefulness of information?

To Test or Not to Test

When a child is referred for testing, an important question that should be asked is whether or not an evaluation is in the child's best interest. We feel that simply because an evaluation is requested by someone is not sufficient reason to conduct the evaluation. A professional must make the decision as to whether or not an evaluation is likely to benefit the child or adolescent. Often this question is ignored for financial reasons. If you don't do the evaluation, you don't get paid. However, we feel that a clinical assessor has the ethical obligation to estimate the potential benefit of the evaluation to the child and then convey this determination to the referring agency.

There can be several reasons why an evaluation would not be in a child's best interest. For example, a child's parent may seek multiple evaluations because the parent does not agree with the findings of previous evaluations. We feel that second opinions are not inappropriate in many cases. However, if this is not considered carefully, a child may be subjected to numerous intrusive evaluations that are not necessary and the evaluator may inadvertently reinforce a parent's denial of a child's special needs. Alternatively, the person referring a child or adolescent may have unrealistic expectations from what an evaluation can accomplish, or the reason for the evaluation may be insufficient to justify performing the evaluation. An example that illustrates both of these issues is a child who is referred by a parent to determine his future sexual orientation.

Even if one determines that a child or adolescent may benefit from an evaluation, one must also question whether or not the assessor is the appropriate person to conduct the evaluation. The appropriateness of an assessor may simply be a matter of one's competence, either because of unique characteristics of the child (e.g., age, culture) or because of the specific nature of the referral question. Assessors must hold closely to the principle noted in the Standards for Educational and Psychological Testing published jointly by the American Educational Research Association, American Psychological Association, and National Council on Measurement Education that "test users should not attempt to interpret the scores of test takers whose special needs or characteristics are outside the range of the user's qualifications" (Standard 11.3, p. 114).

In addition to competence, a clinical assessor must also question whether or not personal reasons might prevent him or her from conducting an objective evaluation. For example, an examiner may have a personal relationship with a child or family that might interfere with the ability to objectively administer and interpret tests. Alternatively, the assessor may have personal issues related to the referral problem that might prevent him or her from being able to competently perform the evaluation. For example, a psychologist who himself is dealing with memories of a past sexual abuse may not be able to conduct an evaluation of another sexual abuse victim because he is unable to transcend his own issues related to the abuse. There are no specific guidelines for determining when personal issues would interfere with an evaluation. Our point is to suggest that assessors should routinely question whether or not they are appropriate to conduct an evaluation, and they should consult with colleagues if there is any question regarding their ability to competently conduct the evaluation.

Rapport Building

There is no aspect of the assessment process that is as difficult to define and to teach as the concept of rapport. However, rapport is a critical component of testing children and adolescents (Fuchs & Fuchs, 1986), although it is rarely discussed in child assessment texts (e.g., Achenbach & McConaughy, 1987; Ollendick & Hersen, 1993) or in administration manuals for tests designed for children (see Fuchs, 1987). The *Longman Dictionary of Psychology and Psychiatry* (1984) defined *rapport* as "a warm, relaxed relationship that promotes mutual acceptance, e.g., between therapist and patient, or between teacher and student. Rapport implies that the confidence inspired by the former produces trust and willing cooperation in the latter" (p. 619). To paraphrase and apply this definition to the testing situation, *rapport* refers to the interactions between the assessor and the person being assessed (client) that promote confidence and cooperation in the assessment process. Rapport building is not something that is done at the outset of testing and then forgotten. Instead, it is a process that evolves throughout the entire assessment endeavor (Barker, 1990; Sattler, 1988).

The importance of rapport is not specific to psychological assessment; it is a critical concept in most clinical endeavors. There are several recommendations that can be drawn from other clinical situations that apply equally well to child testing. For example, Phares (1984) described the basic elements of establishing rapport in psychotherapeutic relationships as "having an attitude of acceptance, understanding, and respect for the integrity of the client" (p. 195). Phares goes on to point that this attitude is not synonymous with establishing a state of mutual liking but is more related to a clinician's ability to convey to the client a sincere desire to understand his or her problems, and to help him or her to cope with them. This general attitude of the assessor is the basic component of establishing rapport with the client. As a result, our specific recommendations are designed to foster this attitude in testing situations.

While the importance of rapport is not confined to the psychological assessment of children and adolescents, there are several unique aspects to the assessment of youth that make rapport building a complicated process in this context. First, the clinical assessment of children typically involves many people (e.g., child, parent, and teacher) who have varying levels of understanding of the assessment process, and who possess varying levels of motivation for the assessment. Therefore, the assessor must be skilled in enlisting and fostering the cooperation of many different participants. The issue of motivation is especially salient in the evaluation of youth because children and adolescents are often not self-referred. Children are often referred for evaluations because their behavior causes problems for significant others in their environment (Frick & Kimonis, 2008). Therefore, enlisting their cooperation and trust is a critical, but often difficult, process. Later in this chapter we provide examples of how testing can be presented to children and adolescents in ways that foster the establishment of a working relationship.

A second factor that complicates the development of rapport in testing situations is the presence of severe time limitations. In many, if not most, testing situations the assessor has limited time for rapport building with all participants. Often testing is confined to one or several discrete testing periods and testing starts early in the first session. This is quite different from the many other clinical contexts, such as the psychotherapeutic context, in which there is likely to be more flexibility in the time allowed for

developing rapport prior to the initiation of some clinical intervention.

Based on this discussion, it is evident that establishing rapport in the typical assessment situation for children and adolescents involves enlisting the cooperation of *multiple participants* to divulge personal and sometimes distressing information, despite a potential *lack of motivation* and despite the fact that the testing must be completed within a *limited time frame*. It is obvious from this description that rapport building is not always an easy task in clinical assessments of youth. Therefore, it is important to outline the important considerations in the development of rapport in clinical assessments of children and adolescents.

Informed Consent

We view informed consent in two ways in this book. The first, which is the more traditional way, is to view it as a legal and ethical right of the recipients of any psychological service. The assessor has the responsibility of ensuring that informed consent is provided for the assessment. However, we also view informed consent in a second way: as a basic element of rapport building. As discussed previously, a fundamental element in developing rapport is expressing a respect for the individual participating in the evaluation. There is no more basic way of conveying respect than by placing great importance on the informed consent process.

In Chap. 4, we discussed the legal requirements of obtaining informed consent from a child's legal guardian. However, the assessor can communicate a sincere respect for the child's guardian by spending a great deal of time reviewing all the testing procedures in very clear and specific terms, by discussing the limits of confidentiality in sensitive terms, by clearly reviewing the intended uses of the test results, and by allowing and encouraging the parents to ask questions about these issues. In essence, the assessor should convey to the parent that the consent procedures are not just a legal formality, but are intended as the first step in establishing a collaborative effort between the parent and assessor. Also, there is no greater damage to the development of rapport than a parents' *perception* that some procedures were used without his or her full knowledge and consent.

The need to transcend legal requirements is even more important with the child. With the view that minors may not be competent to make decisions regarding their need for certain medical or psychological procedures, like psychological testing, the right to informed consent generally rests with a child's parent or legal guardian. Unfortunately, many assessors take this to mean that a child does not have the right to have procedures explained to him or her in understandable language. Although in some situations we agree that a child may not have the right to refuse participation in an evaluation, we feel that *in all situations*, irrespective of a child's age, the assessor should explain to the child all the procedures that he or she will undergo as part of the testing. Clearly, the degree of depth and sophistication of this explanation should be made in recognition of the possible fears about the evaluation that a child or adolescent might experience and with recognition of his or her varying levels of motivation. Boxes 5.3–5.5 provide examples of how testing procedures can be explained to children and adolescents of various ages in ways that enhance the establishment of rapport.

Discussing testing with the child or adolescent is critical for conveying respect towards the child, and helps enlist the child as a collaborative participant in the process. It reduces the feeling of the child that the testing is being done to him or her rather than for or with him or her. Also, many children arrive for testing with substantial

Box 5.3

Explaining Testing to a 5-Year-Old Boy

We have argued that all children should have testing procedures explained to them in terms that are understandable given their developmental level. This is a crucial aspect of developing rapport with a child. However, many beginning clinical assessors have difficulty describing testing in terms comprehensible to young children and fail to recognize some of the fears and motivations that children bring to the evaluation. The following is an example of an explanation of procedures that is given to a 5-year-old boy referred to a private psychologist for testing.

> "Hello, Johnny. My name is Dr. Test. I'm not the type of doctor you come to when you're sick, like with a stomachache or headache, but I'm the type of doctor who likes to get to know kids better, like how they feel about some things and how they act sometimes. So what I'm going to do today is find out a lot more about you. I'm going to ask you to draw some pictures for me and tell me about them. I also have some pictures and I want you to make up stories about them. And then, I have a bunch of questions about how you feel about certain things that I'm going to help you answer. We will have to work pretty hard together but I think it will be fun, too. We're going to take a lot of breaks and please let me know if you need to stop and go to the bathroom. Now, your mom and dad have already been telling me a lot about you and I'm also going to be talking to your teacher at school. After I do this, I'm going to take what you tell me, and what your parents and teacher tell me and try to get a good picture of what you're like, how you feel about things, all the things you're doing well, and anything you might need help in. And then I will talk to your parents and to you about what I find and let you know if there is anything that I can suggest that might help you."

This explanation is designed to be an example of the types of terms and phrasing that can be used in explaining psychological procedures to very young children. As can be seen from the content of the explanation, we feel that in this age group, one of the most important sources of anxiety is the fear of the unknown. Therefore, we try to let the child know that the procedures will be pretty innocuous (e.g., answering questions, drawing). Obviously the actual content of the description will depend on the procedures that are planned. But we feel strongly that *all* procedures to be used should be explained to the child, albeit in a language that is understandable.

Also, to illustrate the level of explanation, the discourse was presented in a narrative form. In actual practice it is helpful to involve the child in the discussion by asking simple questions (e.g., Do you like to draw?) and encouraging him or her to ask you questions if there is anything he or she does not understand. This helps the child feel more respected and valued in the assessment process. Finally, we often find it helpful in this age group to present this information in the presence of the child's parent(s). When children see that their parents are comfortable with the procedures, they often develop a greater sense of comfort themselves.

misconceptions about what the testing will entail (e.g., thinking that the psychologist is going to operate on their brain or that they will be punished for being bad). Simply spending time to clearly review why the child is being tested, what the child should expect during testing, and what will happen with the test results helps to eliminate possible misconceptions and reduce unnecessary anxiety.

Box 5.4

Explaining Testing to a 10-Year-Old Girl

Older, pre-adolescent children often have a better understanding of the basic nature of the testing situation than do younger children. However, the procedures should still be explained in very clear and simple terms to ensure that there are no misconceptions. In this age group, we find that the explanation must be sensitive to the potential threat to a child's self-concept that the testing may present. One of the major emotional tasks during the pre-adolescent period is the development of a sense of mastery and a sense of competence. Testing can be a threat to a child in these areas for several reasons. First, just the term "testing" conveys the possibility of failure. Secondly, the child may have been implicitly or explicitly told that the reason for the testing is to see "what's wrong with you." The explanation of testing in this age group should be sensitive to these issues. Here, we provide a sample explanation to a 10-year-old girl referred for a comprehensive evaluation.

> "Jessica, I want to explain exactly what we are going to be doing together today, and give you a chance to ask me any questions you may have. Your parents were concerned about some of the problems you have been having at school and they wanted to know if there was anything more they could be doing to help you. In order for me to answer this question, I have to find out a lot more about you-what you like to do, how you feel about different things, what things you're good at, what things you might not be so good at. To do this, we are going to do a lot of different things together. First, I am going to ask you to do some reading and math problems with me. Then I will ask you to fill out some questionnaires that will tell me how you feel about different things, how you get along with kids in your class, and how you see your family. Finally, I am going to show you some pictures and ask you to tell me some stories about them. Before we start each of these activities, I will tell you what we're going to do and how to do each thing. I promise to give you a chance to ask me any questions you have about each task. I have already talked to your mother about how things go at home and I am going to ask your teacher to fill out a questionnaire about how she sees you at school. After I get all the information, I should understand you a little better and I will then talk about what I found with you and your parents. Jessica, it is very important that you understand that I'm not looking for things that are wrong with you. My guess is that you are like most kids. You have things that you're good at and some things that you're not so good at, and that there are things you like and other things you don't like. I am just trying to get a good picture of all these different parts of you."

Box 5.5

Explaining Testing to an Adolescent

There are several crucial issues that one must keep in mind when explaining testing to an adolescent. First, adolescents spend a great deal of energy trying to convince people that they are no longer children. Therefore, one must be very careful not to come across as condescending to them. Secondly, because of the importance of peers in adolescence, adolescents are very concerned with fitting in. Coming in for psychological testing may be viewed as a threat to this by making them feel different from other adolescents. Therefore, the explanation should attempt to normalize the testing as much as possible. Thirdly, privacy is

(Continues)

Box 5.5 (Continued)

a major issue for adolescents. In testing, adolescents may be asked many personal questions. They must be warned of these questions and informed as to how the information from the testing will be conveyed to other people. This is very threatening to most adolescents, and the explanation should be sensitive to this issue. Fourth, a majority of adolescents referred for testing do not see the need for such testing and don't want to be there. A major flaw we often see in presenting testing to adolescents is that the assessor tries to cajole the adolescent into being happy to be there and into appreciating the potential benefits of testing. Clearly, the potential benefits of testing should be discussed with the adolescent in an attempt to enhance motivation. However, this often has a minimal effect on motivation, and often one must simply acknowledge to the adolescent that you understand that he or she is not happy about being there but, if you work together, you will get through it quickly and relatively painlessly. The following is a sample explanation of psychological testing provided to a 16-year-old male.

"Jeff, I want to explain what we will be doing today and, please, feel free to ask me any questions about what I say. You probably know that your parents are concerned about your behavior. They have seen some changes in you recently and they want to know if they can do something more to help you. I understand that you are not wild about being here, but if we work together, maybe we can see if there is anything that I can recommend to help you or at least put your parents' minds at ease. But if we're going to get anything out of this we have to work together. I work with a lot of people of your age who don't want to be here at first, but end up getting a lot out of the experience. I will start by just asking you about some of the things that have been going on with you lately to get your view on things. I have already talked to your parents about their views of what's going on. I also have some questionnaires for you to complete about your feelings, your behaviors, and your attitudes. Some of these questions are pretty personal, but they are important for me to get a better understanding of you. After the testing, I will summarize the results in a report and go over it with you and your parents. At that time we can discuss anything that I think may help you."

Building Rapport with the Child

As mentioned previously, the child is often not the one seeking an evaluation but is usually referred by some significant adult who feels that the child or adolescent needs the testing. Therefore, the motivation of the child for the evaluation is often low. Another reason for low motivation is that the child often realizes, or has been explicitly told, that the evaluation is prompted by problems either at home or school. As a result, the child is legitimately concerned about the outcome of the evaluation (i.e., getting into more trouble). In addition, the testing situation is often unique in most children's experiences. Children have had a few similar experiences, and therefore they often have little idea of what to expect in the testing situation. Finally, the many developmental stages that characterize childhood and adolescence imply that assessors must be familiar with development to be able to tailor their rapport-building strategies to the unique needs of children at various stages.

We have already mentioned that rapport building is a process that evolves throughout testing. It starts at the very first contact between the assessor and the

child. When an assessor greets a child, the assessor should (1) use a warm, friendly, and interesting tone, (2) be sure to greet the child by name (don't simply greet the child's parents), and (3) introduce him- or herself using his or her title (e.g., Dr., Ms., Mr.). This last recommendation is a subject of considerable debate by practicing psychologists (Barker, 1990). However, we feel that using a title is important in the time-limited, task-oriented assessment situation because it sets the stage that you are a professional (albeit a caring, friendly, and respectful one) who will be working with the child, and not a friend who will play with the child.

After informed consent, many authors recommend a period of time for discussing innocuous and pleasant topics, such as the children's hobbies, pets, friends, or other interests (Barker, 1990). For younger children, some authors even recommend a period of play to allow the children to become more accustomed to the examiner. In our experiences, such rapport-building strategies should be used cautiously and sparingly. For many children, the assessor may be perceived as simply delaying the inevitable by using these strategies. This could have the paradoxical effect of increasing their anticipatory anxiety. In our experience, one of the best rapport-building strategies is to begin the assessment tasks quickly, so that the child begins to realize that the procedures will not be as bad as they imagined.

Periods of play before the evaluation are especially problematic if structured testing is to follow. Young children often have difficulty switching from unstructured to structured tasks (Perry, 1990). Therefore, it is usually best when testing preadolescent children to start with the more structured parts of the evaluation (e.g., rating scales, structured interviews) rather than starting with less structured tasks (e.g., projective drawing tests). This is not only because of the greater difficulty in switching from unstructured to structured tasks, but also because the structured tasks have clearer demand characteristics. That is, it is usually quite clear to children what is expected of them on these tasks and this, in turn, helps the children become more comfortable in a situation that is different from anything they have experienced in thepast.

Box 5.6 provides a summary of some additional rapport-building strategies for use with children that were proposed by Barker (1990) in his book on interviewing children

Building Rapport with the Parent

There are also some unique considerations in building a working relationship with a child's parents. Of course, the importance of rapport with parents will depend on the degree of their involvement in the testing. However, in most situations their involvement will be substantial. Although many evaluations are conducted at the request of a parent, there are also many situations in which a child is referred by others (e.g., school, court), and, in these situations, building rapport with the child's parent is critical. Under these circumstances, the assessor must allow the parent to express his/her views on the need for evaluation prior to the testing process. The assessor need not necessarily agree with these views, but the assessor should convey to the parents a sincere interest in understanding their views in order to build a working relationship with them.

Even for parents who have initiated the referral for testing, the assessor should be aware of the potential threat to a parent's self-esteem that many testing situations present. For many parents, acknowledging that their child might have some type of disability is quite traumatic and can evoke a sense of failure. Also, parents often struggle with guilt blame for

Box 5.6

Rapport-Building Strategies

Barker (1990), in his book on conducting clinical interviews with children and adolescents, discussed several helpful strategies for establishing rapport. These can be summarized as follows:

1. A critical basis for rapport building is an assessor's communication style. The assessor who is able to adopt a warm, friendly, respectful, and interested communication style is more likely to develop a good working alliance with a child.
2. The assessor's physical appearance can also enhance rapport. Overly formal dress can make a child feel ill at ease.
3. Assessors should attempt to conform his or her posture, movements, speed of speech, voice tone and volume, etc. to the style of the person being tested. This should be done sensitively and unobtrusively.
4. Assessors should tailor their vocabularies to match the vocabularies of the person being tested. Few things impede the establishment of rapport as much as repeatedly using words and expressions that are unfamiliar to those with whom you are speaking.
5. Respect the views of those you are testing. This does not necessarily mean agreeing with or approving of the views expressed.
6. Occasionally the assessor should adopt a one-down position. To reduce the intimidation that children sometimes feel with experts, the assessor can sometimes ask a child, from a position of ignorance, about something with which a child has expertise, such as video games, television shows, or soccer.
7. Taking time during the testing to talk of experiences and interests that the assessor and child have in common can also increase the trust between the assessor and the child.

Barker (1990) also emphasizes that the development of rapport is continuous throughout the testing process. "Rapport can always be developed further; the reverse is also possible. Although it is certainly true that once it is well established, rapport can withstand a lot of stress, it nevertheless can be damaged or even destroyed at any time if continuing attention is not paid to maintaining it" (p. 35).

SOURCE: Barker (1990). *Clinical Interviews with Children and Adolescents.* New York: Norton.

their child's problems and may be concerned that testing will confirm their potential role in their child's difficulties. An assessor should be sensitive to these dynamics and allow the parents to express their concerns at some point during the testing. Additionally, the parents should be supported in their role of getting help for their child. For example, an assessor might tell the parents how lucky their child is to have parents who care enough to obtain help for him or her, and not just let things get worse. This helps to reframe the testing situation as one that could increase the parents' self-esteem, rather than one that is a threat to their self-concept.

Several reasons were given for starting with structured tasks in testing children in an effort to enhance rapport. In our experience, the opposite is true in rapport building with parents. Even prior to obtaining specific background information from a parent, it is important to let the parent discuss his or her concerns about the child in an unstructured format. The unstructured clinical interview is discussed in more detail in a later chapter. However, having such an interview at the start of the

evaluation conveys to the parent (1) a genuine concern with his or her perceptions of their child's adjustment and (2) that the evaluation will be personalized for the individual child. If parents are immediately asked to fill the rating scales or administer a structured interview as part of a standard evaluation, they often develop the impression that the assessor is more interested in administering tests than in actually understanding their child's needs. As one would expect, such an impression is very damaging to the development of rapport.

Building Rapport with Teachers

It is becoming increasingly clear that evaluations of children must involve information from teachers (Loeber, Green, & Lahey, 1990). The degree of teachers' involvement varies considerably depending on the focus of the evaluation. However, many assessors who are not used to working in school settings find themselves ill-equipped to collaborate with teachers to conduct psychological evaluations (Conoley & Conoley, 1991).

In the introduction to the concept of rapport, we defined the basic ingredient to rapport building as exhibiting an attitude of respect towards the client or informant. Although many psychologists work hard in respecting and developing rapport with parents and children, often this respect is lost when dealing with other professionals, such as teachers. A key to demonstrate this attitude is by respecting the importance of teachers' time. Scheduling phone calls during teacher's planning times, eliminating all but the most essential work for the teacher, and always personally thanking the teacher for his or her efforts in the evaluation are very simple, yet important, rapport-building strategies.

If a teacher is sent assessment material for completion (e.g., rating scales), it is important for the assessor to call the teacher and personally request the teachers' participation in the evaluation, acknowledging and thanking the teacher for his or her efforts, rather than simply sending the material to the teacher via the child, parent, or mail. Such a call is a professional courtesy that greatly enhances the collaborative effort. It sets the tone for the teacher being involved in the evaluation as a valued professional who has much to offer in the assessment of the child.

Conclusions

In this chapter, some non-specifics of the clinical assessment of children were discussed. That is, a successful evaluation is not simply a matter of appropriately administering and interpreting psychological tests. It is also dependent on an assessor's ability to provide an appropriate context in which the testing takes place.

The first major issue discussed was the importance of good planning. A good evaluation is focused and goal-oriented. The purpose of the evaluation and the intended uses of the assessment results will have a major impact on how the assessment is structured. Enough information should be available prior to actual testing so that the assessor has some initial hypotheses to be tested in the evaluation.

The second part of the chapter is focused on rapport-building strategies with all participants in the evaluation. Developing a collaborative, respectful, and trusting working relationship is crucial to a successful evaluation. Being able to develop rapport is a skill that often takes years of practical experience to develop fully. However, in this chapter we have tried to highlight some of the important issues in rapport building with children and adolescents of various ages. We have also tried to make some practical recommendations that address these issues.

Chapter Summary

1. The first step in planning an evaluation is to clarify the reason for referral, both in terms of the purpose of testing and the types of behavior that led to the referral.
2. Two important decisions that a clinical assessor should make prior to starting any evaluation is whether or not a formal evaluation is warranted and whether he or she is the most appropriate person to conduct the evaluation.
3. In addition to competently administering tests, clinical assessors must create an appropriate environment within which the evaluation can take place.
4. Building rapport with a child refers to developing a collaborative and supportive relationship with the child for the purpose of conducting the evaluation.
5. Building rapport with other important people who will be involved in the evaluation (e.g., parents, teachers) is also critical to the assessment process.
6. A thorough and sensitive informed consent procedure can play a major role in showing respect to the child client, and his or her parents and thereby can greatly aid in the establishment of rapport.
7. An explanation of the testing procedures with a child must be sensitive to a large number of motivational and developmental issues.