# Chapter 16

# Report Writing

## Chapter Questions

- How does the call for evidence-based assessment lend itself to report writing?
- How does a clinician clarify the referral question?
- What are the common mistakes made in report writing?
- How should assessment results be reported to parents in conferences?

## Reporting Problems and Challenges

Presenting assessment results orally or in writing can be a foreboding task. However, this process is central to assessment. The most sophisticated, accurate, and comprehensive case conceptualization is useless if the key figures in a child's life (e.g., parents, teachers) are unaware of the results or recommendations from an assessment or do not fully understand them. Aside from appropriately and accurately conveying results and recommendations, clinicians are also often faced with fears of litigation and insecurities about their interpretive skill. Thus, a chapter on report writing is crucial for an assessment text. As clinicians know well, their written products can carry a great deal of importance, and if done well, they can facilitate positive outcomes for a child. On the other hand, if a report is faulty (i.e., inaccurate, unclear, full of errors), it will make no impact aside from being a negative reflection on the clinician who wrote it.

Effective psychological report writing is taking on increased importance for practicing psychologists. Psychological reports are made available to parents, judges, lawyers,



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and other non-psychologists, creating the opportunity for improper interpretation of the results by untrained individuals. More positively, psychological reports remain particularly useful to other clinicians who evaluate a child who has previously been seen by a psychologist. A previous psychological report can provide a valuable baseline against which a clinician can gauge response to treatment, the emergence of a comorbid problem, and other factors. A previous diagnosis of Conduct Disorder, for example, may encourage the evaluating psychologist to screen for depression because of known comorbidity (DeBaryshe, Patterson, & Capaldi, 1993). A clinician can significantly enhance the quality of work conducted by a successor through the production of an articulate written report.

Despite its importance, the topic of report writing is relatively neglected in the research literature (Ownby & Wallbrown, 1986). While a number of works are available on this topic (e.g., Braaten, 2007; Lichtenberger, Mather, Kaufman, & Kaufman, 2004; Tallent, 1993), little research has been conducted to assess the effects of report writing on important outcomes such as the likelihood that a recommendation will be followed (Ownby & Wallbrown, 1986).

Ownby and Wallbrown (1986) draw several discouraging conclusions. They conclude as follows on psychological reports:

- Considered useful to some extent by consumers such as psychiatrists and social workers
- Frequently criticized by these professional groups on both content and stylistic grounds
- May (or may not) make substantial contributions to patient management

In addition to the opinions of psychiatrists and social workers, a number of studies have assessed teachers' satisfaction with psychological reports and have found that they are frequently dissatisfied with them (Ownby & Wallbrown, 1986). One can get a sense of why teachers and other professionals are dissatisfied with psychological reports by reading the following excerpt that was taken verbatim from a report. All of the conclusions drawn by the evaluator in this case are on the basis of *one test* requiring the child to simply reproduce nine designs with pencil and paper.
We quote:

> The Bender-Visual Motor Gestalt test suggests delinquency and an acting out potential. He is anxious, confused, insecure and has a low self-esteem. He may have difficulties in interpersonal relationships and tends to isolate himself when problems arise…. [He] also seems to have a lot of anxiety and tension over phallic sexuality and may be in somewhat of a homosexual panic.

This clinician was apparently using a cookbook approach to interpretation, conveying no clear evidence to support his/her case conceptualization. A report like this is of no help to anyone, especially not to the child being evaluated.

One of the difficulties with report writing is that different audiences require different reports. For example, a psychometric summary (i.e., a portion of the report that presents only test scores and is usually given at the beginning or as an appendix at the end of a report) given without context is likely to be of little use to parents but of great potential use to colleagues and perhaps teachers. An important decision that each psychologist must make prior to report writing is to determine the primary audience for the report. For example, a psychometric summary may be of minimal use to parents who have contracted with the psychologist in private practice for an evaluation. In this case, it is more sensible to present test results in context in order to communicate effectively with the parents. A psychometric summary is more in order in a treatment team situation, where it is imperative that a psychologist communicate effectively with knowledgeable colleagues.

In most situations, we recommend that the clinician attempt to make his or her reports accessible and useful to all pertinent audiences so that interested parties do not have different reports for the same assessment of the same child. Our discussion will focus mainly on the expectation that one report will be made available to parents, teachers, physicians, etc., with the understanding that certain presentations of results and interpretations will be most useful to certain audiences.

## Report Writing as Part of Evidence-Based Assessment

Report writing has not specifically been addressed in recent writings on evidence-based assessment of children. Instead, the discussion has focused on the use of tools and methods that are valid and that demonstrate clinical utility (see Mash & Hunsley, 2005). We feel that the move toward evidence-based assessment should, and will, be reflected in the reports that result from psychological assessments.

Mash and Hunsley (2005) point out that evidence-based assessment is not meant to replace the clinician or the clinician's judgment. Similarly, the clinician will continue to be a key figure in assessment reports. That is, it is unlikely and undesirable that reports will be completely boiler plate endeavors that do not allow for flexibility based on the particular assessment approach used, the client's particular presenting problems, or the needs of the client and allied professionals.

In contrast, not unlike a scientific manuscript, reports from an evidence-based approach to assessment can be seen as the means by which a client's history and difficulties are described, results are obtained and interpreted, and suggestions for future (treatment) approaches to the difficulties are discussed.

The main sections of most psychological reports are discussed later in this chapter, but in many ways, they are analogous to sections of journal articles in psychology and other scientific fields. For example, the "Referral Questions" section is essentially a statement of the evaluation's purpose. "Background Information" in a report is similar to a literature review in a research article, wherein the previously noted issues are mentioned and the current questions or problems are presented to the audience. The "Assessment Procedures" or Psychometric Summary provides the methods used in trying to address the referral question(s). The results of the current assessment begin to be addressed fully in the "Behavioral Observations" section. This section provides a context for the assessment results, particularly any testing that occurred directly with the client. The analogy in a scientific manuscript would be initial analyses that point to any variables that need to be controlled or any conditions that might call some results into question. Similarly, testing conditions or client factors (e.g., child was sick on the day of testing) could be important information for interpreting assessment results. The "Assessment Results and Interpretation" sections are ideally a mix of what might be found in the "Results" and "Discussion" sections of a scientific article. In the report, the clinician should not present data with no interpretation, and the clinician should not make interpretations without clearly providing the data on which they were made. Recommendations, which are critical in an assessment report, allow the clinician to suggest what should be done in the future to address the problem. Researchers routinely do this as well in their published manuscripts.

Pointing to consistencies between assessment reports and scientific manuscripts is an oversimplification of the report writing process in some ways. Nevertheless, many clinicians-in-training are also well-versed in research methodology and writing, and this analogy may serve to make report writing seem less nebulous and daunting. The collection of background information, the scoring of measures, and inter-

pretation of results that occur in research are essentially the processes that take place in evidence-based assessment and report writing. The gathering and explaining of evidence allow the clinician to clearly present a case conceptualization (theory) of the client's difficulties that is grounded in data, as opposed to the approach evidenced in the quote earlier in this chapter.

## Pitfalls of Report Writing

Complaints about psychological reports persist. Norman Tallent (1993) wrote a landmark textbook on report writing in which he summarized the literature on the strengths and weaknesses of reports as identified by psychologists' colleagues in mental health care, most notably social workers and psychiatrists. Some of the highlights of Tallent's review are outlined in the next section.

### Vocabulary Problems

The problem of using vague or imprecise language in report writing is commonplace. The colloquial term used to describe such language is *psychobabble*. Siskind (1967), for example, studied the level of agreement between psychologists and psychiatrists in defining words such as the following:

| | |
|---|---|
| Abstract | Defense |
| Affective | Dependent |
| Aggression | Depressive |
| Anxiety | Emotional |
| Bizarre | Hostility |
| Bright | Immaturity |
| Compulsive | Impulsive |
| Control | Normal Constriction |

The results of the study showed very little correspondence between the definitions offered by the two groups of professionals. We suspect that without clear descriptors of problems (e.g., hyperactivity, depression), such disagreement among consumers of reports persists today.

Tallent (1993) refers to one aspect of this problem with language as exhibitionism, which seems to be a frequent criticism of reports, particularly on the part of other psychologists. One commentator stated, "They are written in stilted psychological terms to boost the ego of the psychologist" (p. 33).

Some other pertinent observations by Tallent (1993) on the use of language by psychologists in reports are paraphrased below:

- They include complex (meaningless) words that are often used to add length to the report.
- They are written in esoteric language understood by the psychologist only. For example, it may be said that clients manifest overt aggressive hostility in an impulsive manner – when, in fact, they punch you on the nose.
- They are not frequently enough written in lay language. In particular, scores are over-emphasized, and the fit between the results and the child's actual behavior is under-emphasized. Tallent (1993) argues that an excessive focus on multiple scores or indices may be a method to cover up the clinician's lack of true understanding of the assessment findings.
- They include language that is so vague and unclear that it cannot be falsified or considered wrong.

These latter two points are critical if reports are to address the referral question in a manner that is amenable to subsequent, appropriate intervention. Of course, psychology cannot be singled out as the only profession with a preference for its own idiosyncratic terminology, as anyone who reads a physician's report or a legal contract will attest. Perhaps psychologists can, however, lead the way toward competent reporting of findings.

## Faulty Interpretation

Faulty interpretations may be made on the basis of personal ideas, biases, and idiosyncrasies (Tallent, 1993). The problem is most readily seen when the psychologist is clearly using the same theories or drawing the same conclusions in every report. A psychologist may conclude that all children's problems are due to poor ego functioning, neuropsychological problems, or family system failure. A psychologist who adheres exclusively to behavioral principles, for example, will attribute all child problems to faulty reinforcement histories. The savvy consumer of this psychologist's reports will eventually become wary of the psychologist's conclusions, as the relevance of the favored theory to some cases is questionable. One can imagine the skepticism that may be engendered by a psychologist who concludes that a child whose school performance has just deteriorated subsequent to a traumatic head injury merely needs more positive reinforcement to bring his grades up to pre-trauma levels.

Problems may also occur if a psychologist draws conclusions that are clearly in conflict with the data collected for a child. A psychologist may decide not to make a diagnosis, in seeming contrast to rating scale findings of significant T-scores on the majority of scales. If a clear argument for resolving this incongruity is not made, the consumer of the report may well suspect biases. The psychologist who routinely does not reconcile high T-scores with a lack of a diagnosis may soon be labeled as unwilling to diagnose regardless of assessment results. The reverse situation can also be problematic, wherein the psychologist makes a diagnosis without any clear indications of significant symptomatology or impairment. Teachers, pediatricians, or other referral sources who receive this interpretation consistently from the same psychologist may eventually pay more attention to the data presented in the reports and ignore the psychologist's conclusions, or they may simply refer elsewhere.

## Report Length

Psychologists, more so than other groups, complain about the excessive length of reports (Tallent, 1993). However, length may not be the real issue. Perhaps long reports are used to disguise incompetence, fulfill needs for accountability, or impress others. The possibility that length is a cover for other ills is offered in the following example:

> A business executive likes to relate the anecdote about the occasion when he assigned a new employee to prepare a report for him. In due time, a voluminous piece of writing was returned. Dismayed, the executive pointed out that the required information could be presented on one, certainly not more than two, pages. But sir, pleaded the young man, I don't know that much about the matter you assigned me to (Tallent, 1988, p. 72).

It may also be worth considering that the Ten Commandments are expressed in 297 words, the Declaration of Independence is in 300 words, and the Gettysburg Address is in 266 words.

## Number Obsession

The clinician must always keep clearly in mind that the child is the lodestar of the evaluation, and the numbers obtained from personality tests and the like are only worthy of emphasis if they contribute to the understanding of the child being evaluated. One way to think of the scores is as a means to an end, with the end being better understanding of the child. *The same numbers for two children can mean two quite different things*. Just as a high temperature reading can be symptomatic of a host of disorders from influenza to appendicitis, so, too, a pathognomic behavioral sign can reveal a host of possible conditions.

One horrendous error often made when reporting test scores is a psychologist reporting a score and then saying that it is invalid. Then why report it (Tallent,

1993)? If a test score is invalid, how does it serve the child to have this score as part of a permanent record? Reporting apparently invalid scores is akin to a physician making a diagnostic decision on the basis of a fasting blood test when the patient violated the fasting requirements. In all likelihood, the flawed results would not be reported; rather, the patient would be required to retake the test. We suggest that *one does not have to report scores for a test just because it was administered.* This stance applies to scores that are deemed invalid or circumstances in which the psychometrics underlying the scores are questionable. In these situations, disregarding the information from the measure or providing only descriptions of the responses may better inform case conceptualization.

## Failure to Address Referral Questions

Tallent (1993) points out that psychologists too often fail to demand clear referral questions, and as a result, their reports appear vague and unfocused. This very obvious point is all too frequently overlooked. Psychologists should insist that referral sources present their questions clearly, and if not, the psychologist should meet with the referring person to obtain further detail on the type of information that is expected from the evaluation (Tallent, 1993). Many agencies use referral forms to assist in this process of declaring assessment goals. A form similar to those used by hospitals is shown in Fig. 16.1, and one suitable for use by school systems is given in Fig. 16.2.

On occasion, the referral question(s) can be insidious and, consequently, place the psychologist in the position of disappointing the referral source before the evaluation is even initiated. Under these circumstances, the psychologist may feel helpless or even betrayed because of the negative reaction of the referral source to the presentation of results and recommendations. Psychologists may often need to pursue the true referral question. Some examples of stated and true referral questions are shown below:

| Stated Referral Question | True Referral Question |
|---|---|
| A child's teacher wants to know if child has ADHD | The teacher is convinced that the child has ADHD and expects the psychologist to confirm it |
| A parent wants to know why a child is failing in school | The parent thinks the child is depressed and would like her to be on medication |
| A psychiatrist wants to know if a child is depressed | The psychiatrist has made the diagnosis of depression and has placed the child on medication. The referral was made simply because a second opinion is required for reimbursement purposes |
| A psychologist wants to know if the child is neurologically impaired | The psychologist is seeking a diagnosis of traumatic brain injury in order to bolster her court testimony |

In all of these scenarios, it would behoove the psychologist to clearly determine the referral source's actual needs and/or desires early on in the referral/evaluation process and then determine the most appropriate way to proceed.

## The Consumer's View

Virtually no recent research has been conducted on the consumer's view of psychological reports. One study evaluated teacher preferences for and comprehension of varying report formats (Wiener, 1985). This study required a group of elementary school teachers to read and rate their comprehension of and preferences for three different reports for the same child.

Patient Name John Doe

Medical Record Number 00071103

Attending Physician Lyman

Type of Consultation:

*Patient is a 13 year-old with Type I Diabetes who has poor adherence to treatment regimen. Parents are concerned that John is aware of the risks of this poor adherence but seems apathetic. Patient's affect is flat and may be depressed. Patient to be discharged from hospital following psych. consultation.*

Results of Consultation: *Patient appears depressed and seems knowledgeable about diabetes and his diabetes regimen. In particular, his parents noted that he appears sad most of the time, lacks energy, has reduced his contact with friends, and does not seem interested in activities that he used to enjoy. Rating scales completed by patient and his mother showed moderate levels of depression. Family history of depression is significant. Outpatient therapy is recommended and has been scheduled to begin in 1 week.*

Signed _____ Title _____ Date

FIGURE 16.1
Sample referral form consultation used by hospitals

The three reports used were a short form, a psychoeducational report, and a question-and-answer format. The short-form report was one page, single-spaced. It used some jargon, such as acronyms, to shorten length; conclusions were drawn without reference to a data source; and recommendations were given without elaboration. The psychoeducational report format was three and a half single-spaced pages. It used headings such as Reason for Referral, Learning Style, Mathematics, Conclusions, and Recommendations. Observations were stated in behavioral terms with examples used freely. Recommendations were given and elaborated, and acronyms and other jargon were only used when they were defined in text. The question-and-answer report was similar to the psychoeducational report in many ways, but it did not use headings per se. This report listed referral questions and then answered each question in turn. This report was four and a half pages long.

Amazingly, in this study, the participants preferred length. First, teachers comprehended the two longer reports better. Second, of the two longer reports, the teachers preferred the question-and-

Student's Name Jane Smith Date of Referral 10/11/07
Referring School Stuart Elem. Age 8 Grade 2 Grades Repeated N/A

Is the student now receiving speech therapy? ___ Yes x no

| | Never | Sometimes | Often |
|---|---|---|---|
| Expressive Language (problems in grammar, limited vocabulary) | | | x |
| Receptive Language (comprehension not following directions) | | x | |
| Speech (poor enunciation, lisps, stutters, omits sounds, infantile speech) | | x | |
| Gross Motor Coordination (eye-hand, manual dexterity) | x | | |
| Visual (cannot see blackboard, squints, rubs eyes, holds book too close) | x | | |
| Hearing (unable to discriminate sounds, asks to have instructions repeated, turns ear to speaker, often has earaches) | x | | |
| Health (example: epilepsy, respiratory problems, etc.) | x | | |
| Medications | (yes) | **(no)** | (Type) |

Overly energetic, talks out, out of seat: Sometimes

Very quiet, uncommunicative: Often

Acting out (aggressive, hostile, rebellious, destructive, cries easily): Sometimes

Inattentive (short attention span, poor on task behavior): Often

Doesn't appear to notice what is happening in the immediate environment: Sometimes

Poor Peer Relationships (few friends, rejected, ignored, abused by peers): Often

ACADEMIC PROBLEMS

Reading (word attack, comprehension): Often

Writing (illegible, reverses letters, doesn't write): Often

Spelling (cannot spell phonetically, omits or adds letters): Often

Mathematics (computation, concepts, application): Never

Social Science, Sciences (doesn't handle concepts, doesn't understand rerelationships, poor understanding of cause and effect): Never

Signature and position of referring person

FIGURE 16.2
Referral for consultation used by schools

answer report over the psychoeducational report. The short form was clearly least preferred. These are intriguing results in that they hint that length may be overrated as a problem in report writing and that teachers may prefer a question-and-answer report format. This finding is interesting because this format is rarely used in reports from clinical assessments.

Do parents have different preferences from teachers? In a follow-up study with parents using the same methodology, Wiener and Kohler (1986) found that teachers and parents have similar preferences. In this second study, the same three report formats were used. As was the case with teachers, parents comprehended the two longer reports significantly better than

the short-form report. An interesting additional finding was that parents with a college education comprehended reports better than parents with only a high school diploma. Parents also tended to prefer the question-and-answer format to the other two formats, although the difference in preference scores between the psychoeducational and question-and-answer reports failed to reach statistical significance.

The results of these two studies suggest that the two most frequent consumers of child and adolescent psychological reports, parents and teachers, consider the clarity of reports to be more important than their absolute length. They also show a preference for reports that have referral questions as their focus. Cognizance of these two findings may benefit psychologists who write reports for children and adolescents.

## Suggested Practices

### Report Only Pertinent Information

One of the most difficult decisions to make when writing a report involves gauging the relevance of information to include (Teglasi, 1983). Clinicians happen onto a great deal of information during the course of an evaluation, some of which is tangential. Say, for example, a child is referred for an evaluation of ADHD. During the course of an interview with the child's father, he recounts at length his disappointment with his wife. He tells the clinician that she is dating other men, and he believes that she is not spending adequate time with their children. When writing the report on this case, the clinician has to determine whether or not this information is pertinent to the ADHD evaluation.

Clinicians must think critically about the in-formation that they include in reports and consider its relevance to the case. As discussed by Lichtenberger et al. (2004), the objectives of psychological reports are to "answer the referral questions; describe the person; organize the data; and recommend interventions" (p. 3). If information is not relevant to these objectives, and it is very personal, the psychologist should consider carefully the decision to invade a family's privacy by including such information in the report.

### Define Abbreviations and Acronyms

Acronyms are part of the idiosyncratic language of psychological assessment. They can greatly facilitate communication among psychologists, but they hinder communication with non-psychologists. Psychologists, just like other professionals, need to use nontechnical language to communicate with parents, teachers, and other colleagues in the mental health field. A pediatrician would not ask a mother if her child had an emesis; rather, the physician would inquire whether or not the child vomited.

When writing a report, psychologists should limit their use of acronyms and should define any acronym used in a report. Use of the acronym *SAD* for separation anxiety disorder, for example, without defining, is questionable practice.

### Emphasize Words Rather than Numbers

Particularly in the test results section of a report, clinicians must resist a temptation to focus exclusively on numbers (i.e., test scores). Lichtenberger et al. noted that "some evaluators spend too much time writing about the obtained test scores rather than about what these scores mean" (p. 5). Words often communicate more effectively than numbers because they communicate more directly and in a more accessible manner to a variety of audiences. The typical question of a referral source has

nothing to do with the obtained T-scores but, rather, the psychologist's interpretation of these scores. Most laypersons will not understand the T-score metric but can more easily grasp clinician's interpretation of norm-referenced scores.

## Reduce Difficult Words

The issue of using simple language is by now obvious. The difficult part for report writers is following through on this advice. Consider the following two paragraphs, which differ greatly. The first excerpt uses vocabulary that is unnecessarily complex for most consumers of reports. The second example is a rewrite of the first paragraph that uses a more practical vocabulary level.

> There is also evidence from the test data to suggest that Pam is obdurate in response to anxiety. She may also tend to be very concrete and not notice some of the subtleties of interpersonal discourse. Given these idiosyncrasies, she may find it difficult to generate effective social problem-solving strategies and mechanisms for coping with life's stressors.

The next paragraph tries to communicate more clearly by using, among other things, simpler language.

> Pam responds to stress by withdrawing from others (e.g., going to her room or leaving a group of friends on a social outing), which seems to be the only method she uses for dealing with stress. She also has trouble understanding and responding to messages given by others in social situations (e.g., body language or verbal hints). Because of these behavior patterns, Pam has trouble making friends.

Related to the use of difficult words is the issue of using the correct person. We have occasionally seen reports where instead of using the child's name, he or she was referred to as "the child" or "the subject." This usage sounds too mechanistic and impersonal for a psychological report. In most cases, the use of the child's name is better. It is important to also clearly differentiate among sources of information and between data gathered during the assessment and the clinician's interpretations. Jargon or convoluted writing makes these important distinctions difficult to be made out by the reader.

## Briefly Describe the Instruments Used

In many cases, it is safe to assume that the reader of the report has little knowledge of the tests being used. When practical, we suggest that report writers describe the nature of the assessment devices being used.

The naive reader of a report will also be helped by descriptors of the nature of a scale or subscale that is being discussed. This observation is particularly true for scales that are not adequately described by their names. Depression scales are a good example of scales that may be perceived inappropriately. The label *depression* could conjure up a variety of images in a report reader's mind including the image of a child that is incapacitated by sadness. It may well be that a Depression score indicates significance but, de-pending on the items endorsed, may not warrant the formal diagnosis of depression. In this case, the clinician should try to describe the nature of the scale content and/or its interpretive meaning in order to discourage misuse of results.

## Edit the Report

We have found that a number of our students do not take a critical eye toward editing their own work and not just in terms of grammar and spelling. Editing is necessary to ensure the most accurate communication in the least amount of space.

Tallent (1988) provides the following excellent example of how an editor (and the articulate psychologist) thinks:

> There is the tale of the young man who went into the fish business. He rented a store, erected a sign, FRESH FISH SOLD HERE, and acquired merchandise. As he was standing back admiring his market and his sign, a friend happened along. Following congratulations, the friend gazed at the sign and read aloud, FRESH FISH SOLD HERE. Of course it's here. You wouldn't sell it elsewhere, would you? Impressed with such astuteness, the young man painted over the obviously superfluous word. The next helpful comment had to do with the word *sold.* You aren't giving it away. Again impressed, he eliminated the useless word. Seemingly that was it, but the critic then focused on the word *fresh.* You wouldn't sell stale fish, would you? Once more our hero bowed to the strength of logic. But finally he was relieved that he had a logic-tight sign for his business; FISH. His ever alert friend, however, audibly sniffing the air for effect, made a final observation: You don't need a sign (p. 88).

Psychologists do not need to engage in such severe editing, but they should at least make an attempt to think critically about their word usage in order to reduce report, sentence, and paragraph length. Judicious editing can go a long way toward clarifying meaning in a report. Sometimes new clinicians are not used to critiquing their own writing. One readily available option is to have a colleague read reports. Confidentiality, however, should be kept in mind if an editor is used.

## Use Headings and Lists Freely

Headings and lists can enhance the clarity of communication (Harvey, 1989). If, for example, a clinician draws a number of conclusions about a child, the conclusions can sometimes lose their impact if they are embedded in paragraphs.

As one would predict, the use of headings and lists to excess has a downside. A report that uses too many lists, for example, appears stilted, and it may not communicate all of the texture and subtleties of the child's performance. Report writers should consider using additional headings if a section of their report stretches for nearly a page (single-spaced) without a heading. Clinicians should consider lists if they want to add impact to statements and/or conclusions.

## Use Examples of Behavior to Clarify Meaning

Because there is some disagreement regarding the meanings of particular words, report writers should clarify their meaning in order to ensure accuracy. Words that may conjure up a variety of interpretations include *anxiety*, *cooperation*, *dependent*, *hyperactive*, and *low self-esteem.* One way to foster clarity is to use examples (i.e., behavioral referents) of the child's behavior. Here, for example, are two ways to say that a child, Emilio, was anxious.

> Emilio exhibited considerable anxiety during the testing.

Or, alternatively:

> Emilio appeared anxious during the testing. He frequently asked whether or not he had solved an item correctly. He occasionally looked at the ticking stopwatch during an item and then hurried, and his face became flushed when it was obvious to him that he did not know the answer to a question.

An additional benefit of using examples of behavior generously is that it forces the psychologist to consider the extent of supporting evidence for a conclusion about a child's behavior. If a psychologist writes that a child is anxious but cannot think of behaviors to help explain this, then the conclusion should not be drawn, as it is insupportable by evidence.

Direct quotes, to some extent, are also helpful for clarifying meaning. If a clinician

concludes that an adolescent is suicidal, a quote from the child may help clarify this statement considerably. The child may have said, "I thought about taking some pills once" or "I feel like I want to run out in front of a car tonight and if that doesn't work, I will steal my father's gun and kill myself." These statements convey varying degrees of suicidal intent that are most clearly differentiated by quotes.

### Reduce Report Length

Tallent (1988) gives the following instances as indications of undue length:

- The psychologist is concerned that it took too long to write it (we might add that most reports will seem that way for beginning clinicians, but the time to write reports should decline with experience).
- The psychologist has difficulty organizing all of the details for presentation.
- Some of the content is not clear or useful.
- The detail is much greater than can be put to good use.
- Speculations are presented without a good rationale for them.
- The writing is unnecessarily repetitious.
- The organization is not tight.
- The reader is irritated by the length or reads only a few sections such as the Summary or Recommendations sections.

The issue of length is primarily a concern of other psychologists, and it is intertwined with other issues, such as clarity. Hence, the psychologist in training should not assume that shorter is better. Quality may be a more important issue than quantity. At this early point in training, the new report writer should keep the issue of length in mind while writing reports. Concerns about length, however, should never interfere with the need to portray a child's performance accurately.

### Check Scores

An all-too-frequent and grievous error is to re-port scores that are incorrect. Computerized scoring represents a breakthrough that limits errors. In fact, if the facilities are available, we suggest that each test protocol that is scored by hand be checked against computer scoring. If this is not possible, the test scores should at least be double-checked prior to finalizing a report.

One way of checking scores is to be alert to in-consistencies. If, for example, an adjudicated adolescent who was referred for conduct problems obtains an elevated T-score on depression measures and no elevations on conduct problem scales, then the score should be double-checked to see if a scoring error is the source of the incongruity. If a score doesn't seem sensible, then the clinician should always check for a scoring error in order to rule out this possibility.

### Check Grammar and Spelling

Another problem with reports that detracts from the credibility of the clinician is the presence of spelling errors. Clinicians are strongly advised to take the time to electronically and visually check their spelling and grammar.

## Adapting Reports to Audience and Setting

There is probably no optimal report format. Psychologists often find that they have to adapt their reports to meet the needs of an ever-changing audience. Audiences have varying characteristics, such as literacy levels, and, more importantly, they have differing referral questions.

In a school setting, many referrals are for learning problems. Teachers may also be seeking information to assist them in curriculum decisions. These are very different

referral questions than those that may be of interest in other settings. In a psychiatric hospital setting, issues such as suicide potential, safety, and coping strategies may be of greater concern. These questions are very different than those of the school setting, requiring a focus on topics such as diagnosis and implications for pharmacological treatment. Parents are yet another audience with specific questions. When conducting an evaluation for parents in a private practice setting, the emphasis may be on advising the parents on what they can do to effect change in their child's behavior.

The report excerpts used throughout this book were taken from a variety of settings with differing referral questions. The reader is advised to think carefully about the needs of referral sources when reading these examples and writing reports.

## The Sections of the Psychological Report

### Identifying Information

Most report formats provide some identifying in-formation on the top of the first page of the re-port. This section can include information such as name of the child, age, grade, birth date, and perhaps the name of the school or agency where the child is currently attending or being served. Also, most reports indicate that the report con-tent is confidential.

### Assessment Procedures

This section typically lists the assessment methods (both quantitative and qualitative) and tests that were used in the evaluation. Evaluation procedures can, and frequently do, include inter-views, reviews of records, and classroom or other observations.

### Referral Questions

This section is crucial because the referral questions dictate the design of the evaluation. This section is often brief but should be descriptive so that the purpose of the evaluation is clear. The referral source should also be stated (Lichtenberger et al., 2004). The lack of clear referral questions may lead to consumer or referral source dissatisfaction with the report. As noted previously, psychologists may have to speak more than once with the referral source to clarify the nature of the question(s). The referral questions should be stated in terms of specific examples of the child's difficulties rather than general labels (e.g., "hyperactivity," "academic problems," "anxiety"). This section may also indicate (briefly) the duration, severity, and/or frequency of the problem.

### Background Information

This section should include all of the pertinent information that may affect interpretation of a child's scores. The key word here is *pertinent.* The clinician should report only information that is relevant to the current evaluation, not in-formation that is superfluous or an undue invasion of privacy (Teglasi, 1983). Material should only be included if it has some potential impact on the interpretation of the child's scores in order to answer the referral question(s). While parental occupation and marital status are generally private subjects, these may be important pieces of information, given what is currently known about the effects of parental variables on child functioning. Lichentenger et al. (2004) provide a user-friendly and sensible summary of the types of information to include in this section, as well as tips to provide the information clearly.

The report writer should also be clear about the sources of information. If the father views his son as lazy, then this statement should be attributed to the father.

Statements that could be used for making such attributions include the following:

According to…
His father/mother stated…
His mother'/father's opinion is…
His teacher's view of the situation
Her guidance counselor reported that…
His parole officer acknowledges that…

If care is not taken to make clear the sources of information, questions may arise at the time when feedback is given to involved parties.

Sensitive background information should also be corroborated or excluded from the report if it is inflammatory and cannot be corroborated. For example, a 5-year-old may say something like "My mother shoots people," and later, the psychologist discovers that the child's mother is a police officer.

Previous assessment results should also be included in this section (Teglasi, 1983). Also, previous experiences with psychological or educational interventions should be noted here. The clinician may also refer the reader to a previous evaluation. Referring to previous evaluations, without fully recapitulating them, can substantially reduce written report bulk.

## Behavioral Observations

In this section, the behaviors that the child exhibits during the assessment are recorded. When writing this section, the number of observations made, the setting where the observations were made (e.g., school, clinic, etc.), and the person who made the observations should be identified (Teglasi, 1983). A brief description of the setting, particularly if the report writer is describing classroom observations, is also appropriate. Domains that routinely should be covered include "physical appearance, ease of establishing and maintaining rapport, response to failures/successes, response to encouragement, attention span, language style, distractibility, activity level, anxiety level, mood, impulsivity/reflectivity, problem-solving strategy, attitude toward the testing process, attitude toward examiner, attitude toward self, unusual mannerisms or habits and validity of test results in view of behaviors" (Lichtenberger et al., 2004, p. 60).

Care should be taken not to confuse observations with interpretations. In other words, it is appropriate, for example, to state that the child appeared motivated to perform well, but such a statement should be accompanied by the behaviors that led to this assertion.

## Assessment Results and Interpretation

This section is where the test results for the child are reported. Some report writers prefer to integrate the results from various measures into a single section. Still others opt to divide this section into subsections according to domains assessed. The domains may include: cognitive/intellectual, academic achievement, adaptive behavior, visual/motor, and behavioral/personality. This latter section is of primary interest for this text.

Organization within the behavioral/personality section can be according to theoretical orientation, training, or other preferences of the psychologist. We happen to recommend that this section be organized from the most important construct to least important, such that all evidence from multiple tools regarding the most important domain of functioning for the client (e.g., depression) is discussed first, followed by other comorbid issues, rather than presenting information by each individual measure and then trying again to integrate the information from varied sources. This approach puts the focus, in our view, where it belongs: the constructs/domains of functioning, not the tests. Most importantly, this section should provide coherent interpretations of results that relate logically to one another and to

other sections, such as sections devoted to providing diagnostic considerations. Hence, this section should not simply report numerical findings that are devoid of interpretation.

## Diagnostic Considerations

The decision about whether or not to include a separate portion dealing with diagnostic issues is likely influenced by setting and referral questions. Nonmedical settings, for example, may discourage the inclusion of a discussion of this nature in the psychologist's report. The omission of such a section may be in keeping with interdisciplinary approaches to making classification/diagnostic/eligibility decisions.

The format for this section can be in lists or in paragraphs. A psychologist may simply list diagnoses in a manner consistent with the *DSM-IV* multiaxial approach. Others prefer to use a paragraph or two to more fully explain the rationale for or against making certain diagnoses.

## Summary

The final section of the report is intended to give an overview of the major findings. This review helps to ensure that the reader understands the major points made in the report. A rule of thumb for writing summaries is to use one sentence to summarize each section of the report. In addition, a sentence should be devoted to each major finding presented in the test results section. In some cases, one sentence can be used to summarize multiple findings and recommendations.

One of the common pitfalls of preparing summaries is including new information in the summary section. If a clinician introduces a new finding in the summary, the reader is lost. The reader has no idea as to the source or rationale behind the conclusion. We suggest that students read their draft summaries carefully and check every conclusion made in the summary against the body of the report.

## Signatures

Reports typically require signatures attesting to their authenticity. An important component of this seemingly unimportant aspect of the report is the necessity for clinicians to use titles that represent them accurately. Some states, for ex-ample, do not have specialty licensure, and the use of a title such as Licensed Pediatric Psychologist is not appropriate. In this case, a more generic term such as Licensed Psychologist should be used, especially if the psychologist lacks evidence of board certification of specialty training.

Students should also be careful to represent themselves accurately. A title such as Practicum Student, Intern, Trainee, or something similar should be used. Psychological custom also dictates the inclusion of the highest degree obtained by the clinician.

## Recommendations

Recommendations should be specific and clear (Teglasi, 1983). A recommendation for individual psychotherapy may be difficult to carry out, for example, if the specific problems that need to be addressed and other aspects of the recommendation are not made explicit. Some reasons that recommendations are not subsequently followed may have to do with how they are communicated. Recommendations should be understood by the individuals who will implement them, developmentally appropriate for the child, and practical, and should avoid being unnecessarily complex (Lichtenberger et al., 2004).

Some recommendations may also be difficult to communicate succinctly in writing. Therefore, one approach may be to include hand-outs for treating certain problems that are much more specific than can be included in the typical recommendation section of a report. A handout detailing some specific recommendations for a teacher responding to inattentive behaviors in the classroom may be more valuable to the teacher than an abbreviated

recommendation. In almost all cases, the clinician should relay recommendations in person to psychiatrists, teachers, parents, and other colleagues (Teglasi, 1983) in order to ensure that they are followed.

## Psychometric Summary

Some clinicians include a listing of all of the child's obtained scores with the report. While this summary will be of limited value to the less knowledgeable reader, it may be of great value to another clinician who reviews the report. This summary is best placed on a separate sheet(s) of paper, which makes it convenient for the clinician to be selective about who receives the summary. Some psychologists may prefer to not send the summary to parents and virtually always send it to other psychologists.

## The Report Writing Self-Test

A report-writing self-test is provided in Fig. 16.3. This checklist allows the psychologist to periodically and quickly review principles of re-port writing.

| Item | True | False |
|---|---|---|
| 1. Was the report edited? | T | F |
| 2. Are unnecessary invasions of privacy avoided? | T | F |
| 3. Is the referral question(s) explicitly stated? | T | F |
| 4. Is the referral question answered? | T | F |
| 5. Does the report emphasize words over numbers? | T | F |
| 6. Can a person with a high school education understand the wording used? | T | F |
| 7. Is the report brief enough that major findings are not lost? | T | F |
| 8. Are the conclusions drawn without undue hedging? | T | F |
| 9. Do the conclusions fit the data? | T | F |
| 10. Are invalid results omitted? | T | F |
| 11. Are percentile ranks included for the benefit of parents and clients? | T | F |
| 12. Were spelling and grammar checked? | T | F |
| 13. Are supporting data integrated with conclusions? | T | F |
| 14. Are the recommendations clear and specific? | T | F |
| 15. Are headings and lists added to enhance space? | T | F |
| 16. Are acronyms defined and not overused? | T | F |
| 17. Is the summary free of new information? | T | F |
| 18. Were scores double-checked? | T | F |
| 19. Are examples of behavior used to clarify meaning? | T | F |
| 20. Are test instruments described adequately? | T | F |
| 21. Is the rationale for diagnoses provided? | T | F |
| 22. Is a conference scheduled to accompany the written report? | T | F |
| 23. Was written parental consent obtained prior to releasing the report to interested agencies or parties? | T | F |
| 24. Is a feedback session scheduled with the child or adolescent? | T | F |
| 25. Are the type and paper of professional quality (e.g., laser-quality print)? | T | F |

FIGURE 16.3
Report writing self-test

# Communicating Results Orally

## Parent Conferences

For the purposes of this text, *parent* is used generically to include any consistent caregiver in the child's life. Examples of such caregivers include stepparents, residential caretakers, and grandparents, among others.

Imparting assessment results to parents re-quires considerable savvy, as the individual differences between families are myriad. Because of this diversity, there is not a singular methodology that will be effective with all parents. This section will present some ideas for sharing results with parents or other caregivers. However, it is vital for the psychologist to remain flexible in order to adapt the format of the feedback session to the needs of the parent, other caregiver, or family, as well as the setting.

In an old but insightful article, Ricks (1959) summarized the heart of the parent conference dilemma.

> The audience of parents to which our test-based information is to be transmitted includes an enormous range and variety of minds and emotions. Some are ready and able to absorb what we have to say. Reaching others may be as hopeless as reaching watchers with an AM radio broadcast. Still others may hear what we say, but clothe the message with their own special needs, ideas, and predilections (p. 4).

Regardless of the potential pitfalls, parents must be informed of the results of a psychological evaluation of their child (the legal, ethical, and regulatory mandates for this practice are given in Chapter 4).

Some helpful suggestions for communicating test results to parents are given next:

1. Avoid excessive hedging or deceit. The problem with hedging or failing to report bad news is that many parents sense this deceit and respond to the psychologist with appropriate mistrust. Honesty is also easily sensed by parents, which ultimately enhances the credibility of the psychologist.
2. Use percentile ranks heavily when describing norm-referenced test results. This metric is easier for parents to understand than other norm-referenced scores.
3. Instead of lecturing, allow parents opportunities to participate by asking about topics such as their opinion of the results and how they fit with their knowledge of their child. Moreover, listening carefully to parents helps the psychologist determine the psychological needs of the parents that are relevant to the evaluation. Similarly, it is essential that the parents be given frequent opportunities to ask questions (Lichtenberger et al., 2004).
4. Anticipate questions prior to the interview and prepare responses. How would a psychologist answer the question, "Will my daughter outgrow her ADHD?" Psychologists can gauge the probability that such questions will arise by listening carefully in the intake interview and throughout the assessment process.
5. Schedule adequate time for the interview. Parent conferences often become more involved than one has planned. Adequate time allows the psychologist time to use counseling skills to bring a parent feedback conference to adequate closure. Ideally, 1–2 h could be allocated for such a parent session. If a session ends early, then the psychologist is the recipient of a precious gift – extra time.
6. It is often helpful to seek practice communicating with parents from a variety of back-grounds. Some parents can be addressed as if they are colleagues, while others may have only a limited grasp of the issues being discussed. Translators, ministers, teachers, trusted family

friends, and others may serve as allies in the feedback process.

7. Avoid questionable and/or overly explicit predictions (Kamphaus, 2001). Phrases to be avoided would be statements like, "She will never go to college," or "She will always have trouble with school." These types of statements can be offensive to parents, not to mention inaccurate.
8. Use good, basic counseling skills. Every parent likes to talk about the trials and successes of raising a child. Give parents at least some opportunity to do this, as it allows you to show interest in the child by listening to the parent's perspective.
9. Do not engage in counseling that is beyond your level of expertise. Parents are often very eager to obtain advice from a professional. It is inappropriate (and unethical by most stan-dards) for a psychologist to provide services for which he or she is not trained. If, for ex-ample, a parent requests marital counseling and you have no training in this area, you should inform the parent of this fact and offer a referral. In fact, the psychologist is wise to have referral sources readily available for such eventualities.
10. Be aware that some parents are not ready to accept some test results. Parents may impugn your skills because they cannot accept the fact that their child has a severe handicap. They may leave the session angry, and you may feel inept. The idea that every parent conference will end on a happy note is unrealistic. Examine your skills critically in response to parent feedback, but realize that some parents simply will not accept the results because of their own personal issues. An example of such a situation may involve a parent with the same handicapping condition as the child. If a parent was labeled handicapped and ridiculed by peers, he or she may become defensive and angry at the suggestion that his or her child may have a handicap. The session with such a parent will likely end on a tense note. In many of these cases, however, the parent will adapt and accept the news after developing the psychological resources to cope with the attendant stresses. The psychologist may find this same parent to interact more positively in the next encounter.
11. Maintain a positive tone throughout the session and discuss the child's strengths and competencies.

## Teacher Conferences

Many of the principles used in parent conferences also apply to teachers. Several nuances, however, will be outlined in the following suggestions:

1. Do not monopolize a teacher's break from teaching. Some teachers get few breaks in a day. Most get a brief lunch, when they prefer to unwind with colleagues and prepare for the remainder of the day. A clinician is unlikely to command a teacher's undivided attention during such breaks. If a teacher has an additional free period, it may be a good time for a conference. After school is frequently the best time to get a teacher's undivided attention for a meeting. Teachers are generally very busy people, so the pace of the meeting will be quicker than is the case for parents.
2. Teachers are interested in schooling issues. The diagnosis of Conduct Disorder is of less concern to teachers than getting specific recommendations for helping the child in the classroom (Teglasi, 1983). If a psychologist is not trained and/or has little experience in teacher consultation, the assistance of someone like a qualified school psychologist should be enlisted to assist with the teacher conference.

In any assessment with a school-aged child, the clinician should be prepared to conduct a teacher conference, or at the very least be available to answer any questions and facilitate the implementation of classroom-based interventions. Such a conference is desirable because teachers are usually involved somehow in the treatment of children and adolescents.

### Child Feedback

Providing assessment feedback to a child is often overlooked, but it is important to do so in most cases because the child will likely begin some interventions or experience some changes in his or her environment directly related to the assessment. The major decision that a clinician needs to make before giving feedback to a child regards the type of information that is appropriate for a child's developmental level. Clearly, the kind of feedback given to parents is inappropriate for a 5- or 6-year-old, who may have extraordinary difficulty understanding the concept of a percentile rank. A child this age, however, may be able to understand the consequences of the evaluation. In this situation, the child may be able to understand something like: "Remember those tests I gave you? Well, some of them seemed hard for you. Because of this, I suggested to your parents that you be helped after school. So now, you will be going to visit a teacher after school who will help you with schoolwork."

The older the child, the more similar the feedback session becomes to the one for parents. One dramatic difference, however, is that negative feedback to a child or adolescent can have the opposite of the intended effect. That is, in most cases, the goal is to improve variables such as peer-related social skills. A child who is told that he or she has poor social skills may decide to stop trying to interact with peers. In some cases, the clinician's honesty could harm the child. A few options are available in cases where a clinician is concerned about such negative consequences. One option is to have someone who knows the child well and has a positive relationship with him or her help the psychologist communicate the results in a non-threatening way to the child. A good person to fill this role is a teacher, other professional caregiver, or possibly a parent. A second possibility, if applicable, is to have the child's primary therapist or counselor eventually share the results with the child in a counseling session, when he or she could help the child cope with the results in a supportive setting.

In most cases involving feedback to children or adolescents, it is advisable to consult with a fellow professional (e.g., teacher, counselor, speech therapist, etc.) who knows the child extremely well. This colleague can help the psychologist gauge the ability of the child to deal appropriately with the assessment results and associated interventions.

## Conclusions

Report writing and oral reporting are central, not ancillary, considerations in the assessment process. The most insightful and elegant of evaluations is lost if not translated to usable information in written reports and intervention planning meetings. Unfortunately, these central assessment skills are under-emphasized in the training of clinicians who are left to acquire these skills through trial-and- error. Clinicians are advised to seek out expert supervision in this area, if it is not readily offered. In addition, enlisting the aid of a competent editor can markedly enhance the quality of written work. Writing is not easy. Writing skills, however, can be acquired and improved with diligence and patience.

## Chapter Summary

1. Psychological reports are frequently made available to parents, judges, lawyers, and other non-psychologists, creating the opportunity for improper interpretation of the results by untrained individuals.
2. Psychological reports can be useful to other clinicians who evaluate a child who has previously been seen by a psychologist.
3. Different audiences require different types of written reports.
4. Some of the common problems with report writing include the following:
   (a) Vocabulary problems
   (b) Faulty interpretation
   (c) Report length
   (d) A number emphasis
   (e) Failure to address referral questions
5. Some research has shown that teachers prefer a question-and-answer report format.
6. Parents also tend to prefer a question-and-answer format to other formats, although the difference in preference scores between the psychoeducational and question-and-answer reports in one study failed to reach statistical significance.
7. Suggested report writing practices include the following:
   (a) Report only pertinent information
   (b) Define abbreviations and acronyms
   (c) Emphasize words rather than numbers
   (d) Reduce difficult words
   (e) Describe the tests used
   (f) Edit the report at least once
   (g) Use headings and lists freely
   (h) Use examples of behavior to clarify meaning
   (i) Reduce report length
   (j) Check scores
   (k) Check spelling and grammar
8. Psychological reports often include some or all of the following headings:
   (a) Identifying Information
   (b) Assessment Procedures
   (c) Referral Question(s)
   (d) Background Information
   (e) Behavioral Observations
   (f) Assessment Results and Interpretation
   (g) Diagnostic Considerations
   (h) Summary
   (i) Signatures
   (j) Recommendations
   (k) Psychometric Summary
9. Hints for communicating test results to parents include the following:
   (a) Be direct and honest
   (b) Use percentile ranks heavily when describing test results
   (c) Allow parents opportunities to participate
   (d) Anticipate questions prior to the interview and prepare responses
   (e) Schedule adequate time for the interview
   (f) Practice communicating with parents from a variety of backgrounds
   (g) Avoid questionable predictions
   (h) Use good, basic counseling skills to convey difficult information
   (i) Do not engage in counseling that is beyond your level of expertise
   (j) Be aware that some parents are not ready to accept some of the conclusions offered
10. Teacher conferences are important for ensuring cooperation with recommendations.
11. The major decision that a clinician needs to make before giving feedback to a child regards the type of information that is appropriate for the child's developmental level.