

SECTION I

Processes and Techniques

THE ASSESSMENT PROCESS: AN INTRODUCTION

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In the referral process the assessment of child or adolescent behavior plays a major role in formulating a diagnosis and treatment/intervention, whether in an outpatient setting, in schools, or in a residential center. Assessment is an interactive student-oriented process. The individual assessment of child or adolescent behavior by a skilled professional is a process that may occur only once in a child's life, when one highly skilled clinician devotes a considerable amount of time (ranging from one to many hours) to that individual. Perhaps the assessment process for a given individual will be a once-in-a-lifetime opportunity for a professional to devote all of his or her skills and knowledge to obtain critical information about a child—information that will be used to answer a number of important questions regarding that child's current and future life, such as mental status, cognitive abilities, presence of emotional/psychiatric disorders, eligibility for remedial/special education programs, placement decisions, and treatment and intervention strategies. The assessment of a child's current performance in different dimensions represents a major challenge to all clinicians who interact with children of all ages and ethnic backgrounds. Cronbach's (1949) definition of a test as a systematic procedure for comparing the behavior of two or more persons still stands as the benchmark of the assessment process.

PARAMETERS OF ASSESSMENT

The last two decades in psychology and psychiatry have seen radical changes in the assessment process and in treatment patterns for children suffering from emotional/behavioral disorders—changes arising from the brief-focus approaches to exciting breakthroughs in psychopharmacology. For instance, medication has reduced the course of depression disorders from months to weeks and has allowed individuals with severe cases of schizophrenia to function productively. These changes have led to a major re-orientation toward assessment and treatment; and because of the specificity of the new treatments, the issues of assessment and diagnosis have returned to the center stage. Wetzler and Katz (1989) underscore the importance of understanding how the treatment works to bring recovery from these illnesses. It is necessary to examine in detail

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the characteristics of the illnesses in order to determine which aspects of behavior, emotions, and cognitions are being affected. To conduct research on the process of treatment/intervention or the mechanisms of treatment, it is necessary to assess and diagnose disorders accurately, to assess the change brought about by the treatment, and to evaluate the outcome.

Traditional psychological assessment of behavior was first introduced over 70 years ago by Herman Rorschach and Henry Murray and was expanded in the 1950s by Rapaport, Gill, and Schafer (1968). That model was appropriate in the 1950s and 1960s for the assessment of problems within the parameters of psychology and psychiatry. Since then, however, numerous changes have affected the assessment procedures: public laws, changing diagnostic systems, new trends in assessment, length of treatment, and the incorporation of children and youth in our theoretical orientations. In addition, we have witnessed a complete change in systems of care, third-party payment, and due process and treatment within a focused time frame, as well as in the language of education, psychology, and psychiatry. For instance, the diagnostic system itself has been revamped (American Psychiatric Association, 1994).

Within the last 15 years, our field has witnessed dramatic growth in managed health care, hospital/school utilization and review committees, quality assurance committees (Individual Treatment Plans, or ITP), and peer-review utilization. These new dimensions, added to the already existing parameters and expectations of assessment of children's behavior, have created an impetus for change. If we as professional clinicians do not change with the times, our procedures, knowledge, and skills will become outdated and anachronistic.

TRADITIONAL VERSUS NEW APPROACHES (FOCAL ASSESSMENT)

Historically and traditionally the standard assessment battery for evaluating children with behavioral difficulties consisted of a projective instrument (e.g., Children Apperception Test, Draw-a-Person, Bender Gestalt for visual-motor-perceptual difficulties) and a test of cognition (e.g., Wechsler Intelligence Scale for Children—Revised [WISC-R] and Kaufman Assessment Battery for Children [K-ABC]). The aim was to identify or evaluate the child's personality, structure, defenses, ego strengths and boundaries, reality testing, intelligence, mental status, and inner dynamics. Much was based on analytical theory (Weiner, 1983). Traditionally, one of the only self-report instruments available to a clinician was the Minnesota Multiphasic Personality Inventory (MMPI, adult version). Few psychomechanically sound self-report- or behavior-based assessment tools were available to help the child and adolescent school specialist. Regardless of the referral question, the same battery was administered with loyalty.

As the underlying assessment orientation changed and a different climate developed in the fields of education, psychology, and psychiatry, the traditional test battery began to receive criticism. Courts, clinicians, parents, educators, and advocate groups began to raise questions about the usefulness of such a battery in the present day realities; the MMPI did not address the referral questions (Sattler, 1988), and thus their value was questioned.

Clinicians, parents, educators, and physicians were discovering that the traditional

assessment strategy used in evaluating child and adolescent behavior was not appropriate to many settings (e.g., school, clinics, residential hospital units). The process was time-consuming, laborious, and of questionable validity, and much of the data obtained from the battery were not used or were even ignored. In practice, in fact, I have seen the psychological assessment results (reports) not included in a child's file until after his or her discharge. What is the value of delaying results in times of rapid discharge? Combined with this, information about a child's developing intrapsychic dynamic made the traditional approach grow more vulnerable to criticism. A major concern raised by the consumer was the relevance of the findings in terms of treatment. These traditional assessment instruments are not useless, but this battery was not designed to help choose appropriate treatment modalities or to assist in differential diagnosis, was not developed for children, and is not comparable to the DSM-IV. Further, the influence of ethnic and cultural factors on the development of behavioral/emotional difficulties in children and youth has gained increasing emphasis (Pumariega & Vance, 1999). Cross-cultural assessment issues have given rise to the role of ethnic/cultural factors' influences on the development of behavior/emotional disorders in children and youth. What is the role of one's own cultural biases and values in the assessment process? Could these affect the clinician's use of assessment information? Do our current assessment instruments need new norms for ethnic and cultural minority groups? The benefits of culturally specific tests are rather unclear because the cultural make-up of the United States continues to change, and other intervening variables could affect the results obtained from these instruments.

A More Focused Approach

In recent years there have been several calls for a broader conceptualization of assessment. Such broadening has been noticeable in the use of a focal assessment approach. This approach has contributed greatly in pinpointing psychiatric diagnosis and treatment/interventions. It seems very clear that tools used by assessment specialists and psychologists as recently as 10 years ago are generally different from those used now. Such techniques as computer-based assessment, focal assessment, behavior assessment, structural psychiatric interviews, comprehensive neuropsychological test batteries, and new cognitive batteries are making major contributions in the assessment field. These new assessment procedures have shifted the focus from indirect models to direct acquisition of information and observation. These efforts have bridged the gap between assessment and treatment. There is a distinction between just testing and assessment; assessment is a much broader, thorough concept. Psychologists do not merely *give* tests, but also *perform* assessment, meaning that there are many different ways of evaluating individual differences.

Assessment Schemes

Since the 1960s, a number of comprehensive assessment schemes have been developed (American Psychological Association, 1994; Kamphaus, 1993; Kauffman, 1979; Lazarus, 1973; Sattler, 1988). Sattler's (1988) gold standard test detailed the specifics of his comprehensive model for the assessment of children (see chapters 2 and 3 of his

text). Kauffman (1994) provides the interested reader with a seven-step interpretive approach for using the WISC-III. Cautila (1968) describes a three-stage scheme for behavioral assessment at various treatment stages. Kanfer and Saslow (1969) proposed a seven-step model using interviews to organize a patient's complaints into five behavior categories. Their system complemented the existing DSM-II model. Taylor (1983), a behavioral psychiatrist, incorporated the DSM-III conceptual model into an assessment scheme. Wetzler and Katz (1989) elaborate on the multivantaged approach to assessment. Their system consists of eleven state constructs and their associated factors and vantages. According to Wetzler and Katz (1989), these constructs span the area of the psychological functions of affect, activity level, cognition, perception, socialization, and social behavior (p. 19). The American Academy of Child and Adolescent Psychiatrists publishes practice parameters as a guideline for mental health professionals in its official *Journal of Child and Adolescent Psychiatry*. Since 1991, the journal has published 17 practice parameters. The December 1999 issue contained practice parameters for assessment and treatment of individuals with Mental Retardation and comorbid mental conditions, individuals with autism and other Pervasive Developmental Disorders, and children and adolescents who are sexually abusive of others. These supplements to the *Journal of Child and Adolescent Psychiatry* provide clinicians with an excellent conceptual model not only for assessment but also for interventions. They emphasize a shared commitment to a developmental, interdisciplinary collaboration, and a consultation approach with various professionals. Practice parameters, developed by work groups (members of the American Academy of Child and Adolescent Psychiatrists) are strategies or guidelines for patient management based on scientific research, and they describe the generally accepted approaches to assessment and treatment of specific disorders. The parameters are provided as standard care for specific mental disorders or medical procedures.

EXCITING DEVELOPMENTS

Over the last 15 years, two exciting developments have emerged in the field of assessment: behavioral assessment and focal assessment (Bellack and Hensen, 1988). These two approaches were the outgrowth of clinicians' dissatisfaction with the DSM-II and DSM-III, and with the poor relationship between assessment and treatment outcomes. Goldstein and Hersen (1992) attribute the development of behavior assessment and focal assessment to the growing need for precision and accountability, and to the limited relationship between complicated psychological evaluation and eventual treatment. In addition, many clinicians (clinical, child, school) operated as X-ray technicians (Goldstein & Hersen, 1992), using procedures that had a tangential relationship to the diagnostic-behavior descriptors for each clinical group, such as Mental Retardation, learning disorders, mood disorders, Attention-Deficit Hyperactivity Disorder (ADHD), or children with challenging behavior (PDD or severe emotional disturbances). The isolated and extensive psychological evaluation or examination, according to Goldstein and Hersen (1992), "proved to be an empty academic exercise resulting in poetic jargon in the report whose preclinical validity was woefully limited" (p. 9).

Because the behavioral approach to assessment is excellently covered in this book by

Freddy A. Paniagua (Chapter 3), he elaborates on this model. However, within the last decade the field of behavioral assessment has grown dramatically. The behavioral approach to assessment has undergone changes over the past two decades. Nelson and Hayes (1974) indicated that the goal of behavioral assessment was to identify meaningful response units and their controlling variables. Recent research has identified the goal of behavioral assessment as objectively describing discrete human responses that are controlled by environmental events and whose variability is related to a person's environment (specific behaviors and specific environmental events). Behavioral assessment usually provides clients with a description of environmental contexts, of specific behaviors to describe personality constructs, of direct and specific measures of behavior, and of continuous assessment/measurement of ongoing behaviors and outcomes. Emphasis is usually on direct observation, accuracy of observation, and practicality—usefulness, description of behavior, prediction, or what maintains responses and what reduces responses (chances that occur throughout treatment) (Maag, 1999).

The second change, a somewhat different approach to assessment, is focal assessment. Wetzler and Katz (1989) indicated that the roots of focal assessment can be traced back to Galton's day and that focal assessment is not new! Clarkin and Sweeney (1986) suggested that the instruments used in focal assessment serve a different end than do the standard batteries, and that the focal assessment instruments were developed and refined on homogeneous patient populations. In essence they were developed to evaluate outcome variables (treatment). An example is the Conners Scale (Conners, 1990), which was developed for physicians to evaluate the use of medication (stimulants) in treating hyperactive children. These focal assessment instruments are specific to narrower areas of psychopathology (Wetzler & Katz, 1989). Focal assessment instruments cover a wide and diverse range of functioning, such as the Beck Depression Inventory or the Mental Status Exam, to evaluate a patient's mental status. These instruments usually have good normative data, specific rules for scoring, and solid research data for validity purposes. Their research database provides reliable, quantifiable procedures for evaluating behavior. Major advantages of the focal assessment instruments are their focus on efficiency, time saving, cost-effectiveness, and treatment outcome. Consider the use of medication (such as selective serotonin reuptake inhibitors, or SSRIs) to treat depression: A clinician can track clinical changes by administering a weekly serial rating scale. This type of assessment often helps to evaluate effectiveness of treatment modality, to guide treatment planning, and to generate data for research purposes. Focal assessment instruments allow clinicians to be flexible and tailor treatment to clients' needs. Carr (1985), in an excellent review of focal assessment instruments, identified over 100 popular, well-validated tests. Examples of focal assessment instruments and their corresponding measurement domains are provided in Figure 1.1.

BRIEF EXAMPLE OF FOCAL ASSESSMENT

Tom was an 8-year-old elementary school student who had been having serious academic difficulties over the past six months. He was becoming more and more agitated. He was seen as an outpatient at a psychiatric clinic. Tom was administered the

Depression	Hyperactivity/Inattention	Anxiety/Fears	Disruptive/Oppositional	Global
Helplessness Scale	Conners Parent Rating Scale	Social Phobia and Anxiety	Swanson, Nolan, and Pilham	Behavior Assessment System
Hopelessness Scale	Conners Teaching Rating Scale	Fear Survey for Children	Rating Scale	Inventory for Children
Children Depression Scale	Swanson, Nolan, and Pilham Rating Scale	Revised Children Manifest Anxiety Scale	Eyberg Child Behavior Inventory	Child Behavior Checklist
Peer Nomination for Depression	Attention Deficit Disorder Evaluation Scale	State-Trait Anxiety Inventory for Children	Sutter-Eyberg Student Behavior Inventory	Devereux Scales of Mental Disorders
Children Depression Inventory	Continuous Performance Tests	Behavioral Avoidance Test	Devereux Behavior Rating Scale	MMPI-A
Reynolds Child Depression Scale; also Adolescent Version	Brown Attention Deficit Disorder Scales	Louisville Fear Survey Schedule for Children	Revised Behavior Problem Checklist	Personality Inventory for Children-R (Youth)
	Attention Deficit/Hyperactivity Test	Fear Survey Schedule		Self-Report of Personality
		Feelings, Attitudes, and Behavior Scale		Walker-McConnell Scale
		Trauma Symptoms Checklist for Children		Social Skills Rating System
		Behavioral and Emotional Rating Scale		Child Behavior Checklist
				Diagnostic Schedule Interview for Children
				Social Adjustment Inventory for Children

Figure 1.1 Example of Focal Assessment Instruments

Childhood Depression Inventory (Kovacs, 1992), which indicated severe depression. Tom obtained significantly elevated *T*-scores, a 96 on Negative Mood, 94 on Anhedonia, and 89 on Negative Self-Esteem. His mother and teacher completed the Conners Scale. Results from this scale revealed elevated scores on the Hyperactivity and ADHD Index Scores (*T*-83 and *T*-85). Behavior observation during the Diagnostic Interview Schedule for Children (DISC) revealed elevated scores on ADHD, overanxious disorder, and more disorders. Throughout the assessment, Tom was active, often getting out of his seat and turning and twisting in his chair, and he constantly had to be reminded to pay attention. These same behaviors were scored positive on the Conners Scale by his parents and his teachers. In light of these findings, a referral was made to a child psychiatrist. Formulation of findings indicated a child who was depressed and overanxious; ADHD was secondary to depression and overanxiousness. The treatment team decided on a trial dose of Wellbutrin and an aggressive psychoeducational approach with family sessions and individual cognitive behavior therapy.

COMPUTER-ASSISTED ASSESSMENT

Computers and technology have impacted almost every aspect of our society as well as our professions. The availability of computer technology and software engineering has affected the practice of psychological assessment. These effects have influenced test construction, the standardization of new instruments, interactive assessment, continuous-variable assessment, and scoring and interpretation of tests of intelligence and personality. Powerful computers are used today as an adjunct to the assessment process because of their accessibility, affordability, and sophistication, and the emphasis on actuarial-based interpretation of test results.

The first major computer-assisted psychological program began in the early 1960s at the Mayo Clinic in Rochester, Minnesota (Honaker & Fowler, 1990). This system gives a brief interpretation of each of the MMPI scales that were elevated. By the early 1970s there were seven commercial MMPI interpretation services available for clinicians and physicians. Throughout the 1960s, several computerized scoring and interpretation programs were developed for lists such as the Rorschach (Piodrowski, 1964), 16 PF (Elber, 1964, September) and the California Psychological Inventory (Finney, 1966).

The 1970s witnessed a proliferation of more computer applications in psychology, psychiatry, and medicine. The first line testing services became available, led by Johnson and Williams (1980) working at the Veterans Hospital in Salt Lake City (Psychiatric Assessment Unit). According to Honaker and Fowler (1990), there were 320 Psych System owners with more than 700 list terminals in operation by the early 1980s.

The 1980s ushered in powerful, low-cost personal microcomputers, which became accessible to many mental health coaches. Software development for all types of scoring, interpreting, and report writing became available. Many of these systems were developed by individuals or small companies, and only later by the large test publishers. Honaker and Fowler (1990) reported that CompuPsych was one of the first to market microcomputer systems for psychological assessment. Bob Smith, who founded Psychological Assessment Resources (PAR) in 1978, was a leader in marketing software for assessment purposes with a standard microcomputer. Today PAR is perhaps the major

leader, developer, and distributor of psychological assessment products. Since the late 1970s, numerous companies have been developed and have contributed to the popularization of computer-assisted assessment. In 1987, Krug reported that there were 72 separate suppliers of over 300 computer-based products with applications in psychological assessment. During this same year, Exner (1987) introduced the assistance of computers in Rorschach interpretations.

WISC-III PSYCHOLOGICAL INTERPRETIVE REPORT

Name: Jacob

Date of Birth: March 19, 1991

Chronological Age: 7 years 7 months

School: _____

Date of Evaluation: November 17, 1998

Grade: First

Examiner: Dr. Vance

Referral Information

Jacob was referred for evaluation by his teacher mainly because of learning problems in school but also due to a possible developmental delay. The main goals of this evaluation were to answer the following questions: Is Jacob in an appropriate classroom setting? Are special education services recommended for Jacob? Are therapeutic interventions advised?

Background Information

Jacob is a Caucasian male, aged 7 years 7 months. The background information presented here about Jacob is based primarily on reports from his teacher but also on his school records and a social history. He lives with his biological parents and is one of two children in his residence. Jacob is the younger child in his family. His family economic status is working class. As a child, his home environment is average—that is, neither impoverished nor enriched. Cultural opportunities at home (e.g., availability of books, family trips to museums) are average, neither inadequate nor excellent. Both Jacob's mother and his father attended some high school.

When she was pregnant with Jacob, his mother reported that she experienced bleeding. Jacob's birth was premature and occurred after a long labor. Following birth, Jacob was placed in an incubator. During early childhood, Jacob was described as difficult. He developed physical skills such as sitting, crawling, and walking at about the same time as most children. His early language development was slow in comparison to that of other children. His early motor development and skills acquisition were about the same as those of his age mates, and his social development was average. His cognitive development (e.g., counting, learning the alphabet) was behind that of others his age.

Jacob went to kindergarten and is now in first grade at a public school. He is reported

to enjoy school. Jacob's skill strengths in school are reported to be his ability to please his teacher and to behave correctly. In contrast, his weaknesses are reported to be concentration, organization, and vocabulary, together with verbal expression and understanding concepts.

Appearance and Behavioral Characteristics

Jacob appears the same as his stated age of 7 years. His height is below average for his age, and his weight is average for his build. He has brown eyes, and his hair is blond. At the evaluation, Jacob was dressed appropriately, and his hygiene was good. He appeared pleasant and smiling. He spoke in an age-appropriate manner. Jacob was very willing and compliant when he began the test session. Rapport was easy to establish and maintain.

Jacob displayed good attention during the evaluation; he worked diligently with optimal concentration on the nonverbal tests, which consisted of rapidly copying simple symbols that are associated with shapes, arranging pictures to tell stories, and copying abstract designs with blocks. Jacob showed low risk-taking at times by refusing to guess if unsure of answers on the verbal tests of general information and telling how two concepts are alike. Jacob demonstrated poor expressive language skills while being tested by naming the missing part vaguely or incorrectly or by having to be told "show me where you mean" several times on a test of finding missing parts in pictures, and by giving too much detail or irrelevant information during a test of social comprehension. Jacob demonstrated weak receptive language skills during the evaluation when he didn't seem to understand the wording of some questions on the verbal tests of general information and social understanding. Jacob demonstrated a problem working with numbers when he used "finger writing" to solve some items on a test of arithmetic problem-solving.

The physical environment of the testing session was optimal, and the results of the evaluation are considered valid, though with reservations.

Test Results and Interpretation

Jacob was given the WISC-III, a test that evaluates the present level of intellectual functioning of children and adolescents. He scored in the Low Average range of intelligence (Verbal IQ = 87, Performance IQ = 89, Full Scale IQ = 86), ranking him at about the 18th percentile relative to other 7-year-olds. The chances are very good (about 19 out of 20) that Jacob's true Full Scale IQ falls between 81 and 92. The 2-point difference between his Verbal and Performance IQs is trivial and indicates that he expresses his intelligence equally well when responding verbally to oral questions as when manipulating concrete, nonverbal materials. See Figure 1.2 for the WISC-III results.

The WISC-III contains four indexes. Two are large: Verbal Comprehension (VC), composed of four Verbal subtests; and Perceptual Organization (PO), composed of four Performance subtests. Two are smaller: Freedom from Distractibility (FD), composed of two Verbal subtests; and Processing Speed (PS), composed of two Performance subtests. Jacob earned indexes of 88 on VC (21st percentile), 89 on PO (23rd percentile), 81 on FD (10th percentile), and 93 on PS (32nd percentile).

Jacob's indexes on the two factors composed only of Verbal subtests (VC and FD) do not differ significantly. That is, he performed about as well on tasks that measure verbal comprehension and expression as he did on tasks that require sequencing and number ability, and that are unusually susceptible to behaviors such as distractibility and anxiety.

Jacob's performance on the FD factor is consistent with his overall performance on the various verbal and nonverbal subtests that constitute the WISC-III. He performed about as well on tasks that measure sequencing and number ability—and that are unusually susceptible to behaviors such as distractibility and anxiety—as would be expected in view of his overall performance on a variety of tasks.

Jacob's indexes on the two factors composed only of Performance subtests (PO and PS) do not differ significantly. He performed about as well on tasks that measure visual/motor coordination and nonverbal reasoning as he did on tasks that require highly speeded paper-and-pencil responding and that are unusually susceptible to behaviors such as low motivation, lack of concentration, and reflectiveness.

Summary

Jacob is a 7-year-old Caucasian male who was referred for evaluation by his teacher because of concerns about learning problems in school. During the evaluation, Jacob displayed good attention. On the WISC-III, Jacob earned a Verbal IQ of 87, a Performance IQ of 89, and a Full Scale IQ of 86. Jacob performed about as well on tests of verbal comprehension and expression as he did on tests of nonverbal thinking and visual-motor coordination. Overall, Jacob performed in the Low Average range of intelligence.

Recommendations

For Jacob's receptive language problems:

1. Be careful that language clarifies, rather than disturbs, learning. Check wording of directions to be sure all basic concepts are within Jacob's working vocabulary.
2. Maintain visual contact with the learner. Use gestures to facilitate oral communication.
3. Speak at a tempo that is slower than usual.
4. Touch Jacob before talking to him.

Jacob has been referred for school learning problems and may require remediation. If so, then the following suggestions may prove beneficial for Jacob:

1. Individualize each area of instruction so that Jacob is taught at the appropriate readiness level for each different skill.
2. Teach to Jacob's tolerance level and avoid pushing beyond. For example, help teachers pinpoint his threshold level and stay at it.
3. Begin new tasks only when you know Jacob is not tired and is "ready" to learn.

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4. Employ the following suggestions, which are intended to help strengthen the integration and storage of new learning.
 - a. Make use of all available feedback in the remedial setting (for example, the teacher's feedback when Jacob responds to a question or assignment; Jacob's feedback when the teacher confirms or corrects a response; and the internal/external feedback he receives from his own actual and covert response behavior—vocal or motor—and self-corrections in computer instructional materials).
 - b. Develop abilities functionally, in natural settings, and avoid contrived or artificial ones. For example, integrate new reading skills by having many easy reading materials for Jacob to “practice” on instead of traditional drills and reviews.
 - c. Teach material for which Jacob has a practical need first.

To help a student with a lower IQ like Jacob generalize newly acquired information:

1. Provide set variations of initial learning bits and point out similarities or unity of information.
2. Present the same information in many different ways to create adequate redundancy.
3. Provide generous time allowances for remedial work. Sometimes Jacob does not succeed because he just needs more time on an instructional task.
4. Measure improvement and show the record to Jacob (to prove to him that change is taking place).
5. Employ the following suggestions, which are especially useful for children with multiple areas of deficit.
 - a. Remediate prerequisite deficits first (for example, oral language before written language, word recognition before reading comprehension).
 - b. Ensure that lessons within each area progress from simple to more complex tasks. This may require preliminary task analyses.
 - c. Use minimal steps of increasing difficulty.
 - d. If a teacher, allow sufficient time to supervise new learning. Remedial work must be closely monitored until it becomes a work habit.
 - e. If a teacher, join Jacob in a cooperative effort to set and attain realistic goals.
 - f. Maintain a 90% success rate to avoid negative error learning and feelings of inadequacy.
 - g. Get some improvement each session. Don't keep on the same approach if it is not successful.
 - h. Work on only one new skill at a time, presenting just a few new stimuli and limiting other variables to a bare minimum. This avoids interference and overloading.

Jacob was reported to have weaknesses in concentration and organization. To improve Jacob's work habits and attention and concentration:

1. Use other pupils in cooperative remedial sessions in addition to individual one-on-one tutoring. Peer tutors will serve as role models for appropriate study techniques and will promote social support at the same time. A side benefit of peer tutors is the encouragement of a spirit of cooperation instead of competition.
2. Select instruction materials that are highly interesting to Jacob. For example, instead of a story in a basal reader, substitute reading the directions of a new game to be played later, or reading instructions about how to put together a model airplane that will be built later.
3. Reinforce Jacob with tangible and intangible rewards when appropriate behavior is demonstrated. Gradually increase the requirements for the reinforcement. For example, classroom privileges, free time, and helping the teacher are tangibles; handshakes, smiles, and praise are intangibles).
4. Write a contract with Jacob that lists expected behaviors and the reinforcements that will follow with each term of the contract that is completed.
5. Structure Jacob's work environment in a way that will promote a reduction of distractions and intervening stimuli.
6. Highlight or circle important information on an assigned work paper that may otherwise be missed. For example, circle the directions, the item numbers to be worked on in math, the main theme in an essay, and so forth.
7. Work on remedial activities when others are working on similar work projects, not during enjoyable activity time.
8. Use learning sets and advanced organizers to enhance motivation for learning by relating previous abilities and knowledge to the present task.
9. Keep lessons very brief for short attention spans. Alternate quiet activities with active ones. Planned interruptions of longer lessons are useful (e.g., have Jacob come to teacher's table after a small task is completed, or get a necessary supply from the shelf when that part of an activity is reached).
10. Manipulate Jacob's sense of space within his learning environment. For example, use partitions, cubicles, screens, quiet corners; remove distracting stimuli by making a window translucent instead of transparent, keeping teacher apparel plain and free from distractions.

SUMMARY

We have provided a brief overview of some of the major areas of psychological assessment and their influence on current practices. There has been a shift from indirect methods to a direct method of gathering information and observing clients. More success has been documented in the last five years of linking our assessment data more closely to treatment outcomes. Roles for psychologists in the area of assessment will be expanding, especially in assessment of medically ill populations, in health psychology, and in behavior medicine. Currently, there is an emphasis on exploring the mind/body dialectic as our measurement instruments become more refined, and this will enable clinicians to

identify, treat, and offer suggestions for prevention of stress-related and other psychophysiological disturbances. As Schacht so aptly pointed out, the field of forensic evaluation of children and youth will offer numerous opportunities and challenges for clinicians as more and more clinicians become involved with court cases. This emerging field will require clinicians to upgrade their skills in the forensic practice. Pumariega's paper (Chapter 19, this volume) documents how ethnic variables impact assessment procedures and processes (language, social values, etc.). Rogers (1998) provides an excellent review and offers valuable suggestions to assist psychologists and educational diagnosticians in performing culturally meaningful and technically sound assessment with diverse children and youth. The assessment of a child's behavior will always be a dynamic construct influenced by the individual's age, environment, and culture.

The field of psychological/clinical assessment has expanded rapidly during the last 10 years. New and exciting procedures have been added to the clinician's array of assessment instruments. However, clinical assessment of children's behavior is still dependent on the psychologist's selecting the best possible instrument, whether it be a standardized test, direct observation, or non-norm reference that is firmly rooted in theory and sound psychometric properties (i.e., measuring what it was constructed to do). This may be the most important decision that the clinician makes throughout the assessment process (Vance & Awaad, 1998). The clinical assessment of child and youth behavior requires more than just the ability to select a test, follow the appropriate instructions, and then write a report. Interpersonal and clinical skills are required in addition to a thorough background in assessment and test construction. Interpersonal clinical skills such as report building, accurate observation of behaviors, positive interaction, and interviewing are necessary to be an effective psychologist. The clinical assessment of children behavior is not the mere summation of scores from a test or battery of tests but is a highly complex process that involves the gathering of data from multiple sources and multiple instruments and then extracting diagnostic, meaningful hypotheses regarding the cognitive, social, behavioral, and emotional functioning in a professional and objective manner. It is eminently clear from the chapters in this book that effective, multi-factored assessment of child or youth behavior should be the standard throughout the next decade. As psychology continues to struggle to understand and refine assessment practices, strategic analysis of the *why* of assessment will remain as important as the *how* of assessment. The chapters in this book combine both the why and how as each contributor delineates the purposes of assessing child and youth behavior, matching this to appropriate procedures, and then developing an individualized treatment/intervention plan.

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