

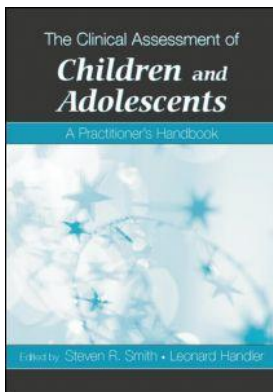
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## **The Clinical Assessment of Children and Adolescents: A Practitioner's Handbook**

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# THE CLINICAL PRACTICE OF CHILD AND ADOLESCENT ASSESSMENT

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The use of tests and measures to understand our patients is one of the hallmarks of applied psychology. Unlike the practices of psychiatry, social work, and other allied mental health disciplines, psychologists rely on measurement to quantify patient cognitive functioning, psychopathology, behavior, strengths, neuropsychological performance, aptitudes, attitudes, and social contexts. Following the empiricist's creed, much of applied psychological assessment rests on the assertion of Thorndike (1918) that "whatever exists at all exists in some amount" (p. 16).

However, the clinical practice of psychological assessment with children and adolescents is different from the mere nomothetic measurement ideal proposed by Thorndike. In fact, a distinction must be made between psychological assessment and psychological testing. Although psychological assessment includes testing, it is far more complex and rife with clinical challenges. Handler and Meyer (1998) clarify the important distinction between psychological testing and psychological assessment, and they emphasize that these are hardly synonymous activities. They state:

Testing is a relatively straightforward process wherein a particular test is administered to obtain a specific score. Subsequently, a descriptive meaning can be applied to the score based on normative, nomothetic findings. For example, when conducting psychological testing, an IQ of 100 indicates a person possesses average intelligence . . . Psychological assessment, however, is a quite different enterprise. The focus here is not on obtaining a single score, or even a series of test scores. Rather, the focus is on taking a variety of test-derived pieces of information, obtained from multiple methods of assessment, and placing these data in the context of historical information, referral information, and behavioral observations in order to generate a cohesive and comprehensive understanding of the person being evaluated. These activities are far from simple; they require a high degree of skill and sophistication to be implemented properly. (pp. 4–5)

A comprehensive psychological assessment includes information from the referring individual; from the child's or adolescent's parent(s) (including a thorough interview and history); from the child or adolescent himself or herself; and from his or her teacher(s) and other relevant informants, such as physicians, relatives, or friends. In addition, to complete a thorough and meaningful assessment, the clinician must help the child's or adolescent's caretakers, the child or adolescent, and perhaps the referring individual to formulate relevant referral questions to be answered by the assessment. After all this activity, including testing the child or adolescent, the clinician then aggregates and integrates the data, writes the report, and provides feedback to the referral source, as well as to the parents and the child or adolescent tested. Compared with this complex series of activities, psychological testing is a far more simple procedure.

### **UNIQUE CHALLENGES IN THE ASSESSMENT OF CHILDREN AND ADOLESCENTS**

It is often the complexity of psychological assessment, rather than psychological testing, that poses several challenges to the assessor, particularly when he or she is working with younger patients. The range of cognitive, affective, and contextual variables that affect a child's or adolescent's performance is seemingly limitless and calls upon a wide array of clinical skills on the part of the assessor. Next follows a discussion of the more important issues that assessment psychologists often face when they work with younger patients.

1. Children (and many adolescents) lack the ability to describe their feelings and experiences. They lack the adult's ability to conceptualize and contextualize their experiences and the ability to describe them to adults. It is difficult to use traditional interviews in the assessment of children, especially young children (although this is less true with adolescents) because children also lack the words with which to express their thoughts and feelings. For example, asking a child how he or she feels about an issue will often result in a response of "I don't know." The examiner might erroneously conclude that the child is defensive or is withholding information, even though the child's response is probably accurate—he or she may not really know how to answer this question. Therefore, poor performance by children may not reflect a lack of knowledge, but, rather, a lack of the capacity to comprehend the complexity of their world and the relevance of various activities to their well-being.

In addition, although children may be able to say, for example, "my teacher is mean," they will typically be unable to describe why they feel that way, or may not be able to explain what the teacher does that makes the teacher "mean." To make matters even more complicated, this opinion of the teacher, or of other people in the child's life, may be transitory, changing with the next positive interaction he or she has with this person.

2. Siegel (1987) makes a very important point concerning the assessment of children. She states, "Children do not appear for a psychological evaluation of their own volition" (p. 15). She adds, "During the early stages of the examination [and perhaps in later stages as well] the child communicates, in open or hidden ways, feelings of trepidation about the unfamiliar experience that awaits him [her]" (p. 23).

Children and some adolescents have little ability to conceptualize the reasons they are being assessed. They typically compare the assessment process with the only similar experience they have had—school testing. Therefore, they come to the assessment sessions with anxiety and concern about giving correct answers. This is especially so if the child or adolescent has one or another kind of learning problem, because the child fears even more the

possibility that he or she will “fail” the examiner’s tests. In addition, given that the examiner is not to provide feedback concerning whether the child’s response is correct or incorrect, the child cannot determine whether he or she has responded successfully. Most often, however, children conclude that their answers are incorrect, and they often feel “dumb” or “retarded.”

This problem is especially troublesome when the child takes a projective test, such as the Rorschach or a storytelling test, because there are few or no right or wrong answers. Therefore, the child is left guessing even more so about whether his or her responses were correct. This situation therefore engenders even more anxiety than the child had upon first entering what was already experienced as an unusual and strange situation. Often, children take a defensive stance to deal with their underlying anxiety, calling the tests and/or the examiner “stupid” or otherwise criticizing the tests.

3. The assessor must work quite hard to assist the child or adolescent with his or her anxiety, providing a “holding environment” (a setting of safety and comfort; Winnicott, 1965), as much as this is possible to do with a relative stranger. Schafer (1954, 1956) indicates that even adults find the assessment relationship stressful, and they respond with regressive and self-blaming behavior. Thus, the assessor must make every effort to make the assessment process more like play rather than like school-related work and tests. In addition, the assessor must accomplish this feat without changing the standardized administration directions. Although this is possible to do with some tests (e.g., the Draw-A-Person Test, the House-Tree-Person Test, the Kinetic Family Drawing Test, and some storytelling tests), it is more difficult to make some tests, such as the Rorschach or some self-report measures, playful.

4. Often, to maintain rapport and cooperation, examiners must process the child’s experience with each test the child experienced as problematic or anxiety-producing. In addition, in order to decrease resistance, some examiners provide for the child or adolescent posttest exploration of his or her responses, finding ways in which the child can derive more successful answers to questions he or she had previously failed (see Handler, 1998, 1999, 2002, 2004b, 2005 for a discussion of this approach). This gives the child a feeling of success and provides the examiner additional clues concerning the child’s problems.

It is also important to note that the children and adolescents we test are typically children with emotional and social problems of different kinds and therefore they are more vulnerable to the pressures engendered in the assessment situation. These children and adolescents tend to degrade themselves when they feel they have missed test items, and often berate themselves. Children and some adolescents have a poorly developed sense of self. Therefore, they are very sensitive to what they might perceive as their poor performance, especially because the examiner cannot offer them feedback concerning the adequacy of their responses. Children evaluate their success by focusing on the adult’s feedback to them (Kohut, 1977). If this is not forthcoming, they almost automatically believe they are wrong or at fault.

5. Children and many adolescents do not understand why they are being assessed, despite the fact that parents and/or assessors attempt to explain the reason(s) they are being tested. What they are aware of is that their parents or their teachers are unhappy with some aspect of their performance or their behavior. However, they do not see the relevance of the assessment, nor can they comprehend that by these procedures the answers to their problem issues will be understood. Therefore, they are often not ego-involved in the process, which can make them even more restless and avoidant during the assessment sessions.

6. Some children and adolescents somehow understand that the assessor is someone who might help fix the problem they are having and will sometimes be able to tell the asses-

essor directly, but more often indirectly, through metaphor, what is wrong. However, in traditional assessment, because the assessor needs time to evaluate the data and write a report, the child or adolescent leaves without helpful feedback. Therefore, because the child or adolescent cannot comprehend the complexity of the assessment process for the assessor, he or she leaves the assessment sessions disappointed and might well view the experience as an empathic failure. D. W. Winnicott writes about this problem in the following quote:

It often happens that we find a child has given all to the psychologist who is performing an intelligence test, and the fact that the material presented has not led to understanding (this not being included in the psychologist's aims) has proved traumatic to the child, leading to a strengthening of suspicion and unwillingness to give the appropriate clues [about his or her problem]. This especially applies in TAT tests in which the patient has reached to unexpected ideas, fears, states. For this reason I have always seen my patients first, referring them to the psychologist where necessary, after I have come to grips with the case by doing something significant in the first interview or first few interviews. (Winnicott, 1989, pp. 319–320)

7. Many children have separation anxiety as one of their problems. They might therefore refuse to separate from the parent or parents who bring them for the assessment. Although most children accompany the assessor without any apparent problem, many others are fearful, with feelings ranging from mild uneasiness to complete terror about separating from the parent. These emotions can persist in the assessment room, permeating the relationship, affecting test results, and making the assessment experience tolerable at best.

Although most children and adolescents will comply, albeit reluctantly, with the examiner, there are nevertheless a significant number of children and adolescents who are very difficult to test because of resistance or behavioral noncompliance. They resist the examiner in various ways, both directly and indirectly. Although this resistance may be due to the cognitive issues, interpersonal problems, or anxiety discussed above, children and adolescents who are behaviorally difficult call for the utmost creativity, flexibility, and clinical skill on the part of the assessor.

Case examples illustrate this point nicely. For example, Roxanna was a 16-year-old girl I (SRS) saw on an acute-care inpatient psychiatric unit. A full assessment was requested in order to assess for disordered thinking or other serious mental illness that might help to explain her erratic and self-destructive behavior prior to hospitalization. She struck a tough pose with me, her peers, and the other clinical staff and referred to all of the assessment materials as “kid stuff” and “bullshit.” When I would encourage her and praise her performance during cognitive testing, she would sarcastically respond, “Yeah, like I was really trying.”

The Rorschach was particularly difficult for Roxanna. The unstructured and somewhat “mysterious” nature of the test brought about the anxiety normally masked by her somewhat antisocial presentation. She immediately rejected Card I, and it was clear that she would not be a willing participant in the assessment. The following day, I met again with Roxanna, but this time, I brought along some paint and paper. Although initially reluctant (because this was “bullshit,” too), she agreed to make inkblots with me, using lots of color and eagerly folding each paper in half to see what she had made. After “defusing” the inkblots in this manner, I was able to convince her to give the Rorschach another try.

The reason for her initial anxiety about engaging in the Rorschach task was immediately clear, because she produced a profile that was rife with aggressive and personalized responses with very poor form and reality testing (e.g., on Card VI, she responded, “This is my father hitting my mother; I’m down here trying to stop him.”). It was evident from her responses and score profile that she was struggling with a psychotic process that was tinged with primitive

aggression. After completion of the Inquiry portion, she asked if we could make inkblots again, and I agreed to do so. As a way of taking ownership of her fears, she kept these “home-made” blots and hung them on the walls of her room at the hospital.

Another case example is provided by Kelly (1999):

When the examiner came to get Virginia, [an eight year-old girl, she announced] that she was busy and that [the examiner needed] to wait. From the outset Virginia attempt[ed] to be in control [of the assessment process], want[ed] to know if she [was] giving the right answers [to] the WISC-R [questions], and pout[ed] when the examiner suggest[ed] she just try and do her best. At times she [was] distractible, inattentive, hyperactive, and markedly impulsive. Her ability to tolerate frustration [was] frequently taxed and she [responded] with derisive comments about the test and the examiner (e.g., “Your dress is ugly and so are your earrings.”). The examiner [found] it necessary to allow frequent breaks so [Virginia could] play with a nearby doll house.

Virginia did better on structured tests, but had increasingly more difficulty with the unstructured tests. For example when she saw the first Rorschach card she shielded her face with it and impulsively stated, “A stupid, dumb, dumb bat with holes in its body.” She threw the card across the table, announced she would not look at any more cards, and walked around the room, and then [stared] out the window. The examiner invited her to return to the testing, telling her the evaluation would not take much longer, but Virginia still refused to continue. The examiner expressed to Virginia that she understood how difficult the testing was for her, but suggested it would be nice to finish the testing that same day, and told her she could get a snack when the testing was completed. She told Virginia she could keep track of the time and could work the stopwatch, and could take another break if it was necessary. In addition, the examiner told Virginia that other girls also found the testing difficult, but that most of them found the testing to be interesting because there were no right or wrong answers. Although Virginia did complete the test, she continued to periodically protest, orally deprecated the tests, and complained angrily. (pp. 132–133)

Such difficulties are thankfully infrequent, but they illustrate the often stressful nature of the assessment process for children and adolescents, just as the process is stressful for adults. Managing such problems involves an appreciation of the child’s needs and problems, along with the ability to devise solutions designed to employ the child’s predominant interactive style to effectively re-interest him or her in the assessment process.

Judging from the examples just cited, the examiner of potentially highly resistant children, in some selected cases, might want to modify the test instructions in order to obtain or increase cooperation and to obtain meaningful data. The issue of modification of standardized instructions must be compared, in each case, with the possibility of obtaining poor or inadequate data. For example, presenting the Rorschach or storytelling test as games, in which the child is invited to have fun making up stories; seeing interesting things on the cards; playing “an imagination game”; or telling a child who is taking an IQ test that he or she is smart, cheering him or her on, or even alternating easy items with more difficult ones might result in far better cooperation of the child or adolescent, compared with reliance on standardized instructions.

The decision whether to violate standardization is a difficult one to make and should not be made casually. Indeed, such a violation of standardized procedures is not recommended in forensic cases, such as custody evaluations, where the violation of standardized testing will likely result in the dismissal of the psychologist’s entire report. Even some learning disability evaluations provided for schools can become quite “heated” and contentious, making any violation of standardization potentially very problematic. In all cases where a violation in standardization has occurred, the psychologist should indicate in the report that it was necessary to violate standardization in order to gain the child’s or adolescent’s cooperation.

Testing children or adolescents can be difficult for assessors who erroneously define their job as obtaining responses to tests. The goal is not to merely obtain responses, but to develop an understanding of the child's or adolescent's prevailing problem(s). Merely obtaining responses such as "I don't know" to a variety of questions gives the examiner little understanding of the child or adolescent. The examiner might also want to use a Testing of the Limits procedure, first suggested by Klopfer (Klopfer, Ainsworth, Klopfer, & Holt, 1954), to clarify Rorschach scoring, after the test is concluded, to obtain more meaningful responses. In this procedure, the examiner might return to missed items and provide the child or adolescent with a series of graded hints to determine whether the child is capable of generating better data. A fuller explanation of this approach is available in Handler (1998, 1999) and in his chapter on therapeutic assessment in this volume.

## A DEVELOPMENTAL PERSPECTIVE ON ASSESSMENT

It is because of this complexity that most psychologists look to psychological assessment to aid in diagnosis and treatment planning. Although survey results suggest that 80% of clinical psychologists spend less than 5 hours per week providing assessment services (Camara, Nathan, & Puente, 2000), these services are particularly important for assessment psychologists who work with younger patients because child and adolescent psychological symptoms tend not to occur or be obvious in the clinical setting (House, 2002). Clemence and Handler (2001) conducted a study of assessment practices in APA-accredited internship settings. Although it may not be representative of what happens in all clinical settings, they found that in settings where assessors work primarily with children, 29% of assessors reported that all patients receive some type of psychological assessment. Another 29% indicated that at least half of their patients received psychological assessment. These rates were higher than all other internship settings surveyed (Clemence & Handler, 2001).

The assessment of children is complicated by myriad overlapping issues in cognitive and emotional development. Specifically, there appear to be three primary cognitive and object relational issues that are most salient for child assessment: self-concept, affective labeling, and concepts of others. Research on the development of self-concept reveals a consistent and cross-cultural progression from infancy to adolescence (Damon & Hart, 1982). First, self-concept shifts from mere physical descriptors and experiences to those that are more psychological in nature. Second, self-concept gradually comes to be based more on internal and self-reflective descriptors, rather than on characterizations by others. Third, the child develops a stable and complex social characterization of the self that is unique and multifaceted. Last, a unified self system develops from disparate, contradictory, or fragmentary self-descriptors.

At the age of three, children begin to have a linguistic understanding of affect (Stone & Lemanek, 1990). General broad categories of affective labels are increasingly refined and honed from early to mid-childhood. Next, as cognitive complexity increases, children are increasingly able to rely on a mental concept of affect rather than rely on physiological or environmental cues. As affective labels become more differentiated, and complex, children and adolescents are able to assert control over affective expression.

Like both self and affective development, social and relational functioning change from external or behavior-based appraisals to desires and preferences that are based on psychological constructs (Lenhart & Rabiner, 1995; McHale, Dariotis, & Kauh, 2003; Westen et al., 1991). The self-other development of mature object relations involves a progression from a

state of infantile narcissism and undifferentiated object states to a more complex and differentiated understanding of self and others. Furthermore, young children tend to understand social relationships primarily by similarity in interest and behavior. Thus a child who enjoys sports might have a social network made up primarily of other children who play sports. Similarities and differences proceed from these behavioral comparisons, as well as from concrete likes and dislikes. As they progress into adolescence, children are more apt to look to psychological factors in others, such as honesty or extraversion, as important factors in relationships. The onset of puberty and development of sexuality shift the child's focus away from relations with caregivers to other social relationships that set the stage for future long-term, reciprocal partnerships.

Psychologists who work with children must understand the normative developmental context in which an assessment takes place. Although a nomothetic approach will involve the use of normative comparisons, the interpretation of test results must accompany a keen understanding of each child's place along a developmental continuum. Developmental and cognitive issues also dictate the choice of tests that psychologists have at their disposal at any particular time. What follows is a discussion of self, affective, and relational development at four ages: preschool, early school age, late childhood, and adolescence. Furthermore, the assessment choices for each stage are highlighted.

### **Preschoolers**

Psychoanalytic and object relations theorists (Fairbairn, 1954; Kernberg, 1976; Kohut, 1977, 1987; Winnicott, 1958, 1971) have posited that this period of development is vital to the creation of a stable concept of self and complex representations of others. For instance, Kohut theorized that an infant is innately driven to find reciprocal and valuable relationships with others who will care for him or her. The infant relies on these significant others not only for proper and healthy physical development, but for psychological development as well. At first, the infant self is characterized by a poor differentiation between the self and others (Kohut, 1977). The self is unstable and without boundaries. For this reason, infants require others to help maintain structure or stability of the self over time. Because others are required to help maintain the infant's sense of self, he or she is unable to differentiate him- or herself from others.

Object relations theory (e.g., Winnicott, 1971) states that a child's sense of self is derived and formed by gradual and inevitable but mild failures of empathy. From time to time, even the best parents will fail to mirror their child or to provide access to idealization. Through this process, the child forms solid and stable internalizations of others and their functions. The child begins to see others in his or her life as real and complex, differentiated, and apart from the child's self-organization. Thus, a child who is imperfectly soothed learns to soothe him/herself; a child who grows hungry learns to cry or seek sustenance on his/her own. The boundaries between "me" and "not me" become clearer, and a self is born.

Research suggests that by age three, most children are able to describe, in at least rudimentary terms, their own physical states (Damon & Hart, 1982). The ability to label hunger, sleepiness, and pain is a vital process that can alert caregivers to the internal states of the child. The labeling of these experiences is not only important for helping the child communicate those needs that are most important for his or her physical survival, but they also ensure continued close contact with primary caregivers. Similar to the situation in the development of self-concept, very young children have a limited ability to label affective experience. As children progress linguistically, they become able to label basic mood states, such as "happy"



and “sad,” as well as interpret the emotions expressed by others. During this period of development, the child’s ability to understand and express behavioral correlates of emotion increases in accuracy and complexity (Bretherton, Fritz, Zahn-Waxler, & Ridgeway, 1986).

Related to the assessment needs of young children is the observation that, although they are not able to express self and affect constructs verbally, they are extremely expressive in their play and behavior. Underlying both play therapy and play assessment is the assumption that children will enact, demonstrate, and project their internal experience onto the toys and objects around them. Although they may lack the ability to label their internal experience, they are quick to enact their internal struggles, fears, and fantasies in whatever manner is available to them. Despite being clinically rich, the play messages of children must be read and interpreted by skilled clinicians who are able to weave theory, context, and the idiographic nature of the child’s history and presentation to accurately read the child’s message. In addition, more and more assessments are available that quantify the parents’ concerns about their child’s affective and behavioral functioning. Several behavior rating scales are available for parents of very young children, some as young as 2 years old (see chapters by Achenbach, and Kamphaus, VanDeventer, Brueggemann, & Barry in this volume).

### **Early School Age**

Between the ages of four and six, children are able to express aspects of self-concept through physical descriptors, behaviors, and activities. Harter (1990) notes that children of this age make reliable appraisals of their cognitive, physical, and social competence, as well as their general behavior and conduct. When asked, “What are you like?” a child at this age might respond with descriptors such as “I’m a boy,” “I have long hair,” or “I’m a fast runner.” Self-concept at this age tends to be rather concrete and “black and white.” Therefore, children will assume that their personal attributes are absolute and unchanging. For example, one is either a fast runner or a slow runner. Moreover, the labels children choose for themselves are often based on what they hear from others. A child who is frequently told that she is smart may begin to label herself as smart, without a full appreciation of what this really means, other than that it is a positive attribute.

Affective labeling becomes much more accurate during this period of development. Children’s repertoires of affective labels continue to increase beyond “happy,” “sad,” and “glad,” to include descriptors of anticipatory anxiety, longing, anger, and frustration (Sprinthall & Burke, 1985). Furthermore, as they develop during this period, children are able to more fully understand their emotional experience beyond that of mere physical sensation. There is increasing consideration of others’ internal experience, and they begin to understand that others may express emotion that is inconsistent with their internal experience, in order to manipulate the affect of others (i.e., deceit and humor). This cognitive and affective development results in a dichotomy that is so often intriguing or troublesome to parents: although the child has a wonderful and newfound appreciation of humor, he or she also has a newfound ability to lie.

Given these changes, children can be increasingly called upon to give voice to their internal and private experiences in a clinical setting. Although limitations in reading preclude self-report measures, oral sentence completion tasks and structured projective techniques such as the Rorschach (Exner, 2003) and Roberts-2 (Roberts & Gruber, 2005) are particularly useful. The ability to deceive or to hide one’s true feelings and intentions has implications for assessment. As children age, they become more and more sophisticated at reporting partial truths or deliberate distortions, due to perceived risks of embarrassment or punishment. Thus, the clinician

must be adept at communicating a sense of safety in the assessment relationship with a child. In addition, the use of projective techniques becomes important here because they are less sensitive to deliberate distortion, compared with various self-report measures or interviews.

### Late Childhood

During the latency years (ages seven to eleven years), children gain an experience of “sometimes” (Harter, 1990). That is, they begin to see that sometimes they can possess a particular attribute or characteristic (such as honesty), but that at other times they may not. Furthermore, latency-aged children begin to incorporate psychological and social processes into their self-concept. The notion of being “caring” or “shy” begins to emerge, as does a more complex manner of social comparison. Specifically, although younger children often have an unrealistically positive self-appraisal, latency-age children are able to use social comparison to modify and alter their self-understanding and self-concept. Therefore, one is not merely a fast runner, but the “fastest runner in class” or “faster than Jens, but slower than Katrina.”

Emotionally, latency children have a greater appreciation for emotional complexity and personal control. They begin to understand that more than one emotion can be simultaneously held or that some emotions are more transient than others (Burgess & Rubin, 2000). The child gains some understanding of the relationship between feelings and thoughts. The object relations literature suggests that there are several developmental affective tasks during latency: the development of a sense of self, the ability to tolerate affect and manage internal urges, and the refinement of an internal, affective locus of control (Freedman, 1996). In some ways, this period is highlighted by a newfound ability to regulate affective experiences and their expression. From an Eriksonian perspective, the child turns his or her affective focus outward so as to learn about and explore the world in preparation for more mature relationship development during adolescence (Erikson, 1993). As Anna Freud (1968) noted, children tend to focus outward and are not typically predisposed to introspection. This is particularly true for emotional development during latency.

Latency-aged children become better descriptors of their social selves than are younger children. They continue to look to activities in which they participate to help in social definition. Thus, if a child participates in an activity (e.g., sports) that is seen as socially positive, the child will describe him- or herself positively. However, as latency-aged children continue to make social comparisons (at both micro and macro levels), self-appraisal suffers. Research indicates that self-esteem diminishes from ages 9 to 13 because children have become more and more socially reflective and self-aware. This trend has even been found to be robust cross-culturally (Gray-Little & Hafdahl, 2000; Rhodes, Roffman, Reddy, & Fredriksen, 2004). Awareness of social functioning and cognitive comparison seem to have a painful consequence for many latency-aged children, because they struggle to reconcile their own sense of fallibility with the perceived positive attributes of others.

Developments in cognitive, linguistic, and reflective capacities allow for the use of self-report measures at this age. The convergence of reading ability and some capacity for self-reflection allows child clinicians to assess these self-reported behaviors, feelings, and thoughts. However, as Woolley, Bowen, and Bowen (2004) asserted, the major assumption of child self-report measures is that children interpret the items in a manner that the test designers intended. Although not generally convergent with parent or teacher reports (Achenbach, McConaughy, & Howell, 1987), the addition of self-reported symptoms is an important addition to the assessment battery. Furthermore, the ability to write and understand the assessment task allows for the use of sentence completion tests with children of this age.

## Adolescence

Because of increased complexity of cognitive processing, adolescents are increasingly able to use several different categories for self-description (Harter, 1990; Nurmi, 2004). As their vocabulary and self-reflection abilities increase, they gain the ability to engage in comparisons with others. Furthermore, they are able to note that seemingly contradictory self-descriptions can be truly contingent upon internal states and social setting (e.g., sometimes one can be gregarious and outgoing, whereas, at other times, he or she is shy and reserved). These conflicting descriptions are a source of distress for middle adolescents. At a time when adolescents are working to understand who they are, they are also able to understand that identity is complex and multifaceted. By late adolescence, teenagers are less distressed by seeming contradictions in self-descriptors and may even be able to look to this as a marker of complexity in a unified whole self-perspective.

As adolescents develop, their understanding of emotion continues to be refined and integrated. It has been hypothesized that adolescents revisit a state of egocentrism because their observations turn increasingly inward, toward their own emotional and cognitive experiences (Bjorklund & Green, 1992; Elkind, 1967). Thus, early to middle adolescents often will be emotionally showy and express affect in transient and superficial ways. Unlike younger children, they are also more able to label affect and reflect on their affective experiences.

As adolescents' ability to express affect increases, so does the complexity of their social relationships. As self-reflection increases, so does anxiety around social comparison. Early adolescence is usually marked by extreme adherence to social rules and mores, trying to fit in with others, and anxiety around any perceived differences (Harter, 1990; Nurmi, 2004). As they grow older and their self-concept grows more complex, teenagers are able to tolerate social differences and adopt a social identity and a self-identity that are based more on choice than on social consequence.

During adolescence, the assessment options available to clinicians are even more varied than they are for adult patients. As is true for younger children, teacher and parent reports can augment self-report and projective test data. Although teenagers are generally seen as important informants about their internal experience (Loeber, Green, & Lahey, 1990), they may be more clandestine about their behavioral issues, particularly when assessment takes place in an inpatient or detention facility (MacLeod, McNamee, Boyle, Offord, & Friedrich, 1999; Stanger & Lewis, 1993). However, clinicians assessing adolescent patients should rely in particular on a multimethod-multirater-multidomain (Campbell & Fiske, 1959) approach to assessment.

## MULTIMETHOD-MULTITRAIT ASSESSMENT

Although a major portion of this book contains specific information about an array of different tests, the reader should understand that these tests are merely tools with which the clinician develops his or her comprehensive understanding of the child or adolescent. The various authors of individual chapters in this volume caution the reader that no particular test should be used alone to answer referral issues. As was stated by Verhulst (1995), "Essential for the assessment and diagnosis of child psychopathology is the recognition that there is no single approach to assessment and diagnosis that is superior to all others. Instead we need different approaches and different data sources to arrive at a comprehensive picture of a child's functioning" (p. 209).

The history of this practice requires a bit of a story, taken from part of Len Handler's (2004b) presidential address to the Society for Personality Assessment in 2004, which was reprinted in the *SPA Exchange* (Winter, 2004):

During World War II the Office of Strategic Services, the forerunner of the CIA, was given the task of selecting men and women to spy for the allies. It seems that previously, those chosen for various espionage duties were failing in the field. Henry Murray, along with a number of psychologists, psychiatrists and anthropologists, got together at Station S (for secret), and constructed a three and a half day evaluation procedure consisting of interviews, some of which were conducted under pressure; observations; self-report measures; projective measures; situational tests; intellectual measures; almost 70 measures in all, many with multiple parts. The data for each candidate were then aggregated by a small group of experts, who wrote an evaluation of the candidate's strengths and weaknesses. This evaluation was then discussed in a full staff meeting, where a final decision was made concerning the candidate's suitability as a spy.

In 1948 Murray and his associates published a book about the program, called *Assessment of Men* (Office of Strategic Services Assessment Staff, 1948). The book gives the reader a vivid and detailed description of the entire program. Murray and his co-authors made several recommendations to future assessors worth repeating here because they have relevance for assessment today.

1. Conduct the assessment program within a social matrix in which it is possible to have *frequent* informal contacts and *many* opportunities to observe candidates' responses.
2. Use many different kinds of evaluation techniques—interview data, self-report measures, projective techniques, and situational tests.
3. Employ life-like complicated tasks in a real environment, so that their solution requires high-level integration.
4. Enough data should be collected and enough time should be taken so that the chief components of the personality are identified.
5. The data should be systematically recorded so they will lend themselves to statistical comparisons.
6. Attention should be given to perfecting appraisal techniques to increase reliability and validity.

One of the members of the OSS evaluation team, by the way, was Donald Fiske. Murray and Fiske must have influenced each other because eleven years after the publication of *Assessment of Men*, Campbell and Fiske (1959) described the Multi-trait, Multi-Method approach to test validation, demonstrating that there could be significant error in validity findings due to the use of similar methods. The validity coefficient could be due to the error caused by using measures that employed *similar* methodology. The implication of this approach is that more than one assessment method must be included in a research design to reduce error and that more than one trait should be measured, as well.

There are a number of clinical advantages of multimethod/multitrait assessments. First, multiple sources of assessment enhance the quality of the assessments by creating a more comprehensive picture of the child's functioning than could be possible through the examination of the results from each informant alone. As stated by Meyer (1996), "Recognizing the limitations and biases associated with each personality assessment method and understanding the ways in which each method is sensitive to different external realities would help to understand how two or more of these incomplete and imperfect tools can be used together to gain a more accurate picture of clinical phenomena" (pp. 560–561). Furthermore, in the Psychological Assessment Work Group (PAWG) Report, Meyer et al. (2001) reported a number of studies that clearly showed a dramatically high number of diagnostic errors when

only one instrument or only one method of measurement was used, instead of multiple measures. The validity of empirical research is compromised when information is derived from a single method of measurement, or from a single construct that has been operationally defined in a single way. The report points out that just as these two sources of bias produce less valid research, they will also compromise the validity of individual assessments. They make the point that "Assessments will be less valid and accurate to the extent that they rely on a single method for gathering patient information and they will be less valid to the extent that they rely on constructs that have been defined according to a single format or set of principles" (p. 14). The logical conclusion, therefore, is that a test battery that is constructed with the use of multiple methods provides a means of avoiding method bias.

Moreover, such a battery represents the standard for good clinical practice. The *Standards of Practice* (1999), authored jointly by the American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education, has the following to say about assessment:

The interpretation of tests or test battery results generally should be based upon multiple sources of convergent and collateral data and an understanding of the normative, empirical and theoretical foundations as well as the limitations of such tests (Standard 12.18).

The interpretation of test scores or patterns of test battery results should take cognizance of the many factors that may influence a particular testing outcome. Standard 11.20 states: In educational, clinical or counseling settings, a test taker's score should not be interpreted in isolation; collateral information that may lead to alternative explanations for the examinee's test performance should be considered (Standard 12.19).

Despite the clinical utility of this model, research has indicated that the correlations between measurement types are often poor (Achenbach, Dumenci, & Rescorla, 2002; Achenbach et al., 1987; De Los Reyes & Kazdin, 2005; Krishnamurthy, Archer, & House, 1996; McCrae, 1994). This does not limit the utility of a multimethod assessment model, nor does it indicate that any of the pieces of data are necessarily less correct than others (Achenbach et al., 2002; Ferdinand et al., 2003; Meyer, 1996; Verhulst, Dekker, & Van der Ende, 1997; Verhulst & Van der Ende, 1992). However, this lack of correlation forces clinicians to make decisions about the relative weights of assessment data and about how to integrate disparate pieces of information.

## SUMMARY

Assessment approaches should match the developmental level of the child or adolescent. As children develop more and more cognitive, affective, and interpersonal resources, an assessor can increasingly rely on the child to provide information. Although projective techniques and the reports of others can be useful for all child and adolescent patients, as children age, they become invaluable reporters of their own affective and cognitive experiences.

It is important that child and adolescent clinicians approach assessment from a multimethod-multirater-multidomain perspective at all ages. The availability of multiple forms and methods of assessment allows for an integration of data that yields a rich clinical picture. Data obtained from cognitive assessment, self-report, projective data, interviews, and reports from others may often be discrepant (Achenbach et al., 2002; Achenbach et al., 1987; De Los Reyes & Kazdin, 2005), but it is this discrepancy that broadens the clinical picture and enhances the validity of the conclusions drawn (Meyer, 2002). Although it may go without

saying, it is vital that clinicians use multiple sources of data, particularly when making diagnostic decisions and classifications that will be meaningful for treatment.

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