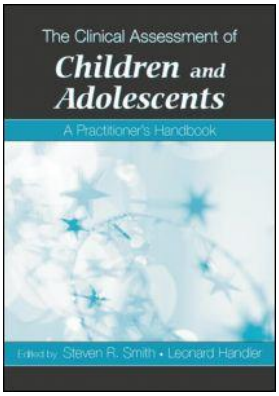

The Clinical Assessment of Children and Adolescents: A Practitioner's Handbook

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Personality Assessment Feedback With Parents

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CHAPTER

5

PERSONALITY ASSESSMENT FEEDBACK WITH PARENTS

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Little is known about how child psychologists are formally prepared to perform one of their most challenging professional roles, the sharing of test data with their patients' families. Although much time and energy is justifiably invested in mastering test procedures and using tests to describe personality characteristics and reach differential diagnoses, there is little formal training in how to convey this information to parents, and most psychologists learn these skills by observation or through trial and error. Although providing feedback to parents is often challenging for clinicians, providing feedback regarding personality assessment can be particularly difficult, as the results of personality assessments frequently involve judgments regarding children's individual attributes, place in the family, the quality of their relationships with parents and siblings, and potential causes of behavior problems. Thus, the results of the evaluation frequently relate to the parents' investment in their view of their child and their relationships, which may elicit intense personal feelings in the parents when they hear this information.

Complicating this issue is the fact that results from personality assessments can be somewhat ambiguous, which can leave parents feeling as if they do not have succinct answers to their questions. In addition, the results may reveal personal, intimate details about the child and his or her parents that can make parents—and clinicians—feel uncomfortable. Thus, it is critical that this feedback be offered in a way that is informative, empathic, and supportive of parental emotional expression. Although there are no clear guidelines for this process, this chapter examines this issue by discussing possible techniques and means of explaining complicated and, at times, contradictory psychological test results to parents, so that parents are best able to plan for treatment and support strengths.

CONVEYING RESULTS TO PARENTS: REVIEW OF THE LITERATURE

There are no published studies on how best to convey psychological test results to parents. However, there is a body of literature that has examined effective communication between

pediatric clinicians and parents, as well as research examining parent preferences for the communication of "bad" or sensitive news. Some of this research can be useful in the development of general guidelines for sharing psychological test results with parents.

Hasnat and Graves (2000) investigated the level of satisfaction parents felt when first provided a diagnosis of developmental disability in their child. The authors found that parents were more likely to be satisfied if they received a large amount of information, and if the disclosing professional had an understanding of parental concerns, yet was direct in the manner in which the information is presented. Krahn, Hallum, and Kime (1993) interviewed mothers and fathers of infants with a recently diagnosed disability regarding their preferences for how they would prefer to hear the news of their child's disability. Nine themes of parental preferences for how to communicate difficult information emerged, seven of which might be applicable to the sharing of personality measures, including: (1) *communication of information*, which indicated parents preferred direct and understandable language, including positive as well as negative characteristics; (2) *diagnostician*, where parents preferred hearing the information from a familiar person; (3) *communication of affect*, whereby the parents preferred an empathic approach from a person who was comfortable with the expression of emotions; (4) *pacing of process*, where the information was presented gradually in a step-by-step fashion that left time for questions throughout the meeting; (5) *when told*, with parents preferring to be told as soon as problems are suspected; (6) *where told*, with parents expressing strong preferences for being told personally (as opposed to over the phone), in a private, uninterrupted setting; and (7) *support persons present*, with most parents preferring to be told together, or with a support person.

In an outcome analysis that attempted to identify and categorize whether support for parents by clinicians led to positive changes in mothers (Wasserman, Inui, Barriatua, Carter, & Lippincott, 1984), the results indicated that mothers who received more clinician empathy were more satisfied with their care and had greater reductions in their level of concern. Some research has also found that parents value a sympathetic and caring approach (Girvin, 2002; Quine & Pahl, 1986; Sharp, Strauss, & Lorch, 1992), and other studies have suggested a desire for parents to know how well the child will function in the home and strategies for facilitating his or her growth (Lynch & Staloch, 1988). Cross-cultural studies on the sharing of bad news with parents (Krauss-Mars & Lachman, 1994) indicated that the use of a language other than the parents' tends to have a negative influence on the communication between doctors and parents, and that an attempt should be made to understand the family's own cultural views about diagnosis and treatment, because various cultures may have different ways of understanding or responding to certain disabilities or diagnoses (Ahmann, 1994).

SHARING INFORMATION WITH PARENTS: THE FEEDBACK CONFERENCE

Feedback is typically provided to parents after all of the assessments, interviews, and observations have been completed. Whether the evaluation included only projective and personality measures, or whether the use of personality measures occurred in the context of a broader evaluation, the feedback session should be approached as a therapeutic intervention that has the potential to significantly influence parents' emotions, beliefs, and attitudes toward their child and their child's future. Finn and Tonsager (1997) have theorized that the assessment process with adults is therapeutic because it provides the patient with self-verification, self-enhancement, and self-efficacy/discovery. In the evaluation of child patients,

the assessment process has the added result of providing parents with verification of their concerns about their child, enhancing their relationship with their child, and providing them with recommendations that enable them to be efficacious when they seek services for their child. Overall, the feedback process should be a collaborative and individualized process in which the patient(s) (i.e., the parents and/or child) and evaluator work together to develop productive understandings (Fischer, 2000).

It is hoped that a positive, supportive clinician-patient/family relationship built on trust emerges through the process of evaluating the child. However, even in the best of situations, parents may be quite anxious about receiving the results of the assessment, and it is sometimes helpful to reflect on the parents' anxiety, and to make them as comfortable as possible. Similarly, clinicians may be anxious about sharing information, which can cause them to lose focus during the feedback session; thus it is typically helpful for the examiner to spend some time thinking about the case before the appointment. In thinking about a case, it is best to identify the most important information that needs to be conveyed. In other words: What is the most crucial information that this family needs to know? How can I best share this information with them in a way they will understand, that will be useful to them? and What next steps are important?

Because parents are frequently anxious about hearing feedback about their children, I often begin the feedback session by saying a few things about what is best about their child, how much I enjoyed working with their child, and why it was enjoyable. Once that is said, I will remind the parent to keep these aspects of their child in mind, because much of what we will discuss will not pertain to their child's strengths, but instead to their concerns about their child. Periodically throughout the feedback session, I will bring up these strengths, so that they do not get "lost" in our discussion of the child's areas of weakness or concern. Once the parents are comfortable and have been reminded of at least a few of their child's positive qualities, it is typically most helpful to begin by restating the referral question, preferably in the parents' own words. For example, "You sought an evaluation for Jim because you were concerned about possible reasons for his increased oppositionality at home, which included stealing and bullying." It is then helpful to check in with the parents about whether that indeed was their understanding. Assuming that there is a commonly "shared" view of the purpose of the assessment, provide the parents with the most salient information that they need to know, including a diagnosis (if there is one). It is not uncommon for parents to tune out much of what comes next, so it is important that the initial information be provided briefly, directly, and sensitively.

Once the essential information has been conveyed, it is helpful for the clinician to check in with the parents, by saying something such as "Does this information fit with how you see Jim?" or "Is there anything that is surprising in these results?" Most often, the parent will state that there is little that is surprising. In fact, there may be a relief that the cause of the problem has been identified. At this point in the process, it is helpful to review the test results more specifically, helping the parent understand the evidence for your conclusions.

However, there are also times when parents disagree with the initial feedback information and the evaluator should allow for, and not be defensive about, questioning, resistance, and denial. What can be most helpful is to spend a little time talking about what is not a "fit" with how they see their child. Sometimes parents are angry or embarrassed about their child; other times they may be using denial of the problem as a defense mechanism that has allowed them to cope with their child's disability; still other times (though much less frequently if the evaluation has been properly completed), the clinician may have not come to the correct conclusion and the parents' input can be crucial in a balanced view of the child. In

any case, it is helpful to review the parents' perception of the problem, as well as their present state of knowledge. For example, Theo was a 15-year-old depressed adolescent who was referred for testing because his grades had dropped considerably and he frequently missed school. The results of the projective measures clearly showed a very significant depression. When this information was shared with his parents, his father immediately disagreed, stating, "He's just lazy; if he'd just get out of bed in the morning and get to school, he'd get better grades." At this point, it was clear that Theo's father had a number of misconceptions about depression in adolescents, and it was the evaluator's role to help him get a more accurate comprehension of the problem. As is frequently the case, Theo's father had some issues of his own, as he had also experienced depression as an adolescent (and as an adult) and tended to think he could "work" himself out of a depression. Helping Theo's father gain a better understanding of depression and giving him time to talk about his own depression (as well as how his ways of coping were frequently maladaptive) ultimately helped him gain an understanding of Theo.

After the initial impressions are shared with the parents, and provided the examiner has done a good job of communicating his or her diagnostic formulations in language the parents understand, the evaluator should provide the evidence for his or her conclusions. Rating scales are frequently easy for parents to understand, and parents tend to feel this is "real data" when compared with projective measures. Thus, if rating scales have been completed, it is sometimes useful to begin by sharing parents' ratings (and teacher ratings, if available). In contrast, parents do not typically have an understanding of what projective or personality testing entails, and they usually respond well to simple information on what it entails and how it is used. For example, "The Rorschach, Thematic Apperception Test, Sentence Completion Test, and Kinetic Family Drawing, etc., are psychological tests in which the person's responses are assumed to be a reflection of his personality." In describing individual tests, parents may have misconceptions about what the tests can and cannot do. Many parents (and children) have heard about the Rorschach or seen it used in cartoons or comedy movies, but have no idea what it measures. A very short explanation of the test can include the following: "The Rorschach is a series of inkblots where the child is asked to describe what they look like to him. His responses can then be compared with others' responses and the responses can provide an overview of how he sees the world, handles emotions, and the kinds of emotional resources available to him." Similarly, the TAT can be explained by saying, "The Thematic Apperception Test consists of a series of stories based upon viewing pictures. Responses can be analyzed in terms of important themes and conflicts and how the child manages emotional material."

Some measures of personality can be particularly difficult for parents to hear. The Sentence Completion Test and the Kinetic Family Drawing are two tests that have the potential to make parents feel uncomfortable because the responses often relate to their relationship with their child. In describing the Sentence Completion Test, it is helpful for parents to know that the child's responses can provide insights into how the child views him/herself and others, as well as to identify important areas of preoccupation or conflict. It is not necessarily an accurate document of what is actually occurring in the child's life. For example, a child might respond to the sentence stem, "My father and I . . ." by saying, "never spend time together." If this response is shared with the parents, the parents may indicate that they spend quite a bit of time with their child and that they are baffled as to why their child perceives this differently. This is where they need to be reminded that this is not an accurate reflection of what is actually occurring, but may be an accurate reflection of how their child feels. The child may be feeling lonely, excluded, depressed, or needy, and the parents need to

understand that it is the *feeling* that is reflected in his response. Conversely, the child's response may be completely accurate and parents may become defensive or guilt-ridden. In either case, it is helpful to keep the focus on the child's inner experiences and world, reminding the parents that no parent is perfect and that the goal is not to blame, but to identify the problems and fix them. Similarly, the Kinetic Family Drawing can also make parents defensive. In fact, regardless of the picture, parents are frequently uncomfortable seeing their family "doing something together," particularly if it is obvious that the family does not appear to be engaged. This can be a springboard for discussing family issues that may be contributing to their child's problem.

Throughout the feedback session, it is important to repeat major concepts by summarizing the information initially, going back over it in detail, and summarizing it again. It is also important to stop periodically to allow parents to ask questions of you and for you to ask questions of them regarding their comprehension of the information (without making them feel as if they are being "put on the spot"). Paying attention to parents' nonverbal cues and emotions is key. Some parents may freely express their emotions, others may listen stoically to the information, and when there are two parents in the room there are often two different emotional styles that need to be validated. Blaming of one parent by another is all too frequent (i.e., "He's just like you" or "She's just as crazy as your mother"), and one way to diffuse this tension is to remind the parents of the differences between their child's experiences and the experiences of the similar relative. For example, sharing with them the fact that mental health services have changed considerably since they were children, or that positive prognosis is associated with early identification and treatment (something which Grandmother may not have had) reframes the issue to one of hope as opposed to one of helplessness.

There are a couple of specific instances where the feedback process can be particularly difficult. One of these occurs when one (or both) parents have significant mental health issues of their own. If the evaluator is aware of these issues, he or she should anticipate that such parents may be frustrating and may have trouble understanding what is being said, and thus the feedback session should be tailored to address not only the needs of the child, but also the parent(s). Another instance that can make for a difficult feedback process occurs when there is no clear diagnosis. This situation can result in feelings of anxieties in both parents and professionals, with the parents feeling there is no clear answer and professionals feeling they have not adequately done their job.

For example, Susan was an intelligent 15-year-old who had begun to exhibit symptoms of psychosis. She had a normal appearance, was still getting relatively good grades in school, and was exhibiting adequate memory skills. In contrast, she admitted hearing voices, became obsessive about certain topics, and had begun to make comments within conversations that had no relevance to the topic being discussed. She had also made a recent suicide attempt. In reviewing the test results, the parents understandably preferred to focus on the fact that she was bright and that, although her grades were not as strong as they had been in the past, she was able to complete much of her homework and still seemed "like their little girl." Unfortunately, the examiner could not offer a succinct diagnosis, as it was unclear whether the behaviors were a sign of an emerging thought disorder, a psychotic depression, or an OCD with psychotic features. Susan's areas of "normal" ability had the potential of giving her parents false hope, and it was difficult for the evaluator to contradict their views, because no clear reason for the behaviors could be determined from the test data. In this situation, it was important to help the parents understand that Susan's behaviors were not mutually contradictory; that is, she had areas of functioning that did appear developmentally appropriate and others that were outside the realm of appropriate behaviors, and that both could describe

Susan at different times. Although this uneven pattern of abilities can be confusing to parents, keeping the focus on "where to go from here" can be most helpful.

In certain situations, a lack of a clear diagnosis can be a sign of a child who is idiosyncratic, who "marches to his or her own drummer." These children may not meet criteria for any psychological disorder, but may be struggling because they see the world in a different way. These individual differences may result in a child with significant difficulties in the elementary school years, but these children often come into their own later in life with support and understanding. Indeed, many of the most valuable contributors to society have been exceptional people who would not appear "ordinary" on childhood measures of personality. In this case, it is important to highlight the positive aspects these traits may have for the child's future, while validating the difficulties they may currently present for the child and providing guidance to the parents in how best to support their child in his or her development.

Regardless of whether there is a clear diagnosis, the end of the feedback meeting should not leave parents feeling helpless. Although the feedback session should be thought of as a therapeutic intervention, it is not the type of intervention where issues should be left "hanging" (as they frequently are in the therapeutic process). In other words, it is important to have a feeling of closure at the end of the session. The examiner should leave adequate time for discussing the steps that are needed to modify the course of the child's behavior and a plan for following through with these steps. Making appropriate referrals is important, and it is helpful for the evaluator to give the parents names of clinicians who are available to see them, and/or their child. Inevitably, parents will have questions after the session is completed, and there should be a plan for how their questions can be answered, such as letting parents know that the examiner is available to talk by phone, giving them the option of a follow-up visit in a few months' time, or advising them to ask questions of their treatment team (if they are qualified to answer them). Following up the session with a report of the findings is also key and allows parents the opportunity to grasp the details of the findings more specifically.

THE PERSONALITY ASSESSMENT REPORT

Much has been written about what constitutes a good psychological report (e.g., Sattler, 2001), yet there is little empirical evidence on whether these qualities actually benefit consumers. Reports are frequently difficult to comprehend (Weddig, 1984), but reports that provide detailed descriptions of the child's strengths and weaknesses, as well as detailed recommendations, are more easily comprehended by parents than shorter reports that present conclusions and brief recommendations (Weiner, 1987; Weiner & Kohler, 1986). Sattler (2001) indicated that the purposes of the psychological report include providing accurate assessment information to the referral source and parents, serving as a source of clinical hypotheses and appropriate interventions, furnishing baseline information, and serving as a legal document.

There are two schools of thought regarding the timing of receiving the report, with some favoring providing the report to parents before the feedback session and others favoring sending the report after the feedback session has occurred. Still other professionals will provide parents with a copy of the report at the feedback conference. There are no data on when it is best for parents to receive this information, and in clinical practice any of the above options

can be helpful, depending upon the case, the parents' needs, and the findings. When the findings indicate significant and/or unexpected difficulties, it is often best to meet before the report is presented to the parents, as there are data indicating that parents prefer to hear "bad" news about their child in person (Garwick, Patterson, Bennett, & Blum, 1995). Some parents are quite insistent on receiving the report first, in that they want time to digest the report and generate questions before the meeting. In this situation, the examiner needs to rely on his or her clinical judgment about what might be in the parents' best interest. There are many cases in which it is totally appropriate for parents to receive the report before the feedback conference, but in cases where the examiner expects the results to be quite disturbing, it might be best to offer the parents two feedback sessions—one that occurs before the parents receive the report and another after they have had time to review the report after receiving it in the mail.

Regardless of when the report is shared with the parents, there are a number of goals that should be addressed in the Personality Assessment Report. First, and most important, *the report should answer the referral question(s).* When personality is being assessed, there is the temptation for the examiner to discuss aspects of the child's character or family dynamics (among other things) that are not pertinent to the referral questions. Because the report is frequently shared with the school, there is the possibility that the report will be read by people (i.e., teacher aides, teachers, and office support staff) who are not bound by the same ethical and confidentiality guidelines that are followed by psychologists. In addition, the people who may have access to the report frequently live in the community with the family, and it can be embarrassing for them to know certain types of information about a parent or child. In contrast, information from the evaluation may have to be shared with the child's therapist (for whom specific, personal information is important for treatment) and the school. In this case, it is best to have two versions of the report—one for the therapist and one for the school—or to have one version of the report that includes only necessary information, but includes additional information in an accompanying letter to the therapist. For example, Don was a 13-year-old who was exhibiting truant behavior and whose test results indicated an undiagnosed ADHD that predisposed him to impulsive acts. This information was helpful for the school to hear. However, the evaluation also indicated that Don had a number of sexual fantasies (and sexualized behavior) that the truant behavior only symbolized. Whereas it would be important for Don's therapist to know about these fantasies, it is not necessary for Don's teachers to know about these issues, and, thus, that information does not need to be shared with the school. In fact, it is rarely helpful for information about sex, drug/alcohol use, or personal family issues to be shared with the school, unless the issues are directly related to the referral question.

In terms of what should be included in the report's contents, the personality assessment report should do more than just discuss the referral question—it should provide an analysis of the intra- and interpersonal issues that cause, support, or maintain the child's behaviors and affect. At a minimum, the report should include: (1) a report heading and identifying information (child's name, date of birth, date of evaluation, age at testing, parents names, etc.); (2) the reason for referral; (3) background information; (4) a listing of the tests administered; (5) behavioral observations; (6) test results and interpretation of the results; and (7) a summary and recommendations. The most important goal of the report may be to assist in effecting change in the child's environment—in other words, to assist those working with the child in understanding the child's problems and needs, and for identifying what can to be done to address those needs.

CASE STUDY: KYLE

Kyle was a 14-year-old boy who had exhibited significant emotional, behavioral, and academic concerns since the age of 10. He attended a therapeutic school, which had been helpful to some extent, but he had recently begun to exhibit escalated oppositionality, aggression, and truancy, such as using his mother's credit card, stealing $200 from a neighbor's purse, and threatening his brother with a knife. At school, he was noted to have significant social skill difficulties, such as making rude, sexualized, and/or grandiose statements. His thinking frequently appeared be tangential, and at times he acted like an "Anime" (e.g., cartoon) character. All of these concerns were noted to interfere with his ability to make friends.

Kyle was adopted at birth, but his adoptive parents divorced when he was in first grade. Kyle had been diagnosed with ADHD and was taking Concerta. He had been treated with antipsychotics, because there was question of a formal thought disorder, but with little positive effects. Because of his poor response to antipsychotics, Kyle's psychiatrist wanted more information about whether Kyle did meet criteria for a thought disorder before attempting other psychopharmacological interventions.

Kyle presented as a small, physically immature boy whose level of cooperation varied throughout the testing. His affect and behavior were consistent with severe emotional disturbance and included extreme impulsivity, rapid and intense shifts in mood, significant anxiety, periodically talking like a cartoon character when angered or stressed, easily entering graphic violent and sexualized fantasy, fluid thinking, loose associations, delusional ideation, suicidal and homicidal ideation including a plan, and sexualized comments and gestures.

Results of tests of intellectual functioning indicated a WISC-IV Verbal Comprehension Index of 92, a Perceptual Organization Index of 123, a Processing Speed Index of 84, and a Full Scale IQ of 104. Tests of academic functioning indicated reading skills at current grade level, but significantly weak mathematical calculation and writing skills. Kyle's language skills indicated he had difficulty organizing his ideas in verbal and written formats, but it was difficult to determine whether this was a function of true expressive language problems or a result of his thought disorder with highly associative thinking. Tests of executive function skills indicated significant problems with effective organization of visual and auditory material, variable sustained auditory attention, and poor impulse control. Results from the measures of emotional and personality functioning were consistent with a thought disorder characterized by loose associations, delusional and fluid thinking, rapid shifts from reality to fantasy especially when stressed, and poor affect modulation.

Both of Kyle's parents arrived for the feedback session, although it was clear that they did not enjoy being in each other's presence. Kyle's father had the attitude that "there is nothing wrong with Kyle other than his mother babies him." In contrast, Kyle's mother was extremely anxious, fearing that Kyle would never lead a normal life. In presenting the results, I briefly reviewed the tests of cognitive and academic functioning. These were not a surprise to Kyle's parents, as they knew he was an intelligent child who frequently struggled with writing and organizational issues. I felt it was important to review Kyle's intellectual resources before telling his parents that he did meet criteria for a Psychotic Disorder, NOS. This was not a surprise for Kyle's mother to hear, but his father understandably had difficulty comprehending this information. He benefited from some brief information about what psychosis entails, remarking, "Does this mean he's schizophrenic?" Because the test results did indicate that Kyle is indeed at risk for schizophrenia, particularly paranoid, I felt it necessary to address this issue directly, by saying that he did not yet appear to meet criteria for schizophrenia, but that the possibility exists that he might in the future, and that Kyle would

need to be closely monitored for further symptoms. This had a sobering effect on Kyle's father, who was then more willing to hear about the results.

In describing the test results, I felt the most important information that Kyle's parents needed to understand involved his significant risk for harming others, including himself. In reviewing the test data, I was able to provide parents with some specific details about Kyle's inner world. For example, there were numerous instances in which Kyle alluded to highly sexual fantasies. His responses on the Rorschach, TAT, and Incomplete Sentences indicated he tended to dehumanize people, and this tendency was quite alarming, given his propensity toward violence, poor impulse control, unmodulated anger/rage, and tendency to become even more disorganized in his thinking/judgment. Consistent with failing to recognize others as "real" and not just as objects of gratification or disposal, Kyle was found to lack empathy and to take pleasure in other people's misfortune. In addition to highly sexualized fantasies, Kyle also shared highly detailed plans for murdering various family members, most notably his birth parents, who he said, "had no right to abandon me!" This was quite difficult for his parents to comprehend, and it was important for them to see these fantasies as a component of Kyle's thought disorder. It was also important for them to see these fantasies in the context of an adolescent whose neuropsychological functioning indicates he has difficulty inhibiting his behavior and organizing his world, which increases the risk that he might act on these fantasies.

What made this particular feedback session quite difficult was that his parents could not "lean" on each other for support. There were unspoken regrets about having adopted a child who so clearly did not meet their expectations and a tendency to blame both themselves and each other for Kyle's problems. Despite these issues, it was also clear that Kyle's parents wanted things to be better, and this was the area in which it was possible for them to find common ground. Once the results were shared and it was clear they had some understanding, the remainder of the session focused almost exclusively on helping them realize that they did share a common perspective and that the evaluation could be used to help them determine what would best meet Kyle's needs. It was clear that Kyle needed a therapeutic school placement that included after-school and/or residential services as needed. Kyle's parents clearly saw the need for continued psychopharmacological interventions and were open to seeking parental counseling, in order to promote consistency between the approaches used during the school day and at their homes. The session ended by reiterating Kyle's strengths and by giving the parents hope that structure, consistency, and therapeutic interventions could promote a sense of safety in Kyle that in turn would facilitate psychological, social, and academic growth.

SUMMARY

Although there are few empirical data on how to best share personality assessment results with parents, results from studies that have examined effective communication between pediatric clinicians and parents, as well as clinical experience, indicate that there are some general guidelines that should be considered:

1. Parents should be informed of the results in the context of a clinician-patient relationship that is built on a sense of trust and support and a genuine sense of caring.
2. There are no clear guidelines as to whether it is most important for parents to receive the written report before or after the feedback session, and, thus, clinicians should

rely on their clinical judgment in deciding what would be most helpful for a particular family.

3. In a two-parent family, it is ideal to have both parents present for the feedback session. In one-parent households, the parents should be invited to have a supportive adult present if they so choose.
4. Results should be shared with parents as soon as possible.
5. Before the feedback session, the professional should identify the most important information that needs to be conveyed. This information should be conveyed early in the session in a manner that is brief, sensitive, and direct. Once this information is given, the examiner should check in with the parents to determine whether they understand what has been said, whether it fits with their understanding of their child, and whether they have any initial questions. Attention to the parents' cognitive and emotional reactions is important in determining where to go next.
6. The results should acknowledge the child's strengths and positive personal characteristics, as well as limitations, and simple, direct language with as little psychological jargon as possible.
7. The professional should be empathic and supportive of the parents' emotional reactions, which can include anger, defensiveness, sadness, or a lack of outward emotions. All of these can be a normal part of the process. Inviting affect into the process by asking parents questions such as "How does it feel to hear this information?" can let parents know that discussing feelings can be part of the process. Conversely, it is also important to keep the focus of the session on the child. In other words, affect should be validated, but the focus should not be on the parents' affect, but on giving the parents an opportunity to express their feelings in the hope that this will allow them to better understand and cope with their child's issues.
8. Answer questions directly and do not be afraid to say "I don't know" when there is no clear answer (e.g., "Will my child always be like this?").
9. Parents should be informed of the findings in their own language and should be able to ask questions in their own language. The clinician should attempt to understand the family's cultural views about diagnosis and treatment.
10. Conclude the session with a discussion of plans for the future and recommendations. Make arrangements for further therapeutic and educational services.

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