The Dissertation Committee for May Fraser Matson certifies that this is the approved version of the following dissertation:

Parent Experience of Traditional versus Collaborative Child Assessment

Committee:

Deborah Tharinger, Supervisor

Stephanie Cawthon

Edmund Emmer

Stephen Finn

Alissa Sherry

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by

May Fraser Matson, B.A., M.A.

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Parent Experience of Traditional versus Collaborative Child Assessment

May Fraser Matson, Ph.D.

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Supervisor: Deborah Tharinger

Collaborative child assessment combines traditional assessment methods with techniques aimed at increasing the therapeutic benefit of assessment for children and parents. Previous studies have found high consumer satisfaction, increased self esteem, decreased symptomatic distress, and greater hopefulness following participation in collaborative assessment. However, full collaborative assessment protocols are complex, time-consuming, and thus not practical to use in many applied settings. This study investigated the practicality and potential benefits of implementing several collaborative techniques into otherwise traditional child assessments, including co-generation of assessment questions, use of a process orientation during child testing, and use of an individualized, level-based approach when providing feedback. It was hypothesized that, compared to parents participating in traditional assessments, parents participating in collaborative assessments would report greater satisfaction, greater collaboration, learning more about their child, stronger alliance with the assessor, more positive feelings

about the assessment process, and more hopefulness about their child's challenges and future. Univariate analysis of variance statistics were used to test these hypotheses, which were not statistically supported, in part due to the limited sample size obtained. However, group differences of small to moderate effect sizes were seen for most of the outcome variables, including parent-reported learning about their child, assessor-parent relationship, assessor-child relationship, collaboration, negative feelings about the assessment, general satisfaction, and negative emotions about their child's future. The results suggest that further research in this area is warranted. Limitations of the study and suggestions for future research are discussed.

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CHAPTER I

Introduction

Psychological assessment is widely used with children and adolescents for diagnostic and treatment planning purposes. In fact, millions of children and adolescents are assessed each year, primarily in school settings (Kamphaus, Petoskey, & Rowe, 2000). At its best, assessment has the potential to provide consumers with useful, individualized information and recommendations that can lead to effective interventions and positive changes in children's lives (Brenner, 2003; J. Cohen, 1997). However, assessments often do not live up to their full potential due to the way in which they are implemented (J. Cohen, 1997). Involving parents in the assessment process, focusing on specific referral concerns, and providing clear, understandable feedback and recommendations are all aspects of the best practices of child assessment (King, 1997), but these features are sometimes neglected in actual clinical practice (Brenner, 2003). In addition, therapeutic and collaborative models of assessment (e.g., Finn, 2007; Fischer, 1985/1994) have been developed based on the premise that assessment in and of itself has the potential to be a change-producing experience for clients. These models provide even greater opportunities for assessment to benefit clients. Because assessment is both time-consuming and expensive, it behooves psychologists to help clients get the most they can out of assessment experiences, and any methods for doing so are deserving of further study.

Therapeutic and collaborative assessment models have been developed in response to the shortcomings of traditional assessment, and in order to take advantage of the opportunities for positive client change that assessment presents, but that are seldom realized. Therapeutic and collaborative assessments are essentially brief interventions centered around psychological assessment methods. Whereas traditional assessment is designed to gather information to be used for placement decisions and treatment planning, therapeutic and collaborative assessment additionally aim to change clients' understandings of themselves and of the problems that led them to seek treatment (Finn & Tonsager, 1997). They do this by collaboratively involving the client in the assessment process, and creating a meaningful and empathic interpersonal relationship between client and assessor. When a child participates in a therapeutic assessment, the goal is to help the whole family system understand the child and the system in new ways (Finn & Tonsager, 2002). After a successful therapeutic assessment, children and their families should see themselves more accurately, but also more adaptively. It is hoped that parents come to view their children's problems as more systemically influenced, more situational, and more changeable than they did previously, and that they will have acquired concrete ideas about how to address these problems.

Research on the use of Therapeutic Assessment with adults has shown many benefits of this method over traditional assessment, including decreased symptomatic distress, increased self-esteem, and greater hopefulness (Finn & Tonsager, 1992; Newman & Greenway, 1997), as well as stronger therapeutic alliance and decreased likelihood of discontinuing treatment prematurely (Ackerman, Hilsenroth, Baity, &

Blagys, 2000). Research on Therapeutic Assessment with children has shown high treatment acceptability, significantly decreased child symptomatology, and enhanced family functioning as reported by children and mothers, as well as more positive and hopeful maternal affect when thinking about their children's challenges and future (Tharinger et al., 2009). These studies suggest that when collaborative and therapeutic methods are used, assessment holds great potential to produce therapeutic change in children and their caregivers. While the assessment protocols utilized in these studies are relatively complex and time-consuming, and thus may not be realistic to use in many applied practice and educational settings, it is likely that incorporating select collaborative techniques into standard assessments would also benefit clients.

In addition, the inclusion of collaborative intervention components in standard assessment has the potential to decrease the need for further interventions, and/or to increase the efficiency and success of recommendations for subsequent intervention. Establishing a collaborative relationship with parents, eliciting and responding to their reactions to assessment findings, and getting their ideas about what should be done to help their child can provide the assessor with practical information about what types of interventions might be most successful with and acceptable to each particular set of parents.

Although much has been written about collaborative and therapeutic assessment practices, and about effective methods for providing feedback to parents, most clinicians have not received training in this area. Thus, this study investigated the feasibility and utility of training assessors who use a traditional model of child and adolescent

assessment to incorporate more collaborative techniques into their practice. Specifically, this study investigated whether assessments that included collaborative methods resulted in greater parent satisfaction, more parental learning about their child, and more favorable parental emotions regarding the child's problems. The study also investigated whether parents perceived their relationships with assessors using these methods to be more positive and collaborative, and whether they perceived the assessor's relationship with their child more positively as well.

CHAPTER II

Literature Review

Overview

This chapter will review the general literature on child and adolescent assessment, as well as specific therapeutic and collaborative approaches to assessment. The stages of the assessment process will be examined at length, detailing both traditional practice and the therapeutic and collaborative methods than can be employed at each stage. Several areas in which collaborative assessment may be provide additional benefits over traditional assessment are then reviewed: the benefits of receiving feedback and learning new things, parent satisfaction, compliance with recommendations, and parental advocacy.

Psychological Assessment of Children and Adolescents

Psychological assessment has a long history (Kamphaus, 2001) and is used for both diagnostic and treatment planning purposes with clients of all ages. Psychological assessment of children is often undertaken to address behavioral, academic, or emotional concerns, assist in school placement decisions, or determine the need for psychosocial interventions. A comprehensive child or adolescent assessment typically involves interviewing the client, parents, and possibly teachers, reviewing the referral information and relevant records, testing the client with norm-referenced cognitive and social-emotional tests, interpreting the data and creating recommendations for intervention,

providing feedback to the client, parents, and referral sources, and preparing a written report (McConaughy & Ritter, 2002).

In child assessments, parents and other adults who know the child well, such as teachers, are considered vital sources of information, particularly if the child is young (Johnston & Murray, 2003). A survey of practicing child and adolescent psychologists (Palmiter, 2004) found that the majority reported using family interviews and parent and teacher rating scales in their evaluations. Other recent studies also attest to the growing use of child behavior rating scales to obtain information from parents and teachers (Cashel, 2002; Kamphaus et al., 2000).

Shortcomings of Traditional Assessment

Although traditional psychological assessment of children has many potential benefits, the way in which it is typically practiced "profoundly undermines the usefulness of this potentially powerful diagnostic and therapeutic intervention" (J. Cohen, 1997, p. 254). Assessments are often conducted quickly, without taking time to gather and integrate the perspectives of multiple individuals including the child, parent, and teachers. Information from multiple informants is important if the assessor is to make sense of the meaning of test data, which often is not definitive by itself (J. Cohen, 1997).

If parents and children are not encouraged and given time to formulate the questions they hope that the assessment might answer, the assessment's scope will be limited. Furthermore, if they are not helped to understand beforehand that testing can never provide all the answers, the disappointment when this is realized after the fact can

limit the extent to which clients and parents accept and use the findings that do emerge (J. Cohen, 1997).

Writing from a consumer-focused perspective, Brenner (2003) suggests several ways to increase the relevance and usefulness of psychological assessments to their primary consumers, which may include parents, children, physicians, or other mental health professionals. Brenner suggests that the elimination of jargon, a focus on referral questions, individualization of written assessment reports, emphasis on clients' strengths, provision of concrete recommendations, and collaboration with consumers during the referral process and when providing feedback have the potential to make assessments more valuable to consumers.

Collaborative and therapeutic models of assessment

In many ways, collaborative models of assessment are a response to the limitations and shortfalls of the standard practice of psychological assessment. These approaches aim to help clients directly and provide transformative experiences during the assessment phase itself, rather than waiting until testing is complete to indirectly help clients by drawing up treatment recommendations (Finn, 2007). A number of different therapeutic and collaborative models, methods, and techniques have been developed by different practitioners. Although all share the goals of helping clients have a positive experience of the assessment and experience positive change (Finn, 2007), and many techniques overlap, there are some important differences between the approaches as well. Below, two models are reviewed: Fischer's model of collaborative, individualized assessment, and Finn's semi-structured Therapeutic Assessment protocol.

Fischer's model of collaborative assessment. Collaborative assessment embraces the belief that clients and their families are the experts on their own lives, and bring that knowledge to the assessment process, while assessors are simply the experts on psychology and on the assessment instruments (Fischer, 2000). Thus, clients and assessors must work together, drawing on their different areas of expertise, in order to fully understand the client's challenges and develop ideas about the kinds of intervention needed. The goal of Fischer's model is to describe the client as an individual – his or her "particular situation" and "life comportment" – and to provide individualized recommendations that have already been tested to some extent during the assessment process (Fischer, 1985/1994). In this model, test scores, rather than reflecting an absolute truth, are viewed as tools that may help illuminate the client's life and challenges; the client's life experiences themselves are regarded as the primary data (Fischer, 2000). The value of tests lies not necessarily in their normative data or resulting scores, but in their ability to produce experiences that bear similarities to situations the client faces in everyday life. For this reason, in some cases the assessor may use tests in idiographic ways or deviate from standardized procedures when opportunities arise to explore the client's experiences in greater depth. Tests are tools that are "used" by the assessor and client as they work together to learn about the client's situation; they are not simply "administered to" the client (Fischer, 1985/1994). Collaborative dialogue between the client and assessor is essential to understanding how test findings and experiential information fit together. Reports are written in very accessible language, in the first person, and include detailed narrative descriptions of the client's behavior and the

assessor's impressions of the client. Fischer discusses with the client what will be included in the report, and notes in the report itself any disagreements between herself and the client about the information presented. She also invites clients to write annotations on the actual copies of reports that will be sent to other professionals, expressing their evaluation of and reactions to what she has written (Fischer, 1985/1994).

Six guiding principles for collaborative, individualized assessment are that it should be *descriptive, contextual, collaborative, interventional, structural,* and *circumspect* (Fischer, 1985/1994). It should be *descriptive* in that life events and comportment are the primary data, and descriptions of the client's actions form the basis for the report. It should be *contextual* in that descriptions always include the context in which the behavior happened: the physical setting, the sequencing within a series of events, the assessor's behavior in interacting with the client, and the personal meaning of the situation to the client. It should be *collaborative* in that the client is involved as a "co-assessor" and active participant. It should be *interventional* in that different possible ways of acting or responding should be tried out by the client during the testing itself. It should be *structural* in describing what the client does, how he or she does it, and when he or she does it, but not focusing on why. And it should be *circumspect* in that the assessor should be mindful of the limitations and ambiguity in the assessment, and aware that a complete, authoritative, and unchanging perspective on the client can never be achieved (Fischer, 1985/1994).

Therapeutic Assessment (TA). Therapeutic Assessment (TA), a form of collaborative assessment developed by Finn (1996), is a brief, semi-structured therapeutic

intervention centered around psychological testing. It is based on the premise that psychological assessment, when practiced in a certain way, can produce benefits beyond its typical information-gathering purposes, and can serve as a kind of short-term intervention in and of itself (Finn & Tonsager, 1997). In contrast to traditional assessment, which focuses on collecting accurate information about the client that can be used to make placement or treatment decisions, the goal of TA is not only to collect accurate test data, but to use that data to help the client (or child client and parents) learn new ways of understanding and addressing the client's current challenges in living (Finn & Tonsager, 1997). Although there are general principles that guide TA, there are also variations as they apply to assessment with adults, couples, adolescents and children.

A child TA, as described by Tharinger, Finn, Wilkinson, and Schaber (2007) and Finn (2007), typically involves 8-10 sessions, usually over a 6 to 12 week time period. In the initial session, the assessor meets with the child's parents to explain the process, gather background information, and explore and formulate questions that the parents would like the assessment to answer. Subsequently, in the following session, the assessor and parents together introduce the assessment process to the child, who is also invited to pose questions. The assessor and child then begin the testing, often with the parents present in some form to observe all or most of the testing sessions. Rather than using a standard battery of tests, the assessor selects the tests that are most likely to provide informative data to address the child and parents' questions, including psychoeducational, social, emotional, behavioral, personality, and neuropsychological instruments as appropriate. The bulk of the sessions consist of standardized assessment of the child

using these instruments. Following standardized administration, extended discussion with the child or the use of "extended inquiry" techniques help the assessor better understand the child's responses and experience of the testing. For example, the child may be asked to make up a story about one of his or her Rorschach responses (Tharinger et al., 2007). Free play and "playful" techniques such as human figure drawings (Tharinger & Roberts, in press) are also incorporated into the testing sessions.

Parents also complete ratings of their child's behavior, as do teachers or other professionals when their perspectives may be relevant to the parents' questions. If the parents have asked questions about how they or their parenting practices might affect the child's challenges, they are invited to complete personality tests themselves in order to help answer these questions.

A major feature of child TA is that parents observe the testing sessions, either with a second clinician (when available) who engages the parents in conversation about what they are seeing, or by themselves, with a discussion with the assessor following the session. Depending on available facilities, the physical set-up for these observations can range from seating the parents in a corner of the office, to using a one-way mirror or a video feed to an adjoining room. The parents' ongoing observations and discussions allow them to watch the testing process unfold and to learn, alongside the assessor(s), what the assessment has to teach them about their child. Observations allow the assessor(s) to orient the parents to responses or behaviors that are particularly illuminating with respect to their assessment questions, or that are surprising or at odds with how the parents have typically viewed their child. This arrangement also provides

opportunities for the assessor(s) to gather additional relevant information from the parents about the child and family, to gauge the parents' reaction to potentially new or surprising information, and to develop a strong alliance with the parents that facilitates therapeutic changes in the way they view their child. Inviting parents to observe the assessment may also serve as a way to help parents understand just what an assessment involves and what the assessor does with their child (Giannoulis, Beresford, Davis, Baird, & Sclare, 2004).

Typically, the latter part of the TA also includes a family intervention session during which the parents and child engage in a structured activity such as playing a game together, completing a family assessment procedure, or role-playing (Tharinger, Finn, Austin, et al., 2008). This allows the assessor to observe family interactions and develop hypotheses about ways in which these may contribute to the child's challenges. The assessor may also structure this session to demonstrate some aspect of the assessment findings to the parents. Observations of child testing and participation in the family intervention session help parents "follow along" as the information the assessor is gathering unfolds. All of these experiences prepare the parents for the answers to their assessment questions that the assessor will eventually propose; it is hoped that as witnesses to and participants in the assessment, the parents will have some understanding of how the assessor arrives at these answers and conclusions.

Feedback is provided in a summary and discussion session, during which parents are invited to share their perspective on the assessor's suggested answers to their questions and to suggest any modifications to the findings (Tharinger, Finn, Hersh, et al.,

2008). When preparing for feedback, great consideration is given to the parents' anticipated reaction to the findings, and their readiness to hear certain feedback. Finn (2007) suggests organizing assessment findings into three "levels" based on clients' probable reactions. Level 1 feedback, which is presented first, should contain findings that parents "already know" and that are consistent with how they currently think of their child. Level 2 feedback, presented next, should contain information that is mildly discrepant from how parents currently think of their child, but which they will be able to understand and assimilate relatively easily. Level 3 feedback, which is presented toward the end of the session or sometimes not at all, consists of findings that are so different from parents' usual thinking that they are likely to disagree with and be unable to assimilate the information. Finn (2007) suggests that offering feedback in this order helps parents gradually take in new information about their child. Following the completion of the assessment, written feedback is usually provided in a letter sent to parents that is organized around their assessment questions, rather than (or sometimes in addition to) a traditionally-formatted psychological report. The letter is typically written in easy-to-understand language, provides many concrete examples, and incorporates parents' comments or reactions from the summary discussion session (Tharinger, Finn, Hersh, et al., 2008).

Finally, findings are also shared with the child in an age-appropriate way, which often involves presenting an individualized "fable" to metaphorically provide assessment feedback (Tharinger, Finn, Wilkinson, et al., 2008). This technique is used in order to avoid overwhelming children with direct feedback, while still allowing them to feel

understood by the assessor and providing a sense of hope for the future. The fable typically presents a metaphorical representation of the child (often as an animal or fantasy character), his or her challenges, the assessment process, and positive changes that are facilitated by the parents' new understandings of the child. While the fable is intended primarily for the child, the parents often benefit from the hopeful new metaphor as well (Tharinger, Finn, Wilkinson, et al., 2008). In other cases, direct feedback may be provided to children, especially if they posed their own assessment questions at the beginning of the process. In this situation, feedback would be organized as answers to the child's questions, similar to the way feedback to parents is organized.

Research on collaborative and therapeutic assessment. A number of case studies attest to the success of collaborative and therapeutic assessment methods with adults (Finn, 1994, 1998, 2003; Michel, 2002). Additionally, controlled studies of TA with adults have found positive effects including decreased symptomatic distress, increased self-esteem, and greater hopefulness (Finn & Tonsager, 1992; Newman & Greenway, 1997). A study comparing traditional and therapeutic assessment also found that adults who received a therapeutic assessment felt a stronger alliance with their assessor and were less likely to terminate follow-up treatment against medical advice than those who received a traditional assessment (Ackerman et al., 2000). Furthermore, a meta-analysis of 17 studies of psychological assessment as a therapeutic intervention (broadly defined) found a significant overall effect size of d=0.423 (classified as a medium effect size), supporting the effectiveness of such interventions (Poston & Hanson, 2010). Although no controlled comparison studies of collaborative assessment or TA with children have

been published to date, a current research project at the University of Texas led by Drs. Tharinger and Finn, the Therapeutic Assessment Project (TAP), is investigating the efficacy of TA with children. Results from 14 child TA cases indicate high treatment acceptability, significantly decreased child symptomatology, and enhanced family functioning as reported by children and mothers. In addition, mothers reported a significant increase in positive emotion and a significant decrease in negative emotion pertaining to their children's challenges and future (Tharinger et al., 2009). Another study, using a replicated single-case time series design to investigate the use of TA with three preadolescent boys diagnosed with ODD, found an improvement in symptoms during and after participation in TA (Smith, Handler, & Nash, 2010). Thus, although more research is needed, the findings support that TA is likely an efficacious child and family intervention. Additionally, several case descriptions attest to the clinical effectiveness of using therapeutic and collaborative assessment procedures with children and families (Guerrero, Lipkind, & Rosenberg, 2011; Hamilton et al., 2009; Handler, 2007; Quirk, Strosahl, Kreilkamp, & Erdberg, 1995; Purves, 2002; Smith, Wolf, Handler, & Nash, 2009; Tharinger et al., 2007).

However, TA also has a significant limitation: its cost in both time and resources. A typical child TA may involve 15 hours of direct work with clients, in addition to the extensive effort required to plan family interventions, write feedback letters, and create fables. It is time-intensive for parents as well, who are asked to attend and observe the child's testing sessions and the family intervention. These factors limit the circumstances in which using the full TA model is a realistic, affordable choice when a child is referred

for assessment. However, while some features of TA such as parent observation of the testing sessions, the use of family sessions, and individualized child feedback in the form of fables may remain "luxuries," other features can easily be integrated into more traditional assessments and extra time kept to a minimum. Below, the general process of conducting a traditional child or adolescent assessment is described. Specific therapeutic and collaborative techniques that can be integrated into each phase are highlighted.

The Assessment Process

Referrals and assessment questions. Psychological assessment is usually undertaken for diagnostic or treatment planning purposes, and referrals may come from many different sources. Many children and adolescents receive assessments due to school or teacher concerns about academic functioning or behavior. In other cases, the child's physician, psychiatrist, or therapist may seek an assessment in order to clarify treatment considerations. Parents may also request an assessment when they observe that their child is having difficulties in some important area. Although the referring party typically has some particular concern in mind, the requests that assessors receive may be very broad and ill-defined, such a request for "a complete assessment" or "assessment of personality functioning" (Lubin, Larsen, Matarazzo, & Seever, 1986). More specific referrals might ask about the presence or absence of particular symptoms, or the severity of an impairment (Sweeney, Clarkin, & Fitzgibbon, 1987). However, even these questions fail to optimally communicate what it is that the referral source hopes to gain from having this information.

L. J. Cohen (1980) suggests that when psychiatrists refer clients for evaluation, there are often latent concerns that underlie the manifest referral questions. Referrals are often made when professionals encounter difficult treatment problems with their clients, but usually are not phrased as questions about how to tackle the problems arising in treatment. Rather, they are phrased as requests for diagnostic information. Cohen suggests that in order for assessors to meaningfully address the latent referral concerns, they need to be able to elicit these concerns from the referring professional.

A similar situation may arise in the context of parental referrals for child or adolescent evaluations. Many parents wonder whether their child's difficulties warrant a specific diagnosis, but underlying this question is usually a concern about how best to address the actual difficulties. For instance, parents may seek an evaluation to learn whether or not their child has ADHD. Although the diagnostic concern is clear, there could be many possible behavioral, academic, or emotional concerns that would lead parents to suspect ADHD. While a diagnosis may be needed as a gateway to receive services, parents are usually most interested in specific recommendations (Tidwell & Wetter, 1978). This is particularly significant if the assessment finds that, in fact, the child does not meet diagnostic criteria for the suspected disorder. Simply learning that their child does not have ADHD and is not eligible for services is unlikely to resolve the concerns that led parents to seek assessment in the first place.

Therapeutic and collaborative approaches to referral questions. Parents' concerns and questions about their children can be better addressed if the assessor is able to elicit specific assessment questions at the beginning of the assessment process (Finn,

2007). Assessment questions are most useful when they are phrased in colloquial rather than technical language. There are a number of ways that assessors can help parents formulate assessment questions. Inquiring about the events or circumstances that led up to the referral will often lead to a more complete description of what it is that the parents are wondering about the child, and why. Asking parents what decisions they need to make about their child based on the assessment results further contextualizes the referral concern and provides information as to what parents are really hoping to learn (Fischer, 1985/1994). For instance, the parents who want to know if their child has ADHD may be wondering how to manage the child's oppositional behavior at home; they may be wondering whether the child would benefit from a different school environment; or they may be wondering why the child's academic performance has suddenly declined recently. Each of these concerns would call for a different kind of recommendation, and perhaps even a different battery of tests. Selecting tests based on clients' assessment questions is more efficient than administering a standard battery, increases diagnostic accuracy, and leads to more useful answers to the clients' concerns (Brenner, 2003).

An additional benefit of gathering specific assessment questions is that it provides an opportunity for assessors to learn parents' expectations of the assessment and to provide information to parents about what the assessment may or may not realistically be able to address. Gauging parents' expectations prior to the assessment is important in light of studies that have shown relatively low parent satisfaction with the degree to which assessments met their expectations for providing help (Bodin, Beetar, Yeates, Boyer, Colvin, & Mangeot, 2007). Well-formulated assessment questions can serve as a

"contract" of what parents can expect from the assessment. When given the opportunity to reflect on what they would like to learn about their child, parents may formulate questions about a broad range of topics including etiology, diagnosis, causes of specific behaviors, parent or family influences on the child's problem, how to help, prognosis, what the child thinks and feels, and triggers or contributing factors (Tharinger et al., 2009).

In addition to the above benefits, the content and phrasing of assessment questions may provide illuminating information about the parents' existing "story" about their child, the parent-child relationship, the parents' openness to certain kinds of feedback or recommendations, and the parents' fears and hopes for their child (Finn, 2007). This information can later be used to inform decision-making about how best to organize and frame feedback to parents about the assessment findings.

Initial meetings with parents. A clinical interview with the child's parents is often the first step in an assessment. This provides the opportunity to discuss referral concerns and the child's current difficulties and functioning, gather developmental history information, determine current levels of parent and family functioning, and obtain any relevant family medical and psychiatric history (King, 1997).

In collecting information about the child's current functioning, King (1997) recommends that the assessor first allow parents to tell their story in their own way, then follow up with specific questions regarding the frequency, intensity, duration, and settings of problems behaviors, as well as the typical responses of parents, teachers, and others. This allows the assessor to begin to develop hypotheses about the functions of the

behaviors. Information about the child's strengths should also be obtained during the parent interview.

Developmental history information should cover the domains of cognitive and school functioning, peer and family relationships, physical development and medical history, emotional development and temperament, conscience and values, interests and hobbies, any trauma history, and any prior mental health treatment history (King, 1997). The history of different family members' involvement with the child, and their functioning at various points in the child's life, should be obtained. Cultural, linguistic, socioeconomic, and religious context should also be explored (King, 1997).

Initial meetings in therapeutic and collaborative assessment. In addition to being an opportunity to gather background information, initial meetings also provide the opportunity to formulate referral questions, as discussed above, and to establish a collaborative and respectful relationship with parents. When using a collaborative/ therapeutic approach, the assessor should explicitly express to parents the intention that the assessment be a collaborative process, and the conviction that parents' input is essential to the success of the assessment. These assertions are then backed up by asking the parents to generate assessment questions, which gives them the opportunity to direct where the assessment will go, as well as by the general tenor of the session.

The assessor should be actively involved in helping parents generate useful assessment questions and understand the purpose of asking questions. It is sometimes difficult for parents to translate their concerns into questions, and many are surprised even to be asked what they would like to learn. While gathering background information,

the assessor should be alert to any implicit questions, confusions, or concerns in the parents' narrative, and ask if these are things they would like the assessment to focus on and be able to answer. When parents propose a diagnosis-focused question (e.g., "Does he have ADHD?"), clarifying what makes the parents worry about this may lead to more specific and useful assessment questions. When parents ask a question about etiology (e.g., "Is her depression genetic?"), it may be helpful to inquire what the parents would do differently or what decisions they would be able to make if they had the answer to that question. Making these underlying concerns explicit may help in formulating more productive questions. It is also important for the assessor to clarify what is meant by the terms parents use, as some parents may use terms in idiosyncratic ways that could lead to misunderstandings if not clarified (Fischer, 1985/1994). Conversely, the assessor should avoid using profession jargon, and should monitor parents' understanding of the assessors' explanations and modify the language used, if necessary.

Throughout this initial session, the assessor should develop and maintain a collaborative stance with the parents by adopting the terms they use, empowering them to make decisions about their child and the assessment, actively and empathically listening to their concerns, and encouraging the parents' questions and comments about the process.

The testing phase. Following the clinical interview with parents, the assessor begins the child testing by administering assessment instruments in standardized fashion. In traditional assessment, the assessor typically has little contact with parents during this phase. In interactions with the child, the assessor may adopt an interpersonally distant

manner in order to avoid influencing the child's responses and maintain the standardized assessment environment. Thus, in traditional assessment the assessor functions as a "technician" or observer during this phase (Finn & Tonsager, 1997).

Standard psychological assessment can be an uncomfortable and confusing process for children. Children may not have been told why they have been referred for assessment, what to expect, or for what purposes the results will be used. Furthermore, the standardized administration procedures for many tests inherently involve "failure experiences," as the assessor is required to continue administering each subtest until the child has answered a string of questions incorrectly, in order to establish a ceiling (Handler, 2007). The assessor generally cannot provide immediate feedback about the child's performance, and this as well as the assessor's often detached, impersonal stance may arouse anxiety for some children.

The testing phase in therapeutic and collaborative assessment. Although TA calls for parents to observe their child's testing, this procedure may not be feasible in most assessment settings and was not used in this study. Thus, this section will focus only on techniques employed with child clients themselves during the testing phase.

In collaborative and therapeutic assessment models, tests are approached as tools that can provide access to clients' typical real-world experiences (Fischer, 2000). Handler (1998) asserts that even seemingly objective, straightforward tests such as the Wechsler intelligence tests provide data far beyond what they purport to measure. By observing the child's response to the assessment situation, the assessor can develop a sense of the child's reactions to success and failure, reactions to interpersonal stress,

regulation of affect, thought processes, tendencies toward perfectionism, level of anxiety, and defensive and coping strategies (Handler, 1998).

Although it is essential to follow standard procedures so that tests can be properly scored and norm-referenced, the collaborative assessor is encouraged to ask about the client's experience of the test once standardized administration is complete (Finn, 2007). While this may not be appropriate in all cases, the assessor may also use a "testing of the limits" approach, following standardized administration of intelligence and achievement tests, to determine what assistance or modifications are needed for the child to succeed on items that were previously failed. For instance, the assessor may encourage the child to take guesses, walk the child through a problem-solving strategy, or provide small hints (Handler, 2007). Different types of "extended inquiry" may be used with other tests (Finn, 2007). For example, the child may be invited to make up a story about a character from a Rorschach or TAT response, or asked follow-up questions to contextualize responses to a self-report measure. These procedures can give greater depth and meaning to the understandings construed from test scores, and also provide opportunities for different, more supportive interpersonal interactions with the child.

Free play may also be incorporated into testing sessions with the child (Tharinger et al., 2007). While this does add to the total time the assessment requires, providing free play opportunities may be beneficial in several respects. The assessor's invitations to play may contribute to a positive child-assessor alliance, with the possible benefit of increasing the child's comfort during and cooperation with the testing. It is likely that the more comfortable and cooperative the child is, the more confident the assessor can be

that the child's performance is representative of his or her true abilities and typical behavior. Furthermore, observation of the content and style of the child's play may provide more information and hypotheses about the child's world.

Data interpretation and case conceptualization. Once tests have been administered and scored, the assessor must interpret the results and integrate them into a case conceptualization, diagnostic impressions, and treatment recommendations. Test data should be interpreted within the context of the child's developmental level, family resources and supports, cultural context, and additional strengths or vulnerabilities (King, 1997). The greatest emphasis should be placed on the most reliable observations and findings – those that are the most consistent across sources, instruments, and time (Knoff, 1986). By looking across the multiple sources of data that have been obtained, the assessor should identify the overriding "themes" of the assessment information and integrate these into a cohesive picture of the child (Tharinger, Finn, Hersh, et al., 2008).

Case conceptualization in therapeutic and collaborative assessment. In developing a case conceptualization, Fischer (as cited in Finn, 2007) recommends approaching the data from multiple theoretical perspectives and asking what a proponent of each perspective would have to say about the client. These perspectives may deepen the conceptualization, but can also be considered as different ways in which the results could be explained to the parents. Based on what the assessor knows and hypothesizes about the parents, they may be more or less likely to understand or accept certain theoretical perspectives.

Feedback to parents. Feedback to clients is currently considered an important part of psychological assessment. Historically, this has not always been the case. In general, psychological assessments have most often been requested by psychiatrists, therapists, physicians, or schools in order to accumulate more information about a client that will then be used in placement or treatment decisions. In this model, clinicians may consider the primary "consumer" of psychological assessment to be the referring professional, rather than the client and his or her family. Consistent with this, feedback is usually directed to the referring professional, often in the form of a written report, but may not be directed to the client, who is treated as the subject of the assessment but not necessarily as a consumer.

However, professional guidelines now specify that feedback to clients is an ethical responsibility of psychologists (American Psychological Association, 2002; National Association of School Psychologists, 2000). Furthermore, over the past several decades a number of authors have asserted that clients can benefit significantly from receiving assessment feedback (e.g., Berg, 1985; Pollak, 1988; Waiswol, 1995). Nevertheless, many practitioners do not place as much emphasis on feedback to clients as they do on other parts of the assessment process and, for a variety of reasons, may even be hesitant about or resistant to the idea of providing feedback to clients (Pollak, 1988). Because traditional assessment paradigms do not view feedback as a treatment mechanism, assessors may not know how to plan and organize feedback sessions in the most optimal ways.

Feedback in therapeutic and collaborative assessment. There is a body of literature both within and outside of the comprehensive therapeutic and collaborative assessment models that suggests ways in which feedback may be made more beneficial to the client. Therapeutic and collaborative approaches encourage attention to a number of factors when presenting feedback, including the influence of language, individualization of findings, collaboration and active client participation, and sequencing of findings within the feedback session. Below, each of these factors is examined in turn.

Language. Language is a key consideration in discussing assessment results with parents. In order to benefit from information provided during feedback, parents first must understand it. Thus, it is important that clinicians use colloquial rather than technical terms (Berg, 1985), and language appropriate the parents' educational attainment and level of familiarity with assessment practices (Pollak, 1988). Unfortunately, the difficulty of translating assessment results filled with psychological jargon into "everyday" language has been cited as one reason assessors may prefer to avoid giving feedback to their clients (Pope, 1992). When feedback is presented in a jargon-filled manner, some clients may not feel comfortable speaking up to ask for clarification due to the assessor's perceived "expert" status (Berg, 1985). Thus, it is especially important for the assessor to ensure that information is presented in clear terms, and to check with clients frequently throughout the session about their comprehension. Some authors suggest asking clients to paraphrase the findings in their own words (Hanson, Claiborn, & Kerr, 1997), which serves as a check on understanding and may help clients better process, remember and make meaning of the information.

Individualization based on client and parent factors. In addition to language and educational level, a number of other factors such as culture, expectations, and environment also influence how parents receive and make sense of assessment feedback. The clinician should strive to anticipate and take into consideration as many of these factors as possible. For instance, the clinician should consider what he or she knows about the parents' frames of reference, their characteristic defenses, and their cognitive styles when planning what to say and how to say it (Pollak, 1988). Additionally, the same objective information may carry different subjective meanings for different people. For instance, one set of parents may be happy to learn that their child has an average IQ, while another set of parents who have expected their child to excel intellectually may find the same information extremely disappointing (Pollak, 1988). The practical meaning of assessment data is also influenced by the demands of the client's environment, so the assessor should present findings within that context (Pollak, 1988). For instance, a child who attends a very competitive school may struggle even when testing reveals average-range IQ scores. The assessor should use impressions of the parents developed during the initial interview or any other contacts to anticipate their possible reactions to feedback and decide how best to frame the findings.

Collaboration and active client participation. Pollak emphasizes that parents should be explicitly encouraged to participate in the feedback discussion and should be given "coequal status" with the clinician (Pollak, 1988, p. 146). Collaboration should be encouraged throughout the discussion (Berg, 1985), and particularly when discussing recommendations (Pollak, 1988). For instance, Pollak suggests that before offering

recommendations, the clinician should pause to ask parents what they think would be helpful to the child, based on the data that has just been discussed. Some research suggests that individuals are particularly amenable to collaboration around issues that are significantly important to them, with persons with whom they have a close relationship, and when their mood state is more positive (Rudawsky, Lundgren, & Grasha, 1999). This suggests the importance of establishing good rapport and comfortable relationships with parents prior to the feedback session. Further, it aligns with recommendations (e.g., Pollak, 1988; Tharinger, Finn, Hersh, et al., in press) that the assessor share his or her positive reactions to or appreciations of the child early in the feedback meeting; this may help parents relax, establish a comfortable atmosphere, and induce positive parental emotions. Finn (2007) emphasizes checking in with parents frequently throughout the session to ascertain how they are taking in the findings. Discussion of the information and its real-life relevance should be promoted, and the assessor should encourage the parents to feel free to disagree with the assessor's conclusions. Just as in the initial parent interview, parents should be reminded that they are still the experts on their child and the ones who know their child the best. In many cases, parents may disagree with a finding and, when doing so, provide helpful new information that changes the assessor's conceptualization of the meaning of particular test results.

Sequencing. A number of authors have made recommendations about the order in which findings should be presented within the feedback session. Berg (1985) suggests first presenting information that the client already knows, then moving on to information that is more unknown to the client. Pollak (1988) suggests presenting information that is

anticipated to provoke the least parental anxiety first, then moving into information that is likely to be more anxiety provoking. In accordance with this, Pollak also suggests that findings be sequenced from most distal to most personal. For instance, the assessor might first discuss the child's relationships with teachers or peers, later move into discussion of the child's relationships with family members and the parents, and save discussion of more sensitive, personal issues such as the impact of the parents' marital relationship on the child until later in the session. A conceptual system of "feedback levels," which incorporates many of the above considerations, has been developed by Finn (2007) to assist in deciding how best to sequence feedback.

After interpreting the assessment data and drawing preliminary conclusions, Finn (2007) suggests sorting the findings into three levels, referred to simply as Level 1, Level 2, and Level 3. Level 1 findings are those that are highly consistent with how clients already think about themselves, and that they are likely to agree with and accept easily. Level 1 findings should not be surprising to clients. In feedback to parents, of course, the relevant consideration is the findings' consistency with how parents view their child, and how they view themselves in relation to their child.

Level 2 findings are those that are mildly discrepant from the clients' usual ways of thinking about themselves or their child. Level 2 findings may be reframes of how parents typically see their child. Although parents may be somewhat surprised by level 2 feedback, they should not be upset by it or challenge it outright; although they may not immediately accept it without question, they should be able to integrate it into their views of their child fairly easily. Ideally, it is recommended that the majority of information

presented during the feedback session be level 2 information (Tharinger, Finn, Hersh, et al., 2008), since this is the information that parents are most likely to learn from or be changed by.

Level 3 findings are those that are highly discrepant from clients' existing self-views or parents' existing views of their child. Parents are likely to become anxious upon hearing level 3 information, and they may challenge or reject these findings. Their views of their child, and in many cases their related views of themselves, may be threatened by this information. Things that parents suspect but fear may also fall into this category, as they will likely be difficult and anxiety-provoking to hear even if they are not fully "unknown." Although parents' immediate reaction may be to deny these findings, over a long period of time (after the assessment is complete) they may come to understand and integrate these findings into the way they see themselves.

It is important to note that whether the assessor considers a finding to be "positive" or "negative" is not a factor in deciding what level it falls under. What is important are the parents' perceptions and existing views of their child. If these are negative, then "negative" findings that fit with these existing views are the most likely to be easily accepted by the client – and thus are considered level 1 feedback. It is equally important to be aware of the idiosyncratic significance some findings may hold for particular parents and families.

The levels of feedback determine the order in which findings should be presented to parents during the feedback meeting. Level 1 findings are presented first, followed by level 2 and then level 3. Thus, the most self-verifying information is presented first, and

then the discussion moves into progressively more self-discrepant information. Presenting the most self-verifying information first makes parents comfortable and supports the expectation that the assessment findings will be valid and useful. In contrast, presenting information that parents have trouble seeing their child in is likely to mobilize the parents' defenses, arouse anxiety, and create the expectation that the assessor has not understood or seen them or the child correctly, and will not be able to provide helpful information or suggestions that are connected to their real life challenges. They are then likely to be less engaged and invested in the remainder of the feedback session, and may not optimally benefit even from feedback on other, more self-consistent findings because they will have already adopted a defensive position and "checked out" to some extent. Or, they may simply remain anxiously preoccupied with the upsetting level 3 findings and be unable to focus fully on the remaining feedback.

The assessor's goal in feedback is to help the parents accept and integrate as many of the assessment results as possible. However, in some cases it may not be beneficial to present every single item of information that the assessor believes the assessment has revealed about the child. Discussing too much new information at once may be overwhelming. Furthermore, some level 3 feedback may be so threatening to the parents that it would not benefit them to hear it at the present time. If the purpose of a feedback session is to promote therapeutic benefit, then information that is likely to be damaging should not be included. However, if the sequencing of feedback is well thought out and the feedback discussion is conducted in a collaborative and supportive way, parents may,

by the end of the session, be ready to hear level 3 findings that they may otherwise not have been able to take in.

In addition to careful sequencing, the practice of organizing feedback around parents' assessment questions may also increase the likelihood that they will accept any level 3 findings. If the information can be framed as an answer to a confounding question or an explanation for something the parents have long wondered about, the parents may be more motivated to process and consider the information rather than defensively rejecting it (Finn, 2007). An additional strategy for increasing acceptance of level 3 feedback is to give careful consideration to the language used. For instance, if the assessor knows that client is especially fearful of "depression," it is likely that using this word would immediately arouse significant anxiety. If alternative terms like "lots of sadness" or "feeling down most of the time" can be used instead, the client may be more able to take in the information and evaluate it against his or her own self-perceptions.

Feedback session organization in Therapeutic Assessment. Tharinger, Finn, Hersh, et al. (2008) suggest a general organization for discussing findings with parents following a TA. The assessor should begin by acknowledging that parents are often anxious about attending feedback sessions, and should check in with the parents about their initial emotional state at the beginning of the session. The assessor should then review the plan for the entire session, explaining what will happen and emphasizing that the parents' questions and collaboration are encouraged. Before beginning the discussion of findings, the assessor should thank the parents for participating in the assessment, and

should particularly acknowledge any factors that may have been especially difficult for the parents.

The assessor should then move into answering the parents' assessment questions, following Finn's (2007) level-based organization of feedback from least to most self-discrepant. Because it is likely that the assessor will not have been able to accurately predict all of the parents' reactions, their responses should be closely monitored and if they appear to be becoming too overwhelmed, the assessor should modify his or her plan for the session and should stop to provide support whenever necessary. The assessor should avoid arguing with parents about assessment findings, and instead encourage them to share their own perspective and how they would explain or make sense of their child's test responses.

Although recommendations to parents may have been offered throughout the session, all recommendations should also be summarized at the end of the session. The assessor should engage the parents in a discussion of how feasible these recommendations may be, and whether they have any questions or concerns about how to implement them. Before ending the session, it is recommended that the assessor discuss with the parents how feedback will be communicated to the child, and by whom. The assessor should also thank the parents again, and share a genuine statement about what the assessor learned or gained from being involved with the family (Tharinger, Finn, Hersh, et al., 2008).

Written Feedback. Most child assessments culminate in the production of a written report, usually intended for the use of other professionals, treatment facilities, or

the child's school. The report serves as an enduring, transportable record of the assessment to facilitate communication of the findings. Because reports have historically been used primarily by other professionals for treatment planning purposes, relatively little attention has been given to the usefulness and comprehensibility of written reports to parents. However, a well-written report can serve as a record for parents of the information presented in the oral feedback session, and can be consulted as a reference for results and recommendations long after the assessment is concluded.

As in oral feedback, language is a key consideration in assessment reports. Nearly three quarters of parents whose children receive psychological assessments are likely to read at the 12th grade level or below, but the average assessment report is written at the 15th or 16th grade level (Harvey, 1997). In order to improve the readability of reports, Harvey (1997) recommends that report authors use shorter sentences, avoid jargon, use the simplest words possible, and avoid using passive voice.

Report format is another consideration in accessibility to parents. In a comparison of three report formats (a brief, one page report; a traditionally-formatted psychoeducational report that was several pages long; and a several-page report presented in a question-and-answer format), parents showed better comprehension of the longer-form reports and preferred the report that was organized in a question and answer format (Wiener & Kohler, 1986).

Written feedback in therapeutic and collaborative assessment. Finn (2007) suggests organizing written feedback around the assessment questions parents generated at the beginning of the assessment process, the same way that oral feedback may be

organized. In fact, the format of written feedback in Therapeutic Assessment is typically very similar to the organization of oral feedback. Findings are organized by assessment question and presented in the same order as during the feedback discussion session, and often take the form of a letter to parents rather than a traditionally organized psychological report (Finn, 2007). The assessor uses the first person, and incorporates comments, examples, or disagreements that the parents offered during the feedback session into the written letter.

Fischer's (1985/1994) collaborative assessment reports take a similar approach to written feedback. Reports are written in the first person, using colloquial language and active voice, and represent a narrative description of the client's presentation during the assessment process. Information about the client is presented in the form of characteristic behaviors rather than labels or categorizations, and the client is always described as an active participant in the testing. The narrative style and tone of the report communicate that it simply provides the assessor's subjective impressions rather than some "absolute truth" about the client, but clear descriptions explain how the assessor arrived at these impressions.

Beneficial Assessment Outcomes

Benefits of receiving feedback and learning new things. Feedback is required by ethical guidelines because of the recognition that individuals have a right to have access to the information about themselves and their children that others will use to make decisions about them. In that sense, the most basic benefit of receiving assessment feedback is that parents then know what other professionals and institutions, such as

schools, will be told about their child by the assessor. However, the benefits of feedback extend far beyond that. Many clinicians may worry about providing "negative" feedback or "bad news" that may distress the client, and instead prefer to focus on "positive" assessment findings (Berg, 1985; Pope, 1992). While it is true that feedback about their child's strengths may be very beneficial to parents (Cox, 2006), it is also the case that children are who are referred for assessment are usually referred because they are experiencing some sort of challenge or difficulty. In many cases, the most useful, and even the most desired, feedback may be a diagnosis or explanation of why the child is experiencing difficulties, rather than a conclusion that "all is well" when parents know that it is not (Tharinger, Finn, Hersh, et al., 2008).

In research with adults, providing feedback following an assessment has been found to increase clients' self-esteem, improve their rapport with the examiner, and decrease their negative feelings about the assessment (Allen, Montgomery, Tubman, Frazier, & Escovar, 2003). Other studies have investigated characteristics of clients and of the feedback process that influence clients' responses to feedback. Collins and Stukas (2006) found that college students were more likely to accept the validity of the feedback they received when they had a pre-existing positive attitude toward therapy, when the feedback came from a therapist who was portrayed as high-status rather than from a therapist portrayed as relatively inexperienced, and when the feedback was consistent with their existing views of themselves. Additionally, having a positive attitude toward therapy was associated with participants being more willing to accept even feedback that was discrepant from their existing views of themselves.

Hanson et al. (1997) investigated the comparative effectiveness of two different methods of feedback to adult clients, which they called “delivered test interpretation” and “interactive test interpretation.” All clients took a personality test and received feedback on their profiles. Clients in the delivered test interpretation condition were informed of the scales on which they had particularly high or low scores, and given an explanation of the constructs measured by these scales and behavioral examples of those constructs. The behavioral examples were personalized with information provided by the clients during the initial interview, if relevant information had been offered. In contrast, clients in the interactive test interpretation condition were shown their profiles and asked to identify for themselves the scales on which they had high or low scores; they were then provided with explanations of the associated constructs. The clients were then asked to think of behavioral examples from their lives, and to summarize the information and draw conclusions about themselves. Although there was no evidence that clients in the interactive condition showed more cognitive processing of the assessment results, they did rate the feedback sessions as having more depth than clients in the delivered-interpretation condition, and they rated their assessors as more expert, trustworthy, and attractive than clients in the other condition did.

A qualitative study of significant events in assessment feedback with college students (Ward, 2008) found that clients responded positively to efforts to create a collaborative atmosphere, and also appreciated experiencing understanding and empathy from their assessors. Participants described having difficulty processing the assessment findings and feeling a sense of lost possibilities in response to some findings, but many

also described that they had tacitly known or suspected much of the information prior to the assessment. Ward proposed two broad processes by which assessment feedback influences clients: it helps them move from implicit to explicit understandings of themselves, and it helps them move from a globally fatalistic perspective on their difficulties to a more informed, autonomous perspective. Many of the participants in this study described that receiving assessment feedback helped them reevaluate their self-image and move away from blaming and deficit-based views of themselves (Ward, 2008). Although the above studies all used adult participants who received feedback about themselves, it is likely that similar processes may occur in feedback to parents about their children.

Therapeutic alliance. Collaborative and therapeutic assessment approaches intentionally blur the distinction between assessment and therapy. These approaches emphasize the creation of a strong alliance between assessor and client, characterized by collaboration, mutual goals, and respect. These relationship and interactional qualities are discussed in the therapy literature as components of therapeutic alliance. Therapeutic alliance refers to the quality of the relationship between a therapist and client, including factors such as collaboration, shared goals, and interpersonal attachment (Kazdin, Whitley, & Marciano, 2005). Strong alliance, particularly a strong collaborative working relationship, is associated with better treatment outcomes in adult psychotherapy (Hatcher & Barends, 1996). For child therapy, not only the alliance between the child and therapist but also the alliance between the therapist and parents has been found to be predictive of child improvement, and the parent-therapist alliance has been found to

predict improvements in parenting practices (Kazdin et al., 2005). Parent-therapist alliance is also associated with a higher frequency of family participation in child treatment and higher therapist agreement with parents' decisions about when to terminate treatment, as well as with a lower frequency of canceled or missed appointments (Hawley & Weisz, 2005). In general, parent-rated alliance is more strongly related to outcome than therapist-rated alliance, suggesting that is the parent's perception of the working relationship that is most important in determining the success of therapy (Kazdin et al., 2005). Parent-therapist alliance is also associated with greater parental satisfaction with services (Hawley & Weisz, 2005). Overall, these findings suggest that parents who experience a strong, collaborative interpersonal relationship with their child's therapist are more willing and engaged participants in treatment than those who perceive lower alliance. It is likely that client-assessor alliance during collaborative/therapeutic assessment would have similarly beneficial effects. In fact, one study has shown that therapeutic assessment promotes therapeutic alliance and decreases the likelihood that clients will terminate treatment against medical advice (Ackerman et al., 2000). In the context of the current study, it was expected that parents participating in an assessment using collaborative methods would rate themselves as experiencing a high level of collaboration and a positive relationship with the assessor, as well as rating their child as having a positive relationship with the assessor.

Parent satisfaction with assessment. Because parents are often among the primary consumers of children's psychological assessments, it is important to ask whether they are satisfied with the services they and their children receive. In a private practice setting

where parents pay significant fees to have their children assessed, care should be taken to ensure that parents feel that the assessment process is worth the cost. In the public sector, parent satisfaction is likewise important in order to maintain positive relationships between parents and the institutions, such as schools, that serve their child and family.

A study of a neurodevelopmental diagnostic service (Giannoulis et al., 2004) revealed that although most parents (81%) felt that their needs had been met with respect to obtaining a diagnosis for their child, less than half were satisfied with the provision of recommendations regarding education (46% satisfied), recommendations regarding behavior management (38% satisfied), and detailed information about their child's diagnosis or condition (30% satisfied). Additionally, only 27% of parents were satisfied with the explanations they received about treatment options and about what to expect for their child in the future. These low satisfaction ratings point to a need for more comprehensive parent feedback following assessment. A similar study of parent satisfaction with neuropsychological evaluations also found high satisfaction overall, but almost half of parents reported some degree of dissatisfaction with the level of help provided to them by the assessment, indicating that parents' expectations for help are often not met (Bodin et al., 2007).

In a study of parent satisfaction with their children's inpatient psychiatric hospitalization, parents reported that they were generally satisfied with the services they and their children received. However, relative to other services provided by the hospital, parents reported lower satisfaction with assessment-related services such as diagnostic testing and feedback about diagnoses, suggesting that in general, parents would have

preferred to receive more information in connection with the assessment process (Palisin, Cecil, Gumbardo, & Varley, 1997).

Kim, Sugawara, and Kim (2000) investigated parent satisfaction with two different methods of assessment used to determine eligibility for special education services. One method involved the use of traditional, norm-referenced tests, while the other method was more idiographic and incorporated parental input about the testing environment. Parents reported greater satisfaction with the method that incorporated their input and suggestions, implying that a higher degree of active participation in the assessment process may result in greater parent satisfaction.

Additional support for the idea that greater parental participation results in greater satisfaction is provided by a study of intervention-based assessment in schools (McNamara, Telzrow, & DeLamatre, 1999). Parents who participated in teams that designed and implemented interventions for their children indicated that they felt included, listened to, and respected during the process. Parents with a greater degree of involvement in the process reported higher satisfaction with the interventions selected by the team and higher satisfaction with their child's progress.

A common feature of many of the studies that found the highest parental satisfaction is the explicit use of collaboration with parents. However, it is notable that of the studies reviewed here that included parental collaboration, most involved informal assessment procedures rather than traditional, norm-referenced testing. Given that in many cases it is essential to obtain norm-referenced data, but also that collaboration with

parents appears to increase satisfaction, studies of collaborative assessment techniques used in combination with traditional psychological assessment seem warranted.

Adherence to assessment recommendations. Despite expressed parent interest in receiving recommendations (Giannoulis et al., 2004; Tidwell & Wetter, 1978), many assessment recommendations are never implemented. A recent study (MacNaughton & Rodrigue, 2001) found that only 67% of assessment recommendations were initiated by parents; the initiation rate for recommendations for psychological services (e.g., family or individual therapy) was even lower. The number of perceived barriers to implementing a recommendation was the most significant predictor of parents' failure to pursue it; satisfaction with the assessment was not found to be a predictor. A number of other factors that have been found to influence parents' compliance with recommendations include the type of recommendation, its complexity, and the number of times it has been suggested to parents in the past. Parents' understanding of how to implement the recommendation, belief in its efficacy, and level of concern about the problem it is meant to address also influence adherence (Human & Teglasi, 1993).These findings highlight the need for assessors to engage in collaborative discussion and problem-solving with parents about how recommendations can be implemented, and to provide clear rationales as to why each recommendations is needed (MacNaughton & Rodrigue, 2001). Pollak (1988) also suggests beginning discussions of recommendations by asking parents what they think would help their child, given the assessment findings presented. Collaborative discussion and problem-solving can help ensure that parents understand the recommendations and how to implement them; alternately, if it becomes clear that there

are too many barriers to implementation, this discussion provides an opportunity for assessors to modify the recommendations or offer other suggestions that parents could more effectively implement (Human & Teglasi, 1993). In the current study, it was expected that careful planning and presentation of feedback would support parental understanding of recommendations and possibly influence adherence. Although adherence to recommendations was not measured quantitatively due to the difficulties inherent in such measurement, parents were asked about understanding of and adherence to recommendations in qualitative interviews.

Parental advocacy. One factor that influences the implementation of recommendations and assessment outcome is parents' ability to advocate for their child's needs. This is particularly relevant to assessments conducted in private settings, which require that parents actively communicate or facilitate the communication of assessment results to schools or other agencies involved with their child. For instance, if a school-based assessment results in a recommendation for the child to receive special education services, such services are likely to be initiated unless parents do not consent. In contrast, if a private assessment results in the same recommendation, the parents must actively advocate to school personnel regarding their child's needs. Schools are required to consider the results of an independent educational evaluation when making decisions about a student, but are not required to implement all of the recommendations (Jacob & Hartshorne, 2003).

Studies of parental advocacy in schools suggest that advocacy is important to the educational outcomes of children with special needs (Bailey et al., 2006; Munn-Joseph &

Gavin-Evans, 2008). Thus, it is important to investigate processes by which advocacy may be enhanced. Although the effects of therapeutic and collaborative assessment on parental advocacy have not been investigated, several features of these models seem likely to promote improved parental self-efficacy about their ability to advocate for their child. By establishing a collaborative orientation during the initial assessment interview, collaborative assessors help parents have a successful experience of explaining their struggles with their child, identifying their needs for the assessment, and participating in the process of gathering information and drawing conclusions about their child. Furthermore, because feedback discussions are conducted in a collaborative and easy-to-understand manner, parents are more likely to understand the conclusions about their child, and thus more likely to be able to communicate them to others. Parents' participation in the process of developing plans for intervention may also increase their motivation and competence in following through on recommendations and communicating the child's needs to relevant others. Finn (2007) also suggests that involving parents in a conversation about how to present assessment findings to the child's school or to other professionals may serve as a way of "coaching" parents to better advocate for their child's needs.

Contribution of This Study

Statement of purpose. Traditionally, psychological assessment has been conceptualized as an information-gathering process, which may inform subsequent intervention but is not an intervention in itself (Finn & Tonsager, 1997). However, assessment experiences have the potential to teach clients much about themselves, their

challenges, and their strengths. Collaborative assessment of children presents the same benefit for the child, and also his or her parents by providing them opportunities to learn about their child and respond in new ways. Previous studies of collaborative and therapeutic assessment have found high consumer satisfaction, increased self esteem, decreased symptomatic distress, and greater hopefulness following participation in an assessment (Finn & Tonsager, 1992; Newman & Greenway, 1997). Currently, collaborative and therapeutic assessment methods are in limited use, though interest in training and practice is growing. The full Therapeutic Assessment (TA) protocol developed by Finn is complex, requiring extensive training for the assessor and typically more time for the client. However, Finn has proposed that it is possible to incorporate select collaborative techniques into otherwise more traditional assessments, and that these techniques likely will benefit the consumer even when used apart from the entire model. The current study aimed to investigate the practicality and potential benefits of implementing several collaborative techniques in child assessments conducted in a private practice setting. These collaborative techniques included co-generating, with the child's parent(s), questions and concerns to be addressed by the assessment; use of a process-oriented testing approach with the child; and structuring feedback as a discussion in which findings were presented in ways that were individualized to be best understood, accepted by, and useful to each set of parents and to respond to their assessment questions.

It was hypothesized that parents whose children participated in an assessment that incorporates collaborative practices would report greater satisfaction in a number of

areas. It was expected that they would feel that the assessment was more collaborative, that they learned more about their child, that they experienced a stronger alliance with the assessor, and that they had the sense that their child also experienced a stronger alliance with the assessor, compared to parents participating in a traditional assessment. It was also expected that parents in the collaborative condition would report having a more positive affective experience of the assessment process, and high general satisfaction with the process.

The study was conducted at a private practice assessment group located in Austin, TX. Three assessors were selected for participation; however, one assessor left the practice during the study and hence participated in only the first phase of the study. Initially, data was collected on seven to nine assessments completed by each assessor according to their practice-as-usual methods. Following the completion of these cases, the assessors were trained by the researcher on selected collaborative assessment methods, and will then completed additional cases each incorporating these methods (one assessor completed eight cases and the second assessor completed three cases). Analysis of variance was used to compare the standard practice (before training) and collaborative assessment (after training) groups.

Research Hypotheses

Hypothesis 1. Collaborative psychological assessment versus standard psychological assessment will have a direct overall treatment effect on the combination of the nine dependent variables: learning new things, positive parent/assessor relationship, positive child/assessor relationship, collaboration/informed consent,

negative feelings about the assessment, general satisfaction, positive emotions, and negative emotions.

Rationale. Previous research on therapeutic and collaborative assessment has found positive treatment effects on a number of constructs including symptomatic distress, self-esteem, hope, and assessor-client alliance (Ackerman et al., 2000; Finn & Tonsager, 1992; Newman & Greenway, 1997; Tharinger et al., 2009). The set of constructs to be measured in the current study overlaps somewhat with those examined by previous research, but adds additional constructs that are theoretically influenced by the practice of therapeutic and collaborative assessment. Given the variety of constructs on which group differences have been found in previous research in this area, it is likely that the combination of constructs used in the current study will create a distinct effect that statistically differentiates the two treatment groups on the dependent measures.

Hypothesis 2. Parents participating in a collaborative assessment of their child will report that they learned more about their child as a result of the assessment than parents participating in a standard assessment.

Hypothesis 3. Parents participating in a collaborative assessment of their child will report a stronger and more positive relationship with the assessor than parents participating in a standard assessment.

Hypothesis 4. Parents participating in a collaborative assessment of their child will rate their child's relationship with the assessor more positively than parents participating in a standard assessment.

Hypothesis 5. Parents participating in a collaborative assessment of their child will report a higher level of experienced collaboration with the assessor than parents participating in a standard assessment.

Hypothesis 6. Parents participating in a collaborative assessment of their child will report a lower level of negative feelings about the assessment experience than parents participating in a standard assessment.

Hypothesis 7. Parents participating in a collaborative assessment of their child will report greater general satisfaction with the assessment than parents participating in a standard assessment.

Hypothesis 8. Parents participating in a collaborative assessment of their child will report experiencing more positive emotions about their child's difficulties and future than parents participating in a standard assessment.

Hypothesis 9. Parents participating in a collaborative assessment of their child will report experiencing fewer negative emotions about their child's difficulties and future than parents participating in a standard assessment.

CHAPTER III

Method

Participants

The participants in the study were 3 assessors (two licensed psychologists and one postdoctoral associate) at a private practice located in central Texas, and 35 parents/caregivers of children ages 6-17 who were seen by these assessors between October 2009 and March 2011. Almost all children assessed at the private practice were referred by their parents, and the assessment fees are paid by the parents. Most referrals involve school-related difficulties, and findings are often used to document the need for school-related services.

Parent participants included mothers (89%), fathers (9%), and one stepmother. The mean age of participants' assessed children was 8.94 years (*SD* = 3.03). 62% of the children were male; 38% were female.

Instruments

Parent Experience of Assessment Survey (PEAS). The PEAS (Appendix A) is a 64-item, Likert-scale questionnaire that measures parents' satisfaction with and experience of their child's assessment. Respondents rate statements on a five-point scale ranging from "Strongly Disagree" to "Strongly Agree." The PEAS was developed by the University of Texas Therapeutic Assessment Project (led by Drs. Tharinger and Finn). A pool of items was written by project members and national experts in collaborative and therapeutic assessment, and the items were then sorted into groups by nine independent

judges, all licensed psychologists who practice assessment with children. Six distinct subscales were determined by factor analysis of these sorts. The subscales measure various aspects of parents' experience of the assessment process: Learned New Things, Positive Assessor-Parent Relationship, Positive Assessor-Child Relationship, Collaboration/Informed Consent, Negative Feelings about the Assessment, and Family Involvement in Child's Problems.

The "Learned New Things" scale addresses the degree to which parents felt that they learned about their child or understood their child differently as a result of the assessment. A sample item is, "I learned new ways of interacting with my child." The Positive Assessor-Parent Relationship scale addresses parents' perceptions of their interpersonal relationship and rapport with the assessor. A sample item is, "I felt the assessor respected me." The Positive Assessor-Child Relationship scale measures parents' perception of the assessor's interpersonal relationship and rapport with their child. A sample item is, "The assessor worked well with my child." The Collaboration/Informed Consent scale measures the degree to which parents were meaningfully involved in the assessment and the degree to which they felt that they understood the process. A sample item is, "I felt like part of a team working to help my child." The Negative Feelings about the Assessment scale measures parents' affective responses to the assessment process. A sample item is, "I felt blamed for my child's problems." Finally, the Family Involvement in Child's Problems scale measures the extent to which parents developed a systemic perspective on their child's problems as a

result of the assessment. A sample item is, "I now see how our family's problems affect my child." Chronbach alphas for the six scales range from .84 to .96.

Client Satisfaction Questionnaire – 8 (CSQ-8). The CSQ-8 (Appendix B) is an 8-item questionnaire that measures general client satisfaction using a 4-point Likert scale. Sample items include, "How satisfied are you with the amount of help you have received?" and "If a friend were in need of similar help, would you recommend our program to him or her?" It has been used both with adult clients and with parents of child clients, and has been found to be a short and robust instrument for measuring general satisfaction (Attkisson & Zwick, 1982). Reported coefficient alphas are between .93 and .96 (Byalin, 1993; Gerkensmeyer & Austin, 2005; Plante, Couchman, & Hoffman, 1998).

Parents' Positive and Negative Emotions (PPNE). The PPNE (Appendix C) was adapted from a longer measure, the Positive and Negative Affect Schedule – Expanded Form (PANAS-X; Watson & Clark, 1994), to address parents' feelings about their children. The PANAS-X is a 60-item questionnaire that measures Positive Affect and Negative Affect broadly as well as eleven specific affect states. The scales' internal consistency coefficients range from 0.72 to 0.93, maintain adequate construct validity, and achieve significant inter-rater reliability (Watson & Clark, 1994). The PPNE contains 18 items and measures only the broad constructs of Positive Affect and Negative Affect. The questionnaire reads, "Today as I think about my child's challenges and future I feel…" and then lists nine positive emotions (e.g. "encouraged," "compassionate") and nine negative emotions (e.g. "overwhelmed," "stuck"). The parent is asked to rate each of these emotions on a 5-point Likert scale ranging from "Strongly

Disagree" to "Strongly Agree." Using a shorter version of the PPNE, previous research on child Therapeutic Assessment has found moderate to strong effect sizes (0.61 to 1.23) for parents' increase in positive affect and decrease in negative affect after participating in a Therapeutic Assessment (Tharinger et al., 2009).

Post-feedback parent qualitative interview. Previous studies of consumer satisfaction with psychological services have found that responses to open-ended questions often provide unique information about areas of dissatisfaction even when general ratings of satisfaction on Likert-style questionnaires are high (e.g., Stallard, Hudson, & Davis, 1992). Therefore, a brief qualitative interview (Appendix D) was included in the study in order to obtain a more complete picture of parents' satisfaction with the assessment. Following the completion of the written outcome measures, parents participated in a brief (approximately 10 minutes) interview with the researcher regarding their experience of the assessment, which was conducted by telephone.

Follow-up parent qualitative telephone interview. Approximately one month after the feedback session, the researcher again contacted parents by telephone to conduct a brief (approximately 10 minutes) follow-up qualitative interview (Appendix E). The interview focused on ways in which the assessment had or had not been useful to the parents. In cases where the parent could not be reached for the post-feedback qualitative interview until more than one month after their final feedback meeting with the assessor, the post-feedback and follow-up interviews were combined.

Assessor qualitative interview. Following the completion of all other data collection for the study, each assessor participant who remained in the study completed a

brief, individual qualitative interview with the researcher (Appendix F), conducted by telephone. The purpose of this interview was to explore the assessor's experience of learning and using collaborative assessment methods, including the perceived utility of the methods, feasibility of incorporating them into assessments in this setting, and likelihood that the assessor will continue to use the methods in the future.

Procedure

Approval by the Human Subjects Committee. This study was conducted in compliance with the ethical standards designated by the American Psychological Association, as well as the standards of the Institutional Review Board at the University of Texas at Austin. Each participating caregiver and each participating assessor signed an IRB-approved consent form before beginning participation in the study.

Recruitment of Participants. Assessor participants were selected based on the appropriateness of their typical cases to the study (i.e., involve children ages 6-17 with referral questions related to school, learning, behavioral, or emotional difficulties). The three assessor participants' areas of specialization included ADHD, learning disabilities, Autism/ Asperger's, emotional functioning, and neuropsychological assessment. None of the assessors had received prior formal training in therapeutic or collaborative assessment, although one assessor had had some exposure to collaborative assessment principles during her graduate coursework.

Parent participants were recruited with the assistance of the private practice and the assessor participants. At their final feedback meetings with any parents who met criteria for the study, the assessors explained the study to parents using a provided script

and inquired about their willingness to be contacted by the researcher to receive more information about the study. If the parents agreed, the assessor provided their contact information to the researcher, who then contacted the parent by email to provide information about study and a link to complete the written measures electronically using an online survey format. If the parent had not completed the online survey after approximately one week, period reminder emails were sent. After the parent completed the survey, the researcher contacted the parent by phone to complete the qualitative interview. The response rate for the standard practice phase was 63%. The response rate for the collaborative assessment phase was 69%. Most parents who chose not to participate did not offer a reason, though several stated that they were too busy or that participating would take too long.

Standard Practice Phase. At the beginning of the study, a meeting was held with participating assessors to explain the study procedures and obtain their consent to participate. Following this meeting, all cases assigned to these assessors that involved a child age 6-17 were considered for inclusion in the study. In the initial phase of the study, data was collected on 24 "practice-as-usual" cases, which were roughly equally divided among the three assessors' caseloads, ranging from seven to nine participants per assessor.

Standard practice in this private practice setting included a clinical interview with parents, review of background history and school records, and individualized testing in the domains of cognitive abilities, memory, attention, academic and language skills, and emotional and behavioral functioning. Additional tests and procedures were selected

based on the referral concerns. The child testing was typically conducted in a single day, following a parent interview the same morning. Parents were provided with a comprehensive report as well as a one-hour feedback meeting with the assessor; this typically occurred about two weeks after the child is tested.

Training Phase. Once the 24 cases from the standard practice phase were obtained, the assessors participated in six hours of training in collaborative assessment methods, led by the researcher. The training was divided into two three-hour sessions, one focusing on methods to be used in the initial parent interview and during testing, and the second focusing on methods to be used during case conceptualization and parent feedback. Topics covered in the training included eliciting parents' collaboration during the initial parent interview, helping parents generate natural-language questions to be addressed by the assessment, using a process orientation with the child during the testing process, and adopting a collaborative, level-based approach to parent feedback.

Collaborative Assessment Phase. After completing the training in collaborative methods, the participating assessors incorporated these methods into all of their assessments (see Appendix G for treatment protocol). The procedure for recruiting parent participants remained the same during this phase, with the assessors inviting parents to participate in the study at the end of the parent feedback session. However, several changes occurred at the private practice around the same time that the collaborate assessment phase began. First, one of the assessors, the postdoctoral associate, left the private practice and thus did not participate in the study beyond the training phase. Second, another assessor's caseload changed such that she saw fewer cases that met

inclusion criteria for the study; thus, she had only three participants in the collaborative assessment phase. Third, the private practice became a training site for two predoctoral psychology interns, who conducted much of the testing for the other assessor's cases. Although this assessor was the primary clinician in these cases, the interns sat in on parent interviews and feedback meetings and conducted a portion of the testing. This assessor had eight participants in the collaborative phase, two of which were cases that she completed independently and six of which were cases in which she was assisted by an intern.

During the collaborative assessment phase, data collection procedures continued as in the standard practice phase, with minor additions. The assessors were asked to complete brief ratings at the end of each assessment indicating how effectively they perceived themselves to have used various collaborative techniques (see Appendix H for rating scale). This data was intended to serve as a treatment-fidelity check as well as to provide information about which collaborative assessment techniques the assessors were most effectively integrating into their assessments.

CHAPTER IV

Results

Overview

Complete quantitative data was obtained for 35 parent participants. Qualitative interview data was obtained for 22 parent participants. The quantitative data include five subscale scores from the PEAS-I: Learned New Things, Positive Assessor-Parent Relationship, Collaboration, Positive Assessor-Child Relationship, and Negative Feelings about the Assessment; an overall mean score from the CSQ-8; and two subscale scores from the PPNE, Positive Emotions and Negative Emotions. The qualitative interviews covered general satisfaction as well as probing for more specific information about positive and negative features of the assessment experience; an additional focus was on obtaining information about what steps parents took after the assessment was completed (e.g., implementing recommendations, sharing results with others, working with the child's school).

Additional data were obtained for two assessor participants. These included the assessor's self-ratings of treatment fidelity for a portion of their collaborative assessment cases, as well as qualitative interviews conducted at the end of the study to explore their experience of learning and implementing collaborative assessment techniques.

The following sections detail the results from the study. First, quantitative data is examined. Descriptive statistics for the parent data are provided to describe the sample and trends in the data, followed by descriptive statistics for the assessors' treatment

fidelity ratings. Main analyses with results for each hypothesis are then provided. A summary and content analysis of the parent qualitative data is then provided, followed by a summary and content analysis of the assessor qualitative data.

Descriptive Statistics

Descriptive statistics for the dependent variables are provided in Table 1. These include means and standard deviations by group and for the total sample. To put these statistics in context, the response options for the PEAS subscales and the PPNE subscales consist of a 5-point Likert scale ranging from 1 = Strongly Disagree to 5 = Strongly Agree. The response options for the CSQ consist of a 4-point Likert scale; although the qualitative labels vary by item, ratings of 1 generally reflect low satisfaction while ratings of 4 reflect high satisfaction.

Although the primary comparisons of interest were those between groups (standard vs. collaborative assessment) rather than between assessors, comparisons among assessors were examined in order to better understand their influence on observed group differences. Table 2 provides comparisons of effect size differences on each of the dependent variables among the three assessors for the standard practice condition. Table 3 provides comparisons of effect size differences on each dependent variable between the two assessors who participated in the collaborative assessment condition. As the tables show, the average effect size for the difference between assessors in the standard practice condition was in the moderate range for each of the dependent variables. In the collaborative assessment condition, the effect size for the difference between assessors ranged from small to large for the different dependent variables. Overall, each of the

assessors appeared to have particular individual areas of strengths and weaknesses. Because of the medium to large effect size seen for assessor differences on some variables, analyses were used which allowed assessor differences to be partialed out so that the conditions could be compared apart from the assessor differences.

Table 1.

Descriptive Statistics

Condition	Assessor		PEAS: Learned New Things	PEAS: Assessor-Parent Relationship	PEAS: Collaboration	PEAS: Assessor-Child Relationship	PEAS: Negative Feelings about the Assessment	CSQ-8	PPNE: Positive Emotions	PPNE: Negative Emotions
Standard	1	*M*	3.60	4.39	3.97	4.47	1.44	3.53	4.36	2.05
	(n=9)	*SD*	0.65	0.45	0.51	0.41	0.26	0.71	0.45	0.68
	2	*M*	3.68	4.14	3.91	4.20	1.86	3.50	4.14	2.60
	(n=7)	*SD*	0.51	0.34	0.59	0.31	0.49	0.43	0.39	0.14
	3	*M*	3.94	4.44	4.32	4.39	1.75	3.78	4.10	2.68
	(n=8)	*SD*	0.48	0.27	0.35	0.43	0.46	0.37	0.45	0.69
	Total	*M*	3.74	4.33	4.07	4.36	1.67	3.60	4.21	2.42
	(n=24)	*SD*	0.56	0.37	0.50	0.39	0.43	0.53	0.43	0.63
Collaborative	1	*M*	4.11	4.56	4.16	4.63	1.46	3.81	4.32	1.97
	(n=8)	*SD*	0.39	0.23	0.30	0.35	0.33	0.24	0.53	0.58
	2	*M*	3.83	4.27	4.30	4.23	1.63	3.71	4.15	2.04
	(n=3)	*SD*	0.30	0.15	0.10	0.64	0.06	0.29	0.26	0.53
	Total	*M*	4.04	4.48	4.20	4.52	1.51	3.78	4.27	1.99
	(n=11)	*SD*	0.38	0.24	0.26	0.45	0.29	0.24	0.47	0.54
Total	1	*M*	3.84	4.47	4.06	4.54	1.45	3.66	4.34	2.01
	(n=17)	*SD*	0.59	0.36	0.43	0.38	0.29	0.55	0.48	0.61
	2	*M*	3.73	4.18	4.03	4.21	1.79	3.56	4.14	2.43
	(n=10)	*SD*	0.45	0.29	0.52	0.40	0.41	0.39	0.34	0.39
	3	*M*	3.94	4.44	4.32	4.39	1.75	3.78	4.10	2.68
	(n=8)	*SD*	0.48	0.27	0.35	0.43	0.46	0.37	0.45	0.69
	Total	*M*	3.83	4.38	4.11	4.41	1.62	3.66	4.23	2.29
	(N=35)	*SD*	0.52	0.34	0.44	0.41	0.39	0.47	0.44	0.63

Table 2.

Between-Assessor Effect Size Differences (Cohen's d), Standard Practice Condition

	Learned New Things	Assessor-Parent Relationship	Collaboration	Assessor-Child Relationship	Negative Feelings about the Assessment	CSQ-8	Positive Emotions	Negative Emotions
A1 v. A2	.14	.68	.12	.69	.98	.06	.51	.87
A1 v. A3	.89	.14	.70	.21	.72	.47	.60	1.0
A2 v. A3	.46	.81	.82	.49	.26	.53	.09	.13
Average	.50	.54	.55	.46	.65	.35	.4	.67

Table 3.

Between-Assessor Effect Size Differences (Cohen's d), Collaborative Assessment Condition

	Learned New Things	Assessor-Parent Relationship	Collaboration	Assessor-Child Relationship	Negative Feelings about the Assessment	CSQ-8	Positive Emotions	Negative Emotions
A1 v. A2	.74	1.2	.54	.89	.59	.42	.36	.13

Treatment Fidelity

During the collaborative assessment phase of the study, the assessors completed self-ratings of treatment fidelity (Appendix H) for some of their cases, indicating the extent to which they included each of 20 components of collaborative assessment with a particular child and family. Response options included: 1 = Did not use; 2 = Used somewhat; 3 = Used effectively; 4 = Used very effectively. An overall treatment fidelity score was calculated by averaging the 20 item scores, and three subscales were calculated

by averaging the scores for items pertaining to the three assessment sessions (Initial Meeting, Child Testing, and Feedback Meeting). Descriptive statistics are provided in Table 4.

Table 4.

Descriptive Statistics for Treatment Fidelity Self-Ratings

	Initial Meeting		Child Testing		Feedback Session		Overall Average		Average for Parent-Focused Sessions	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Assessor 1 (n = 6)	2.79	.11	2.29	.13	2.81	.27	2.62	.11	2.79	.19
Assessor 2 (n = 2)	3.14	.20	2.64	.11	3.08	.59	2.95	.07	3.12	.16
Total (N = 8)	2.88	.23	2.38	.20	2.88	.34	2.70	.18	2.88	.22

Item-by-item descriptive statistics for the assessors' self-ratings are provided in Appendix I. Overall treatment fidelity fell in the range of "used somewhat" to "used effectively" for both assessors. Self-rated treatment fidelity was lowest for items pertaining to the child testing session; although these components were discussed in the collaborative assessment training, assessors were not necessarily expected to incorporate

them into their assessments. In addition to the ratings, assessors responded to two open-ended questions. The first asked how many assessment questions were generated. The number of assessment questions generated ranged from two to three. The second open-ended question asked what "levels" of feedback the assessor provided to parents. In two cases, the assessor reported providing only Level 1 feedback; in two cases, only Level 2; in three cases, both Level 1 and Level 2; and in one case, the assessor provided feedback at all three levels.

Preliminary Analyses

Power Analysis

Prior to beginning this research, a sensitivity power analysis was conducted using G*Power 3 (Faul, Erdfelder, Lang, & Buchner, 2007) to evaluate the adequacy of the sample size to detect an effect. G*Power uses the Pillai-Bartlett V criterion as a multivariate test statistic corresponding with f^2 as the effect size statistic. The analysis found that, using a standard Type I error probability of $\alpha = .05$ and standard power of $(1 - \beta) = .8$, the planned sample size of 60 would be large enough to detect an effect size of $f^2(V) = 0.29$ using a global effects MANOVA with nine dependent variables. In the event that the available sample size was smaller than expected, a sample of 50 participants would still be sufficient to detect an effect size of $f^2(V) = 0.36$. For the f^2 statistic, a value of .02 is considered to be a small effect size, a value of .15 is considered medium, and a value of .35 is considered large (Cohen, 1988). Thus, it was expected that the study would have adequate power to detect a moderate to strong effect if one exists.

In fact, however, the obtained sample size was considerably smaller than expected, with the result that, using a global effects MANOVA, the power to detect even a strong effect would be low. For this reason, hypothesis 1, positing a direct overall treatment effect for the combination of the eight dependent variables, was not tested. Instead, hypotheses 2-9 were tested using a series of one-way and two-way ANOVAs. Although using separate ANOVAs rather than a MANOVA theoretically increases the risk of a type I error, this was judged not to be of great concern because the power to detect an effect was so low, given the small sample size.

Data Excluded from Analyses

One of the three assessors participating in the study left the private practice after the standard practice phase, and thus did not have any cases included in the collaborative assessment phase. For this reason, her eight cases from the standard practice phase were dropped from the analyses.

Missing Data, Outliers, and Assumptions

All data analyses were run using SPSS 19 for Microsoft Windows (released 2010). All dependent variables were examined to determine suitability for use in analyses. There was no missing data for any of the dependent variables. No data were removed as outliers. Levene's test for equality of error variances was used to test for homoscedasticity. Six of the eight dependent variables were found to have sufficient homogeneity of variance. However, two dependent variables (the PEAS Collaboration subscale and the PPNE Negative Emotions subscale) were significant for Levene's test, indicating heteroscedasticity. Because SPSS does not enable two-way univariate tests

that do not assume homogeneity of variance, one-way tests were conducted for these two variables using the Welch statistic, which does not assume homogeneity of variance. The other six variables were judged appropriate for two-way ANOVAs.

Equality of Groups

A one-way ANOVA was used to analyze equality of groups for child age. The standard and collaborative conditions were found not to differ significantly on child age, $F = .38$, $p > .05$. A Pearson's chi-square test was used to analyze equality of groups for child gender. The standard and collaborative conditions were found not to differ significantly on child gender, $\chi^2 = 1.47$, $p > .05$. Similarly, cases completed by each of the two assessors were found not to differ significantly on child age, $F = 3.13$, $p > .05$, or child gender, $\chi^2 = 2.83$, $p > .05$.

Main Analyses

Hypothesis 1. Hypothesis 1 predicted that collaborative psychological assessment versus standard psychological assessment would have a direct overall treatment effect on the combination of the eight dependent variables: Learning New Things, Positive Assessor-Parent Relationship, Positive Assessor-Child Relationship, Collaboration, Negative Feelings about the Assessment, General Satisfaction, Positive Emotions, and Negative Emotions. As discussed above in the section on power analysis, the obtained sample size of 35 (27 after dropping eight cases), split unevenly between the two treatment groups, was too small for a multivariate analysis to have sufficient power to detect an effect. For this reason, hypothesis 1 was not tested, and each of the eight dependent variables was examined separately.

Hypotheses 2-9. Hypotheses 2-9 concern the treatment effects on individual dependent variables. Each was analyzed using either a two-way analysis of variance (ANOVA) with condition and assessor as factors, or a one-way analysis of variance (ANOVA) with a comparison of the two conditions (in cases of heterogeneity of variance). Using a two-way ANOVA with unbalanced data allowed the assessor effect to be partialed out from the differences between conditions so that the condition effect could be examined separately. It also allowed for examination of any interaction effects between assessor and condition; if present, these could interfere with interpretation of the main effect for condition. However, no interaction effects were apparent. Results specific to each hypothesis are discussed below.

Hypothesis 2. Hypothesis 2 predicted that parents participating in a collaborative assessment of their child would report that they learned more about their child as a result of the assessment than parents participating in a standard assessment. The PEAS-I subscale Learned New Things was found not to be significantly affected by condition, $F = 2.26$, $p = .15$, $d = .77$. Although not statistically significant, the results show a trend toward greater reported parental learning in the collaborative assessment group, with a medium effect size.

Table 5.

Two-Way ANOVA for Learned New Things

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	1.235[a]	3	.412	1.514	.237
Intercept	325.779	1	325.779	1198.406	.000
Condition	.613	1	.613	2.256	.147
Assessor	.057	1	.057	.208	.652
Condition * Assessor	.182	1	.182	.669	.422
Error	6.252	23	.272		
Total	397.519	27			
Corrected Total	7.487	26			

a. R Squared = .165 (Adjusted R Squared = .056)

Hypothesis 3. Hypothesis 3 predicted that parents participating in a collaborative assessment of their child would report a stronger and more positive relationship with the assessor than parents participating in a standard assessment. The PEAS-I subscale Positive Assessor-Parent Relationship was found not to be significantly affected by condition, $F = 1.05$, $p = .32$, $d = .59$. Although not statistically significant, the results show a trend toward more positive assessor-parent relationships in the collaborative assessment group, with a medium effect size.

Table 6.

Two-Way ANOVA for Assessor-Parent Relationship

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	.692[a]	3	.231	1.941	.151
Intercept	423.137	1	423.137	3563.002	.000
Condition	.124	1	.124	1.046	.317
Assessor	.412	1	.412	3.471	.075
Condition * Assessor	.003	1	.003	.029	.866
Error	2.731	23	.119		
Total	517.380	27			
Corrected Total	3.423	26			

a. R Squared = .202 (Adjusted R Squared = .098)

Hypothesis 4. Hypothesis 4 predicted that parents participating in a collaborative assessment of their child would rate their child's relationship with the assessor more positively than parents participating in a standard assessment. The PEAS-I subscale Positive Assessor-Child Relationship was found not to be significantly affected by condition, $F = .33$, $p = .57$, $d = .43$. Although not statistically significant, the results show a trend toward more positive assessor-child relationship in the collaborative assessment group, with a small effect size.

Table 7.

Two-Way ANOVA for Assessor-Child Relationship

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	.799[a]	3	.266	1.682	.199
Intercept	431.174	1	431.174	2723.202	.000
Condition	.052	1	.052	.326	.574
Assessor	.608	1	.608	3.843	.062
Condition * Assessor	.022	1	.022	.139	.713
Error	3.642	23	.158		
Total	531.570	27			
Corrected Total	4.441	26			

a. R Squared = .180 (Adjusted R Squared = .073)

Hypothesis 5. Hypothesis 5 predicted that parents participating in a collaborative assessment of their child would report a higher level of experienced collaboration with the assessor than parents participating in a standard assessment. Due to heterogeneity of error variance for the PEAS subscale Collaboration, this hypothesis was analyzed using a one-way ANOVA using the Welch statistic with four groups (Condition 1 Assessor 1; Condition 1 Assessor 2; Condition 2 Assessor 1; and Condition 2 Assessor 2), followed by contrast tests pooling the results by condition. The overall ANOVA was not significant, Welch Statistic = 1.88, $p = .19$. The contrast test was also not significant, $p = .08$. Comparing mean differences between the two conditions, the results show a trend

toward greater experienced collaboration in the collaborative assessment group, with a medium effect size, $d = .57$.

Table 8.

Robust Tests of Equality of Means

Collaboration

	Statistic[a]	df1	df2	Sig.
Welch	1.875	3	12.450	.186

a. Asymptotically F distributed.

Table 9.

Contrast Tests

		Contrast	Value of Contrast	Std. Error	t	df	Sig. (2-tailed)
Collaboration	Does not assume equal variances	1	-.58155	.306451	-1.898	16.193	.076

Hypothesis 6. Hypothesis 6 predicted that parents participating in a collaborative assessment of their child would report a lower level of negative feelings about the assessment experience than parents participating in a standard assessment. The PEAS-I subscale Negative Feelings about the Assessment was found not to be significantly affected by condition, $F = 0.50$, $p = .49$, $d = .35$. Although not statistically significant, the results show a trend toward less negative feelings about the assessment in the collaborative assessment group, with a small effect size.

Table 10.

Two-Way ANOVA for Negative Feelings about the Assessment

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	.822[a]	3	.274	2.296	.105
Intercept	57.457	1	57.457	481.466	.000
Condition	.059	1	.059	.498	.487
Assessor	.478	1	.478	4.006	.057
Condition * Assessor	.082	1	.082	.688	.415
Error	2.745	23	.119		
Total	70.780	27			
Corrected Total	3.567	26			

a. R Squared = .230 (Adjusted R Squared = .130)

Hypothesis 7. Hypothesis 7 predicted that parents participating in a collaborative assessment of their child would report greater general satisfaction with the assessment than parents participating in a standard assessment. Overall score on the CSQ-8 was found not to be significantly affected by condition, $F = 1.36$, $p = .26$, $d = .52$. Although not statistically significant, the results show a trend toward greater general satisfaction in the collaborative assessment group, with a medium effect size.

Table 11.

Two-Way ANOVA for CSQ-8

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	.497[a]	3	.166	.662	.584
Intercept	297.152	1	297.152	1187.892	.000
Condition	.341	1	.341	1.364	.255
Assessor	.024	1	.024	.098	.757
Condition * Assessor	.008	1	.008	.033	.858
Error	5.753	23	.250		
Total	361.047	27			
Corrected Total	6.250	26			

a. R Squared = .079 (Adjusted R Squared = -.041)

Hypothesis 8. Hypothesis 8 predicted that parents participating in a collaborative assessment of their child would report experiencing more positive emotions about their child's difficulties and future than parents participating in a standard assessment. The PPNE subscale Positive Emotions was found not to be significantly affected by condition, $F = 0.01$, $p = .93$, $d = .02$.

Table 12.

Two-Way ANOVA for Positive Emotions

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	.247[a]	3	.082	.403	.752
Intercept	404.224	1	404.224	1979.021	.000
Condition	.002	1	.002	.008	.931
Assessor	.210	1	.210	1.027	.322
Condition * Assessor	.003	1	.003	.013	.909
Error	4.698	23	.204		
Total	496.654	27			
Corrected Total	4.945	26			

a. R Squared = .050 (Adjusted R Squared = -.074)

Hypothesis 9. Hypothesis 9 predicted that parents participating in a collaborative assessment of their child would report experiencing fewer negative emotions about their child's difficulties and future than parents participating in a standard assessment. Due to heterogeneity of error variance for the PPNE subscale Negative Emotions, this hypothesis was analyzed using a one-way ANOVA using the Welch statistic with four groups (Condition 1 Assessor 1; Condition 1 Assessor 2; Condition 2 Assessor 1; and Condition 2 Assessor 2), followed by contrast tests pooling the results by condition. The overall ANOVA was significant, Welch Statistic = 4.63, $p = .044$. However, the contrast test was not significant, $p = .18$. Rather than a main effect for condition, the overall significant ANOVA reflects mean differences between the groups "Condition 1 Assessor

2" and "Condition 2 Assessor 1." Although the condition comparison was not statistically significant, the results show a trend toward lower negative emotions in the collaborative assessment group, with a medium effect size, d = .56.

Table 13.

Between-Condition Effect Size Differences (Cohen's d) for all dependent variables

Condition		PEAS: Learned New Things	PEAS: Assessor-Parent Relationship	PEAS: Collaboration	PEAS: Assessor-Child Relationship	PEAS: Negative Feelings about the Assessment	CSQ-8	PPNE: Positive Emotions	PPNE: Negative Emotions
Standard (n=16)	*M*	3.64	4.28	3.94	4.35	1.63	3.52	4.26	2.29
	SD	.58	.41	.53	.38	.42	.59	.43	.58
Collaborative (n=11)	*M*	4.04	4.48	4.20	4.52	1.51	3.78	4.27	1.99
	SD	.38	.24	.26	.45	.29	.24	.47	.54
sd used for effect size calculation*		.52	.34	.46	.40	.34	.5	.45	.54
Effect size (Cohen's *d*)		.77	.59	.57	.43	.35	.52	.02	.56

*For all effect size calculations, the square root of the mean square error was used as the estimate of standard deviation.

Content Analysis of Parent Interviews

Brief phone interviews were conducted with 16 parents in the standard practice group and 6 parents in the collaborative assessment group in order to obtain more

information about their experience with the assessment, as well as what they had done with the assessment results after receiving them. The interviews were then transcribed, and a chart was made for each interview indicating the parent's response to each of the major interview questions. After reading through and organizing all interviews in this way, the primary investigator grouped and tallied responses to some of the questions, and noted several emergent themes that were apparent across interviews. For themes that did not correspond directly to one of the original interview questions, the primary investigator read through all interviews to code any references to the theme. As a reliability check, another graduate student familiar with Therapeutic Assessment read through two of the interviews to organize them into charts and code them by themes. A comparison of the two raters revealed 82% agreement in classifying statements by question, and 64% agreement in coding by theme. In all cases where the raters differed in classifying statements by question, the statements had been sorted as responses to similar questions (e.g., one rater sorted a statement about a problem dealing with the school as "Shared results with school?" while the other sorted it as "Anticipated or experienced problems"). This was expected, as some of the questions overlapped. The lower disagreement in coding by theme was due to the fact that many statements could potentially fit more than one theme (e.g., both "collaboration" and "parent relationship with assessor," or both "learning/understanding" and "parent's emotional experience"), but each rater listed only one theme per statement. These differences were resolved by coding two themes per statement in the cases where the raters differed. An example of this organizational and coding scheme is provided in Appendix J. A summary of

information obtained from the interviews is provided below. The experiences of the standard practice group are discussed first, followed by the experiences of the collaborative assessment group. Similarities and differences between the groups' experiences are then discussed. Because parents' responses to what they had done with the assessment results did not appear to differ by group, these responses are discussed together at the end of the section. A sample of parents' quotes illustrating each of the categories discussed below is provided in Appendix K.

Standard Practice

Parents in the standard practice condition generally reported high levels of satisfaction with the services provided at the private practice. Commonly mentioned positive features of the assessment were learning things about their child, receiving a diagnosis, and receiving recommendations, and the assessors' thoroughness, interpersonal manner, and ability to work well with their child. Although all but one parent reported an overall positive (81%) or neutral (13%) experience, many (63%) offered at least one area of disappointment or suggestion for improvement. Many (31%) reported at least one area they had hoped to gain information about from the assessment but did not (e.g., wanted to know more about the child's learning style), or noted that they had not understood some disappointing limits of the testing until the feedback session (e.g., did not realize that results might not be "exact" or precisely accurate; did not realize that some areas, such as creative abilities, would not be assessed). Several parents reported wishing that more time had been spent discussing recommendations, or that more detailed and specific recommendations had been provided (e.g., a list of referrals

for tutors). Additionally, several parents reported wishing that the assessor had helped them plan how to introduce the testing to their child. One parent did report that her assessor had helped her with this, and identified it as one of the things she liked most about the assessment process.

Collaborative Assessment

All parents in the collaborative assessment group reported a generally positive experience with the assessment. No parents reported any areas of dissatisfaction or suggestions for improvement. Several parent comments seemed particularly in line with collaborative practices, including references to "answering our questions", having parents re-explain feedback in their own words to check for understanding, and, in the feedback meeting, "leading us through to get us to a certain point rather than just telling us 'she has ADHD.'"

Similarities between Groups

As expected, a common theme across both groups involved the value parents placed on learning about their child, receiving a diagnosis, answering questions about their child, and/or knowing what steps to take to help their child. In particular, many parents reported that the assessment had "put them on the right path" toward helping their child, making comments such as, "now that we know what the problem is, we know what to do to help." Parents' comments on their emotional experience of the assessment were also similar in both groups, with more parents reporting relief at getting answers than anxiety or dismay about their child's diagnosis. Although some parents did report that

the results were upsetting or caused anxiety, this appeared to be more common in cases where the parent had not expected the diagnosis that was given.

Another theme concerned the frequency, across both groups, of parents' references to logistical procedures surrounding the assessment, or other features that may not be considered core components of the assessment process. (e.g., had a comfortable office, ordered pizza for the child at lunchtime, provided an iPad for the child to play games on while waiting). Although such procedures may be overlooked by psychologists or researchers, who may instead focus on more assessment-relevant features, it is clear that to parents, these small details may in fact make a significant impression.

Another commonality was parents' references to their relationship with the assessor and to the use of collaborative practices; these references occurred in both groups. For example, parents in both groups reported that the assessors took time to listen to them, put them at ease, helped them make decisions, and were willing to make reasonable adaptations to their usual procedures when parents requested this (e.g., meeting a parent informally before she made a decision about having the assessment; providing key recommendations over the phone immediately after the testing was completed rather than waiting for the feedback meeting). These comments suggest that regardless of whether or not collaboration is specifically targeted by the assessor, it is something that parents appreciate in the assessment process. Parents also frequently commented on the assessor's interactions with their child, noting that the child's comfort with the assessor and with the testing were of great importance to them.

Differences between Groups

The most striking difference between the groups concerned the incidence of negative comments about the assessment. Though most parents in both conditions provided overwhelmingly positive feedback, two prompts specifically asked parents to describe things that they disliked about the assessment, suggestions for the private practice, or ways the assessment had not met their expectations. While the majority of parents in the standard practice group identified at least one area of dissatisfaction, no parents in the collaborative group contributed any negative feedback or identified any areas they had hoped to learn about during the assessment, but did not. Similarly, while some parents in the standard practice group reported not understanding the limits of the testing until the feedback session, no such comments were present in interviews with the collaborative assessment group. This is in line with the literature on collaborative assessment, which asserts that asking for parents' explicit assessment questions and expectations allows the assessor to address any limitations of the assessment in advance. Along the same lines, many parents in the standard practice group reported at least one area they had hoped to gain information about, but did not. Had the assessors explicitly asked for questions and expectations in advance, it is possible that parents would have mentioned these areas and the assessors could then have addressed them in feedback.

Steps Taken After the Assessment

An additional goal of the qualitative interviews was to gain information about what parents did with the assessment results after the feedback meeting. Because the two groups did not show substantial differences on these questions, responses from all

participants are discussed together. All parents reported that they had shared or planned to share the assessment results with the child's school, and/or that they were seeking school-based services or accommodations, most often under a 504 plan. There was significant variation in parents' reported experiences interacting with schools. Some (38%) reported that the school was unwilling to make accommodations, or, if they had not yet had a school meeting, that they feared this would be the outcome. On the other hand, many parents reported full satisfaction with the school's response; 44% said that accommodations were in place for their child. One parent noted that her child's private school would not provide accommodations, but that she was satisfied with this because the school advertised that they did not make accommodations.

The most common people parents shared the results with were schools (100%), extended family members (23%), doctors (18%), and tutors (18%). 77% of parents reported that they had discussed the assessment results with their child, though many with young children reported that their discussion had been limited to a few sentences or that they had chosen not to share all of the findings (e.g., focusing on strengths rather than weaknesses, or sharing recommendations rather than diagnoses). Among parents who had not discussed the results with their child, the most common reasons provided were the child's young age or fear of damaging the child's self-esteem.

Most parents reported that they had tried most or all of the recommendations, and that the recommendations offered were helpful. When some recommendations had not been tried, reasons provided included cost, wanting to try other things first, or believing that some recommendations would be more appropriate in the future. Most parents

reported having read the assessment report and finding it helpful, clear, and easy to understand.

Content Analysis of Assessor Interviews

Brief phone interviews were conducted with both of the assessors who completed the study in order to obtain more information about their experience with learning and using collaborative methods. The interviews were transcribed, and a chart was made for each interview indicating the assessor's response to each of the major interview questions. After reading through and organizing both interviews in this way, the primary investigator noted several themes and findings from the assessor interviews. A summary is provided below, and a sample of quotes illustrating each of several categories is provided in Appendix L.

Both assessors reported having a very positive experience with learning and using collaborative techniques. Both noted that many of the techniques were similar to how they already practiced, but that the collaborative assessment training caused them to be more consciously aware of and consistent in the way they used the strategies.

Both assessors noted that asking for parents' assessment questions was especially helpful. One assessor described the importance of asking for questions in making sure parents' needs were met: "Occasionally, without [asking for questions] you can have a situation where you think you have an understanding of what the parent questions are and why they're seeking the assessment, but you could miss something. And then in the feedback, it was lacking for them. You didn't meet all their needs. And that's a horrible feeling. And so [when I asked for questions] I trusted that that wasn't going to happen."

The other assessor noted that because she sees many children with similar presenting concerns and life circumstances, she often catches herself assuming that parents have the same concerns and reasons for pursuing the assessment as most of her other clients, although this is not always the case. She reported that asking about assessment questions had helped her become more aware of cases when parents had additional concerns, such as questions about behavior management at home or general parenting strategies that she could address through recommendations or additional testing.

When asked if they would continue to use any of the collaborative methods, both assessors answered, "Of course!" One noted that she wanted to learn about collaborative and therapeutic assessment more thoroughly now that the study was over. Both reiterated that they thought they had approached their assessments with generally collaborative mindsets even before participating in the training, but that learning more specifically about the collaborative and therapeutic assessment models had focused their efforts and made them more effective.

CHAPTER V

Discussion

Prior research on collaborative and therapeutic assessment has found high consumer satisfaction, increased self esteem, decreased symptomatic distress, and greater hopefulness following participation in an assessment (Finn & Tonsager, 1992; Newman & Greenway, 1997). Despite the growing research attesting to the benefits of these assessment models, collaborative and therapeutic assessment models remain in limited use. Although interest in these methods is increasing, they are complex, time-consuming and expensive to implement in most applied settings, requiring extensive training for the assessor and a greater time (and typically monetary) commitment from clients. In order to decrease the barriers to implementing beneficial collaborative techniques into typical practice settings, the current study aimed to investigate the practicality and potential benefits of implementing several collaborative techniques apart from the more extensive "full model" of collaborative/therapeutic assessment. The targeted collaborative techniques included co-generating, with the child's parent(s), questions and concerns to be addressed by the assessment; use of a process-oriented testing approach with the child; and structuring feedback as a discussion in which findings were presented in ways that were individualized to be best understood, accepted by, and useful to parents and to respond to their assessment questions.

The study was conducted at a private practice assessment group located in central Texas. As originally proposed, four assessors were to participate in the study; however,

only three assessors were identified as potential participants and enrolled in the study. In addition, one of the three left the private practice, and therefore the study, halfway through the study. In the initial phase of the study, data was collected on seven to nine assessments completed by each assessor according to their practice-as-usual methods. Following the completion of these cases, the assessors attended six hours of training on selected collaborative assessment methods, and then completed additional cases incorporating these methods. Due to changes in caseloads and testing practices, one of the assessors completed eight cases incorporating collaborative assessment methods, while the other completed only three.

Overview of Results

Findings Relevant to Original Hypotheses

Due to a variety of unanticipated changes at the private practice over the course of the study, the obtained sample size was considerably smaller than desired and, additionally, was unbalanced across condition and assessor, resulting in low statistical power to detect differences between groups. This study hypothesized a significant overall treatment effect on the combination of eight dependent variables concerning parents' experiences of assessment. However, the small obtained sample size was insufficient for a multivariate analysis with adequate power to detect an effect; thus, this hypothesis was not tested. Instead, the eight dependent variables were examined individually. No statistically significant results were found, but the data showed trends in the hypothesized directions for most of the dependent variables, with effect sizes

generally in the moderate range. Assessor self-ratings indicated adequate treatment fidelity.

It was predicted that parents participating in an assessment including collaborative methods would report learning more about their child than parents participating in a standard practice assessment. This hypothesis was not statistically supported, although the observed moderate effect size in favor of the collaborative assessment group was suggestive of possible clinically significant differences. Examination of the qualitative interview data suggested that parents in the collaborative assessment group were less likely to identify areas they had hoped to learn about during the assessment, but had not, while almost one-third of parents in the standard practice group did identify such areas. This may partially explain the observed mean difference in ratings for the PEAS subscale Learned New Things.

An additional prediction was that parents in the collaborative assessment condition would report a more positive relationship with the assessor than parents in the standard practice condition. In fact, both groups had high mean ratings (corresponding to ratings of "Agree" to "Strongly Agree") on the Positive Assessor-Parent Relationship subscale of the PEAS. However, the collaborative assessment condition showed even higher mean ratings than the standard practice group; though not statistically significant, there was a moderate effect size. In the qualitative interviews, parents in both groups spoke positively of their relationship with the assessor, commenting that the assessors put them at ease, listened to their concerns, and supported them in interactions with the school, among other things.

Similarly, it was predicted that parents in the collaborative assessment condition would report a more positive relationship between their child and the assessor than parents in the standard practice condition, and in fact both groups had high mean ratings (corresponding to "Agree" to "Strongly Agree") on the Positive Assessor-Child Relationship subscale of the PEAS. There was a non-significant trend toward higher ratings in the collaborative assessment group, with a small effect size. In both conditions, many parents who participated in the qualitative interviews spoke positively of the assessor's interactions with their child, noting that the assessor put their child at ease, helped the child feel comfortable with the testing, and made the experience fun.

Experienced collaboration was also predicted to be higher for parents participating in assessments including collaborative methods than for those participating in standard-practice assessments. This hypothesis was not statistically supported, though observed mean differences showed a trend toward greater experienced collaboration in the collaborative assessment group, with a moderate effect size. Examination of the qualitative interview data revealed positive parent experiences of collaboration in both groups, although comments from parents in the collaborative assessment group seemed to align better with specific collaborative techniques discussed in the assessor training, such as references to "answering our questions," "leading us through [the results] to get us to a certain point rather than just telling us," and having parents re-explain feedback in their own words to check for understanding.

An additional hypothesis was that parent-reported negative feelings about the assessment would be lower in the collaborative assessment group than the standard

practice group. In fact, mean ratings on the PEAS subscale Negative Feelings about the Assessment were low in both groups (corresponding to "Strongly Disagree" to "Disagree" ratings), though there was a non-significant trend toward lower negative feelings in the collaborative assessment group, with a small effect size. The PEAS Negative Feelings about the Assessment subscale asks about the parent's emotional experience of the assessment process (e.g., feeling angry, guilty, ashamed, or anxious). Although some parents did report in the qualitative interviews that they felt somewhat anxious or nervous at times during the assessment process, parents in both groups more commonly reported feeling a sense of relief.

General satisfaction, as measured by the CSQ-8, was predicted to be higher in the collaborative assessment group than in the standard practice group; although not statistically significant, this trend was indeed observed, with a moderate effect size for the mean difference between the groups. However, mean score on the CSQ-8 was high in both groups, indicating that both sets of parents were generally well satisfied with the assessment. This was also reflected in the qualitative data; in the standard practice group, 81% of parents described their overall experience in clearly positive terms, while 13% used neutral terms and only one parent reported being dissatisfied overall. In the collaborative practice group, 100% of parents described their overall experience in clearly positive terms.

Additional hypotheses concerned parents' reported emotions about their child's challenges and future. It was predicted that parents in the collaborative assessment group would report higher levels of positive emotions when thinking about their child's

challenges and future, relative to parents in the standard practice group; however, no difference was seen in the results for the two groups. Positive emotions were high for both groups. In qualitative interviews, parents in both groups reported feeling hopeful about the future and feeling like the assessment had set them on a good path toward helping their child. It was also predicted that parents in the collaborative assessment group would report lower levels of negative emotions when thinking about their child's challenges and future, compared to the standard practice group. Although not statistically significant, such a trend was indeed observed, with a moderate effect size.

Overall, the results are suggestive of high-quality standard assessment practices at the private practice, and high parent satisfaction, limiting the potential magnitude of improvements that could theoretically be seen by introducing collaborative practices. The fact that improvements of small to moderate effect size (though no statistical significance) were observed in spite of this suggests the potential beneficial nature of collaborative methods over and above that seen for the best-practice traditional assessment methods the assessors were already using.

In summary, this study provided no statistically significant evidence that parents participating in an assessment involving collaborative methods experienced the assessment differently or had higher satisfaction than parents participating in a traditional assessment; however, the lack of statistical significance was unsurprising given the small sample size. The results, which included trends in the expected direction for all but one of the dependent variables, do provide some preliminary support for the effectiveness of

training assessors in selected collaborative assessment methods, and could be considered promising pilot data indicating that a larger study in this area would be warranted.

Treatment Fidelity

The treatment fidelity self-ratings completed by the participating assessors contributed important data about the feasibility and effectiveness of providing assessors with brief training in collaborative and therapeutic methods and inviting them to incorporate these methods into their practice. Qualitative interviews with the assessors added context to these ratings. Overall treatment fidelity fell in the range of "used somewhat" to "used effectively" for both assessors. Examination of the item-by-item ratings suggested that the assessors considered themselves to have more successfully integrated techniques focused on the initial and final meetings with parents rather than techniques focused on child testing. It was unclear whether this was due to logistical limitations, relative difficulty of mastering various techniques, or the assessors' personal preferences and judgments regarding which techniques to implement. However, it is also notable that, as this was a study of parents' experiences of assessment, child-focused techniques received less emphasis in the assessor training than parent-focused techniques. The technique that the assessors reported using least was extended inquiry during child testing. This is unsurprising, given the lack of emphasis in training, the additional assessment time required for extended inquiry, and the psychoeducational focus of the assessments. In contrast, the assessors particularly appreciated the technique of asking for parents' assessment questions and exploring their expectations for the assessment, and reported that this was one of the techniques they had used most. They also noted that

they appreciated the training on organizing feedback according to parents' expected response. One assessor reported making use of this technique in her cases for the study, but the other reported that although she planned to use it in the future, it had not been relevant in her recent cases.

Additional Findings

In addition to the qualitative findings that are discussed above, some additional themes were apparent in the parent interviews that did not pertain to the hypotheses of the study. First, the interviews showed that many parents were particularly appreciative of logistical or non-assessment-related features that made their experience and their child's experience more comfortable or enjoyable, such as having a calming office environment and ordering pizza during child testing. Second, all parents who were interviewed chose to share the results with their child's school, and reported varying degrees of satisfaction with the school's responses. Many expressed frustration that the school would not accept the outside testing, did not approve services for their child that the parent believed the child qualified for, or was slow in responding to the parent's requests. On the other hand, some parents reported positive experiences sharing the results with their child's school and advocating for services. Parents also reported sharing assessment results with extended family members, doctors, and tutors, and 77% of parents having at least some discussion of the results with their child, although often this was very limited due to the child's age. Finally, most parents interviewed reported trying most or all of the assessor's recommendations, and most parents reported having read the assessment report and finding it helpful.

Implications for Future Research

Despite the small sample size obtained in the current study, the positive trends in line with predicted group differences show that this is an area that warrants further research. A larger study along the same lines, incorporating more assessors and attaining a larger sample size, would be advisable. The current results show an average observed effect size of $d = .48$ across the dependent variables included in this study. This is relatively consistent with the overall effect size of .423 found in a recent meta-analysis of psychological assessment as a therapeutic intervention (Poston & Hanson, 2010). With an expected medium effect size of .48, a sample size of 110 would be recommended in order to achieve the recommended power of $(1 - \beta) = .8$. Thus, a future study should aim for that sample size.

A number of considerations related to data collection procedures might affect the feasibility of obtaining a larger sample size in a future study. As originally proposed, the current study called for participants to be enrolled in the study prior to beginning the assessment process; to complete measures in person at the private practice immediately following their meetings with the assessors; and to allow audio-taping of all parent-assessor meetings. This procedure proved to be infeasible with the setting and population studied: over a six month period during which all parents meeting study criteria were invited to participate when scheduling their initial appointment, no parents agreed to take part in the study. The most common reasons provided were lack of time and desire for privacy. For this reason, modifications were made to the protocol including enrolling participants only after the assessment was complete, allowing online completion of

measures and phone interviews at participants' convenience, and eliminating audio-taping of clinical sessions. After these modifications were put in place, 96% of parents initially agreed to participate when asked by the assessor following their feedback session, with 65% actually following through on completing the online survey. This suggests the benefits of using online data collection methods, which allow for greater convenience and privacy for participants. On the other hand, some downsides to online data collection were also encountered. These included a loss of control over how soon after feedback parents completed the measures, and the fact that many parents did not follow through on completing the measures at all. Even among those who did complete the online measures, scheduling difficulties interfered with completion of qualitative interviews for many of the participants.

The increased response rate after implementing modifications to the study also suggests that parents may be more willing to agree to participate in such a study once the assessment is complete rather than before the assessment has begun. One can imagine a variety of reasons why this may be the case: for example, after the assessment parents already know what it has revealed, eliminating uncertainty about the information they may be asked to discuss as part of the research process; given their established relationship with the assessor, they may feel more interpersonal pull to participate in the research; or parents with especially high or especially low satisfaction may feel motivated to have their experience represented in the study results. Of course, it would be preferable to enroll parents in the study before beginning the assessment, as all of these factors could introduce sampling bias if they resulted in a differential response rate.

Based on the difficulties encountered during the current study, enrollment of participants prior to the assessment may require providing a more substantial incentive than the $10 gift card used in this study.

Prior to modifying the study procedures, the private practice employee responsible for schedule appointments, who had been asking parents to participate in the study during their initial phone contact, provided her impressions of parents' refusal to participate. She explained that parents calling to schedule an assessment often knew little about the process prior to their call, and frequently sounded overwhelmed when she explained the time commitment and expense. She hypothesized that ending this conversation with a request for a greater time commitment and loss of privacy, with an incentive that seemed quite insignificant in comparison to the expense of the assessment, was not appealing to parents. Thus, if a future study were to try to enroll participants before they began the assessment, it may be advisable to offer a more substantial incentive or to delay the request for participation to a follow-up phone call made specifically for that purpose.

An additional consideration is the impact of changes in the private practice that interfered with the data collection process. Any study conducted in a single, small practice setting, with a small group of assessors, over a protracted period of time would be vulnerable to the same difficulties that this study encountered. One assessor left the practice, another's caseload changed such that she saw fewer clients who qualified for the study, and the third began having much of her testing completed by interns. In order to reduce the potential of such events to interfere with data collection, an improved study

design might use a larger practice setting, a greater number of assessors, and require a shorter time period to attain to desired sample size (e.g., by choosing a well-established practice with a high volume of referrals). Further research in this area might also aim to incorporate a variety of practice settings, a more diverse group of clients, and a wider range of referral concerns in order to improve the generalizability of the findings.

An additional direction for future research would be the isolation of specific components of collaborative assessment for integration in traditional assessments. While the current study provided assessors with a brief overview of several collaborative and therapeutic assessment practices and invited them to integrate the ones that they found most feasible and potentially useful, another method would be to provide training in one specific technique (e.g., only asking for assessment questions, or only ordering feedback according to parents' anticipated reaction) and having assessors incorporate that technique in isolation. This would help identify the utility of specific techniques and could be used to better target recommendations for training assessors.

Implications for Assessment Practice

This study showed that it was feasible to train psychologists who had no prior experience with collaborative assessment methods to incorporate some of these methods into their practice. The participating assessors reported that they were able to integrate some methods, particularly the use of assessment questions and the practice of ordering feedback based on parents' expected response, into their assessments with little additional time required. Both of the assessors spoke very positively about their experience using these methods and planned to continue to use them in the future.

In addition to it being feasible for assessors to integrate collaborative methods, this study also provided some preliminary support for the idea that the inclusion of collaborative methods may improve parents' experience of the assessment. In particular, parents' quantitative ratings, parents' interview responses, and assessors' interview responses all converged to suggest the benefits of asking parents for assessment questions at the initial meeting, and gauging what they hope to learn from the assessment. Although the assessors' standard practice included gathering referral concerns, the qualitative interviews revealed that some parents had latent hopes and expectations for the assessment process that did not emerge until during or after the final feedback meeting, contributing to some degree of disappointment or dissatisfaction. In this study's small sample of parents who participated in assessments incorporating collaborative methods, there was no indication that these parents had that experience. As one assessor noted, "I was much more overt about asking what their questions were and sort of rank-ordering them. And I didn't really do that before. I mean I would want to know what their concerns were, and I probably had a vague sense of what the importance was to them, but… [when I asked for questions] it was more specific and targeted." This finding is particularly significant because asking parents for their assessment questions appears to be one of the most feasible collaborative methods to incorporate in isolation. It requires little additional time, and assessors can be taught to implement it at a basic level without requiring extensive training (although mastery of the technique, resulting in higher-quality assessment questions, would require more training). In light of these findings, psychologists who frequently assess children and adolescents may wish to consider

learning about selected collaborative and therapeutic assessment methods and to explore integrating them into their standard practice for assessments.

Limitations

Significant limitations of the current study include the small sample size and unbalanced groups, contributing to low statistical power to detect an effect. A further limitation was the use of a quasi-experimental design and the possibility that observed group differences could in fact be attributable to some other factor. In particular, the fact that all standard-practice data was collected before all collaborative-assessment data meant that a number of time-based factors could potentially have influenced the data. For example, changes made at the private practice, changes in the referral base, or assessors' increased general experience over the 18-month data collection period could have contributed to observed differences between the groups.

Additional limitations concern the data collection methods. The fact that the only available treatment fidelity ratings were the assessors' own self-ratings prevented adequate independent observation of the extent to which the intended techniques were actually and effectively incorporated into the assessments. A better method would involve audio-recording clinical sessions for later rating by an independent rater; although this was originally proposed for the current study, it was no longer possible after modifications to the study procedures eliminated the opportunity to audio-record sessions. Additionally, the qualitative interviews were all conducted by the primary investigator, who necessarily was not blind to treatment condition; a more rigorous study would use an interviewer blind to condition.

Even with these limitations, the apparent trends in the data suggest that future research in this area could be fruitful. The study provides promising preliminary indications of the feasibility of training assessors to incorporate selected collaborative techniques into their assessments, as well as the positive effects on parents' experience of and satisfaction with the assessment experience when such techniques are incorporated.

Appendix A

PEAS-I Case Information Sheet

To be filled out by respondent						
Respondent's Name						
Respondent's Gender	□ male □ female					
Relationship to Child						
Highest Grade Completed						
Date Form Completed						
Child's Name						
Child's Gender	□ male □ female					
Child's Date of Birth						
Child's Race	American Indian or Alaskan Native	Asian or Pacific Islander	Black, not of Hispanic Origin	Hispanic	White, not of Hispanic Origin	Other/ Unknown
(please check one)						

To be filled out by assessor				
Case ID Number				
Name of Facility				
Assessor's Name				
Type of Assessment	Psychoeducational	Personality/ Socio-Emotional	Neuropychological	Other- Explain
(please check all that apply)				
Start Date of Assessment				
End Date of Assessment				
Number of Sessions				
Number of Hours of Client Contact				
Child Diagnosis				

Parent Experience of Assessment Survey-I (PEAS-I)

Respondent's Name	
Child's Name	
Date	

This questionnaire deals with your thoughts and feelings about your child's psychological assessment. Please read each statement carefully. Once you decide how much you agree or disagree with a statement, circle the number that best matches how the statement applies to you. Be as honest and as accurate as possible. Please do not skip any item and check only one box for each statement.

Use the following scale to rate each statement:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. The assessor worked well with my child.	1	2	3	4	5
2. I learned new ways of interacting with my child.	1	2	3	4	5
3. The assessor was genuinely interested in helping us.	1	2	3	4	5
4. I had a say in what the assessment focused on.	1	2	3	4	5
5. My child did not like the assessor.	1	2	3	4	5
6. The assessment process was very confusing.	1	2	3	4	5
7. I now see that our family will need to change to help my child.	1	2	3	4	5
8. I am more aware of my child's strengths.	1	2	3	4	5
9. The assessment made me feel guilty.	1	2	3	4	5
10. I liked the assessor.	1	2	3	4	5
11. The assessor helped me explain the assessment to my child.	1	2	3	4	5

Use the following scale to rate each statement:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
12. Our family has little to do with why my child has problems.	1	2	3	4	5
13. Now I know more about why my child acts the way he/she does.	1	2	3	4	5
14. My child never really warmed up to the assessor.	1	2	3	4	5
15. The assessor liked me.	1	2	3	4	5
16. I was informed about each step of the assessment.	1	2	3	4	5
17. I am uncomfortable with how much the assessment revealed.	1	2	3	4	5
18. I didn't learn anything new about my child from the assessment.	1	2	3	4	5
19. I felt close to the assessor.	1	2	3	4	5
20. I never really understood the point of the assessment.	1	2	3	4	5
21. Many of my child's difficulties have to do with our family.	1	2	3	4	5
22. I learned a tremendous amount about my child from this assessment.	1	2	3	4	5
23. The assessment made me feel ashamed.	1	2	3	4	5
24. I felt like part of a team working to help my child.	1	2	3	4	5
25. The assessment revealed how family members play a role in my child's problems.	1	2	3	4	5
26. I felt the assessor respected me.	1	2	3	4	5
27. Now I am more confused about how to handle my child.	1	2	3	4	5
28. I helped make sense of the test results.	1	2	3	4	5

Use the following scale to rate each statement:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
29. The assessor never really understood my child.	1	2	3	4	5
30. I don't believe our family makes my child's problems worse.	1	2	3	4	5
31. I felt blamed for my child's problems.	1	2	3	4	5
32. Now I know specific things I can do to help my child.	1	2	3	4	5
33. I understood the goals of the assessment.	1	2	3	4	5
34. I felt the assessor was cold towards me.	1	2	3	4	5
35. My child looked forward to meeting with the assessor.	1	2	3	4	5
36. My child is the only person in our family who needs to change.	1	2	3	4	5
37. I wish I had learned more concrete ways to help my child day to day.	1	2	3	4	5
38. The assessor asked me if the assessment findings seemed right to me.	1	2	3	4	5
39. The assessment was a humiliating experience.	1	2	3	4	5
40. The assessment completely changed the way I view my child.	1	2	3	4	5
41. I felt the assessor looked down on me.	1	2	3	4	5
42. My child felt comfortable with the assessor.	1	2	3	4	5
43. My child is worse with our family than with other people.	1	2	3	4	5
44. I trusted the assessor.	1	2	3	4	5
45. The assessor got my child to work really hard.	1	2	3	4	5

Use the following scale to rate each statement:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
46. I am better able to communicate with my child.	1	2	3	4	5
47. No one ever told me what would happen during the assessment.	1	2	3	4	5
48. I now see how our family's problems affect my child.	1	2	3	4	5
49. My child and the assessor really connected well.	1	2	3	4	5
50. The assessment made me feel like a bad parent.	1	2	3	4	5
51. Now I know what to expect from my child.	1	2	3	4	5
52. I felt judged by the assessor.	1	2	3	4	5
53. My child's problems are partly caused by other struggles in our family.	1	2	3	4	5
54. The assessment has helped me have more patience with my child.	1	2	3	4	5
55. I felt that my opinion was valued.	1	2	3	4	5
56. The assessment was overwhelming.	1	2	3	4	5
57. My child dreaded almost every meeting with the assessor.	1	2	3	4	5
58. I have lots of new ideas about how to parent my child.	1	2	3	4	5
59. My child struggles more when people in our family aren't getting along.	1	2	3	4	5
60. At the end of the assessment, I was left feeling angry.	1	2	3	4	5
61. The assessor seemed to like my child.	1	2	3	4	5
Use the following scale to rate each statement:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**

62. I was anxious throughout the assessment.	1	2	3	4	5
63. The assessor really listened to me.	1	2	3	4	5
64. I understand my child so much better now.	1	2	3	4	5

Appendix B

Client Satisfaction Questionnaire (CSQ-8)

Please help us improve our program by answering some questions about the assessment your child received. We are interested in your honest opinion, whether it is positive or negative. Please answer all of the questions. Thank you very much, we really appreciate your help.

CIRCLE YOUR ANSWER

1. How would you rate the quality of service you received?

1	*2*	*3*	*4*
Poor	*Fair*	*Good*	*Excellent*

2. Did you get the kind of service you wanted?

1	*2*	*3*	*4*
Yes, definitely	*Yes, generally*	*No, not really*	*No, definitely not*

3. To what extent has our program met your needs?

1	*2*	*3*	*4*
None of my needs have been met	*Only a few of my needs have been met*	*Most of my needs have been met*	*Almost all of my needs have been met*

4. If a friend were in need of similar help, would you recommend our program to him or her?

1	*2*	*3*	*4*
Yes, definitely	*Yes, generally*	*No, not really*	*No, definitely not*

5. How satisfied are you with the amount of help you have received?

1	*2*	*3*	*4*
Very satisfied	*Mostly satisfied*	*Indifferent or mildly dissatisfied*	*Quite dissatisfied*

6. Have the services you received helped you to deal more effectively with your child's problems?

1	*2*	*3*	*4*
No, they seemed to make things worse	*No, they really didn't help*	*Yes, they helped somewhat*	*Yes, they helped a great deal*

7. In an overall, general sense, how satisfied are you with the service you have received?

1	*2*	*3*	*4*
Quite dissatisfied	*Indifferent of mildly dissatisfied*	*Mostly satisfied*	*Very satisfiend*

8. If you were to seek help again, would you come back to our program?

1	*2*	*3*	*4*
Yes, definitely	*Yes, generally*	*No, not really*	*No, definitely not*

Appendix C

Parents' Positive and Negative Emotions (PPNE)

Name:_____
Child: _____
Date: _____

Please answer the following questions, using the 5-point scale provided. Think about how you're feeling RIGHT NOW.

	Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5
Today as I think about my child's challenges and future I feel…..					
1. patient	1	2	3	4	5
2. scared	1	2	3	4	5
3. sympathetic	1	2	3	4	5
4. frustrated	1	2	3	4	5
5. compassionate	1	2	3	4	5
6. like I want to give up	1	2	3	4	5
7. encouraged	1	2	3	4	5
8. overwhelmed	1	2	3	4	5
9. at my wits end	1	2	3	4	5
10. determined	1	2	3	4	5
11. stuck	1	2	3	4	5
12. hopeful	1	2	3	4	5

	Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5
13. anxious	1	2	3	4	5
14. positive	1	2	3	4	5
15. tired	1	2	3	4	5
16. that I have support	1	2	3	4	5
17. alone	1	2	3	4	5
18. pretty good	1	2	3	4	5

Appendix D

Post-Feedback Parent Qualitative Interview

Name: _____

Child: _____

Date: _____

1. Overall, how was your experience with your child's assessment? How was your child's experience?

2. What stands out for you from the feedback you received?

3. How well did the assessment address the questions or concerns that you had about your child?

4. Did the assessor's recommendations seem useful and realistic? Do you think that you will follow through on them?

5. How do you expect the assessment to help you and your child in the future?

6. Were there parts of the assessment process or things the assessor did that you really liked?

7. What didn't you like about the assessment?

8. What suggestions do you have for things the assessor or ApaCenter could change about the way they do assessments?

Appendix E

Follow-Up Parent Qualitative Interview

Name: _____

Child: _____

Date: _____

1. Looking back on the assessment, how has it been helpful to you?

2. What do you remember most about your feedback meeting with the assessor?

3. Have you reviewed the written report or the audio recording of the feedback session again?

4. Have you and your child continued to discuss the assessment?

5. Have you been able to implement any of the recommendations from the assessment?

6. Have you shared the results with your child's school or with anyone else? If so, what was that process like?

7. What will your next steps in seeking help for your child?

8. Have you contacted ApaCenter for any reason since the assessment?

9. In general, how satisfied are you with your decision to have your child assessed at ApaCenter?

10. Looking back, is there anything ApaCenter could have done to make the assessment more useful to you?

Appendix F

Assessor Qualitative Interview

Assessor: _____

Date: _____

1. On the whole, what was your experience of learning and using collaborative methods like?

2. What methods were the easiest to learn or the most similar to the ways you already practiced assessment?

3. What methods were the most challenging to learn or the most different from your typical practices?

4. What methods were the easiest to incorporate into your assessments?

5. What methods were the most difficult or time-consuming to incorporate into your assessments?

6. In your experience, what were the benefits (to your clients and to you) of using collaborative methods?

7. Are there any methods that you think you may continue to use in future assessments?

Appendix G

Intervention: Assessments Incorporating Collaborative Methods

Initial Interview with Parents	• Explicitly invite parents' collaboration • Use parents' language • Co-construct assessment questions with parents • Ask what answers parents would expect for some of the questions • Find out what parents hope and fear learning from the assessment
Child Testing	• Ask for child's understanding of reasons for the assessment • Provide an explanation of the purpose of the testing and what it will involve • Explain each test and what it will help the assessor learn about the child • Following standardized administration, ask about the child's experience of the test and how it might be connected to other, "real life" experiences • In some cases, use "testing of the limits" or "extended inquiry" techniques to explore test responses in more detail
Interpretation/Conceptualization	• Organize findings as responses to parents' assessment questions • Based on what is known about parents, develop hypotheses about how they will react to various feedback • Sequence feedback according to Finn's levels, based on these hypotheses • Develop an outline for presenting information to parents during the feedback session
Feedback to Parents	• Assess parents' affective reactions and re-order sequence in which later findings are presented, if necessary • Ask for parents' reactions throughout the session; find out if they agree or disagree with findings

Appendix H

Assessor Self-Ratings

As you think about your interview with this child's parent(s), please rate your use of the following techniques and behaviors:

1. Explicitly invited the parent(s) to collaborate

1	2	3	4
Did not use	Used somewhat	Used effectively	Used very effectively

2. Asked parents about previous experience with psychological assessment and addressed any areas of concern

1	2	3	4
Did not use	Used somewhat	Used effectively	Used very effectively

3. Adopted terms and language used by the parent(s)

1	2	3	4
Did not use	Used somewhat	Used effectively	Used very effectively

4. Co-generated assessment questions with the parent(s)

1	2	3	4
Did not use	Used somewhat	Used effectively	Used very effectively

5. Asked about events and context that led parent(s) to ask these questions

1	2	3	4
Did not use	Used somewhat	Used effectively	Used very effectively

6. Asked what answers parent(s) would expect to some of the questions

1	2	3	4
Did not use	Used somewhat	Used effectively	Used very effectively

7. Asked what parent(s) hoped and feared learning from the assessment

1	2	3	4
Did not use	Used somewhat	Used effectively	Used very effectively

How many assessment questions were generated? _____

As you think about your testing session today with this child, please the extent to which you used the following techniques and behaviors:

1. Made sure the child understood the purpose of the assessment

1	2	3	4
Did not use	Used somewhat	Used effectively	Used very effectively

2. Explained what each test would help you learn about the child

1	2	3	4
Did not use	Used somewhat	Used effectively	Used very effectively

3. Asked how the child experienced each test

1	2	3	4
Did not use	Used somewhat	Used effectively	Used very effectively

4. Asked the child how test experiences might be connected to "real life" experiences

1	2	3	4
Did not use	Used somewhat	Used effectively	Used very effectively

5. Used "testing of limits" following standardized administration

1	2	3	4
Did not use	Used somewhat	Used effectively	Used very effectively

6. Used extended inquiry following standardized administration

1	2	3	4
Did not use	Used somewhat	Used effectively	Used very effectively

7. **Was very encouraging of the child**

1	2	3	4
Did not use	Used somewhat	Used effectively	Used very effectively

Approximately how much time did you spend with the child? _____

As you think about your feedback session with this child's parent(s), please rate your use of the following techniques and behaviors:

1. Organized feedback according to anticipated "levels" prior to session

1	2	3	4
Did not use	Used somewhat	Used effectively	Used very effectively

2. Presented findings as answers to parents' assessment questions

1	2	3	4

Did not use	Used somewhat	Used effectively	Used very effectively

3. Assessed parents' affective reactions and re-ordered feedback, if necessary

1	2	3	4
Did not use	Used somewhat	Used effectively	Used very effectively

4. Asked for parents' reactions throughout the session

1	2	3	4
Did not use	Used somewhat	Used effectively	Used very effectively

5. Invited parents to agree or disagree with findings

1	2	3	4
Did not use	Used somewhat	Used effectively	Used very effectively

6. Asked parents for examples of how findings do or do not fit with their experiences of their child

1	2	3	4
Did not use	Used somewhat	Used effectively	Used very effectively

Were there any assessment findings that you did not share with the parents?

Did you share findings that you felt were (circle as many as applicable):

Level 1 **Level 2** **Level 3**

Appendix I

Item-by-Item Descriptive Statistics for Assessor Self-Ratings

		A1 (n = 6)		A2 (n = 2)		Total (n = 8)	
		M	*SD*	*M*	*SD*	*M*	*SD*
Initial Session	Explicitly invited the parent(s) to collaborate	3.00	.00	3.50	.71	3.13	.35
	Asked parents about previous experience with psychological assessment and addressed any areas of concern	3.00	.00	3.00	.00	3.00	.00
	Adopted terms and language used by the parent(s)	3.17	.41	2.50	.71	3.00	.53
	Co-generated assessment questions with the parent(s)	2.67	.52	4.00	.00	3.00	.76
	Asked about events and context that led parent(s) to ask these questions	3.33	.52	3.50	.71	3.38	.52
	Asked what answers parent(s) would expect to some of the questions	2.33	.52	2.50	.71	2.38	.52
	Asked what parent(s) hoped and feared learning from the assessment	2.00	.00	3.00	.00	2.25	.46
Child Testing Sessions	Made sure the child understood the purpose of the assessment	2.83	.41	3.50	.71	3.00	.53
	Explained what each test would help you learn about the child	1.83	.41	2.00	.00	1.88	.35
	Asked how the child experienced each test	2.50	.55	2.00	.00	2.38	.52
	Asked the child how test experiences might be connected to “real life” experiences	2.00	.63	2.50	.71	2.13	.64
	Used “testing of limits”	1.83	.41	2.00	1.41	1.88	.64

	following standardized administration						
	Used extended inquiry following standardized administration	1.17	.41	2.50	.71	1.50	.76
	Was very encouraging of the child	3.83	.41	4.00	.00	3.88	.35
Feedback Session	Organized feedback according to anticipated "levels" prior to session	2.50	.55	3.50	.71	2.75	.71
	Presented findings as answers to parents' assessment questions	3.33	.52	2.00	1.41	3.00	.93
	Assessed parents' affective reactions and re-ordered feedback, if necessary	3.17	.41	3.50	.71	3.25	.46
	Asked for parents' reactions throughout the session	2.17	.41	4.00	.00	2.63	.92
	Invited parents to agree or disagree with findings	3.00	.00	3.00	.00	3.00	.00
	Asked parents for examples of how findings do or do not fit with their experiences of their child	2.67	.82	2.50	2.12	2.63	1.06
Overall Average Score		2.62	.11	2.95	.07	2.70	.18

Appendix J

Example of Organizational and Coding System for Parent Qualitative Interviews

	Time 1 Interview	Time 2 Interview
Overall experience	it was a good experience	
What was helpful/liked	it seemed like a very calm place to be… It wasn't, you know, a huge, busy office in a building[f], and… I was really nervous about leaving my son.[d] And just the fact that it just... there wasn't a lot of people there, and the doctor was very laid back, and calmed us[b], so... she just, to listen and genuinely care[b]	It has been helpful. We're struggling getting help from the teachers, but [the assessment] itself was helpful. getting us to understand what, where his problems lie, and actually getting the diagnosis,[a] and all of the recommendations that she had were good, and helped.
What was not helpful/not liked or suggestions for improvement	I do wish I had learned more about his strengths, like what he could do with those strengths. Like what he could do in the future.	
How was it to hear feedback? (What do you remember most, was any difficult to hear, how was the experience of the meeting?)	It was good… I think I like the fact that she, the doctor, wanted to start minimally, you know, and not... not just right away start out with medication, and just try the simplest things. I think some of it was confusing[d] to me, I didn't know exactly what she was talking about, I think I had to have her explain it a lot.[c]	Just that it was very helpful, and it helped us to understand what's going on… to help him try and do better.[a]
Recommendations –	Very useful. Very realistic.	We have tried, but it doesn't

helpful, useful, tried, not tried?	I think I understood them all.	seem to be working…. I think they were good recommendations, but for some reason it's just not working with him. and all of the recommendations that she had were good, and helped. *[I: So some of them helped?]* Well, when I say they've helped… they… it, it made us understand better what we could do, because at that point we didn't know where to go or what to do,[a] but -- *[I: Right. So you got an idea of where to start]*Right, right.
Next steps in seeking help for your child?		I might end up taking this assessment to his primary care doctor and seeing if we can get him started on some medication.
How well did the assessment address your concerns?	Very well.	
Anything you hoped to get out of the assessment but didn't?	Just the thing with the strengths. I guess wanting to... I guess I thought I was going to learn more about what he would be good at in the future. When he grows up.	
Who do you plan to share the findings with?	[school, child]	[considering sharing with doctor]
Shared results with child?/Continued to discuss assessment with child?	A little. Not much. we didn't explain it to him too much, and he's not too worried about it or anything. We just talked about it a	No, not really.

	little.	
Shared results with school? How did that go?	We've already gone, we've already met with the school, everything is already in place.	We've talked a couple times, but it's not really helping. Basically. That's just the school.
Any anticipated problems (e.g., with school or with implementing recommendations)	I don't think [the school] thought that it was a problem of, an attention problem. I think they thought it was a problem of... discipline, or maturity.	
Feel able to communicate results effectively to others?	Somewhat… I think they had a lot of... the principal and the teachers kind of already had set in their minds what the problem was	
How do you expect the assessment to help in the future?	I think we'll always go back to her recommendations, and just always looking back at that report to see what we can do. Um, and I know if maybe, maybe if it didn't work I would always go back to her, and see what her recommendations were.[e]	
Have you reviewed the written report since the end of the assessment?		I haven't since then. … I do need to go back and look over it
Have you contacted the assessor since the end of the assessment?		No. No, I haven't.
In general, how satisfied with your decision to go there for the assessment?		Very satisfied.

[a] Learned new things/better understanding
[b] Parent's or child's relationship with the assessor
[c] Collaboration
[d] Parent's emotional experience

[e] Outlook for future
[f] Logistics or non-assessment-related features of the experience

Appendix K

Selected Quotes from Parent Interviews

Areas of Dissatisfaction

(Standard) I thought I'd get a more accurate picture of where he would be. It was not as clear as I thought it would be. They work with parents well, but could communicate better up front that it may not be fully accurate, just a minimum measuring stick.

(Standard) I'm just learning with the limits to some of the testing, particularly the gifting testing. It's really, I mean I understand it to be a very left brain assessment in a lot of ways, and so trying to understand where she might be gifted, more artistic areas and things like that, I guess just has to come from other observations. ..Some of my hopes for information were not necessarily exactly what was being tested.

(Standard) [I would have liked] for the doctor really to give me some help prior to [the testing] on how to explain to my child, "Hey look, you're going to be assessed, this is what's going to happen, and this is how it works."

(Standard) I wanted more time talking at eh end, and wanted to incorporate my child into it. He was not included but he feels like something was wrong with him. He did all the testing and he should have gotten something out of it. I would have liked to meet as a family to have the results explained."

(Standard) I would have liked a consultation first before deciding to go ahead with the testing, and that they'd recommended coaching instead. That would have been a better use of money. … I want him to learn how to compensate for his ADHD – testing doesn't mean so much.

Collaboration

(Standard) I was appreciative of the fact that she approached the feedback a little more holistically. You know, it wasn't just the numbers and that sort of thing, it was the whole thing that she heard from me that she was addressing.

(Standard) She was informative and patient with us, good about answering questions; she used real-world terms I could comprehend.

(Standard) She explained everything about the process and she was just very thorough in going through what they did during the assessment.

(Collaborative) It was wonderful. I felt that they both took a lot of time and explained

everything to me. And answered any questions that I could possibly think of, and took the time to listen to me, and have me, like, re-explain the feedback. You know, so that I made sure I understood exactly what was going on. And they just spent a lot of time with me.

(Collaborative) She was real explanatory, with both of us. I think she treated [son] like someone who could understand, and, you know, didn't treat him like a baby. And with me, didn't give me information in a patronizing way, was very even keel level with me.

(Collaborative) The way things were explained to us; the care she took in having that conversation, leading us through to get us to a certain point rather than just telling us, "She has ADHD."

Importance of logistical procedures

(Standard) It seemed like a very calm place to be – it wasn't, you know, a huge busy office in a building.

(Standard) They need to have someone there in the office at 8 a.m. … she was running late and we had to wait in the car.

(Standard) The office was very warm; it wasn't clinical. More of a living room type environment.

(Standard) I thought it was really good that [the assessor] ordered pizza for my daughter during lunch. It made it so my daughter had a very positive experience, because she got to eat pizza at lunch

(Collaborative) I loved how they offered up the iPad with games when we walked in that morning. It just immediately put [daughter] at ease, and she just knew that she could have fun there – I mean, I have a second grader, so, I mean, she's young. And didn't know why she was there, but just thought it was the best thing ever.

(Collaborative) She was very accommodating on our schedule, and when we could get my son back in there for his testing.

Learning/Understanding

(Standard) It helps us be more patient and understand he's not just goofing off and misbehaving.

(Standard) It helps us understand what's realistic to expect and how to hold him accountable.

(Collaborative) Being told that she's slightly dyslexic is way better than ADD. Because I felt like I knew what I could do to fix dyslexia. I did not even want to go where, what I Had to do with ADD. To try to figure that out. I didn't want to go down that road. And so for me it was awesome. It was great to hear [that it wasn't ADD].

(Collaborative) I think it's helped us because we know where some of her strengths lie, and her weaknesses… and it just explained a lot of who she is. And it's helped us, the last few weeks, discipline her a little bit… or get her back on track.

(Collaborative) I found out a lot more about my child than just the fact that he was dyslexic. It sort of opened up a lot of information channels for me to understanding him.

(Collaborative) It answered a lot of questions for us on her behavior. The way we parent her is different now. It gave us options of things to do.

(Collaborative) I learned a lot about it because I'd never really known very much about ADD and ADHD. So, I felt like I was very well educated on what it is and, you know, the signs of it, that I never would have thought that he had it. Because I always thought, you know, ADHD is just for hyper kids.

Benefits of the assessment/outlook for future

(Standard) I feel like we are on the right track, and I feel like the assessment was a catalyst, you know, as well as an insight.

(Standard) I think it just kind of filled out our picture of reality. Of what [daughter]'s strengths and weaknesses are, and where we need to look at some issues, you know, with regards to behavior.

(Standard) We'll know what his differences are going forward and how to help him.

(Standard) It was just a reassurance that we weren't nuts and that we weren't imagining things. I was nervous that he didn't have anything, but he did. I was thankful that he did and I could go on to the next step.

(Standard) Relief! It doesn't solve everything but at least I know I'm going in the right direction.

(Collaborative) It'll help hugely, because he has ADHD, and it has set us on a new path. Of training and understanding.

Discussing with child

(Standard) No, because he has confidence issues and gets frustrated easily – I just want to

encourage him.

(Standard) [We explained it] as best we can for a six year old. We call it "a little hiccup."

(Standard) Not in detail, because I don't want to make him feel like something is wrong. I've told him his brain works differently and we've found the best way to help him.

(Standard) I still sometimes stumble on my words because I don't want him to think that it's his fault that he's going through this. And trying to make him understand that sometimes people are just born with things that are not always, you know, the best, and that's the hard part, but I think between my husband and me I we're doing pretty good.

(Standard) Yeah, she kind of knew that her brother was so severely dyslexic, and she was resistant at first, but now that we've started kind of applying the results [to help her] … It's like, oh, okay. She's very accepting of the results, if you kind of try to work it in with explaining why she's having trouble with her issues in school. I would say at first she was very upset about the results, and now she's very accepting.

(Standard) Oh yeah, he wanted to know that night. We just told him that he was gifted and talented as anticipated, and that he needed to work a little harder.

(Collaborative) Not really, we made light of it because she has older siblings and we didn't want her to feel different.

(Collaborative) She had a meeting with him for feedback, and then a meeting with us, and then a meeting with all of us together. And going into the whole thing, my son didn't want to do it. You know, mind of his own, didn't think he needed it and didn't understand what it was all about. And so, you know, eventually he was glad he did it. Now that he's seeing the results and what medication is doing for him, now he says he feels like a totally different person.

Interactions with school

(Standard) It's going to be an ongoing kind of a vigilance thing, making sure that it [appropriate gifted education] is occurring. You know, every year I have to make sure that she's going to get into the right class with a teacher who's really trained to do this kind of stuff, and all that.

(Standard) I gave the report to the school, but they wanted to do their own testing. I just got the findings back, and they said he didn't qualify [for services] even though [assessor] said he did… I used to think the school cared about kids' best interests, but now they seem like just another corporation.

(Standard) I don't think [the school] thought it was an attention problem. I think they thought it was a problem of discipline, or maturity. … The principal and the teachers kind of already had set in their mind what the problem was. … We've talked a couple times, but it's not really helping, basically. That's just the school.

(Standard) His diagnosis is rare, not many people have heard of it, and the public school doesn't offer many options.

(Standard) We're not asking for anything from the school. They already make some accommodations for her, but they advertise that they don't really make accommodations, so we're not asking for anything.

(Standard) She didn't really give him a diagnosis, so I don't know if without a diagnosis if they'll pull him out of the class.

(Standard) [The assessor] gave very specific notes to the teachers about what would and wouldn't benefit her. … She goes to a private school that's known for catering to special needs.

(Collaborative) It is my plan to show them her recommendations, but I probably will not be sharing my entire report. Because I just don't want them to have that. You know, they didn't pay for that information. And there's just, you know, they just don't need to know that much detailed information on my particular child. I just don't feel that it's any of their business. I just don't want them to know. I mean, there's some family history, you know, it's just nobody's business. Recommendations, specifics -- but I don't want that part of any permanent record for her. So, I mean, I'm more than willing to share verbally, but not written, the whole assessment. I don't feel that's appropriate. Because they don't have that information on every other child.

(Collaborative) Right now I'm in the process of working with his high school to hopefully get him part of the 504 program so he can have extra time on his SATs, because he's very very slow at test taking.

Recommendations

(Standard) I think we'll always go back to her recommendations, and just always looking back and that report to see what we can do. And I know if maybe if it didn't work, I would always to back to her and see what her recommendations were.

(Standard) They seem pretty useful. But again, I could've used more than just kind of the top-level. I needed to go a level or two down. I need to know where to go. To say, go see this person to interpret the results, who really knows dyslexia, to tell you what to do. I got kind of the top-level saying yeah you need tutoring, but [I wanted to know where to go]

to interpret the results more. What I did, I ended up taking the results to two different people that I knew and had them interpret it more to give a program for my daughter. So I'm still working on getting a program developed. Whereas with my son [who had a similar assessment elsewhere], when I got the results they said do this, do this, do this, do this -- this is what you do.

(Collaborative) They were very realistic. We've used all of them.

Report

(Standard) The school report is not very clear and has inconsistencies. I have more faith in the [private practice] testing – the report is longer, more detailed.

(Standard) The report was awesome – thorough and easy to understand.

(Collaborative) It's helpful, it's great. But not helpful in that I did provide [the whole report] to the school, against my better judgment… I was very much pressured by the school… and I felt that if I didn't give it to them that they felt like I was hiding information. And the most unhelpful part of it is that it had raw data, so people in our school… looked at the data and made their own interpretations.

Appendix L

Selected Quotes from Assessor Interviews

Getting parents' assessment questions:

Occasionally, without [asking for questions] you can have a situation where you think you have an understanding of what the parent questions are and why they're seeking the assessment, but you could miss something. And then in the feedback, it was lacking for them. You didn't meet all their needs. And that's a horrible feeling. And so [when I asked for questions] I trusted that that wasn't going to happen. I mean I guess it still could, but I just felt more confident with that.

I would say it helped with report writing some, because you wanted to make sure you really addressed the questions. I mean, you address that anyway, but I might elaborate more in certain areas than I typically would to make sure that they really had a better understanding of that. … And I also think I would sort of order my recommendations based on their questions, too. You know, those are going to be the first ones; they're going to be the top part of the recommendations -- what their questions were. Even if there was kind of a null finding on that, I'm still going to give some kind of recommendation based on strengths or weaknesses because they had that question to begin with.

I think the problem with my narrow referral base with all of the [specific private school] parents is they come in, usually, with the exact same question. And that puts me then in this zone of thinking that I know what everyone wants. So, like, yeah yeah yeah, same thing everyone else wants, that's what you want… I mean, half of time it is what it always is, but other times when I'm trying to get more specifics I find out there are also some issues at home that they're really wondering about, and a lot of times there are sort of parenting issues and ways of managing the kids that they're hoping to better understand. So that piece, I think it helped me with that.

Occasionally it would make me realize we needed to do a little more, maybe sentence completion or projective or a little more interview with the student than if it was a strict kind of dyslexia question. So there were times where it might have modified the testing a bit, but definitely the recommendations… Because sometimes there were issues about, like, food sensitivities and so forth, that our direct testing wasn't going to be helpful, but the recommendations and discussion about general parenting techniques and methods. You know, kind of the psychology piece of it, that we could give them as part of the assessment experience.

There was one question on the [treatment fidelity self-rating form] that it seemed like every time I went, "Oh, that would probably be a good idea," but I kept not doing it….

"Asked about events and context that led parents to ask these questions." That one. I make assumptions rather than explicitly asking. And that's probably the one where I thought, "Oh yeah, I need to stop assuming." I mean, that's a real problem with me, mind-reading. And I think that's the problem of sort of putting on expert goggles when I don't need to. And seeing so many [similar private school families], when I really probably am right a fair amount of the time, but it's the times you're not right that are important. So asking explicitly is important.
Ordering feedback into levels: I think that I've always -- I'm not one that just goes through the report section by section. [pause] Or maybe I was before the whole training, and I just don't remember. But I definitely am at least more mindful of the idea of having a plan for feedback. And sort of going with the information – you know, always leading with strengths, and then kind of going down the continuum of the levels. Although sometimes also being flexible, which was part of the training too… It at least reinforced if it didn't change the way that I do it, which is if I sense a lot of anxiety about, you know, "Just tell us already, is it ADHD or not?", then I'll say, let's just get to the diagnosis and then talk about supporting evidence. So I'm flexible in that way. Sometimes people can't hear the diagnosis until they hear all the supporting evidence, and sometimes people, you can tell they're not getting anything until they know what it is. And so I think it's at least helpful to know that that has some basis, to sort of do it that way, to have a plan, but to be able to take the parents' lead as well, and flow from that. I think I wasn't always as planful as I would like to consistently be, but I do prefer to be. I had one recently that was totally level 3, but the parents were relieved in a way. It was one where … they were worried it was ADD, they were certain it wasn't dyslexia, because they had an older kid with dyslexia and this kid didn't seem like it at all. And it turned out to be dyslexia. It was very odd. And so they were like, "Oh! We know what to do with dyslexia." So that was kind of an easy level 3. Unexpected, and very odd. But then they wrote me an email later, "Gosh, now that we listen to him read, we totally see it."
Plans for using collaborative techniques in the future: When this is over, I really kind of want to learn more about it. Because I know we kind of did sort of a truncated version of it. Oh, yeah. Yeah. It's the way that I practice, and the training just reinforced what I believe is the right way to do things, and just helped me to sort of structure it a little bit more.

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VITA

May Fraser Matson attended Thomas Jefferson High School for Science and Technology in Alexandria, Virginia. In August 1999, she entered the College of William and Mary in Williamsburg, Virginia and received the degree of Bachelor of Arts in Psychology and English in May 2003. In August 2003, she entered the Graduate School at the University of Texas at Austin in the Department of Educational Psychology. In August 2010, she completed her pre-doctoral internship at the Texas Child Study Center in Austin, Texas.

Permanent E-mail: may.matson@gmail.com

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