

"problem-specific" approach—one that focuses on areas important for a specific problem, yet that assesses certain factors that are relevant for all cases (e.g., marital conflict, parent-child relationship). Mash and Terdal (1988) further state that the clinician needs three kinds of information in order to provide adequate assessment: ① knowledge of general theories and principles of psychological assessment, including how to evaluate and select assessment methods, conduct an assessment, and communicate findings; ② knowledge of normal child and family development, such as that presented in Chapter 1 of this volume; and ③ information about the incidence, prevalence, developmental characteristics, biological influences, and other characteristics of specific problems. In this chapter, we briefly cover the general prevalence of child problems, present a system for comprehensive assessment that will be adapted to specific problems as they are covered in later chapters, and discuss methods of assessment that we have found most useful in our clinical practice.

## PREVALENCE OF PROBLEMS

### Issues of Classification

The prevalence of disorders in children is difficult to determine because of the variety of nonstandardized criteria used to identify the presence of a particular problem, as well as the varying labels and definitions of problem behaviors. Currently, no one classification system for children's behavioral problems is accepted and employed by all health care professionals. The system most commonly used in the United States at present is the revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R; American Psychiatric Association, 1987). DSM-III-R lists nine diagnostic categories that apply to infants, children, or adolescents, and also indicates the adult diagnostic categories that are appropriate for children because the essential features are the same for children as adults (e.g., Schizophrenia, Mood Disorders). The DSM-III-R disorders that usually appear during the first 10 years of life, and the age of onset for each, are listed in Table 3.1.

The DSM-III-R classification system is relatively new and thus has not been thoroughly critiqued for its usefulness. Earlier versions of the system, however, have been criticized for using behavioral criteria that do not correspond well to empirically derived clusters of behavioral symptoms, particularly for children under age 7 (Achenbach, 1980; Cantwell, 1988). On the positive side, DSM-III-R is widely used to classify children for research purposes, and thus provides a basis for determining the comparability of children across studies.

A number of behaviorally oriented mental health workers use a dimensional rather than a categorical approach to classification (Achen-

## Chapter 3

## Assessment

In dealing with children's behavior problems, assessment is a critical and complex component of the treatment process. The clinician not only must directly observe and record the child's behavior, but also must take into account social, cultural, biological, and developmental influences on the child. In choosing methods to assess clinically significant childhood behaviors and the potential influences on these behaviors, the clinician often feels like a juggler balancing an ever-increasing number of objects of different shapes and sizes! Behavioral psychologists, recognizing the complexity of human behavior, have defined assessment as "an exploratory, hypothesis-testing process in which a range of specific procedures are used in order to understand a given child, group, or social ecology and to formulate and evaluate specific intervention strategies" (Ollendick & Hersen, 1984, p. 6). Thus, treatment strategies depend on accurate assessment of the behavior of concern and the conditions that maintain it (Bornstein, Bornstein, & Dawson, 1984). This view of assessment is consistent with our approach to childhood problems.

Mash and Terdal (1988) suggest that because of the complexity of human development, behavioral assessment is moving more toward a

TABLE 3.1. Age of Onset and Prevalence of DSM-III-R Categories of Disorders Relevant for Children from Birth to 10 Years of Age

Disorder	Age of onset	Prevalence
<b>Developmental Disorders</b>		
Mental Retardation	Birth	1%
Pervasive Developmental Disorder	Before 3 years	10-15 per 10,000
Autism	Before 3 years	4-5 per 10,000
<b>Academic Skills Disorders</b>		
Developmental Arithmetic Disorder	6-10 years	Unknown
Developmental Expressive Writing Disorder	7-10 years	Unknown
Developmental Reading Disorder	6-9 years	2-8%
<b>Language and Speech Disorders</b>		
Developmental Articulation Disorder	3-6 years	10% < 8 years; 5% > 8 years
Developmental Expressive Language Disorder	Before 3 years for severe forms	3-10% of school-age children
Developmental Receptive Language Disorder	2-7 years	3-10% of school-age children
<b>Motor Skills Disorders</b>		
Developmental Coordination Disorder	Preschool	6% of 5- to 11-year-olds
<b>Disruptive Behavior Disorders</b>		
Attention-deficit Hyperactivity Disorder	Before 4 years	3%
Conduct Disorder	Prepubertal	9% of males, 2% of females
Oppositional Defiant Disorder	Precursors in preschool years	Unknown
<b>Anxiety Disorders</b>		
Separation Anxiety Disorder	Preschool to 18	Common
Avoidant Disorder	2% to early school years	Uncommon
Overanxious Disorder	Unknown	Common

<b>Eating Disorders</b>		
Anorexia Nervosa	12-18 years	1 in 100-800
Bulimia Nervosa	Adolescence	4.5% of females, 0.4% of males
Pica	1-2 years	Occasional
<b>Gender Identity Disorders</b>		
Gender Identity Disorder of Childhood	Before 4 years	Uncommon
<b>The Disorders</b>		
Tourette's Disorder	1-14 years	0.5 per 1,000
Transient Tic Disorder	2 years to adolescence	5-24% of school-age children
Chronic Motor or Vocal Tic Disorder	Before 21 years	Unknown
<b>Elimination Disorders</b>		
Functional Encopresis	4-8 years	1% of 5-year-olds
Functional Enuresis	5-8 years	5-year-olds: 7% of males, 3% of females; 10-year-olds: 3% of males, 2% of females
<b>Speech Disorders not Elsewhere Classified</b>		
Cluttering	After 7 years	Unknown
Stuttering	2-7 years	10% of school-age children
<b>Other Disorders</b>		
Elective Mutism	Before 5 years	<1%
Reactive Attachment Disorder	Before 5 years	Unknown
Stereotypy/Habit Disorder	Infancy	Unknown

Note: From *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., rev.) by the American Psychiatric Association, 1987, Washington, DC: Author. Copyright 1987 by the American Psychiatric Association.

bach, 1985; Quay, 1979). This approach does not lead to a statement that a child has a particular disorder, but rather describes the degree to which one or many characteristics are evident (Kazdin, 1987a) and allows the clinician to identify clusters of problems. A dimensional approach avoids the problem of deciding how severe a problem has to be before it is considered a psychopathological disorder, and also allows the clinician to deal with children who present with mixed clinical pictures (Rutter & Tuma, 1988). On the other hand, the dimensional approach assumes that symptom labels have the same meaning throughout the distribution (which might not be true). Moreover, classifying individuals is often difficult because they can have symptoms that fall on a number of different dimensions. As Rutter and Tuma (1988) point out, the distinction between the categorical and dimensional approaches is not always clear, with dimensions being translated into categories and vice versa. In reality, a combination of these approaches is probably most useful. For example, the categorical distinctions between severe and moderate mental retardation, and between both of these and normality, are useful for planning services and determining etiology and prognosis. The dimensional aspect of the intelligence level, however, is a very useful indicator in both the normal and abnormal ranges for planning specific educational and rehabilitation programs.

We have found both the categorical and dimensional approaches to classification useful in our work. Our assessment system (to be discussed later in this chapter) uses a variety of assessment methods to get a picture of the child; his or her family and important social/ecological factors; the child's behavior, compared to that of other children the same age; and the ways in which that behavior is viewed by the child's family and others in the child's environment. This leads to a judgment about the significance of the behavior problem and, if necessary, the appropriate areas to be considered for treatment. It can also result in the classification of a specific disorder.

### Estimates of Prevalence

Various epidemiological studies have led to a general consensus that from 5% to 15% of all children (or between 3 and 9.6 million children in the United States) have problems that require mental health services (Goldberg, Roghmann, McInery, & Burke, 1984; Kazdin, 1989; Richman, Stevenson, & Graham, 1975; Rutter, Tizard, Yule, Graham, & Whitmore, 1976; Starfield et al., 1980). As Kazdin (1989) and Chapter 2 of this book have pointed out, however, prevalence figures are influenced by many factors, including age, sex, geographic region, socioeconomic status, and so on. For example, prevalence of problems is greater for boys than for girls, for children living in urban than for those in rural settings, and for

children from single-parent than for those from two-parent families. Estimates of prevalence are also influenced by the perceptions of the referral persons (Kazdin, 1989). Children's problems are most often identified by parents; yet parents' perceptions of deviance are clearly influenced by their own characteristics (depression, marital conflict, self-esteem, etc.).

Despite these problems with estimates of prevalence, it is important to have some idea of the types of problems that are typically seen in young children. Table 3.1 above shows the estimated prevalence rates of DSM-III-R diagnoses. In contrast, Table 3.2 shows the percentage of concerns expressed by parents of non-clinic-referred children from birth to 10 years of age. One group was comprised of parents from a pediatric primary care practice who sought brief telephone consultation from psychologists over a 9-year period; the other was a random sample of 140 parents from the same pediatric practice who did not use this service (Schroeder, Gordon, Kanoy, & Routh, 1983). The table indicates that parents had similar concerns, whether or not they consulted the psychology staff. Negative behaviors (defined as noncompliance, temper tantrums, bossy and demanding behavior, crying, whining, and aggression) were the most troublesome for both groups of parents, supporting what others have found. Guidance of a talented child, specific fears, bad habits, sibling/peer problems, other family concerns/problems, food/eating problems, and concerns about death all caused considerable worry for the random sample of parents, particularly when one considers that parents' use of the telephone consultation service for these areas was relatively low. Toileting, school problems, and divorce-related problems were more often reported as concerns by the service users.

For both groups of parents, different problems seemed to peak at different ages. Table 3.3 illustrates the areas of concern to parents of children of a particular age. Problems with eating, sleeping, and toileting, as well as developmental delays, were reported as concerns more often in the preschool years; problems involving socialization were of greater concern in the school years. Negative behavior did not appear to center around the "terrible twos," but rather was a concern of parents of children at all ages. The greatest number of problems were reported for the 2- to 4-year-old group, with the ages of 5 and 6 being relatively calm, and another peak of problems reported between the ages of 7 and 10.

Another interesting question is the extent to which problems early in childhood are likely to persist. Earls (1983), for example, reported that 25% of the children in his sample with problems at 3 years also had problems at age 6. Externalizing problems (e.g., discipline problems, hyperactivity, and aggression) have predicted problems persisting beyond the preschool years (Bates & Bayles, 1988; Campbell, 1987; Fischer, Rolf, Hasazi, & Cummings, 1984; Gelfand & Peterson, 1985). For

TABLE 3.2. Definitions of Problem Categories and Percentage of Parental Concerns of a Random Sample and Users of Brief Psychological Consultation

Problem category and definition	Random sample (n = 523) <sup>a</sup>	Service users (n = 2,008) <sup>a</sup>
Negative behaviors	12%	15%
Noncompliance, temper tantrums, bossy and demanding, cries, whines, aggression.		
Toileting problems	2%	10%
Toilet training, enuresis, encopresis.		
Personality or emotional problems	6%	10%
Lacks self-control, no motivation, won't assume responsibility, lies, steals, dependent, difficult temperament.		
School problems	2%	9%
Hates school, poor achievement, learning problems, aggressive behavior, getting appropriate services, teacher-child relations.		
Sleep problems	4%	8%
Won't go to bed, wakes in night, nightmares, night terrors.		
Developmental problems	4%	7%
Slow development, perceptual-motor problems, school readiness, speech/language problems, overactive.		
Sibling/peer problems	6%	7%
Won't share, no friends, aggression, fights a lot, sibling rivalry.		
Divorce/separation	1%	7%
Custody, visitation schedule, adjustment, how to tell child.		
Family problems	6%	4%
Parents disagree on discipline, depressed/isolated mother, marital conflict, child abuse.		
Infant management	1%	3%
Feeding/nursing, colic, postpartum depression, difficult temperament.		
Specific bad habits	6%	3%
Nail biting, tics, thumb sucking.		

(continued)

TABLE 3.2. (continued)

Problem category and definition	Random sample (n = 523) <sup>a</sup>	Service users (n = 2,008) <sup>a</sup>
Specific fears	7%	2%
Dogs, dark, trucks, etc.		
Sexuality	3%	2%
Cross-sex dressing, lack of sex-appropriate interests/friends, gender confusion, sexual abuse.		
Physical complaints	4%	2%
Headaches, stomachaches.		
Parent's negative feelings	4%	2%
Don't like child, no enjoyment in child.		
Death	6%	1%
Understanding concept, adjustment, how to talk to child.		
Eating problems	6%	1%
Picky eater, too thin, obesity.		
Moving	3%	1%
Preparation, adjustment.		
Adoption/foster care	5%	1%
Advice on placement, what to tell child.		
Guidance of gifted child	8%	1%
Special services, appropriate stimulation, parenting.		

Note. From "Managing Children's Behavior Problems in Pediatric Practice" by C. Schroeder, B. N. Gordon, K. K. Kanoy, and D. K. Routh, 1983, in M. Wolraich and D. Routh (Eds.), *Advances in Developmental and Behavioral Pediatrics* (Vol. 4, p. 69). Greenwich, CT: JAI Press. Copyright 1983 by JAI Press, Inc. Reprinted by permission.

<sup>a</sup>These numbers refer to the total number of problems reported by parents.

example, in a follow-up study of 3-year-olds referred by their parents hard to manage, Campbell, Ewing, Breaux, and Szumoski (1986) found that at age 6, one-half of the sample had persistent behavior problem and one-third of the sample met DSM-III criteria for Attention Deficit Disorder. Sixty-seven percent of those children who had problems at age 6 met DSM-III criteria for an externalizing disorder at age 9 (Campbell Ewing, 1990). Campbell and Ewing (1990) also found that earlier chi

Note: Columns do not add to 100 because more than one problem could be checked on the Parent Questionnaire. From "Managing Children's Behavior Problems in Pediatric Practice" by C. S. Schroeder, B. N. Gordon, K. Kanoy, and D. K. Routh, 1983, in M. Wolrich and D. K. Routh (Eds.), *Advances in Developmental and Behavioral Pediatrics* (Vol. 4, p. 70). Greenwich, CT: JAI Press. Copyright 1983 by JAI Press, Inc. Reprinted by permission. Boxes indicate ages at which specific problems were of concern to the greatest percentage of parents.

Problem category	0-3 months	3-6 months	6-9 months	9-12 months	1 year	2 years	3 years	4 years	5 years	6 years	7 years	8 years	9 years	10 years
Infant management	10	20	20	10	0	0	0	0	0	0	0	0	0	0
Toileting	0	0	0	0	0	60	0	0	0	0	0	0	0	0
Developmental delays	0	10	10	10	0	20	50	20	0	20	0	0	0	0
Sleeping	20	10	0	0	0	50	40	20	10	10	10	10	10	20
Food/eating	0	10	10	0	10	60	30	50	30	20	20	10	10	20
Specific fears	20	0	30	0	20	70	40	40	40	30	40	0	20	10
Specific bad habits	30	20	20	0	30	30	20	40	20	20	40	20	0	10
Sex-related	0	0	0	10	0	30	30	20	10	20	0	0	0	10
Physical complaints	10	10	30	10	10	20	0	10	20	0	30	30	10	40
Negative behaviors	40	30	10	10	30	70	50	80	30	30	60	70	60	50
Death	10	10	0	0	0	0	0	0	0	0	0	0	0	0
Emotional	0	10	10	10	10	20	20	40	10	20	30	30	30	40
Sibling/peer	0	0	0	0	0	10	10	20	10	30	0	40	50	40
Adoption/foster/guardianship	10	10	20	20	10	50	10	10	0	10	0	40	30	60
Family	10	10	10	10	10	20	30	10	10	20	0	20	30	20
Parents' negative feelings	10	10	0	0	0	0	0	20	10	10	20	30	50	50
Guidance of talented child	10	10	10	0	0	0	0	20	0	0	0	40	30	20
Parents' school concerns	0	0	0	0	0	0	0	20	30	20	20	50	80	50
School problems	0	0	0	0	0	0	0	40	0	0	0	20	30	30
Divorce/separation	0	0	0	0	0	0	0	10	0	0	0	10	10	20
Moving	10	10	0	0	0	0	0	10	0	0	0	10	10	10

TABLE 3.3. Problems as a Function of Age: Percentage of Parents with Children of a Particular Age (n = 10 in Each Age) Who Had Concerns in Each Problem Area, 1977-1978 Random Survey Data

behavior, maternal behavior symptom ratings, and ongoing family stress predicted which children would evidence later behavior disorders.

In summary, it is important to note that estimates of the prevalence of children's behavioral and emotional problems depend upon the classification system used and the characteristics of the population studied. Overall, however, it seems that at any point in time up to 50% of children will evidence at least one specific but transient problem behavior, such as fears or bedwetting; that 5-15% will evidence a cluster of specific behavior problems requiring mental health services; and that fewer than 1% will evidence a severe psychological disorder. Furthermore, children's behavior problems are often associated with a particular developmental period. These problems are transient for most children, but there is a certain group of children for whom problems persist. Biological vulnerability, environmental instability, the quality of the parent-child relationship, the number and frequency of problems, and the type of disorder all appear to contribute to prediction of the outcome.

### PURPOSE OF ASSESSMENT

In clinical practice, assessment can have multiple purposes; depending on the case in question, these can be interrelated. We suggest that psychological assessment has three primary functions: (1) determining the nature and cause(s) of a disorder; (2) classifying, or grouping cases on the basis of distinguishing characteristics; and (3) providing guidelines for intervention (Gordon & Schroeder, 1990). It is important for the clinician to be aware of the potential purposes of assessment, because these will influence the focus and conduct of the assessment, choice of methods, and so on.

In clinical practice, most cases referred for assessment involve some combination of purposes, and many complicated cases involve all three. For example, a 6-year-old girl was described by her parents as impulsive, moody, and having difficulty in school. The parents sought an understanding of the problem, specific guidance to help their daughter make a better adjustment, and behavior management suggestions. In the process of assessment, the parents indicated that several male relatives on the mother's side of the family were mentally retarded. One of these relatives had been recently diagnosed as having a fragile-X chromosomal disorder. In reviewing the literature on this disorder, the clinician discovered that females are the carriers of the defective gene and that there is a phenotype for these females. As the assessment process progressed, the child's profile was found to have many of the characteristics of the female fragile-X carrier. After discussion with the parents, the child was referred for a genetic evaluation, which indeed indicated that she was a fragile-X

carrier. The assessment also revealed a child with a learning disability and Attention-deficit Hyperactivity Disorder, who was functioning cognitively in the high average range. Socially, she had many friends and age-appropriate activities. Emotionally, she felt loved, but recognized that her impulsive behavior often created problems for herself and her family. Thus, the nature and cause of this child's problems were determined and classified (fragile-X carrier, Attention-deficit Hyperactivity Disorder, and a learning disability), and the assessment process gave specific information for intervention strategies. These included class placement, supportive work with the family in regard to the diagnosis, specific behavior management techniques for the parents, and individual work with the child to help her understand and cope with her strengths and weaknesses.

## A COMPREHENSIVE ASSESSMENT-TO-INTERVENTION SYSTEM

Clearly, many factors must be taken into account when identifying the emotional and behavioral problems of children. Some method of systematically collecting and organizing information during the assessment process is critical. We and our colleagues (Schroeder, Mesibov, Eastman, & Goolsby, 1981; Schroeder & Gordon, in press) describe a behaviorally oriented system for the assessment of children's behavioral problems that is based on Rutter's (1975) work (see Table 3.4). This system is referred to in this book as the Comprehensive Assessment-to-Intervention System (CAIS). It focuses on the specifics of the behavior of concern, as well as taking into account other characteristics of the child, family, and environment that influence the behavior. It also provides a framework for choosing instruments or techniques for gathering information, and for summarizing the assessment data. Specific methods are discussed later in the chapter.

### I. Clarifying the Referral Question

Although clarification of the referral questions seems an obvious step in the assessment process, its importance cannot be overemphasized. The clinician and the referring person (whether it is a teacher, parent, or someone else) must agree on the issues to be addressed before assessment procedures can be selected. It is often the case that parents or teachers have questions that are not well articulated or of which they are not even aware. Once the issues are clarified, the clinician must then decide which questions he or she can adequately or appropriately address, and these must be agreed upon by the parents. The information gathered in the

TABLE 3.4. Comprehensive Assessment-to-Intervention System (CAIS) for Child Behavioral Problems

I. *Clarifying the referral question.*

After the parent has described the problem, the clinician should be certain that he or she and the parent are thinking about the same problem. This can be done by simply reflecting what the parent has said: "It sounds like you are concerned about your child getting up in the night, as well as the different ways you and your husband are handling the situation."

II. *Determining the social context.*

A child is referred because someone is concerned. This does not mean that the child needs treatment or that the child's behavior is the problem. The clinician should ask: "Who is concerned about the child?" "Why is this person concerned?" "Why is this person concerned now as opposed to some other time?" The parents' affect in describing the problems is significant: Are they overwhelmed, depressed, nonchalant?

III. *Assessing general areas.*

A. Developmental status

1. Physical/motor
2. Cognitive
3. Language
4. Social
5. Personality/emotional
6. Psychosexual

B. Parent and family characteristics

1. Personality characteristics
2. Psychopathology
3. Marital status
4. Availability and use of social support
5. Parenting styles and techniques
6. Sibling relationships

C. Environmental characteristics

1. Recent stressful life events
2. Socioeconomic status
3. Subcultural norms and values

D. Consequences of the behavior

1. Past and present management strategies
2. "Payoff" for child
3. Impact of behavior on child, parents, and environment
4. Prognosis with and without treatment

(continued)

TABLE 3.4. (continued)

E. Medical/health status

1. Family history of medical/genetic problems
2. Chronic illnesses (e.g., otitis media)
3. Medications
4. Prenatal history, birth history, and early development

IV. *Assessing specific areas.*

- A. Persistence of the behavior
- B. Changes in the behavior
- C. Severity of behavior
- D. Frequency of behavior
- E. Situation specificity
- F. Type of problem

V. *Determining the effects of the problem.*

- A. Who is suffering?
- B. Interference with development

VI. *Determining areas for intervention.*

A. Development

1. Teaching new skills to the child
2. Providing appropriate stimulation
3. Changing the behavior by increasing or decreasing it

B. Parents

1. Teaching new parenting techniques
2. Changing the emotional atmosphere
3. Treating marital problems or parent psychopathology
4. Changing parental expectations, attitudes, or beliefs

C. Environment

1. Changing the cues that set off or prevent the behavior from occurring
2. Helping parents build support networks and deal with daily living problems
3. Helping child/family cope with life events

D. Consequences of the behavior

1. Changing parent's responses to the behavior
2. Changing others' responses to the behavior
3. Changing the payoff for the child

E. Medical/health status

1. Intervening in the cause of the problem
2. Treating the effect of the problem

assessment process will be useful only to the extent that there is agreement on what is being asked.

## II. Determining the Social Context of the Problem

As Furman (1980) states, child behaviors must be viewed in the wider context of societal attitudes and values, which vary both by culture and with the age of the child. In some cultures and subcultures, for example, aggression may be sanctioned for survival purposes. The goal for a child from this culture would be to learn to discriminate inappropriate and appropriate settings for aggression, rather than to decrease the level of aggression. On a more narrow scale, the accepted or common behavior in one social setting may be considered deviant or atypical in another social setting. For example, aggression on the streets of an inner-city neighborhood may be common (and may even have survival value), whereas in the classroom it is very inappropriate.

## III. Assessing General Areas

In assessing a child's behavioral problems, it is important to keep in mind the general areas that influence the development of behavior problems (see Table 3.4): (A) the child's developmental status, (B) characteristics of the child's parents and extended family, (C) environmental characteristics and events, (D) the consequences of the behavior in both a narrow and a broad sense, and (E) the child's medical or health status.

### Developmental Status

Knowledge of the child's developmental status allows the clinician to evaluate the behavior in comparison with that of other children of the same age or developmental level. Behavior that may be considered a significant problem at one stage in development may be quite normal at another, and the job of the clinician is to judge whether the behavior of concern is more or less than one would expect of any child at that age and in that environment. A 3-year-old child who wets the bed, for example, has a problem that may be considered "normal" or common for that age, whereas a 10-year-old who wets the bed is viewed as having a more significant problem. Also, the frequency of problem behaviors changes developmentally, and some behaviors change in the appropriate or desired direction without any intervention. Physical aggression, for example, reaches a peak during the preschool years and then naturally declines (Feshbach, 1970). Although physical aggression may be considered a problem at any age, its significance increases with age. Thus, the time when a behavior occurs in a child's life is as important as the behavior

itself. Furthermore, as previously mentioned, the preschool years are a critical time for identification of and intervention with children with developmental problems. It is obvious that knowledge of normal development is critical in the assessment of these children.

### Characteristics of the Parents and Extended Family

Although it is difficult to identify causal mechanisms in the development of childhood disorders, and equally difficult to delineate the specific factors contributing to or mediating outcome, the child development and child clinical literature do provide evidence for certain parent characteristics and parenting practices that facilitate development, as well as those that make the child more vulnerable (Clarke-Stewart, 1989). These are discussed in Chapter 2.

In assessing this area, it is important to gather information about various members of the family and their relationships with the child and the parents. Parenting history and models, and the presence of psychopathology in parents or other family members, are especially important areas to assess. Sensitivity to the affect expressed by parents is also important. Two mothers, for example, described their 3-year-old daughters as being anxious and fearful. One mother was calm, was in control of herself, and was using good judgment in attempting to deal with the problem. The other mother, however, was extremely upset and fearful, and was unable to view the problem objectively. Each parent presented a different focus for the assessment/intervention process.

### Environment

The child's environment provides the setting conditions for the behavior in question and may be a more appropriate target for intervention than the behavior itself. The setting conditions can include very specific antecedents to the behavior (repeated commands, teasing, criticism, or hunger) or major events such as parental divorce, a death in the family, or an impending move. Setting conditions can lead to the appearance of behavior problems in young children, which may then persist and become increasingly severe because of environmental conditions.

In addition, it is important to remember that children rarely refer themselves for assessment or treatment. Rather, a child is referred because someone (usually an adult) is concerned about his or her behavior, and the perspective of the referring person must be taken into account. The referring person may lack information about children's development, may have emotional problems, or may be experiencing stress, all of



which can distort his or her perception of the child's behavior. Forehand, King, Peed, and Yoder (1975) found that low parental tolerance, high expectations for child behavior, marital stress, and family problems influenced parents' perception of their child's behavior. Furthermore, Wahler's (1980) work shows that a mother's perception of her child's behavior is highly correlated with the type of environmental interaction (positive or coercive) she has just experienced.

#### *Consequences of the Behavior*

Assessment of the consequences of the behavior includes finding out the ways in which parents are currently managing it, the techniques that have been tried in the past, and the "payoff" for the child. Lack of careful assessment of these factors usually leads to parents' responding to suggestions regarding management of the child's behavior by saying, "Yes, but we've tried that and it didn't work." Assessment in this area can also involve looking at the consequences of the behavior for parents and others in the child's environment. Some behaviors may be totally acceptable to the family but may interfere with the child's functioning outside the home. For example, a child who is not toilet-trained because the parents do not want to "pressure" the child is likely to suffer negative consequences when he or she starts school.

#### *Medical or Health Status*

The clinician must be aware of the child's current medical or health status, as well as his or her medical history. Assessment of problems in this area requires that the clinician have some knowledge of the emotional and behavioral effects of physical conditions. For example, a 2½-year-old boy was referred by his parents because of noncompliance, irritability, and sleep problems; his parents felt incapable of parenting him appropriately. In the course of the assessment, it was found that his language skills were delayed and he did not always attend to language directed toward himself or others. Questioning the parents about the child's medical history revealed that he had had recurrent bouts of otitis media since 13 months of age, and that medication had not been effective in controlling the infections. Furthermore, the family's pediatrician did not believe in elective surgery for young children. After discussing the potential negative effects of otitis media on the child's development, the parents sought a second medical opinion, which resulted in surgical insertion of tubes. The child's emotional lability improved immediately, and a brief course of parent training resolved the remaining parent-child problems.

#### *IV. Assessing Specific Areas*

In addition to the general areas mentioned above, specific areas to consider (see Table 3.4) include (A) the persistence of the behavior (how long has it been going on?); (B) changes in the behavior (is it getting worse?); (C) severity (is the behavior very intense or dangerous, or "low-level" but annoying?); (D) frequency (has the behavior occurred only once or twice, or many times?); (E) situation specificity (does the behavior occur only at home or in a variety of settings?); and (F) the type of problem (is the problem a discrete behavior or a set of diffuse problems?).

#### *V. Determining the Effects of the Problem*

It is important to note who is suffering from the referral problem. It may be that the child's behavior is bothering one parent but not the other, or is annoying to the teacher but is not a problem for the parents. In other cases, although the behavior may be interfering with some aspect of the child's development, it may not be seen as a problem for the parents or other adults.

#### *VI. Determining Areas for Intervention*

Given our behavioral orientation, we attempt to apply the science of human behavior to teach new behavior, decrease inappropriate behavior, and increase desired behaviors. A clinician cannot be prepared to answer every question and/or to intervene effectively in every situation. If, however, the clinician looks systematically at the developmental status of the child and the emotional as well as the physical context in which the child lives, ideas for intervention follow naturally from the assessment. For example, interventions in the developmental area may include teaching new responses; increasing or decreasing behaviors; or changing parental expectations, attitudes, or beliefs. Environmental interventions may involve changes in the specific cues that elicit inappropriate behavior or prevent appropriate behavior from occurring, in the emotional atmosphere of the home, or in the physical setting where the problem behavior occurs most often. Focusing intervention on the consequences of the behavior may entail changing the responses of the parents or other significant people, or changing the payoff for the child (e.g., providing reinforcers). Intervening in the medical/health area may involve referral for treatment of the cause of the problem (e.g., persistent ear infections), or treating the effect of the problem (e.g., teaching relaxation skills to a child with cerebral palsy).

The CAIS framework should not be seen as rigid. Rather, it is offered as a logical and systematic way to generate and test hypotheses and to plan intervention for children's problems. The information can be gathered from a variety of sources via many different methods. The system is useful for complex cases, but also works well to assist the clinician in gathering essential information very quickly for brief assessment cases. The approach taken for a parent call-in service is a good example of a brief (15- to 20-minute) assessment-to-intervention process that incorporates the steps of the framework presented (Schroeder, Gordon, Kanoy, & Routh, 1983). The parent call-in service is discussed in detail in Chapter 14. Table 3.5 illustrates the use of the CAIS framework in assessing the case of a 6-year-old girl who was disrupting her class in school. As demonstrated in the table, most of the necessary information can be gathered quickly by listening carefully and asking specific questions, following the guidelines presented above.

### METHODS FOR GATHERING INFORMATION

It should be clear from the CAIS framework that assessment of children's behavior problems necessitates a multimethod approach. It is also essential for the clinician to choose methods for assessment that are empirically based and developmentally sensitive (Mash & Terdal, 1988; Ollendick & Herson, 1984). The number of possible methods for gathering information is vast. This section presents a description of some of the instruments and techniques that we have found most useful with children. The clinician should, of course, select methods that will provide information appropriate to the nature of the presenting problem. In almost all cases, however, we have found two items to be essential: (1) a general parent questionnaire providing demographic information and the parent's perception of the problem, and (2) a normed behavior checklist. The reader is referred to Weaver (1985) and Rutter, Tuma, and Lann (1988) for more comprehensive reviews of available instruments. Descriptions of instruments we have found useful are provided in Appendix A. The CAIS provides a framework for ensuring that the pertinent areas for assessment of childhood problems are covered and that the assessment process proceeds in an orderly, stepwise fashion. The following outline illustrates the order in which various assessment methods may be used.

#### Step 1: Initial Contact

The initial contact is most often a telephone conversation during which the behavior or behaviors of concern are described and the referral question clarified. At the time of the initial contact, parents are informed

TABLE 3.5. The Assessment Process in a Brief Case Example

#### I. Clarifying the referral question.

A father called at the request of his daughter's first-grade teacher, who was concerned that the 6-year-old girl, once or twice a week, became distraught, walked in circles, and cried inconsolably. The clinician stated, "It sounds like Jane is disrupting the class and her teacher is not able to give her or the other children the attention they need. You're also wondering why she seems so genuinely distraught one or two times a week."

#### II. Determining the social context.

The father indicated that he and his wife were separated and that Jane was living with him.

##### A. Listening to affect

"I had so hoped this wouldn't happen again in Jane's new school. I don't know what I can do to help her."

##### B. Who was concerned?

The teacher was concerned for both Jane and the other children. The father stated, "I have been worried about Jane for the last 2 years, but generally her teachers and I have been able to calm her down."

##### C. Why now?

Jane just started in a new school.

#### III. Assessing general areas.

##### A. Developmental status

"Jane is a very bright child who rarely gives any problem at home. She has friends in the neighborhood and generally likes going to school. Recently she started wetting herself during the day and having nightmares."

##### B. Parent and family characteristics

"Her mother and I have been divorced for 3 years and went through a terrible custody battle. We still fight a lot over Jane."

##### C. Environmental characteristics

Jane visited her mother every Wednesday and every other weekend. She hated to go, reported being left alone, and was afraid of some of her mother's friends.

##### D. Consequences of the behavior

The father described the ways in which he had tried to deal with Jane's upset: "I tell Jane that the court says she has to visit her mother, that she should love her mother and have a good time. I also have told her not to act up in school because it gets me in trouble."

##### E. Medical/health status

"Although Jane has generally been healthy, in the last 3 months she has been to the doctor because of her wetting. She has complained of stomachaches and has had nightmares. I also should tell you that the

(continued)

department of social services investigated my ex-wife's charges against me for sexual abuse, which were not substantiated. Recently, Jane's doctor called the department because Jane had a number of bruises when she came home from a visit with her mother."

#### IV. Assessing specific areas.

##### A. Persistence of behavior

"Jane has been upset since the divorce, 3 years ago."

##### B. Changes in behavior

"She has never liked to visit her mother, but in the last 3 months it has gotten to the point where I have to force her to go."

##### C. Severity of behavior

"The night before she goes to visit her mother, she becomes very upset, doesn't listen to me, and has a very hard time getting to sleep. Sometimes she has nightmares."

##### D. Frequency of behavior

"These problems only seem to occur when she has to visit her mother."

##### E. Situation specificity

"She used to be upset only at home, but now it's happening at school too. I also think she looks sad a lot of the time."

##### F. Type of problem

This child's behavior was indicative of significant emotional distress. She was beginning to exhibit a variety of problematic behaviors both at home and at school. The extent of her upset was likely to have serious consequences for her functioning and development unless immediate intervention took place.

#### V. Determining the effects of the problem.

##### A. Who was suffering?

The child, the parents, the teacher, and other children in school.

##### B. Interference with development

The behavior was already interfering with Jane's adjustment at school. Most importantly, the child's emotional needs were not being met. Furthermore, she had few appropriate alternatives available to express her feelings.

#### VI. Determining areas for intervention.

The severity of this child's behavior and the complexity of the situation warranted further evaluation and treatment. In the meantime, the father and teacher were advised to work together to provide more emotional support within the school environment on the days Jane visited her mother. The father was also advised to tell the child, "It's OK for you to act upset if you're feeling bad on those days." The father and teacher were told to give her specific ways to express her feelings, such as drawing, working with clay, or simply talking to them.

that several questionnaires will be sent for them to complete and return before they come to the clinic. Since some of these questionnaires cover areas that parents may not perceive as directly related to the presenting problem (e.g., the marital relationship), the questionnaires are described and the importance of this information for our understanding of the child's problem is discussed. Parents are always given the option of not providing this information if they are uncomfortable doing so. Information from these questionnaires sets the stage for an interview with the family and allows the clinician to begin to develop various hypotheses about the nature of the problem and possible interventions. Descriptions of questionnaires and information about where they can be obtained are included in Appendix A. The questionnaires we most frequently use are the Child Behavior Checklist (Achenbach & Edelbrock, 1983), the Eyberg Child Behavior Inventory (Eyberg & Ross, 1978), the Parenting Stress Index (Abidin, 1990), and the Conners Parent Rating Scale (Goyette, Conners, & Ulrich, 1978). A copy of the Eyberg Child Behavior Inventory is included in Appendix B. The Conners Parent Rating Scale, the Child Behavior Checklist, and the Parenting Stress Index are described in Appendix A. We also use two instruments developed in our clinic (the Parent Questionnaire and the Daily Log), which are described below.

#### Parent Questionnaire

Our Parent Questionnaire provides information on the family's socioeconomic status; the child's developmental milestones, day care and school history, and medical history; and the parents' perception of the child's problem, its causes, and what they have done about it up to this point. A copy is included in Appendix B.

#### Daily Log

Daily records can be useful in providing information about the actual day-to-day functioning of the parent and child. The format can be quite variable, depending on the behaviors of interest. On our Daily Log (see Appendix B), parents record appropriate and inappropriate behavior on a daily basis and give their child a rating from 0 ("dreadful") to 10 ("fantastic!"). On the reverse side (the Specific Events Causing Concern form; see Appendix B), parents record the antecedents and consequences of behaviors identified as specific problems. This record helps the parents and clinician determine what the child is actually doing (in contrast to what the parents *think* the child is doing). The Daily Log also can be used during treatment to help the parents and clinician monitor progress.

### Step 2: Parent and Child Interview

Information gained from the completed questionnaires permits the clinician to generate preliminary hypotheses about the nature and causes of the problem, as well as to plan for and focus the initial session with the parents and the child. In our work with preschool children, we routinely include the child in the initial parent interview. Although some clinicians may find this difficult, we have discovered that the information shared is rarely new to the child, and the opportunity to observe the child and the parent-child interaction at first hand far outweighs the drawbacks. Later interviews can be conducted with the parents alone, to go over more sensitive information or to provide information to the parents without the distraction of a particularly disruptive child. Parents of school-age children are typically interviewed alone, before the child is seen; adolescents are first seen with parents or alone depending on the nature of the problem.

#### Parent Interview

The parent interview provides a vehicle for understanding the parents' perception of the problem and the ways in which it has affected both the child and the family. The CAIS framework guides the interview, helps the clinician decide what questions need to be asked, and ensures that essential information is gathered quickly and efficiently. The parent interview also provides an opportunity to follow up on information gathered from the previously completed checklists and questionnaires. The clinician can also begin to test his or her hypotheses about the nature of the problem by asking parents for further information, and can determine what other areas need to be assessed, as well as the methods to be used. There are a number of structured parent interviews available; the reader is referred to Edelbrock and Costello (1988) for a review of these instruments.

#### Child Interview

The child interview (typically, the child is age 6 or older) provides valuable information on the child's perception of himself or herself (wishes, fears, interests, self-concept), the environment (peers, school, family), and the presenting problem, as well as on how the child attempts to cope with and solve personal and interpersonal problems. Much has been written recently about interviews with children (Bierman, 1983; Bierman & Schwartz, 1988; Boggs & Eyberg, 1988; Eyberg, 1985; Gross, 1984). Knowledge of the cognitive-developmental characteristics of children at different ages is essential to conducting a successful child interview.

Eyberg and her colleagues (Boggs & Eyberg, 1988; Kanfer, Eyberg, & Krahn, 1983) provide guidelines for organizing interviews with children, as well as techniques for maximizing rapport and information gathering. These include (1) using language that is at or just above the child's cognitive/language level (shorter, less complex words and sentences); (2) recognizing that children interpret silences as disapproval and interpret many direct questions as demanding, which can lead to increased resistance; and (3) introducing topics of interest to the child that are developmentally appropriate (TV shows, games, cartoon characters, etc.). General communication techniques that can be useful with children include (1) statements that describe the child's clothing, demeanor, or activity; (2) comments that reflect or restate what the child has said; (3) verbal and physical praise; and (4) structured, concrete questions ("Tell me one thing you like about your brother" vs. "What do you like about your brother?"). Providing age-appropriate, unstructured materials (crayons and paper, Legos, Play-Doh, etc.) for the child to play with while talking helps the child to feel more comfortable.

Several structured and semistructured interviews exist. As examples of these, descriptions of the Child Assessment Schedule (Hodges, Kline, Stern, Cytryn, & McKnew, 1982) and the Semistructured Interview for Children Aged 6-11 (McConaughy & Achenbach, 1990) are included in Appendix A.

### Step 3: Observation of Behavior

#### Play

Obtaining useful information from interviews with young children is challenging, to say the least. Observation of a young child's play, however, can be a valuable source of information about how the child perceives his or her world. There is general agreement that play provides more reliable and useful information from preschool children than do verbal interviews (Gelfand & Peterson, 1985). Play is an extremely important part of development in the preschool years, and observation of the child's play can give information about intellectual and language development, feelings, thoughts, social relationships, and current concerns and anxieties.

It is useful to provide the child with opportunities to interact with a variety of age-appropriate toys and to vary the degree of structure during the play observation; this allows assessment of the maximum number of strengths and weaknesses. For example, providing the child with Legos enables the clinician to observe fine motor skills, frustration level, distractibility, persistence, creativity, and use of help (e.g., appropriate requests for help). Puppets allow observation of language skills, symbolic and

"pretend" play, emotional expression, and coping skills. A doll house allows the child to demonstrate organizational skills, perceptions of family interaction, and role play. Simple rule-governed games reveal cognitive skills, compliance, frustration tolerance, and interactive play skills. The overall patterns of behavior in play are more important than any specific behavior (e.g., aggression only during puppet play vs. aggression with all types of materials).

#### *Parent-Child Interaction*

In the assessment of child behavior problems, observation of parent-child interaction is extremely important. Various methods for structuring and recording these observation sessions have been proposed (see, e.g., Barkley, 1981, 1987; Barton & Ascione, 1984; Eyberg & Robinson, 1983; Forehand & McMahon, 1981; Mash, Terdal, & Anderson, 1973; Patterson, Ray, Shaw, & Cobb, 1969). These methods vary in their complexity, but there is general agreement that the important dimensions of the interaction are (1) the extent to which the parent gives the child positive versus negative feedback, and whether that feedback is contingent on the child's behavior; (2) the number of demands placed on the child; (3) the number of questions asked; and (4) the child's compliance or noncompliance to parental demands. Most observations typically last 10-20 minutes and include both structured and unstructured time. With younger children, for example, parents might be provided a variety of toys and asked to "play with your child as you would at home." After 5 or 10 minutes they can be instructed to "have the child pick up all the toys." Older children and their parents can be asked to play a game, draw a picture together, or solve a family problem (e.g., where to go on vacation, how to spend a windfall).

#### **Step 4: Further Assessment**

By this point in the assessment process, the clinician should have a good idea about the nature of the problem and what other information is needed. For example, the child may be observed at home or at school. Permission to contact the child's teacher may be obtained, and questionnaires related to school behavior and academic progress sent. Measures of parent and/or child personality, a standardized test of intelligence, and/or a test of academic achievement may also be administered. For a discussion of standardized tests of intelligence and achievement, the reader is referred to Sattler (1988). Adaptive behavior, personality/emotional status, and school behavior can be assessed via the measures described in Appendix A. We most frequently use the Elementary School

Questionnaire developed in our clinic, a copy of which is sent to the child's teacher. This questionnaire is described below, and a copy is included in Appendix B.

#### *Elementary School Questionnaire*

Our Elementary School Questionnaire provides information on the child's academic progress and any behavior problems that occur in the school setting. The teacher's responses enable the clinician to screen for attention problems or hyperactivity, and also indicate specific academic areas in which the child may be having difficulty. The child's behavior in school can be further assessed by a number of standardized teacher rating scales: The Teacher Version of the Child Behavior Profile (Edelbrock & Achenbach, 1984); the Sutter-Eyberg Student Behavior Inventory (Sutter & Eyberg, 1984); A Behavior Rating Scale for the Preschool Child (Behar & Stringfield, 1974); and the Conners Teacher Rating Scale—Revised (Goyette, Conners, & Ulrich, 1978). Description of these instruments can be found in Appendix A.

#### *Home and School Observation*

Observation of the child's behavior at home or in school is important, as children often exhibit very different behavior in these two environments. Although the same recording methods used in the clinic could be used in the naturalistic setting, home and school observations usually go on for longer periods of time, so that the child can be seen engaging in a variety of activities. A good manner in which to begin the observation process is simply to keep a running record of the behavior as it occurs in 1-minute segments of time. In this way the clinician can quickly determine the salient behaviors of the child, his or her peers, and/or the adults in the situation. The clinician can then record the frequency and duration of those particular behaviors. It is also helpful to record the behavior of a sibling or randomly selected peer every other minute for about 20 minutes. This allows some comparison of the behavior of the referred child to at least one other child in his or her environment.

#### **Step 5: Referral to Allied Health Professionals**

If the nature of the problem is not yet completely understood at this point in the assessment process, the clinician may need to refer the child to an appropriate allied health professional (pediatrician, pediatric neurologist, occupational therapist, physical therapist, communication disorders specialist, or special educator) for further evaluation.

### Step 6: Communication of Findings and Treatment Recommendations

Communicating the findings of the assessment and the clinician's interpretation of those findings provides the critical link between the assessment and intervention processes, and sets the stage for intervention. It can do these things in either a positive or a negative way: It can motivate parents, teachers, and others to obtain or provide the services required to meet the needs of the child effectively, or it can function to immobilize or overwhelm parents to the extent that the child's needs become secondary to their own. Information can be communicated to any number of individuals involved with the child (parents, teachers, social workers, lawyers, the child himself or herself, etc.), and this communication can occur through oral means (feedback conferences), through written material (reports and letters), or both.

#### Feedback Conference

The purpose of the feedback conference is not only to share information, but to engage with parents in problem solving that is focused on how best to meet the needs of their child. Preparation for the feedback conference really begins when the child is referred for assessment. At this time, the clinician can set the stage for the feedback session by carefully listening to and clarifying parents' concerns about the child (Shea, 1984). This, coupled with explanation about the nature and course of the assessment, can help to engage parents and others as active participants in the assessment process and can convey a sense of control over how the assessment proceeds. Conversely, when parents feel that their concerns and observations are not being taken seriously, they are more likely to be defensive and/or to question the clinician's conceptualization of the child's problem at the feedback conference.

It is reasonable to assume that the feedback conference constitutes a crisis of sorts for parents, regardless of the nature or severity of their child's problem (Schnell, 1982). The clinician may perceive the assessment results as "good news" (e.g., the child has a learning disability rather than mental retardation), whereas parents may perceive the same results as "bad news." The clinician's role is one of facilitating expressions of feelings about the information presented and promoting good coping responses on the part of parents by being supportive—that is, being empathic yet objective and truthful (Schnell, 1982; Shea, 1984). When the clinician is successful in this task, the parents will be ready to move to the next step: deciding what to do about the problem.

At this point, it is important to recognize that parents and professionals often have different values and priorities regarding services (Bailey,

1987). Parents, for example, may feel the best intervention is the one that requires the least expenditure of time, effort, or money on their part (Piersel & Gutkin, 1983); they may resist, ignore, or sabotage intervention programs that require their active participation. Bailey (1987) suggests that engaging parents in collaborative goal setting is an effective way to avoid this pitfall. In collaborative goal setting, the parents are asked to specify and prioritize their goals for their child. Then the clinician adds and prioritizes his or her goals. A process of negotiation between the parents and the clinician determines which goals will be addressed first (usually a combination of parent and clinician goals).

#### Written Reports

The purpose of written reports is to summarize the data gathered in the assessment, to interpret the data in order to answer the referral question(s), and to make recommendations for intervention. There are many sources of information about the content and organization of psychological assessment reports (see, e.g., Knoff, 1986; Sattler, 1988) but it is important to note that recent work has demonstrated that many parents and teachers have difficulty understanding these reports (Weddig, 1984). This is not surprising when one considers that the average reading level of psychological reports has been found to be about grade 14½ (Weddig, 1984)!

Written feedback to parents need not take the form of a formal report. Parents often benefit more from a letter summarizing the discussion that occurred at the feedback conference. Reports sent to community agencies (e.g., the school, the department of social services, or lawyers) may include more specific information on the test results, but the report should contain no information or interpretations that have not been shared with the parents. Many parents request a copy of the formal report for their records, in addition to the summary. Parents have a legal right to any information pertaining to their child; indeed, the collaborative relationship between parents and professionals would dictate their having easy access to this information.

On a broader scale, written reports provide a permanent record of the assessment process; they should also be used at a later date to provide a permanent record of the intervention methods used, as well as the response of the child and significant others to these methods. In some cases, it may be essential to provide a written summary of each session held with the parent or child. For example, in a recent case involving parental conflict over visitation following their divorce, the therapist summarized the areas discussed and the intervention plans agreed upon in each session, and sent this information to both parents as well as to both lawyers. This helped prevent miscommunication and promoted

follow-through on the part of both parents. In addition, the court asked for a written summary and recommendations after 1 year of treatment. This gave the therapist and the parents an opportunity to reassess the current situation and the effectiveness of the intervention.

Although it is common practice to provide written feedback to parents about the initial assessment, it is equally important to give them a written summary of the intervention process and the changes that have been made. To this end, it is important to readminister the pretreatment assessment measures and, in a posttreatment session, to review the changes that have occurred. When possible, the review of pre- and posttreatment videotaped parent-child interactions can serve to make the parents more aware of changes that may have occurred gradually throughout the treatment process, and thus may increase generalization of the new parental responses.

## PART II

### MANAGING

### STRESSFUL

### LIFE EVENTS

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### Step 6: Communication of Findings and Treatment Recommendations

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