CHAPTER 1

Clinical Interviews in the Context of Multimethod Assessment

Clinical interviewing has long held a venerable position in psychological assessment. The importance of clinical interviews is reflected in the following quotes from several authors writing for clinical and school-based practitioners:

> Interviewing is a hallmark of assessment processes and perhaps the most common method used to obtain information to evaluate individuals. (Busse & Beaver, 2000, p. 235)

> Whether one is meeting informally with the teacher of a referred student, conducting a problem identification interview with a parent, or undertaking a diagnostic interview with a child or adolescent, interviewing is a widely used and valuable assessment method. (Whitcomb, 2018, p. 155)

> The interview is one of the most useful techniques for obtaining information, because it allows interviewees to express, in their own terms, their views about themselves and relevant life events. (Sattler, 2014, p. 164)

In a survey of American Psychological Association (APA) members, clinical interviews were ranked first as the most frequently used of 38 listed assessment procedures (Watkins, Campbell, Nieberding, & Hallmark, 1995). Ninety-three percent of the 412 respondents said that they "always" or "frequently" use clinical interviews, versus only 5% who "never" use them. The respondents to this survey included clinicians who work with adults and children. (For brevity, we use the term *child* and *children* to include adolescents, unless the focus of discussion is pertinent only to adolescents.) In a 1992 survey of National Association of School Psychologists (NASP) members, over 70% of 123 members reported that they used child, teacher, and parent interviews for behavioral–social–emotional assessments (Stinnett, Havey, & Oehler-Stinnett, 1994). A more recent 2017 survey of 1,317 school psychologists showed that 69% of school psychologists routinely conducted developmental history interviews with parents or caregivers and 51% conducted

unstructured interviews with children. These types of interviews were ranked in the top 10 most frequently used assessment practices. In addition, 53% of school psychologists commonly conducted problem-solving interviews and functional assessment interviews with teachers, and 43% conducted problem-solving interviews with parents (Benson et al., 2019).

This book discusses clinical interviews with children, parents, and teachers for purposes of assessment and intervention planning. It is intended to be a practical guide and resource for school psychologists, child and adolescent clinical psychologists, school mental health and social workers, guidance counselors, special educators, school behavioral specialists, and trainees in those fields. Many of the interviewing formats and strategies discussed can also be employed by child psychiatrists and other mental health practitioners who evaluate and treat children outside of schools. Appendices for specific chapters provide reproducible interview formats and other relevant materials that practitioners can copy and use.

It is assumed that practitioners who use this book and its materials will have received appropriate professional training in clinical interviewing, as well as in the theory and methodology of standardized psychological assessment. Practitioners are also expected to adhere to the ethical codes of their professional associations, such as the APA, NASP, the American Psychiatric Association, the American Counseling Association (ACA), or the National Association of Social Workers (NASW).

This chapter lays the foundation for discussing clinical interviews in the context of a multimethod approach to assessment and intervention planning. The next section provides a brief historical perspective on clinical interviewing, followed by sections discussing the nature of clinical interviews and the working assumptions that underlie the use of clinical interviews as components of multimethod assessment. Subsequent chapters focus on specific techniques for clinical interviews with children, parents, and teachers, as well as assessment procedures that can be used in conjunction with interviews.

HISTORICAL PERSPECTIVE ON CLINICAL INTERVIEWING

Clinical interviews can serve multiple educational and mental health purposes, including (1) providing initial clinical assessments of children's problems; (2) making psychiatric diagnoses; (3) designing school-based interventions and other mental health treatments; (4) evaluating the effectiveness of current services; and (5) screening for at-risk status, such as risk for suicide, risk for violence, or more general risk for emotional, behavioral, or learning problems. School psychologists, in particular, often conduct interviews with children, parents, and teachers as part of a comprehensive assessment to determine whether a child exhibits "emotional disturbance (ED)," as defined by the Individuals with Disabilities Education Improvement Act (IDEIA; 1990, 1997, 2004). The information obtained from children, parents, and teachers in interviews can be particularly helpful for assessing ED, as well as for planning appropriate school interventions and mental health services for children with ED. Clinical psychologists and psychiatrists also rely heavily on clinical interviews with parents and children to make psychiatric diagnoses, as defined by the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013). Interviews with children, parents, and teachers are equally important in school-based behavioral assessment and problem-solving consultation for behavioral and academic problems (e.g., Beaver & Busse, 2000; Kratochwill & Shapiro, 2000;

Clinical interviews are widely used for assessing children's problems and planning interventions.

Mazza, 2014; McConaughy & Ritter, 2014; Sheridan, Kratochwill, & Bergan, 1996; Whitcomb, 2018).

Historically, clinical interviews have been a central feature of what has been termed *traditional assessment* of children's emotional and behavioral problems (Hughes & Baker, 1990; Kratochwill & Shapiro, 2000; Shapiro & Kratochwill, 2000; Whitcomb, 2018). This term has been used to encompass diverse paradigms, including medical diagnostic, psychodynamic, psychometric, and personality assessments. Early contributors to behavioral assessment made clear distinctions between their approach and what they called traditional assessment (e.g., Hartmann, Roper, & Bradford, 1979). Traditional assessment was said to focus primarily on underlying states or personality traits in the individual as causes of behavior. Medical approaches also focused on physical states, diseases, or disorders in the individual as probable causes of behavior. By contrast, *behavioral assessment* focused on observable, discreet, problem behaviors and contingent events in the environment that reinforced and maintained those behaviors, without any assumptions about underlying causes in the individual, such as personality traits or disorders.

Traditional assessment has also been described as *nomothetic,* because it compared an individual's functioning with groups of other individuals (e.g., normative samples). Behavioral assessment, by contrast, was considered to be *idiographic,* because it focused on target behaviors of individuals without comparisons to other people or groups (Shapiro & Kratochwill, 2000; Stanger, 2003). Traditional approaches to assessment relied more heavily on clinical interviewing, self-report forms, and tests, whereas behavioral assessment relied more on direct observation of current behaviors in naturalistic settings.

As behavioral assessment developed and matured, it began to broaden its focus and assumptions to encompass diverse methods. As a result, distinctions between traditional and behavioral assessment have become less clear-cut. In fact, as Stanger (2003) pointed out, "to contrast behavioral and traditional assessment approaches [now], one must necessarily create a false dichotomy between them" (p. 4). Instead, advocates of modern behavioral assessment argue that it is more helpful to consider methods of behavioral assessment along a continuum of direct to indirect approaches (Mash & Hunsley, 2007; Shapiro & Kratochwill, 2000; Stanger, 2003; Whitcomb, 2018). Clinical interviews, behavior rating scales, and self-reports are considered more indirect methods of assessment because, presumably, interviewees report behaviors that have occurred in the past. Observations in naturalistic settings are considered more direct methods of assessment because they focus on current behaviors.

Within the context of modern behavioral assessment, clinical interviews are now valued as much as they have been valued in traditional assessment:

> "Behavioral assessment" is no longer synonymous with the direct observation of behavior; rather it refers to the use of multiple methods to assess a greatly expanded range of person and situation variables that empirical investigators have found to be important to the development, maintenance, and treatment of childhood disorders. . . . In such a broad-based assessment scheme, parent, child, and family interviews are essential components of the behavioral assessment of childhood disorders. (Hughes & Baker, 1990, p. 108)

Current versions of behavioral assessment include behavioral interviewing to pinpoint specific problem behaviors and variables that may have controlling or maintaining effects of those behaviors (Whitcomb, 2018). Later chapters of this book present formats for clinical interviews with children, parents, and teachers. These interviews combine aspects of traditional and behav-

ioral assessment in order to understand children's current functioning and to develop interventions, when needed. The interview topics include children's school functioning, social relations, home situation, family relations, and relevant developmental and educational history, as well as behavioral descriptions of children's current problems and competencies. The interview formats assume that practitioners will also use other assessment procedures, including tests, questionnaires, and standardized rating scales. Practitioners can use clinical interviews to obtain data that are not easily obtained by the other methods they plan to use. Interview formats are also tailored to the type of information that can best be provided by each particular informant: the child, the parent, and the teacher. The challenge for practitioners is to integrate interview data with other data to formulate a comprehensive picture of the child and to plan needed interventions.

THE NATURE OF CLINICAL INTERVIEWS

As we begin our discussion of clinical interviews, it is important to be clear about what they are and are not. Hughes and Baker (1990) defined clinical interviews with children as follows: "The child interview is a face-to-face interaction of bidirectional influence, entered into for the purpose of assessing aspects of the child's functioning that have relevance to planning, implementing, or evaluating treatment" (p. 4). This definition is a good one because it captures the basic elements of a clinical interview: a one-on-one interaction, with the dual goals of assessment and intervention planning. A similar definition can be applied to clinical interviews with parents and teachers. Whitcomb (2018) also points out that the term *clinical*, in this context, refers to a purpose rather than a place. Clinical interviewing can be conducted in many different settings, including schools, clinics, hospitals, homes, and detention centers. Thus, Whitcomb states, "The purpose reflected in the word *clinical* is to gather specific information regarding behavioral, social, and emotional functioning, particularly regarding deficits or problems in functioning that may be occurring in any of these areas" (p. 155, emphasis in original).

A clinical interview involves face-to-face interaction between the interviewer and interviewee to gather information about a person's behavioral, social, and emotional functioning.

Clinical interviews, as defined above, are different from ordinary conversation. Whereas there are many linguistic parameters for good communication, ordinary conversation is usually a relatively informal, spontaneous verbal interchange between two people on some topic of mutual interest. As Sattler (2014) pointed out, clinical interviews differ from ordinary conversation in the following ways:

- The clinical interview usually takes place during a formally arranged meeting.
- The clinical interview has a specific purpose.
- The interviewer chooses the topics or broad content of the discussion.
- The interviewer and interviewee have a defined relationship—the interviewer asks questions, the interviewee responds to the questions.
- The interviewer keeps attuned to aspects of the interaction—the interviewee's affect, behavior, and style—as well as the content of discussion.
- The interviewer directs the interaction and flow of conversation.
- The interviewer accepts the interviewee's expressions of feelings and factual information without casting judgment on them.

- The interviewer clarifies questions and does not presume complete understanding.
- The interviewer follows guidelines for confidentiality and privileged communication.

Clinical interviews are also different from interviewing during psychotherapy. Sattler (2014) used the term *clinical assessment interview* to distinguish this type of interviewing from psychotherapeutic interviews. A major goal of clinical assessment interviews is to obtain information. The information is then used to evaluate an individual's emotional and behavioral functioning and to decide whether interventions are warranted, and if so, which types of interventions. The goals of psychotherapeutic interviews, by contrast, are usually to relieve emotional stress, foster insight, and promote changes in behavior or affect that can lead to improvements in an individual's life situation. This book focuses only on clinical assessment interviews, though some of the interview topics and strategies discussed may be equally applicable to psychotherapy situations.

Sattler (1998, 2014) also noted that the goals of clinical assessment interviews are different from those of forensic and survey interviews. Forensic interviews are designed to investigate specific questions about an individual or family and to provide expert opinions for a legal decision. Examples are forensic interviews for child custody disputes, termination of parental rights, and investigations of child abuse and neglect. Survey interviews are designed to collect data relevant to specific questions or variables of interest to a researcher. Examples are epidemiological surveys on the prevalence of different disorders or diseases. This book does not discuss forensic or survey interviews. Chapters 9 and 10 discuss clinical interviews that focus specifically on two special issues faced by school-based practitioners and mental health clinicians: assessing suicide risk (danger to self) and assessing potential for violence or threats of violence (danger to others), respectively. Interviews for evaluating child sexual and physical abuse also are not covered in detail because these types of interviews are more typically conducted by professionals who specialize in social service or criminal investigations.

WORKING ASSUMPTIONS FOR CLINICAL INTERVIEWS

When done well, clinical interviews can be rich sources of information about a child. However, in some forms of traditional assessment, interview data have been given more weight than data from other assessment methods. The sole use of structured diagnostic interviews for making psychiatric diagnoses is a good example of overreliance on interview data (McConaughy, 2000b, 2003). In the early forms of behavioral assessment, the opposite was true: Direct observations were deemed more important than any other assessment method, including interviews (Shapiro & Kratochwill, 2000). With this history in mind, our discussion of clinical interviewing rests on several important working assumptions.

The Need for Multiple Data Sources

The first assumption is *There is no gold standard for assessing children's functioning.* Instead, it is assumed that comprehensive child assessment requires data from other methods in addition to interviews. Other data sources include direct observations in classrooms and other group situations, standardized parent and teacher rating scales, youth self-reports, background questionnaires, tests, and other procedures, as appropriate. Accordingly, it is helpful to keep in mind the following good advice from Shapiro and Kratochwill (2000):

> It is especially important to recognize that data collected from one method are not inherently better than data collected from others. That is, data obtained through an indirect method from a parent (such as a rating scale) are not "less true" than data obtained by directly observing a student within a natural setting. Likewise, data collected through interviews with the student are not inherently more accurate than those collected through direct observation of analog settings. The key to good assessment is to find conceptual links and relationships between methods and modalities of assessment. Each form of behavioral assessment contributes unique elements to solving the assessment puzzle. (p. 13)

Situational Variability

A second assumption is *Children's behavior is likely to vary across situations and relationships.* In behavioral assessment endeavors, it is assumed that environmental conditions influence children's behavior (Shapiro & Kratochwill, 2000; Stanger, 2003; Whitcomb, 2018). Because environmental conditions can vary across situations, children's behavior is likely to vary from one situation to the next. Children's behavior is also likely to vary in the context of relationships with different adults, such as parents versus teachers. Situational variations in behavior can lead to hypotheses about factors that maintain certain behaviors—for example, increased or decreased adult attention, presence or absence of peers, and rewards or punishments (Stanger, 2003; Whitcomb, 2018).

Children's behavior often varies across situations and relationships with different people.

At the same time, certain patterns of children's behavior may remain consistent across different situations and relationships. Research has shown, for example, that aggressive behavior tends to be relatively stable across situations and over time (Achenbach, Howell, McConaughy, & Stanger, 1995; Achenbach & McConaughy, 1997; Whitcomb, 2018). Good assessment requires identifying patterns of children's behavior that vary across situations and relationships, as well as patterns that remain consistent, despite changes in situations and relationships.

Limited Cross-Informant Agreement

A third assumption is a corollary to the second: *There is likely to be only low-to-moderate agreement between informants who are in different situations or different relationships with the same child.* The limitation on agreement between different informants was demonstrated in a meta-analytic study by Achenbach, McConaughy, and Howell (1987). Aggregating findings across 119 studies, Achenbach and colleagues found significant, but modest, correlations for ratings of children's behavior by different informants under different conditions. The results showed an average correlation of only .28 between ratings of children's behavior by parents versus teachers, parents versus mental health workers, or teachers versus mental health workers. This low correlation contrasted with an average correlation of .60 between informants from similar situations or relationships with the child (e.g., pairs of parents, pairs of teachers, pairs of mental health workers, or two observers in the same situation). Similarly low cross-informant correlations for parents and teachers have been found in many other cultures and societies (Rescorla et al., 2014).

Low agreement between informants does not mean that one is right and the other is wrong, or that one has a "truer" picture of a child than does the other. De Los Reyes (2011) posited that discrepancies exist because informants systematically differ on at least three characteristics:

(1) what they attribute to be the causes of behavior (e.g., dispositional qualities or environmental circumstances), (2) the biases or decision thresholds that influence whether the informant thinks a problem warrants treatment, and (3) the contexts in which the informant observes the behavior (e.g., home, school). Parents may know more than teachers about certain aspects of their child's functioning and behavior simply because parents spend more time with the child and they have specific expectations for behavior at home. Teachers may know more than parents about other aspects of functioning, such as the child's approach to academic tasks or ability to relate to peers, because of the special circumstances of school versus home. As an example, in a nonreferred community sample, researchers found that for some children, parents more often reported severe levels of aggression and rule breaking at home, whereas teachers reported little or no such problems in school. By contrast, for some children, teachers more often reported attention problems at school, whereas fewer parents reported attention problems at home. Still for other groups of children, there was consistency across parent and teacher reports (Rettew et al., 2011). Mental health professionals may also learn more than either parents and teachers about certain aspects of functioning, such as the child's feelings, attitudes, and coping styles, because of the special circumstances surrounding clinical assessment or therapy.

Research has demonstrated only low to moderate agreement between different types of informants regarding children's behavioral and emotional functioning.

It is possible, of course, that a particular informant may be biased, as De Los Reyes (2011) suggested, or may deliberately falsify reports for personal gain. However, when there is no evidence of prevarication or intentional misrepresentation in informants' reports, you should assume that different informants each contribute valid information that represents one part of a bigger picture of the child. Differences in people's perceptions of the child can be as informative as similarities in perceptions. Moreover, research has shown that qualitative differences in reports from different informants (e.g., child vs. parent) can provide important information for predicting children's response to treatment and children's behavioral outcomes over time (De Los Reyes, 2011). The challenge is to put all the different pieces of information together to form a meaningful picture of the child's functioning under the given circumstances. By examining similarities and differences in informants' perceptions, you can identify important clues about factors affecting the child's behavior in different situations and relationships. These clues, in turn, can lead to intervention strategies that are best suited to particular circumstances and relationships.

Variations in Interview Structure and Content

A fourth assumption is *The structure and content of clinical interviews should vary in relation to the informant and the goals of the interview*. Later chapters in this book present formats for semistructured clinical interviews with children, parents, and teachers. As indicated above, each informant provides a unique perspective on the nature and circumstances affecting a child's functioning. By interviewing children, you can learn children's views of their problems and competencies; their desires, fears, and coping strategies; and their reactions to the circumstances and relationships affecting their behavior. You can also directly observe children's behavior, affect, and coping strategies during the interview. By interviewing parents, you can learn parents' views about their child's problems and competencies, the child's developmental and medical history, family circumstances, and parents' reactions to their child's behavior. Parent interviews can also provide

clues about parents' own psychological functioning and coping strategies. By interviewing teachers, you can learn teachers' views of a child's problems, competencies, and academic performance. You can also learn about teachers' instructional strategies, school interventions for academic and behavioral problems, and forms of special help or services that have been provided.

INTERVIEW CONTENT AND QUESTIONING STRATEGIES

Clinical interviews need to be tailored to particular informants. Accordingly, the content and questioning strategies should be shaped by the kind of informant to be interviewed and the kind of information sought, as outlined in Table 1.1. Later chapters discuss interview content and questioning strategies in detail for each kind of informant.

As Table 1.1 shows, the clinical interviews presented in this book combine aspects of traditional and behavioral interviewing techniques. Interviewers can use *semistructured questions* to query children, parents, and teachers about many different aspects of children's functioning, including children's activities and interests, school and social functioning, and family relations. If parents have completed questionnaires about their child's developmental and medical history prior to the interview, interviewers can examine that information and then ask questions about aspects of the child's history that are likely to affect current behavior. The format of semistructured questions is relatively open-ended and flexible to simulate a natural flow of conversation. Semistructured questions

Semistructured questions are open-ended and flexible to simulate a natural flow of conversation.

TABLE 1.1. Content and Questioning Strategies for Child, Parent, and Teacher Interviews

Questioning strategies	Informant and interview content		
	Child interview	Parent interview	Teacher interview
Semistructured questions	Activities and interests School and homework Friendships and peer relations Home situation and family relations Self-awareness and feelings Adolescent issues	Social functioning School functioning Medical and developmental history Family relations and home situation Child's strengths and interests	Academic performance Teaching strategies Child's strengths and interests
Structured questions		Symptoms and criteria for psychiatric disorders	
Behavior-specific questions	Child's view of problems	Concerns about the child Behavioral and emotional problems	Concerns about the child School behavior problems
Problem-solving questions	Feasibility of interventions	Feasibility of interventions Initial goals and plans	Feasibility of school interventions Special help/services Initial goals and plans

generally do not elicit "yes" or "no" answers but instead encourage interviewees to express their views, opinions, and feelings about specific topics. Probe questions can then be used to obtain more detailed information. The Semistructured Clinical Interview for Children and Adolescents (McConaughy & Achenbach, 2001), discussed in a later section, is an example of a child interview format with semistructured questions that cover the content areas shown in Table 1.1.

Structured questions are appropriate for querying parents about symptoms and criteria for psychiatric disorders, as defined in DSM-5 (American Psychiatric Association, 2013). Structured diagnostic interviews have a standardized set of questions and probes focusing on specific problems relevant for diagnoses. Several structured diagnostic interviews have been developed for research and mental health assessments. Two examples are the National Institute of Mental Health Diagnostic Interview Schedule for Children—Version IV (NIMH DISC-IV; Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000) and the Schedule for Affective Disorders and Schizophrenia for School-Age Children—Present and Lifetime Version (K-SADS-PL DSM-5; Kaufman et al., 2016). The NIMH DISC-IV, K-SADS-PL DSM-5, and most other structured diagnostic interviews have formats for parents and older children. Few have formats for interviewing teachers.

Because of their length and detail, structured diagnostic interviews are usually not feasible for school-based assessments or even many clinic-based assessments. However, school practitioners and mental health clinicians may still want to use structured questions with parents to determine whether a child meets criteria for certain common psychiatric diagnoses. One example is attention-deficit/hyperactivity disorder (ADHD), which can qualify a child for special education services under the category of "other health impairment" in IDEIA, or for classroom accommodations through a Section 504 plan under the Rehabilitation Act (1973). Many children with ADHD are treated by pediatricians, child psychiatrists, and mental health practitioners outside of school. Children with diagnoses of depression or anxiety can also benefit from school-based interventions, as well as mental health treatment (Merrell, 2008b).

Interviewers can use *behavior-specific questions* to query parents and teachers regarding their current concerns about the child. Behavior-specific questions are narrower in scope than semistructured questions because the focus is on a limited number of specific problem areas (Beaver & Busse, 2000; Whitcomb, 2018). Behavior-specific questions comprise the initial phases of behavioral assessment and behavioral consultation, wherein the main purposes are to (1) identify and define problems of concern to parents and teachers (problem identification), and (2) examine antecedents and consequences that surround the identified problems (problem analysis). Interviewers can also use behavior-specific questions to query children about their views of particular problems and their understanding of the circumstances around the problems.

Behavior-specific questions focus on a limited number of specific problems and are narrower than semistructured questions.

Problem-solving questions focus on parents' and teachers' current concerns, with the goal of developing interventions for identified problems (Beaver & Busse, 2000; Whitcomb, 2018). In behavioral consultation, problem-solving questions usually comprise later stages of plan implementation and plan evaluation. However, in initial clinical interviews, practitioners can use problem-solving questions to explore and gauge parents' and teachers' receptivity to different kinds of interventions prior to implementing any interventions. For example, some parents or teachers may have negative feelings about

Problem-solving questions focus on current concerns and possible interventions for identified problems.

certain types of interventions (e.g., medication treatments or structured behavior contracts), but may be willing to try other alternatives. Interviewers can also use problem-solving questions to explore the children's views of different interventions and to find out which approaches are acceptable to them.

INTERVIEWS AS COMPONENTS OF MULTIMETHOD ASSESSMENT

The working assumptions discussed in the previous section bring us to the following conclusion: *Interviews are best viewed as components of a multimethod approach to assessment of children's functioning.* Many authors have stressed the importance of multimethod assessment of children (e.g., Achenbach & McConaughy, 1997; Kratochwill & Shapiro, 2000; Mash & Hunsley, 2007; McConaughy & Ritter, 2014; Sattler, 2014; Shapiro & Kratochwill, 2000; Stanger, 2003; Whitcomb, 2018). However, the need for multiple data sources cannot be overstated. Interviews, like other assessment procedures, have their advantages and disadvantages. Advantages include flexibility, opportunity to observe the interviewee under structured conditions, opportunity to explore underlying causes of behavior (e.g., thoughts and feelings), and opportunity to establish rapport and trust to create a therapeutic alliance (Mazza, 2014; McConaughy, 2000b; Sattler, 2014; Whitcomb, 2018). By interviewing children, parents, and teachers, practitioners can also explore details of children's problems and circumstances from different points of view.

One disadvantage is that the flexibility of interviews also makes them vulnerable to low reliability and inconsistencies or misinformation across informants (Mazza, 2014; Sattler, 2014; Whitcomb, 2018). For example, children may not report certain types of behavior, such as attention problems or aggressive behavior. Instead of using child interviews to assess the presence of these types of problems, it might be better to rely more on parent and teacher interviews, standardized parent and teacher rating scales, and direct observations. Another disadvantage is that interviews require more time than other assessment procedures. For example, parent and teacher interviews may not be as efficient, or as reliable, as standardized rating scales for assessing a wide range of potential problems. Parent and teacher interviews are also less efficient than questionnaires for obtaining the details of a child's medical, developmental, and educational history. By contrast, parent and teacher interviews are good for clarifying concerns about specific current problems and for learning how parents and teachers react to identified problems. Parent and teacher interviews can also provide insights into children's strengths and competencies, and the feasibility of different intervention options.

To reap the benefits of clinical interviews while avoiding their disadvantages, practitioners are encouraged to combine interviews routinely with other assessment procedures (Mash & Hunsley, 2007; McConaughy, 2000a, 2000b, 2003). To illustrate such a multimethod approach, Table 1.2 outlines examples of data sources for five different assessment axes described by Achenbach and McConaughy (1997): I. Parent Reports, II. Teacher Reports, III. Cognitive Assessment, IV. Physical Assessment, and V. Direct Assessment of the Child.

In multimethod assessment, clinical interviews are used with other assessment methods, including questionnaires, standardized tests, rating scales, self-report scales, and/or direct observations.

Axes I and II include parent and teacher interviews, along with standardized rating scales, background questionnaires, and historical and educational records. Axis III covers cognitive assessment, including standardized ability and intelligence tests, standardized achievement tests, curriculum-based assessment, and tests of perceptual–motor skills and speech

TABLE 1.2. Data Sources for Multimethod Assessment

I. Parent reports	II. Teacher reports	III. Cognitive assessment	IV. Physical assessment	V. Direct assessment of the child
Parent interview	Teacher interview	Standardized ability and intelligence tests	Medical exams	Child clinical interview
Standardized parent rating scales	Standardized teacher rating scales	Standardized achievement tests	Neurological exams	Observations during child clinical interview
Background questionnaires	Background questionnaires	Observations during test sessions	Illnesses, injuries, and disabilities	Standardized self-reports
Historical records	Educational records	Curriculum-based assessment	Hospitalizations	Direct observations in classroom, playground, and other settings
		Perceptual–motor tests	Medications	Personality tests
		Speech and language tests		

and language. Observations during test sessions are also important Axis III data sources. Axis IV covers aspects of physical assessment, such as medical and neurological exams, illnesses, injuries, disabilities, hospitalizations, and medications. Axis V includes the child clinical interview, along with standardized self-reports, direct observations in settings such as classrooms and playgrounds, standardized personality tests, and other direct assessment procedures. For comprehensive assessment, information relevant to all five axes in Table 1.2 should be considered. However, you may not need to obtain data from all five axes for all children.

Achenbach System of Empirically Based Assessment

The Achenbach System of Empirically Based Assessment (ASEBA) is an example of a family of standardized instruments specifically designed to fit the multimethod model outlined in Table 1.2. For school-age children, the ASEBA includes the Child Behavior Checklist for Ages 6–18 (CBCL/6–18) for obtaining parents' ratings of their children's competencies and problems; the Teacher's Report Form (TRF) for obtaining teachers' ratings of academic performance, adaptive functioning, and school problems; and the Youth Self-Report (YSR) for obtaining youth self-ratings of their competencies and problems (Achenbach & Rescorla, 2001). The ASEBA also includes the Test Observation Form (TOF; McConaughy & Achenbach, 2004b) for obtaining test examiners' ratings of children's problems during test sessions; and the Direct Observation Form (DOF; McConaughy & Achenbach, 2009) for conducting observations of children in school classrooms, playgrounds, and other group settings. Other ASEBA instruments are designed for preschool children (Achenbach & Rescorla, 2000), adults ages 18–59 (Achenbach & Rescorla, 2003), and older adults ages 60–90+ (Achenbach, Newhouse, & Rescorla, 2004).

Semistructured Clinical Interview for Children and Adolescents

The Semistructured Clinical Interview for Children and Adolescents (SCICA; McConaughy & Achenbach, 2001) is a clinical interview for children ages 6–18 that was designed to dovetail with other instruments in the ASEBA, particularly the CBCL/6–18, TRF, and YSR. The SCICA Protocol Form contains open-ended questions and probes that cover the six content areas for child interviews shown in Table 1.1. In addition to its protocol form, the SCICA provides two structured rating forms that interviewers can use to rate their observations of children's behavior during the interview and children's self-reported problems. The SCICA Observation Form contains 120 items for rating observations of children's behavior, affect, and interaction style. Examples include argues; avoids eye contact; defiant, talks back, or sarcastic; disjointed or tangential conversation; doesn't sit still, restless or hyperactive; limited conversation; sudden changes in mood or feelings; and unhappy, sad, or depressed. The SCICA Self-Report contains 125 items for rating problems that children may report in response to questions about the various topics covered in the interview. Examples include reports acts of cruelty, bullying, or meanness to others, including siblings; reports being disobedient at home; reports deliberately harming self or attempting suicide; reports feeling worthless or inferior; reports not being liked by peers; reports getting into physical fights; and reports worrying. There are also two open-ended items for observations and self-reports not covered by the more specific items.

The SCICA has a protocol of semistructured questions plus observation and self-report forms for rating specific problems that interviewers observed and children reported during the child clinical interview.

After completing the interview using the SCICA protocol, interviewers rate the child on each item of the SCICA Observation and Self-Report Forms using a 4-point scale from 0 (*no occurrence*) to 3 (*definite occurrence with severe intensity or 3 or more minutes duration*). The SCICA manual (McConaughy & Achenbach, 2001) provides guidelines for scoring the items 0, 1, 2, or 3. Practitioners can also obtain a training DVD and computer software to practice scoring the SCICA rating forms (McConaughy, Arnold, Jacobowitz, & Achenbach, 1994; *www.ASEBA.org*).

To provide quantitative data from the SCICA, interviewers' ratings are scored on a standardized profile of problem scales similar to profiles of other ASEBA forms. The SCICA Profile includes five empirically based syndrome scales based on interviewer observations: Anxious, Withdrawn/Depressed, Language/Motor Problems, Attention Problems, and Self-Control Problems. It also includes three additional syndrome scales based on problems reported by the child during the interview: Anxious/Depressed, Aggressive/Rule Breaking, and Somatic Complaints (scored for ages 12–18). The SCICA Profile has six additional scales for scoring problem items that are consistent with DSM-5 diagnoses: Affective Problems, Anxiety Problems, Somatic Problems, Attention Deficit/Hyperactivity Problems, Oppositional Defiant Problems, and Conduct Problems. The SCICA DSM-oriented scales correspond to similar scales scored from the ASEBA CBCL/6–18, TRF, and YSR (Achenbach & Rescorla, 2001). The SCICA Profile provides separate scores for Total Observations and Total Self-Reports.

Clinical *T*-scores on the SCICA problem scales indicate areas where a child exhibits fewer or greater problems than other clinically referred children of the same age range.

The SCICA Profile can be scored by hand or by computer. The profile provides normalized clinical *T*-scores and percentiles for ages 6–11 and 12–18 for the eight syndrome scales, Inter-

nalizing, Externalizing, Total Observations, Total Self-Reports, and the six DSM-oriented scales. The clinical *T*-scores indicate how scale scores obtained by an individual child compare to scores obtained by clinical samples of children in each of the two age groups.

Behavior Assessment System for Children—Third Edition

The Behavior Assessment System for Children—Third Edition (BASC-3; Reynolds & Kamphaus, 2015a) is another example of a family of standardized instruments for multimethod assessment of school-age children and college students. The BASC-3 includes instruments for obtaining parent and teacher ratings of children's problems and adaptive skills, youth self-reports, and structured observations in school settings. It also provides a structured questionnaire for obtaining parents' reports of children's developmental histories.

Subsequent chapters discuss how practitioners can conduct child, parent, and teacher clinical interviews in ways that dovetail with other assessment methods so as to maximize the best of what interviews have to offer.

CASE EXAMPLES

Throughout this book, we visit and revisit case examples that illustrate the kind of information that can be derived from clinical interviews with children, parents, and teachers. As indicated in the preface, the cases are based on research and clinical experience with many children. The names of the children, parents, and teachers are all pseudonyms and details of the cases have been altered as necessary to protect confidentiality. The following synopses introduce these case examples.

Andy Lockwood, Age 7

Andy Lockwood was repeating first grade because of social immaturity and below-grade-level academic performance. His previous first-grade teacher had complained that he was boisterous and noisy and took forever to get anything done. At the end of that year, Andy was far behind other children in basic reading and math skills. Andy's current first-grade teacher voiced similar concerns. She said he was disruptive in class, failed to complete assigned work, and was still achieving far below other children in her class. Andy's mother agreed that he was an active child, but thought that he was typical of boys his age. She suspected that the teachers did not like Andy and were too rigid in their expectations about behavior. Ms. Lockwood also questioned whether Andy understood directions for assignments, because her attempts to help him with homework often led to tears and arguments. After several phone calls from the current teacher, Andy's mother started to worry that his second year in first grade would be no better than his first year, so she agreed to an evaluation of his learning, behavioral, and emotional functioning. The evaluation was carried out by the school psychologist and special education staff.

Bruce Garcia, Age 9

Bruce Garcia had been receiving speech and language services since age 4. When he was in third grade, the school multidisciplinary team requested a psychological evaluation as part of his 3-year

reevaluation. Bruce's teacher complained that his school performance was erratic, and he seemed disorganized and confused. She also worried that Bruce had trouble fitting into peer groups because of his "odd" behavior. Bruce's mother was concerned that he seemed socially withdrawn at home and had difficulty paying attention to schoolwork. Bruce's school district had a contract with a nearby psychiatric outpatient clinic for school-based mental health and consultation services. The school multidisciplinary team referred Bruce to the clinic for a psychological evaluation of his social–emotional functioning and cognitive ability.

Catherine Holcomb, Age 11

Catherine Holcomb was the younger of two children living with her mother. Catherine's father died when she was 7 years old, and her mother had not remarried. Catherine's fifth-grade teacher was concerned because she seemed inattentive in class, was erratic in completing assignments, and was having difficulty in reading and written work. Catherine also seemed socially withdrawn and had few friends in school. Catherine's teacher voiced her concerns to Ms. Holcomb and the school psychologist. Ms. Holcomb then agreed to a school-based psychoeducational evaluation of Catherine's emotional functioning and possible learning disabilities.

Karl Bryant, Age 12

Karl Bryant's sixth-grade teacher referred him for an evaluation because of behavior problems in school. She reported that Karl got into fights, had problems getting along with other students, and frequently violated school rules. Because Karl failed to complete assignments, he was failing in several subjects. With permission from Karl's mother, the school multidisciplinary team conducted an evaluation to determine whether Karl qualified for special education services due to a learning disability and/or emotional disturbance. Karl's mother also wanted advice on how to manage his behavior at home.

Kelsey Watson, Age 14

Kelsey Watson was in the custody of the state social service agency due to unmanageable behavior at home and episodes of running away. She lived in a residential group home and was enrolled in eighth grade in the local school district. She continued to have occasional home visits with her mother, who lived in a different town. Despite a history of behavioral and emotional problems and underachievement, Kelsey had never received any special services in school. Therefore, the multidisciplinary team in her new school referred her for a psychoeducational evaluation to determine whether she was eligible for services. They also wanted recommendations for coping with potential behavior problems at school.

William Mariani, Age 15

Will Mariani was a ninth-grade student at a charter school in an urban school district. Previously, Will had been diagnosed with autism spectrum disorder. Though he was considered to be extremely bright, verbal, and high functioning, he received special education services at school that mostly targeted the development of organizational skills and social communication. Recently, school staff and Will's parents had become more concerned about his almost obsessional focus on

online gaming and chat rooms, plus his increasing patterns of social avoidance at school and failing grades in several academic subjects. Will was referred to a local community-based psychological service for an intake assessment and possible psychotherapy. During the initial assessment with the clinic psychologist, it became clear that, in addition to his social problems at school, Will was also questioning his sexual orientation.

In each of the above cases, clinical interviews were conducted with the child, one of the child's parents or guardians, and teachers. Parents or guardians and teachers completed standardized rating scales to provide normative assessments of the child's competencies and behavioral and emotional problems. Catherine, Karl, Kelsey, and Will completed standardized self-reports of their competencies and behavioral and emotional functioning. Standardized tests of cognitive ability, achievement, speech/language, and perceptual–motor functioning were also administered, as needed.

STRUCTURE OF THIS BOOK

After we discuss interviewing strategies in Chapter 2, you will learn more about each of the case examples in subsequent chapters. Chapters 3–5 discuss topics covered in child clinical interviews. These chapters include segments of clinical interviews with one or more of the children in the case examples. An appendix for Chapter 3 provides a reproducible protocol for the Semistructured Student Interview—Second Edition (McConaughy, 2020). The interview protocol is modeled on the SCICA (McConaughy & Achenbach, 2001), as indicated earlier. Chapter 6 discusses parent interviews. Appendices for Chapter 6 provide a reproducible protocol for a Semistructured Parent Interview (McConaughy, 2004a), plus a reproducible background questionnaire concerning the child's developmental history and family circumstances. Chapter 7 discusses teacher interviews, with an appendix that provides a reproducible protocol for a Semistructured Teacher Interview (McConaughy, 2004b). Chapter 8 discusses interpretations of clinical interviews for intervention planning, returning to the case examples to illustrate how to integrate interview data with other assessment data to develop intervention plans. Chapters 9 and 10 address two special issues for clinical interviewing. In Chapter 9, David Miller describes procedures for assessing risk for suicide. In Chapter 10, William Halikias describes school-based risk assessments of violence or threats of violence. As scholars and licensed practicing psychologists, Miller and Halikias each have special expertise in their respective topic areas.

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