Preface

With this ninth edition of *Diagnosis and Evaluation in Speech Pathology*, we welcome a new coauthor and invite a new group of students and practitioners to consider the complex and fascinating arena of assessment in communication disorders. For over 40 years, this text has introduced diagnosis and evaluation as a process conducted in the context of an interpersonal relationship between clinicians and clients. This interesting and challenging process is a curious blend of science and art. On the science side, each case requires the clinician to think, solve problems, form hypotheses, gather data, and arrive at conclusions. Assessment, however, is much more than the simple administration of a few psychometrically adequate tests or scales, which takes us into the more artistic side of the process.

The diagnostician is much more than a neutral conduit through which test scores pass, and he or she must interact with clients to determine the real effects of communication impairment on their lives. The clinician must be able to interpret scores and measurements in the context of an individual client’s circumstances. Thus, in this edition, we again remind readers that most communication disorders have functional consequences for a person’s life. The World Health Organization continues to emphasize the role of functional effects of disorders in its International Classification of Functioning, Disability and Health (ICF). Third-party coverage in the United States, be it through Medicare or other insurers, also emphasizes functional outcomes, and so our assessment baselines are of critical importance. Another emphasis of the current edition is the ongoing nature of assessment. We must move beyond the notion of a single diagnostic session and think of assessment as gathering baseline data, monitoring treatment progress, determining if generalization has occurred from training, and documenting functional gains in communication in a client’s life.

Many readers of the prior editions have commented that they found the book to be both readable and clinically relevant. They have also made insightful suggestions, which we have endeavored to address in the present edition. Since the first edition appeared in 1973, the field of communication disorders has gone through many changes. With each successive revision of the text, we have attempted to reflect theoretical, clinical, and technological advances that have taken place in the field. The ninth edition is no different. The reader will notice that we have attempted to maintain the strong points of the former edition while including new research and clinical tools in this new edition.

NEW TO THIS EDITION

We have made every effort to modernize assessment practice patterns in this book and have done so for a more expansive array of speech, language, and swallowing disorders. Here is a summary of these changes and additions:

- Expansion of assessment tools available for each disorder, many with insightful critiques and procedural guidelines


• Additional chapter (Chapter 10) dedicated to assessing adult dysphagia and pediatric feeding and swallowing disorders
• Expansion of clinical interviewing to include ethnographic and motivational interviewing
• Expansion of child speech-language assessment issues, including phoneme awareness and literacy
• Additional chapter (Chapter 13) dedicated to head and neck cancer and the ongoing assessment of alaryngeal speakers
• Addition of sample sections of diagnostic reports showing writing attributes covering a wide array of communication disorders
• Expansion of billing and coding issues inherent in diagnostic evaluations, including coverage of the new ICD-10 system
• Addition of an appendix (Appendix A) dedicated to the oral peripheral examination
• Addition of an appendix (Appendix B) offering various assessment resources, such as information on developmental milestones, transcription symbols, hearing screening guidelines, hearing-related case history questions, and a selection of reading passages for clinical use
• Inclusion of learning tools for the reader in each chapter, such as learning outcomes and end-of-chapter self-assessment questions

ACKNOWLEDGMENTS
We would like to express appreciation to our students, clients, colleagues, and past teachers who helped to mold our thinking about the assessment process. We would also like to acknowledge Dr. Lon Emerick, who provided the initial impetus for this work. His basic philosophy, sensitivity, and enthusiasm still echo through the text. We also thank the reviewers of this book: Beverly Henke-Lofquist, SUNY Geneseo; Karen Harris Brown, University of West Georgia; Rosemary Lubinski, University of Buffalo.

Many of their helpful suggestions have been incorporated into the ninth edition of Diagnosis and Evaluation in Speech Pathology.

Finally, we should remember that the diagnostic session is our initial contact with clients; we never get a second chance to make a first impression. Every evaluation is unique, and each client deserves the best we can offer in terms of our ability, knowledge, judgment, and interpersonal sensitivity. We hope that this text can communicate to our readers both the method and the magic of this challenging task.
LEARNING OUTCOMES
After reading this chapter you will be able to:
1. Define and describe the difference between the terms evaluation and diagnosis.
2. Describe the two major reasons evaluations are performed.
3. Define the three levels of diagnosis and evaluation.
4. Describe the three parts of evidence-based practice.
5. Describe response to intervention and how it is used for evaluation.
6. Compare and contrast the differences between dynamic and static assessment.
7. Describe the guidelines described by the World Health Organization that drive the American-Speech-Language-Hearing Association’s preferred practice patterns.
8. Describe the three components in determining a communication disorder.
10. Describe how the diagnostician is a factor in the evaluation process.
11. Describe factors that require consideration when making prognoses.

Speech-language pathology is a wonderfully diverse profession that requires a practitioner to possess a wide range of skills, knowledge, and personal characteristics. A speech-language pathologist (SLP) works as a case selector, case evaluator, diagnostician, interviewer, parent counselor, teacher, coordinator, record keeper, consultant,
Diagnosis is one of the most comprehensive and difficult tasks of the speech-language pathologist. The diagnosis of a client requires a synthesis of the entire field: knowledge of norms and testing techniques, skills in observation, an ability to relate effectively and empathetically, and a great deal of creative intuition. Because communication is a function of the entire person, the diagnostician must try to scrutinize all aspects of behavior. We must remember that we are not simply working with speech sounds, fluency, vocal quality, or linguistic rules but rather with changing people in a dynamic environment. The ambiguous findings that sometimes culminate in a diagnostic evaluation must be dealt with in a fashion that perpetuates the evaluative undertaking rather than closes the door on further probing and a greater understanding of the presenting problem(s). Diagnosis is a continuous and open-ended venture that results in answers or partial answers that themselves are open to revision with added information. The experienced diagnostician does not look at objective scores of articulatory skill, point scales of vocal quality, or standard scores as ends in themselves but rather as aspects of an individual’s communication ability—we diagnose communicators, not just communication. That revelation is a major factor in the transition from a technician to a professional clinician.

DIAGNOSIS AND EVALUATION DEFINED

Some clinicians, at first glance, may consider the words diagnosis and evaluation to be synonymous. It is our intent in this text that the term diagnosis refer to the classical Greek definition of distinguishing a person’s problem from the large field of potential disabilities. The term diagnosis in Greek means “to distinguish.” The prefix dia- means “apart,” and -gnosis translates as “to know.” To distinguish a person’s particular problem from the many possibilities available, we must know the client thoroughly: how he or she responds in many conditions and how he or she performs a variety of tasks. Evaluation refers to the process of arriving at a diagnosis. Thus, informal probes, trial therapy tasks, and gathering generalization data are part of evaluation. In standard dictionary definitions, the term diagnosis is generally described as “the use of methods or processes to identify or determine the nature and cause of a disease or problem. This process is accomplished through an analysis of patient history, examination of signs and symptoms, administration of special tests, and a review of data.” Our conception of diagnosis, then, includes a thorough understanding of the client’s problem and not merely the application of a label. Evaluation refers to the process of arriving at a diagnosis. Thus, informal probes, trial therapy tasks, and gathering generalization data are part of evaluation. In standard dictionary definitions, the term diagnosis is generally described as “the use of methods or processes to identify or determine the nature and cause of a disease or problem. This process is accomplished through an analysis of patient history, examination of signs and symptoms, administration of special tests, and a review of data.” Our conception of diagnosis, then, includes a thorough understanding of the client’s problem and not merely the application of a label. It is relatively simple to call a child “language impaired,” but it is a more difficult matter really to understand how this child deals with linguistic symbols in a variety of tasks and situations. The latter is diagnosis in our view. We would also like to expand the notion of diagnosis to include distinguishing the nature and evolution of a person’s problem at different points in time. Thus, diagnosis and evaluation are ongoing processes. We perform evaluation activities to arrive at an initial diagnosis, and we also examine the client repeatedly during the course of treatment. A client’s diagnosis and the nature of the client’s difficulties often changes over time. For example, a child may initially present with language delay and, after a period of language treatment, be characterized as primarily demonstrating a phonological disorder. A neurogenic patient may initially be diagnosed with aphasia but may experience
further neurological damage and be re-diagnosed with aphasia and dysarthria. Another major thrust of this text is that the diagnostic process need not be confined to a 2-hour block of time in a university setting or a 30-minute period in a medical facility. The competent clinician will continue evaluation activities until the client’s performance is understood to the extent necessary to determine an effective treatment approach.

We perform evaluation tasks with two major goals in mind. First, we evaluate to arrive at a good understanding or diagnosis of a client’s problem. Arriving at a diagnosis is a complex task. It requires problem solving, reasoning, and the ability to recognize patterns (Richardson, Wilson, & Guyatt, 2002). Sometimes these evaluation activities will be confined to an assessment period, and at other times they will be performed well into the beginning of treatment. Often we must begin therapy with a client before arriving at a firm diagnosis. This approach is not optimal, but it is justified as long as we realize that (1) any treatment approach is experimental to a certain degree in the beginning, (2) most initial treatment goals will generally be “in the ballpark” in terms of appropriateness (e.g., we probably would not engage in voice therapy for a stuttering client), and (3) beginning treatment does not mean that we have abandoned our efforts to define the parameters of the client’s problem and arrive at a diagnosis. We can always fine-tune a treatment program based on an increased understanding of a client’s problem and capabilities.

A second major reason to perform evaluation activities is to monitor the client’s progress in treatment and describe changes in the communication disturbance. In this use of evaluation activities, we are not necessarily trying to diagnose the problem but to document treatment progress and determine possible changes in the course of treatment. In the chapters of this text that deal with disorders, we will suggest evaluation tasks often used for these purposes that are not in the formal test category. Formal tests are designed more for categorizing clients as exhibiting certain disorders, whereas non-standardized evaluation tasks are used to gain insight into specific client abilities and to gauge treatment progress. We will now discuss some of the purposes of diagnosis and evaluation in more detail.

BROADENING THE NOTION OF ASSESSMENT
Most people tend to think of diagnosis and treatment as two separate parts of the clinical process. We schedule clients for an “assessment” and then, if they evidence a problem, we arrange for them to receive “treatment.” This distinction between assessment and treatment is somewhat arbitrary and nothing more than an administrative dichotomy made by school systems, medical settings, and insurance companies. In reality, we perform evaluations at the beginning of a clinical relationship with a client in order to determine the existence of and nature of a communication disorder, but the assessment does not stop there. Figure 1–1 shows a process in which diagnosis, to determine the existence of a problem, is only the first step in assessment. We diagnose the problem typically by using a combination of norm-referenced standardized tests coupled with nonstandardized communication tasks. Once the problem is confirmed, many additional evaluation tasks are performed to determine a client’s baseline performance on very specific aspects of communication. These tasks are often performed after the initial diagnostic session and become part of measurements taken during the treatment phase of clinical work. We continue to evaluate in order to understand the client’s baseline performance levels for specific treatment goals, functional communication, and communicative effectiveness in the natural environment. We must also continue to evaluate in order to monitor treatment progress. Thus, even though treatment may have been going
on for months, we continue to gather assessment data on the client’s performance in the clinic, his or her changes in functional communication abilities, and the generalization of these abilities to other environments. These three levels of diagnosis and evaluation form a continuum ranging from diagnosis on one end, moving through establishing baseline performance data, and finally ending at measurement of treatment progress.

ILLUSTRATING THE IMPORTANCE OF MEASUREMENT IN CURRENT TRENDS

The assessment activities that take place after the initial diagnostic session have taken on increased importance in recent years with the emergence of three important influences in the field of communication disorders. These three influences have had and should continue to have far-reaching effects on our field in terms of research, theory, and clinical practice. The areas of which we speak are evidence-based practice (EBP), the response to intervention (RTI) initiative in public education, and research in dynamic assessment. You will soon see that the three areas overlap and in many ways deal with the same underlying construct of ongoing assessment or measurement of treatment progress. The three areas are illustrated in Figure 1–2. We will briefly discuss each of these important influences in the following sections.

Evidence-Based Practice in Speech-Language Pathology

The Joint Coordinating Committee on Evidence-Based Practice of the American Speech-Language-Hearing Association (ASHA) produced a position statement (American Speech-Language-Hearing Association, 2005). Among the recommended skills for speech-language pathologists, we emphasize following:

- Ability to perform screening and diagnostic procedures to gather information in a cost-effective manner; the SLP, then, must be aware of assessments as well as their efficacy.
- Ability to evaluate the efficacy, effectiveness, and efficiency of assessments as well as ongoing treatment.
These skills suggest two major implications of evidence-based practice. First, in selecting diagnostic measurements, it is our responsibility to choose those that have the most scientific support and psychometric adequacy. The second implication involves the notion that assessment is ongoing, and it is only through such continued evaluation that we can monitor treatment progress on the goals we have selected as targets. In short, what is the “evidence” in evidence-based practice? In many ways it all boils down to measurement of one type or another.

Evidence-based practice was initially developed in the medical profession as a means of promoting “… the integration of best research evidence with clinical expertise and patient values” (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000, p. 1). Obviously, this implies a three-part model with research evidence, clinical expertise, and patient values at each point, presumably each contributing significant importance to making clinical decisions. Figure 1–3 depicts the relationships in this model to the assessment process. This model has been recently applied to many other professions, including education, social work, psychology, and communication disorders.

It is important to discuss how the three parts of the model in Figure 1–3 apply to assessment in communication disorders. The part of the model that deals with research evidence is critical in selecting both norm-referenced assessment instruments and
nonstandardized measurements of client behaviors. As we will discuss in Chapter 3, all standardized tests should have been carefully developed so that they have psychometric qualities that make them both valid and reliable. These tests should have been normed on populations that make them applicable to clients from a variety of social and cultural groups. A clinician must be very careful to use standardized tests that meet exacting psychometric criteria and have been scientifically shown to identify clients with communication disorders adequately. When a clinician chooses a nonstandardized method of examining client communicative behavior, research evidence is even more critical. We should not simply design our own methods of gathering data on clients, but we should use nonstandardized methods that research has shown to be reliable and valid. For example, measurements such as mean length of utterance, type–token ratio, maximum phonation time, and percentage of disfluency are nonstandardized procedures that have well-documented definitions, procedures for sampling/calculation, and data on reliability/validity from many scientific investigations. It is almost always preferable to use a technique that has been implemented in research rather than develop an idiosyncratic approach with no empirical support.

Another way that knowledge of research evidence comes into play is in selecting a treatment procedure. There is no shortage of manuals and programs that tell the clinician how to do therapy. However, not many scientific studies actually document treatment effects on clients who underwent specific therapy procedures. The implication here is that clinicians should choose treatment methods that have scientific support in research literature and not use untested techniques when others are available with evidence that shows effectiveness. Thus, research evidence is an extremely important component of the EBP model and applies to both assessment and treatment enterprises in communication disorders.

The second part of the EBP model includes the clinical expertise of the practitioner. Clinical expertise is important for several reasons. First of all, one cannot be clinically competent unless he or she keeps up with the current research literature in the field. This is where the second part of the EBP model intersects with the first, research evidence. We assume that a competent clinician is familiar with the latest developments in assessment and treatment. We also assume that if a practitioner uses new clinical methods, then he or she will study and practice them so that they are used appropriately with the
client. The practitioner is responsible for choosing appropriate assessment and treatment methods and knowing how to use them.

The third part of the EBP model involves the values and perspective of the patient with whom we are working. It is the responsibility of the practitioner to evaluate the client as a person rather than merely a communication disorder. Every person has perceptions, values, and preferences that should be taken into account in a clinical relationship. For example, in the field of medicine, a person who has been diagnosed with cancer has many treatment options, ranging from surgery to chemotherapy and radiation. Each treatment has research data associated with it; these results can be communicated so that the patient and physician can make the decision that is best for the patient and family. Note that patients are not simply told which option to take; they have a choice. Sometimes they may choose to have a shorter survival chance but a better quality of life. The decision is up to the patient. Although this choice is not as dramatic in communication disorders, there are many possible ways of dealing with most speech and language disorders. For example, it may be preferable for a family to receive an intense parent training program instead of having to make frequent visits to a clinical setting, which may be more of a strain on finances and scheduling. Again, the patient’s view should always be taken into account and his or her preferences should be included in the clinical decision-making process. This part of the EBP model interacts with practitioner expertise because a good clinician will be able to assess the values and preferences of the family and take them into account when arriving at a clinical decision. In Chapter 2 we discuss interviewing, which is the mechanism by which we get to learn about patient concerns, preferences, and goals. There is also an interaction between the patient perspective and research evidence. As a clinician chooses assessment and treatment techniques, he or she must determine if the technique has been used effectively on patients who fit the profile of the current client. That is, we should select treatment and assessment options that have been successful with clients similar to our patient.

It is easy to see from Figure 1–3 how research evidence, practitioner expertise, and patient preferences are not only important as individual entities but also in how they interact in carrying out the clinical transaction, both in assessment and in treatment. ASHA recently developed practice portals to help speech-language pathologists identify the best existing evidence and resources with credibility that are available. The content contained within the practice portals includes information on a variety of professional issues and clinical topics. To date, professional issues included are bilingual service delivery, caseload/workload, classroom acoustics, cultural competence, speech-language pathology assistants, and telepractice; clinical topics include aphasia, autism spectrum disorder, dementia, pediatric dysphagia, social communication disorders, and speech sound disorders. Evidence maps are provided within the practice portals to guide clinicians through an evidence-based clinical decision-making process and highlight the three components of EBP within each professional issue or clinical topic. You can search for the practice portals and the information contained within each portal at www.asha.org.

The Response to Intervention (RTI) Model
Authorities in the field of education and learning disabilities have recently postulated a procedure for identifying and treating students with disorders using a model called response to intervention (RTI). The National Association of State Directors of Special Education (2005) defines RTI as “the practice of (1) providing high-quality instruction/intervention matched to student needs and (2) using learning rate over time and level of performance to (3) make important educational decisions.” The legal groundwork for RTI was laid by PL 108-447: IDEA 2004, which states: “In determining whether a child
has a specific learning disability, a local educational agency may use a process that determines if the child responds to scientific, research-based intervention.” No Child Left Behind (NCLB) advocates the use of scientifically based research, which is described as “research that involves the application of rigorous, systematic, and objective procedures to obtain reliable and valid knowledge relevant to education activities and programs.” These two legal perspectives seem to be quite compatible. Justice (2006) and Ukrainetz (2006) detailed how the SLP would fit into this type of approach to assessment and intervention for language, reading, and literacy disorders. We discuss RTI here only as an example of the important role that ongoing assessment plays in any program that involves continuous monitoring of client progress.

It is important to provide some perspective on why RTI is a novel approach to evaluating students. Historically, students with learning disabilities, the majority of which are language/literacy based, were given special education services after being diagnosed with a particular learning problem. In most cases this was done by using outdated discrepancy formulas, which showed a disconnect between a student’s potential as measured through intelligence and aptitude testing and the student’s performance on tests of specific abilities such as reading, writing, or oral language. Often, such evaluations were not completed until the end of second grade and, at this point, remediation is difficult and the social/psychological effects of failure may have already begun. The historical scenario described above has been called the wait-to-fail model. Currently, most authorities do not support the sole use of discrepancy models in diagnosis.

In an effort to be more proactive, educators have posited that variables other than just test scores could be used to determine the existence of a learning or language disorder. One such variable involves placing the student in a limited, intense period of treatment to determine if he or she can benefit from additional assistance. Proponents of RTI characterize the approach as having a number of tiers that provide progressively more specialized and intensive treatment. The number of tiers varies depending on the specific RTI model considered. Figure 1–4 illustrates a general four-tier model of RTI. Movement through the tiers depends on monitoring student response to treatment as revealed by continuous assessment. Those students who benefit from the assistance could continue to be served in the general education classroom on a consultative basis by the SLP. The students who do not benefit from the intense treatment regimen could then be declared eligible for special education services by the speech-language pathologist. In this way, a student’s actual learning response can be a significant consideration in the decision to enroll him or her for specialized services instead of just using arbitrary cutoffs and test scores. Enrollment in specialized special education services often involves pulling the student out of the classroom, which could contribute to further academic problems caused by missing critical material. If a student can be served adequately in the general education setting in Tiers 1 to 3 without having to be admitted to a special education program, such additional academic problems might be avoided.

RTI involves prevention and intervention goals in an outcomes-driven system. For RTI to be successful, it must include a team approach involving parents, educators, special educators, administrators, and related service providers (e.g., SLPs). The American Speech-Language-Hearing Association has developed guidelines regarding the role of the SLP in RTI (Ehren, Montgomery, Rudebusch, & Whitmire, 2007). Most of the early work with RTI concerned children who have learning disabilities, but currently it has been applied to all children receiving services in early childhood. According to Jackson, Pretti-Frontczak, Harjusola-Webb, Grisham-Brown, and Romani (2009, p. 425), “Common principles of RTI include (a) many tiers to insure maximum support for each child, (b) instruction implemented with high quality, (c) a core curriculum that encompasses a research base, (d) a data collection system consisting of both formative
and summative sources of information, (e) interventions that have an evidence base, (f) procedures for identifying the selection and revision of instructional practices, and (g) measures to monitor the fidelity of implementation.” It is clear from this statement that assessment and evaluation procedures are intimately related to almost every principle. Jackson et al. (2009) go on to point out that preferred methods of assessment should include naturalistic observation, family preferences, and functional outcomes. When monitoring treatment progress, some allowance should be made not only for pre- and postintervention measures but also on more frequent assessments on a daily or weekly basis to determine if the program needs modification. For some SLPs this may require an adjustment. For example, Jackson et al. (2009, p. 429) indicate: “Although SLPs have specific knowledge in the area of communication and language, the challenge is to shift their focus from the discipline’s traditionally ‘clinical,’ norm-referenced assessment approaches to engagement in collaborative assessment practices that are authentic and focus on all areas of child development.”

So what does this have to do with assessment? It should be abundantly clear that evaluating a student’s baseline abilities and then continuing to monitor his or her performance during an intensive, short-term treatment regimen involves copious measurements. In the RTI model, such assessment is very important because it can be used in the decision-making process to determine eligibility for special education services.

**Dynamic Assessment**

If diagnosis is to be of utmost benefit, it must be goal-oriented. Diagnosis is an empty exercise in test administration, data collection, and client evaluation if it fails to provide
logical suggestions for treatment. Most clinicians would like to believe that there is a magic or set procedure that will work for each client to improve communication. In almost every disorder area (fluency, voice, language, articulation), however, there is a multitude of procedures from which to select. Not only are there different types of treatment in terms of philosophy, entry level, and targets trained but there are also differences in the nature of the delivery system (e.g., highly structured, behavioral, client directed, cognitive, etc.). Thus, the SLP is faced with a number of avenues from which to choose in terms of making treatment recommendations.

The notion of using time in a diagnostic session to gain insight into performance on treatment tasks is known as dynamic assessment (Gutierrez-Clellen & Pena, 2001; Johns & Haynes, 2002; Lidz, 1991; Miller, Gillam, & Pena, 2001; Pena, 1996; Wade & Haynes 1989). We feel that dynamic assessment is an important part of any diagnostic venture because, from these tasks, learning processes and a direction for treatment emerges. Table 1–1 illustrates salient differences between dynamic and static assessment. Static assessment is like a snapshot of a child’s performance at a given moment in time. When we administer a standardized test, we are capturing a child’s performance at a certain point, and we may characterize this behavior as a number or score. Static assessment, however, does not address how the child may be able to perform more effectively with assistance by the clinician or under altered circumstances. Dynamic assessment relies heavily on Vygotsky’s (1978) notion of the zone of proximal development, which defines a range of performance that a child can produce with assistance from adults or peers. Standardized tests do not allow the clinician to assist a child or ask the client why he or she answered a question in a particular manner. In dynamic assessment, the clinician can determine a client’s range of performance, given help by the clinician, and can find what types of circumstances result in improved performance. Almost every communication disorder area has a variety of variables to experiment with during a diagnostic session. We are of the opinion that treatment should be viewed rather like a single-subject experimental design. No one really knows which type of treatment will be effective for a given client or which variables will have the most impact on performance. This is typically learned during the first stage of treatment as the clinician begins to fine-tune the management program. However, the diagnostic session can easily be used to gain some insight into client tendencies and preferences. Clients with aphasia may respond more favorably to certain combinations of cues in word retrieval. Clients

<table>
<thead>
<tr>
<th>Static Assessment</th>
<th>Dynamic Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passive Participants</td>
<td>Active Participants</td>
</tr>
<tr>
<td>Child does task without help</td>
<td>Child participates with adult help; can ask questions and get feedback</td>
</tr>
<tr>
<td>Examiner Observes</td>
<td>Examiner Participates</td>
</tr>
<tr>
<td>Scores test; typically right/wrong responses</td>
<td>Gives feedback; helps child develop strategies</td>
</tr>
<tr>
<td>Results Identify Deficits</td>
<td>Results Describe Modifiability</td>
</tr>
<tr>
<td>Test results profile deficits, what child can and cannot do</td>
<td>Results profile how responsive the child is, given help; describe strategies</td>
</tr>
<tr>
<td>Standardized Administration</td>
<td>Administration Fluid, Responsive</td>
</tr>
<tr>
<td>Given in standardized manner; no deviation from standard format</td>
<td>Nonstandardized administration; examiner responses contingent on child’s behavior</td>
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Source: Adapted from Pena, Quinn, and Iglesias (1992).
with fluency disorders may become more fluent with one particular technique than with a second method. A child with a language impairment may respond better to a structured task as opposed to a child-directed one, or vice versa. A nonverbal child may show a marked tendency to learn a few gestures during a diagnostic session rather than to master vocal productions or words.

We could continue with examples of ways in which the clinician can use a portion of the diagnostic session to learn about the client’s response to certain treatment variables. Although the diagnostician should never make treatment recommendations based only on hunches, the judicious use of evaluation tasks in the assessment can suggest a reasonable starting point for treatment in many cases. Of course, these recommendations should be treated as working hypotheses and should be stated as such in the diagnostic report. The initial selection of a treatment option is in most cases only an educated guess and is always subject to change based on client performance, which is why we view evaluation as an ongoing process throughout the treatment experience.


Over the years, the World Health Organization (WHO) has developed various conceptual frameworks to draw attention to the functional sequelae of an illness or disorder. WHO’s International Classification of Functioning, Disability and Health, better known simply as ICF, provides a standard way of describing a person’s health and health-related states (World Health Organization, 2002). The ICF is a multipurpose classification system that helps healthcare professionals describe a person’s changes in two ways. The first concerns body function and structure: what the person can do in a standard environment. Such levels of capacity are often assessed through standardized testing. The second addresses what the person can actually do in his or her usual environment. These levels of performance are often assessed via nonstandardized probes and indexes of daily activity and participation. This ICF classification system is a radical change in healthcare diagnosis and evaluation—rather than emphasizing a person’s disability, the focus is shifted to the level of health. Said another way, the focus is shifted from cause to impact. We see this change echoed in recent clinical research literature. The speech-language pathologist also no longer diagnoses and evaluates only a client’s communication deficit. Rather, attention is also directed toward assessing a client’s communicative functioning in his or her environment. What can the client do? What impact do the client’s communication abilities have on her or his socialization? Psychological state? Education? Vocation and avocations? Clearly, the modern SLP is concerned with the concepts of functioning and social disability as espoused in the ICF (World Health Organization, 2002). In each chapter of this text, we will present this ICF model as a reminder of our professional concerns with both functioning and disability in our realm of diagnosis and evaluation.

Beginning in 2008, the U.S. Department of Education required all states to submit accountability data regarding programs that serve young children with disabilities. Hebbeler and Rooney (2009, p. 451) state, “Across professional organizations, the recommendations related to assessment contain similar themes, emphasizing the use of multiple sources of information, focusing on the child and family, and highlighting the use of assessment data for program planning and monitoring . . . . A balanced assessment, according to ASHA, includes gathering child-centered, contextualized, performance-based, descriptive and functional information from families, teachers and other service providers.” The specific areas of interest involve social-emotional skills, acquiring and
using knowledge/skills, and abilities of clients to make their needs known to others. Functional outcome assessments, as mandated by the U.S. Department of Education, typically take the form of a 7-point rating scale—7 being age-appropriate skills and 1 being lack of foundational skills to accomplish the task. All of the seven levels carry operational definitions, and the scale values can be used to determine functional response to treatment. Such rating systems are prevalent in healthcare settings (e.g., Functional Independence Measures; FIM) and in the ASHA National Outcomes Measurement System (NOMS). Thus, there seems to be a convergence of the various professional organizations and governmental agencies on the value of initial and ongoing assessment, no matter what the age group or disability.

Diagnosis and evaluation of communication disorders require significant input from speech-language pathologists, so it is important to review briefly the guidelines put forth by ASHA regarding assessment. First of all, ASHA develops what are called preferred practice patterns (PPPs) that generally define acceptable clinical approaches to assessment and treatment of communication disorders. Specifically, the PPPs “represent the consensus of the members of the professions after they considered available scientific evidence, existing ASHA and related policies, current practice patterns, expert opinions, and the collective judgment and experience of practitioners in the field. Requirements of federal and state governments and accrediting and regulatory agencies also have been considered” (American Speech-Language-Hearing Association, 2004, p. 3). It is easy to see that such guidelines can have a far-reaching effect on the knowledge and skills required in speech-language pathology training programs and also on clinical practice in the field. The ASHA document on PPPs is driven in large part by “fundamental components and guiding principles,” which are based on guidelines from WHO mentioned earlier. According to these fundamental guidelines, the evaluation must first of all be comprehensive, which means that several important areas must be addressed:

1. **Body structures and functions.** Clearly, medically based problems are implicated in body structures (e.g., neurogenic disorders, cleft palate). Functions include “mental functions such as attention as well as components of communication such as articulatory proficiency, fluency and syntax” (p. 4). Thus, this first component would involve making a thorough diagnosis and defining the nature of a client’s communication problem, similar to what professionals do in the assessment of any health-related condition. Obviously, we can accomplish the goal of a thorough diagnosis by administration of standardized and nonstandardized tests.

2. **Activities and participation.** This component deals with the client’s ability to participate in daily social, communicative, and self-help activities and perform tasks that may be relevant to educational and/or vocational enterprises. Essentially this means that part of an effective assessment must involve looking at how a communication disorder may affect a client’s daily activities and ability to perform in the real-life environments of society, work, or education. Clearly, the use of tests is likely not the most efficient way to gain this information because there is no substitute for case history information, clinical interviewing, observing the client in the natural environment, and rating his or her functional abilities in communication and related activities.

3. **Contextual factors.** These factors can include personal attributes of culture, education, social status, and environmental variables that may present obstacles or facilitate communication. Again, standardized testing may not be the most efficient vehicle for gaining this information. Rather, nonstandardized approaches such as interviewing, patient rating scales, and observation in natural settings may provide the most relevant clinical data.
The ASHA PPP document also provides other diagnostic and evaluation guidelines of a more general nature. Following are some selected principles that are especially pertinent to the present text:

1. *Measuring outcomes.* According to the guidelines, “Outcomes of services are monitored and measured in order to ensure the quality of services provided and to improve quality of those services” (p. 5). As we have stated previously, assessment is not confined to a diagnostic session but rather continues throughout treatment as well.

2. *Going beyond static assessment.* An emphasis of the present text is that diagnosis and evaluation are far more than simply administering a battery of standardized tests. While standardized tests can tell us if a problem exists, they rarely describe the nature or complexities of the problem. The ASHA PPP document states: “Assessment may be static (i.e., using procedures designed to describe structures, functions, and environmental demands and supports in relevant domains at a given point in time) or dynamic (i.e., using hypothesis testing procedures to identify potential for change and elements of successful interventions and supports)” (p. 5). We will be covering both static and dynamic assessment in this text.

3. *Approaching assessment scientifically.* The ASHA PPP recommends that “services are consistent with the best available scientific and clinical evidence in conjunction with individual considerations” (p. 5). This notion is essentially what has become known as EBP. ASHA and other disciplines are emphasizing EBP and following the lead of the medical profession in applying research to clinical practice. We will discuss selected aspects of EBP that apply to assessment later in this text.

The American Speech-Language-Hearing Association has also been involved in examining functional outcomes of treatment for communication disorders. Since 1994, a variety of ASHA task force groups have been active in developing NOMS, which includes functional communication measures (FCMs) for most speech, language, and swallowing disorders for children to adults. The FCMs are composed of 7-point rating scales that rate the patient from the least functional (level 1) to the most functional (level 7). The ratings are based on clinical observations by the SLP and do not necessarily rely on any formal assessment procedures. To date, FCMs have been developed for adults and prekindergarten children in the following areas: articulation/intelligibility, alaryngeal communication, attention, augmentative-alternative communication, cognitive orientation, fluency, memory, motor speech, pragmatics, reading, problem solving, spoken language comprehension, spoken language expression, swallowing, voice, voice following tracheostomy, and writing. Currently, ASHA releases the FCMs only in the context of NOMS, and the scales are used mainly in this ongoing research. Eventually, the FCMs will be useful for widespread clinical use. It is important to note, however, that in most healthcare settings worldwide, professionals in speech-language pathology, physical therapy, occupational therapy, and other disciplines have routinely used functional independence measurements (FIMs) to gauge client progress in the rehabilitation process. Such scores are typically on a 7-point scale, just like the FCMs described above; the scale runs from total assistance (level 1) to total independence (level 7). The scales are used for abilities such as ambulation, communication, grooming, bathing, dressing, memory, and social interaction. These FIM scores are used for many purposes, ranging from discharge decisions to reimbursement guidelines. Anyone working in a medical setting will tell you that FIM scores are one of the most important determiners of the effectiveness and efficiency of rehabilitation programs and a favorite tool of healthcare administrators.
It can be seen from this discussion that functional outcome measurements are important components in initially assessing clients and in monitoring progress through treatment. We want clients not only to improve their abilities on chosen methods of assessment but also to be able to master functional abilities that will affect their lives. The term *activities of daily living* (ADLs) refers to practical behaviors related to common activities such as eating, communicating, and ambulation. These ADLs are often selected as targets for treatment and measured in terms of functional gains. Thus, assessment is not only about testing; it also includes educated clinical observations and functional estimates of a client’s performance.

**DIAGNOSIS TO DETERMINE THE REALITY OF THE PROBLEM**

One function of diagnosis is to determine whether the presenting communication pattern does indeed constitute a handicap. Before this determination is possible, however, it is necessary to have a clear idea of what constitutes a communication disorder. Van Riper’s classical definition of a speech disorder is widely quoted: “Speech is abnormal when it deviates so far from the speech of other people that it calls attention to itself, interferes with communication, or causes the speaker or his listeners to be distressed” (Van Riper & Emerick, 1984, p. 34). Figure 1–5 depicts three components that must be considered in determining a communication disorder.

1. *Speech difference.* Speech difference refers to whether the speech signal calls attention to itself and when this might occur. We can quantify the physical characteristics of the speech signal through recording, measurement, and observation. In other words, we must scrutinize the physical characteristics of the speech signal and judge its quality. But these data are of limited value unless it can be determined what difference a particular speech parameter makes.

   In most areas of communication disorders, the state of the art has not progressed to where we can simply take the quantified data, compare them with established numerical norms, and determine the correctness of the speech sample. Rather, each diagnostician must use professional judgment and develop a personal frame of reference. Vocal qualities are subject to individual impressions; although a clinician may know that the voice is awry, evidence of the difference may often elude the algorithms of our high-tech instrumentation. The question of whether the presenting speech difference is different enough to be of concern thus becomes a matter of human judgment. This judgment involves filtering incoming data through the clinician’s many synaptic junctions, whose thresholds may have been worn thin by bias and experience. An inordinately critical or uncritical ear is a hazard with far-reaching implications.

**FIGURE 1–5**

*Three Components of a Definition of a Speech Disorder*

- **Difference**
  - Is there a speech difference?
  - When and in what context was the difference noted?

- **Disturbance**
  - Does the speech difference produce a breakdown in the message transmission?

- **Disorder**
  - In what respect do the difference and disturbance produce a handicapping condition?
What constitutes normal behavior? Several definitions are available, but we will discuss only two, representing the diverging philosophies with which each clinician must contend in establishing his or her own concept. The first theory we shall call the concept of *cultural norms*. The assumption is that society considers some behaviors aberrant in terms of group characteristics. According to this model, each bit of behavior can be judged against a real or theoretical standard, the nature of which is independent of the individual’s personal idiosyncrasies. The second theory we shall call the concept of *individual norms*. Advocates of this model assume that each individual has made a unique adjustment to life based on previous experiences, physical limitations, and the environment’s reactions. Any judgment about the normalcy of a bit of behavior must be contingent on individual characteristics such as age, intelligence, and experience. Taken to the extreme, the latter model would assert that each person is normal no matter what he or she does because the behavior is the end product of all that plays upon the person. Within this theory the concept of individual norms loses meaning. But some case examples may help to clarify and give perspective.

The audiologist who examines the hearing of the 70-year-old individual and who obtains the typical presbycusic audiometric curve could make a case for the judgment that this person has “normal” hearing. According to individual norms, this is average or normal behavior for a person at age 70; according to cultural norms, however, the individual’s hearing level is below the average for the total population. Follow-up procedures would thus be based on the practical matter of getting a more efficient communication system for the individual and also on providing counseling so that the person will understand the nature of his or her hearing. Therefore, both cultural and personal norms play a part in diagnostic judgments and rehabilitative programs. A 10-year-old child with severe cognitive delays and an unstimulable distortion of the /r/ phoneme may not be judged to have seriously defective speech, whereas an 8-year-old presenting a similar speech pattern but a different intellectual potential may be recommended for treatment. Such judgments have implications for case selection, and the clinician must reconcile the variances between the physical differences in the sounds involved and the individual variables in conjunction with what is normal for the population as a whole. Each clinician must continually use both concepts of normalcy in diagnostic work.

A speech signal can call attention to itself in all sorts of ways and yet be perfectly appropriate. For example, an African American English (AAE) speaker may alter aspects of speech and language when style-shifting between members of one culture and another. Although Standard American English (SAE) speakers may notice the differences in AAE, these variations certainly would not be viewed as evidence of a communication disorder. Another example might be when speakers alter their rate, loudness, and vocal quality in order to tell a funny story or relate a particular experience in a dramatic way. Age is another variable. If the speaker is a child of 2 who exhibits many articulatory substitutions and omissions, does this difference constitute a problem? The answer can only lie in an examination of these errors against the context of normal 2-year-old communication. Thus, a difference is not enough to constitute a communication disorder if the context suggests normality. This underscores the importance of the SLP knowing the contextual effects on communication and the contributions of age and the wide variety of cultural, ethnic, and geographical dialects on the speech signal.

2. *The intelligibility of the message*. The second component of determining a communication disorder involves the perception of disturbance in the signal that is transmitted. Is the signal distorted, or is its intelligibility affected? If the message transmission is adversely affected, there is a high probability of the existence of a problem. Many factors play a part in both the encoding and decoding processes, and the diagnostician must be capable of representing the standard for society when listening and making judgments.
We have mainly been content with clinical insight and intuitive estimates when we have judged the impact of speech differences on intelligibility. The clinician is able to count the phoneme errors, quantify the number of disfluencies per sentence, and establish various quotients of language ability, but it is still a challenge to assess the intelligibility of the message with any degree of reliability. In most cases the clinician resorts to scaling techniques to mark the impact of the disorder on intelligibility, and we do not really know what specific speech or language components contributed to the overall signal distortion. Clearly, severe disfluency can interrupt a message, intermittent cessations of phonation and poor vocal qualities can distort transmission, inappropriate phoneme selection or production can lead to unintelligibility, and ambiguous vocabulary or sentence structure can lead to misinterpretations. Whatever the cause of the communication failure, we must document that it occurs. At present, however, we have no widely accepted system to use in this documentation for most areas of communication disorders.

3. **Handicapping condition.** The final component in defining a disorder involves the determination of handicap in the life of the client. Emerick (1984) suggests:

   In the final analysis this third aspect justifies the existence of our profession. If the speech difference has no discernible impact on the child’s behavior, and ultimately on his adjusting abilities and learning potential, there is little justification for concern on the part of the speech clinician. Although it is not feasible to compile a listing of all of the possible conditions under which a communicative difference would become handicapping, it is generally agreed that communicative differences are considered handicapping when: (1) the transmission and/or perception of messages is faulty; (2) the person is placed at an economic disadvantage; (3) the person is placed at a learning disadvantage; (4) the person is placed at a social disadvantage; (5) there is a negative impact upon the emotional growth of the person; or (6) the problem causes physical damage or endangers the health of the person.

   There are numerous examples of famous people who are highly successful and seemingly content with their lives despite manifesting a communication disorder. Some famous personalities have happy, fulfilling lives even though an SLP would have classified them as having a handicap. On the other hand, a minor deviation in a teacher or business executive may mean a significant handicap in terms of credibility and evaluation of job performance. Two people with hearing impairment can have identical audiograms and yet report significantly different effects that hearing loss has on their lives. If a person does not view his or her communication disorder as a handicap, it is difficult to justify clinical work or to motivate the client to improve communication skills.

**DIAGNOSIS TO DETERMINE THE ETIOLOGY OF THE PROBLEM**

Far too many clinicians view diagnosis simply as a labeling process; however, the actual labeling, or categorizing, is only a small part of the total assessment. Classification systems within our profession are poor at best, and high-level abstractions (e.g., stuttering) tend to emphasize the similarities within populations rather than the individual differences. The keen diagnostician regards classifications as communication conveniences to be viewed with suspicion. Of course, the convenience factor is important, and each clinician who makes a determination of the reality of the problem must be willing to label it. This necessity must, however, follow an orderly description of the characteristics of the disorder so that it can be clear what route the diagnostician took in arriving at the final classification. A diagnosis that only describes the
characteristics of the problem, without judging its type or class, is a dead end. Nelson (2010, p. 102) points to three major difficulties with categorization: “(1) lack of recognition of complexity of human differences, (2) unnecessary stigmatization, and (3) not enough benefits to overshadow the limitations.” She goes on to say that categorization will not be abandoned in the real world because it is helpful in qualifying children for special services, funding, and admission to special programs run by state and federal governments.

The opposite path is also dangerous; the diagnostician who is willing to begin an evaluation by labeling the problem has reversed the orderly sequence of acquiring knowledge and often effectively closes his or her mind to factors that may later point away from the premature diagnosis. Nelson (2010) applies an old metaphor to the diagnostic process. If a clinician focuses only on the macrolevels of diagnosis such as applying a label to a client, he or she is likely to miss the trees for the forest. On the other hand, if the focus is only on microlevels, such as memory or auditory processing, the forest is missed for the trees. This is a wise notion to remember as we engage in diagnosis and evaluation. If we concentrate on macrolevels, we do not become familiar with the individual needs of the client; if we focus on microlevels, we may not see how the client’s abilities or impairments represent a broader syndrome.

The notion of “cause” has different meanings depending on its distance from the problem. As you look at a client in a diagnostic session, you search for reasons for the presenting behaviors. In fact, many of these reasons may be buried in the past and can be revealed only by painstaking effort. In many cases, cause and effect may be layered in complex patterns. Not only must we search through the client’s past experience in order to uncover events that may help us alter current behaviors but we must also guard against looking for causes in only one dimension of behavior. A child’s brain damage, once identified, is probably not the only etiological factor because communication is a complicated human function. Social, learning, motivation, and many other factors enter into the total process. Paul (2001) illustrates the complexity of determining causation in an example of babies who were exposed to cocaine because their mothers used the drug during pregnancy:

Cocaine was usually not the only risk to which they were exposed. Mothers who abused cocaine during pregnancy also tended to abuse other street drugs, as well as alcohol. Alcohol itself is known to be a serious teratogen and could cause many of the problems thought to be present in these babies, even without any other substance abuse. Further, mothers who abused cocaine and other drugs during pregnancy frequently continued to do so after the child was born. These mothers would not be very available to their infants for either basic care or for social interaction . . . . Finally, mothers who abuse cocaine and other drugs tend to live in poverty. Poverty itself affects both general and communicative development through the tendency for poor children to have been born small and prematurely and to have poor nutrition, inadequate medical care and incomplete or absent inoculation against disease. (p. 99)

Thus, determining the etiology of a problem is not always straightforward, and we must be cautious about attributing the cause of a disorder to a particular event or factor. Classically, etiology has been defined in terms of predisposing, precipitating, and perpetuating factors. Predisposing factors are generally thought to be important because of their potential link with a third agent. A classic example of predisposing factors is the apparent genetic predisposition to stutter. We know that stuttering tends to run in families; however, it could be that environmental factors cause it to surface. The wary diagnostician must watch for factors that occur with high regularity in association with
certain communication disorders. Such data could ultimately be instrumental in uncovering some basic information regarding the nature of the disorder.

Precipitating factors are generally no longer operating and, as such, may or may not be identifiable. For example, a child with a language disorder may have begun to lag behind in linguistic development during a period of recurrent ear infections that occurred when language was being learned. If the otitis has long since disappeared and the language disorder remains, it is difficult for the diagnostician to observe or even pinpoint the true cause of the disability. Even if the child did have recurrent bouts with ear infections, it can never be truly substantiated that these infections actually precipitated or played a role in language delay, especially because many children experience frequent ear infections and manage to develop language normally. In many cases the precipitating factors are clear, as in instances of stroke, vocal abuse, structural abnormalities, and certain congenital conditions.

The perpetuating factors are those variables currently at work on the individual. Almost without exception, habit strength is a prime perpetuating factor in many disorders because the client has made various compensations for the problem in terms of cognitive/linguistic strategies and motor adjustments. Other factors are also crucial, however, and it is the diagnostician’s task to uncover the environmental and physical factors that are reinforcing and thus perpetuating the disorder. A hearing loss may be a precipitating and a perpetuating factor in a child’s language delay. This child needs a thorough audiological evaluation and possibly amplification, if indicated, or else the problem will perpetuate. We must always work to identify and, if possible, remove or reduce any factors that maintain a communication disorder.

**DIAGNOSIS TO PROVIDE CLINICAL FOCUS**

Although it is important to know the causes of the disorder, it is substantially more important to gain some insight into the possible ways to improve the client’s communication. At this point, diagnosis and clinical management overlap. This is also where the importance of knowing a host of evaluation techniques becomes significant in the diagnostic enterprise. The diagnostician must ask a series of questions, such as the following:

1. **What do I know about this condition?**
   - What are the usual etiologies?
   - What are the usual effective treatment procedures?
   - What is the typical prognosis?
2. **What do I know about this person?**
   - What is the impact of the condition on the person?
   - What are the person’s strengths and needs?
   - How is this person like others I have worked with?
   - How is this person different from others I have worked with?
3. **What do I know about my own skills in the treatment of this disorder and this type of person?**
   - How have I approached similar problems effectively?
   - How have I worked effectively with similar people?
4. **What do I know about the services of other professionals available for this person?**
   - What referrals need to be made?
   - What consultations do I need to make?
5. What factors need to be removed, altered, or added to improve the prognosis?
   What inhibiting environmental factors exist?
   What organic factors need alteration?
   What can enhance the person’s motivation?
   How can the family be involved in treatment?

Note how many of these questions address components of evidence-based practice discussed earlier.

DIAGNOSIS: SCIENCE AND ART

Diagnosis demands a unique blend of science and art (Silverman, 1984). The scientific method is applicable to our work as diagnosticians, both in guiding our procedures and in focusing our attitude of operation. The scientific method directs the diagnosticator to observe all of the available factors, to formulate testable hypotheses by using clearly stated and answerable questions, to test those hypotheses to determine their validity, and to reach conclusions based on the tested hypotheses. The method demands rigorous adherence to standardized procedures and has as its favorable characteristics objectivity, quantifiability, and structure. The scientific diagnostician tends to rely on tests, test data, and other procedures that lend themselves to quantification. As an attitude of operation, the scientific method implies that the diagnosticator has not predetermined the test findings and that there is no bias in seeking the proof or disproof of hypotheses. The diagnosticator sees hypotheses as something to be tested rather than something to be defended.

The self-fulfilling prophecy is a lethal but almost universal human characteristic; it must be counterbalanced by a scientific approach to testing. We are familiar with parents of children with language impairment who have traveled all over the country in search of a diagnostic explanation for the linguistic delay. Often these children are victims of the “fat folder syndrome,” in which a case file has accrued over the years with reports from various authorities and clinics. Each report often reveals more about the examiner than the child because it cites facts in support of a theory of etiology congruent with the diagnosticator’s particular specialty. For example, in the same client, the audiologist finds auditory processing disorder, the autism specialist diagnoses an autism spectrum disorder, the psychologist discovers attention-deficit disorder, and the speech-language pathologist finds language impairment. Finding what you want to find is not always in the realm of the scientific method. Diagnosticians often use their pet test instruments, to use a famous saying, as the drunk uses the street lamp—more for support than illumination!

The strict adherence to fact that is demanded by the pure scientific method is often a bit confining. That may explain in part why we all practice the art of diagnosis at times. The artistic approach has several specific characteristics. The artist is less dependent on specific observations than on casual and unstructured scrutiny for the formation of hypotheses. This type of clinician is perfectly willing to disregard formal test results or standard testing procedures in favor of what appears obvious on the basis of clinical experience and expertise. The hunch, or clinical intuition, plays a significant part in such evaluations. This diagnosticator will contend that facts can be approached from several directions and that we are capable of assessing the same kinds of behaviors that are measured on formal tests by using nonstandardized evaluation tasks. Such contentions are disconcerting to the test-bound person who has come to expect that the only valid way to gain information is through standardized procedures. One of the emphases in
this text is that these informal, nonstandardized evaluation procedures are valuable indeed in defining a client’s problem and the potential response to treatment. In many ways these procedures may be more valid than standardized tests, as we will discuss in Chapter 3.

It is obvious that, in the extreme, there are weaknesses in both approaches. The scientist may tend to become so dependent on objective methods of measurement that he or she fails to see the client through the maze of percentiles and standard scores. The whole is greater than the sum of its parts, and every diagnostician must guard against simply measuring the isolated characteristics without getting a full picture of the individual. The possibility of a diagnostician projecting more than a modest amount of personal bias into the evaluation is greater when a less scientific approach is used. Clinical intuitions are often simply clinical biases, and it is very easy to make new evidence fit old categories. The diagnostician must find the proper mix of each philosophy in establishing assessment procedures.

**DIAGNOSIS VERSUS ELIGIBILITY**

As our legal system, medical settings, and public school systems have become more complicated, clinicians are faced with increasing pressure to conduct their clinical work within parameters that are set by administrators. The resulting procedures for case selection, testing, and determining eligibility for services many times fall short of the ideal professional criteria used to make these decisions.

The influence of administrative decision making on our profession has blurred the distinction between diagnosis, on the one hand, and determining eligibility, on the other. While we cannot always do everything optimally for a client in certain work settings, we need to be very careful in our decisions to streamline services and not make arbitrary decisions for administrative purposes that undermine our profession. For example, it is not unusual for private practitioners and community clinics to provide services to children who have clear language/phonological disorders but who are ineligible for such services in the local school system. Similarly, it is not unusual for private practitioners and university clinics to provide services to medically involved patients whose insurance carriers will no longer pay for treatment. Ehren (1993) nicely describes how caseloads are often influenced by eligibility. And the art of diagnosis has, in essence, been traded for the process of determining eligibility. The process of evaluating and describing what a child’s communication needs are has been lost. She urges the community to return to its diagnostic clinical roots and the traditional process of first making a diagnosis, followed by treatment or service recommendations. Only after the diagnosis and service recommendations are made should eligibility be determined.

**THE DIAGNOSTICIAN AS A FACTOR**

What skills are necessary to develop in order to become an effective diagnostician? How do you develop them? What makes one diagnostician better than another? There are no easy answers to these questions. Experience in the diagnostic process is an absolute necessity, but experience in number of clients seen is not enough. A pompous clinician once bragged, “I’ve had over 20 years of experience.” The unfortunate thing, however, is that this person had the first year of experience repeated 19 times, which is altogether a different matter. The diagnostician must be able to gain from new experiences, and this demands flexibility. The stereotyped, dogmatic, and stagnant diagnostician learns little from increased exposure to people and new situations. Diagnosticians who use their experience as a pattern to be compared against, rather than as a mold into which
all new experiences must fit, will continue to grow and learn. The diagnostician must be flexible enough within the testing situation to shift from predetermined plans to new modes of evaluation as the client presents unpredicted behaviors. The examiner who fails to recognize that a client presents some interesting new behavior or exhibits valid instances of communication ability in non-test contexts will miss an important opportunity to gain insight into the problem. It is not atypical for beginning clinicians to panic in the face of unanticipated performance or behaviors. There is the tendency to become uncompromising in the application of a series of formal tests because there is a certain degree of comfort in known processes and sticking with the initial plan. Continued experience in diagnosis may provide the flexibility needed to move freely to other avenues of information.

Another characteristic of a good diagnostician is a healthy skepticism and ability to evaluate critically new clinical techniques. Practicing clinicians often eagerly accept new and novel techniques as they become available. New techniques must not be accepted or rejected carte blanche but rather must be scrutinized for their merit. We must learn to keep up with new developments by participating in an active continuing education program, both personal and professional. On the other hand, the beginning student must guard against the “recent article” or “new test” syndrome to which we all fall prey on occasion. Typically, the behavioral pattern goes something like this: You read an article that depicts a particular syndrome and explains the distinctive characteristics of a disorder; for a few weeks thereafter every child you see appears to fall into the pattern described in the publication. The way to overcome the “recent article” syndrome, of course, is to be aware that it exists and to have a thorough understanding of the nature of human perception. With regard to new tests, some clinicians get into the “new test” syndrome and use the most popular test of the day simply because it is new. Many forms of assessment have stood the test of time and should not be discounted for their age or dated packaging.

A clinician must possess many important interpersonal relationship attributes. Empathy, congruency, and unconditional positive regard are necessary characteristics of the clinician, and they most certainly apply to the diagnostic process as well. In many studies of clinical competence and outcome, the interpersonal or therapeutic relationship is a major factor contributing to successful treatment (Norcross & Wampold, 2011). Generally these qualities must be nurtured by consistent effort and proper guidance in training programs through analysis by clinical supervisors and review of session video recordings by clinicians in training.

The development of an evaluative attitude and sensitivity is often a rather difficult task for the beginning clinician. We are, to a large extent, slaves to our experience; each clinician tends to bring a social attitude into the test setting. Rather than look on the client’s performance as having meaning for the evaluative process, we consult our own responses and formulate our own points of view in the give and take of the conversation. The critical, questioning attitude must be developed so that the clinician looks on the behaviors in terms of their meaning rather than in terms of the response expected. Social interaction lends itself to superficiality, whereas the flow of the diagnostic interaction must, by design, lend itself to uncovering the meaning of the incorporated behavior. Effective diagnosticians tend to question the surface validity of behaviors and search for motivations, explanations, and interpretations that are not readily apparent. Sensitivity may be defined as a keenness of sense or a heightened awareness of incoming sensory data. When viewed in this manner this term then has meaning for the diagnostician. The clinician must be able to detect subtle physical, psychological, or interactional changes in a client’s behavior because these small changes may have significant meaning in the diagnostic process.
Closely allied with the concept of the evaluative attitude and sensitivity is the idea of persistent curiosity. The diagnostician must develop an inquisitiveness that will make him or her persistent in searching for explanations. Answers are seldom apparent at first, and continuous effort is imperative. The curious and persistent clinician continues to place the client in situations that will permit additional scrutiny. In an attempt to give each student a variety of clinical experiences, training institutions often tend to sever clinical undertakings with a client at each semester’s end. It would be ideal, albeit probably unworkable in training programs, for students to follow their clients over longer periods of time so that the students could see how diagnosis is an ongoing process and an integral part of treatment as the client changes.

Objectivity comes from practicing the art of controlled involvement. The diagnostician must cultivate objectivity because everyone is subject to human errors. We must be warm, understanding, and accepting, on the one hand, and objective, evaluative, and detached, on the other. Without some degree of balance between the two extremes, the diagnostician may distort the interaction with the client so severely that little information of value is obtained. Objectivity demands more than simply guarding against undue emotional involvement. To grow as a diagnostician, the examiner must be objective about his or her skills, knowledge, and personal characteristics and must take an objective attitude toward the client.

Rapport may be defined as the establishment of a working relationship, based on mutual respect, trust, and confidence, that encourages optimum performance on the part of both client and clinician. Rapport is developed over a period of time and is not easily established in a single session or during a few minutes at the initiation of one diagnostic encounter. Rapport must not only be developed, it must also be maintained, and this calls for continued effort. We have known for decades that, especially with children, performance on formal tests varies with clinician familiarity (Fuchs, Fuchs, Dailey, & Power, 1985). Children tend to perform better if they have had an opportunity to become familiar with an examiner. While the reasons for this phenomenon are not totally clear, the concept of rapport is obviously involved.

It is important that our focus be on the client as much as possible instead of on our own performance and internal states. Diagnosticians are people too, and we often forget that they occasionally have a bad day. They too can experience the influence of pervasive personal problems and physical frailties that sometimes make them feel as though they should have stayed at home in bed. The most knowledgeable and skillful diagnostician, however, may fail to achieve adequate results if he or she lacks the inquisitiveness necessary to encourage continuous effort and if there is no professional drive to serve each individual to the maximum potential. Each of us is subject to individual variations in daily behavior (physical problems, depression, stress, etc.) that can have a direct effect on performance; however, it is incumbent upon every professional to control those variations to provide each individual with the best service available.

THE CLIENT–CLINICIAN RELATIONSHIP

Although much standardization is possible through strict adherence to test routines, the lowest common denominator in diagnostic evaluations is the examiner. Test results are the product of the subject, examiner, test, and test circumstances, and each has a certain influence. Examinations are clearly selected as a result of the experiences and biases of the examiner. Just as the answers we receive to questions are in part a function of the questions we ask and how we ask them, the diagnostic findings we obtain are in part a function of the tests we administer and the way they are administered. An impaired communication pattern may be partially due to a defective testing pattern or an incompetent tester.
The most crucial factor in conducting a successful diagnostic session is the client–clinician relationship and the establishment of a working alliance. When one person works with another, there is always human impact. No matter how well prepared and rehearsed an examiner may be, if his or her approach to people is poor or if his or her approach is incongruent with that of the clients, failure will result. All tests, all examinations, all so-called objective diagnostic procedures are mediated by person-to-person contact.

Impersonal, test-oriented clinical examination sessions can make assessment more difficult because there is no absolute division between diagnosis and therapy. The first contact with a client initiates treatment. During a diagnostic session, the client is forming opinions and conceptions about the clinician and the total clinical situation. Not all clients will require the full impact of this interpersonal dimension. Indeed, some individuals simply want to find out what is wrong and then rectify the situation. The point is, however, that the clinician should be able to discern what the client needs and then adjust his or her style appropriately.

**THE CLIENT AS A FACTOR: CHILDREN, ADOLESCENTS, AND OLDER ADULTS**

Although all age levels present unique diagnostic problems, three groups in particular—young children; adolescents; and, to a lesser extent, older or elderly clients—require special effort and expertise. The present chapter is generic in nature, so we will talk mainly about the general business of relating to the different age groups seen in diagnostic evaluations. Subsequent chapters will provide additional and more specific suggestions for dealing with the different age groups in the context of evaluating particular disorders. A major reason for including this generic section is that many readers of the present text are students in training to become speech-language pathologists. It is often difficult for a young person to capture the ephemeral guidelines for relating to people of different ages. It is not as simple as just “being yourself” or talking one way to a child and another way to an adult. Students have made certain common errors over the years that we can at least alert you to so that you may avoid them. These precepts, of course, are drawn from the experiences of the authors, and obviously many more guidelines could be added.

**Young Children**

Preschool and kindergarten children are often difficult to test and examine. Unlike most older children and adults, they just do not see the payoff for all the questioning and prodding. Often a major problem is dealing with the child’s fear of the clinical situation. This apprehension may stem from one or more of the following related factors: (1) inadequate preparation for the examination by parents, (2) uncertainty about what will be done to or with the child by the clinician, (3) vivid memories of trauma during visits to dentists and physicians, (4) the contagious anxieties and uncertainties experienced by the parents, and (5) stress and conflicts engendered by past listener reactions to the communication impairment. Children confront the clinical examination in a variety of ways, but the two most trying responses are shyness and withdrawal and, at the other extreme, aggressiveness and hyperactivity.

In many cases with very young children, it is possible to have the parent participate in the interaction, and this avoids any separation anxiety on the part of the child. The parents are typically willing to cooperate, the child is happy, and the parents can often get the child to participate in many ways that the clinician would take several sessions
of rapport building to accomplish. Parents can even be used to administer some formal tests that just involve turning picture plates and reading the cues on the backs of the pictures, while the clinician scores the child’s responses. We have to choose our battles very carefully, and fighting an obstreperous child in a diagnostic session mainly leads to unsatisfying results for all concerned. In dealing with the children in the birth-to-age-2 age range, most of the pertinent information will be gleaned from parents, both from interview data and by observation of parent–child interactions. Not many 1-year-olds do well with an unfamiliar clinician, and we need to focus on the parent–child dyad anyway because treatment will doubtless involve the entire family.

Obviously many other considerations could be discussed; additional suggestions will be offered in the chapters concerning various disorders. For the present, here are several basic precepts on the management of preschool children in a clinical examination:

• Help the parents prepare the child for the diagnostic session. The parents can tell their child what will transpire and maybe even bring along some stimulus items favored by the child (toys, picture albums, books, etc.).

• Play, rather than small talk, is the natural medium of expression for children. This is especially important when dealing with youngsters who may have a communication impairment. While we have all known children in the 3-year-to-5-year age range who are impressive conversationalists, most children referred for communication disorders are not on this end of the conversational continuum. Try to arrange the diagnostic tasks with this in mind.

• As a general rule, ask less and observe more. Children usually lack the insight and cooperation necessary to analyze their problem rationally and objectively. Naturalistic observations—assessing a child’s behavior in natural environments—yield more useful information.

• Learn everything possible about typical children in order to provide a baseline for observations of youngsters presenting problems. This can be done by taking courses, studying relevant norms, and most of all by extensive scrutiny and interaction with children in daycare and preschool facilities. You should have a good idea of the typical or modal behavior for children at various age levels.

• Limit the choices you offer a child. Don’t ask if he or she would like to go with you, or do this or that, unless the alternatives do not conflict with the examiner’s goals. The child will invariably say “No!” Also, refrain from saying “Okay?” after your utterances (“I want you to name these pictures, okay?”). This question suggests that there is an option available to the child.

• Be flexible in your use of tests and examinations. If you cannot employ the rigid standardized format for administration, use the test to obtain all the data you can. If the child refuses to name the test pictures or objects, you may be able to get a language sample from other items. Also, if there is no standard order for administration of tests and tasks, use items the child appears to be interested in at a particular time. For example, if a test has some objects associated with it and the child is attending to these items, start this examination even if you had initially planned it for later in the session.

• Absolute honesty and candor is important in working with children. Do not make promises unless you can keep them.

• The whole assessment does not have to be done in one session; marathon diagnostics tend to be counterproductive. Remember that all we can hope to obtain in one
time frame is a sample of a child’s behaviors. It is better to terminate (preferably on a pleasant, successful note) than to continue an unproductive session until the child is fatigued or upset.

- Watch your language complexity when talking to children. For obvious reasons, the examiner should avoid sarcasm, idiomatic expressions, ambiguous statements, and indirect requests.

**Adolescents**

Experienced clinicians frequently report that adolescents, especially those in grades 7 through 11, are often difficult to examine and resistant to treatment. The main problem seems to be getting through to the adolescent. There is no magic formula, but we would like to offer the following suggestions that we have found helpful in guiding our work with adolescent clients:

- Acquire an understanding of the myriad pressures and changes the teenager is experiencing: rapid physical growth, sexual maturity, conflicts between dependence and independence, the development of self-confidence and interpersonal skills necessary to make decisions, a search for identity and life work, intense group loyalty and identification, and many more. It is a turbulent, trying period of behavioral extravagance and excess. It is little wonder that teenagers are often overloaded with personal concerns and do not always welcome an overture of clinical assistance. Empathy that flows from understanding is a powerful force in establishing a working relationship.

- There is an intense desire to be like others, not to stand out from the group in any way that would suggest frailty. Hence, the adolescent may find it extremely difficult to reveal a communication impairment, even if help is desired. Often teenagers are simply sent for evaluation or treatment by parents. In some instances, the teenager with a chronic problem may have been in treatment for a long time and is weary of the idea of more therapy. Many tend to cover up true feelings with a sullen bravado or a dense “it-doesn’t-bother-me” shell. Denial is a particular forte. “Coolness” and image are very important. You can neither beat this down nor simply dismiss it with a shrug, nor is silence a particularly effective tool in dealing with adolescent resistance. We advocate a straightforward approach: Acknowledge the forces that are bearing on the individual, point up objectively the paths that others have taken, and provide information about the economic and social penalties that accrue to the person with a communication disorder. Basically, try to demonstrate by your demeanor and what you say that you care about the client; a growing person needs lots of nourishment, and personal involvement and commitment are key factors.

- Do not abandon your professional role for that of a teenager. Be yourself. As Will Rogers pointed out, if they don’t like you the way you are, they are sure not going to like you the way you are trying to be.

- Approach adolescents with tolerance and good humor. Do not be shocked or annoyed by their overstatements and superlatives; do not overreact to expressions of hostility or tempests of other emotions. Sometimes adolescents, in order to uphold their protective armor, resort to all sorts of strategies to confuse, defeat, or anger the clinician. The ability to laugh at yourself and to use humor in a gentle manner is an asset. Remember, though, to always treat the adolescent with honesty and dignity—don’t make fun of intense or idealistic views.

- Explain the diagnostic process as much as possible by explaining what we are about, the reasons for the various tests and examinations, and how we will use the
information. We encourage the adolescent to challenge and question what we are doing. Finally, we usually give the client an idea of the route we would follow when therapy commences, or we even do some trial treatment activities.

- If the client is highly critical of parents or school officials, we must keep the person’s confidences and not act in a judgmental manner. We do not enter into the criticism or side with the client against others, nor do we try to defend the institution or retreat to moralisms.

- Discuss the results of the evaluation with the client before talking with the parents or school personnel. Be sure to let the client know exactly what you intend to tell parents and teachers and determine any feelings the client has about these suggestions.

These recommendations have been distilled from our clinical experience and are not presented as magical touchstones for all diagnosticians or all clients, nor do these recommendations represent the full range of possibilities for successful interaction with teenage clients. We present them here to encourage other workers to develop clinical generalizations on the basis of their experience.

**Older Adults**

Older clients may present some rather special problems for the diagnostian, or they may need no particular special handling. Although the concept of “older” is relative, we refer here to persons in their 60s or older. A word of caution: Although certain generalizations are useful for planning and conducting evaluations, older people are not any more “all alike” than are children or adolescents.

The clinician should be alert to fatigue, disorientation, failing eyesight, and hearing loss. With advanced age, the person may find it more difficult to focus attention on a task and generally may have trouble remembering directions because of possible short-term memory decline. Many of these potential problems are exacerbated when the person has experienced a neurological insult, as can happen in a good number of elderly clients. Therefore, we need to explain each step of our clinical procedures at greater length and repeat instructions when necessary to ensure understanding. Our pace should be geared to the client’s abilities—if necessary, to a slower pace. Organize the testing sequence carefully to reduce distractions, noise, or interference. Older people are often more cautious and have a greater need to be certain before they respond, so adapt the tasks with this in mind; following standard procedure may not be as important as providing an environment in which the person is able to perform at an optimal level.

Because many older clients tend to feel useless and discarded in our youth-oriented culture and resentful that their bodies are betraying them, we may find it important to spend some time listening to their memories of past achievements. Older clients should always be treated with respect and not referred to by their first names unless they request that you do so. The clinician should also guard against using a louder vocal intensity and increased pitch range, as if talking to a child. It is grossly offensive to infantilize an adult client. Many of our older clients come to us with neurologically based disorders, serious vocal pathologies, and other medically related problems. There is a tendency among many to talk about medical issues because older clients’ problems have originated from this area. It is important for the diagnostian to be patient with these clients and listen to their concerns while not allowing conversation about medical issues to interfere with the testing.
In most cases, clinicians will find older clients to be interesting, socially adept individuals to be treated with courtesy and respect. The number of people over age 60 comprises a significant proportion of the population, and we cannot afford to perpetuate the stereotype that old people are expendable or that they should be relegated to demeaning idleness. As with children and adolescents, the diagnostician should know as much as possible about aging. Many references pertinent to communication disorders are readily available (Kirkwood, 2000; Morrison, 1998; Shadden & Toner, 2011; Sheehy, 1996).

PUTTING THE DIAGNOSIS TO WORK

Perhaps the most demanding of all diagnostic ventures is the ultimate synthesis of findings into a coherent statement of the nature of the problem. The skilled clinician draws the findings together by using the data available, past experience, knowledge, and intuition to formulate a total picture of the condition. At this point, textbooks, research findings, and academic lectures fail to provide all of what is needed to succeed. Maturity of skills develops only in an extensive practicum under the close supervision of a knowledgeable diagnostician. The essence of the synthesis process is a comparison of what is observed with what we expect to observe from our knowledge of the normal process. The incongruities between the observed and the normal provide the building blocks for completion of the picture. Figure 1–6 identifies a model of diagnosis as a synthesis of findings and shows a number of outcomes to which the synthesis might lead.

Figure 1–6 points out several important concepts. First, the bedrock of the entire model is the clinician’s knowledge and skill base. Without adequate training and experience, the administration of tests and tasks becomes meaningless.

A second important point in the model is the series of six boxes immediately above the clinician’s knowledge and skill base. These boxes highlight the diversity of information that the diagnostician should ideally obtain in order to make a principled judgment about a client’s disorder (case history, prior reports, observation, interview, informal testing).

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**FIGURE 1–6**
Components of an Effective Diagnosis/Evaluation

- Parent Information and Counseling
- Referral
- Prognosis
- Further Testing
- Clinical Management Suggestions
- Addition to Clinician’s Experience and Knowledge Base
- Diagnosis and Synthesis of Findings
- Case History Information
- Prior Tests and Reports
- Observation of Clients
- Interview Findings
- Informal Testing
- Formal Testing
- Clinician’s Knowledge, Skill, and Experience Base
testing, and formal testing). It is not unusual for prior reports and tests to be missing, case history information to be returned by the client at the time of evaluation instead of prior to it, the case history forms to be incomplete or lost, and the interview cut to a 10-minute conversation because of time pressure. It is also not unusual for the clinician to spend the entire assessment time giving tests, with little opportunity left for informal testing or observation of clients in relevant situations. While it is difficult to obtain information from all six boxes in the model, we must try to get as close to the ideal as possible. In many settings, the evaluation does not take place unless the client has submitted all pertinent information and unless reports from other agencies have been received. This practice is certainly the case in many other professions (medicine, psychology, etc.). We must ask ourselves about the quality of the diagnostic evaluation that is done with incomplete information. What is the efficacy of performing an evaluation if we do not have access to critical information and are not willing to spend the time to carry on a decent interview and do informal testing and client observation? Remember that a crucial part of evidence-based practice is to understand the client’s disorder and perspectives as fully as possible.

A third area, in the center of the model, is the synthesis of findings. This is where we begin to see overlaps in the data from case history, interview, reports, observations, and testing results. We should look for common threads among all these information sources and tie them together in the synthesis and diagnosis. Often, this is where certain informational components begin to disagree with one another, which is also informative. For example, the parents indicate intense concern over their child’s articulation in the case history and the interview. They also bring a host of prior reports that indicate the child has no clinically significant problem, and they look to you for guidance. If your own test results, informal task performance, and observations indicate that the child is performing within normal limits, the discrepancy between these components and the parents’ perceptions is obvious. The prior reports also now gain significant importance in terms of counseling the parents and pointing out the disparity between their views and the perceptions of many professionals. Another example may point out the foibles associated with one or more of the sources of information. For instance, a child may not perform within normal limits on formal tests of language ability, yet that same child communicates well in informal tasks and observations of play interactions with caretakers and peers. The clinician must question the formal test results if the child’s communication exceeds that which these measures suggest he or she is capable of.

The fourth box in the series of five boxes in the model points out some important components of a diagnostic evaluation that are present after the synthesis of information. As we mentioned earlier, a good diagnostician will make suggestions for treatment in terms of which goals may be logically selected for initial intervention. The parents need to be counseled about the results of the evaluation, and any problems or feelings they express must be dealt with. Often we are so zealous in performing the evaluation and in scheduling time for doing everything we feel is necessary that we give the client or parents short shrift in explaining our results. In many cases, the results we report to parents and clients represent a significant affective burden. For example, even though parents usually know in their hearts that their child has a communication disorder, they often hold out the hope that their child really is typically developing and will grow out of a language or articulation difference. Telling parents that their child is indeed showing an impairment forces them to come to terms with this problem. Diagnosticians may experience parents or clients who cry at the culmination of the evaluation session when they are told something that confirms the idea of a disorder or commits them to an undetermined length of time spent in rehabilitation. Other emotions also emerge, such
as anger and denial, which must sometimes be dealt with at the end of the diagnostic session. Emotions aside, it is enough of a challenge simply to communicate the complex evaluation results to parents of different educational levels and abilities. A skilled diagnostician has the ability to summarize assessment results and recommendations on the correct level of abstraction for different parents and clients. Another aspect to deal with after synthesis is the possibility of referral. Many cases require a consultation by other professionals, such as audiologists, laryngologists, neurologists, special educators, psychologists, and others. Often the assessment raises more questions than it answers, and this is perfectly acceptable. We need to know the parameters of the patient’s problem, and many times this insight can be gained only from professionals who have expertise in areas with which we are not totally familiar.

Prognosis is another variable depicted in Figure 1–6. Prognosis may be defined as a prediction of the outcome of a proposed course of treatment for a given client: how effective treatment will be, how far we can expect the client to progress, and perhaps how long it will take. Inasmuch as diagnosis is a continuing process, prognosis should, like treatment planning, have both long-range and immediate facets. Immediate prognosis covers what the person can do now, what steps in therapy are possible, and what is the best route to take. Prognosis for specific communication disorders will be discussed in subsequent chapters; in this section we present some generic purposes and a possible danger involved in predicting a client’s response to treatment.

Patients and families want to know what they may expect in terms of progress. Some general factors that the clinician must consider when making predictions are as follows:

1. Age—The chronological age of the client is a gross predictor of treatment success. In general, the younger the client, the better the treatment outcome. For example, the earlier the intervention is begun in childhood disorders, the more progress can be made prior to the start of school. The earlier we involve children in treatment, the more likely we are to prevent the formation of secondary problems (Shine, 1980; Starkweather, Gottwald, & Halfond, 1990), such as social, psychological, and educational penalties. In adult cases, it is well known that patients who develop neurogenic disorders at younger ages (40–60) are generally given better prognoses than patients who develop these problems at later ages (70–90) (Rosenbek, LaPointe, & Wertz, 1989). This, of course, is due to a variety of factors, including psychological, motivational, and physical. Thus, age is a macrovariable that, in and of itself, is not a potent variable, but it subsumes many factors that do have an influence on prognosis.

2. Length of time the impairment has existed—The length of time a client has had a communication impairment may relate to prognosis. Obviously, if the impairment has a component of habitual activities (motor patterns, processing strategies, etc.), these are more difficult to alter in clients who have performed them for a lengthy period. In addition to the habit patterns developed over time, the client has also learned complex ancillary adjustment patterns to compensate for the communication impairment that may involve social, psychological, and motoric activities. These compensatory patterns eventually become part of the problem and often must be eliminated, as in the case of operant behaviors learned by people who stutter (head jerks, timing devices, etc.).

3. Existence of other problems—It is axiomatic that the more problems a client has, the more difficult it will be to deal with the disorder. A client with aphasia who is also hearing impaired will be more difficult to treat than one with the language disorder alone. A child with a cleft palate and articulation problems will be more difficult than one with the articulation problem alone. A child who is language delayed and cognitively impaired is different from one who presents only a language disorder.
4. **Reactions of significant others**—A child with a communication disorder will make better progress in treatment if the parent takes an active role in the intervention. Many parents are interested in participating in treatment and will carry on home programs. On the other hand, if a child is brought to the clinic by a social worker and the parents do not appear interested in treatment, this child will probably take longer to succeed in remediation. If the spouse of a patient with aphasia is disinterested in facilitating communication, the client may make slower progress. The same can be said about the cooperation of teachers, aides, daycare providers, siblings, peers, and anyone else who comes in significant contact with the client and is in a position to help with treatment. Generally, the more assistance available from significant others, the better is the prognosis.

5. **Client motivation**—While we have no reliable way to measure motivation in a client, most diagnosticians can recognize it when they see it. If the client appears enthusiastic, interested, and anxious to begin treatment, it is clearly a plus. If the client is an adult, was he or she self-referred? Self-referral may be a positive indication compared to referral by an employer or teacher or being dragged to the evaluation by a domineering spouse. There may also be some positive prognostic value in cases where the client has something to gain from successful treatment (better social life, higher-paying job, etc.). Motivation is always difficult to quantify, but few would totally disregard the importance of this admittedly hard-to-define construct.

Accurate prognoses can help establish our credibility with other professions. The ability to predict with reasonable precision is perhaps the highest form of scientific achievement. Needless to say, however, these predictions should be based on something more than clinical intuition. Impressionistic conclusions, especially when made by experienced workers, can often be startlingly accurate, but they should always be labeled as impressionistic: A prognosis should be supported by a substantial amount of information. We never say that “the prognosis is favorable” without some documentation, both impressionistic and scientifically based. It is much better to say the following: “The prognosis is good because the child is stimulable for all error sounds, trial therapy has indicated good attention and a cooperative attitude, parents have committed to a home program, the client has stated he wants to change his speech, the client has normal hearing, and language problems are not evident.”

In what sense might a prognosis be dangerous? First, no one really knows the future. A client’s prognostic variables might soon change with unforeseen circumstances (e.g., the uninterested parents become involved, the client develops motivation, the client makes a breakthrough in the ability to perform certain functions). Prognosis as a construct is thus dynamic, not static. A second danger is that the prognosis may well influence a client’s performance and perceptions. If a clinician has certain expectations regarding the case’s potential performance, this could be inadvertently communicated to the client or the family and could negatively affect the course of therapy. It could also influence the level of effort exhibited by the clinician. The old notion of a self-fulfilling prophecy is still alive and well. We must always be willing to alter prognostic judgments in light of new data and, perhaps more important, we must be willing to refrain from making prognostic statements in the first place if we do not know what we are talking about. It is better to say, “I don’t know how he will do in treatment; let’s see what happens” than to jaundice the whole enterprise with a negative prognosis that has no real basis, or to disappoint all concerned with a positive prognosis that is never realized. This is *not* an exact science!
CONCLUSION AND SELF-ASSESSMENT
In this chapter we have presented some suggestions for general conduct of the diagnostic session. We dislike diagnostic formulas, and our purpose has not been to give out recipes but rather to describe some way of approaching various problems without going too far astray. By way of summary, we now present a list of interrelated and overlapping precepts regarding the clinical examination:

• We examine persons, not communication problems. Our primary concern is with communicators, not just communication.

• The clinical examination is conducted interpersonally; the catalyst of a diagnostic session is the person-to-person relationship between clinician and client.

• There is an element of magic in every transaction between people. A diagnostic session can, in some instances, ameliorate a problem situation by engendering hope, or it can be deeply disappointing to a client who hopes that a test or examination will resolve a difficulty.

• A most important requisite for conducting a clinical examination is a thorough understanding of normalcy.

• Diagnosis is the initial phase of treatment. The very first contact with a client—the manner in which he or she is treated during a clinical examination—is a crucial determining factor in response to therapy.

• Diagnosis is not necessarily confined to a single session.

• Treatment is often diagnostic; we often discover the nature of a client’s problem in the initial stages of therapy.

• The clinical examination is performed to provide a working image of the individual; it is accomplished by interviewing, examining, evaluating, and testing.

• An important aspect in acquiring a working image of an individual is determining the person’s self-perception and situation.

• An individual makes certain adjustments to a problem (attempts to solve the difficulty), which may include a protective cover of defenses. These defenses may be part of the problem, but they must not be confused with the problem.

• Behavior is a function of the individual and the situation. We should be aware that our test results reflect not just the client’s abilities but also performance in the diagnostic setting rather than the natural environment.

• Our diagnostic activities should include an assessment of a client’s larger social context (home, family, peers, job, school, etc.).

• Tests are only tools to provide a systematic guide for our observations. They enable the clinician to scrutinize a client in a structured manner.

• Although, for the examiner, the testing situation may be very familiar and routine, it is a novel experience for the client.

• Examination and testing can be iatrogenic: They can suggest problems to the client that he or she had not previously considered.

• Simply because a testing device is made up of a series of precisely defined tasks, administered and scored in a rigidly structured manner, does not mean that a client’s responses are similarly precise.
• It is as important to observe how the client responds during a testing procedure as it is to obtain a score. Informal evaluation tasks are as important or more important than formal, standardized procedures.

• The needs of the client, not the work setting in which the clinician labors, should determine the scope of diagnostic activities. A good diagnostic is over when sufficient information about a client is gathered and should not be short-circuited because of administrative red tape, arbitrary guidelines of a facility, or government regulations. A good clinician will find ways to obtain critical information even if the evaluation extends into the realm of treatment.

This chapter has served as a general introduction to diagnosis and evaluation. The following chapters will focus more closely on important parameters of this interesting process with specific areas of communication disorders. We hope that students can see that this is an exciting enterprise that combines instruments with interpersonal relationships, testing with talking, and measurement with personal magnetism. The assessment process is the portal through which real people with real problems come to us for help. We must offer them the best of scientific as well as human resources.

After reading this chapter you should be able to answer the following questions:
1. How do the terms evaluation and diagnosis differ from one another?
2. What are the two major reasons that evaluations are performed?
3. What are the three levels of diagnosis and evaluation?
4. What are the three parts of evidence-based practice and how do they contribute to the clinical decision-making process?
5. What is RTI and how is it incorporated into the evaluation process?
6. How do dynamic and static forms of assessment differ from one another?
7. How did the WHO contribute to the development of ASHA's preferred practice patterns?
8. What three components require consideration when determining whether a communication disorder is present?
9. What is the difference among predisposing, precipitating, and perpetuating factors when considering etiology?
10. How does the diagnostian contribute to the evaluation process?
11. What factors must the clinician consider when making prognoses?
CHAPTER 2

Interviewing

LEARNING OUTCOMES

After reading this chapter you will be able to:

1. Describe the potential disadvantages of relying solely on paper-and-pencil techniques for collecting client information.
2. Describe three common barriers to interviewing.
3. Describe the seven general topics or areas of inquiry that are useful in any diagnostic session.
4. Provide the three basic goals in diagnostic interviews.
5. Describe the types of behaviors and questions to avoid during an interview.
6. Describe the types of questions that are commonly asked during an interview.
7. Distinguish among different types of listening.
8. Describe three popular techniques used in clinical interviewing.

The clinician sets in motion the process of recovery at the very first contact with a client. This is accomplished through the vehicle of the spoken word—in short, by means of the initial, or intake, interview. Because the intake interview ushers the client into treatment, it is the key link in the evaluation process. To assess and treat persons with communication disorders, it is essential that we know how to talk with them in a manner that reflects our expertise, inspires confidence, fosters trust, and sets the stage for a fruitful working alliance.
THE IMPORTANCE OF INTERVIEWING

Although clinical evaluation obviously involves more than proficiency at conducting interviews, the interview is central to the role of the diagnostician. By means of verbal exchange, we gather data about the individual, deliver information, and establish and sustain a working alliance. The interview is also the means by which treatment is carried out and, as such, serves both as a therapeutic tool and as a relationship (see Figure 2–1).

For the clinical speech-language pathologist, interviewing and professional communication in general are extremely important activities (Burrus & Willis, 2013).

Although widely used, interviewing is often one of the least understood aspects of the clinician’s role. Prospective clinicians are expected to acquire an impressive array of knowledge, but it is often presumed that they know how to communicate effectively with clients. The mastery of interviewing is either taken for granted or expected to accrue somehow as an artifact of required coursework and practicum experiences.

Some clinicians consider interviewing to be secondary; they use paper to replace personal interaction. An elaborate case history form containing a plethora of questions is mailed to the clients, and they are asked to fill it out and return it before the diagnostic appointment. The rationale for this procedure is that it saves the clinician time and reveals problem areas that can then be explored in the personal interview. Although the clinician certainly should get some idea of the problem before the diagnostic examination, there is no substitute for an in-depth interview. An approach that uses only paper-and-pencil techniques has several disadvantages:

1. The questions on forms are often generic—they cover all possible respondents—and thus are ambiguous or not applicable to any particular type of client. Therefore, a client or caregiver may not understand the relationship between the questions posed and the communication problem. Face-to-face interviews permit greater flexibility in formulating precise and germane inquiries.

2. Clients may ignore certain questions, forget to address important information, or omit important information. Clients or caregivers may not be able to remember the specific information requested or understand the relevance of the questions asked.

3. The queries may be misinterpreted, may be perceived as threatening, or may engender guilt, and the clinician is not present to observe the respondent’s reactions or to explain, support, and assist the respondent as he or she searches for an answer. A large percentage of our communication is visual, and a face-to-face interview provides gestural and other visual cues that are not available in written format.

4. It is difficult to determine cause-and-effect relationships from questionnaire data because it is impossible to account for all influential variables in a single questionnaire.
5. Does the mailed questionnaire allow time for the respondent to plan a defense? Is it more likely that we end up with a view of what the respondent wants us to see, a view that he or she perceives as being more socially acceptable? More often than not we are able to obtain more complete information through an interview, where primary questions may be followed up with pertinent secondary inquiries.

Do not imply from this list of disadvantages that the present authors are opposed to obtaining information by having clients complete well-designed case history forms. Such data are critical for understanding the client’s perspective. Our emphasis is that one should not rely exclusively on paperwork in assessment. In fact, see the section in Chapter 4 on preassessment as a valuable part of planning an evaluation.

THE NATURE OF INTERVIEWING

An interview is essentially a process, not an entity—a process of verbal and nonverbal communication between a trained professional and a client or parent who is seeking services. More specifically, an interview, in a clinical and diagnostic sense, is a purposeful exchange of meanings between two persons, a directed conversation that proceeds in an orderly fashion to obtain data, to convey certain information, and to provide counseling. The professional, by reason of his or her position and clinical expertise, is expected to (and usually does) lead and direct the verbal exchange. Thus, an interview is not just an ordinary conversation in terms of a desultory exchange of opinions and ideas but rather a specialized pattern of verbal interaction directed toward a specific purpose and focused on specific content. The roles of interviewer and respondent are more highly specified in a professional interview than in a conversation. The clinician knows that an interview is a unique and distinct mode of verbal exchange. But does the client need to know? Probably not. Indeed, we typically advise students to refer to an interview as a “talk” or “a chance to share information” when they contact clients or parents to request an appointment time. An “interview” can sound rather ominous and frightening.

An interview differs from a social conversation in that the time and location of an interview is specified formally and the inquiries are generally unilateral. That is, the clinician may ask about the parents’ relationship with their child, but it is not expected that the client will reciprocate with questions about the clinician’s children. The clinician also does not necessarily avoid unpleasant topics in the interest of social propriety. Perhaps for the first time, the respondent can talk freely, without fear of criticism or admonishment.

In a good diagnostic interview, the clinician and client must develop a working alliance, multiplying their efforts by creating a mutual feeling of cooperation. The term “alliance refers to the quality and strength of the collaborative relationship between client and therapist” (Norcross, 2011, p. 120). It is futile to expect straightforward answers to simple questions. A good diagnostic interview and the establishment of a good working alliance always involve more than making queries and recording answers. It also involves skillfully navigating the human elements of personality and the personal culture that both the clinician and the client bring to the interaction. Egan (2014) suggests that demonstrating behaviors that show empathy and respect for clients is foundational to the ability to develop and maintain a working alliance. Empathy is “the ability to understand the client from his or her own point of view and, when appropriate, to communicate this understanding to the client” (p. 48), whereas respect refers more to the regard, esteem, or way in which we view another.

In summary, a diagnostic interview is a directed conversation, carried out for specific purposes such as fact finding, informing, or altering attitudes and opinions. The
clinician’s efforts are directed toward the creation of mutual respect and team effort in the understanding and solution of the communication problem.

COMMON INTERVIEWING CONSIDERATIONS
Several factors can prevent the establishment of effective communication and a working alliance between a speech clinician and those whom the clinician interviews. Although the list could obviously be expanded, we have picked three aspects that, in our experience, are the most common interviewing barriers: the clinician’s fears, lack of specific purpose, and failure to consider the client’s cultural background. We will discuss each of these factors next.

The Clinician’s Fears
At two points in a student clinician’s career, anxiety can rise to very high levels: the confrontation with his or her first therapy case and the first diagnostic interview. It is—and should be—an awesome responsibility to undertake the professional treatment of another human being. There is always an element of risk in offering help.

Perhaps the most common fear expressed by the beginning clinician is that clients will not accept the clinician in a professional role because of the clinician’s youth. The clinician doubts that he or she can bridge the age gap, especially when the clinician deals with parents: “Who am I to be asking questions and giving suggestions to them when they are older and more experienced? Won’t they look down on me if I don’t have children?” Most of this is pure projection on the clinician’s part (Haynes & Oratio, 1978). If the clinician indicates deep concern for the welfare of the client, then nearly every parent and client will respond in a positive manner, without scrutinizing the clinician for wrinkles, or gray hairs, or looking for photographs of children on the clinician’s desk. The clinician, of course, should not communicate any uncertainty during the interview; otherwise, he or she will never establish competence or inspire confidence.

Another common fear among beginning clinicians—and one that is also largely projected—is that the client will become defensive or resentful during questioning. We have seen students omit a whole series of important questions when a client, especially a parent, responded curtly or showed mild annoyance. While it is not uncommon for parents to think of their child’s communication disorder as an outward and visible sign of their own failure, in our experience few parents are resentful or defensive about the clinician’s sincere efforts to determine the nature of the child’s problem. Again, the important point is to make the clients and their families feel that they have done the best they could do, and now, with some assistance from the clinician, they can do better. The clinician should always maintain a nont hreatening posture in the clinical transaction.

Many beginning clinicians are leery of questions directed at them. “What do you do when the client starts asking you questions?” the beginning clinician frequently despairs. “Will I be able to explain to the client adequately what he or she needs to know? How will I know if I have communicated properly if the client just sits there and nods?” We shall return to this important topic of client questions in a later section of this chapter.

Lack of Specific Purpose
Many beginning clinicians either have purposes that are too broad and general or interviewing goals that are too nebulous. It is important to write out carefully and rather explicitly the purposes for an interview before meeting with the client. We must know why we want the answers to the questions we ask. Specifying the purposes of an
intererview is also an effective way to reduce the interviewer’s uncertainty and anxiety. Kadushin (1972) summarizes the importance of planning in this way: “To know is to be prepared; to be prepared is to experience reduced anxiety; to reduce anxiety is to increase the interviewer’s freedom to be fully responsive to the interviewee” (p. 2). The clinician should keep in mind, however, that thorough planning does not mean the application of an inflexible routine.

Failure to Consider the Client’s Cultural Background

When the client and clinician represent differing cultural or racial backgrounds, there is an additional potential obstacle to overcome. Some clients may not feel as comfortable when they must reveal certain information to a stranger, and this discomfort may be intensified when the clinician represents a different race or culture. The solution is clearly not to make certain that clients and clinicians are culturally homogeneous. Given the diverse nature of our society, this would be impossible from a scheduling standpoint and unwise from a philosophical one. The best way to approach cultural diversity in clinical situations is to make certain that, as clinicians, we have consideration and sensitivity for cultural differences, and knowledge of multicultural issues in assessment and treatment. The American Speech-Language-Hearing Association (ASHA) has mandated that every accredited training program in communication disorders infuse multicultural information into each area of academic preparation and clinical practicum. A major implication of multicultural issues on assessment concerns the diverse belief systems of the various cultural groups regarding disabilities and communication. Some cultures believe that a handicapping condition is a situation that nothing can or should be done about, or that the help for this condition is spiritual rather than clinical (Cheng, 1989). If the clinician charges into the initial interview with a client and makes a host of recommendations without addressing cultural attitudes toward remediation, the suggestions may fall on unsympathetic ears. The clients may also be offended and not return for treatment.

AN APPROACH TO INTERVIEWING

We now present an interviewing approach, an eclectic product of our clinical experience together with an intensive study of relevant bibliographic materials. No doubt the reader will want to modify our approach in order to suit individual settings. It is desirable for you to do so: Only through critical self-evaluation and modification can any clinician acquire an interviewing procedure that is uniquely personal.

Diagnostic interviews have three basic goals: to obtain information, to give information, and to provide counseling. For the purpose of discussion, each goal will be considered separately in the next sections.

Goal One: Obtain Information

Although it may seem obvious, it is worth restating that, as clinicians, we must actively listen before we speak. There are essentially three reasons for this: (1) It gives clients an opportunity to talk about problems, to express fears and feelings, thus enabling them to benefit more from the guidance that the speech clinician offers; (2) it gives the clinician an idea of the nature and scope of the information the client will need; and (3) it allows the clinician to formulate hypotheses concerning the individual’s communication disorder.

Setting the Tone

The first important task of the clinician is to set the right tone for the interview, to get a structured conversation initiated and channeled in the proper direction. How
does one go about setting the right tone? We find that defining the roles is an effective procedure:

Ms. Taylor, I want to talk with you before we start our evaluation with Larry. I know you filled out the case history form we sent you, and that provided a lot of important information. I did have a few questions about some of the things you said about Larry’s early development and I also wanted to ask you about some of the speech and language he uses at home. It’s hard for us to get an accurate picture of a person just by reading paperwork, so if we can talk a bit about Larry and get some examples of his communication from you, it will help us to do a more effective evaluation.

It is helpful to think of the interview as a kind of role-playing situation. As the clinician, you define the roles for the client and indicate the rules and responsibilities for these roles. You tell who you are, what you intend to do, and what you expect of the client. In other words, you structure the situation by explaining the purposes of the interview—why the information is needed and what will be done with it. Initially, of course, the client accepts the respondent role because of the nature of the situation and the official sanction of the interviewer’s position. Then it is up to you to demonstrate your empathy and clinical expertise in order to engender further cooperation.

Two problems sometimes arise here. First, some clients may be inhibited by such explicit role definitions; respondents from lower-middle or lower social classes may have had little experience in holding directed conversations. In this case, a clinician can prolong the small-talk phase, emphasize the nature of the interview as chatting, and gently ease into the more structured situation as the relationship develops. When two or more people get together, even for serious purposes, a certain amount of social and small talk seems to foster positive attitudes toward continued interaction.

Second, many cultural and socioeconomic variables, as they relate to clinical interactions, deserve consideration. We have indicated that much of the information exchanged in a clinical interview is of a highly personal nature and possibly charged with considerable affect. Many cultures (e.g., Native Americans and certain Asian groups) find it difficult to share personal information with unfamiliar people. Thus, in the interview it may be extremely uncomfortable for them to reveal some types of data. The clinician must be sensitive to such cultural beliefs and not press the client to provide information too soon. In some cases it will be necessary to conduct multiple interviews and establish a strong relationship with the clients before they will give information or take advantage of clinician suggestions for treatment. This issue alone is a strong indictment of some rigid policies in which an evaluation is expected to be completed in an hour or two or in which Individualized Education Plan (IEP) goals must be written in limited time frames. We must learn that different cultures may require alterations in our methods if we are to serve them optimally.

Another multicultural influence is the possibility of working with children and adults from bilingual backgrounds. In some cases, the clinician must be bilingual, and in others the interviewer must provide interpreters. The use of an interpreter, however, is a very specialized operation, and the clinician must be certain that the person has adequate knowledge and experience to perform this specialized task. In some areas of the country, there is an increased likelihood that the speech-language pathologist (SLP) will encounter a bilingual population, and he or she should reflect on how these clients will be served appropriately in assessment and treatment. It is not possible to provide adequate services to these populations without a knowledge of and sensitivity to multicultural issues. Lynch (1998) describes the ideal interpreter as someone who (1) is proficient in the language (including specific dialect) of the family as well as that of
the interventionist, (2) is trained and experienced in cross-cultural communication and the principles (and dynamics) of serving as an interpreter, (3) is trained in the appropriate professional field relevant to the specific family–interventionist interaction, and (4) can understand and appreciate the respective cultures of both parties and convey the more subtle nuances of each with tact and sensitivity. Lynch (1998) cautions against the use of family members as interpreters because they rarely meet these criteria and could inject significant bias and family difficulties into the clinical situation. Most authorities on the use of interpreters emphasize the importance of thorough preparation of the interpreter prior to the clinical encounter in terms of the goals and purposes of the evaluation, potentially sensitive clinical and family issues, the format of the interview, and any technical terms and paperwork to be used in the conference. It is helpful to introduce all people present and clarify the goals and purposes of the interview so family members will know what to expect. Diligent clinicians may take the time to learn several social phrases in the language of the family so that greetings, saying thank you, and leave-taking can be done in a manner comfortable to the clients. This demonstrates respect for the family and shows that the clinician is making an attempt to understand and appreciate cultural differences. During the interview it is customary for the clinician to address remarks and questions to the family, not the interpreter. Also, while listening to the family, it is appropriate to look at the person who is speaking, not just at the interpreter. In this situation it is clearly beneficial to avoid technical jargon and figurative language that not only is difficult to translate but may also be confusing to the clients. As the interview progresses, especially in the portion where information is provided to the clients, it is wise periodically to check the families’ understanding of facts presented and any recommendations given by the clinician. Finally, most experts on the use of interpreters recommend a debriefing session in which the clinician and interpreter can discuss the information collected, any difficulties encountered in the conference, any problems with the interpreting process, and any subtle impressions gleaned by the interpreter that go beyond the literal translation of the client’s utterances (e.g., anger, hostility, fear, etc.). Although such impressions are subjective on the part of the interpreter, they may represent important information about the family’s acceptance of the problem, perceptions of the clinical situation, and possible compliance with a treatment program. It is vital that you convey sincere interest in the situation as the client sees it. Demonstrate to the client that you are genuinely trying to comprehend what the problem is and what it means to the client personally.

Part of setting the tone is the establishment of rapport and hopefully a working alliance. Rapport, of course, is not a separate substance you can pour into a session; it is mutual respect and trust, a feeling of confidence on your part, and a large measure of understanding. Empathy, warmth, and acceptance are also crucial aspects; strive for the ability to understand sensitively and accurately the interviewee’s situation. Also try to be genuine, not contrived, with a professional demeanor. In addition to the words spoken, a number of forces shape the interview. For example, the setting and the clinician’s dress, manners, and nonverbal expressions all influence the tone or nature of the interview. In professional interviewing, the goal is to provide an atmosphere that fosters communication between client and clinician.

**Asking the Questions**

You should use an interview guide or outline rather than read prepared questions. The questions should be worded in a manner that is in keeping with your understanding of the individual’s situation. This will result in an interview that is much more spontaneous and meaningful. In most cases, formal preestablished questionnaires operate as another type of barrier or crutch for the insecure interviewer.
The specific content of the queries addressed to a respondent depend on the age of the client, the nature of the problem, and the purposes of the interview, among other factors. Most clinicians find that the younger the client being evaluated, the more important the parent interview. Because we intend to focus on style of interviewing in this chapter, we will not include lists of questions that pertain to particular disorders of communication. Many examples from specific areas are provided in later chapters. Seven general topics or areas of inquiry are useful, however, in any diagnostic session:

1. **What is the respondent’s perception of the problem?** Here, the clinician seeks a global description of the communication disorder. In a parent interview, for example, we frequently open the session with an open-ended question: “Tell me why you brought Jamie to the clinic” or “What concerns do you have about Jamie?”

2. **When and under what conditions did the communication disorder arise?** The purpose of this question is to determine the onset and developmental history of the problem. An example of when the etiology of the problem would be especially important is in the development of a voice disorder. (e.g., rapid versus gradual onset, occurrence of vocally abusive behaviors, changes in medication).

3. **In what ways has the communication disorder changed since its onset?** The goal of this question is to determine whether the problem has lessened, worsened, or changed in form since its onset. When interviewing the parents of a child who is exhibiting early signs of stuttering, for example, we are interested in how the speech disfluency has changed since it was first noticed.

4. **What are the consequences (handicapping conditions) of the problem?** In what manner—socially, educationally, occupationally—does the communication disorder affect the person’s life? In what ways has he or she adapted to the disorder?

5. **How have the client and family attempted to cope with the problem?** What lay remedies have been tried by the client and family to resolve the problem? How has the client responded to the families’ efforts to resolve the problem?

6. **What impact has the client’s communication disorder had on the rest of the family?** When a family member has a disability, it creates fertile ground for familial conflict (see Featherstone, 1980). To obtain a description of a child’s ongoing behavior and how he or she fits into the family regimen, ask the parents to describe a “typical” day, from the time the youngster gets up until he or she goes to bed.

7. **What are the client’s (or parents’) expectations regarding the diagnostic session?** The client or caregivers often come to a helping professional with an agenda (hidden or otherwise) and set expectations. The client may want the problem finally diagnosed after months of wondering about it. The parents may want a recommendation for treatment because they already know that their child has a communication problem. Sometimes parents have been agonizing over some hypothesis that has been advanced by a relative (“He’s tongue-tied” or “We’re afraid he is behind in his development”) and their biggest concern is that the clinician address this issue. Whatever the expectations, do your best to determine what those expectations are and to manage those expectations in a way that is solution-oriented and continues to foster a positive working alliance. Although it may sound counterintuitive, managing expectations does not always mean having all the answers or providing the resolution to the client’s communication problem. You need to be honest with your clients from the start. Some problems can’t be fixed, some don’t have easy solutions, and generally too many factors are at play to make grandiose promises.

A good diagnostic interview is characterized by a shifting of styles: objective questions that ask for specifics, subjective queries that deal with feelings and
attitudes, and finally the indeterminate questions, like “Tell me more,” to keep the respondent going. The interviewer should start with the least anxiety-provoking queries, mostly objective questions that have high specificity, and then proceed to more subjective questions as the relationship develops. Quite often, however, we find it useful to employ a “funnel” sequence of inquiry during the course of a diagnostic interview—starting with broad, open-ended questions and then progressing to more specific or closed questions. An “inverted funnel,” used less often, would be just the opposite: starting with the tougher, more specific questions first, followed by the broader, more open-ended questions. The approach used depends on the amount of time you, as the interviewer, have. If you have ample time, use the funnel approach. If time is limited and you need to get to the meat of the interview quickly, however, use the inverted funnel. Here is an example of a funnel sequence for questions from a parent interview:

- How does Jimmy function in the family setting?
- How does he get along with his brothers and sisters?
- How does his older sister “help” him communicate?
- Can you describe an instance in which she talked for him?

It is best to avoid the checklist or long series of “tunnel” questions that call for information on one level of specificity, all of which are asked in a similar style (e.g., “Did your child have earaches, fevers, head injury?”).

**The Presenting Story**

Most persons who anticipate visiting a helping professional will mentally rehearse what they intend to say. Often you will have to contend with events that occurred prior to the session—the family car’s failing to start, a burned breakfast, absence of a convenient parking place. A few words to reveal your understanding of the distracting antecedents will generally assist the respondent in shifting to the topic of the interview. In some cases, the client may even have a pseudoconversation with you while he or she is driving to the appointment: A person often rehearses, en route, how to describe his or her symptoms. We must allow this story to be unraveled, or the respondent will be left with a sense of frustration. A question such as “What seems to be the problem?” or “What brings you here today?” will permit the flow of conversation to begin. Remember that the client’s description is how the client perceives the problem—it is the client’s unique way of looking at the situation. The client’s description may be grossly inaccurate, but you should hear it out; nothing turns a respondent off more quickly than for the interviewer to suggest by word or action that the respondent’s views are silly or misguided. Sometimes the presenting story will become a motif that occurs again and again during the course of the interview.

This is generally a crucial point in an interview. The interviewee may cautiously extend a portion of him- or herself verbally, carefully scan the interviewer’s response, and then decide whether to reveal more or tell the whole story. Sometimes a respondent may even set up a straw man to see how the interviewer deals with it.

This is not the proper time to debate an issue with the client. The story can be accepted initially on the level of feeling, and later in the interview—when rapport is stronger—an issue can be discussed more fully. We feel very strongly that these initial stories, these primitive theories, should be respected as the best possible answer that clients have been able to think of. It does not mean that you agree with a client’s conclusions; it just means that you accept a client’s perceptions and judgments with understanding so that you can form a basis for further communication.
Actually, the presenting information can be a very rich source of clinical hypotheses to be explored during the course of the interview. How do the client and parent present themselves—as long-suffering, anxious, diffident? How do they associate ideas or items of information sequentially? What priorities do they assign to issues they raise? Do they seem to be realistic in their expectations regarding the diagnostic session and treatment? Do they express likes or dislikes that can be capitalized on or that should be avoided during the diagnostic session or treatment?

**Nonverbal Messages**

The clinician and respondents do not communicate by words alone, and the discerning clinician attends to the client’s as well as his or her own bodily behavior and oral language during an interview. The nonverbal messages we convey with our posture, degree of eye contact, facial expression, and physical appearance can carry significant weight during silence or when combined with a verbal message. As a matter of fact, some observers suggest that a large portion of the total message—particularly messages involving strong feelings—is carried by nonverbal cues. They are considered harder to disguise because they are often less likely to be under conscious control. However, resist the urge to interpret a client’s every twitch; each instance of nonverbal behavior should be related to the *content* of the oral message and to the *context* in which it occurs. For example:

If a parent leaves her coat on during an interview, it may mean she feels vulnerable and the garment provides a bit of protective armor. It may also mean that she has a spot on her dress, or that all the hangers in the waiting room were taken again by forgetful students, or that the room is chilly. However, if she shifts her chair away from the clinician, sits with her arms and legs tightly crossed, avoids eye contact, and responds to questions with one-word answers, then it may be possible that she is defensive and guarded in the clinical setting.

The issue here is to avoid making one item of nonverbal behavior the sole basis for interpretation; be on the lookout for patterns. The most important thing to look for may be lack of congruence between the respondent’s verbal and nonverbal messages; in cases where the two conflict, body language is generally a more accurate indicator of how a person feels about an issue. Nonverbal behaviors often give insight into what a client may be thinking or feeling but not saying.

During the interview process, nonverbal behaviors require close consideration when interviewing an individual from another culture. Nonverbal behaviors vary considerably across cultures, and what is considered or perceived as appropriate and desirable for one culture could be perceived as disrespectful and inappropriate for another. Here are a few examples:

- **Touch** In the United States patting a child’s head is considered an affectionate or friendly gesture. However, the Asian culture considers it inappropriate because it is believed to be a sacred part of the body. And in Muslim cultures, touch between individuals of opposite genders is generally inappropriate.

- **Eye contact** In mainstream U.S. culture, eye contact is desirable and interpreted as an act of attentiveness. In many other cultures like Hispanic, Asian, Middle Eastern, and Native American, it is perceived as rude or disrespectful.

- **Physical space** The acceptable physical distance between one person and another can vary significantly across cultures. The acceptable distance for Latin American and Middle Eastern cultures is generally shorter than that of European and American cultures.
Things to Avoid in the Interview

Beginning interviewers commit several common errors. The following list is not meant to be exhaustive, but it does cover the most glaring mistakes:

1. **Avoid questions that may be answered by a simple yes or no.** Open-ended questions produce longer responses, encourage clients to start talking and include more detailed information. Such questions often start with the words *what, why,* or *how.* When an interview is loaded with closed-ended questions, the number and type of answers are limited. While they should be used sparingly, closed-ended questions are useful for fact checking.

2. **Avoid asking questions that are “double barreled.”** This mistake occurs when a question is asked in a manner that addresses two or more questions at one time before giving the client a chance to respond. Generally, if a client is required to answer more than one question, he or she will often answer only one of the questions: the easiest or the one he or she was asked last.

3. **Avoid phrasing questions so that they inhibit freedom of response.** Leading questions lead another to a predetermined conclusion or insight. Do not say, “You don’t have any difficulty with ringing in your ears, do you?” or “You don’t tell Billy to stop and start over again, do you?” Such leading questions are not effective interviewing and can be perceived as manipulative, judgmental, and/or dishonest. The beginning interviewer tends to be anxious about asking open-ended questions, fearing that silence will result and that this will damage his or her relationship with the client. So the interviewer will ask an open-ended question and then close it with a closed-ended leading question: for example, “How do you feel about David’s stuttering? Does it bother you?” Leave questions open! Although open-ended questions consume more time and may produce some rambling and irrelevant responses, they have many advantages.

4. **Avoid abrupt transitions or topic shifts.** Try to avoid abrupt shifts in your line of questioning. For example, if you are exploring the client’s feelings or attitudes on a particular issue (subjective questions), don’t suddenly ask a question on a different topic. Inexperienced interviewers tend to jump around. If you are interested in learning about a child’s play, ask all your questions pertaining to the child’s play together. Do not skip around from play to language, to book reading, to medical history, and so on. The interview should flow so that one question logically links or flows into the next. When the client causes the interview to wander, avoid abrupt transitions to bring it back to the point. Most of the clients you will interview have had little experience in directed, orderly conversation. They tend to follow chance associations and wander far afield. The experienced interviewer has the ability to make smooth transitions. The best way to get the interview back on track is by building a bridge to the respondent’s previous statements: for example, “That’s interesting, Ms. Davis. Maybe we can come back to that in a little while. Now earlier you were mentioning that your child’s loss of hearing occurred suddenly. . . .” The goal here is to use respondent antecedents—what the client has said earlier in the interview.

5. **Avoid talking too much.** This is perhaps the most common mistake of the beginning interviewer, who feels that every pause must be filled with verbiage. It is much better to rephrase what the respondent has said or make some comment like “I see,” “Tell me more,” or “Anything else?” Sometimes a smile and an understanding nod are effective when it seems that the client has more to say but needs some silent time to collect his or her thoughts. If there is a positive attitude—a good rapport—and if the client feels comfortable in the situation, then these encouragements increase the length of the response. If the topic or situation is neutral, these comments tend to expand the message. As a general metric, about 80% of the talking should originate with the client.
6. **Avoid concentrating on physical symptoms and etiological factors to the exclusion of the client’s feelings and attitudes.** There is a little bit of physician in all of us; we yearn to play the role of omniscient healer. The interviewer should remember to distinguish between items of information that are simply interesting and background information that is really important.

7. **Avoid providing information too soon.** There will be plenty of time to clear up misconceptions later in the interview. The surest way to cut off the flow of information is to stop a parent, for instance, after he says, “I just tell Michael to stop, take a deep breath, and start all over again,” and counsel him on the proper responses to nonfluency. It is best to take note of areas that need clarity and address those areas when you are providing information rather than gathering information.

8. **Avoid qualifying and hemming and hawing when asking questions.** Ask questions in a straightforward fashion and maintain eye contact. Rather than asking, “Did you find that, well, you know, when you were, uh, shall we say . . . with child, did you experience any untoward conditions?” say, “Did anything unusual happen during your pregnancy?” Instead of inquiring, “Did you discover, hmm, I mean, well, after your father, uh, passed away, did your stuttering problem increase?” say, “What impact did your father’s death have on your speech?” Beating around the bush and qualifying questions can result in the perception of discomfort or a lack of confidence.

9. **Avoid negative, judgmental, or moralistic responses, verbal or nonverbal, to the client’s statements.** The flow of information will stop abruptly and the relationship will be impaired severely if the client senses that a clinician finds him and/or his behavior distasteful. Avoid even the response “Good” because it implies a value judgment. We do not have to subscribe to a person’s values or code of behavior for us to show compassion for and understanding of his or her situation. Use inquiries that begin with “Why . . .?” very sparingly because beginning a question with the word why is often perceived as a challenge or threat; this line of questioning is too reminiscent of disciplinary sessions (“Why were you late for class?” “Why can’t you behave properly?”). In a clinical setting, we must not let our values obscure our perception of the client’s frame of reference. An interview is not the place to push the clinician’s personal points of view. This can immediately alienate or offend clients if they do not share the clinician’s point of view.

10. **Avoid allowing the interview to produce only superficial answers.** We need to get deeper, more significant responses from our clients. Several interviewing devices, termed probes, can be helpful to the clinician. Clinicians who are skillful at probing can stimulate the client to provide more information without leading the client or injecting themselves into the process. Several different types of probes can be used.

   **Crosshatch, or interlocking,** questions are useful when we need to elicit more detail about a topic that has been glossed over. Often discrepancies must be resolved. To elicit more detail, ask the same question in different ways and at different points during the interview. For instance, the father of a young child who stuttered responded in a superficial manner to our query about his relationship with the child. He assured us that he had a “loving relationship” with his son and then complained at length about his working conditions. Later in the interview, when we asked him to describe the sorts of activities he did with the child, he was unable to mention a single one. We don’t mean to imply that the clinician should attempt to catch the client lying and then demand an explanation. The clinician must examine discrepancies, however, in order to enhance understanding of the problem because such discrepancies could have a significant effect on the mode of treatment.

   **Pauses,** or silent probes, can be very helpful. When there is a lull in the interview, it may mean simply that the client has exhausted his or her store of information, that a
memory barrier has prevented further recall, or that he or she senses lack of understanding by the clinician. It can also mean, however, that a sensitive area has been touched on. Do not feel that pauses harm the interview. Much significant information can be forthcoming if we keep quiet and indicate with a smile or a nod that we expect more.

The summary probe is one of the best ways to keep the interview moving smoothly. The clinician summarizes periodically what the client has said, ending perhaps with a request for clarification or further information. Incidentally, this procedure also demonstrates to the interviewee that the interviewer is listening and is indeed trying to understand the problem. We generally use “minisummary probes”—echo questions—all the way through an interview, for example:

**Respondent:** After my husband’s stroke, my whole world collapsed.

**Interviewer:** You were overwhelmed by the sudden change in your life.

**Respondent:** Yes, one day he was happily planning our trip to Sanibel Island . . . and then, in just a moment, he was paralyzed and couldn’t talk. Now all our plans are up in the air . . . the new car, the checking account, he took care of all that.

The stumbling probe is a variation of the summary probe; we have found it helpful, especially with the reticent respondent. The interviewer rephrases a portion of the respondent’s communication and then, attempting to interpret or comment upon it, the interviewer pretends to halt or stumble. For example, when interviewing the mother of a child allegedly beginning to stutter, the clinician might say: “Now, you were saying that Bruce first started to repeat and hesitate after he caught his finger in the car door. Under these conditions, it would be natural for you to . . . uh . . .” The respondent’s need for closure may elicit additional significant information and, perhaps more important, significant insights.

Finally, an interviewer can use the assuming probe. If the client has avoided an important area, leaving much unsaid regarding the speech or hearing problem and what it means to him or her, then it is up to the interviewer to bring this out. One adolescent boy, who had been vehemently denying that his stuttering bothered him, unburdened himself when we said, “It bothers you so much that you don’t want anybody to know, do you?” While the assuming probe can be very powerful; it should be used sparingly and with care because the client could become put off or offended.

11. **Avoid letting the client reveal too much in one interview.** Sometimes a beginning interviewer makes the mistake of trying to get everything in one sitting. The client, sensing perhaps that this is the first person who really understands him or her, may want to provide more personal details than are necessary. Later, however, the individual will feel embarrassed and foolish, perhaps even exposed and guilty, at revealing so much to a comparative stranger.

12. **Avoid trusting to memory.** Record the information as the interview progresses. Tell the client that you will take some notes during the interview so that you can plan the treatment program more effectively and make recommendations for other services. Such note taking, or even recording devices, is rarely questioned. Indeed, we have found that clients expect you to write down some of the information they are giving you; they doubt that you would be able to remember all of their answers. You obviously would damage or lose the client relationship, however, if you scribbled furiously while the client was revealing some sensitive information. It is also self-evident that the client’s confidence will be respected, but this is often not explicitly stated to the client. The clinician’s manner should suggest that all information received is to be held strictly confidential.
Prepare a report of the interview as soon as possible. Commit your observations to paper while the encounter with the respondent is still fresh in your mind (see Chapter 14 for information on writing reports).

**Goal Two: Give Information**

No one likes uncertainty. All too frequently any information that is not supplied by the professional will become distorted by input from other sources. We can do an admirable job on our evaluation, but if we drop the ball on communicating the results to our client, we have not been successful. When not correctly informed, clients and parents can become misinformed, and this misinformation leads to confusion and misunderstanding, and further compounds the problem. It is our responsibility, therefore, to provide accurate, unemotional, objective information of the status of the individual’s problem. This forwarding of information is generally accomplished during the postdiagnostic conference.

Summarize the findings of the clinical examination in simple, nontechnical language, and use common terms compatible with the client’s background. We prefer to commence, if possible, with results that show a client’s area of normal functioning and thus review findings that indicate what is good before describing deficiencies. Relate comments to normative values whenever possible. Clarify and help the respondent ask questions by using examples and simple analogies. If you are in doubt concerning the client’s understanding of the diagnostic material (clients will rarely ask if they don’t understand), talk more slowly, employ longer descriptions, and use many examples and more redundant language.

**The Questions Clients Ask**

An interview is much more than a clinician posing questions and recording the client’s answers. It is an important forum for exchange—a reflexive, dynamic experience of sharing between the diagnostician and the informant. Indeed, we find that a client—especially a parent of a young child being evaluated—frequently is eager to probe the clinician’s expertise. The clinician must evaluate the client’s or parent’s inquiries and determine, What is the person really asking? Is there an unstated concern behind the questions? Luterman (1979) divides the questions that clients ask into three categories: content, opinion, and affect. We will describe and illustrate these three types of inquiries with excerpts from an initial interview with the mother of a 3-year-old child brought to the clinic because she was concerned that her child was beginning to stutter.

1. **Questions dealing with information or content.** In this instance, the client seeks an informative or factual response from the clinician. The inquiry usually takes the form, “I want to know about something, and I hope you have the right information.”
   
   **Ms. Bell:** The type of choppy speech [disfluency] Jesse has—is it common among children his age?

   **Clinician:** It sure is. Most children between the ages of 2 ½ and 5 do a lot of repeating and hesitating.

2. **Questions with predetermined opinions.** Here the client has an opinion regarding a particular subject and wants to determine if the clinician agrees with it. The clinician must be careful not to dismiss the client’s opinion until the clinician understands why and how strongly the client holds it.
   
   **Ms. Bell:** Um, on TV a couple of times, I’ve seen a demonstration of the airflow technique for stuttering. What do you think of it?
Clinician: Those demonstrations are very dramatic, aren’t they? What’s your impression of the technique as it applies to Jesse?

3. Questions that are a “faint knocking on the door.” In this case, the client is not asking for information or to determine the clinician’s opinion but rather for emotional support and reassurance. The question conceals a feeling that the client either is unaware of or is reluctant to reveal.

Ms. Bell: Do you think my divorce and remarriage had anything to do with Jesse’s speech problem?

Clinician: It’s pretty common for parents to feel guilty about something they might have done to cause their child to begin stuttering.

You may have already detected a flaw in the triad: On the surface, each question posed by Ms. Bell could be classified in any of the three categories. How does a clinician know what the client means? The clinician doesn’t know in every case, but he or she tries to determine the purpose of a question by scrutinizing how a client asks it—by vocal inflection and body language—and by examining the context in which the inquiry appears. As long as the clinician is trying to understand, a client will not be alienated by an inaccurate interpretation.

In our experience, beginning clinicians, probably because the bulk of their training focuses on information, do a good job of responding to content questions. However, many clinicians in training find it difficult to respond appropriately to a client’s expression of emotion. Avoid superficial statements of reassurance. The client’s anxiety and uncertainty will be better relieved once he or she begins to understand his or her particular speech problem; the best antidote to fear and uncertainty is knowledge. Do not use terms or suggest consequences that will precipitate more stress for the client. Do not communicate any negative expectations regarding the outcome of therapy to the client. It is possible that such statements could influence the client’s performance in treatment.

The following six basic principles are addressed to the beginning clinician. We have found them useful for imparting information to clients.

1. Emotional confusion may, and often does, inhibit the client’s ability to understand cognitively what you are trying to say. Just because you have once reviewed the steps of therapy is no reason to expect that their importance will be grasped.
2. Refrain from being didactic; do not lecture your clients. Focus on sharing options rather than giving advice.
3. Use simple language with many examples and illustrations. Err on the side of being too simple rather than too complex. And repeat, repeat, repeat the important points—rephrasing each time.
4. Try to provide something that the client—especially a parent—can do. Action reduces the feelings of futility and anxiety. The activity should be direct and simple and should require some kind of reporting to the clinician.
5. Say what needs to be said pleasantly—but frankly. Do not avoid saying something that must be said on the assumption that the client cannot take it or that you will be rejected. People often display an amazing reserve of courage in difficult situations.
6. Remember, however, that the one who finally communicates what the client may have been dreading to hear is often hated and malignèd. If you are the first to say the feared words, you may become the focus for all the hostile, negative feelings thus aroused. As a professional, you will have to be strong enough to be the lightning rod for these emotions.
Clients and parents expect to receive help from the clinician but often will resist change. No matter how maladaptive a client’s behavior may seem from an objective point of view, it represents the client’s best solution. In fact, the client will often resist attempts to alter his or her equilibrium, precarious as it may appear to others. Change is stressful. Diagnosis and treatment imply change; therefore, assessment and therapy are stressful.

We must listen for two aspects of our clients’ utterances: a cognitive aspect (the content) and an affective aspect (the feelings). For genuine understanding to take place, both aspects must be included in the interviewer’s response to the client’s statement. If you are successful in crystallizing both aspects of your response, you provide an interchangeable base that allows the interview to move forward to levels of helping that involve direct action. Here are some examples taken from diagnostic interviews:

**Client:** (In response to a query regarding his marital status) No, I’m single. . . . Who would want to marry someone who stutters like me?

**Clinician:** You feel rejected because of your speech problem, is that right?

**Parent:** We tried to be good parents, we really did . . . but somehow we messed up in helping Peter learn to talk.

**Clinician:** You feel a sense of failure, perhaps even guilt, that your child has a speech problem.

**Client:** I stutter so badly that life is worthless. . . . I can’t get a job. . . . The business of living just doesn’t seem to meet expenses.

**Clinician:** You feel thwarted and frustrated by your speech problem. Sometimes you wonder if you can go on.

Note the clinician’s responses carefully. The clinician does not simply repeat the client’s comment but attempts to restate it in clarified form. Observe that the interviewer used the second-person singular “you” in referring to the client’s affect. Feelings are commonly stated first because they are more important than content. We sometimes add a tag question (“Is that right?”) to check on the client’s intake of our responses.

**Goal Three: Provide Counseling**

The clinician does not, of course, wait until the end of the interview to provide release for the frustrations and fears of the client. Most parts of the interview already discussed will serve this purpose. By helping the client talk about his or her problems, the clinician is providing an excellent escape for pent-up feelings. We maintain that our purpose is not just to remove discomfort but also to promote a state of comfort and well-being.

More than advice is needed during interviews for the purpose of helping a client take some specific action or move in a particular direction. The client needs help in sorting out confusing choices and recognizing opportunities that they may not be able to see at the moment. To support a respondent’s real strengths, we need to make it clear that we understand what the situation means to him or her and that we uncritically sympathize with his or her feelings and attitudes. We can restore the client’s self-esteem and ability to function more appropriately if we convey our interest in him or her as a person and our solid acceptance of the client’s importance.

Client counseling has an unfortunate tradition of “sweetness and light.” A person has a problem. The person is sad and depressed, and we try to cheer that person up. Sometimes this degenerates into a debate, with the interviewer attempting to persuade the person not to feel miserable. A person who feels depressed, anxious, and fearful does not want to count his or her blessings. That person wants you to feel miserable,
too, and to share and identify with him or her on the same level. Thus, you are given a basis for communication with the person. Start where he or she is, accept it as the proper place to start, and agree that it is a sad state of affairs that would make anyone sad and depressed. This bond of identification becomes a basis for communication, and you can use this bond to assist in solving the problem. The main ingredient is empathy, the capacity to identify with another’s feelings and actions. The best way to demonstrate an attempt to understand a client’s point of view is by listening creatively. In our judgment, of all the skills inherent in effective interviewing, the most important is the ability to listen carefully and empathically. This skill can be learned, although beginning clinicians find it difficult to listen and respond in ways that facilitate a client’s expression of feelings. One of the best ways to increase your active listening skills is to recognize when you are engaging in a poor form of listening. Egan (2014) describes four forms of poor listening:

Nonlistening occurs when your mind wanders. While it may appear that you are listening, you are truly not engaged. You also would not be able to restate the provided information reliably.

Partial listening occurs if you are able to pick up part of the message but the depth of the message is being lost. Egan describes this as “phony” listening.

Tape-recorder listening may appear like listening on the surface because you are able to repeat the words of the client, but in reality there is a lack of psychological and emotional presence. In this scenario the clinician can relay the content of the message but fails to identify or realize the corresponding meaning and relevance.

Rehearsing occurs when the clinician prepares his or her response to the client rather than remaining in the state of active listening.

How does one handle emotional scenes? They are bound to arise at some point in your interviewing experience. Some clinicians excuse themselves from the room and allow the respondent to recover his or her dignity alone. Others try to change the subject to something less emotional. Both of these approaches may, with certain clients, give the impression that you are rejecting their feelings. It is more effective to indicate understanding of the feelings that are being expressed and accept them as natural human reactions: for example, “That’s okay to let it come out, Ms. Cobb. You have been holding it back too long. Sometimes it helps to get it out in the open.”

Not all clients seen by the speech clinician will need or even want extensive supportive interviewing. In some cases, the procedures discussed here would be grossly inappropriate. Visualize an interview as ranging along a continuum from affective concern, such as feelings and attitudes, to objective matters, such as goals and advice. Some respondents simply need objective information so that they can take over and modify their behavior. The clinician’s role in some interviews may consist of simply listening to and supporting a client. A good relationship is a necessary but not a sufficient condition for good interviewing. Although it may sound trite, it is true that the secret of care of a client is caring for the client. The sense of being understood by a helping professional is a powerful stimulant to the client’s growth.

USING INTERVIEWING SKILLS BEYOND THE DIAGNOSTIC EVALUATION

As we mentioned in Chapter 1, evaluation is not confined to a 2-hour block of time in a university or a 1-hour session in a school district. The speech-language pathologist constantly gathers data on clients as treatment progresses in order to determine if the
remediation is successful or if goals should be adjusted. In many types of cases seen by the SLP, the treatment plan is formulated jointly by the clinician, parents or family members, and other professionals. In such instances, the amount of information gathered in the diagnostic evaluation is not sufficient to generate a meaningful treatment plan that takes into account both the clinician’s and the family’s perspectives. Thus, more extensive interviewing is necessary to discover information on family strengths, concerns, and needs. More interviewing of related professionals is needed to determine how the client is performing in a variety of contexts. We will briefly illustrate this notion with the following three popular clinical techniques:

1. Ethnographic interviewing. As clinicians, we often need to attend to potential sources of cultural bias during the interview process because the families we treat often come from backgrounds and/or lead lives that are very different from our own. That is, we need not only to understand the presenting problem but also to understand the problem through the same lens of our clients. Ethnographic interviewing provides the structure for accomplishing this task. This kind of interviewing requires that a clinician have the ability to develop relationships with others and the ability to embrace the unfamiliar. This is accomplished through an empathic understanding and having a genuine curiosity and interest in the differences we encounter in the way people and families go about their daily lives (Schensul, S. L., Schensul, J. J. & LeCompte, M. D. (2013).

An ethnographic interview has three phases (Spradley, 1979). The first phase entails defining or explaining the specific purpose of the interview to the client. During the second phase, you as the interviewer explain, through ethnographic explanations, how the purpose of the interview will be achieved. That is, during this process you describe to the client what topics or areas will be covered during the interview, the methods you will use to record responses, and how you would like the participant to respond to the questions that are raised during the interview process. Finally, after the stage for the interview is set, the interviewer will ask a variety of ethnographic questions to guide the client through the interview process. Ethnographic questions include grand-tour, mini-tour, structural, and contrast questions. Grand-tour questions are used to get a verbal description that captures the essential features associated with the goal of the interview. More specifically, these questions are designed to capture the client’s experience with the problem, the daily routine, and who the client interacts with in his or her daily life. For example, a typical grand-tour question could be “Walk me through the routine of a typical day.” Mini-tour questions are used to get more details about information that comes about from the grand-tour question. For example, “Tell me more about the structure of a typical school day.” Structural questions are asked when you need to understand the organization of the information provided. Contrast questions, on the other hand, are asked when events or descriptions need to be set apart or further differentiated.

Especially in cases where the SLP is working with infants, toddlers, and preschool children, the law requires that families be an integral part of treatment planning and monitoring. In fact, the clinician, along with other professionals and the family, must generate an individualized family service plan (IFSP) that states specific information related to the treatment program (see Chapter 4 for more details) (Nelson, 2010). If you were to use ethnographic interviewing, the focus would be on the parent and the goal would be to obtain the parent’s perspective of the problems, goals, and approaches used in treatment. The clinician asks both broad-based grand-tour questions and more specific mini-tour questions that are not meant
necessarily to lead the parent but just to guide the conversation and explore the problem. The goal is to let the parent set the direction of the interview toward what is important to him or her; ideally, the parent will do most of the talking, with encouragement and structure from the clinician. This type of in-depth interview is used to understand the family situation and its goals and aspirations for the child with a communication disorder. Parents are encouraged to tell the clinician what goals are most important to them and which ones they would like to see incorporated first into the remediation plan. If you consider the wealth and depth of possible information to gather in such a case, it should be no surprise that ethnographic interviews take hours of conversation to complete effectively.

2. Motivational interviewing. For cases where intrinsic motivation for change needs to be explored or developed and ambivalence needs to be overcome, the method of motivational interviewing might be ideal (Miller & Rollnick, 1991). Motivational interviewing is client-centered. Through expressed empathy, the clinician is able to help clients recognize and take some sort of action to resolve a problem. The goal is to foster change from within by developing the client’s intrinsic motivation rather than suggesting changes that can come across as imposed. Motivational interviewing is not advice giving. Clients are encouraged to think about their current situation or problem and how life would be if they did or did not incorporate changes. Through weighing the pros and cons, the client is able to explore and resolve any ambivalence. Miller and Rollnick (1991, 2002) provide five clinical principles on which motivational interviewing is based:

- **Expressed empathy** through reflective listening is viewed as an essential component of motivational interviewing. This process requires an attitude of acceptance and a belief that ambivalence is normal. That is, you must understand and have tolerance for the concept that people resist change even when change is desired.

- **Identification of discrepancy** requires that the clinician amplify and create opportunity for the client to self-identify discrepancy between behavior and stated goals. You want the client to develop the argument for change through the use of reflective listening and objective feedback.

- **Avoid persuasive arguments** and develop a facilitative, mutual working relationship. Direct persuasion is viewed as counterproductive to the motivational interviewing process because an argumentative or persuasive demeanor can lead to increased resistance and defensiveness. The more a client verbally defends or argues her or his position, the more likely it is that the client will talk her- or himself out of changing a behavior. It is ultimately the client’s responsibility and decision to change.

- **Accept and roll with resistance** rather than confront it or oppose. Resistance should be acknowledged and explored.

- **Support self-efficacy** because the client is viewed as an instrumental resource and partner in the process of finding a solution. The goal is to enhance the client’s degree of optimism and confidence so he or she can adequately cope with and succeed during the change process.

The emphasis in motivational interviewing is that it is often best for the client, rather than the clinician, to develop an argument for change. It has been found to be more efficacious than traditional advice giving with regard to the treatment of a variety of health-related problems (Burke, Arkowitz, & Menchola, 2003; Rubak, Sandbaek, Lauritzen, & Christensen, 2005). It is often perceived as effective when used by itself or when combined with other forms of intervention.
3. **Curriculum-based assessment.** In cases where a school-age student is being treated for a language disorder, many considerations in planning therapy go beyond the diagnostic evaluation. Curriculum-based assessment is concerned with finding out the demands placed on a child by the educational environment in which he or she must use language and literacy skills (Nelson, 2010; Paul, 2007), and developing a plan where the child can experience success within her or his educational environment. For this to happen, the child is evaluated to determine the functioning level of instruction where the child can succeed within the general education curriculum. Teachers are given instructional placement information, which is valuable for planning and advancing the child’s skills in a manner that can reduce feelings of failure and frustration. To determine the types of communication, language, and literacy skills necessary to compete in the classroom environment, the SLP must interview teachers and examine curricular materials. This, again, requires conversation with other professionals to design treatment programs and monitor progress and generalization of the skills focused on in therapy.

**Telepractice**

In many geographical areas, access to an SLP is limited. Barriers to service access can include distance, impaired mobility, and the lack of an available SLP or specialist. To overcome the barriers of access to service, *telepractice* (as ASHA prefers to call it) is now accepted as an appropriate service delivery model for the evaluation, diagnosis, and delivery of treatment (American Speech-Language-Hearing Association, 2005a, 2005b). Telepractice involves the use of telecommunication to establish a real-time audio and video connection with a client to create an experience that will simulate and be equivalent to a traditional in-person encounter. Technology requirements include a secure videoconferencing platform, Internet access, headphones, scanners, and printers.

**IMPROVING YOUR INTERVIEW SKILLS**

You can see that interviewing never stops, from the beginning to the end of our clinical relationships. The same types of skills that we use in our initial intake interview are used again or are modified as we gather and disseminate information through therapy and dismissal. The more practice and experience in talking with families and clients you can obtain, the better your clinical skills will become. We have included a series of activities and projects for your own practice. Let them serve as the beginning steps in a continual learning effort toward improved interviewing. You will find that the time devoted to such training exercises is well spent. Now, consider these steps for improving your interviewing skills:

1. **Read widely from a variety of sources.** Find out what people are like by reading in sociology, psychology, anthropology, and philosophy. This is, of course, a lifetime project, which we feel is delightful because there is always a new frontier, an open horizon toward which we can set our sails.

2. **Listen to all sorts of people.** Listen to their dreams, their rationalizations, their insights—or lack of them—and their gripes. Get acquainted with the way people think and talk by following the example of others (Least Heat-Moon, 1982; Terkel, 1980, 1993, 2001).

3. **Form small heterogeneous groups of students majoring in speech pathology and audiology.** Conduct some sensitivity and values clarification training, particularly as it relates to your self-concept, assets and liabilities, responses to people, and your relationship with your own parents and other older adults (Kaplan & Dreyer, 1974). To provide assistance
to others, we must know our own foibles and potential blind spots and have them under reasonable control.

4. **Evaluate your degree of self-awareness.** To understand the way our actions will affect those we are trying to help, we have to acquire the skill of self-awareness. Self-awareness is an attitude toward interaction that helps you understand the impact that your personal thoughts, behaviors, and actions will have on others. Through self-awareness, you can build rather than burn bridges and develop better relationships with your clients. Self-awareness can be developed (because it is a skill) through being open-minded and engaging in self-introspection. It will take a conscious effort. The power and courage behind knowing yourself and how you affect others, and then letting that understanding guide your interactions with others should not be underestimated.

5. **Role-play to prepare for interviewing.** Set up several typical interview situations in front of a class and play, for example, the roles of the reluctant parent, the spouse of a patient with aphasia, or a hostile father. Discuss the interaction and replay the situations with others, assuming different roles. Write interview purposes prior to the role-playing and determine, or have the class determine, how effectively the interviewer accomplished the stated purposes. Whenever the viewers feel that the interview went wrong or the responses were ineffective, see how many different ways the interview could have been handled. This builds up the beginning interviewer’s repertoire of adaptive responses. You can do a surprising amount of intrapersonal role-playing in your spare time. While we are waiting for a class to begin or for a light to change, we frequently imagine ourselves in various interviewing situations and then explore alternate statements, probes, and so forth.

6. **Record your first few interviews, then analyze them carefully with your clinical supervisor or a colleague.** Evaluate your diagnostic interviews by using the checklist of interviewing competencies (see Figure 2–2). Obviously, no beginning clinician will remember, let alone exhibit, all the skills in the checklist; practice only a few at a time, and provide constructive feedback for each other.

We would like to end this chapter with a challenge: Utilize the interviewing approach delineated in the chapter, find the errors, the things that just don’t work for you, and then develop your own methods. We have given you the foundation blocks. Can you use them to make stepping-stones?

**FIGURE 2–2**

*Checklist of Interviewing Competencies*

<table>
<thead>
<tr>
<th>Interviewer: __________________________</th>
<th>Date: ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client/Respondent: ____________________</td>
<td></td>
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</table>

I. **Orienting the Respondent**
   A. Attends to comfort (coats, seating, and so on)
   B. Engages in appropriate “flow” talk
   C. Explains purposes, procedures
   D. Structures roles

II. **Engendering Communication**
   A. Attending behaviors (demonstration receptiveness)
      1. Relaxed, natural posture
      2. Appropriate eye contact
      3. Responses that follow the client’s comments (restating, overlapping the client’s message)
   B. Open invitation to share (open-ended questions)

(continued)
FIGURE 2–2  (continued)

C. Nondistracting encouragement to continue talking
   1. Verbal (“Yes,” “I see,” and the like)
   2. Nonverbal (nodding, shifting posture toward client)
D. Obtains an overview of the presenting problem

III. Use of Questions and Recording
A. Orderly, sequential questions
B. Nondistracting note taking

IV. Active Listening
A. Reflects feelings (empathic statements)
   1. Matches affect
   2. Matches content
B. Periodic summarizing of affect and content message

V. Monitoring Nonverbal Clues
A. The diagnosticians’s
B. The respondent’s

VI. Skills in Presenting Information
A. Transmission of information
   1. Content
   2. Style and language
B. Responds to questions appropriately
C. Appropriate use of humor, “flow” talk

VII. Closing the Interview
A. Summary, review of findings
B. Recommendations
C. Supportive comments

VIII. Analysis of Information
A. Major themes in the client’s presentation, association of ideas, inconsistencies and omissions
B. Descriptive report

Note: This checklist is designed to help monitor the performance of beginning interviewers. It can be used as a self-rating device or as a format for supervisory feedback.

CONCLUSION AND SELF-ASSESSMENT
We hope the material in this chapter will be useful to students majoring in clinical speech pathology and to our colleagues working in various settings. However, no one ever became proficient in interviewing solely by reading about it. Nor, it seems, are interviewing skills enhanced by increasing knowledge about communication disorders. It took us many years of constant searching and experimenting to evolve the interviewing approach presented here. And with the indulgence of our clients and parents, we continue to explore for better ways.

After reading this chapter you should be able to answer the following questions:
1. What are some potential disadvantages to using only paper-and-pencil techniques for collecting client information?
2. What is a diagnostic interview?
3. List and describe three common barriers to conducting an effective diagnostic interview?
4. What are the three basic goals in conducting diagnostic interviews?
5. List and describe the different types of questions that are commonly asked during an interview.
6. What types of things should be avoided while conducting a diagnostic interview?
7. What are three popular techniques used in clinical interviewing? Describe how they are distinct from one another.