Report Writing

Reports

The culmination of most psychological evaluations, they summarize information from testing, behavioral observations, and history to address the presenting question

If done well, they can inform treatment and provide critical information

If done poorly, they may be incomprehensible to others and have unrealistic recommendations

Objectives of a Report

Answer the referral question as explicitly as possible, providing the referral source with additional information if needed and relevant

Describe the person and his/her behaviors and cognitive status as fully as possible

Interpret the data in a meaningful fashion

Make recommendations based off the results

Individualized Reports

Refers to reports that go beyond just describing the test results

The best reports draw conclusions that are based on an integration of background information, behaviors, and scores

These look at the scores through the person, rather than the person through the scores

Remember!

Answering the referral question is the primary task of a report

All information in the report should be geared towards answering that question

The report can also be thought of as an argument, and testers must support their conclusions from the data in the report

Parts of the Report

- Title
- Identifying information
- Referral reason
- Tests administered
- Background information
- Behavioral observations
- Test results and interpretation
- Summary and diagnostic impressions
- Recommendations

Title

Usually just a single phrase that describes the type of report, such as:

Psychological Evaluation
Psychoeducational Evaluation
Neuropsychological Evaluation

May also include a privacy disclaimer, such as "for confidential use only"

Identifying Information

Standard information about the client, such as

Name
D.O.B.
Age
Grade / Occupation (if relevant)
Date of testing
Examiner & supervisor's names

Reason for Referral

State the reason for your evaluation

Should *concisely* express the questions and reasons for the evaluation
- Short, 1-2 paragraphs long

Include the names/positions of referral source and specific reason for the referral

Background Information

This should be inclusive of all historical information for a person *that is relevant to answering the referral question*

Sources of information include the examinee, significant others, parents, teachers, physicians, and anyone else with important data on the examinee, as well as previously documented medical/psychological history

Background Information

Typically divided into discrete sections:

- Developmental history
- Medical / psychological history
- Educational history
- Occupational history
- Social / family history
- Current functioning

Other areas may be added as needed (e.g., previous evaluations, treatment history)

Developmental

Should include, if available,

- Health of mother, including any difficulties during labor
- Prenatal exposure to any drugs or toxins
- Health upon birth, including Apgar scores if known
- Achievement of developmental milestones

Medical / Psychological

Notable medical events in person's life, such as

- Diagnoses or hospitalizations
- Medications taken, with frequency and dosage, especially those relevant to referral question
- Drug / alcohol use
- Eating and sleeping habits
- Current or previous psych diagnoses
- History of psych treatment
- Past psych / educational evaluations

Educational

Record of performance in school, including

- Type of school
- If person was held back or skipped any grades
- Placement in special classes
- Overall grades and standardized test scores
- Highest level of education attained
- Classes which were easy/hard for examinee
- Peer relationships

Occupational

History of work activities, including

- Type of job
- Length of employment
- Reason for leaving job
- Level of responsibility (e.g., managerial)
- Any jobs that were particularly enjoyable
- Relationship with coworkers or superiors

Social / Family

Information about social development and family history, including

- Family members living in home growing up
- Status of living family members
- Typical family interactions
- Mother's and father's occupation
- Marital status and current family situation
- History of family members diagnosed with psychological or relevant medical problems

Social / Family

- Quality of friendships
- Social networks and supports
- Strengths / weakness of individual
- Level of adaptive behaviors

Current Functioning

Information on a client's current behaviors, including any difficulties or strengths, can be worked into the discrete categories (e.g., Developmental, Educational) or in a separate area

Includes more detailed information about why he/she was referred for an evaluation than the "Referral" section

Collecting Background Info

Primary sources should be records review and face-to-face interviews if possible

When pressed for time, use of structured histories completed ahead of time by the client can be invaluable

Don't be afraid to discuss sensitive information, but do so after rapport is established

Collecting Background Info

Note the source of information to assist in clarifying issues for the reader

- "Medical records indicate…."
- "Mrs. Dough reported that…."

When gathering information from multiple sources, note and interpret any discrepancies

Behavioral Observations

As discussed in the previous lectures, BOs are an important piece of data in a report

Always use specific behavioral descriptors and examples with proper interpretations

Include a statement indicating if the results are reliable and valid, and state why

Tests Results & Interpretation

This section contains both the data from any tests or measure given and meaningful interpretations of that data

Focus should be on interpreting the data in light of the individual, drawing from the previous sections of the report

Amount and type of data/interpretation can vary greatly, but basic principles are the same

Principles of Organization

- Decide on a basic format
- Use subheadings
- Move from global to specific
- Move from standardized to informal results
- Use global themes to organize
- Use contrasts to organize

Decide on a Basic Format

Domain by Domain
- Groups data by different domains
- E.g., Intelligence, Achievement

Ability by Ability
- Groups data by different abilities
- E.g., Memory, expressive language

Test by Test
- Groups data by individual tests
- E.g., WAIS-III, MMPI-2

Decide on a Basic Format

One can use any of these, or a combination

Intelligence
- WISC-IV
- CTONI

Achievement
- WIAT-II
- WJ-III-Ach

Emotional Functioning
- BASC-2
- RADS
- RCMAS

Adaptive Functioning
- SIB-R
- VABS

Use Subheadings

Regardless of which format you use, use subheadings to organize the information

Specify the information contained in each paragraph / section

Allows reader to more easily refer back to certain areas when looking at your conclusions and recommendations

Move from Global to Specific

Include the broadest / most comprehensive information first
- E.g., full scale IQ, overall memory ability

Then move to more specific details
- E.g., subtests scores, types of memory skills

Conclusions can come either first or last when presenting these results

Standardized to Informal Results

Start with standardized scores, move to observations or informal information:

John's Numerical Operations score of 62 (1st percentile) revealed basic mathematical skills at a third-grade level. He was able to perform simple addition and subtraction, but was unaware of how to regroup and subtract multi-digit numbers (e.g., 120-15) or perform simple multiplication (e.g., 8 x 5).

Organization

Use of Global Themes

- Should be based around referral question
- Generally focuses on level of performance or specific strengths/weaknesses

Use of Contrast

- Comparing different types of abilities or skills can be useful to highlight a person's strengths or weaknesses
- Can also be used to describe similarities or differences between types of skills

Consistency of Findings

Always consider how the data fit together

- How are the findings consistent?
- What patterns of data support the common themes?
- Which data are contradictory?
- How can you explain the contradictions?

Consistency of Findings

Look for consistency or patterns across tests scores, behavioral observations, history, self- or other-report, and previous data

Link together the quantitative and qualitative data to make better support for your results

Note and address (explain if possible) any contradictory data

Contradictory Findings

Look at behavioral observations before, during, and after the test that yielded inconsistent data

Consider the type of stimuli

Consider the environmental differences

Determine impact of any situational factors during the assessment itself

Reporting & Interpreting Scores

Examine all levels of score information

- Don't focus only on global scores (FSIQ, Total Composites, etc.)
- Focus on factor and subtests scores as well, in an effort to more fully describe someone
- Look at the pattern of scores within the context of the individual's history and background

Reporting & Interpreting Scores

Focus on the individual, not the score

- Write on the person's abilities and skills, strengths and weakness, not just a standard score or a percentile

Describe what a person could and could not do on the test, not just a score

Report scores in the most understandable way

- Percentile ranks are usually the easiest

Summary & Diagnostic Impressions

This should be where you draw together all the relevant information in your report to answer the referral question(s)

Points out key data from the report, interprets those data, and sets the stage to make recommendations based on the data

Crucial piece of the report, as it may be all that someone reads

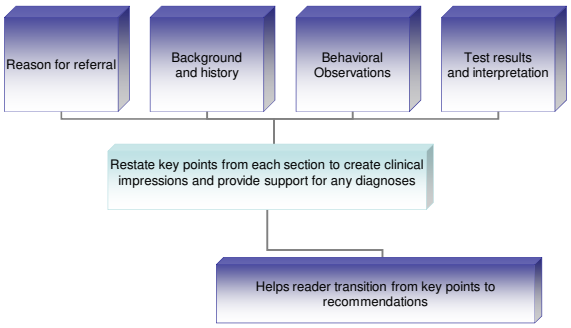
Summary

Should consist of a brief recap of *relevant* information from the body of the report

Organize it into paragraphs based around either the referral question(s) or diagnoses

Within each paragraph, provide your support (from multiple sources) for the diagnoses or answer to the questions asked

Summary



Summary Priniciples

Keep it concise

Do *not* include new material

Avoid vague or ambiguous statements

Describe what person can and cannot do

Diagnostic Impressions

For any and all diagnoses, be sure to have

- Described the data that support the diagnosis
- Provided enough data to support the conclusions
- Used a diagnostic code when appropriate

Do NOT make a diagnosis when you have contradictory information

Diagnostic Impressions

Include the DIs in sentence format within the summary, but also include a five axis table

Axis I	315.00	Reading Disorder
	315.2	Disorder of Written Expression
	296.32	Major Depressive Disorder, recurrent, moderate
Axis II	V62.89	Borderline Intellectual Functioning
Axis III		Reported lower back pain and related functional disability due to fused vertebrae and degenerative disk disease
Axis IV		Educational problems (functional illiteracy); Occupational problems (unable to work due to back injury); Economic problems (living on wife's income alone)
Axis V	GAF =	35

Recommendations

Should be logically based on the summary and diagnostic impressions

Attempt to address each difficulty or strength found in the evaluation

Be as specific as possible

E.g., Cognitive-behavioral therapy for depression rather than just psychotherapy

Recommendations

If recommending services (therapy, medication), provide specific referral information if possible

These should be geared towards improving functioning in both specific areas (e.g., depressive symptoms) and overall quality of life (e.g., increase social support network)