Getting Started:
ToMI-2 Caregiver Interview

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Caregiver interviews are a time-honored, evidence-based practice for gathering information that can be used to guide treatment planning and improve therapeutic outcomes. The primary reason for their effectiveness is that they capitalize on the knowledge of those who know the child best. Indeed, caregivers are invaluable sources of information because they have had the opportunity to observe the child across settings and over time. Caregiver interviews are also inherently family-centered and can be used to ensure that treatment targets are aligned with families' cultural beliefs and values and priorities for intervention. When used to maximum benefit, caregiver interviews also engage families in the assessment and intervention process. Caregivers are the most invested people on the planet when it comes to supporting a child's success. When caregivers and other family members are partners in theory of mind assessment and intervention, they can reinforce key concepts outside of the treatment setting. They also become increasingly keen observers about the theory of mind concepts and social lessons that are being targeted and, as such, can provide invaluable feedback about what is working, what is not working, and what might work better.

The purpose of this caregiver interview is to begin a conversation about a child's theory of mind strengths and challenges. The content of the ToMI-2 caregiver interview should flow from the results of the ToMI-2. Ideally, it is preferable to conduct the interview soon after the caregiver has completed the ToMI-2 so that the questions from the ToMI-2 are fresh in mind. To create the interview, you will need three things: the ToMI-2 report, the ToMI-2 Quick View, and the ToMI-2 Caregiver Interview template.

STEP 1: See the Table for Treatment Planning and select the items of focus

The first step is to decide which theory of mind areas you want to focus on during the interview. To do this, you should first orient to the Table for Treatment Planning (this is the table that appears at the very end of the ToMI-2 report). Recall that this table arranges items according to their raw score and standard score:

scores in the top row are + 1 SD above the mean expected, scores in the middle row are in the normal range (they are within 1 SD), and scores in the bottom row are more than – 1 SD below expected. Unless there is compelling reason to do otherwise (and we can imagine a few candidate scenarios), we recommend that clinicians focus on the bottom row and select interview items from here. This is because these are the relative deficit areas and so there is good rationale for their selection as potential treatment targets. That said, there could also be viable treatment targets that appear in the second row since items in this row can fall at the 'low average' range.

Recall also that the ToMI-2 is comprised of 60 items. Depending on the individual being assessed, few or most of those items will fall in the *bottom row*. In cases where only a handful of items appear in the bottom row (this can occur for older children, adolescents, and adults with higher cognitive and linguistic skills), we recommend exploring all of them. Clearly, in cases where the majority of items fall in the bottom row, clinicians will need to be selective about their focus of attention. Good targets for intervention would be items that are developmentally appropriate and likely to have developmental significance. The child should be ready to receive these theory of mind lessons and they should be areas that are likely to have broad impact for academic or social outcomes (more specific guidance on how to choose developmentally appropriate using the Table for Treatment Planning is provided in the ToMI-2 Guide to Clinical Decision-Making).

Finally, we recommend selecting a few items from *each column* in the Table for Treatment Planning. The items in the left column are those for which the caregiver has the least confidence that the theory of mind concept is developed. For the items in the middle column, the caregiver is undecided and for the items in the right column the caregiver has rated the theory of mind concept as probably, but not definitely, developed. By selecting items from across columns, clinicians can sample caregiver's levels of confidence that the skill area is or is not developmentally appropriate. Clinicians can use this information to inform what might be appropriate immediate versus distal treatment goals. We generally find that the items in the left-hand column represent distal goals (and they tend to be the most advanced items on the ToMI-2 – they are in dark blue) but not always. When asking about items in the left-hand column, a clinician might learn the reasoning behind a caregiver's very low score and decide that this is a developmentally-appropriate target after all (e.g., the caregiver reports "I know for a fact that he doesn't understand most idioms so I rated that item very low but he can surely learn idioms and he loves learning about them").

We also find that items in the middle column tend to be the richest source of developmentally-appropriate treatment goals. This may seem counterintuitive but there is a good rationale: when items fall in the 'undecided' range, it is typically not because the caregiver is lacking data to inform the question. Rather, we find that the

most common response is, “it depends” or “sometimes he does it and sometimes he doesn’t”. In other words, the caregiver’s indecision is rooted in knowledge, not ignorance. When this occurs and clinicians hear things like “He can recognize surprise but only when the face is really exaggerated” or “He understands disgust in response to substances but not to moral outrage” or “He is experimenting with using deception but I don’t think he can detect it when others use deception on him”, clinicians should *take special note!* This kind of testimony strongly suggests developmental readiness for a treatment target.

With regard to the right column, recall that the caregiver rates these items as probably, but not definitely, developed. These items represent strength areas relative to the items in the other columns. As such, decisions regarding these items generally turn on whether there are foundational areas theory of mind that need ‘shoring up’ to support subsequent, more advanced theory of mind. It is also important to learn about these strength areas because they can be capitalized on during intervention.

STEP 2: Create the interview

After you have selected the ToMI-2 items that you want to focus on, it is time to create the interview. To do this, you will need two documents: 1) the ToMI-2 Caregiver Report Template; and, 2) the ToMI-2 Quick View. Orient to the Quick View which provides a list of all ToMI-2 items (including the item number, the item content, the subscale it belongs to, and the theory of mind concept area) and simply cut and paste the items you are going to focus on into the appropriate section of the Template (see Template for specific instructions).

STEP 3: Conduct the interview

Once you have selected the ToMI-2 items that you want to focus on and you have created the interview, you are ready to conduct the interview. It will be important that you listen and reflect back on what you hear a parent describe to make sure you understand the perspective s/he is sharing. It is always good to ask for more examples or ask a ‘what if’ question to make sure you understand the context or situation the parent is describing. Please be aware that the interviews can (and should) also be used in the context of the ToMI-2 self-report measure which is designed for older children, adolescents, and adults with good language and reading skills (~ 9th grade level). The ToMI-2 Self-Report Interview and Self-Report Quick View are available to users for this purpose.