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Therapeutic Assessment "on the Front Lines": Comment on Articles From WestCoast Children's Clinic

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I comment on the articles by Mercer (2011/this issue); Guerrero, Lipkind, and Rosenberg (2011/this issue); and Haydel, Mercer, and Rosenblatt (2011/this issue), which describe their practice of collaborative and therapeutic psychological assessment in a community mental health setting. These articles demonstrate that collaborative and Therapeutic Assessment can be used successfully with clients from underprivileged, high-risk backgrounds. Such assessments are rigorous for both clients and assessors, and their success depends on the ability of clinicians to form trusting relationships with clients. In fact, empathic disruptions by assessors are almost inevitable during the collaborative assessment process, especially if assessors' backgrounds and contexts are quite different from those of their clients. However, if assessors receive enough support to "take off their white coats" and reach into their clients' worlds, such disruptions can be repaired, leading to positive changes in both clients and assessors. This kind of assessment work is not for the faint of heart, but it is immensely rewarding.

It is a great honor to comment on these papers by my colleagues at the WestCoast Children's Clinic (WCC) in Oakland, California. My association with WCC has been a bright spot in my life in recent years. One reason I was excited about this special section was because more people would learn about this impressive community clinic, which deserves much more recognition than it has been given. In this discussion, I hope to highlight some of what is special in the assessment work at WCC, and also to draw some lessons from these articles for the practice of collaborative and Therapeutic Assessment. Also, I am in a unique place to comment on these articles, because in my role as a consultant I got to observe most of the assessment sessions as they took place, and I had the pleasure of collaborating with the two teams as they did their work. Thus, I beg the reader's permission to make a few comments that go beyond the articles as presented, and that are based on my observations during the assessments.

So what can we learn from these articles about collaborative and Therapeutic Assessment?

LESSON #1: IT IS POSSIBLE TO CONDUCT EFFECTIVE COLLABORATIVE AND THERAPEUTIC ASSESSMENTS WITH POPULATIONS OTHER THAN WHITE, UPPER MIDDLE-CLASS CLIENTS WHO HAVE ALREADY BEEN TRAINED TO THINK PSYCHOLOGICALLY

To me this is an important point, as I often get asked about the applicability of Therapeutic Assessment to different types of clients. As discussed in Mercer's (2011/this issue) introduction, and in the two cases presented by Guerrero et al. (2011/this issue) and by Haydel et al. (2011/this issue), the clinicians working at WCC are "on the front lines," dealing with children and families who have had incredibly difficult things happen to them, and who live in environments where resources are generally extremely limited. In the midst of this difficult setting, the dedicated and highly talented clinicians at WCC persevere, bringing their considerable expertise to the clients they serve, and treating them with respect, openness, and a desire to learn. Furthermore, I've never had the feeling (which I run into in other agencies dealing with similar populations) of the staff being overinvolved in caretaking or "rescuing" "poor underprivileged children." Instead, at WCC there is a recognition of and admiration for the resourcefulness, creativity, and resiliency of people who come there for services. These qualities are evident in the articles in this special section.

Not only *can* Therapeutic Assessment be practiced in such settings, but I also believe this set of articles demonstrates how perfect the model is for many underprivileged, multicultural clients. The techniques of Therapeutic Assessment are directly derived from its core values: collaboration, respect, humility, compassion, and openness/curiosity (Finn, 2009). Some clients are deeply impacted by being treated in accord with such values, and this experience in itself can be deeply healing.

LESSON #2: THE BASIS OF ANY EFFECTIVE PSYCHOLOGICAL ASSESSMENT IS THE TRUST THAT IS BUILT BETWEEN THE ASSESSOR AND CLIENT(S)

Guerrero et al. (2011/this issue) related many of the details of her assessment sessions with Lanice, and about how this 11-year-old girl gradually gave her access to her internal world in a way that helped the team, and then her family, understand her problem behaviors at home and at school. What I can add from

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my observations is that Dr. Guerrero was very skilled in her ability to form a relationship with Lanice—hovering attentively as Lanice played, asking gentle questions when appropriate (but never in an intrusive manner), and sensitively and respectfully letting Lanice find her own way of helping the assessors and her family know what was going on inside of her. I am convinced that Lanice would never have given such clear test responses, and the assessment team would never have been so sure about what to tell her family, had Dr. Guerrero and Lanice not built such a relationship grounded in trust and safety.

Such trust is essential, not only for helping assessors get clear and useful assessment information, but also allowing clients to withstand the emotional rigors of coming to view themselves, their loved ones, and the world in a new way. Again, in Lanice's assessment, it was emotionally quite challenging for the aunt to come to see that Lanice was not "bad," but instead was unable to express her emotions in adaptive ways. The intense emotions of relief, sadness, and guilt that came with this interpretation were only tolerable, I am convinced, because the aunt felt "held up" by the relationship she developed with the assessment team.

Lesson #3: Disruptions and Repairs Are Often a Crucial Part of the Success of a Collaborative or Therapeutic Assessment

Guerrero et al. (2011/this issue) wrote about the crisis during the first assessment, when Lanice's aunt blamed the assessment team for Lanice's acting out behavior out at school. As they wrote, this was a surprising, even shocking moment for the team, but they rose to the occasion beautifully, did not get defensive or blame themselves, and used the opportunity to understand the family's context better. This is a beautiful example of an empathic disruption followed by a repair, and it led to an increased alliance between the team and the family, which was evident in the final part of the session. Guerrero et al. mentioned that the end of the family session involved the family (aunt, Lanice, and mentally retarded mother) playing UNO with the three-person assessment team. I can add that this was a joyful and healing occasion for everyone, and as I watched over the video link from the other room, I found tears rolling down my face to see this widely disparate group of people engaged in an activity in which all of them could participate in and have fun.

This moment was truly magical, more so because the relationships had been on such shaky ground in the middle of the assessment. Kohut (1977) believed that empathic disruptions between clients and therapists are inevitable in treatment and that repairs are essential for clients to develop a sturdier sense of self. Also, the disruption–repair process has been found to be an essential aspect of secure attachment relationships (Stern, 2004). Not only is it impossible to avoid empathic disruptions during Therapeutic Assessment (except, perhaps by constraining ourselves so much that we limit our effectiveness), but it would be inadvisable to do so, because we would deprive our clients and us of a potentially powerful therapeutic tool. Instead, it is important that each of us learn more about how to recognize and repair empathic disruptions that occur during our psychological assessments.

The reflections by Guerrero et al. (2011/this issue) on the assessment process and the eventual outcome of the first case, and the comments by Haydel et al. (2011/this issue) on the rigors of dealing with the intense grief in the second family highlight another lesson.

Lesson #4: If We Are Going to Risk "Getting in Our Clients' Shoes," We're Going to Need Support to Do So

Both groups of clinicians wrote about how important it was to get support during the assessments: from the other team members, from the primary consultant (me), and from the WCC community, who listened as the cases were presented in a Grand Rounds, and gave emotional support and very helpful comments and suggestions. For these reasons, I myself always get consultation from at least one colleague on any assessment I do. This practice recognizes that my own background, biases, and context inevitably shape my understanding of test data and of clients. Having another person with whom to discuss my observations and hypotheses provides a check against my limited perspective. Also, sometimes I have pretty clear ideas about what I think about the testing or what I want to say to the client, but I need the support of having another person help "hold" the sadness, inspiration, fear, hope, or despair that I am containing during the assessment. If you're not accustomed to getting consultation I urge you to try it—it will really help you do much better work.

Lesson #5: Therapeutic and Collaborative Assessments Have the Potential to Change Assessors as Well as Clients

I so appreciated Drs. Guerrero, Lipkind, and Rosenberg disclosing the way they grew as a result of Lanice's assessment, to become more aware of power dynamics and issues of privilege with the clients they see at WCC. In my mind, their increased awareness of these issues illustrates how difficult it is for each of us to get beyond our own context and truly enter the intersubjective worlds of our clients. Of course, this process is even more difficult when our clients' contexts are very different than our own. However, if we can take off our "white coats" and—as I mentioned earlier—get the support and consultation we need to open ourselves to our clients, we can enlarge our own perspectives and get a taste of what it's like to lead other lives. Guerrero et al. (2011/this issue) were able to do this in this assessment and it benefited Lanice, her family, and the assessment team.

Lesson #6: There Are No Fixed Procedures in Collaborative and Therapeutic Assessment, and It Is Essential That Usual Procedures Be Adapted to Each Client

As Haydel et al. (2011/this issue) explained regarding the second case (Joey and his mother), it was both unfeasible and impractical in this instance to ask the mother to observe assessment sessions unobtrusively from the corner of the room. This child and mother were so connected that it would have been inappropriate and unempathic to even try this. So the team actively involved Joey's mother in a number of the sessions, and then had other sessions when Dr. Haydel worked with Joey alone and Dr. Mercer and Dr. Rosenblatt talked to his mother. Not only did this adaptation work well, but it turned out to be crucial in understanding the dynamics of this family. As Haydel et al. explained, Joey was much more competent when he was

away from his mother, and much less competent when he was with her. The major intervention in this case was to find a way for both Joey and his mother to accept his being competent in her presence.

This case made me wonder about how much we lose when we only evaluate our clients in one context and how much more we might be able to understand if we could see them at home, at work, at school, with friends, and so on. Fischer (1985/1994) regularly makes home visits a part of her collaborative assessments, and my colleagues and I have also found them to be very useful. In complex cases, I suspect the payoff of such visits (or of school or work observations) might well outweigh their costs in terms of assessor time and inconvenience.

Lesson #7: Above All, It Is Important for Assessors to Maintain a Curious, Nonjudgmental Attitude

Although this lesson was evident in both cases, for me it is most clearly illustrated in the second case. As you could perhaps grasp from the account by Haydel et al. (2011/this issue), Joey's mother was at times extremely self-focused and inaccurate in her perceptions of her son. As I watched the sessions with her from the other room, at times I felt a lot of intense negative emotions. Although the team also struggled with some of this, overall they were able to maintain a nonjudgmental stance, to become curious about the mother's dilemma of change, and to develop a compassionate, nonpathologizing understanding of what she needed to allow Joey to individuate more. I know that in other clinical settings, this mother might have been labeled as "overly dramatic," "undermining," and as having "excessive dependency needs." Instead, the assessment team joined with her and helped her take her next steps in healing.

Lesson #8: Listen Closely to Your Clients and Adopt Their Metaphors

I hope readers were as moved as I was by Dr. Haydel's beautiful, sensitive interaction with Joey about the "thinking cap" (Haydel et al., 2011/this issue). It was extraordinary. Again, I have to say that this would be even more impressive if you could view it on videotape, for you could see how closely Dr. Haydel was paying attention not only to Joey's words, but to his body language, and how her facial expression, tone of voice, and body language were crucial for setting the stage for him to be so open with her. To me, this event was a beautiful example of the power of coconstructing a metaphor with a client, and then using it to understand his dilemma of change. Who would have thought that a 6-year-old could explain so clearly why it was important for him not to be competent? Also, I saw in this interaction evidence of Schore's (2003) insistence that healing clinical interactions involve not only verbal communication, but a host of nonverbal signals, which are communicated unconsciously from skilled clinician to client.

Finally, Dr. Mercer (2011/this issue) gave us the last lesson, which I now repeat.

Lesson #9: Collaborative and Therapeutic Assessment Are Not for the Faint of Heart!

In this model of assessment, the intensity of the emotions experienced by the assessor is much greater than in traditional assessment, where we keep our "white coats" on to "preserve the objectivity of the data" (or so we tell ourselves), but also perhaps to make sure that we don't have to deal with inconvenient and inefficient counter-transference experiences. I want to acknowledge here that there are many contexts where traditional assessment practices are perfectly appropriate, and where it would be overkill to conduct a full collaborative or Therapeutic Assessment.

As Mercer (2011/this issue) stated, collaborative and Therapeutic Assessment are often rigorous, demanding processes, especially in settings where the clients have undergone severe trauma and neglect. They can only be practiced in their highest form with community support—but the benefits are also evident in terms of our ability to positively affect clients, and also the ways in which we can grow and be challenged personally and professionally. The shifts made by the clients in these cases are highlighted beautifully in the two case studies. In short, Joey learned that his mother could enjoy his competence, and she found that letting him thrive did not dishonor her grief. In the other assessment, Paula became more empathic to Lanice, Lanice's mother felt more included, and Lanice became more expressive of her internal world. Dr. Guerrero's ongoing relationship with Lanice and her family also reveals that a successful pretreatment Therapeutic Assessment can set the stage for further positive developments in subsequent therapy.

In their articles, the clinicians involved in these cases also revealed much about how these assessments impacted their professional and personal growth. Each left with a better understanding of their clients' lives and of the potential power of psychological assessment. I would add that I saw each assessor and supervisor shift before my eyes, to appreciate more deeply their personal impact on clients and those clients' personal impact on them. Finally, I must add that my involvement with these clients and clinicians has left me with a keen sense of my own blessings and a better understanding of the strength and challenges of those whom privileged society looks down on. In closing, I want to reiterate that it has been an honor to be involved with WCC over the years, to serve as a consultant on these cases, and to comment on these articles.

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