Collaborative/Therapeutic Assessment: Procedures to Enhance Client Outcomes

Filippo Aschieri, Francesca Fantini, Jason D. Smith

Pre-print version of the chapter published as: *Collaborative/Therapeutic Assessment: Procedures to Enhance Client Outcomes*, in [The Oxford Handbook of Treatment Processes and Outcomes in Psychology.](https://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780199739134.001.0001/oxfordhb-9780199739134)

**History of Collaborative/Therapeutic Assessment**

Traditionally, psychological assessment has been defined as “an activity based on the systematic gathering of information within a professional relationship that is aimed at providing the least biased description and/or explanation of client functioning within the constraints of allowable resources” (Friedman & MacDonald, 2006, p. 515). Historically, the aims of psychological assessment are to describe clients’ psychological functioning, provide a diagnosis, and plan treatment in the framework of a unilaterally managed, objective relationship with the assessor. In order to achieve these goals, assessors relied primarily on clinical observation, norm-based test scores, and subjective evaluation of responses to tests without norms. However, as early as 1972, Brown criticized this approach as a dehumanizing practice, which robbed clients of their resources and dignity and illuminated only their psychopathology. At the same time, the pioneering work of Connie Fischer (1970, 1973) demonstrated that humanistic and intersubjective values and practices could be incorporated into psychological assessment. Fischer laid out the basic tenents and foundations of what would later come to be referred to as the paradigm of collaborative/therapeutic assessment.

Beginning with Fischer, clinicians were to approach assessment with the intent of gaining a deeper, individualized understanding of the client through the use of psychological tests followed by discussions with the client concerning the way in which the testing situation might mirror the clients’ struggles outside of the consultation room. The clinician is interested in not only undestranding the root of the problems, but also in providing clients the context for appropiate insights into the factors that spawned and now serve to maintain their way of being in the world. Fischer noticed that tests often represent a “situation” that challenges clients in the same way they do in daily life; hence, providing the ideal context to explore possible solutions to those problems. In this way, struggles and solutions emerging while completing the testing or highlighted by the testing could have a direct positive impact on clients’ lives. Fischer noted several practical differences between her appraoch and the traditional practice of psychological assessment, which were further refined by Finn and Tonsager (1997) who pointed out that the main areas of divergence concerned (1) the aims (description vs. understanding), (2) the assessment process (unilaterally managed vs. codirected), (3) the testing perspective (objective nomothetic tools vs. occasions to see the world from the clients’ point of view), (4) the focus (test scores vs. participants’ experiences and observations), and (5) the role of the clinician (abstinent and objective vs. participant–observer). These values guide the work of assessors practicing from the collaborative/therapeutic assessment paradigm today.

Further, Fischer introduced specific techniques to enhance direct collaboration between assessor and client, such as asking the client to provide instances of times they experienced the behavior she noticed or anticipated based on the testing. Alongside the client Fischer refined their understanding of those instances, explored situations in which they were different and worked throught possible explanation for those problems, and introduced viable solutions. Fischer (1985/1994) described her approach to clients as “individualized psychological assessment” to stress how the focus was on the client’s life and the unique aspects of it that would give meaning to their problems. This was opposed to the prevailing focus on test scores, which Fischer refferred to as “a colleagues’ perspective” on the clients’ psychological functioning.

Today, collaborative/therapeutic assessors work with clients based on the premises first described by Fischer. Assessors participate in the collaborative process as experts in psychological theories and metaphors while clients are enlisted as experts in their own lives (Anderson & Goolishan, 1992). Assessment practiced with the goal of explaining the clients’ psychopathological behavior results in a presentation of the “facts” (test scores, problem behaviors in real life) grounded in psychological theories and complex intrapsychic process. The idea that assessors participate in a personal, transformative process during a psychological assessment calls for psychologists to evaluate (a) the influence of the test administration context on the way tests are introduced to the client, on the client’s responses to the tests, and on the interpretation of the test results; (b) the influence of the assessors’ implicit theories of psychopathology on their choice of specific tests; and (c) the impact of the assessor’s actions and attitudes on the client’s problematic behaviors displayed in the sessions (Aschieri, 2012a; Chudzik & Aschieri, 2013).

This chapter describes the conceptual underpinnings of the most researched and best described model of collaborative/therapeutic assessment, Therapeutic Assessment (TA; Finn, 2007). We illustrate how the principles and practices of TA apply to working with adults, families with children (TA-C), families with adolescents (TA-A) and adult couples. We then provide a description of the steps of TA with different types of clients, and review the empirical literature concerning the efficacy and effectiveness of the TA model prior to additional treatment and as a treatment in and of itself. Finally, we review the techniques used in TA, with a special emphasis on those applicable to TA with adult clients.

**How Does TA Work?**

The basic tennent of all forms of collaborative/therapeutic assessment is that assessment provides clients with a powerful occasion for change inasmuch as it taps inner stories they hold about themselves and their life. We refer to stories (or narratives) as the emotional and representational accounts that organize perceptions, shape the meaning of life events, structure the self and our relationships with others (McAdams & Olson, 2010). The assessment process can help clients to move toward more coherent, compassionate and developmentally viable narratives, often integrating affects, emotions, aspects of self previously dissociated and loaded with shame emerged from the assessment (Finn, 2007). Such healing processes are hindered by two potent factors: self verification and disintegration, which are common to all kinds of psychological interventions but can be particularly evident during psychological testing (Smith & Finn, 2014).

Clients in TA are supported in “walking the line” (Finn & Martin, 2013) between self verification and disintegration: on the one hand, research concerning self-verification theory empirically supports the strong human need to confirm their views of themselves (also called “epistemological competence”), seeking and attending selectively to information that supports the pre-existing assumptions (Swann, Wenzlaff, Krull, & Pelham, 1992). Self verification is by no means weaker when the view of the self is negative, limiting, or painful. Self verification contributes to what many psychotherapists call “resistence” to change and is triggered particularly by psychological tests, which directly challenge the integrity of client’s self views (Finn & Martin, 2013). Kohut (1984) defined the experience of abruptly changing these core beliefs as a “disintegration” of the self, which is an intense emotional distress, disorientation, and fear that accompains encountering evidence that some central and tightly held belief about the self is wrong.

Recognition of the inherent need to walk the line between self verification and disintegration during TA, or therapy for that matter, dictates that the assessor structure the assessment so as any change in the client’s core beliefs are not experienced by the client as imposed upon them by the assessor. Rather changes in the view of the self are co-created between the client and the assessor, who uses tests as “empathy magnifiers” (Finn, 2007) to identify aspects of the client’s stories that can be safely addressed or that need more emotional support before being worked through. Establishing a safe attachment relationship with clients (Byng-Hall 1999) through collaborative communication, emotional attunement, and repair of disruptions are among the basic processes assessors use to validate clients’ sense of self-efficacy, foster the client’s feeling that they are an expert about themselves and their relationships, and promote safety to foster self disclosure and therapeutic change.

When working with families with children, the TA-C model, children’s stories about themselves are generally more flexible, and depend to a great extent on the parents’ view of their behaviors and actions. Thus, the practice of testing the child in TA-C is used primarly to help the parents to develop a more accurate narrative about the child and the meaning of the problems exhibited. Simultaneously, the sequence of procedures in the TA-C models allows the child, through testing and through other semi-structured means of expression, to convey to their parents any needs or fears. Among the assessor’s goals is to facilitate the child’s expression of these needs and fears, support parents in hearing it accurately and helping the family to take the appropriate steps to respond in ways that will foster positive child adaptation and development.

Working with families with adolescents, the TA-A model operates under the belief that adolescents possess their own stories about themselves and who they are; so just as with adults, the assessor works with the adolescent individually to promote new awareness and insights from testing. However, TA-A borrows the idea from the TA-C that parents’ projections on their offspring can be powerful determinants of behavior. Therefore, the assessor devotes some effort to actively include parents and important caregivers in the assessment with the aim of reshaping or eliminating projections and improving the accuracy in understading the adolescent’s behaviors and emotional world.

In both the TA-C and TA-A models, the assessor attempts to ease parents’ anxiety and defenses by joining with the parents’ initial agenda for the assessment and focusing on their concerns (Tharinger, Krumholz, Austin, & Matson, 2011). The more the assessor can help parents feel respected and engaged the more success they will have in enlisting the parents as co-observers and co-assessors when defining the reasons for their child’s problems. These two facets are critical to helping parents toward to start considering their role in shaping or sustaining the child’s problems, which de-triangulates the child from marital and intergenerational issues (Fulmer, Cohen, & Monaco, 1985).

Finally, TA of couples focuses both on the couples’ partner individual narratives and on dinsentangling pathological mutual projective identifications between the partners. The couple engages in a two pronged process when participating in a TA: First, each member of the couple completes an individual assessment that procedes accrding to the individual adult TA model. Second, at the begginging of the TA, the couple is to pose questions for the assessment pertaining to both the individual and relational aspects of being in the couple. Further, they agree to share the results of both individual and relational questions with the partner at the end of the TA. The couples model of TA attempts to meld individual change in each partner with a systemic intervention. Individual interventions, germane to the couple’s dynamics and relational questions, are carried out during the respective individual assessments with each member of the dyad and come together later in the assessment process.

**The Structure of the TA Model**

TA is a semi-structured model based on a core 5-step process comprising (1) gathering assessment questions; (2) standardized test administration and extended inquiry procedures; (3) assessment intervention; (4) collaborative verbal and written feedback to the client and referring professional(s) when applicable; and (5) follow-up. The steps proceed in this order for each type of client (adult, children, adolescents, couples) with some variations based on developmental needs of children and adolescents, as well as the dyadic issues of couples. For example, TA with children promotes healthy parent-child boundaries and reinforces the parental hierarchy, while TA with adolecents models healthy autonomy and the separation-indiviudation process. The TA procedure is shown in Figure 1 for each client type. Because of these differences, we detail each step of the TA with regard to the type of client being assessed. We describe the adaptations made to the adult TA model for working with families with younger children, adolescents, and couples.

**Step 1: Collecting assessment questions and relationship building.** In the first meeting of a TA, the client and the assessor collaboratively formulate a set of assessment questions (AQ) to be addressed by the assessment. The AQs serve a dual purpose: First, they guide the assessor’s selection of assessment instruments most salient to the client’s agenda and goals. Second, they foster curiosity by promoting self-reflection. Further, the AQs a client poses can be an indication of the clients’ current understanding of their problems and their level of anxiety concerning specific issues, which can guide the way the assessor procedes with the TA. AQs informs can later be used as “open doors” (Finn, 2007) through which assessors begin shifting clients’ narrative about themselves and their problems.

In order to arrive at a set of useful AQs, the assessor employs a series of techniques, described by Finn (2007) and Fischer (1985/1994), to assist the client in moving from initial general worries to specific questions that can be addressed though the assessment process. Clients are often asked when the problem behavior began, what factors or contexts increase or diminish the problem, the ways in which the client has attempted to cope with the problem, the level of effectiveness of these strategies, and times when they expected the problem to occur and it did not. The assessor also asks the client to propose his or her “best guess” as to the origins of the problem and, thus, pose potential answers to the AQs. By proceeding with this line of questioning, the assessor invites clients up on what Finn (2007) calls the “observation deck.” The practice of stepping out of one’s skin to observe the self elicits client curiosity and helps to ease the powerful affect that is often associated with situations and behaviors that have led to the cleint’s problems. Finn suggested that this process sets the stage for therapeutic change to occur.

In TA-C, with families with children ages less then 12 questions are generally gathered in a session where the assessor works only with the parents/caregivers. In the session, the assessor works with the parent(s) to co-construct AQs that capture the main concerns and worries about their child and their relationship with their child. By focusing on the parents’ questions, the assessor aims to involve parents as active participants from the beginning of the process. AQs serve to foster parents’ curiosity about their child and they build the alliance between parents and assessor by setting an agenda focused on the parents’ motivations and goals contained in the AQs. A product of establishing AQs lowers the parents’ anxiety about the assessment. Once the AQs are established, the assessor gathers background information about the family, using the AQs as a guide to identifying themes the parents are open to discussing and don’t find threatening. In addition to the explicit goal of collecting parents’ questions, the assessor also works to build a secure relationship with them based on experiences of emotional attunement, collaborative communication and the repair of possible disruptions (Finn, 2012a). The creation of a secure relationship is considered essential for a therapeutic change to occur within the family or with an individual. The child being assessed may have his/her own questions too. These are collected in the second session when the child is first involved in the TA.

TA-A affords the adolescent a developmentally appropriate level of privacy and confidentiality compared to children in the TA-C model. Granting adolescents a higher level of privacy and confidentiality, with parents’ consent, encourages them to pose AQs that can be either shared (with the parents) or confidential (between the adolescent and assessor). In contrast, with pre-adolescent children, all the child’s questions are disclosed to their parents. In TA-A, all the parents’ AQs are shared with adolescent who is aware from the outset that they will be te first to receive a summary of the assessment findings, including hearing the assessor’s responses to their parents questions.

In a couples assessment, the assessor meets with the both members of the dyad for an initial interview during which they discuss their concerns and develop AQs. The AQs can include both individual-level questions (e.g., What can I do to help myself feel less anxious?) and relationship-level questions (e.g., Why isn’t therapy helping us feel closer to each other?). Due to the threat of triangulation and individual alliances between assessor and one member of the couple, there are no confidential AQs (i.e., the indivdual-level questions are known to both members of the couple). The assessor then begins assessing each individual member of the couple.

**Step 2: Standardized testing, extended inquiry and other collaborative techniques. AQs** orient the selection and ordering of test administration. Building on research showing that self report and performance based test yield unique, yet often overlapping, information on different aspects of the clients’ personality, TA assessors routinely use a multimethod approach comprising both self-report and performance-based tests (Smith & Finn, 2014). Finn (2012) points out how self-report tests represent a highly structured stimulus, administered in a non-interactive way mainly involving the use of cognitive mechanisms. For these reasons, clients who perform well with self-report instruments are those who tend to use intellectual defenses and who function well in structured, nonrelational contexts. The rsults generally correspond to the clients’ conscious self view. In contrast, performance-based tests such as the Rorschach (Rorschach, 1921/1942), the TAT (Murray, 1943/1971), the TEMAS (Costantino, Dana, & Malgady, 2007; Costantino et al., 2011), or the Adult Attachment Projective (AAP, George & West, 2012), are administered in an interpersonal, loosely structured situation; the task is largely unfamiliar to clients, often generating anxiety; and, in the case of the Rorschach, the blots’ shadings and colors often stir up client affect. The psychological problems revealed through performance-based tests typically emerge during unstructured, interpersonal, emotionally arousing real-life situations (Finn, 1996). Finn (1996) interprets convergencies and divergencies between these two typologies of tests through five possible combinations of self-report and performance-based test results, according to the level of disturbance shown by each instrument and the degree of engagement shown in the Rorschach (see Finn, 1996 and Smith & Finn, 2014).

Concerning the sequence with which tests are administered, self-verification theory suggests that the first tests should be those with the highest “face validity” – aligned with the immediate concerns expressed by clients in the AQs and initial session interview. This approach conveys that the assessor is indeed focusing on the primary issue identified by the client. In TA, tests and assessment instruments are administered in a standardized manner in order to obtain valid, reliable, and norm-based scores. Tests are scored and interpreted immediately upon completion, which provides the clinician with useful data to shape or refine the case formulation and select subsequent assessment instruments. Moreover, test data often helps the assessor to understand how to interact with the client during the assessment in order to meet their therapeutic needs.

In addition to the formal test results, TA also routinely incorporates various follow-up procedures, such as the extended inquiry, to better understand clients’ experience of the testing and how test responses and results fit within the greater context of the clients’ life (Aschieri, 2012a; [Finn, 2007](#_ENREF_15)). After the standardized administration, the assessor engages the client in a collaborative discussion of the experience of the assessment to gather additional information that might not be reflected in the responses or norm-based results. This process includes discussion of the context and personal meaning of response content or the psychological and interpersonal processes that occurred during the administration of the tests. Finn (2012) articulated how the visual and mainly nonverbal nature of performance- based tests tap into affect-laden material stored in the brain’s right hemisphere, which is inaccessible via self-report methods because they require verbal processing. Therefore, thematic material and content that emerge on performance-based tests create an opportunity to reflect on the meaning of those images. Discussion and support from the assessor are often needed to move to left hemisphere processing of the images and themes. Performance-based tests are useful in TA because they often result in images that can serve as metaphors of the subjective experience of the client, such as identifying dissociated states and affects. The TA process presents an opportunity to safely reprocess and integrate a split-off affect state.

In TA-C the assessor begins the testing phase with the child to collect useful information relevant to the AQs. The parents are typically asked to observe the administration of unstructured activities (i.e. drawings) from behind a one-way mirror, over a video link, or from the corner of the testing room. After test administration, the assessor and parents discuss their observations and their relevance to the parents’ AQs (Tharinger, Finn, Wilkinson, & Schaber, 2007). In TA-C the parents are involved directly as co-assessors, observing and interpreting their children’s behaviors during the testing, which is different from other systemic collaborative interventions (see, for example, Teixeira de Melo & Alarcao, 2011). The involvement of parents in this phase of the assessment allows them to witness, new and surprising aspects of the child, with the emotional support of the assessor, and begin to shift their view and understanding of their child’s behaviors outside the testing setting. Because parents observe test administration in TA-C, some tests are selected with the expressed intent of facilitating indirect communication from the child to the parents. Doing so through a test or activity reduces the inherent anxiety and threat often felt by both the child and the parents.

In TA-A the administration of standardized testing follows similar principles as adult TA. One important aspect differentiates TA-A from TA-C and TA with adults. TA-A assumes that the testing results that are relevant to address parents’ AQs will be discussed with them at the end of the TA. TA-A protects the privacy of the adolescent more than is appropriate for a younger child in TA-C. Thus, the parents are not allowed to directly observe the testing sessions. However, parents are invited to attend one or more sessions in which the assessor meets only with them. The primary goal of additional sessions with parents is to further explore the parents’ AQs by asking about relevant developmental and family history. This session also allows the parents to share information that they might not have felt comfortable discussing in front of their child, or that would not have been appropriate for the teen to hear (e.g., marital conflict, details about financial stress, information about an absent parent, etc.). Parents may also have additional AQs that they were not comfortable posing in front of the adolescent. If this is the case, the assessor typically works with the parents to formulate the question(s) in a way that can be shared comfortably with the teen in a later session. Meeting with parents only is also an opportunity for the assessor to strengthen the parent-assessor collaborative relationship, and to empathize with aspects of their lives; particulary the difficulties of parenting and frustration about the adolescent’s problems.

The TA model with couples laregely follows the individual adult model during Step 2. After collecting initial questions, each partner begins individual testing as would be conducted in the adult TA model. Partners can be also assessed together as a couple with specific procedures (Aschieri, 2012b). Tests are completed that pertain to both the individual-level and couple-level AQs.

**Step 3: Assessment intervention sessions with adults, families and couples**. Assessment intervention sessions are a unique technique to collaborative/therapeutic models of assessment and borrow from a variety of schools of therapy (e.g., play therapy, gestalt therapy). The purpose is to assist the client in experientially encountering information that has been revealed through the testing and that might be useful in answering his or her AQs during the subsequent summary and discussion session. The assessor attempts to expose the client to information that would be difficult to hear and integrate without further preparation due to raising anxiety and enacting the client’s characteristic defenses (Finn, 2007). The assessment intervention session provides an opportunity for the client and assessor to experientially work together to provoke a salient problem and its associated affect and then develop and practice a more adaptive solution. Although increasing self-knowledge and understanding are valuable, they are not synonymous with behavior change. Thus, facilitating experiential learning increases the likelihood that the TA will have an enduring impact on clients’ lives. Intervention sessions can be highly complex, and, as such, are conducted with an eye to a multitude of smaller goals. The assessor seeks to engage the client in: (1) exploring hypotheses derived from the testing, (2) understanding aspects of the assessment findings, (3) heightening awareness of findings that would otherwise likely be rejected, (4) experiencing a “living example” of an assessment finding, (5) independently discovering assessment findings, (6) testing out possible interventions for managing clients’ problems in living and experiencing more adaptive solutions, and (7) preparing for the summary/discussion session. A comprehensive discussion and presentation of assessment intervention sessions is beyond the scope of this chapter. Readers are referred to published case examples for additional information (e.g., Aschieri & Smith, 2012; Finn, 2003; Fischer, & Finn, 2014).

After the testing is completed in TA-C, the assessor schedules one or more intervention sessions that typically are family intervention sessions involving the child and any relevant caregivers and family members. The session represents an occasion to continue work on the systemic aspects of the child’s problem and to work with the family members on possible new ways of interacting (Tharinger , Finn, Austin et al., 2008). Atthe end of the child’s testing, the assessor has collected enough information to formulate a tentative case conceptualisation that, in nearly all situations, has an important systemic component. Therefore, the whole family is asked to do an activity that is likely to elicit systemic aspects of the child’s problem during the assessment intervention session. As described by Smith, Wolf, Handler and Nash (2009), during family intervention sessions: (a) the assessor observes the child in the family context while testing out systemic hypotheses; (b) parents can develop a more systemic view of the child’s problems; and (c) possible interventions are tested. Assessors often use one or more family therapy techniques in this session, such as parent coaching and skill development, family drawing or family sculpting, or psychodrama and family reenactments, with different levels of expected emotional arousal in the family members (Tharinger Finn, Austin et al., 2008).

The TA-A model includes both individual intervention sessions informed by the adult TA model and family sessions in which the experiences of the individual assessment intervention session(s) are tested in the context of other family members. This second kind of intervention session follows the same principles as family sessions with children but the activities are developmentally appropriate for an adolescent ranging in age from 13 to 19.

In a couples TA, the intervention session follows two or more individual assessment intervention sessions with each partner alone. The focus of the couple assessment intervention session is on the couple’s interactive processes. Typically, interactive tasks such as the conjoint Rorschach or the conjoint TAT are administered. The assessor aims to help the couple experience how their individual contributions, identified in the individual sessions, coalesce into a relational dance sustained by both partners’ personalities, attachment needs, and past experiences of relationships. Observing and commenting on videotaped sections of the conjoint test administration, completing new testing responses with the assessor scaffolding partners to produce new desired behaviors, and reflecting with them on the experience of participating in the tasks allows the couple to further integrate the experiences of the session and apply them in their real life outside of the testing situation.

**Step 4a: Oral summary and presentation of the assessment findings**

In the summary and discussion session, the assessor and client collaboratively use the test findings to answer the AQs. In contrast to a unilateral delivery of assessment results and their interpretations by the assessor, which is a typical practice of traditional psychological assessment, TA assessors invite the client to interpret the meaning of their assessment results and modify interpretations extended by the assessor. The assessor and client work together to integrate the information obtained from the assessment process, including test scores and interpersonal experiences with the assessor, in a way that results in a more accurate and compassionate understanding of the client’s experiences and current problems (Finn, 2007).

In the development of the TA model, Finn elaborated an empirically researched strategy to organize and present test findings when answering the AQs. Finn’s heuristic is based on self-verification theory (Swann, 1997), which posits that people are more willing to take in information that confirms their preexisting self-views or schemas (even when this information is negative), and less willing to accept feedback that contradicts these views. From this, Finn devised the levels of information model. Level 1 is information that is familiar to the client and congruent with their existing self-image. Level 2 is information that differs somewhat from the current self-image but should not preduce undue anxiety and mobilize the client’s defenses when presented with some preparation. Level 3 information significantly differs from the client’s current self-view and without proper preparation will raise the client’s anxiety and could result in a rejection of the findings or, worse, a disintegration experience. In many cases clients are not ready to integrate Level 3 information at the end of a TA. It requires a strong therapeutic alliance and often a good deal of time to prepare the client. Empirical research by Schroeder, Hahn, Finn, and Swann (1993) indicated that clients are most likely to view assessment feedback as being accurate and useful when it is presented beginning with Level 1 feedback and ending with Level 2 feedback. Smith and Finn (2014) suggested that the majority of feedback should be level 2 because, even though critical to the success of the session, clients won’t experience therapeutic benefits from the TA if they hear predominantly information that they already know and believe (Level 1) or that challenges this view too greatly (Level 3). Finn Smith and Finn (2014) discuss the process of delivering feedback in accord with TA’s levels of information approach.

In TA-C, the assessor first meets with the parents without the child, in a session where the goal is to answer to the parents’ initial AQs. The session is conducted according to the same oprinciples adopted with adult clients. At this point in the process, however, parents have generally started to develop a new understanding of the child’s struggles and difficulties from having observed the testing sessions and having participated in the assessment intervention session. The summary and discussion session may then become an occasion for the parents and the assessor to summarise what they have learned about the child and the family and to discuss next steps. Tharinger, **Finn, Hersh et al.** (2008) stressed that during the discussion of the assessment results with parents, the assessor: (a) supports parents in making connections between their new understanding of their child’s problems and the answers to their questions, (b) tracks the parents’ emotional reactions to the new story being developed about the child and the family and supports these emotions; and (c) usually also gives parents new pieces of information that have emerged from the assessment, while supporting the parents in processing the most distressing results (i.e., Level 3 information).

 Feedback is provided to the child in the following session, in which the parents are present. This technique was first described by Fischer (1984/1994). Congruent with the developmental needs of the child, feedback is typically given in the form of an individualised age-appropriate fable or story written by the assessor to express the major assessment results and the most important pieces of the child’s history in metaphor. Images and metaphors that appear in the testing (e.g., story themes to picture cards) are often used in the writing of the fable. Assessors also incorporate the parents’ suggestions, which are discussed in the parent-only session. Tharinger, **Finn, Wilkinson et al.** (2008) described this process in significant detail. Further, fables from TA have been published in a number of case studies (Fantini, Aschieri & Bertrando, 2013; Aschieri, Fantini & Bertrando, 2012).

In TA-A the summary and discussion sessions are generally divided between the adolescent and parents individually. First, a limited summary and discussion session is conducted with the parents, with the approval of the adolescent, following the individual assessment intervention session. Feedback at this point is generally very tentative, principally because the assessor’s ideas are based only on adolescent testing and on informal observations of the family, and he hasn’t had the chance to test his hypotesis with the family as a whole in the family intervention session. The advantage of providing parents with some preliminary results of their adolescent’s assessment is two-fold: first, the assessor can gauge the parents’ reactions to new knowledge about the adolescent in order to inform the family intervention session. Second, the parent has time to process the new information about the child before meeting with the assessor at the end of the assessment to discuss the answers to their assessment questions. The formal summary and discussion sessions, which occur after the family intervention session, begin by meeting with the adolescent alone. Again being minful of the developmental needs of the adolescent, the assessor discusses the test findings. Conducting this session prior to meeting with the parents promotes autonomy and individuation, repects the initial contract between the adolescent and assessor, and allows the adolescent time to incorporate new findings with support of any emotional reactions from the assessor. Next, the assessor schedules a session with the adolescent’s parents, preferably that same day or a day or two after. Sometimes, adolescents are invited to this latter meeting, but the adolescent may decline to participate. In the event that there are private questions from the adolescent, the assessor may support the adolescent in sharing some of the information with the parents if it is deemed appropriate and useful to do so, but some topics could remain private.

Again, the TA-A summary and discussion session melds aspects of the adults and child TA models. The primary goals of the individual summary and discussion session with the adolescent are to answer the AQs and increase their self-knowledge; to present a more accurate and compassionate story through which to understand their problems (e.g., they are depressed rather than “lazy and unmotivated”) and to provide the experience of being understood in an emotionally supportive environment. As would be done in TA-C, the session with the parents promotes systemic and contextual thinking, as opposed to focusing on the adolescent in isolation, aims to detriangulate the adolescent, and help the parent(s) respond in an attuned and developmentally appropriate manner to the adolescent’s problems and needs.

Finally, couples TAs culminates in a joint summary and discussion session in which the assessor – using the same princliples than with adult clients – addresses the AQs concerning each individual member of the couple. Then, in a second session, the relational or “couple” AQs are discussed.

**Step 4b: Written summary of the assessment findings.** At the end of a TA, the assessor prepares a letter for the client covering the material discussed during the summary and discussion session. TA assessors have found the letter to be a powerful means to enhance the utility of the assessment and the stability of the client’s insights. The letter is provided to the client(s) 2–6 weeks after the summary and discussion session. This timeframe is critical to allow the client time to “live” the results of the TA and integrate the findings. The letter serves as a reminder of the session and another opportunity to hear feedback in a different manner and time – leading to a deepening of their understanding.

In TA-C, parents receive a formal letter covering the AQs while the child receives a hardcopy of the fable that was read to them during the summary and discussion session. In TA-A the adolescent receives two letters: The first contains a complete set of answers to their AQs; the second is the same as the letter sent to parents and contains answers to the parents AQs. Parents of adolescents receive only the second letter. In a couples TA, the feedback letters are addressed to both partners and include the formal responses to both the individual and relational AQs formulated by each partner.

**Step 5: Follow-up session.** All of the TA models include a follow-up session that is typically scheduled to occur a few weeks to several months after the end of the assessment. The follow-up session serves to evaluate the changes that have occurred in the client’s life following the assessment, affords an opportunity for the client to pose any new questions or revisit previously unanswered questions, and formally process the end of the TA.

**Empirical Support for Collaborative/Therapeutic Assessment**

The efficacy of collaborative/therapeutic assessment, highlighted by Finn’s TA model, has been tested with adults and families with preadolescent children in multiple studies, and with families with adolescents and adult couples to a somewhat lesser extent. The adult studies can be grouped into two broad categories: The first concerns studies focused on collaborative/therapeutic assessment as a means to enhance salient psychotherapy process variables, such as the therapeutic alliance and motivation to change and engage in treatment. The second group of studies focused on applications of collaborative/therapeutic assessment as a stand-alone treatment. Scientists studying the TA model are at the forefront of the latter. We now provide a summary of the key empirical findings for these models of assessment.

CTA research consistently finds that these models are effective at improving treatment-relevant process variables, such as the therapeutic alliance, treatment readiness, and motivation to engage in recommended services.Akerman, Hilsenroth, Baity and Blagys (2000) found that college students participating in a therapeutic assessment at a university-based clinic had greater compliance with treatment recommendations, compared to assessment as usual (i.e., traditional assessment) (effect size = .42). In a follow-up study, Hilsenroth, Peter and Akerman (2004) found that the group receiving therapeutic assessment had a significatively stronger therapeutic alliance in subsequent psychotherapy, compared to the group that received assessment as usual (effect size = 1.02). Intervening with adolescents presenting to a hospital emergency room for serious self-injury, Ougrin, Ng and Low (2008) found that participation in TA resulted in higher rates of attendance at follow-up appointments in the community, as well as remaining in community-based services, compared to assessment as usual. Rates for TA and assessment as usual were 75% versus 40% and 62% versus 30% for the two outcomes, respectively. However, in a second study, Ougrin et al. (2012) found no significant benefit of TA for adolescents with nonsuicidal self-injury compared to assessment as usual.

A trial with 74 adult patients awaiting treatment for severe personality pathology randomly assigned participants to TA or a structured goal-focused pretreatment intervention (De Saeger et al., 2014). The findings revealed that participants receiving TA had higher outcome expectancies and higher perception of progress toward treatment (Cohen’s *d* = 0.65 and 0.56, respectively), as well higher satisfaction (*d* = 0.68) and marginally stronger therapeutic alliance to the TA assessor than to GFPT clinicians (*d* = 0.46), even though therapists perceived the alliance as equally positive in both groups. However, symptom severity ratings were not significantly different between the two conditions post intervention.

Smith, Eichler, Norman, & Smith (in press) conducted a replicated single-case time-series study with 10 participants in which TA was used as a model consultation to psychotherapists with clients in ongoing treatment. Results indicated a significant reduction in symptom severity (*d* = .50), a significant change in the slope of symptom severity, and higher client ratings of the therapeutic alliance (with the psychotherapist).

TA has been studied as a brief intervention with adult clients and families with preadolescent children. Finn and Tonsager (1992) conducted a randomized controlled trial in a university counseling center comparing a short version of TA (collection of assessment questions, administration of the MMPI-2, and feedback) to counseling sessions as usual. They found a significant and large reduction in client-reported symptomatology (*d* = .85) and increases in self esteem (*d* = .45). Similarly, Newman and Geenway (1997) replicated the Finn and Tonsager study with similar results favoring TA. Little and Smith (2008) compared TA with structured supportive therapy and psychiatric treatment. The results indicated superior outcomes for clients receiving TA in terms of satisfaction with treatment, reduction of distress and increased well-being. Morey, Lowmaster and Hopwood (2010) compared a brief manualized cognitive treatment for clients with borderline personality disorder and this treatment augmented with a therapeutic assessment (pretreatment) and found superior outcomes for clients in the therapeutic assessment condition.

Aschieri and Smith (2012), Tarocchi, Aschieri, Fantini and Smith (2013), and Smith and George (2012) used quasi-experimental single case repeated measure methods to test the effectiveness of the TA model as a stand alone intervention. Clients’ presenting concerns were emotional trauma, complex posttraumatic stress disorder, and disorganized attachment after medical trauma, respectively. The results of each single case experiment indicated significant improvement in client-reported symptoms after TA, compared to pretreatment levels.

A meta-analytic study that included 17 randomized trials with 1,496 adult and adolescent participants, examined the overall effectiveness of individualized assessment feedback and included trials of the TA model and less structured approaches. The results indicated a significant overall effect for both symptom reduction and therapeutic process outcome variables combined (*d* = .423; Poston & Hanson, 2010). A reanalysis of the data, which included 14 studies with 1,375 participants, also resulted in a significant effect (*d* = .403; Hanson & Poston, 2011), confirming the effectivenss of indivualized assessment feedback for adults.

The TA-C and TA-A models have been studied as a brief family system intervention and the results are promising. In an aggregate single-group study of families with children ages 9 to 13, participation in an 8-session TA-C resulted in significantly decreased symptomatology in both children and mothers, decreased family conflict, and increased communication and cohesion. Additionally, mothers reported more positive and fewer negative feelings about their child following the assessment (Tharinger et al., 2009).

In a series of single-case studies conducted by Smith and colleagues demonstrated the effectiveness and efficacy of TA-C for behavior problems in preadolescent children. First, Smith et al. (2009) found that behavior problem severity decreased following participation in TA (*d* = .30). Next, Smith, Handler and Nash (2010) examined the efficacy of TA-C with preadolescent boys with oppositional defiant disorder. Using a replicated single-case time-series design with daily measures, the effects of TA in reducing family distress and child symptom severity occurred in all 3 families. The results of the time-series analysis were supported by clinically meaningful reductions in parent and child reported problems on the Behavior Assessment System for Children, Version 2 (Reynolds & Kamphaus, 2002).

The effectiveness of specific components of TA-C have also been studied. Smith, Nicholas, Handler and Nash (2011) found that changes in the trajectory of child symptoms and family distress was correlated with the family intervention session *(r* = .71). The effects of working with parents behind a one-way mirror in TA-C was shown in a pre-post single-case study by Tharinger et al. (2012). Improvements were found in the mother's perception of the child, empathy, quality of the mother-child relationship, positive feelings, negative feelings, communication, and awareness of the systemic aspects of the child’s problems. Last, Tharinger and Pilgrim (2012) evaluated the effect of adding a personalized fable to provide feedback to the child after a standard neuropsychological assessment. This was compared to a delayed fable condition (the fable was given to the child after post-assessment outcome measures were collection). Children receiving the fable reported a greater sense of learning about themselves and their strengths and difficulties; a more positive relationship with the assessor; a greater sense of collaboration during the assessment; and a sense that their parents learned more as a result of the assessment compared to the children in the comparison group who received the fable later. Parents in the fable group reported a more positive child-assessor relationship; a greater sense of collaboration; and greater overall satisfaction with services.

**Essential Skills and Techniques in Therapeutic Assessment**

The TA model incorporates therapeutic skills and techniques from the larger psychological intervention literature. In this section, we outline the techniques commonly used in TA but are by no means unique to this model. However, the techniques used by TA assessors might be unexpected in the context of a psychological assessment. Assessors apply these skills in typical situations or when encountering specific situations during a session. We provide a brief description of the technique and its origins and specify the steps of the TA model where the technique is generally recommended. In general, we discuss each technique with respect to an individual adult client but they are applicable to working with all client types. Further, excerpts and examples from published literature on TA are provided to illustrate its use.

**Active listening.** Active listening is a crucial component of building an empathic relationship (Barone et al., 2005; Othmer & Othmer, 2002). The use of of active listening skills, such as eye contact, leaning forward, head nods, facial expressions, and short verbal comments (i.e. “yes”, “uh huh”) demonstrates involvement and interest in what the client is discussing. Further, the assessor might reflect back to the client what has been said by paraphrasing (i.e. "what I'm hearing is…" and "sounds like you are saying…"). Listening actively to clients’ words during the sessions can have a potent therapeutic effect and is central to a number of prominent therapeutic models (e.g., Miller & Rollnick, 2002; Rogers, 1961).

Assessors use active listening skills in all steps of the TA model. However, active listening is particularly useful when working toward defining the AQs in Step 1 of TA and as clients begin to achieve new insights or come into contact with affect, which often occurs during the extended inquiry, intervention session, and the summary and discussion session.

When a client begins to articulate goals for the assessment, describe struggles and explain the reasons for discomfort, a silent presence with nonverbal and limited verbal indications of active listening from the assessor fosters a feeling of being attended to and communicates implicitly that the assessor is listening to their needs and will take care of them (Shea, 1998).

Active listening is also a powerful tool to help a client reflect upon the insighs achieved during the TA (Meier & Davis, 2008; Strupp & Binder, 1984). For example, when an assessor works with a client during the extended inquiry or the intervention session, the client can begin to draw connections between testing behaviors, problems in living, and the potential answer to their AQs. As clients begin to connect these elements in a meaningful way, assessors use active listening to support them in this task; hence, promoting the clients’ experience of actively authoring a new awareness about themselves and their problems in living.

**Accurate mirroring.** Identifing, labeling and accurately describing a clients’ state of mind is an important process in psychotherapy exemplified by Carl Roger’s (1951) emphasis on helping clients becoming aware of their inner states and thoughts. According to Rogers, accurate mirroring requires “the therapist’s sensitive ability and willingness to understand the client’s thoughts, feelings, and struggles from the client’s point of view. [It is] the ability to see completely through the client’s eyes, to adopt his frame of reference” (Rogers, 1980, p. 85). Kohut (1971, 1977, 1982)also repeatedly stressed the universal importance of “being accurately seen” by significant others for the development of a coherent self. Linehan (1993) listed accurate mirroring as the most important aspect of validation and suggested that when clients feel accurately seen, they tend to better regulate their emotions, their identity is reinforced, and they feel more close to the clinician. Clinicans can reflect clients’ inner states in the here and now interaction (“I see how angry you must be”), help them gain awareness of their own inner states by mirroring them in a tentative way (“I guess this may raise your sense of helplessness”), normalize their reactions framing their states within their relational history (“given your previous expericenes with man, no wonder you are suspicious of him”) or within universal human experience (“I see you were overwhelmed by sadness, but everybody would have felt the same in those conditions”).

Research has shown that clients who perceive assessors to be accurately mirroring their strengths and struggles manifest significant increases in self-esteem and significant decreases in symptomatic distress (Newman & Greeway, 1997). Emotional attunement comprises two basic components: (1) activation of the corresponding motor and mental representations of the client (i.e., neural resonance or mirroring; Zaki and Ochsner, 2012); and (2) understanding the client’s goals by inferring the clients’ state of mind (i.e., mentalizing; Amodio & Frith, 2006; Spunt, Satpute, & Lieberman, 2011). In fact, both emotional and cognitive processes are required for accurate mirroring of others’ states of mind (Bombari, Shmid Mast, Brosch, & Sandler, 2013).

In TA assessors seek to mirror accurately the clients in every step of the process, and generally, the more deeply they know the client, the more accurate their mirroring becomes. During the collection of AQs, assessors pay close attention to clients’ narratives and emotional reactions, and mirror what the client expresses. Assessors also actively stimulate the client to express their emotions around the more affectively charged topics of the session by asking direct questions (i.e. “How is it like for you to talk with me about your struggles with your husband?”). If the client denies any emotional arousal because, for example, she has told the story of her marital problems many times, the assessor may mirror the client’s hoplessness of being understood by another person. If the client expresses shame (i.e. “I feel you may be thinking that I’m an idiot.”), the assessor may mirror the feelings of inadequacy (i.e. “I see. You feel that the struggles in your marriage are all your fault.”) and then suggest that the client may benefit from building compassion for herself (i.e. “It seems you’re very hard on yourself.”). Mirroring the client’s reaction in this way can lead to developing or refining the AQs, such as “Why am I unable to differentiate between people who are able to help me and those who are not?” or “why do I end up blaming myself and feeling ashamed when I suffer?”

As the TA progresses, and especially during the summary and discussion session, the assessor uses formal test results as “empathy magnifiers” (Finn, 2007); that is, they use the test data to develop an accurate understanding of how clients tend to think and feel in different circumstances. For example, following Finn’s model of integrating self-report and performance-based test results (Finn, 1996; Smith & Finn, 2014), the discrepancy between MMPI-2 and Rorschach results may inform the assessor about different aspects of the client’s personality. If a client shows low disturbance on the MMPI-2 and high disturbance on the Rorschach, he will feel more accurately seen and understood if the assessor mirrors his strenghts in structured, predictable environments, and empathizes with his struggles in intimate or unstructured situations where expectations are less clearly defined. On the contrary, if a client shows high disturbance at the MMPI-2 and low disturbance at the Rorschach, she will be more prone to feel mirrored by the clinician’s appraisal of his “cry for help” (Finn, 1996) or need to be cared for and his needs to be taken seriously. As the assessment unfolds and the assessor collects historical information relevant to the AQs, it becomes easier to mirror the clients’ states of mind related to their problem behaviors while contextualizing their struggles in the context of their development and family environment. This helps the clients release any shame about the problem, increases hope, and fosters the development of a more compassionate self-view.

**Scaffolding.** The term *scaffolding* builds upon Vygotsky’s conceptualization of zone of proximal development, elaborated from his studies on cognitive development in children (Vygotsky, 1987). In Vygotsky’s writings, the zone of proximal development is the distance between the child’s actual level of ability, measured in independent problem-solving tasks, and the potential level of development, reflected by the performance obtained with adult guidance or in collaboration with older or more capable peers. Scaffolding is the process by which a more capable person provides temporary support through verbal and nonverbal communication (questions, cues, reminders, prompts, contexts) in order to help another person learn something new on the foundations of what was already known. In psychotherapy, the use of scaffolding is used to enrich a “problem-saturated story into new space that previously was not visible, opening up new opportunities for children and families to address problems” (Ramey, Tarulli, Frijters, & Fisher, 2009, p. 274), supporting emotional development (Kassett, Bonanno, & Notarius, 2004) and a new understanding of problems (Muntigl, 2004).

 In TA, scaffolding is used in the different steps of the model to help the client feel that they are authoring, in “first person”, the results of the assessment, so that they can find new meaning and understand difficult information without experiencing disintegration or the anxiety that it could occur (Kohut, 1984). Scaffoling in TA occurs within the collaborative atmosphere where, as experts of test results, assessors offer their knowlegde concerining the meanings of test scales and indices to help the client make sense of specific aspects ofpsychological functioning, and the client interacts from the standpoint of an “expert on their own life” (Anderson & Goolishan, 1992).

Scaffolding is a central notion to the summary and discussion session procedures used in TA. Scaffolding provides the client with small bits of information and allows them to accept, reformulate or refuse the new information in a collaborative process aimed at joint meaning-making. The client’s strivings to engage as active interpreters of their own results and their insights and associations are positively reinfornced. Further, the client’s disagreements are seen as powerful occasions to explore unexpected meaning and to reflect on possible resistance and lack of trust in the assessment or the assessor.

Scaffolding during the extened inquiry portion of TA is aimed at expanding the meaning of a certain aspect of the testing. However, at this point in the assessment the assessor generally has only a tentative case conceptualization (as the standardized testing phase is not completed yet); thus, the scaffolding is used more to help the client feel actively engaged in the assessment than on guiding clients to incorporate specific content as would be the case in the summary and discussion session. Eliciting new meaning from the testing through scaffolding enhances the relationship between the client and assessor and sets the stage for later use of this technique. When the assessor develops a more comprehensive case formulation, scaffolding can enhance both the relational aspects of the TA (empowering the client in the process of active meaning-making) and with content (incorporating new psychological elements of a client’s identity). Scaffolding during intervention sessions or during summary and discussion sessions focuses on helping the client to take an active position in interpreting the results and supporting them to draw connections between the data, real world experiences, and potential answers to the AQs.

In any case, the assessor typically proposes the findings in a tentative manner (e.g., “It look like…”; “Your testing suggests…”), leaving space for disagreement, comment, and modifcation from the client. For example, when a client has a DEPI Index (Exner, 2003) of 7 on the Rorschach, the assessor may introduce this finding as a half-step by saying, “As to your Rorschach test, one of the indicators of emotional distress was positive, and relatively high. Does this fit with your experience?”. Should the client agree, the assessor may proceed with another half step by asking the client for examples of emotional distress and proceded to explore more information concerning the psychopathologic processes evident by the DEPI (e.g., low self-worth). Then the assessor may scaffold the client in linking depression to specific problems in living. Again, the process of scaffolding can be promoted through a question (e.g., “Do you see any possible relationship between depression and lack of sexual desire to your wife?”) or though additional information and comments (“Back to your question about your unsatisfying intimate life with your wife; I would like to share with you that depression can sometimes impact aspects that are not emotional at all, such as hunger or even sexual desire. What do you think of this?”). Proceeding with half steps and providing cognitive and emotional scaffolding to the clients permits disagreement on all or parts of the interpretation of the test results or how the results pertain to the clients’ AQs. When clients disagree with a finding, the TA assessor supports disagreement and engages in a search for possible alternative meanings in a three-step manner involving half steps. First, the same concept or finding is communicated with different words. For example, the assessor might respond to a client who denies a test finding indicating that he might be “sad” by saying, “Okay, wait. Sometimes people with this result may feel damaged or hurt rather than sad or gloomy. Does this sound more familiar to you?” In this case, scaffolding provides different pathways to increase self-awareness without putting forth test results as “truths” from a one-up position. Disagreement of test interpretations provide the assessor an opportunity to scaffold. The assessor might ask the client, “Is even one aspect or one part of what I have proposed correct?” In doing so, the clients can actively shape the information provided by the assessor to better fit their expreinces and current story. The assessor then gains important information on the zone of proximal development in the client’s self view.

Conceptualizing the client’s ability to incorporate new information in terms of the zone of proximal development helps the assessor to accept disagreement and in some cases even praise this when it, represents healthy movement toward entitlement. When a client enters the TA with disavowed anger, pride, and self worth, even when it could be adaptive in certain situations, a disagreement is an important occasion to scaffold clients’ efforts to try out new ways of being in relationships. In this case, scaffolding is based more on process than on content. In fact, disagreement may signal that the client feels secure enough in the relationship to express new and potentially adaptive aspects of the self.

**Circular questioning.** Circular questioning “seeks to reveal recurrent circular patterns that connect perceptions and events” (Tomm, 1988, p. 8). This technique was initially developed by the Milan Associates as a procedure to interview families participating in family therapy (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980) and has since been adapted to many other therapy models. Circular questioning involves asking questions that help draw connections between the experiences of various family members or between the different aspects of a client’s expericences.

“The premise behind circular questioning is that information comes from difference and that difference implies a relationship, through connections or distinctions in the surrounding environment. The questioning is aimed at creating or maximising difference and then drawing connections in order to provide information that frames problems in new ways. When clients generalise a particolar problem situation to their entire life, it is often helpful to deconstruct the generalisation by asking questions that create difference. When clients are overwhelmed by a problem, they often see it as isolated from the context in which it exists. Seeing the pattern that connects the problem with the context puts the problem unter a more systemic point of view and it’s helpful to therapist and client in creating under standing and facilitationg change” (Brown, 1997, p. 109).

In this way, circular questioning helps the clients and therapist contextualize behaviors and problems in living, and allows both of them to construct a case conceptualization centered upon the clients’ problems, which Selvini Palazzoli et al. (1980) referred to as a *hypothesis*.

Circular questioning explores differences in the problem across time (“when did your depression begun?”, ”when is it harder/less hard to tolerate?” ,”how might your depression change in one year from now?”), between people (“with whom are you less at ease since you started to feel depressed?”, “who is more concerned about your depression? And who is less?”), between parts of the client (“when you start feeling depressed, which part of you feels sad and which part angry because of your current situation?”), between contexts (“is your depression worse at work or at home?). Circular questioning is used to connect information about behaviors (“what happens when you start feeling depressed and the people around you try to cheer you up?”), feelings and emotions (“how do you feel when they don’t understand that you drink to self soothe?”), and meanings of behavior and affect (“when your husband says that your depression is related to unresolved issues with your mother, how do you think that he gets that idea?”) (Brown, 1997).

In TA, the use of circular questioning is used as one of the first intervention techniques, since the initial meeting, to begin to transform clients’ narratives from overgeneralized and isolated from context to versions that are more sensitive to the influences of the environment. The assessor predominantly uses circular questioning during the initial session to help clients formulate AQs and collect backgroud information and during the extended inquiry and intervention session to help clients explore different narrative options.

In the context of AQs, circular questioning may lead for example from a client initially wishing to understand “Why do I have a hard time forming deep bonds?” to realizing that these struggles are sensitive to specific aspects of relationships, which results in a revised question of: “Why am I so sensitive to rejections, so that I don’t allow myself to bond easily?” Then, the assessor relies heavily on circular questioning as backgroud information is collected. Each problem in living is refected in an AQ and explored by the assessor concerning when it began, the contexts in which it is better or worse, the results of different potential solutions that the client has tried out, and how the client feels, or what the client believes, when other people react to the problem.

 During extended inquiry precedures or the intervention session, the assessor uses images and stories provided by the client during the testing to help the client identify information that could help answer an AQ. As previously described, the goal is to help the client view images and stories as metaphors of their subjective experiences, as a means to reintegrate previously dissociated experiences and affect. Circular questioning is helpful in building bridges between the “static” images of the Rorschach or a TAT card and the client’s real life problems. Depending on the clients’ age, several techniques can be employed. Children can be asked to complete the “fantasy animal drawing” (Handler, 2007) as a means to share personal information an reflect upon it in non threatening ways with the assessor. Such technique is described in detail elsewhere (with young children, see Smith & Handler, 2009, and Handler, 2012; with adolescents, see Toivakka, 2012). With adults, the assessor might use circular questioning to expand the meaning of a test response (i.e. TAT, card 13, “a young poor boy sitting in front of the empty house…”) by connecting information about the character’s perceived behaviors, feelings, emotions and meanings (“How did the boy feel when he started crying and the mother scolded him?”; “Where did he get the idea that expressing sad feelings were a sign of weekness?”). Afterwards, the assessor helps the client connect himself to the character in the story (i.e. “Do you see any connections between the main character of the story and yourself?”). This practice helps the client access new information that may lead to insight and help to answer the AQs.

**Building a secure relationship: Emotional attunement, collaborative comunication and repair of disruptions.**

Research on psychotherapy outcomes showed the ubiquitous effect of a secure, attuned and responsive relationship with the clinician as one building block for treatment success (Norcross, 2002). Infant researchers empirically demonstrated that the quality of the relation with the caregiver depends of three semi-independent processes: emotional attunement, collaborative communication and repair of distruptions (Tronick et al., 1998; Tronick, 2007, Threvarten, Aitken, Vandekerckhove, Delafield-Butt, & Nagy, 2006).

Intersubjective psychotherapy defined emotional attunement as the outcome of a complex process that allows the participants to feel reciprocal understanding and a sharing of mental states, aimed at soothing negative states and enhancing positive ones, eventually allowing the clients to better self-regulate emotional arousal and reflect on their inner states (Threvarten & Hubley, 1987). In TA, emotional attunement is promoted by the values endorsed by the assessor, the use of specific techniques, and the supervision/consultation relationship. Among the values that help clinicians to find emotional attunement with clients, *curiosity* and *humility* play a central role (Finn, 2007). The assessor’s *curious* attitude toward the clients helps to grasp “the client’s lived world and his way of travelling it” (Fischer, 1972, p. 367). Exploring with curiosity the ways clients have been able to cope with their struggles helps clinicians find authentic acknowledgement, admiration, and respect for clients’ adaptation strategies, yelding emotional attunement through a positive and benevolent view of their symptoms (Cecchin, 1987). Humility as an assessor aids emotional attunement and serves as a reminder that clients are “more simply human than otherwise” (Sullivan, 1953, p. 4). On these premises, TA assessors endeavor to “find their own versions of the struggles experienced by clients. They are humbled by how a clients’ struggles mirror their own and are also acutely aware that all of us are growing, struggling human beings, generally doing the best we can given our respective backgrounds and resources” (Tharinger, Gentry, & Finn, 2013, p. 390).

Emotional attunement accoimpained by the use of two specific techniques characteristic to promote a secure attachment relationship: collaborative communication and repair of disruptions (Siegel, 1999). “Contingent, collaborative communication – is … a fundamental component in how interpersonal relationships facilitate internal integration” (Siegel, 1999, p. 333). Besides including nonverbal communication patterns, verbal language and interactive rituals and narratives, collaborative communication in TA specifically connects to the use of tests. In fact, collaborative communication in TA incorporates the recursive shifts between face-to-face interactions and the side-by-side administration of tests, the “vocabulary” of the images and metaphors drawn from the testing, and the choice of wording that clients and clinicians come to use in understanding the answers to the AQs.

Repairing therapeutic impasses and disruptions to the therapeutic relationship is a core technique to psychological intervention and a large literature is devoted to it (e.g., Safran & Muran, 2000). Repair of disruptions helps the assessor restore emotional attunement and collaboration after the inevitable empathic breaks of an intimate relationship, such as that between assessor and client. As with mother–infant dyads, conjunction and disjunction dynamics in assessment prove to be messy and frought with the potential for “missteps, apologies, tries, retries, match ups, and missteps again” (Tronick & Beegly, 2011, p. 112). The crucial difference between healthy and critical attachment dyads are the repairing processes that follow disruptions in secure relating. The assessor processes and attempts to repair disruptions as soon as they emerge. TA produces many circumstances that have the potential to result in a disruption with the client. During the collection of AQs the assessor may inadvertently violate clients’ privacy by inquiring about certain areas of the client’s life (Wolberg, 1995), may re-state a client’s questions inaccurately, may miss the client’s signals of increased anxiety or discomfort and proceed with the interview. Following the administration of tests, clinicians may fail to accurately acknowledge the clients’ feelings of being exposed or may overwhelm the client by unwittingly exposing them to Level 3 information. During the summary and discussion session, the assessor may interpret the testing results in ways that hurt the client, may not task take the client’s perspective or feedback into account, or may fail to adequately process the ending of the assessment. With so many potential pitfalls in TA, the assessor pays close attention to nonverbal and verbal signs of emotional disruption and actively attempts to repair any disruptions. When the assessor deems it necessary to explore a potentially sensitive topic that falls outside of the scope of the clients’ AQs, which is the agreed upon contract for the TA, they may ask permission to do so and explain why such inquiry may be beneficial to the goals for the assessment. Assessors try to notice signals of discomfort as quickly as possible, pausing to dialogue with the client regarding the cause, and repairing a disruption if one occurred.

Concerning disruptions occurring as a result of standardized test administration, if the assessor realizes that the client felt exposed, a repair would involve allowing the client to describe their discomfort; the assessor would review the reasons for administering the test (i.e., how it contributes to answering the AQs); exploring how the clients could signal their discomfort earlier; and agreeing on a plan for the future to lessen the feeling of being exposed. When the assessor realizes that discussing a particular test result or answer to an AQ unexpectedly hurt the client, or was too great a shift from the current self view that it caused anxiety, a discussion of the disagreement and accompanying affect is encouraged and the assessor attempts to identify how the misstep occurred (e.g., misinterpretation of a test finding). If the assessor fails to process important relational aspects inherent to the disruption, it is often necessary to apologize and explain, simply and sincerely, how the assessor’s dynamics and affect interfered. Appreciating the client’s vulnerability during assessment, and perhaps in all forms of therapy, will help the assessor to pay close attention to their own contributions to empathic breaks. When the client experiences a sincere and complete repair from the assessor, a stronger alliance and more positive emotions toward the assessment typically result.

Finally, emotional attunement is facilitated in the supervisory/consultation relationship. Assessors hold a lot of information about the client during a AT, which necessitates simultaneusly processing the information. Supervision is the ideal venue for emotional support, particularly when working with a challenging clients, a client with a severe trauma history, or a client that triggers powerful countertransference in the assessor. Supervision also provides a situation for a cognitive-level of clarification when deciphering puzzling test results (Selicoff, 2006). At the same time, the involvement of the therapeutic assessor as a real person and the active use of emotional reactions and empathy to enhance clients’ the understanding can lead the assessor to a need to confront their own “blind spots” (Finn, 2007). In TA, supervision helps to differentiate between clients’ struggles and similar assessor issues, potentially elaborating the latter within the relationship with the supervisor; uses the test results gauge the quality of the assessor-client relationship; and it helps the assessor “see through” their countertransference and its effect on appriasals of the client to the test results.

**Modulating pathological shame**. There is growing recognition that shame is a primary mechansism in the development and maintenance of many forms of psychopathology. Shame is rooted in the consequences of interpersonal and social threats to self identity (Dickerson, Grunenwald, & Kemeny, 2004). The role of shame in psychopathology largely rests on the difference between primary emotions and secondary emotions. Primary emotions are primarily genetically-based responses that serve as adaptive indicators of environemental changes (Prinz, 2004). Secondary emotions, such as shame, result from the way the environment responds to the individual displaying primary emotions, such as fear and joy. For example, fear originates from a set of environmental (internal or external) changes that signal the emergence of a threat. Such signals trigger a set of behaviors and biological responses (e.g., heightened awareness and attention, fight-flight-freeze response of the sympathetic nervous system) that have evolved to return to safety. However, if during early development the infant perceives that the expression of fear actually treatens the attachment bond (i.e., the mother withdraws when the child expresses fear), over time the child becomes conditioned to suppress the awareness of somatosensorial reactions related to the emergence of fear, avoid situations that elicit a fear response, and/or repress or downplay the behavioral expression of fear (Fosha, 2001). By so doing, the child aims to reduce the risk of the mother’s withdrawal. As an adult, danger in the environment becomes underestimated and the associates sympathetic arousal in response to danger becomes blunted and the set of adaptive behavioral, emotional, and cognitive responses to danger are unavailable to the individual. When changes in the environment signal a potential treat, the dissociated state will be at risk of emerging but the conditionment will hold the dissociation in place.

In this framework, shame is an important aspect of the way the in which conditioning serves to quash the emergence of the dissociated state. The repeated experience of a mother's withdrawal, associated with the expression of fear and a less than optimal parenta response, results in the child repeatedly feeling shame about expressions involving fear. Over time, fear becomes a dissociated state such that the emotional experience is no longer available due to shame. Shame is triggered whenever changes in the environment activate the dissociated state. The painful experience of intense shame operates as a strong motivator in keeping the conditioned emotion dissociated. In this way, shame operates as a defense against the bigger treat of compromising the attachment relationship should the dissociated state be displayed. Since one of the main therapeutic goals in TA is to re-integrate client’s dissociated affect states, it becomes crucial to identify, address, and modulate shame, because of its machistic role in dissociation.

 Shame is identified during the interview process of TA and through testing. In the interviewing, the assessor pays close attention to interruptions in verbal and nonverbal connection with the client because these could be signals of the expression of shame (Dickerson, Grunenwald, & Kemeney, 2004). Covering the face, interrupting eye contact, becoming suddenly silent could signal that the client is approaching a disavowed emotional state and shame for feeling this way hinders the emergence of the affect state. In some cases, these behaviors relate to the emergence of cognitive self-representations or memories that the client feels are too shameful to share.

 Shame can also be directly or indirectly identified through standardized testing. It can directly emerge in a self-report test of self-esteem, self-worth, or pride, which a person with high levels of shame might feel to be internally “wrong” to feel. Shame also appears somewhat indirectly through testing. For example, when the validity scales of the MMPI-2 indicate that the clients are defensively presenting themselves in unrealistically good ways, the assessor might hypothesize that shame is one of the mechanisms motivating this presentation. Shame can also appear on performance-based tests results that suggest a dissociated affect state because shame often inhibits disavowed affect states from emerging.

 The TA model incorporates a number of strategies to manage and target shame. The aim is to convey to the client that dissociated affect states do not pose a threat to the therapeutic relationship, nor will the clinician reject the client. On the contrary, the assessor is there to support the client in getting nearer to affect that feels dangerous. The techniques used differ in the extent to which the assessor is personally involved in the communication. Whichever intervention against shame the assessor selects, the assessor should re-extablish direct eye contact with the client immediately following the intervention in order to break through the “interpersonal barrier” clients experience when shame is present (Fosha, 2001).

At the low end of the personal involvement by the assessor, shame is modulated by the assessor pointing out the universality of the dissociated emotional experience (Yalom & Leszcz, 2005). A client ashamed to cry when the assessor is present, of showing fragility or sensitivity, may feel validated when the assessor suggests that “it’s very normal to be protective of your sensitivity, and a number of my clients feel unease about the idea of crying in front of me, becasue they feel crying is a unacceptable reaction. Many messages and values whithin our culture send this message.” This technique can be extended to explore the reasons the clients feels shame about a specific emotional state. When the dissociated affect is tied to early childhood experiences, the assessor might say, “It’s very normal to be protective of your sensitivity, and a number of my clients feel unease about the idea of crying in front of me, becasue they feel crying is a unacceptable reaction, and I wonder if this is even harder for you after your father told you as a child that only weak children cry?”

In some cases, clients’ assumptions regarding what people may think of their dissociated affect requires a more interpersonal intervention to provide them with the corrective experience of a meaningful other (the assessor) who does not judge nor reinforce the reasons for feeling shame. For example, the assessor may ask the client to look carefully at his face to check whether the client perceives any signal of disdain, shame, or rejection while the assessor expresses that “it is perfectly normal to cry.” Checking the client’s “mind reading” can strentghen the assessor-client relationship as it represents a form of assessor self-disclosure (Safran & Muran, 2000).

At the high end of assessor personal involvement is direct self-disclosure. This may be the strongest intervention against shame. Self-disclosure, in general, refers to the sharing, deliberate or otherwise, of personal details from the therapist to the client. A good deal is written about therapist self-disclosure due to the clinical acumen required to use it effectively (Barrett & Berman, 2001; Kearns, 2007). In the TA model, the assessor uses self-disclosure to target clients’ shame and dissociated affect judiciously and with three caveats: (1) the previously exposure to the less “interpersonal” techniques (described previously) have not effectively conveyed to the client a sufficient sense of safety; (2) the self-disclosure needs to be short to avoiding switching attention from the clients’ issue to the assessor’s issues; and (3) the self-disclosure should refer to something that the assessor truly experienced in the past, and is currently resolved, to communicate both deep understanding of the clients’ struggle and convey them hope that it can be overcome. Assessors should not use this technique with a personal example that has not been sufficiently resolved.

 **Psychoeducation**. Psychoeducation is an approach that integrates and synergizes psychotherapeutic and educational intervention techniques (Lukens & McFarlane, 2004). Two common psychoeducational interventions are (a) providing information about the disease and the course of treatment to increase patients’ compliance (Mechanic, 1995), and (b) normalizing the experience of illness to reduce the patients’ sense of isolation (Pennix et al., 1999). Psychoeducation interventions in TA relate to a view of psychopathology as a expression of the ways individuals have learned to to adapt to problematic environments. A large body of research in various fields views psychological problems as adaptation to specific developmental histories (i.e. research on complex traumatic stress disorder, Curtois & Ford, 2009). Such research and writing, which are more positive than the psychiatric taxonomy of psychopathology, can be used when providing clients with information about their problem behaviours in order to help them better understand their struggles and the reasons for specific treatment suggestions. For example, with a young adult female struggling to find her way in life, the assessor might explain what current research shows about the effects of experience child abuse similar to the ones she experienced on young adult adaptation. The assessor could explain that the ability to develop fulfilling relationships with others is not fully developed and that there are problems with assertiveness (Curtois, 2008). Hearing this explanation could relieve the client from shame and a sense of inadequacy, providing a stong framework to develop a new and more compassionate self narrative.

In TA, psychoeducation is especially used during the summary and discussion session when the assessment findings are discussed with the client and a new understanding about the client’s problems is put forth in an organized manner. The assessor may also decide to use psychoeducation to reduce client’s sense of isolation and shame whenever a relevant topic is broached and additional information is needed to understand the phenomenon (i.e., in the previous example, information about the client’s difficulty in forming close relationship, about her lack of assertiveness, and about her childhood experiences of abuse). When an assessor educates the client about their struggles, and the recommended course of intervention, the information is presented according to Finn’s model of Level 1, Level 2 and Level 3 information.

It is intrinsic to the collaborative nature of the TA model that all recommendations for subsequent intervention be given at the end and discussed with the client, leaving open space for disagreement and for exploring potential anxiety and resistance. Further, TA provides the client with a structured and time-limited experience of what subsequent psychological intervention might be like. For example, clients with problems regulating anger might have tried to tell angry stories and role play situations that elicit anger with the assessor during the intervention session. Through this experience, by the end of the TA, clinicians and clients can refer to actual shared experiences and discuss the suitability of different treatment options that could be recommended.

**Techniques to foster emotion regulation capacity.** Emotion regulation typically refers to “how we try to influence which emotions we have, when we have them, and how we experience and express these emotions” (Gross, 2008, p. 497). Problems with emotional regulation can lead to rumination, brooding, and dwelling on maladaptative emotions (Mennin & Farach, 2007). Emotion regulation is a process that happens across time, from when the individual encounters a context that “triggers” the emotion, on to the point of its emergence and display, and finally the steps the client takes to manage its expression. During this process emotions can be regulated by (a) selecting contexts in which different emotions may arise (i.e., avoiding contexts that elicit negative emotions); (b) modifying the situation directly so as to influence the emotional response (i.e., telling a joke when an unexpected problem arise); (c) directing attention toward desireable aspects of a situation; (d) changing the cognitive meaning of the situation (i.e., shifting how one “reads” or “interprets” a marital conflict from a burden to an occasion to show to the partner one’s own care and attention); and (e) modulating the emotional response (i.e., leaving a situation before anger is expressed).

Avoidance, rumination, and suppression of emotion have been found to be associated with psychopathological outcomes, while problem solving, acceptance and reapprisal appear to promote adjustment and well being (Aldao, Nolen-Hoeksema, & Schweizer, 2010). Typically, when clients have problems in regulating emotions TA assessors intervene as soon as they identify this process, to avoid clients being re-traumatized by their own emotions (McCullogh et al., 2003). Therapeutic interventions should promote emotion recognition because failing to recognize emotions not only undermines their adaptive value, but also can have negative interpersonal consequences (Sloan & Kring, 2007; Suveg, Southam‐Gerow, Goodman, & Kendall, 2007; Adrian, Zeman, & Veits, 2011) and help decrease or manage negative emotion. Repeated exposure, relaxation techniques, and cognitive restructuring are prominent techniques for the management of negative affect (Sloan & Kring, 2007). Further, assessors want to facilitate and encourage the expression of problematic emotions so to create the potential for changing the meaning structures associated with them (Paivio & Greenberg, 1995; Whelton, 2004).

In TA, the intervention session is when the assessor most often intervenes with a client’s emotion regulation capactities. The assessor uses the case conceptualization to carefully plan the intervention session. The integration of observations and test results help the assessor to tailor the interventions to match the client’s “window of tolerance” (Siegel, 1999, p. 253), that is, the amount of emotional contact that can be achieved without causing disruption to the client’s meaning making activity. Armstrong (2012) provides an example of a tailored intervention to promote a traumatized woman’s assertiveness thought collaborative discussion of testing.

Depending on how the client may best be helped achieve the goals of the TA, the assessor provides occasions during the intervention session to develop emotion regulation skills concerning (1) the promotion of emotional awareness and allowing intersubjective emotional expression; (2) modulating emotional expression; and (3) mentalizing about the meaning of the emotional experience.

 Clients whose problems are mainly connected to a lack of emotional awareness or a suppression of emotional expression are generally those with large discrepancies on the degree of disturbance between self-report and performance based test results (Finn, 1996). In such cases, a TA assessor typically conducts an intervention aimed at allowing the client to get in touch with dissociated affect states through a derivation of prolonged exposure (Cloitre, Koenen, Cohen, & Han, 2002) or affect exposure (McCullough et al., 2003) by using visual and imaginatory stimuli. This approach is based on the postulation that negative emotion activates the ventromedial region of the right frontal cortex hemisphere (Davidson, Pizzagalli, Nitschke, & Putnam, 2002). Thus, the intervention sessions typically uses narrative activities (e.g., telling stories to thematic test cards) because the visual stimuli activates as well right hemisphere and subcortical areas of the brain involved in the processing of negative affect (Asari et al., 2008; Vuilleumier, 2005). Picture cards are selected based on the emotion the assessor is attempting to elicit. For example, eliciting sadness can be accomplished using cards 3GF, 3BM, and 13B from the Thematic Apperception Test (Murray, 1943/1971). Rorschach cards might be also be used to this end but are most useful when the client previously indicated that the image triggered the emotional. For example, if on Card I the client said, “This looks like a terrible darkness; like when you are lost and lonely,” the assessor might select this card to elicit sadness or hopelessness.

Depending the client’s level of emotional awareness and emotional expression, the assessor can opt to use up to four of the following specific intervention techniques, which can potentially build on one another in a hierarichcal sequence where the first techniques are the least emotionally arousing with increased intensity.

*Intervention 1: Storytelling using an emotionally arousing stimuli.*For some clients with an affect phobia (McCullogh et al., 2003), no matter the level of interpersonal support and emotional dyadic regulation provided by the assessor, verbalizing stories to clearly emotionally charged stimuli is very hard, if impossible in some situations. When a client struggles to formulate a storiy (i.e., strongly stutter, are confused and disorganized, suddenly shut down), the assessor ceases this part of the intervention and proceeds to help the client make sense of the difficulty. After allowing the client to share their experience of the task, the assessor may follow up by scaffolding a more effective story until the assessor and client are able to jointly formulate an version of the client’s difficulty in feeling and expressing the emotion elicits by the stimulus. This is done in service of relating the in-session process and experience to the answer to an AQ. Typically, a client with affect phobia adapted to challenging experiences, such as trauma, by developing affect-avoidance strategies. Oftentimes there is an avoidance of a single emotion (e.g., anger) or a set of related emotions (e.g., sadness, loss, hopelessness) but the phenomenon of avoidance of nearly all affect is possible and is typically described as someone with flat affect or a limited range of emotional expression. As indicated by Siegel (1999), suppression of emotion and emotional numbing is an extreme reaction to overwhelming emotional experiences faced without support. Affect avoidance as an adaptative process, which granted the individual psychological survival, cost the person the opportunity to develop the skills needed to effectively regulate emotion through behavior, cognition, and interpersonal connection.

Assessments often take place at a time when the client is caught between the status quo situation and an awareness that overcoming their problems in living requires acquiring the skills needed to express previously numbed emotions. Unfortunately, a client with affect phobia fears that expressing the avoided affect would result in retraumatization and exposure to pain and overwhelming fear. The exercise of exploring a client’s difficulty in telling a story to an emotionally arousing stimulus is effective with affect phobia because it provides a means to develop a coherent narrative, examine developmental antecedents to the actual problem, and reappraise the problems that led to the need for an assessment. Experientially, when clients realize that they can verbalise difficult emotions while the assessor remains present and supportive, integration of affect is more likely to occur.

*Intervention 2: Re-telling a story with congruent emotional content to the stimulus*. Some clients are capable of verbalizing stories to picture cards during the initial administration of the test (e.g., TAT) but the themes or emotional tones are incongruent with the emotional pull of the stimulus. This phenomenon is typically connected to the suppression of emotional awareness, deficits in the ability to detect ones own emotions or correctly recognize emotions in the displays of others, and can be a sign of the implicit defensive process of avoiding the disavowed affect. The client might miss or avoid the negative affect altogether or actively turn a negative emotion into a positive or hopeful outcome rather than acknowledging and sitting with the negative affect. This type of avoidance is common to PTSD, depression and borderline personality disorder (Gur et al., 1992). When the client’s stories do not match the emotional pull of the stimulus when first administered, the assessor may engage the client in taking a step back to observe the difference between the properties of the stimulus and the content of the stories. The assessor then proposes that the client try to formulate a new story with affect congruent to the pull of the stimulus. Re-administration is typically accompained by asking to the client to be attentive to and report on the physical sensations they experience during the re-telling of the stories. Physical sensations such as muscle tension, urge to flee, and clamminess are often indicative of the automated, rigid somatovisceral responses that clients typically experience when fearful, anxious, or tense (Roemer & Orsillo, 2005). Assessors might employ exercises like progressive muscle relaxation or guided visualization during the session to increase body flexibility and allow recognition of previously ignored psychosomatic states. Further, asking the client to role play the character of the stories or using Fosha’s (2005) portrayal technique may help the client to experience in vivo the integration and awareness of three fundamental elements of the targeted emotion: (1) the physiological response; (2) the behavioral response, including expressive elements (e.g., facial displays) and motor actions (e.g., physical escape, avoidance); and (3) the subjective response, including verbally mediated thought (Damasio, 2010).

*Intervention 3: Exploring differences between responses to different stimuli.* There are instances when the client is able to verbalize congruent affect to some of the stimuli presented but not to others. When this occurs, the assessor might engage in a reflective dialogue with the client concerning differences in the stilmulus that elicited or hindered the perception verbalization, and elaboration of specific affect states when telling stories. This process, in conjunction with the previous interventions discussed in this chapter, can help the client to integrate their emotional and representational affect states while identifying and working through contextual barriers to emotional awareness and display. Research suggests that treatment outcomes improve as the client becomes more are aware of and expresses emotion (Whelton, 2004). Further, the depth of in-session emotion processing also contributes to better outcomes (Diener, Hilsenroth, & Weinberger, 2007). Once the client begins to feel and express a previously dissociated, avoided, or numbed emotion, the assessor helps in the mentalizing process. This intervention is described in the section titled Mentalizing about the meaning of the emotional experience.

**Modulating emotional expression**. In a related vain to fostering emotional regulation is a set of techniques assessors can use to help the client to modulate emotional expression during a session. Interventions aimed at modulating emotional expression may or may not use testing material. Test-based interventions, as a part of an intervention session for example, might be used to alter the client’s focus of attention. Altering attention can be useful with clients whose standardized Rorschach protocols indicate emotional disregulation in the last three cards that feature color. This is the Affect Ratio score in the Comprehensive System (Exner, 2003) and the 8910% in the Rorschach Performance-Assessment System scoring (Meyer, Viglione, Mihura, Erard, & Erdberg, 2011). It is not uncommon for the assessor to witness a rapid deteriotation in emotion regulation as the client confronts the colored, more emotionally arousing cards of the test. Such dysregulation can take the form of reponses that vagure (percepts feature shapeless forms with no form demand, such as clouds, fire, or water), have poor form quality (in which the content do not match the blot contours), or feature formless determinants (pure color, pure shading).

A useful intervention involves the assessor re-administering cards 8, 9, and 10 of the Rorschach in black and white print (i.e., copying the cards in grayscale). This new stimulus often helps a client with affect regulation issues to produce a more definite, well fitting, and contour-based content when responding. When this occurs, the assessor helps the client see the difference between the two administrations and reflect on the factors that contributed to the difference. The client often realizes that the lack of bright colors was an important factor. The assessor attempts to connect this finding to the client’s everyday life –finding ways to “stick to the form” of emotionally arousing events and situations, so to speak, and recognize the affective arousal in order to use modulation strategies. Overton provides an example of how the Rorschach test can be used to train a severely overwhelmed client to see reality in a more simple and detached manner, preventing from being flooded by intrusive thoughts in her daily life as well (Overton, 2012).

The assessor can also help the client access healthier emotions during distressing situations by promoting a strategy referred to as *changing emotion with emotion* (Moses & Barlow, 2006). For example, the assessor helps the client access anger rather than sadness and despair before an important exam at the university. To accomplish this, the assessor first administers the Picture Frustration Study (PFS) (Rosenzweig, 1978) and observes how the client is in the position of the victim in frustrating situations and is therefore unable to assertively fight for her rights. This can lead to a discussion of why this happens and to connecting information about the client’s life experiences that reinforce this process. Afterwards, the assessor and client can role play one or more of the PFS scenes so that the client has the opportunity to get in contact with and express anger in a protected and supportive environment. This will help the client to translate learned strategies and responses to life outside the testing room.

Non-test-based interventions are usually helpful when the client becomes unpredictably dysregulated during a session. In that moment, the assessor selects an intervention on the basis of the clients’ specific needs, mindful of the strengths of the therapeutic alliance. For example, when a self-reliant client becomes dysregulated in the early phases of the TA, the assessor might use techniques from Dialectical Behavior Therapy (Linehan, 1993), which do not heavily rely on interpersonal contact and the alliance. When dysregulation occurs in session, distraction techniques might be used (Morrow & Nolen-Hoeksema, 1990). For example, if a client is flooded by sadness while formulating the AQs, the assessor may ask the client to describe the drawings on the carpet in the office in detail or to focus on the flowers on the desk and describe their number, shape, color, disposition, and so forth.

The ending of a session is moment when a client can become affectively overwhelmed. This is particularly possible when new information emerged during the session and was not properly elaborated and contained; therefore closing the session can stir up separation anxiety. The assessor should first reflect on their possible shortcomings in managing some aspects of the session and, if necessary, apologize to the client and devote time to managing the anxiety. In other cases, dysregulation has less to do with the assessor’s management of the session and more to do with the client’s separation anxiety. When this occurs, the assessor should not allow the client to leave the office in a dysregulated state and might employ distraction techniques. such as asking the client to describe plans for a pleasant activity he may be doing later that day, so to promote self-regulation capacity. If a client reports feeling dysregulated between sessions, self-soothing techniques are taught and the assessor normalizes the feeling of being “stirred up” by the testing and how it might be necessary for the client to develop a “safety toolbox” (Linehan, 1993). These self-help toolboxes typically include real objects that the clients can use to self-sooth at a perceptual and sensory level, like favorite foods, movies or music, soft or textured objects, and favorite perfumes or essences.

When a preoccupied or highly anxious client becomes dysregulated during a later session in the TA when the alliance is strong, interpersonal dyadic emotional regulation techniques are preferred (Fosha, 2001). Dyadic regulation occurs when the client and assessor

“remain engaged and oriented toward one another even when things get difficult. […] It means being motivated to maintain connection and communication […] without withdrawing into oneself and closing up or putting up a wall. Working on *explicit empathy* (i.e., saying “It’s painful for me to think about how you suffered”), f*ocusing on the patient’s experience of the therapist’s empathy, affectivity, and of the relational connection* (i.e., “What do you see when you look into my eyes?”) and *encouraging the awareness and experiential elaboration of receptive experiences, and their aftermath* (i.e., “How do you feel when you see how moved I am by what you are telling me?”, “What’s it like for you when you feel understood by me?”)” (Fosha, 2001, p.234).

These dyadic regulation skills allow the client-assessor dyad to maintain connection and emerge well regulated after the emotional crisis.

Self-help techniques for emotion regulation can be recommended at the end of the TA as part of the treatment plan. When this is done, the techniques the assessor suggests for emotion regulation are accompained by a rational for its use based on the testing results. For example, aerobic exercise has been shown to promote mental well-being and adaptive emotion regulation across various forms of psychopathologies (Stathopoulou, Powers, Berry, Smits, & Otto, 2006).

**Mentalizing about the meaning of the emotional experience**. Many therapeutic approaches tightly link emotional change to representational change. Literature on therapeutic change in cognitive behavioral therapies highlight the link between cognitive reapprisal and modification in representaional schemas, beliefs, and categories and a higher degree of effectiveness when clients experience their correspondent emotions in the session (Mennin & Farach, 2007). Mentalization-based treatments suggest that in order to promote change, emotional experience and expression need to be accompained by cognitive processing and reappraisal. Emotion-focused therapies demonstrated “that individuals whose cognitive processing is stuck in a “cold” propositional mode of mind (e.g., *conceptualizing/doing*) may benefit from learning to shift attentional resources to an incompatible processing mode (e.g., *mindful experiencing/being*) through “hot” schematic processing in order to facilitate beneficial meaning change (Greenberg & Safran, 1987; Teasdale, 1999)” (Mennin & Farach, 2007, p. 345). Hence, the change of meaning in therapy is directly connected to emotional awareness and to the degree to which clients change or accept the action tendencies associated with their emotions (Moses & Barlow, 2006; Greenberg, 2002).

Further, the TA assessor structures the session by first involving clients in “doing” (e.g., collecting AQs, administering tests, participating in controlled experiments to find aswers to the assessment questions, discussing the findings), accompanied by the client being helped to notice, experience, express, reflect upon the emerging emotions (e.g., pride for being able to formulate AQs, grief for failing a cogntive performance test, anger for discovering through an intervention session that previously idealized parents fell short in many ways, sadness and relief for hearing the test findings), and, finally, engaging the client in a conversation concerning the meaning of such emotions.

In particular, assessors help clients make sense by reflecting on the emotional experiences through “half steps” or “scaffolding” (discussed in the next section) of a more coherent personal narrative (Mahoney, 1991). In order to help a client mentalize about their experiences in the session, the assessor may work with them to draw connections between the “here and now” of the session and the client’s real life outside the assessment. For example, in the case of a client asking, “Why am I unable to have sex with my girlfriend?” the assessor may explore if he sees any connection between the “sad bat” he saw on Card V of the Rorschach and the way he experienced the loss of his mother as a way to start exploring the connection between the sadness he may be harboring about loss and abandonment of a loved one and his fear of entering into intimate relationships.

 When the assessor hypothesizes that a connection between an emotional state and the answer to an AQ is accessible to the client, the process of meaning-making directly links the testing with the client’s experiences. The assessor might say, “What might this experience teach us about the answer to your assessment question about ?”. For example, a couple argues around the husband’s lack of sensitivity for the wife’s sadness and fragility. If the testing and the assessment suggest that the husband is suppressing contact with these emotions because he feels he whould be overwhelmed by them, the couple might be encouraged to discuss how this process addresses their AQ pertaining to emotional support. This, in turn, could lead them to understanding the impact of the husband’s undiagnosed depression on the couples’ marital problems (see Finn, 2012b, for a detailed example of the use of the Consensus Rorschach to disentangle projective identification and promote mentalization in a couple Therapeutic Assessment)

**Conclusions**

In this chapter we reviewed the procedures of the TA model with adult clients, families with children and adolescents, and adult couples; illustrated each steps of TA using examples and theory; provided a review of the empirical research on CTA; and, unique to this chapter, is a description of the basic therapeutic processes and techniques used in the clinical practice of TA. Due to space limitations, our discussion focused on the application of these techniques with adult clients. However, we expect the reader will be able to readily apply these techniques in a nuanced and appropriate manner with other types of clients.

We would like to close this chapter by expressing optimism. With CTA models gaining empirical support, recognition, and even notoriety, the practice of psychological assessment is in the midst of a new and promising era; an era in which assessors are experts at both describing clients, prescribing treatments and making recommendations as well as helping clients in the therapeutic endeavor, irregardless of additional professional intervention. The somewhat inherent tension between the traditional aims of psychological assessment and the therapeutic goals of CTA requires a reflexive self-awareness on the part of the assessor. CTA practitioners simultaneously adhere to best practices in assessment and reflect on our role and influence on the results through the relational process in which assessent occurs. We are encouraged to acknowledge and appreciate the different narratives and discourses we encounter in our work with clients, which arise from the testing and in the intersubjective relationship. In the CTA framework, clients are actively involved in their own assessment and assessors are authentic co-creators in the task, leading to better outcomes for the clients and the professionals with whom we work.

**References**

**Ackerman, S. J., Hilsenroth, M. J., Baity, M. R., & Blagys, M. D. (2000).** Interaction of therapeutic process and alliance during psychological assessment. *Journal of Personality Assessment*, *75*, 82-109.

Adrian, M., Zeman, J., & Veits, G. (2011). Methodological implications of the affect revolution: A 35-year review of emotion regulation assessment in children. *Journal of experimental child psychology*, *110*(2), 171-197.

Aldao, A., Nolen-Hoeksema, S., & Schweizer, S. (2010). Emotion regulation strategies and psychopathology: A meta analysis. Clinical Psychology Review, 30, 217-237.

Amodio, D. M., & Frith, C. D. (2006). Meeting of minds: the medial frontal cortex and social cognition. *Nature Reviews Neuroscience*, *7*, 268–277.

Anderson, H., & Goolishan, H. (1992). The client is the expert: A not-knowing approach to therapy. In S. McNamee & K. J. Gergen (Eds.), *Therapy as social construction* (pp. 25-39)*.* Thousand Oaks: Sage.

Asari, T., Konishi, S., Jimura, K., Chikazoe, J., Nakamura, N. & Miyashita, Y. (2010). Amygdalar enlargement associated with unique perception, *Cortex*, *46*(1), 44-49.

Aschieri, F. (2012a). Epistemological and ethical challenges in standardized testing and collaborative assessment. *Journal of Humanistic Psychology*, *52*, 350–368.

Aschieri, F. (2012b). The conjoint Rorschach comprehensive system: Reliability and validity in clinical and non–clinical couples. *Journal of Personality Assessment*, *95*, 46–53.

Aschieri, F., & Smith, J. D. (2012). The effectiveness of therapeutic assessment with an adult client: A single–case study using a time–series design. *Journal of Personality Assessment*, *94*, 1–11.

Aschieri, F., Fantini, F., & Bertrando, P. (2012). Therapeutic assessment with children (TA-C): Psychological assessment as a family systems intervention. *Australian and New Zeland Journal of Family Therapy*, *33*, 285–298.

Armstrong, J. (2012). Therapeutic Assessment of a dissociating client: Learning internal navigation. In S. E. Finn., C. T. Fischer, & L. Handler (Eds.) *Collaborative/Therapeutic Assessment: A casebook and guide* (pp. 27-46). Hoboken, NJ: John Wiley & Sons.

Barone, D. F., Hutchings, P. S., Kimmel, H. J., Traub, H. L., Cooper, J. T., & Marshall, C. M. (2005). Increasing empathic accuracy through practice and feedback in a clinical interviewing course. *Journal of Social & Clinical Psychology*, *24*(2), 156–171.

Barrett, M. S., & Berman, J. S. (2001). Is psychotherapy more effective when therapists disclose information about themselves? Journal of Consulting and Clinical Psychology , 69 (4), 597-603.

Bombari, D., Schmid Mast, M., Brosch, T., & Sander, D. (2013). How interpersonal power affects empathic accuracy: Differential roles of mentalizing versus mirroring? *Frontiers in Human Neuroscience*, *7*, 1-6.

Brown, E. C. (1972). Assessment from a humanistic perspective. *Psychotherapy: Theory, Research, & Practice, 9,*103-106.

Brown, J. (1997). Circular questioning: An introductory guide. *Australian and New Zealand Journal of Family Therapy*, *18*(2), 109-114.

Byng-Hall, J. (1999). Family and couple therapy: Toward greater security. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 707–731). New York: Guilford Press.

Cecchin, G. (1987), Hypothesizing, Circularity, and Neutrality Revisited: An Invitation to Curiosity. *Family Process*, *26*, 405–413.

Chudzik, L., Aschieri, F. (2013). Clinical relationships with forensic clients: A three-dimensional model*. Aggression and Violent Behavior, 18*, 722-731.

Cloitre, M., Koenen, K. C., Cohen, L. R., & Han, H. (2002). Skills training in affective and interpersonal regulation followed by exposure: A phase-based treatment for PTSD related to childhood abuse. *Journal of Consulting and Clinical Psychology*, *70*, 1067 –1074.

Costantino, G., Cardalda, E. B., Dana, R. H., Martinez, J. V., Fantini, F., Aschieri, F., & Bevilacqua, P. (2011). TEMAS (Tell-Me-A-Story) Multicultural Assessment in the New Millennium. In R. G. Malgady (Ed.), *Cultural Competence in Assessment, Diagnosis, And Intervention With Ethnic Minorities: Some Perspectives from Psychology, Social Work, and  Education* (pp. 28-37). Sharjah: Bentham Science Publishers.

Costantino, G., Dana, R. H., & Malgady, R., (2007), *Tell-me-a-story assessment in multicultural societies.* Lawrence Erlbaum Associates, Mahwah.

Courtois, C. A. (2008). Complex trauma, complex reactions: Assessment and treatment. *Psychological Trauma: Theory, Research, Practice, and Policy*, *Vol S*(1), 86-100.

Courtois, C. A. & Ford, J. D. (Eds.). (2009). *Treating complex traumatic stress disorders: An evidence‐based guide*. New York: The Guilford Press.

Damasio, A. (2010). *Self Comes to Mind*. New York, New York: Pantheon.

Davidson, R. J., Pizzagalli, D., Nitschke, J. B., & Putnam, K. (2002). Depression: Perspectives from affective neuroscience. *Annual Review of Psychology*, *53*, 545 – 574.

De Saeger, H., Kamphuis, J. H., Finn, S.E., Smith, J. D., Verhuel, R., van Busschbach, J. J. V., Feenstra, D., & Horn, E. (2014). Therapeutic Assessment promotes treatment readiness but does not effect symptom change in patients with personality disorders: Findings from a randomized controlled trial. *Psychological Assessment,* 26(*2*), 474–483*.*

Dickerson, S. S., Gruenewald, T. L., & Kemeny, M. E. (2004). When the social self is threatened: Shame, physiology, and health. *Journal of Personality*, *72*(6), 1192-1216.

Diener, M. J., Hilsenroth, M. J., & Weinberger, J.  (2007). Therapist affect focus and patient outcomes in psychodynamic psychotherapy: A meta-analysis.  *American Journal of Psychiatry, 164,*936-941.

Exner, J. E. (2003). *The Rorschach: A comprehensive system* (4th ed.). New York, NY: Wiley.

Fantini, F., Aschieri, F., Bertrando, P. (2013). “Is Our Daughter Crazy or Bad?”: A Case Study of Therapeutic Assessment with Children. *Contemporary Family Therapy*, *35*, 731-744.

Finn, S. E. (1996). Assessment feedback integrating MMPI–2 and Rorschach findings. *Journal of Personality Assessment*, *67*(3), 543–557.

**Finn, S. E. (2003).** Therapeutic Assessment of a man with "ADD." Journal of Personality Assessment, 80, 115-129.

Finn, S. E. (2007). *In our clients’ shoes: Theory and techniques of Therapeutic Assessment*, Mahwah, NJ: Lawrence Erlbaum Associates.

Finn, S. E. (2012a). Implications of recent research in neurobiology for psychological assessment. *Journal of Personality Assessment*, *94*(5), 440–449.

Finn, S. E. (2012b). Therapeutic Assessment with a couple in crisis: Undoing problematic projective identification via consensus Rorschach. In S. E. Finn., C. T. Fischer, & L. Handler (Eds.) *Collaborative/Therapeutic Assessment: A casebook and guide* (pp. 379-400). Hoboken, NJ: John Wiley & Sons.

Finn, S. E., & Martin, H. (2013). Therapeutic assessment: Using psychological testing as brief therapy. In K. F. Geisinger, B. A. Bracken, J. F. Carlson, J. C. Hansen, N. R. Kuncel, S. P. Reise, M. C. Rodriguez (Eds.), *APA handbook of testing and assessment in psychology*, Vol. 2: Testing and assessment in clinical and counseling psychology (pp. 453-465). Washington, DC US: American Psychological Association.

**Finn, S. E., & Tonsager, S. E. (1992).** The therapeutic effects of providing MMPI-2 test feedback to college students awaiting psychotherapy. Psychological Assessment, 4, 278-287.

Finn, S. E., & Tonsager, M. E., (1997). Information-gathering and therapeutic models of assessment: Complementary paradigms. *Psychological Assessment*, *9*, 374-385.

Fischer, C. (1970). The testee as co-evaluator. *Journal of Counseling Psychology, 17*, 70-76.

Fischer, C. (1972). Paradigm changes which allow sharing of results. *Professional Psychology*, *3*, 364-369.

Fischer, C. (1973). Contextual approach to assessment. *Community Mental Health Journal*, 9, 38-45.

Fischer, C. (1985/1994). *Individualizing psychological assessment*. Monterey, CA: Brooks/Cole.

Fischer, C. T., & Finn, S. E. (2014). Developing the life meaning of psychological test data: Collaborative and therapeutic approaches. In Archer, R. P., & Smith. S. R. (Eds.), *Personality assessment, 2nd edition* (pp. 401-431). New York: Routledge.

Fosha, D. (2001). [The dyadic regulation of affect](http://www.aedpinstitute.org/wp-content/uploads/2013/04/Fosha_The_Dyadic_Regulation_of_Affect_2001.pdf). Journal of Clinical Psychology/In Session. 57 (2), 227-242.

Fosha, D. (2005). Emotion, true self, true other, core state: toward a clinical theory of affective change process. *Psychoanalytic Review*, *92*(4), 513-552.

Friedman, H. L., & MacDonald, D. A. (2006). Humanistic testing and assessment. *Journal of Humanistic Psychology*, *46*, 510-530.

Fulmer, R. H., Cohen, S., & Monaco, G. (1985). Using psychological assessment in structural family therapy. *Journal of Learning Disabilities*, *18*, 145–150.

George, C., & West, M. L. (2012). *The Adult Attachment Projective Picture System: Attachment theory and assessment in adults*. New York, NY: Guilford Press.

Greenberg, L. S. (2002). *Emotion-focused therapy: Coaching clients* *to work through their feelings*. Washington, DC: American Psychological Association.

Greenberg, L. S., & Safran, J. D. (1987). *Emotion in psychotherapy: Affect, cognition, and the process of change*. New York: Guilford Press.

Gross, J. J. (2008). Emotion regulation. In M. Lewis, J. M. Haviland-Jones, and L.F. Barrett (Eds.), *Handbook of emotions* (3rd ed) (pp. 497-512). New York, NY: Guilford.

Gur, R. C., Erwin, R. J., Gur, R. E., Zwil, A. S., Heimberg, C., Kraemer, H. C., et al. (1992). Facial emotional discrimination: II. Behavioral findings in depression. *Psychiatry* *Research*, *42*, 241– 251.

Handler, L. (2007) The use of therapeutic assessment with children and adolescents. In S. R. Smith and L. Handler (Eds.), *The clinical assessment of children and adolescents* (pp. 53-72). Mahwah, NJ: Erlbaum.

Handler, L. (2012). Collaborative storytelling with children: An unruly six-years-old boy. In S. E. Finn., C. T. Fischer, & L. Handler (Eds.) *Collaborative/Therapeutic Assessment: A casebook and guide* (pp. 243-268). Hoboken, NJ: John Wiley & Sons.

Hanson, W. E.; Poston, J. M. (2011). Building confidence in psychological assessment as a therapeutic intervention: An empirically based reply to Lilienfeld, Garb, and Wood (2011). *Psychological Assessment*, *23*(4), 1056-1062.

Hilsenroth, M. J., Peters, E. J., & Ackerman, S. J. (2004). The development of therapeutic alliance during psychology assessment: Patient and therapist perspectives across treatment. *Journal of Personality Assessment*, *83*, 331-344.

Kassett, J., Bonanno, G., & Notarius, C. (2004). Affective scaffolding: a process measure for psychotherapy with children, *Journal of Infant, Child and Adolescent Psychotherapy*, *3*(1), 92-119.

Kearns, A. (2007). *The mirror crack’d: When good enough therapy goes wrong and other cautionary tales*. Karnac Books: London.

Kohut, H. (1971) *The Analysis of the Self.* New York: International Universities Press.

Kohut, H. (1977). *The Restoration of the Self.* New York: International Universities Press.

Kohut, H. (1982). Introspection, empathy, and mental health, *International Journal of Psychoanalysis*, *63*, 395-408.

Kohut, H. (1984). *How does analysis cure?* Chicago, IL: University of Chicago Press.

Linehan, M. M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.

Little, J. A., & Smith, S. R. (2008). *Collaborative assessment, supportive therapy, or treatment as usual: An analisys of ultra-brief individualized intervention with psychiatric impatients*. Paper presented at the Society for Personality Assessment Annual Meeting, Chicago, IL.

**Lukens, E.**, & McFarlane, W. (2004). Psychoeducation as evidence-based practice: Considerations for practice, research and policy. Journal of Brief Practice & Crisis Intervention, 4, 205-225.

Mahoney, M. J. (1991). *Human change processes: The scientific foundations of psychotherapy*. New York: Basic Books.

McAdams, D. P., & Olson, B. D. (2010). Personality development: Continuity and change. In S. Fiske, D. Schacter, and R. Sternberg (Eds.), *Annual review of psychology,* Vol. 61 (pp. 517-542). Palo Alto, CA: Annual Reviews, Inc.

McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., & Hurley C. (2003). *Treating Affect Phobia: a Manual for Short-Term Dynamic Psychotherapy*. New York: The Guilford Press.

Mechanic, D. (1995). Sociological dimensions of illness behavior. *Social Science and Medicine, 41,* 1207–1216.

Meier, S.T., & Davis, S. (2008). *The elements of counseling* (6th ed.). Pacific Grove, CA: Wadsworth.

Mennin, D. S., & Farach, F. J. (2007). Emotion and evolving treatments for adult psychopathology. *Clinical Psychology: Science and Practice*, *14*, 329−352.

Meyer, G. J., Viglione, D. J., Mihura, J. L., Erard, R. E., & Erdberg, P. (2011). *Rorschach Performance Assessment System: Administration, Coding, Interpretation, and Technical Manual.* Toledo, OH: Rorschach Performance Assessment System.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford.

Morey, L. C., Lowmaster, S. E., & Hopwood, C. J. (2010). A pilot study of manual-assisted cognitive therapy with a therapeutic assessment augmentation for borderline personality disorder. *Psychiatry Research*, 178, 531-535.

Morrow, J., & Nolen-Hoeksema, S. (1990). Effects of responses to depression on the remediation of depressive affect. *Journal of Personality and Social Psychology*, *58*, 519-527.

Moses, E. B, & Barlow, D. H. (2006). A new unified treatment approach for emotional disorders based on emotion science. *Current Directions in Psychological Science*, *15*, 146– 150.

Muntigl, P. (2004)*.* Ontogenesis in Narrative Therapy: A Linguistic-Semiotic Examination of Client Change. *Family Process*, *43*, 109–131.

Murray, H. A. (1971). *Thematic apperception test. Manual.* Cambridge, MA: Harvard University Press. (Original work published 1943).

**Newman, M. L., & Greenway, P. (1997).** Therapeutic effects of providing MMPI-2 test feedback to clients at a university counseling service. Psychological Assessment, 9, 122-131.

Norcross, J. C. (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. Oxford University Press.

Othmer, E., & Othmer, S. C. (2002). *The clinical interview using* DSM-IV-TR: *Vol 1*: *Fundamentals*. Washington, DC: American Psychiatric Publishing.

Ougrin, D., Ng, A. V., & Low, J. (2008). Therapeutic assessment based on cognitive-analytic therapy for young people presenting with self-harm: Pilot study. *Psychiatric Bulletin*, 32, 423-426.

Ougrin, D., Zundel, T., Kryiakopoulos, Banarsee, R., Stahl, D., & Taylor, E. (2012). Adolescents with suicidal and nonsuicidal self-harm: Clinical characteristics and response to therapeutic assessment. *Psychological Assessment, 24*(1), 11-20.

Overton, C. G. (2012). Therapeutic Assessment of severe abuse: A woman living with her past. In S. E. Finn., C. T. Fischer, & L. Handler (Eds.) *Collaborative/Therapeutic Assessment: A casebook and guide* (pp. 199-222). Hoboken, NJ: John Wiley & Sons.

Paivio, S. C., & Greenberg, L. S. (1995). Resolving “unfinished business”: Efficacy of experiential therapy using empty-chair dialogue. *Journal of Consulting and Clinical Psychology*, *63*, 419– 425.

Penninx, B. W., van Tilburg, T., Kriegsman, D. M., Boeke, A. J., Deeg, D. J., & van Eijk, J. T. (1999). Social network, social support, and loneliness in older persons with different chronic diseases. *Journal of Aging and Health, 11,* 151–168

Poston, J. M., & Hanson, W. E. (2010). Meta-analysis of psychological assessment as a therapeutic intervention*. Psychological Assessment*, *22*, 203-212.

Prinz, J. (2004). Which Emotions Are Basic? In D. Evans and P. Cruse (Eds.),  *Emotion, Evolution, and Rationality* (pp. 1-19). Oxford University Press.

Ramey, H., Tarulli, D., Frijters, J., & Fisher, L. (2009). A sequential analysis of externalizing in narrative therapy with children. *Contemporary Family Therapy*, *31*(4), 262–279.

**Reynolds, C.R. & Kamphaus, R.W. (2002). *The clinicians guide to the behavior assessment of children*. New York: Guilford Press.**

Roemer, L., & Orsillo, S. M. (2005). An acceptance-based behavior therapy for generalized anxiety disorder. In S. M. Orsillo & L. Roemer (Eds.), *Acceptance and mindfulness-based approaches to anxiety: Conceptualization and treatment* (pp. 213–240). NewYork: Springer.

Rogers, C. R. (1951). *Client-centered therapy*. Boston: Houghton Mifflin.

Rogers, C. R. (1961). *On becoming a person*. Boston: Houghton Mifflin.

Rogers, C. R. (1980). *A way of being*. Boston: Houghton Mifflin.

Rorschach, H. (1921/1942). *Psychodiagnostics* (5 ed.). Berne, Switzerland: Verlag Hans Huber (Original work published 1921).

Rosenzweig, S., (1978). *The Rosenzweig Picture Frustration Study (P-F Study)*. St. Louis: Rana Houge.

Safran, J.D. &  Muran, J.C. (2000). Negotiating the therapeutic alliance: A relational treatment guide. New York: Guilford.

Schroeder, D. G., Hahn, E. D., Finn, S. E., & Swann, W. B., Jr. (1993, June). *Personality feedback has more impact when mildly discrepant from self views*. Paper presented at the fifth annual convention of the American Psychological Society, Chicago, IL.

Selicoff, H. (2006). Looking for good supervision: A fit between collaborative and hierarchical methods. *Journal of Systemic Therapies*, *25*(1), 37–51.

Selvini Palazzoli, M., Boscolo, L., Cecchin, G., & Prata, G., (1980), Hypothesizing — Circularity — Neutrality: Three Guidelines for the Conductor of the Session, *Family Process*, *19*, 3-12.

Shea, S. C. (1998). *Psychiatric interviewing: The art of understanding* (2nd ed.). Philadelphia: Saunders.

Siegel, D.J. (1999). The developing mind: Toward a neurobiology of interpersonal experience. New York: Guilford Press.

Sloan, D. & Kring, A. M. (2007). Measuring changes in emotion during psychotherapy: Conceptual and methodological issues. Clinical Psychology: Science and Practice, 14, 307-322.

Smith, J.D., Eichler, W., Norman, K., Smith, S.R. (in press). Effectiveness of a therapeutic model of assessment for psychotherapy consultation: A replicated single-case study. *Journal of Personality Assessment.*

Smith, J.D., & Finn, S.E. (2014). Integration and therapeutic presentation of multimethod assessment results: Empirically supported guiding framework and case example. In C.J. Hopwood & R.F. Bornstein (Eds.), *Multimethod clinical assessment of personality and psychopathology* (pp. 403–425)*.* New York, NY: Guilford Press.

Smith, J.D. & George, C. (2012). Therapeutic Assessment case study: Treatment of a woman diagnosed with metastatic cancer and attachment trauma. *Journal of Personality Assessment,* 94(*4*), 331–344.

Smith, J. D., & Handler, L. (2009). “Why do I get in trouble so much?”: A family Therapeutic Assessment case study. *Journal of personality assessment*, *91*(3), 197-210.

Smith, J.D., Handler, L., & Nash, M.R. (2010). Therapeutic Assessment for preadolescent boys with oppositional defiant disorder: A replicated single-case time-series design. *Psychological Assessment*, 22(*3*), 593–602.

Smith, J.D., Nicholas, C.R.N., Handler, L., & Nash, M.R. (2011). Examining the clinical effectiveness of a family intervention session in Therapeutic Assessment: A single-case experiment*. Journal of Personality Assessment,* 93*(3),* 204–212.

Smith, J.D., Wolf, N.J., Handler, L., & Nash, M.R. (2009). Testing the effectiveness of family Therapeutic Assessment: A case study using a time-series design*.* *Journal of Personality Assessment,* 91(*6*), 518–536.

Spunt, R. P., Satpute, A. B., & Lieberman, M. D. (2011). Identifying the what, why, and how of an observed action: an fMRI study of mentalizing and mechanizing during action observation. *Journal of Cognitive Neuroscience, 23*, 63–74.

Stathopoulou, G., Powers, M. B., Berry, A. C., Smits, J. A. J., & Otto, M. W. (2006). Exercise interventions for mental health: A quantitative and qualitative review. *Clinical Psy- chology: Science and Practice*, *13*, 179 –193.

Strupp, H. H., & Binder, J. L. (1984). *Psychotherapy in a new key*. New York: Basic Books.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. New York: Norton.

Suveg, C., Southam‐Gerow, M. A., Goodman, K. L., & Kendall, P. C. (2007). The role of emotion theory and research in child therapy development. *Clinical Psychology: Science and Practice*, *14*(4), 358-371.

Swann, W. B., Jr. (1997). The trouble with change: Self-verification and allegiance to the self*. Psychological Science, 8*, 177-180.

Swann, W. B., Jr., Wenzlaff, R. M., Krull, D. S., & Pelham, B. W. (1992). The allure of negative feedback: Self-verification strivings among depressed persons. *Journal of Abnormal Psychology, 101*, 293-306.

Tarocchi A., Aschieri, F., Fantini, F., & Smith, J. D. (2013). Therapeutic Assessment of complex trauma: A single-case time-series study. *Clinical Case Studies, 12*(3)*,* 228-245.

Teasdale, J. D. (1999). Emotional processing, three modes of mind, and the prevention of relapse in depression. *Behaviour* *Research and Therapy*, *37*, S53 – S78.

Teixeira de Melo, A., & Alarcao, M. (2011). Integrated family assessment and intervention model: A collaborative approach to support multi-challenged families. *Contemporary Family Therapy*, *33*(4), 400–416.

Tharinger, D. J., Finn, S. E., Arora, P., Judd-Glossy, L., Ihorn, S. M. & Wan, J. T. (2012). Therapeutic Assessment with children: Intervening with parents “behind the mirror”. *Journal of Personality Assessment*, *94*, 111–123.

**Tharinger, D.J., Finn, S.E., Austin, C., Gentry, L, Bailey, E., Parton, V., & Fisher, M. (2008).** Family sessions in psychological assessment with children: Goals, techniques, and clinical utility. Journal of Personality Assessment, 90, 547-558.

**Tharinger, D.J., Finn, S.E., Gentry, L., Hamilton, A., Fowler, J., Matson, M., Krumholz, L., & Walkowiak, J.** (2009). Therapeutic Assessment with children: A pilot study of treatment acceptability and outcome. Journal of Personality Assessment, *91*(3), 238-244.

**Tharinger, D.J., Finn, S.E., Hersh, B., Wilkinson, A., Chistopher, G., & Tran, A. (2008).** Assessment feedback with parents and children: A collaborative approach. Professional Psychology: Research and Practice, 39, 600-609.

**Tharinger, D. J., Finn, S. E., Wilkinson, A. D., DeHay, T., Parton, V., Bailey, E., & Tran, A. (2008).** Providing psychological assessment feedback with children through individualized fables. Professional Psychology: Research and Practice, 39, 610-618.

Tharinger, D. J., Finn, S. E., Wilkinson, A. D., & Schaber, P. M. (2007). Therapeutic Assessment with a child as a family intervention: Clinical protocol and a research case study. *Psychology in the Schools, 44*, 209–293.

Tharinger, D. J., ,Gentry, L. B., & Finn, S. E. (2013). Therapeutic Assessment with Adolescents and Their Parents: A Comprehensive Model. In D. Sakllofske & V, Schwean (Eds.), *Oxford Press handbook of psychological assessment of children and adolescents* (pp. 385-420). New York: Oxford University Press.

**Tharinger, D. J., Krumholz, L. S., Austin, C. A., & Matson, M. (2011).** The development and model of Therapeutic Assessment with children: Application to school-based assessment. In Bray, M. A. & Kehle, T. J. (Eds), Oxford Press Handbook of School Psychology (pp. 224-259). Oxford University Press.

Tharinger, D. J., & Pilgrim, S. (2012). Parent and child experiences of neuropsychological assessment as a function of child feedback by individualized fable. *Child Neuropsychology: A Journal on Normal and Abnormal Development in Childhood and Adolescence*, *18*(3), 228–241.

Threvarten, C., & Hubley, P. (1978). Secondary Intersubjectivity: Confidence, confiding and acts of meaning in the first year. In A. Lock (Ed.), *Action, Gesture and Symbol*, (pp. 183-229). London: Academic Press.

Toivakka, H. (2012). Collaborative assessment on an adolescent psychiatric ward: A psychotic teenage girl. In S. E. Finn., C. T. Fischer, & L. Handler (Eds.) *Collaborative/Therapeutic Assessment: A casebook and guide* (pp. 335-354). Hoboken, NJ: John Wiley & Sons.

Tomm, K. (1988). Interventive Interviewing: Part III. Intending to Ask Lineal, Circular, Strategic, or Reflexive Questions? *Family Process*, *27*, 1-15.

Trevarthen, C., Aitken, K. J., Vandekerckhove, M., Delafield-Butt, J., & Nagy, E. (2006). Collaborative regulations of vitality in early childhood: Stress in intimate relationships and postnatal psychopathology. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychopathology: Vol. 2. Development neuroscience* (pp. 65-126). New York, NY: Wiley.

Tronick, E. (2007). *The neurobehavioral and social-emotional development of infants and children*. WW Norton & Company.

Tronick, E. Z., Bruschweiler-Stern, N., Harrison, A. M., Lyons-Ruth, K., Morgan, A. C., Nahum, J. P., ... & Stern, D. N. (1998). Dyadically expanded states of consciousness and the process of therapeutic change. *Infant mental health journal*, *19*(3), 290-299.

Tronick, E., & Beeghly, M. (2011). Infants' meaning-making and the development of mental health problems. *American Psychologist*, 66, 107-119.

Vuilleumier, P. (2005). How brains beware: neural mechanisms of emotional attention. *Trends in Cognitive Sciences*, *9*, 585–594.

Vygotsky, L. S. (1987). Thinking and speech (N. Minick, Trans.). In R. W. Rieber & A. S. Carton (Eds.), *The collected works of L. S. Vygotsky: Vol. 1. Problems of general psychology* (pp. 39‐285). New York: Plenum Press. (Original work published 1934)

Whelton, W. J. (2004). Emotional processes in psychotherapy: Evidence across therapeutic modalities. *Clinical Psychology* *and Psychotherapy*, *11*, 58 – 67.

Wolberg, L. R. (1995). *The technique of psychotherapy*. (4th Rev. ed.). New York: Grune & Stratton.

Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.

Zaki, J., & Ochsner, K. (2012). The neuroscience of empathy: progress, pitfalls and promise. *Nature Neuroscience, 15*, 675–680.

*Figure 1: Flow chart of Therapeutic Assessment with adult clients, families and couples*

Couple summary and discussion session

Drafting and sharing a fable forthe child

Summary and discussion session with parents

Family intervention session

Individual summary and discussion session

Individual intervention session

with partner B

Individual intervention session with partner A

Standardized test administration and Extended Inquiry with partner B

Standardized test administration and Extended Inquiry with partner A

Family intervention session

Individual intervention session with adolecent

Standardized test administration and Extended Inquiry with the adolescent

Individual intervention session

INTERVENTION SESSIONS

Standardized test administration and Extended Inquiry

STANDARDIZED TESTING SESSIONS

Standardized test administration and Extended Inquiry child (parents observe behind the one-way mirror)

Collection of background information with parents

Collection of individual assessment questions with parner B

Collection of individual assessment questions with parner A

Collection of couples’ assessment questions

Collection of assessment questions with adolescent

Collection of parents’ assessment questions (adolescent attends the session)

Family session with eventual questions from child

Collection of parents’ assessment questions

Collection of individualassessment questions

INITIAL SESSIONS

Couples

Family w. adolescents

Family w. children

Couple intervention session

Individual summary and discussion session with adolescent

Family summary and discussion session (adolescent can attend)

Therapeutic Assessment Flow Chart

Adult

SUMMARY AND DISCUSSION SESSIONS

Feedback letter(s)

Follow up session