

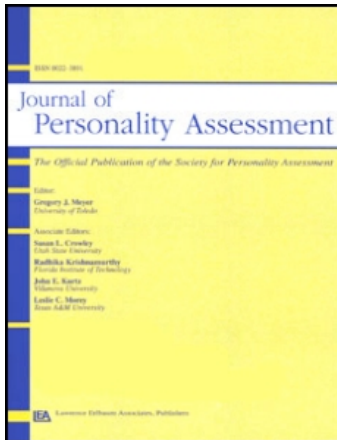
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CLINICAL CASE APPLICATIONS

“Why Won’t My Parents Help Me?”: Therapeutic Assessment of a Child and Her Family

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We present a case study of a child’s psychological assessment using the methods of Therapeutic Assessment (TA). The case illustrates how TA can help assessors understand the process and structure of a family by highlighting how maladaptive family processes and interactions impact a child’s development. It also illustrates how TA with a child can serve as a family intervention. In this case, it became apparent that the child’s social difficulties were significant, not minor as initially reported by the parents, and were rooted in an insecure attachment, underlying depression, an idiosyncratic view of the world, and longing for attention, all of which were hidden or expressed in grandiose, expansive, and off-putting behaviors. In addition, the familial hierarchy was inverted; the parents felt ineffective and the child felt too powerful, leading to enhanced anxiety for the child. Intervention throughout, punctuated by the family session and feedback sessions, allowed the parents to develop a new “story” about their child and for the child to experience a new sense of safety. Following the TA, the parents and child indicated high satisfaction, enhanced family functioning, and decreased child symptomatology. Subsequent family therapy sessions allowed the family to further implement the interventions introduced in the TA.

Therapeutic Assessment (TA) is a semistructured form of collaborative psychological assessment that is described in a series of publications by Finn (1996a, 1996b, 1998, 2003, 2007) and colleagues (Finn & Kamphuis, 2006; Finn & Martin, 1997; Finn & Tonsager, 1997, 2002). TA with children has been practiced for many years (Finn, 1997, 2007) and has been described recently by Tharinger, Finn, and members of the Therapeutic Assessment Project (TAP) at the University of Texas have written about the overall model of TA with children (Finn, 2007; Tharinger, Finn, Wilkinson & Schaber, 2007; Tharinger & Roberts, in press), the efficacy of TA with children (Tharinger, Finn, Gentry, et al., in press), providing parent feedback (Tharinger, Finn, Hersh, et al., 2008), providing child feedback through individualized fables (Tharinger, Finn, Wilkinson, et al., 2008), and utilizing family intervention sessions in TA (Tharinger, Finn, Austin, et al., 2008). This article is the first complete case study using TA with a child and family.

THERAPEUTIC ASSESSMENT WITH CHILDREN

Child-focused TA begins with an interview with the parents and/or caregivers to learn more about their presenting concerns. The child’s parents are invited to generate questions about their child, their family, and themselves to guide the focus of the assessment. Parents are also given the opportunity to invite other significant caregivers of the child (e.g., grandparents) to take part in the initial interview and to pose questions of their own. As

each question is gathered, the assessor then collects background information relevant to the question, always connecting requests for more information to the parents’ agenda for the assessment. In the second session, the parents are supported in introducing the assessment to the child. The child is also given the opportunity to generate his or her own questions during this session. Children are first invited to pose questions with their parents present and are then given the opportunity to add to those questions after their parents have left the room. This session with the child also typically involves unstructured, relationship-building activities such as human figure drawings and free play.

Subsequent assessment sessions, usually three to six in number, consist of assessment activities individualized for that child and family based on the specific assessment questions generated in the first two sessions. Additional assessment questions can be generated in these sessions. Assessment activities can include cognitive and academic testing, self-report measures, and performance-based personality testing. Typically, each of the child-focused sessions also includes free play to assess the child’s play and to allow the child to destress from the assessment activities.

A unique feature of TA with children that likely strengthens its intervention potential involves inviting parents to observe some or all of their child’s testing sessions. In clinical practice, parents often sit in the corner of the office (typically behind their child) to observe and then discuss their observations and reactions with the assessor after the session. When available, parents can observe from another room through a video link or from behind a one-way mirror. Children are always told beforehand that their parents are observing and listening. The opportunity for parents to observe and discuss their reactions

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is thought to affect the process and outcome of the therapeutic assessment in significant ways (Tharinger et al., 2007). For example, when parents are given the opportunity to watch their child's testing, it can foster their curiosity about their child, engage parents as active participants, demystify psychological assessment, and educate them about psychological tests and the assessment process. Furthermore, by discussing parents' perceptions of the testing sessions, the assessor can help them discover answers to their questions about their child and can help them begin to shift their "story" about why their child has problems. The assessor emotionally supports the parents as they reach new understandings or confirm their existing beliefs about their child. This process also allows the assessor to ascertain parental readiness and resources for change, thus informing the subsequent sessions involving the parents including a family assessment session and feedback sessions. As mentioned by Tharinger et al. (2007), most young children willingly accept their parents observing the assessment, and many of them use the setup to communicate to their parents either directly or through some of their test responses.

When parents pose questions about themselves during the assessment, such as wondering if their parenting style or emotional states may affect their child, they are invited to participate in personality testing themselves. Results of such testing are then integrated into discussions of the child's needs at the end of the assessment. Following the formal testing sessions and development of an initial case formulation, child-focused TA includes a family session. During this family session, the assessor creates an opportunity for the family to interact with one another in a novel way through an individualized therapeutic activity such as child-centered play or family sculpting (Tharinger, Finn, Austin, et al., 2008).

Next, a session is conducted in which the assessment findings and recommendations are summarized and discussed collaboratively with the child's parents (Tharinger, Finn, Hersh, et al., 2008). In a subsequent session, usually the following week, developmentally appropriate findings are presented to the child who is typically accompanied by his or her parents. Findings are generally adapted for children by constructing an individualized fable that illustrates a key piece of the assessment results and presents a new solution for problems that have existed within the family (Tharinger, Finn, Wilkinson, et al., 2008). Finally, a written letter summarizing the findings and recommendations is sent to the parents.

In this case study, we present the TA of Rachel and her family.¹ We also include data on satisfaction, symptom reduction, family functioning, and the family's sense of what they learned from the TA. In addition, we briefly discuss six family intervention sessions conducted with the family after the TA was completed. Intervention sessions are not standard TA practice but were included in this case to explore the feasibility and impact of a brief intervention following TA.

CASE STUDY—RACHEL AND HER FAMILY

At the time of the TA, Rachel was an 8-year-old Euro-American female who lived with her biological mother, father, and 14-year-old sister, Rebecca. They were of high socioeconomic status. We came to work with Rachel and her family

after Sherry, her mother, called a local child guidance center seeking group counseling for Rachel to help with her social difficulties. After the center notified Rachel's family of the opportunity to participate in TAP, Sherry called D. J. Tharinger to receive more information. Sherry reported that her daughter, Rachel, had trouble maintaining relationships with other girls due to what Sherry perceived as bossiness. Sherry was sent an information sheet about TAP to review with her husband, Aaron, and D. J. Tharinger encouraged both of them to think of questions that they would like answered through the assessment.² The parents were asked to come to the first meeting at our university-based clinic with Rachel to complete informed consent and assent procedures and pre-TA measures. Although TA can be conducted by a single assessor, which is typically the case in clinical practice, we utilized a three-person assessment team composed of three advanced doctoral students, A. M. Hamilton (Amy), J. L. Fowler (Johnathan), and B. Hersh (Brooke), who rotated working with Rachel and her parents in conducting assessment activities. The assessment team was supervised by S. E. Finn and D. J. Tharinger.

A research team consisting of two doctoral students collected research data from the family (independent of the TA activities) prior to the beginning of the assessment, immediately following each assessment session, and a week after the completion of the assessment. The assessment team was not privy to the research findings. One of the research team members, C. A. Austin, played with Rachel in a child care capacity when the assessment team worked just with her parents. All assessment activities took place in a room with an attached observation room, separated by a one-way mirror. The parents observed most of the assessment sessions conducted with their daughter from behind the mirror; a video camera also recorded each session from behind the mirror for research purposes. The child and parents were given a tour of this setup prior to beginning the research and assessment activities and all were aware of the taping and direct observation. When one assessment team member worked with Rachel, the other two sat behind the mirror observing and discussing the session with the parents.

First Session

We found Rachel's parents to be quite enthusiastic about participating in the assessment. They described Rachel as extremely bright and energetic but said that at times her behavior seemed out of control and was embarrassing. Sherry told us that she called Rachel her "gusto girl" and told stories of Rachel's enthusiasm in school and at home. When Sherry talked about her daughter, she described Rachel's behaviors as both endearing and exhausting, and she seemed confused about whether these behaviors were healthy or pathological. Sherry and Aaron also shifted back and forth between a description of Rachel's problem behaviors and the ever-present conflict between Rachel and Rebecca.

Initially, Sherry and Aaron were most concerned about Rachel's social skills, self-expression, and level of maturity. They wondered about the dynamics of her peer relationships and her constant need to be in control. Sherry and Aaron also conveyed the desire for Rachel to feel comfortable and confident

¹All names have been changed to protect client confidentiality.

²A sample information sheet such as might be used in clinical practice is available from S. E. Finn at sefinn@mail.utexas.edu.

TABLE 1.—Parent assessment questions.

1. Why does Rachel gravitate toward boys and why is she competitive around girls?
2. Why does she need so much attention and need to be the best?
3. What things would she like to be different about her family and how does she feel about her family compared to others?
4. When she expresses herself emotionally, how much is real stress and how much is dramatics? Why does she start acting silly when she gets attention? Why is she so curious about sexuality? Why does she present herself this way and does she understand what it means to present her body this way? Why does she need to act older and different?
5. Why is having true friends important and what makes friends “true” to her?
6. Does she feel able to just let things wash over her shoulders?
7. What is it about death that scares her?
8. Is Rachel moody? If she is, what can we do to help her be aware of it and learn skills to cope?
9. How can we help Rachel be more aware of others? How can we help Rachel get along better with others at school? How can we help her feel better when others are in control?
10. How can we help her feel more comfortable about herself?
11. How can we communicate with Rebecca and Rachel so that Rachel is satisfied and Rebecca isn’t angry?
12. What methods can we use to help Rachel realize when she has gone too far and how can we help her to change her behavior?
13. What is Rachel’s real self?

with herself and her body, but they remained concerned that her behavior and self-expression were inappropriate and overly mature. In particular, excessive demands for attention, hypersexual presentation, and dramatic emotional behavior were discussed. Sherry and Aaron were also curious about how they could help Rachel and Rebecca as illustrated by their assessment question, “How can we communicate with Rebecca and Rachel so that Rachel is satisfied and Rebecca isn’t angry?” (See Table 1 for a list of all the parents’ assessment questions.)

The team had a strong impression that Sherry and Aaron were a psychologically minded couple. In particular, Sherry was forthcoming about her own struggles with anxiety and depression. She explained that her anxiety sometimes translated into her inability to provide structure and follow-through with rules for her children. Sherry and Aaron asked about how their own psychological makeup contributed to the family dynamic. As part of the assessment, they were invited to take the Minnesota Multiphasic Personality Inventory–2 (MMPI–2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989).

In summary, the first session introduced the assessment team to Rachel’s parents. We noticed that Sherry’s anxiety seemed to drive the discussion and that a general theme of maternal helplessness was present. The major issues brought up by Rachel’s parents seemed relatively benign, and we wondered whether Sherry’s anxiety was making these problems seem worse or if there were deeper issues that had not yet come to the surface. Although Sherry and Aaron were willing to explore their roles in Rachel’s presenting issues, the overriding question being asked seemed to be, “What’s wrong with our daughter?”

Second Session

In TA, the second session involves seeing the parents and child together and then beginning the testing of the child. This observation gives the team the opportunity to see how the parents and child interact prior to starting the testing. With this family, we decided to begin by having a short check-in meeting with the

parents before bringing Rachel into the session. This check-in was a practice later adopted for every session because the team found that it helped to align the parents as an executive team. In addition, Sherry told us that she was worried about being able to remember important themes from the session. She asked us if the team would send her an e-mail recapping the events of each session. In keeping with the collaborative nature of the assessment, we decided to devote time at the end of each session to formulating a list of that day’s themes with Sherry and Aaron, which we then e-mailed to them directly afterward.

During this first check-in, Sherry discussed a recent incident that helped us develop a clearer picture of the difficulties this family was experiencing. Rachel and Rebecca had been bickering in the car, and it became so overwhelming for Sherry that she decided she needed one of them to leave the car. Because they were close to home, Sherry asked Rachel and Rebecca to decide which one of them was going to get out and walk the rest of the way home. Rachel got out of the car and walked home. This event helped us better understand how inappropriate demands could be placed on Rebecca and Rachel when Sherry became overwhelmed.

After the parent check-in, we met Rachel for the first time. She walked into the room quickly, climbed between her parents on the couch, kissed her father, and then settled in between them. Rachel was a little reserved at first, but she quickly opened up, and the team was struck by how well she expressed herself verbally. For example, she eloquently explained what she knew about psychologists: “They are people who help people understand their problems and get better.” With our guidance, Sherry and Aaron then shared one of their assessment questions with Rachel: “How can we help you get along better with others at school?” Rachel was then asked if she had any of her own assessment questions, and she provided several (see Table 2). Sherry and Aaron then went behind the one-way mirror with Johnathan and Brooke while Amy stayed with Rachel to talk. Amy checked in with Rachel to see if she had additional questions. With her parents behind the mirror, Rachel asked, among other things, why her parents were not doing anything to help when she and Rebecca argued and why they were unable to help. As it turned out, Rachel’s questions were quite prophetic.

After Amy and Rachel discussed Rachel’s questions, they began the first “testing” activities. As mentioned earlier, the first child session in TA involves relationship building, usually by doing unstructured assessment activities such as human figure drawings (Tharinger & Roberts, in press). Drawing seemed to be a comfortable modality in which Rachel could begin to relate to and connect with Amy. In addition, Rachel’s drawings provided helpful information. Her first drawing (Draw-a-Person; Harris, 1963) was of a 10-year-old girl who she said was happy,

TABLE 2.—Rachel’s assessment questions.

1. Why does Rebecca enjoy picking on me? How can I learn to handle it when she picks on me?
2. How do I balance my school and my social life?
3. Why do other kids think I’m bossy?
4. Why don’t my parents do anything to help when Rebecca and I argue?
5. Why do they say they will help but they don’t?
6. Why can’t they help?
7. Why before now were they not trying to get information about how to help?

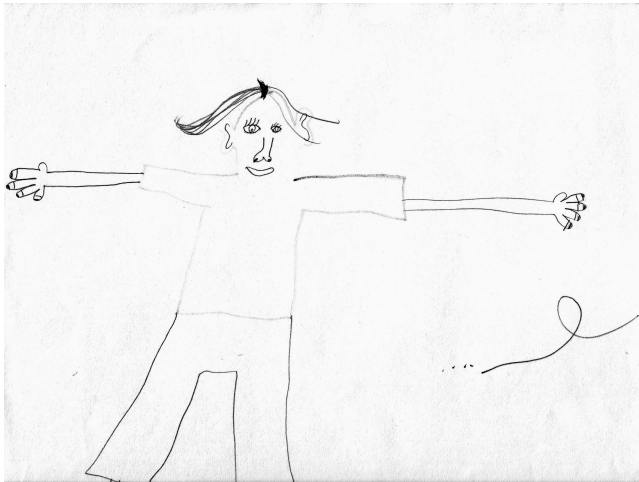


FIGURE 1.—Rachel's "Draw-a-Person" drawing.

liked school and sports, and was playing with friends (see Figure 1). As the parents watched from behind the mirror, Sherry voiced that the position of the girl's arms suggested the girl was "ready for a hug." Aaron observed that Rachel took up so much space on the paper that she had limited room to complete the drawing, which reminded him of how Rachel often ran out of space on her homework papers. Rachel also ran out of space on the chalkboard when she played hangman during free play. It seemed to us that Rachel commonly running out of space when she drew or did work illustrated how difficult it was to contain her and her expansive personality.

Rachel also completed a Kinetic Family Drawing (KFD; Burns, 1987). She was asked to draw every member of her family doing something. Her drawing included herself, her sister, mother, father, and dog. She drew every family member in his or her bedroom, compartmentalizing each family member by enclosing the member in his or her own separate box. Sherry and Aaron observed that Rachel drew her room on the opposite corner of the page from Rebecca's room, even though their actual rooms were next door to one another. Rachel also drew her sister last. We wondered whether this drawing illustrated Rachel's possible feelings of isolation from her family members, especially her sister.

Following the drawings, Amy invited Rachel to play. Rachel took on the leader/teacher role during her free play with Amy. This behavior was similar to the way Rachel had previously played with Cynthia during child care. Cynthia had shared that Rachel seemed very focused on winning or controlling every game or activity. For example, Rachel offered Cynthia French lessons during child care, which even included assigning Cynthia homework at the end of their "class" to be completed by the time they met the next week.

During her play with Amy, Rachel used a hangman game to test Amy's knowledge of her favorite things. Although they had just met, Rachel made it very clear that it was important that Amy prove how well she already knew her. While they completed these activities, Sherry and Aaron watched from behind the mirror. At one point, Rachel reprimanded her parents for talking too loudly. Sherry and Aaron explained that Rachel often chastised them at home as well.

By the end of the second session, the assessment team had developed a clearer picture of Rachel and her family. We were surprised that Rachel was so openly critical of her parents both within session and at home (as reported by Sherry and Aaron). We also noticed that Rachel seemed determined to lead and control her play time with Amy and Cynthia. The team was also struck by several stories Sherry and Aaron shared such as the story in which Sherry had to ask her children to leave the car because she felt so powerless to resolve their conflict. This information led us to begin to wonder how much power Rachel had in her family and conversely how Sherry and Aaron might be struggling with exerting their own power in the family. The team also suspected that Rachel's drawings illustrated her feelings of isolation from her family, her desire for attention and love, and her difficulty containing her own thoughts and feelings.

Assessment Sessions 3 Through 8

Following the initial meetings with the parents and the child, the next six TA sessions focused on self-report, interview, and performance-based personality measures. Observations of the family's process and dynamics during these sessions were also used to develop a clearer picture of the family. The measures administered were chosen to help answer the family's assessment questions. Rachel's TA did not include cognitive or academic testing because the family did not have any questions that addressed these areas of her functioning, and we had no reason to suspect difficulties in this area.

Self-report measures. Rachel completed self-report measures in the third and fourth sessions. She responded to a series of incomplete sentences (constructed by the assessment team based on the presenting issues), a social skills scale (Social Skills Rating System [SSRS]; Gresham & Elliott, 1990), a self-esteem scale (Self Perception Profile for Children; Harter, 1985), and an anxiety scale (Revised Children's Manifest Anxiety Scale [RCMAS]; Reynolds & Richmond, 1979). We started with these measures because they were clearly focused on many of Sherry and Aaron's initial concerns about Rachel.³ Rachel's responses to the incomplete sentences task helped to show how she processed and coped with emotion. For most of the sentence stems, Rachel gave lengthy and detailed responses, for example, "It makes me happy when . . . *people want to play with me or my dog comes up and licks me.*" However, on those few prompts that concerned difficult emotions, her responses were impoverished, for example, "When I'm mad I . . . *am mad,*" and "Deep down I worry that I . . . *don't know.*" To us, this pattern suggested that Rachel had difficulty understanding and expressing painful emotions.

Rachel's responses to the incomplete sentences and her parents' reactions suggested that she was aware of her mother's anxiety and sense of inadequacy. Sherry and Aaron were often worried that Rachel filtered her answers during the assessment to protect their feelings. We witnessed this behavior during the sentence completion task when Rachel was asked to finish the prompt, "I wish that my Mom, . . ." and she hesitated for a

³In TA, assessors are encouraged to begin early testing sessions with those tests that clearly reflect the major presenting concerns of the client. It is believed that this practice lowers clients' anxiety and reassures them that their agendas are those guiding the assessment process (Finn, 2007).

significant length of time. When Sherry anxiously said, “Yikes!” behind the mirror after hearing the prompt, we better understood Rachel’s anxiety about finishing this sentence. Rachel eventually completed the sentence with, “. . . *could feel better from her stomachache*.” Our sense was that she had struggled with how to respond to the prompt without hurting her mother’s feelings.

When Rachel was asked to list three wishes, she answered the following:

1. A perfect world—blue everywhere, monkeys hanging from buildings, monkeys being pets, everything being perfect.
2. Flawless people—people who never make mistakes.
3. A lot of fun fantastic stuff (moon jumps, baseball, basketball, sports, being able to play sports).

These answers suggested that Rachel was very focused on perfection, perhaps as a way to ward off disappointment or feelings of anxiety. We wondered whether Rachel’s desire for herself and others to be perfect contributed to her difficulties connecting with others. Rachel seemed to have standards for relationships that were impossible to achieve. The team also wondered if this expectation contributed to Sherry’s feeling that Rachel wanted more than she could provide.

Rachel’s answers on the other self-report measures continued the theme of a desire for perfection; her ratings of herself indicated a very happy girl who saw little or no fault in herself. For example, on the RCMAS, she reported much less anxiety than is normative for a girl her age ($T = 28$, second percentile). She also rated herself very highly on the Self Perception Profile for Children, which included social, scholastic, athletic, behavioral, and appearance-based ratings of self. On a scale ranging from 1 (*lower perceived competence*) to 4 (*higher perceived competence*), Rachel’s Global Self Worth score was 4.00, far above the normative score of 2.76. Although Rachel’s scores on the SSRS were not as extreme, she rated herself as average or higher on each scale, with a total standard score of 110 (75th percentile). Clearly, Rachel was painting a picture of a girl with few or no problems or perhaps simply a girl who was uncomfortable showing or even entertaining any negative thoughts or feelings about herself.

Developmental history interview. In TA with children, after the assessor–parent relationship has developed, a developmental history is collected from the parents. With Sherry and Aaron, this interview occurred during the fourth session. They told us that Rachel was hard to conceive and that she was difficult to soothe as an infant, especially in comparison to Rebecca, who they saw as an easy baby from “preconception” on. Sherry revealed that she felt unable to calm Rachel down when Rachel was distressed, and Sherry had relied on Aaron to comfort and hold Rachel when she was colicky. Sherry’s difficulties soothing Rachel in infancy seemed to have left Sherry feeling inadequate as a mother and somewhat disconnected from Rachel. In addition, Sherry told us that her own father was very ill during Rachel’s early years, and Sherry had been highly involved in caretaking her father during this period. Sherry explained that taking care of him had been emotionally and physically taxing, in part because her father lived 3 hr away by car, and that it left her with fewer resources to care for a colicky infant. What remained unclear from the interview was the extent to which Sherry and Aaron had supported each other during this difficult time.

Early Memories Procedure (EMP; Bruhn, 1981, 1990). To better understand Rachel’s early experiences, perceptions of herself and family, and ability to manage emotions, we administered the EMP during the fourth session. The EMP is a semistructured assessment tool in which the individual is asked to recall his or her earliest memories, answer follow-up questions about each memory, and then rate each memory as to its positivity–negativity and clarity. Bruhn’s (1990) research suggested that early memories provide clues to an individual’s “core narrative” and to unresolved conflicts underlying the individual’s current problems in living. Adult clients record their own memories and ratings by writing in the EMP booklet; with Rachel, as with most children, we allowed her to dictate her memories.

In Bruhn’s (1990) theory, the clearest, most negatively rated memory is often a metaphor for a core unresolved issue of the client. The memory of Rachel’s that fit this criterion was of her spraining her ankle at age 5 while doing back flips in an inflated “moonwalk” at a local mall. She commented there was a sign posted saying “don’t do flips” and that she had called her mother’s attention to the flips she was doing right before she hurt herself. In the inquiry, when asked how she would change the memory, Rachel said, “Reading the sign and not doing a flip.” To us, this memory reflected Rachel’s sense that she could not count on her mother (and perhaps father) to protect her by setting limits on her behavior even when she clearly signaled that she wanted them to do so. Furthermore, Rachel’s solution was for her to become unusually precocious and fend for herself (e.g., by reading signs and monitoring her own behavior at age 5).

Rachel rated almost all of her other memories as exceptionally clear and positive, and several incidents centered on times when she was the center of attention. In fact, for one of the later memories, Rachel talked about giving her second memory earlier in the task, when she had begun by saying, “open memory file,” and heard everyone laugh. When asked what the strongest feeling in the memory was, Rachel said, “Excitement and happiness. Having everybody laugh at what I do, because I love being funny for you [Johnathan].” Then, pointing to the mirror that hid her parents, Amy, and Brooke from view, she continued, “and you and you and you.” Bruhn (1990) suggested that clear positive memories indicate how the client is attempting to resolve the dilemma reflected in the clearest, negative memory (parental neglect in Rachel’s case). We wondered if her constant desire to be attended to by others was an attempt to deal with feelings resulting from this neglect.

It was clear from the parents’ discussion behind the mirror that they were uncomfortable with the paucity of negative memories expressed by Rachel during this procedure. Thus, in the next session, we tried to engage the parents’ curiosity and see how Rachel would respond if Johnathan asked her to tell a negative memory. Rachel told about the death of her paternal grandfather when she was 5 years old, and instead of showing genuine emotion, she rubbed her eyes melodramatically and pretended to cry, saying, “I will just dab up all of my tears.” Her behavior deteriorated, and she began interacting with her parents through the mirror by making noises and funny faces. Aaron indicated that Rachel had not been close with this grandfather and that he thought she was holding back memories that were truly upsetting to her so that she would not appear vulnerable.

Rachel’s behavior became even more difficult during the free playtime after the EMP. She made faces at Johnathan, vocalized strange noises, and even threw a chalky eraser at him. When

TABLE 3.—The structural summary for Rachel’s Rorschach.

LOCATION FEATURES	DETERMINANTS			CONTENTS			APPROACH		
	BLENDS		SINGLE						
Zf = 12	FM.FY	M	= 0	H	=	0	I		DdS.WS
ZSum = 40.5	m.CF	FM	= 1	(H)	=	1	II		DdS.DdS
ZEst = 38.0		m	= 1	Hd	=	2	III		Dd.D.D
		FC	= 0	(Hd)	=	1	IV		D.W.W
W = 13		CF	= 3	Hx	=	0	V		Dd.Dd.Dd
D = 3		C	= 3	A	=	5	VI		W.W
W+D = 16		Cn	= 0	(A)	=	2	VII		W.W.W
Dd = 8		FC'	= 1	(Ad)	=	0	VIII		W.W
S = 4		C'F	= 1	An	=	3	IX		W
		C'	= 0	Art	=	1	X		Dd.W.W
		FT	= 0	Ay	=	0			
DQ		TF	= 0	Bl	=	0	SPECIAL SCORES		
+		T	= 0	Bt	=	1	DV = 2	Lv1	Lv2
o		FV	= 0	Cg	=	2	INC = 1	x1	0x2
v/+		VF	= 0	Cl	=	0	DR = 0	x2	1x4
v		V	= 0	Ex	=	1	FAB = 1	x3	0x6
		FY	= 2	Fd	=	1	ALOG = 2	x4	1x7
	FORM QUALITY	YF	= 0	Fi	=	0	CON = 0	x5	
		Y	= 0	Ge	=	0	Raw Sum6	= 8	
	FQx	MQual	W+D	Fr	= 0	Hh	Wgtd Sum6	= 29	
+	= 0	= 0	= 0	rF	= 0	Ls			
o	= 2	= 0	= 0	FD	= 0	Na	AB	= 0	GHR = 1
u	= 10	= 0	= 8	F	= 10	Sc	AG	= 0	PHR = 3
-	= 9	= 0	= 5			Sx	COP	= 0	MOR = 1
none	= 3	= 0	= 3	(2)	= 3	X	CP	= 0	PER = 0
						Id			PSV = 0
..... RATIOS, PERCENTAGES, AND DERIVATIONS									
R = 24	L = 0.71			FC:CF+C = 0.7		COP = 0	AG = 0		
EB = 0: 8.5	EA = 8.5	EBPer = 8.5		Pure C = 3		GHR:PHR = 1:3			
eb = 4: 5	es = 9	D = 0		SmC':WSmC = 2:8.5		a:p = 2:2			
	Adj es = 6	Adj D = 0		Afr = 0.33		Food = 1			
				S = 4		SumT = 0			
FM = 2	SumC' = 2	SumT = 0		Blends/R = 2:24		Human Cont = 4			
m = 2	SumV = 0	SumY = 3		CP = 0		PureH = 0			
						PER = 0			
						Isol Indx = 0.33			
a:p = 2:2	Sum6 = 8	XA% = 0.50	Zf = 12	3r+(2)/R = 0.13					
Ma:Mp = 0:0	Lv2 = 2	WDA% = 0.50	W:D:Dd = 13:3:8	Fr + rF = 0					
2AB+Art+Ay = 1	WSum6 = 34	X-% = 0.38	W:M = 13:0	SumV = 0					
MOR = 1	M- = 0	S- = 3	Zd = +2.5	FD = 0					
	Mnone = 0	P = 0	PSV = 0	An + Xy = 3					
		X+ % = 0.08	DQ+ = 6	MOR = 1					
		Xu% = 0.42	DQv = 6	H:(H)+Hd+(Hd) = 0:4					
PTI = 3	DEPI = 5	CDI = 4	S-CON = N/A	HVI = No					OBS = No

Johnathan calmly asked her to stop throwing things at him, she said, “Okay, I have a better idea.” She then rubbed chalk onto two other erasers and proceeded to beat them together directly in front of Johnathan’s face. These behaviors led him to set a firmer limit with her, and Rachel then grew noticeably calmer. Rachel’s parents were mortified by her behavior toward Johnathan but also relieved that we had seen how Rachel could act out at home. This incident helped us understand why Aaron, Sherry, and other adults were so frustrated with Rachel. However, it also helped us hypothesize several reasons for her “obnoxious” behavior. First, it seemed that Rachel was trying to compensate for a lack of mirroring and appropriate limits from her parents by always being the center of attention. Also, she tended to avoid negative feelings because she was not emotionally equipped to

handle them; and when she got emotionally overwhelmed, her behavior could be provocative and aggressive. It seemed clear that our experiment with the EMP had overwhelmed and upset her. Finally, Rachel’s parents, especially her mother, seemed confused about whether Rachel’s disruptive behavior was simply the result of too much “gusto” or a real problem. Sherry also seemed unclear as to how to set limits on Rachel’s behavior in a way that would contain but not shame her. Neither parent seemed to see the link between Rachel’s acting out and our request for her to tell a negative memory.

Rorschach (Exner & Weiner, 1995). To further investigate Rachel’s emotional controls, reality testing, and self-concept, she was administered the Rorschach during the sixth

assessment session. Rachel's behavior during this task was noticeably different than her behavior in other sessions. She seemed disengaged and complained about being bored, frequently counting how many cards were left and lying down in the chair. She became increasingly withdrawn as the task continued, which was in direct contrast to her animated behaviors during the EMP. The Rorschach results (Table 3) supported our earlier hypothesis that Rachel was an emotionally sensitive girl (WSumC = 8.5) and that she had major difficulties in emotion management. Her scores suggested that Rachel tended to avoid emotions (Afr = .33) because she was prone to affective flooding and loss of emotional control (FC:CF + C = 0.7; Pure C = 3) when exposed to emotional situations from which she could not escape. As can be seen in the Sequence of Scores (Table 4), when subjected to the emotionally arousing stimuli on cards VIII through X, the quality of Rachel's responses deteriorated rapidly. Three of her six responses to these cards had no form ("the colors of the rainbow," "a color-coded picture," and "something really really pretty, because of the colors"), and only one of the remaining responses had good Form quality (R22: "fireworks"). This pattern suggested that emotions could quickly override Rachel's judgment and ability to think clearly and conventionally (XA% for Cards I-VII = .56; XA% for Cards VIII-X = .33). Similarly, on the other colored cards (II and III), Rachel had no good Form responses. It seemed noteworthy that Rachel had no Popular responses in her entire protocol, and we felt this typified her tendency to view the world differently than most people. Also, the absence of any human movement responses (M = 0) suggested that she was emotionally delayed in her ability to reflect on her behavior and inhibit action. In contrast to the pattern in her Form quality scores, cognitive special scores were distributed throughout the protocol. Although Rachel's Rorschach responses did not suggest she was psychotic, they indicated that her thinking could

become quite illogical and unconventional at times (ALOG = 2; FABCOM2 = 1).

Rachel's responses on the Rorschach also suggested a vulnerability to depression. Her DEPI was 5, and her CDI was 4. The elevation of these two indicators can suggest an underlying and longstanding depression (Exner & Erdberg, 2005), and one of Rachel's responses (to Card VI) was simply, "A black puddle." This image seemed a metaphor for the raw, painful emotion she was defending against, and her extremely low score on the Egocentricity Index [$3r+(2)/R = .13$] suggested that deep down Rachel did not feel worthwhile and valued. It is worth remembering that Rachel reported no depression and extremely high self-esteem on the self-report measures she completed. Finn (1996a) suggested that such discrepancies between the Rorschach and self-report testing indicate the relatively successful use of character defenses to ward off underlying states of painful affect.

Another poignant part of Rachel's Rorschach were the many indicators of problems with attachment and close relationships (T = 0; COP = 0; GHR:PHR = 1:3; H responses = 0; Isolation Index = .33; Fd Content = 1). To us, these scores suggested that Rachel had not developed a sense that human relationships were reliable sources of comfort, affection, support, and attunement. Hence, she tended to vacillate between being demanding and overly self-reliant.

Adult Attachment Projective (AAP; George, West, & Pettem, 1997). Given the information about the disruptions in Rachel's early life and the markers of insecure attachment on her Rorschach, we decided to give Rachel the AAP in Session 7. The AAP is a relatively new, validated measure of attachment status developed by George et al. (1997). It consists of eight cards with line drawings on them: a neutral warm-up scene and then seven scenes depicting increasingly difficult attachment threats. The client is asked to tell stories to the pictures; these stories are then transcribed verbatim and are rigorously coded. Although primarily designed for use with adults, validation work is in process with adolescents, and the AAP can also be informative with bright, latency-aged children (George, 2005). Rachel's AAP was coded and classified by the developer of the test, C. George.

Rachel's stories showed many of the features of the insecurely attached individual, and they contained elements of both the insecure-ambivalent style and the insecure-avoidant style. For example, one card shows a child in bed reaching out toward a woman who sits at the end of the bed. In Rachel's story, the child is a boy who doesn't want to go to bed: "He doesn't like bed and he's not tired and he wants his mom. And he reaches out and tried to give his mom a hug." However, the mom is not responsive: "[She] is just thinking, 'Honey, you've got to get used to bed sometime or another.'" So, in the story, the boy eventually turns on his own nightlight, "goes to sleep and wakes up in the morning and gets ready for school." This and the other stories suggested that Rachel had come to see attachment figures as vulnerable or unavailable and was already developing premature self-sufficiency and/or diverting her attachment needs to others (e.g., her sister and peers).

Parent MMPI-2s. As mentioned earlier, both Sherry and Aaron agreed to take the MMPI-2 to learn more about how best to parent Rachel. The basic MMPI-2 profiles for Sherry

TABLE 4.—The sequence of scores for Rachel's Rorschach.

Card & Response No.	Loc & DQ	Determinant(s) and Form Quality	(2) Content(s)	P	Z	Special Scores
I	1	DdSo	FC-	An	3.5	
	2	Wso	FYu	(Hd)	3.5	GHR
II	3	DdS+	CF-	Hh, Id	5.5	DV
	4	DdSo	CF-	Ls	4.5	
III	5	Ddo	Fu	Ad		
	6	D+	Fu	A, Cg	3.0	FAB
	7	D+	Fu	A, An	3.0	MOR
IV	8	Do	F-	Hd		PHR
	9	Wo	FY-	(H)	2.0	ALOG, PHR
	10	Wv	F-	(A)		DV, ALOG
V	11	Ddo	Fo	A		
	12	Ddo	Fu	Bt		
	13	Ddo	F-	An, Fd		
VI	14	Wv	C'Fu	Na		
	15	W+	mau	Na	2.5	INC2
VII	16	Wo	Fu	Cg	2.5	
	17	Wo	Fu	Hd	2.5	PHR
	18	W+	FMp.FY-	(A), A	2.5	INC
VIII	19	Wv	C	Na		
	20	Wv	C	Art		
IX	21	W+	Fma-	2 A, Ad	5.5	FAB2
	22	Ddo	mp.CFo	Ex		
X	23	Wv	CFu	Id		
	24	Wv	C	Id		

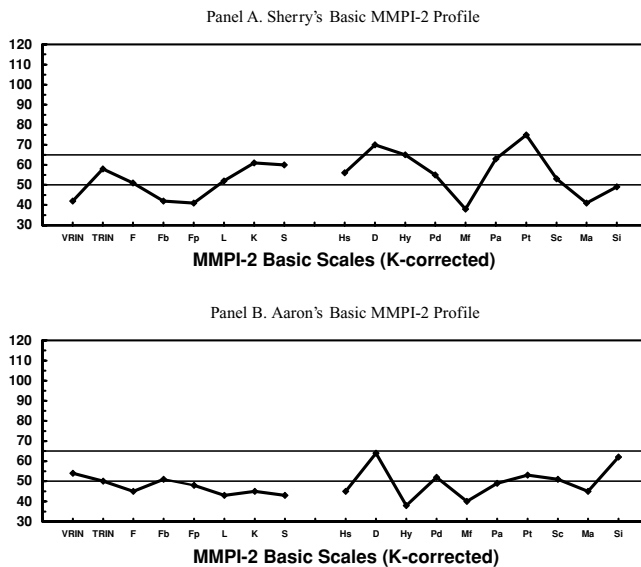


FIGURE 2.—Basic Minnesota Multiphasic Personality Inventory–2 (MMPI–2) profiles. Panel A: Sherry's Basic MMPI–2 Profile. Panel B: Aaron's Basic MMPI–2 Profile. VRIN = Variable Response Inconsistency scale; TRIN = True-Response Inconsistency scale; F = Infrequency; Fb = Back F; Fp = Infrequency Psychopathology; S = Superlative Self-Presentation; Hs = Scale 1, Hypochondriasis; D = Scale 2, Depression; Hy = Scale 3, Hysteria; Pd = Scale 4, Psychopathic Deviate; Mf = Scale 5, Masculinity-Femininity; Pa = Scale 6, Paranoia; Pt = Scale 7, Psychasthenia; Sc = Scale 8, Schizophrenia; Ma = Scale 9, Hypomania; Si = Scale 0, Social Introversion. Excerpted from the *MMPI® -2 (Minnesota Multiphasic Personality Inventory® - 2) Manual for Administration, Scoring, and Interpretation*, Revised Edition. Copyright © 2001 by the Regents of the University of Minnesota. All rights reserved. Used by permission of the University of Minnesota Press. "MMPI–2" and "Minnesota Multiphasic Personality Inventory–2" are trademarks owned by the Regents of the University of Minnesota.

and Aaron are illustrated in Figure 2. As shown in Panel A, Sherry reported a moderate amount of depression (Scale 2 = 70T), anxiety and worry (Scale 7 = 75T), and low energy (Scale 9 = 40T). The 7-2-3 code type suggests chronic moderate depression and insecurity in a person with very low self-esteem. People with similar profiles are extremely unassertive and have difficulties expressing anger directly. There were also indications that Sherry was quite sensitive to criticism (Scale 6 = 63T, Pa2 = 63T) and that she tended to use denial and minimization to handle difficult situations (Scale 3 = 65T, K = 61T). Parents with this type of profile have great difficulties setting appropriate limits with their children and are excessively guilty if they ever express anger. They "sweep problems under the rug" because if they don't, they feel paralyzed by anxiety. They can also have periods in which they are highly emotional (Scale 3 = 65T).

Aaron's MMPI–2 (Panel B) also suggested a longstanding mild depression (Scale 2 = 64T) but in a man who dealt with conflict through withdrawal (Scale 0 = 62T). People with this code type (2-0) keep emotional distance from close ones, in part because they experienced little warm affection themselves as children. Like Sherry's MMPI–2, Aaron's test results suggested he would be very poor at dealing with either his children's or his wife's anger and that he would tend to withdraw rather than set limits. He would be likely to take an unemotional, structured

"problem-solving" approach to difficult situations (Scale 5 = 40T).

Child-centered play. By Session 7, the clinical team had formed the hypotheses that Rachel had difficulty understanding, expressing, and coping with her emotions and that she strongly desired attention and understanding from her parents. A technique often used in the treatment of children with these difficulties is nondirective, child-centered play therapy (West, 1996). The clinical team decided it would be helpful when giving feedback to Sherry and Aaron to see how Rachel would react to this type of intervention. So, at the end of Session 7, Brooke invited Rachel to join her in a nondirective play session. The theme of the play, which was an extension from the previous week, was making "new brains" for her parents out of Play-Doh.® The session focused on allowing Rachel to control the play while Brooke provided mirroring and narration of Rachel's actions and emotions. For example, Brooke showed her attunement to Rachel's actions by making comments such as, "Now you are making a brand new brain with the Play-Doh." The clinical team thought that Rachel making new brains for her parents was another example of how powerful she felt in the family. Rachel seemed to thoroughly enjoy the play and was calm and contained throughout the activity. This change in behavior led the clinical team to think that regular exposure to this type of play therapy could be very beneficial for Rachel.

Photograph activity. In preparation for Session 8, Rachel had been asked to take photos of people or things that were important to her (Finn, 1997, described this activity as part of child-focused TA.) In Session 8, Rachel was asked to arrange these photographs according to how important the people or things were to her. In S. E. Finn's experience, most children Rachel's age with secure attachments will place their parents first. Initially, Rachel put her dog first, then several friends, then her parents. When she got to the picture she had taken of herself, she placed it before the picture of her dog so that she would be ranked first. Also atypical for this activity, based on S. E. Finn's clinical experience, was that Rachel took 8 of her 24 pictures of the assessment team and Cynthia. We wondered if the pictures reflected the fact that Rachel felt more mirrored and accepted by us than she generally did by other people.

Case Formulation

This is clearly a case in which psychological assessment was crucial in developing an empathic understanding of the client's problems in living. Rachel and her parents presented as a high-functioning, intact family, with some minor concerns about Rachel's peer relationships and social functioning. In fact, the family had many strengths, including their intelligence and openness to seeking help. As the assessment unfolded, however, it became clear that Rachel's "social problems" were significant and were rooted in an insecure attachment, underlying depression, idiosyncratic view of the world, and longing for attention, all of which were hidden or expressed in grandiose, expansive, and off-putting behaviors. In fact, although she was only 8 years old, Rachel already seemed to be developing some narcissistic character defenses to ward off deep feelings of emptiness and inadequacy.

The assessment also illuminated complications within the family system and how they may have contributed to Rachel's

difficulties. Stresses on the family during Rachel's early years may have interfered with Rachel getting the kind of early attunement she needed. In addition, the familial hierarchy was inverted at the time of the assessment, with Sherry and to some extent Aaron feeling helpless and ineffective and Rachel and Rebecca having more control than was appropriate. This pattern led Rachel to feel even more anxious, which she coped with by being even more condescending toward her parents. It seemed to us that Rachel was constantly pushing the boundaries of appropriate behavior because she wanted Sherry and Aaron to set appropriate limits for her. In the face of such challenges, Sherry grew more anxious and insecure, and Aaron withdrew even more, leaving Rachel lonely and frustrated.

Family Intervention Session

In TA, families participate in a family intervention session between the assessment and feedback sessions (Tharinger, Finn, Austin, et al., 2008). During the family session, the family is asked to interact so that the assessment team can test hypotheses and bring family patterns to light through actual experienced behavior. The family session also helps the assessment team consider how ready the parents are for systemic feedback. Thus, what is learned from the family session adds to the previous assessment findings and further informs the plan for the subsequent feedback sessions.

In our session with Rachel and her family, we drew on our hypothesis that Rachel's problem behaviors were the result of inadequate mirroring and attunement on the part of her parents and Rachel's attempts to compensate for her resulting feelings of loneliness. We hypothesized that if Rachel could experience undivided attention, mirroring, and understanding from her parents, it would help her feel safe, calm, and valued and would lead to better emotional regulation. Based on Rachel's positive experience with child-centered play in Session 7, we thought that this might be a useful technique to teach to Sherry and Aaron. In addition, we felt the use of these techniques would allow Sherry opportunities to interact with Rachel without becoming overwhelmed or exhausted. The specific techniques we focused on teaching Sherry and Aaron were narrating Rachel's behaviors during play, mirroring her affect, and allowing her to direct the playtime. We asked the parents to take a noncompetitive and nonevaluative approach to this kind of play.

During the planning stage, we carefully considered the logistics of the session, how to ease Sherry and Aaron's anxiety, and how to empower the parents with a new skill. In keeping with the collaborative process, we allowed Sherry and Aaron to choose whether they wanted us in the room or behind the mirror and whether they wanted to play with Rachel together or individually. We thought it would be helpful for Sherry and Aaron to observe these techniques before trying them out. Behind the mirror, Aaron and Sherry observed as Johnathan and Brooke used nondirective play techniques with Rachel. During the parents' turn to try the new play techniques with Rachel, each parent was deliberately given a specific role based on his or her parenting style as suggested from their MMPI-2 results. Sherry was instructed to mirror Rachel's affect, whereas Aaron was instructed to narrate Rachel's activities.

Once her parents were in the room, Rachel tested them by creating a game with very complex, hard-to-follow rules. Rachel's parents, especially her mother, were able to narrate her actions

and compliment her creativity without interrupting or pointing out flaws in Rachel's rules. After approximately 15 min, Sherry and Aaron went behind the mirror to discuss their experience with Amy and Brooke while Johnathan returned to play with Rachel. Amy and Brooke praised Sherry and Aaron for narrating Rachel's actions and then asked them to play with Rachel again, this time focusing more on mirroring Rachel's affect. When the parents reentered the room, they were able to successfully stay attuned to and mirror Rachel's emotions, even laughing and becoming silly with her. Several times during the play session, Rachel became overwhelmed and somewhat hyperactive, but in response to the mirroring her parents were providing, she was able to regroup and continue acting in an age-appropriate manner. The family seemed connected and appeared to enjoy the time they were spending together. At the end of the session, the parents reported that this type of play, rather than being overly demanding and exhausting, had been enjoyable and an activity they were eager to work into their routine at home. Sherry and Aaron also told us that the activity had been especially helpful because they had been given a previous recommendation for play therapy with their older daughter, Rebecca, but had not received the kind of collaborative training that made the techniques clear and helped them to feel that they could use them effectively. This successful family session set the stage for a positive feedback session and provided Sherry and Aaron with new skills to help build their relationship with Rachel.

Summary/Discussion Sessions

The final component of TA involves providing collaborative feedback to the parents and the child, typically in two separate sessions (Tharinger, Finn, Hersh, et al., 2008). The first session consists of a meeting with the parents to provide a summary of the assessment results, make connections between what was learned and the parents' original questions, solicit reactions and questions, and review recommendations. The assessor also collaborates with the parents on plans for presenting feedback to the child. This discussion often includes eliciting reactions and suggestions from the parents about the story constructed for their child. This story is often presented in the form of a fable, song, or poem. In the subsequent session, the assessment team meets with the child, typically with the parents present. During this final meeting, the child's assessment questions are addressed, and the story is shared with the child. Finally, a comprehensive letter to the parents is sent to the family as a lasting record of the TA experience (Tharinger, Finn, Hersh, et al., 2008).

Parent feedback. We began the feedback by discussing with Sherry and Aaron how the session would be conducted. In keeping with the collaborative nature of TA, this discussion included being open to suggestions from Sherry and Aaron about how to modify the session. We also discussed with them how we might best share the assessment findings with Rachel the following week. Prior to discussing the assessment findings, we expressed our appreciation to the parents for their dedication to the assessment and discussed the strengths we saw in Rachel over the course of the assessment.

Typically in TA, feedback includes both a summary of the assessment findings in general and a discussion of how those findings relate to the questions asked by the parents at the beginning of the assessment. With this particular family, we felt that it was important to provide a brief overview of the assessment

TABLE 5.—Major feedback themes

-
1. Rachel is an emotionally sensitive girl.
 2. Difficult early events may have influenced Rachel's development.
 3. Rachel has delays in her emotional development.
 4. Rachel gets emotionally overwhelmed easily, which affects her behavior.
 5. Rachel doesn't seem comfortable with herself.
 6. Rachel has an idiosyncratic view of the world.
 7. Rachel is behind in her ability to relate to others.
 8. Rachel is susceptible to experience sad or irritable moods.
-

findings early in the feedback session to reduce potential anxiety. The summary focused on the major themes that developed over the course of Rachel's TA supported by the family session. These themes are summarized in Table 5.

After providing this overview to the parents, we presented feedback addressing their assessment questions (see Table 1). We organized their questions into two main groups: questions about Rachel herself and questions about how Sherry and Aaron could help Rachel and the family. We used this organization both to help clarify the feedback and to conclude the session by giving Sherry and Aaron the confidence that they had the tools necessary to make positive changes in their family. The questions were also organized based on what we believed would be Level 1, 2, and 3 information for the parents (Finn, 2007). Level 1 feedback consists of information that the parents were already aware of prior to beginning the assessment or information that they learned and readily accepted over the course of the assessment. This feedback is typically given early in the session. An example of Level 1 feedback presented to this family was Rachel's emotional sensitivity. Sherry and Aaron had witnessed Rachel becoming overwhelmed by emotions throughout the assessment. We had based the family session around helping the parents to learn a play technique designed to help Rachel recognize and manage her emotions. Because Rachel's emotional sensitivity had been discussed throughout the assessment and had been the focus of the family session, we anticipated that this feedback would not surprise or overwhelm Sherry and Aaron.

Level 2 feedback consists of information the assessor believes is a slight reframing of parents' usual way of thinking about their child and typically is presented midway in the session. An example of Level 2 feedback is the finding that difficult family events early in Rachel's life may have influenced her development. Sherry and Aaron had some awareness that these early events had been difficult for them and that they may have affected Rachel. By focusing on these early events rather than on any inadequacy in their parenting responses during this period, we also wove a compassionate new story about why Rachel had the difficulties she did and indirectly addressed Sherry's and Aaron's shame about their daughter not being like other girls her age.

Level 3 feedback is information that the assessor feels may be especially difficult for parents to hear and may be the most difficult to integrate into their perception of their child. This feedback is usually provided later in the session. An example of Level 3 information for this family was Rachel's susceptibility to depression. Sherry and Aaron asked whether Rachel was moody as one of their assessment questions, and we felt they were indirectly asking whether Rachel was depressed. Although they asked this question, we worried that Sherry and Aaron might struggle with the assessment finding that Rachel

was susceptible to developing depression. Throughout the assessment, Sherry explained that her brother had been diagnosed with bipolar disorder and had struggled with it for many years. Sherry was afraid that Rachel would develop a mood disorder in the future; she did not want Rachel to experience the same struggles she had watched her brother go through. As a result, this finding was presented later in the feedback session.

Because of the parents' likely anxiety surrounding this finding, we were also prepared to phrase this information differently depending on Sherry and Aaron's affective reactions up to that point. The two options we considered using were the more straightforward phrase "susceptibility to depression" and also the more sensitively worded "susceptibility to experience sad or irritable moods." In the session, Sherry and Aaron were so receptive to the feedback presented before this finding that Johnathan, Amy, and Brooke actually used the word *depression*. The feedback outline was also structured such that Sherry and Aaron's questions about how to help Rachel directly followed this discussion. During the latter portion of the session, we were able to empower Sherry and Aaron by discussing techniques they could use to prevent Rachel from developing depression in the future.

We also interpreted the MMPI-2 results in terms of parenting styles. We gave feedback to the parents that Sherry was very good at understanding the emotions involved in a situation, and Aaron was very good at setting limits and implementing structure. We discussed with them how both of these abilities were equally important in effective parenting and how they could better work together to capitalize on each other's strengths.

There were also findings that we felt Sherry and Aaron were not yet ready to hear. These findings were related mainly to the inverted family hierarchy we had observed over the course of the assessment. As we knew that this family would be participating in a series of family therapy sessions after the TA, we chose to help the parents observe these patterns and shift them during the postassessment intervention rather than run the risk of overwhelming them during feedback.

Child feedback. The final session in a TA focuses on providing the child with feedback and usually features a personalized story or fable written for the child by the assessor. Before presenting Rachel with her story, we attempted to give her feedback on the questions she had generated at the beginning of the assessment. This feedback included suggesting that Rachel ask her parents for help when she is not getting along with her sister. In addition, we explained to Rachel that siblings of their ages often do not get along well. We also pointed out that she was a natural leader but that sometimes it might come across as bossiness. While Rachel was listening to this feedback, she became quite visibly overwhelmed. She started acting very silly and did not seem to be paying close attention, even taking out her cell phone and playing a game while being spoken to. Sherry and Aaron were able to see that this behavior was a good example of Rachel's emotional sensitivity and her tendency to become overwhelmed and cope by acting out. We decided that Rachel was not able to hear the direct feedback and made the decision to skip ahead to presenting the fable.

We wrote a fable for Rachel that represented some of the conflict between her and Rebecca at home. As mentioned previously, we knew that Rachel craved attention, and she had even quizzed us to see if we knew her favorite animals (monkeys),

favorite color (blue), or other things that she liked. Accordingly, Rachel's fable was about two sisters who were a pair of blue circus monkeys who were not getting along. In the fable, their parent monkeys receive advice about how to help them to get along with each other. By the fable's end, the parents are successful in helping the sister monkeys learn to work together despite their differences.

In TA, we ask the child if they want to read the story aloud themselves or if they want anyone else in the room to read it to them. When given this option, Rachel took her father's coat and tucked herself in on the couch as if she was going to bed. She then asked each of us to read one paragraph at a time and then pass the story to the next reader. Rachel appeared extremely content and seemed to bask in the undivided attention she was receiving from everyone in the room. After the story was read, we asked Rachel if she wanted to make any changes. She wanted to change the main character's name to Rachel. She also considered changing the other monkey's name to Rebecca but decided against it. We assumed she did not want to "share" the story with her sister. She also wanted to change some other things about the story. Most of these changes involved using a thesaurus to replace our adjectives with more extreme ones (such as "pretty" into "beautiful"). Rachel persisted with her changes for so long that we had to ask her to finish her corrections at home. The family left the session and discussed how they were eager to read the story again together at home.

Follow-Up

The week after the child feedback session, Rachel and her parents returned to complete brief interviews about their experience as well as follow-up measures. When asked what part of the assessment had been most helpful in gaining new insight into Rachel, Sherry said, "I thought the Rorschach was [most helpful] because it demonstrated that she is not all drama and contrived and that really and truly she does not see things the way the rest of the world sees things." Aaron reported that watching Rachel from behind the mirror had been particularly useful in learning about how Rachel responds to other people and requests. Building on their new insights about their daughter, both Sherry and Aaron indicated that they came away from the assessment with specific ideas of how to better relate to Rachel. Sherry said

I'm focused on the [empathic] listening because I know I tend to listen and then try to solve and don't really need to do that as much. . . . She's shown she just wants to be listened to. And she's eating up having specific, undivided attention.

Aaron also emphasized the special playtime that had been demonstrated during the family session: "I kind of came away with the importance of having dedicated time with her where everything else can be forgotten. So, focusing on just the activity with her is something I learned." When asked what she learned from the assessment experience, Rachel said she now understood that "at school I come on a little strong" and endorsed the special playtime at home:

It's good to set aside time for just one person in your family to do whatever they want. We might get along a little better because we will each be getting the same amount of attention and not feeling left out.

Sherry also mentioned the impact of receiving feedback from the MMPI-2 in relation to her and Aaron's parenting styles:

It just highlighted that I respond to things more emotionally and he responds more pragmatically. . . . When I grew up everything was very rational in my home . . . so I think I was overcompensating a bit. I wanted to make sure my kids knew their emotions and that they know my emotions . . . but maybe I don't need to let them know quite so much. So I think that tool [MMPI-2] . . . raised that awareness for me a little bit.

Responses to the research measures indicated high satisfaction and notable change. Sherry reported a decrease in Rachel's internalizing and externalizing symptoms, with scores moving well into the normal range. Rachel indicated a decrease in symptoms of hyperactivity, the only area she had endorsed as problematic prior to the TA; her score moved from the clinical range to well within the normal range. Furthermore, Rachel and both her parents reported a decrease in family conflict. Finally, both Sherry and Aaron reported an increase in their positive affect regarding their view of Rachel's challenges and future. They reported feeling more patient, empathic, compassionate, and hopeful toward Rachel. In addition, Sherry and Aaron reported a decrease in their negative affect regarding Rachel. They reported that they felt less frustrated, less like they wanted to give up, less at their wits end, and less anxious. Overall, the experience appeared to have a positive impact on Rachel and her parents.

Family Therapy Sessions

Following the completion of the TA, the family chose to participate in six family therapy sessions. Our goal was to give the family the opportunity to practice and solidify what had been learned from the assessment. We also invited Rebecca, and she attended five of the six sessions; Rachel and both parents attended all six. Each session began with a check-in followed by a variety of activities designed to promote healthier and more appropriate family structure and communication.

To explore how the whole family communicated, the team asked the family to participate in a Consensus Rorschach in the first family therapy session. This activity was videotaped so that the family could later view their own interactions and come to a better understanding of their family dynamic. Rather than working collaboratively on the task, family members competed with one another by attempting to come up with and take credit for the most interesting responses. Throughout this exercise, we also noted the absence of a parental hierarchy. For instance, when it was Sherry's turn to hold a card and organize the family's responses, she became overwhelmed by the responsibility and passed it on to Rebecca; the children commented that this behavior was similar to Sherry's behavior at home. Rachel dominated the task and talked down to her parents, stating that they did not contribute as much because they were not as bright or quick as her and her sister. In the following session, in an attempt to empower the parents, we had the family view portions of their Consensus Rorschach videotape and discussed with them the distinction between competition and connection. We encouraged Sherry and Aaron to try to mediate the discussion of the Rorschach cards as the family worked together to come up with responses. The family then reattempted the activity with the parents taking a greater leadership role. Sherry and

Aaron decided to take turns as the group leader, a decision that prompted us to dedicate future sessions to building a stronger parental alliance.

For the next two sessions, we split the family into parent and child subsystems. The discussions with Sherry and Aaron were dedicated to their struggles with communication and collaborative parenting. When they attributed the struggles to their distinctive parenting styles, we encouraged them to utilize one another's strengths. The parents, Brooke, and Johnathan then brainstormed ways for Sherry and Aaron to reconnect with each other without their children present; the idea of a date night was settled on.

In a separate room, Amy asked Rebecca and Rachel to create a cartoon to express what it was like to be a part of their family. The goal of this activity was to begin strengthening the sibling alliance. During this activity, Rachel revealed thinking that Rebecca hated her. Rebecca refuted this idea but explained that she often felt angry and embarrassed when Rachel attempted to socialize with Rebecca and her friends. The team saw Rachel's desire to spend more time with Rebecca as a way to fulfill her unmet needs for attention but also saw this responsibility as inappropriate for Rebecca to wholly assume. To enhance the sibling alliance while promoting appropriate boundaries, we helped create a "deal" such that Rebecca would spend sister time (10–15 min a week) with Rachel playing a game if Rachel would not intrude on Rebecca's time with her friends. The children later reported success with this arrangement.

In an effort to enhance effective communication for the entire family, a session was dedicated to an activity in which the parent and child dyads were separated and seated facing each other. In this seating arrangement, the family was asked to discuss how to problem solve highly emotional situations at home. We sat behind each dyad providing guidance on how to more productively communicate with and listen to one another. The family thought that the exercise was quite successful and hoped that they could carry the strategies home. The final session encompassed a review of the work, appreciations, and ideas about practicing the new skills at home.

By the end of the family therapy sessions, we felt that the family unit had become more functional and structured, with appropriate hierarchies in place. For example, Sherry and Aaron displayed acceptance of their new leadership roles when Rebecca initially showed resistance to attending the sessions. They required that Rebecca attend the sessions, although they also showed her empathy by communicating that they understood her frustration. At the conclusion of the process, Sherry shared, "I think the big thing is just learning that I need to reassure them that I'm strong and that Daddy and I help each other. We use each other to give each other strength."

SUMMARY/DISCUSSION

The TA with Rachel involved 10 sessions dedicated to initial interviews, testing sessions, a family intervention session, and parent and child feedback sessions. When we first met Rachel and her family, their initial concerns focused on her social difficulties and bossiness. The TA allowed us to work with the family to determine that Rachel's difficulties were more complex and systemic than originally thought. The major feedback presented to Sherry and Aaron involved a discussion of Rachel's emotional sensitivity, the stressful events in her early life that had

an impact on her development, and the need for the family to help Rachel further develop her understanding and management of emotions. Although the assessment findings were different than what the family was originally expecting, the collaborative nature of TA allowed us to help the family slowly move toward a new understanding, or story, of Rachel and their family as a whole. Given the vulnerability of this family to shame, the collaborative approach seemed essential in helping them understand their difficulties without feeling overwhelmed or humiliated.

The family therapy sessions focused on helping the family to incorporate the new systemic information learned from the assessment and to use this information to improve the family dynamic, thus heightening the utility of the TA. The family was encouraged to interact in a connected rather than competitive manner, and Sherry and Aaron were asked to take more of a leadership role in structuring family interactions. By the end of these sessions, the family was able to interact in a more connected way. Sherry and Aaron were also able to be a more effective leadership team. Once Sherry and Aaron were able to demonstrate greater leadership in the family, we were able to help Rachel and Rebecca develop a healthier sibling relationship. The addition of family therapy sessions following Rachel's TA illustrated that providing such services to families may help them consolidate and incorporate further therapeutic changes.

Although this TA utilized a three-person assessment team, two supervisors, and two research assistants, in clinical practice, a solo well-trained clinician can offer the service. Finn (2007) delineated numerous ways a single assessor can engage parents as collaborators in their children's assessments. For example, rather than having parents observe assessment sessions from behind a two-way mirror, S. E. Finn often has them sit in the testing room behind the child's back. Then Finn either checks in with parents at the end of the session (if the child can be left in a play or waiting room) or calls the parents at home later to discuss their observations, thoughts, and emotional reactions.

Our work with Rachel and her family illustrates how TA can be used both to help a family develop more empathy and understanding for their child and as a springboard for subsequent family intervention. Our hope is that Rachel's TA, along with those of the other families we have worked with in TAP, will continue to demonstrate the many ways in which this collaborative model can contribute to the field of psychological assessment. It is our belief that TA is a beneficial model for children, their families, adults, and professionals alike. As we and others continue to study TA, we encourage professionals to begin incorporating collaborative assessment practices into their everyday work.

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