

Therapeutic Assessment With Children: A Pilot Study of Treatment Acceptability and Outcome

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Therapeutic Assessment (TA) with children is a hybrid of psychological assessment and short-term intervention. It uses the ongoing process and results of psychological assessment to enhance parents' understanding of their child and to facilitate change. Clinical reports and single case studies suggest that TA with children is an acceptable and effective brief intervention. However, no aggregate data have been published to support this claim. This pilot study investigated the acceptability and preoutcome–postoutcome of TA with 14 clinically referred children with emotional and behavior problems and their parents. Results indicated high treatment acceptability as well as significantly decreased child symptomatology and enhanced family functioning as reported by children and mothers. In addition, mothers demonstrated a significant increase in positive emotion and a significant decrease in negative emotion pertaining to their children's challenges and future. The findings, although limited due to the design and small sample size, support assertions from published single case studies that TA is possibly an efficacious child and family intervention for children with emotional and behavioral problems and should be studied in a larger, comparison design.

Therapeutic Assessment (TA), developed by Finn (1996, 1997, 2003), Finn and Kamphuis (2006), and Finn and Tonsager (1997), is a method of assessment that is collaborative, is guided by consumers' questions of interest, and uses psychological assessment as the centerpiece of a potent, short-term intervention. TA seeks to make assessment an acceptable and beneficial experience for clients through collaboratively involving them in the assessment process and helping them to make meaning of the findings in relation to their everyday lives. The primary goal of TA with children is to provide a family systems intervention in the context of a collaborative child assessment. The collaboration is primarily with the parents; therapeutic alliances are sought with the child and the parent. The aims are (a) to help parents understand and become more empathic to their child's challenges through their ongoing processing of the findings from the child's testing and (b) to guide parents in shifting their attitudes toward and interactions with their child in ways that will foster positive child and family development. To date, published controlled research on TA has been conducted exclusively with adult clients. Studies by Finn and Tonsager (1992) and Newman and Greenway (1997) have documented positive treatment effects of TA with adults including decreased symptomatology and increased self-esteem and hopefulness. In addition, Ackerman, Hilsenroth, Baity, and Blagys (2000), who used a modified version of Finn's (2007) model, found that following TA, adult clients were more likely to complete recommended treatment and felt a stronger alliance with their assessor than did those who received a traditional psychological assessment. Finn (1996, 2003), Finn and Martin (1997), Finn and Kamphuis (2006), and Fischer and Finn (2008) have provided detailed adult case illustrations containing verbatim transcripts

of clinical sessions that have demonstrated convincing positive change.

Although collaborative and therapeutic assessments have been used for some time with children, we know of no published studies examining the acceptability or outcome of these methods with a group of children and families. However, there have been numerous published clinical case studies of collaborative and therapeutic assessment with children and adolescents (DuBose, 2002; Fischer, 1985/1994, Fulmer, Cohen, & Monaco, 1985; Hamilton et al., 2009; Handler, 2006; Michel, 2002, Mutchnick & Handler, 2002; Pollack, 1988; Purves, 2002; Quirk, Strosahl, Kreilkamp, & Erdberg, 1995). In these cases, parents have indicated decreased behavioral problems and improved mood and social functioning in their children. Parents also have reported gaining an enhanced understanding of their children's problems, feeling more effective in their parenting, and being more motivated to pursue appropriate services subsequently.

The Therapeutic Assessment Project (TAP) is the first study to evaluate systematically the treatment acceptability and outcomes of TA with a child clinical population. A case study repeated measures (preassessment and postassessment) design, with both quantitative and qualitative methodologies, was utilized in TAP. In this article, we present the quantitative results. It is important to note that although TA is proposed to be effective with a variety of types of assessment (e.g., psychoeducational, social/emotional/personality, and neuropsychological), the TAs provided in our study were primarily focused on social/emotional/personality concerns, as participants were sought who had challenges in these areas.

An overview of the methods used in TAP can be found in Tharinger, Finn, Wilkinson, and Schaber (2007). As TAP is a preliminary research program, we made no attempt to control for competing change agents such as nonspecific therapeutic elements like clinician attention or regression to the mean via one or more control groups. Our goal was simply to see if we could document in a group of children the kinds of positive

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effects that have been reported in single case studies. In the event that such positive effects were demonstrated, we reasoned that it then would be prudent for further studies to control for threats to the internal validity of the claim that TA is, in fact, a specific beneficial change agent. If we could not document such effects, there is no reason to proceed with more elaborate and expensive controlled studies.

The following hypotheses guided this pilot study: (a) that that ratings of children's symptoms of psychopathology would decrease and ratings of positive family functioning would increase, as reported by children and mothers; and (b) that parents would report more positive and less negative emotions.

METHOD

Recruitment

Participants were referred to TAP from the waiting list of an outpatient, public community mental health clinic serving children and families in a large Southwestern city. The clinic intake coordinator invited the parents of potential participants to take part in the study if the following criteria were met: (a) The parents were seeking assessment or intervention services for a child between the ages of 7 and 11 due to moderate to serious social, emotional, or behavioral concerns that included depression, oppositional and conduct problems, trauma reactivity, encopresis, anxiety, and strained parent-child relationships; (b) the family appeared likely to be able to attend weekly sessions at the nearby university over a 3-month period (i.e., had transportation and perceived interest and motivation); and (c) the child and/or family were not currently participating in a psychosocial intervention focused on the child. Interested parents contacted D. J. Tharinger and were given additional information. Parents were informed that the length of participation would approximate the waiting time to receive services at the public community clinic, which was 3 months at the time. The parents were told that they would be placed at the top of the clinic's waiting list immediately on their completion of the TA and would subsequently receive intervention services from the clinic within 1 to 2 weeks. The assumption that most or all parents would seek additional intervention services limited the possibility of obtaining meaningful follow-up findings that could be linked specifically to the impact of the TA; therefore, we do not have follow-up data to report. Families who elected to participate then met with members of a TAP Research Team to sign consent and assent forms, complete preassessment research measures, and schedule their first TA session. All procedures were approved by the Institutional Review Board at the University of Texas at Austin.

Participants

A total of 14 children and 14 female caregivers (2 of whom were grandmothers with longstanding legal custody) participated in the study. A total of 8 male caregivers (fathers, stepfathers, grandfathers) also participated in the TAs, as well as predata and postdata collection. However, the fathers' data are not reported here due to the very limited sample size. The children, 10 boys and 4 girls, ranged in age from 8 to 11 years, with a mean age of 9 years 2 months. Of the children, 10 were White and 4 were of mixed ethnicity. The mothers ranged in age from 28 to 68 years, with a median age of 40; 12 were White, 1 was Hispanic, and 1 was of mixed ethnicity. Family structure

varied across the 14 participating families. In 5 of the families, the child lived with biological parents or grandparents and in 1 with adoptive parents. In 4 families, the child lived with the biological mother and stepfather. In the remaining 4 families, the child lived with the mother, with various levels of contact with his or her biological father. More than half of the families were experiencing significant stressors; 7 appeared to be overtly challenged by family issues, the most common of which were unresolved separation/divorce and coparenting or stepparenting issues. An additional 2 families appeared to have marital issues that likely influenced their effective functioning. The remaining 5 marriages seemed to be functioning fairly well. The annual income of the households ranged from less than \$25,000 to more than \$100,000, with 80% of the families earning less than \$50,000. For 3 of the families, lack of financial resources appeared to be a constant and significant stressor.

We encouraged and facilitated the families obtaining services at the referring community guidance center after the TA; 7 of the 14 families sought child or family therapy after completing the TA (typically within 2–4 weeks): 5 at the referring community child guidance clinic, 1 with a private practitioner, and 1 from TAP (we conducted a 6-session, family-based intervention for 1 family who was aware of this option at the beginning of the study—see Hamilton et al., 2009).

Research Measures

The Behavior Assessment System for Children-Parent Report Scales-Child (BASC-PRS-C; Reynolds & Kamphaus, 1992). The BASC-PRS-C is a 138-item behavior rating scale that parents complete about children between the ages of 6 and 11 years old. Each item includes a descriptor of behavior and is rated on a 4-point scale. The BASC-PRS-C provides *T* scores for nine clinical scales, three adaptive scales, and five composite scales. The Externalizing Problems, Internalizing Problems, and Behavioral Symptoms Index (BSI) composite scales were used in this study, as the individual clinical scales would have been too specific given the variety of presenting problems and concerns across the cases. The BASC-PRS-C has satisfactory reliability and validity (Reynolds & Kamphaus, 1992).

The BASC-Self-Report of Personality-Child (BASC-SRP-C; Reynolds & Kamphaus, 1992). The BASC-SRP-C is a 152-item self-report personality inventory for children between the ages of 8 and 11 years old. Items are rated true or false. The BASC-SRP-C provides *T* scores for eight clinical scales (Anxiety, Atypicality, Locus of Control, Social Stress, Attitude to School, Attitude to Teachers, Depression, and Sense of Inadequacy), four adaptive scales, and four composites. The BASC-SRP-C has adequate reliability and validity (Reynolds & Kamphaus, 1992). A composite score from five of the eight clinical subscales (Anxiety, Atypicality, Locus of Control, Social Stress, and Depression) was constructed for this study. This composite is equivalent to the Clinical Maladjustment Composite developed by Reynolds and Kamphaus (1992), adding the Depression subscale. (As many of the children in our study presented with depressive features, we felt it was important to include measurement of this syndrome.) We titled the composite "Clinical Maladjustment and Depression." Although the construct of locus of control may not appear to fit with a scale of general distress and maladjustment, an examination of the items indicated an emphasis on powerlessness, particularly in the family

context, and therefore we felt it was a useful contribution to the composite.

Self-Report Measure of Family Functioning–Child, Revised (SRMFF–CR; Stark, 2002). The SRMFF–CR is a 40-item self-report measure of family functioning and environment that was completed by both the children and the mothers. It is rated on a 5-point scale ranging from 1 (*Never True*) to 5 (*Very True*). This instrument is the revised version of the Self-Report Measure of Family Functioning (SRMFF; Bloom, 1985). The original SRMFF was modified to simplify the language of the items to increase the measure's accessibility to children (Stark, Humphrey, Crook, & Lewis, 1990). The measure was subsequently revised to improve the wording of items and remove subscales that were not validly measuring the intended underlying constructs. The SRMFF–CR yields information on six subscales: Communication, Conflict, Social/Recreational Orientation, Cohesion, Laissez-Faire Style, and Authoritarian Style. The three subscales used in this study were Communication, Conflict, and Cohesion; we totaled them to comprise a composite index of Family Connection, which consisted of the mean score across the items. Cronbach alphas for these subscales have been reported by Greenberg, Sander, and Stark (2008): Conflict = .74, Communication = .87, and Cohesion = .73.

Parents' Positive and Negative Emotions About Their Child (PPNE–C). This pilot instrument is a 10-item self-report questionnaire we created for this study to investigate possible changes in parental empathy and hopefulness. It uses a 5-point scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The questionnaire reads, "Today as I think about my child's challenges and future I feel . . ." and lists five positive emotions ("patient," "sympathetic/empathetic," "compassionate," "hopeful," and "positive") and five negative emotions (i.e., "frustrated," "like I want to give up," "at my wits' end," "discouraged," and "anxious"). The mean scores are totaled for two subscales, Positive Emotion and Negative Emotion. Cronbach's alpha was computed for each subscale (Positive = .74; Negative = .66).

Client Satisfaction Questionnaire–Revised (CSQ–R; Larsen, Attkisson, Hargreaves, & Nguyen, 1979). The CSQ–R is an eight-item self-report questionnaire that measures satisfaction with mental health services; it was completed by the mothers. It uses a 4-point scale ranging from 1 (*poor*) to 4 (*excellent*). The measure results in two subscales: Service Satisfaction and Help Received. The measure was modified slightly from the original CSQ by altering several items to refer to the child as the client. Psychometric properties of the original scale are acceptable (Larsen et al., 1979; Weltzien, McIntyre, Ernst, Walsh, & Parker, 1986), and it is assumed that the minor modifications had minimal effect on reliability and validity.

Research Procedures

The parents and children came to the university clinic site for all research activities and TA sessions. The clinic was equipped with observational rooms with one-way mirrors as well as the capacity for digital video recording. Research data were collected, in each case, by a team of two trained doctoral graduate students. One research team member worked primarily with the parent(s) and the other with the child. Each assessment was

conducted by two or, in two instances, three advanced doctoral graduate students (referred to as the Assessment Team), trained extensively in TA by Dr. Finn and supervised by Drs. Finn, Tharinger, and Frackowiak. In each case, the Assessment Team was not privy to any of the research findings until the family had completed their participation in the project. There were two phases of research data collection: preassessment and postassessment. At preassessment, mothers completed a demographic form constructed for this project as well as the BASC–PRS–C, the SRMFF–CR, and the PPNE–C. The children completed the BASC–SRP–C and the SMRFF–CR. At posttesting, the mothers and children completed the identical measures, and mothers also completed the CSQ–R.

All mothers completed all the measures. All but two children completed preassessment and postassessment research measures. One child who was extremely oppositional refused to complete the postmeasures (although he participated in all assessment sessions), and thus his data were not used. (His mother's data were complete and were used.) Another child completed most of the premeasures and postmeasures, but his data were deemed invalid due to his limited cognitive abilities and inconsistent patterns of response. (He also participated in all assessment sessions.) His data were not included in the analyses, but his grandmother's data were complete and were used. Also, we failed to administer the SRMFF–CR to one child at postassessment; thus, all analyses of that measure include only 11 children. Finally, the PPNE–C was not introduced into the study until we had completed our work with four of the participating families. As such, there are data for only 10 mothers on this measure.

Therapeutic Assessment Protocol

Each TA consisted of approximately eight 1.5-hr sessions conducted approximately weekly over a 3-month period for an average of 12 hr of direct service. This 12-hr average is longer than the typical direct time in a traditional assessment but is not unlike a typical course of brief family or cognitive behavioral treatment. The TA protocol is briefly described herein (see Hamilton et al., 2009; Tharinger et al., 2007; and Tharinger & Roberts, in press, for a detailed description of the TA protocol).

The first session consisted of a parent interview in which the Assessment Team helped the parents formulate individualized "assessment questions" to guide the assessment (and later to organize the parent feedback) and gathered background information related to the questions. In the second session, the Assessment Team first checked in with the parents and then invited the child to join the session. At that time, the parents were asked to present one of their assessment questions to the child, typically one that asked how the family could work together on the presenting problems. Then the child was invited to pose his or her own assessment questions. Subsequently, the parents were invited into an observation room equipped with a one-way mirror (or in two cases to watch a monitor equipped with a video feed) to watch their child's session accompanied by one member of the Assessment Team. The child remained with the other Assessment Team member and was given another opportunity to raise questions or concerns for the assessment. The remainder of this session typically involved inviting the child to complete Human Figure Drawings (HFDs; Tharinger & Roberts, in press) and to engage in free play while the parents observed and collaborated with one of the assessors.

The subsequent four to five sessions consisted of child testing activities using a variety of instruments chosen according to their relevance to the assessment questions posed in each individual case. As all of our cases included questions related to the children's social, emotional, and behavioral functioning, HFDs, free or structured play, idiographic sentence completions, thematic apperception stories in response to Thematic Apperception Test (Murray, 1943) and Roberts Apperception Test (McArthur & Roberts, 1982) cards, and the Rorschach (Exner & Erdberg, 2005) were utilized along with extended inquiry procedures (Handler, 2006). For several cases, the Early Memory Procedure (Bruhn, 1990) and Adult Attachment Projective (George, West, & Pettem, 1997) were utilized (see Hamilton et al., 2009, for an example). For approximately 50% of the cases, psychoeducational and tests of attention were also utilized. The parents continued to observe from behind the mirror (or watch the video feed monitor) and collaborate with an assessor while the child was tested. These interactions allowed the assessor to explain the assessment methods being used, address questions from the parents, begin to discuss some of the findings, and in general support the parent in coming to understand and interact with their child in new ways. Thus, the nature of the work with the parents behind the mirror was dependent on the child's test responses and the parents' reactions and associations to these. In addition, the assessors made a point to relate the child and parent responses and accumulating findings to the assessment questions that the parents had posed at the beginning of the assessment. Thus, feedback began early and was continuous, cumulative, and collaborative. As appropriate, the parents also met with the Assessment Team at the end of the session, without the child, for further clarification of their observations. These "check-outs" allowed for further opportunity to collaborate and process the findings from the child's testing.

After the completion of the formal testing sessions, a structured family intervention session was held (see Tharinger, Finn, Austin, et al., 2008). The plan and format of this session was individually designed to meet the needs of each family and to further explicate the accumulating assessment findings, that is, to "bring them alive" in the session. In the following session, the Assessment Team met with the parents to provide feedback in the form of answers to the parents' assessment questions (Tharinger, Finn, Hersh, et al., 2008). The Assessment Team followed a comprehensive plan/outline in this session, which incorporated Finn's (2007) concept of "three levels of feedback"; remained flexible; and accepted and responded to parents' comments, additions, and disagreements. Overall, the clinicians strove to assist the parents in coming to a new explanation of, or story about, the child/family based on the assessment findings that they had absorbed along the way and their now taking in the integrated findings. At the end of this session, plans were discussed for the subsequent and final session, the child feedback session, which took place the following week and included the child and the parents. In this last session, each child was presented with a unique "fable" written especially for the child by the Assessment Team (see Tharinger, Finn, Wilkinson, et al., 2008). The fable was constructed based on the assessment findings that we thought would be accessible to the child as well as supported strongly by the parents. The fable metaphorically presented the child's challenges followed by a potential solution, or next step, for the future, usually one in which the parents responded to and supported the child in new ways. The child

was invited to edit the fable in any way she or he wished. Each family left with a copy of the fable in hand. In our experience, the fable also is an effective way to continue to communicate and collaborate with the parents.

Within the next 2 weeks, the Assessment Team sent a letter to the parents summarizing the assessment results as well as the recommendations that had been discussed during the feedback session (excerpts from a sample letter are published in Tharinger et al., 2007). The letters were based on the outline presented in the parent feedback session.

RESULTS

Participation and satisfaction among the families with whom we worked was noteworthy. All 14 families who began the project completed the TAs, with the average number of TA sessions being 8.1. All parents readily coconstructed assessment questions, as did several of the older, verbally advanced children. In addition, mothers reported high satisfaction with the services they received following the completion of the TA on the CSQ-R, with Service Satisfaction, $M = 3.7$, $SD = .39$, and Help Received, $M = 3.4$, $SD = .60$ in which 4 = "highly satisfied."

To examine pre-post changes in reported child symptomatology on the parent and child version of the BASC, we conducted four 1-tailed repeated measures t tests using the Internalizing Problems, Externalizing Problems, and BSI composite scores from the BASC-PRS-C as well as the constructed Clinical Maladjustment and Depression Composite score from the BASC-SRP-C. Cohen's d was used to report effect sizes. The most accepted rubric for effect size interpretation is that of Cohen (1992) in which 0.2 is indicative of a small effect, 0.5 a medium, and 0.8 a large effect size.

Mothers indicated a significant decrease in their ratings of Externalizing Problems (pre $M = 70.1$, $SD = 14.09$; post $M = 64.8$, $SD = 12.14$), $t(13) = 2.01$, $p = .05$ and a small to medium effect size ($d = 0.41$) as well as a significant decrease in their ratings of Internalizing Problems (pre $M = 62.0$, $SD = 12.19$; post $M = 58.4$, $SD = 14.24$), $t(13) = 1.75$, $p = .05$ and a small effect size ($d = 0.28$). The mothers' ratings on the BSI composite score also revealed a significant decrease (pre $M = 67.6$, $SD = 12.34$; post $M = 63.5$, $SD = 10.11$), $t(13) = 1.78$, $p = .05$ and a small to medium effect size ($d = 0.36$). Results from the children's scores on the Clinical Maladjustment and Depression Composite revealed a significant decrease in children's self-ratings (pre $M = 49.2$, $SD = 7.12$; post $M = 44.4$, $SD = 5.72$), $t(11) = 3.18$, $p = .01$ and a large effect size ($d = 0.74$).

To examine pre-post changes on the Family Connection composite index, we performed two 1-tailed repeated measures t tests. Children reported significant increases in Family Connection pre, $M = 3.7$, $SD = .61$; post $M = 4.1$; $SD = .66$, $t(10) = 3.13$, $p = .01$ and a medium effect size ($d = 0.50$) as did mothers (pre $M = 3.5$, $SD = .71$; post $M = 3.8$, $SD = .67$), $t(13) = 1.80$, $p = .05$, with a small to medium effect size ($d = 0.38$).

To examine pre-post changes on the mothers' PPNE-C, we conducted two 1-tailed, repeated measures t tests. Mothers reported a significant increase on the Positive Emotion subscale (pre $M = 4.0$, $SD = .77$; post $M = 4.4$, $SD = .44$), $t(9) = 2.26$, $p = .05$ and a medium effect size ($d = 0.58$) as well as

a significant decrease on the Negative Emotion subscale (pre $M = 3.0$, $SD = .94$; post $M = 2.3$, $SD = .67$), $t(9) = 3.19$, $p = .01$ and a large effect size ($d = 1.18$).

DISCUSSION

Our results indicate that both mothers and children participated and engaged enthusiastically in the process of TA. In addition, mothers reported satisfaction with the services and help they received after completing a TA. Thus, TA seemed to have high acceptability to participating mothers and children. We believe these findings are important, given that Finn (1996, 2007) and others have found that many consumers of psychological assessment are quite unhappy with the assessments they take part in and often feel that their own concerns were not addressed or that they were not given adequate feedback. We hypothesize that the collaborative principles and procedures embodied in TA with children (perhaps particularly the collaboration with the parents as they cumulatively process their child's testing results in relation to the assessment questions they have generated) make psychological assessment a much more satisfying experience for parents. However, this question remains to be addressed with more specific measurement and with a comparative study.

It is important to note other possible contributors to the general finding of acceptability. First, the intake professional at the community mental health center screened potential families for inclusion in the project based on parents' apparent motivation to participate in the assessment. Thus, the sample may have been biased. Second, once identified, participating families received the TA and all associated services free of charge. Furthermore, throughout each of the TAs, we strove to create a welcoming and hospitable environment for all participating families by offering beverages and snacks, child care for siblings, T-shirts for the participating children, and flexible scheduling. (Such accommodations are in keeping with the spirit of collaborative/therapeutic assessment but may not be feasible in many clinical settings.) In short, we worked to provide a consistently positive atmosphere for the participants (which we actually view as a part of collaboration). Therefore, we may have "overdetermined" acceptability, depending on what one sees as desirable conditions of service provision.

We were also interested in outcomes beyond satisfaction. Our results indicated that mothers and children, using broad composite scores, both reported statistically significant improvements in their perceptions of the child's symptomatology. These results are important given the relatively short-term nature of the TA intervention, its multiple aims, and the comparable effect sizes to studies of the efficacy of various psychological treatments for youth that have used symptom reduction as a major outcome (Miller, Wampold, & Varhely, 2008). It is also possible that the use of composite scores was not sensitive to more case-specific changes depending on the child's constellation of symptoms. In future studies, it will be important to measure changes that reflect each child's individual profile.

In addition, given the possibility of TA acting as a family systems intervention, we were interested in measuring possible changes in family functioning. We found that both mothers' and children's perception of family functioning (looking across a composite index of enhanced communication and cohesion as well as decreased conflict) improved following their participa-

tion in the TA. These findings are important and encouraging, as one of the hypothesized mechanisms of TA, similar to many psychotherapies but not traditional assessment, is the alliance established between the client and the assessor (Tharinger, 2008). In the case of TA with children, there is an alliance established between the assessor(s) and the parents and a separate alliance formed with the child (likely heightened if two assessors are involved). As the TA progresses, the potential is great for creating a bridge across the two alliances and thus supporting improved relationships between the child and the parents. As it has been our clinical experience that the relationship between parents and children is almost always severely taxed when they enter a TA experience (with scapegoating of the child a common pattern), we are pleased to see that the experience of a TA may help shift that dynamic. Future research should continue to explore this possibility.

We were also interested, based again on our clinical observations of the negative attitudes held by many parents toward their children (usually families are quite stuck when they seek a TA), in determining whether TA would facilitate a shift in parents' feelings about their children. The mothers in our study reported significantly more positive and, perhaps most important, less negative emotion toward their child's challenges and future from the beginning to the end of TA. Changes in parents' attitudes and feelings toward their children may be a key mechanism underlying other therapeutic changes. For example, postinterview data indicated that in many of our cases, attributional shifts occurred on the part of parents. Whereas prior to the assessment, many children were judged to be "bad" and individually responsible for their problems, after the assessment, they were seen as "hurt" or "troubled" or "sad," and parents recognized their own contributions to the children's difficulties. An old family therapy saying is, "If you can change the viewing, you can change the doing." It is possible that TA is uniquely suited to help parents become more empathic to their children, a shift that then has the potential to change the transactional patterns within the family. Future research hopefully will examine this possibility more fully.

Clearly, there are a number of methodological, design, and analytic limitations to this pilot study. First and foremost, the results are limited and must be interpreted with caution given the small sample size and the lack of a control or comparison group. Even though positive changes did occur, we are unable to eliminate threats to internal validity such as regression to the mean or nonspecific therapeutic factors such as clinical attention. In addition, due to our small sample size and the ethical requirement to support families who wanted follow-up clinical services to receive these immediately, we were not able to investigate whether the changes we noted in our participants from pretesting to posttesting were sustained over an appropriate follow-up period, say of 3 to 6 months. Finally, although the graduate student assessors were dedicated, enthusiastic, and well supervised, their practice of TA was not at the level of experienced clinicians. It is possible that our results underestimate the positive outcomes that can occur when highly trained psychologists conduct the assessments.

It is important to address the generalizability of the TA methods to other settings. TA requires a high level of competence on the part of the assessor in assessment and intervention skills as well as practice in their integration. Practitioners will need additional training in this integration and in how to use

assessment in a collaborative way with clients. Many practicing assessors are interested in obtaining training in TA, and as this need is met, we are encouraged that the practice of TA, or at least a version of it, will become more common in many settings.

It may not be possible in many or most settings to utilize two assessors, which may limit the intensive “in the moment” collaboration with the parents. However, Finn (2007) has successfully practiced TA with children as a solo practitioner for decades.

It also is important to begin to ascertain the set of assessment principles that best comprise TA with children. As our work is still in the beginning stage, it is premature to offer any definitive list. However, at this time, both through our clinical work and research, we offer the following guidelines: (a) seek assessment questions collaboratively from parents and children; (b) create the conditions for secure alliances to be established with the parents and the child; (c) after standardized testing procedures with the child, be creative and engage in an extended inquiry that allows for a fuller idiographic process; (d) process the testing findings along the way with the parents to allow them time to absorb and integrate the information in the context of a strong, supportive alliance; (e) provide feedback in a way that builds on parents’ new understandings, responds to their assessment questions, and connects the assessment results to their everyday life with their child; (f) provide feedback to children in a way they can process and understand, with attention to strengthening the child–parent relationships; and (g) be flexible and respectful every step of the way.

We think that the positive results of this study, although not conclusive, indicate that more expensive, rigorously controlled studies with larger numbers of participating families are warranted. There are several paths that such research could now take. Future research should utilize a larger sample and include a wait list control or better yet a comparison group. It would be interesting to contrast TA with children with “psychological assessment as usual” to ascertain if and how the active collaborative methods and interventions used in TA affect clinical outcomes and client experiences of an assessment. It also would be instructive to contrast TA with a course of family therapy to investigate how the process and outcomes of psychological testing in TA compare to those of family therapy. These suggestions reflect the hybrid that TA is: assessment and intervention (or collaborative assessment “as” intervention). Finn and Tonsager (1997) and Hayes, Nelson, and Jarrett (1987) have outlined a number of relevant designs.

In conclusion, our results are promising and support the claims reported in single case studies that TA is an effective intervention for some latency-aged children and their families. These accumulating findings are important in that as children are frequent recipients of psychological assessment, children and their parents stand to experience positive benefits as psychologists integrate TA methods into their child assessment procedures.

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