

Therapeutic Assessment With Children and Families: Current Evidence and Future Directions

by Justin D. Smith*

Children and adolescents are referred for psychological assessments with a host of identified problems, ranging from aggression and impulsivity to depression and academic difficulties. Despite abundant empirical, theoretical, and clinical knowledge of the influence of family and other systems, many clinicians and parents nevertheless focus solely on the child's problems, with little parental involvement in the child's assessment. This approach has been termed "traditional assessment" and typically focuses on gathering information in order to determine diagnoses and plan subsequent treatment (Finn & Tonsager, 1997).

More recently, some prominent experts in the field of assessment psychology have noted a paradigmatic shift in the way child and adolescent assessments are conducted and conceptualized toward more *collaborative* and *therapeutic* approaches that intend to more fully engage and potentially produce change in clients (e.g., Finn, 2007; Handler, 2006; Tharinger Finn, Austin, et al., 2008). From this shift, the Therapeutic Assessment (TA) model has emerged as an innovative and promising intervention for children and families that blends the extensive conceptualizing benefits of assessment with evidence-based brief psychotherapeutic techniques (Finn, 2007). This article describes the application of the TA model with children and families and presents the current empirical evidence for its effectiveness.

The Therapeutic Assessment Model: History, Goals, Theoretical Foundations, and Core Values

The TA model is a semistructured, brief therapeutic intervention grounded

in psychological assessment developed by Stephen Finn and colleagues at the Center for Therapeutic Assessment in Austin, Texas (Finn, 2007; Finn & Tonsager, 1997). TA is based on the work of such psychologists as Constance Fischer (1985), Leonard Handler (1995; 2006), and Caroline Purves (2002), who, along with Finn, pioneered the therapeutic and collaborative assessment movement over the past quarter century. One way in which TA differs from traditional assessment is the overarching goal of the model, which is to provide an experience that shifts the "story" parents hold about their child toward one that is more coherent, accurate, compassionate, and useful (Finn & Tonsager, 1997; Tharinger et al., 2007).

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Drawing from the principles of phenomenological, intersubjective, and interpersonal psychology, Finn and Tonsager (2002) describe how TA interacts with clients' motivations for gaining a better understanding of themselves and/or their children, in an effort to produce change. A successful TA leads to new ways of understanding the child's and family's problems, and to more positive and effective ways of interacting with the child.

TA's theoretical foundation comprises several perspectives, including family systems (e.g., Sholevar, 2003), narrative (e.g., Josselson et al., 2007), and self-verification theories (e.g., Swann et al., 2007). The procedures of TA also facilitate the development of a working alliance between the child and the clinician and the clinician and the family (Hilsenroth et al., 2004; Smith et al., in press; Tharinger et al., 2009), which has been found to account for substantive variance in treatment outcome (Samstag, 2006). TA is guided by a set of core values and defining characteristics that govern all applications of the model. These core values are collaboration, humility, respect, compassion, and openness/curiosity (Finn,

2009). The core values and goals serve to differentiate TA from the practice of traditional assessment and are foundational to the techniques employed in TA, including the therapeutic use of assessment instruments, and the way in which assessment findings are discussed and disseminated to the parents and child. The defining characteristics of the TA model are embedded within six phases:

1. The assessment question and relationship-building phase;
 2. The test-administration phase;
 3. The intervention phase;
 4. The summary/discussion phase;
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5. The written communication of feedback phase; and
 6. The follow-up period.

TA was originally developed as a therapeutic process of conducting psychological assessment. Early studies demonstrated empirical evidence regarding the therapeutic effectiveness of components of the model (e.g., the process by which findings are presented to and discussed with clients), which suggested the potential of utilizing TA as a treatment modality (e.g., Finn, 1996; Finn & Tonsager, 1992; Newman & Greenway, 1997). Finn (2007) describes TA's evolution, particularly the way in which each component was developed and incorporated into what is now referred to as the "comprehensive TA model," which is presented in the next section.

The evidence from a small body of empirical studies employing the comprehensive TA model with children and families is promising (Smith et al., in press; Tharinger et al., 2009). Given these findings, and those in which components of the comprehensive model, alone, have some therapeutic effectiveness, TA can be characterized as both a

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therapeutic assessment process and a brief therapeutic intervention, depending on the application of the model, the aim of the clinician, and client factors. The following section discusses the specific procedures and components employed with children and families. (A variety of TA-related resources, and the dates and locations of upcoming training workshops, are available on Stephen Finn's website: www.therapeuticassessment.com.)

Therapeutic Assessment With Children and Families (TA-C)

Given the systemic nature of many children's problems, and agreement among

of the intervention. The other phases of TA-C may include the entire family or just the parents.

The following description is a summary of each component of the comprehensive TA-C model, on which Tharinger, Krumholz, Austin, and Matson (in press) have written an extensive chapter. Finn has noted that certain settings, clients, clinicians, and available resources may preclude adoption of all six phases, and he encourages clinicians to adapt the model accordingly.

Assessment Question and Relationship-Building Phase. In accordance with the core values of TA, the goals of the initial meeting include establishing a safe and

questions about the child in a reliable and valid fashion (Finn & Tonsager, 1997). Clinicians practicing TA administer tests according to their proscribed standardized protocol in order to protect the integrity of norms-based comparisons, but tests also serve other functions in TA that transform them into therapeutic tools.

In TA-C, where parents observe the testing, assessment instruments provide the child with an avenue to communicate with the clinician and parents regarding his or her perceptions on the identified problems. In contrast to the anxiety-provoking nature of direct dialogue about difficult or shameful issues, assessment instruments provide stimuli for indirect expression. This often occurs through the use of extended inquiry procedures as simple as asking the child to reflect, or further elaborate, upon a particular response: When administering commonly used self-report measures, such as the Youth Self-Report (YSR; Achenbach, 1991) or the Behavior Assessment System for Children (BASC; Reynolds & Kamphaus, 2004), the clinician often uses particular responses to gain additional information. For example, if a child responded that he or she often feels depressed, the clinician might say to a child: "Can you tell me about a time when you felt depressed?" or "What came to mind when you were answering this question?" Similarly, the clinician might ask the child to tell a story about a time he or she felt depressed. These inquiries provide the clinician with additional background information about the child and his or her experiences, and an individualized context for interpretation of nomothetic scores, while further promoting the observing parents' curiosity and understanding of their child.

A second consideration is that prior to adolescence, children have yet to fully develop self-reflective capacities, which makes explicit communication about feelings and their correlates difficult. Due to the goal of assisting parents and caregivers in coming to understand their child differently, many clinicians who practice TA utilize performance-based assessment instruments, such as the Roberts Apperception Test (Roberts & Gruber, 2005), Rorschach (Exner, 2003), and other semistructured storytelling or drawing exercises. These instruments are by no means mandated by the TA-C model, yet have been found to be fruitful in promoting parents' curiosity about their child, which in turn stimulates discussion with the clinician.

Parent observation and discussion of findings can also be used in conjunction

The parents reported that the ability to observe and collaboratively discuss their child's testing was one of the most effective components of the intervention.

experts regarding the importance of treating the child within the greater family context (Dishion & Stormshak, 2007; Pardini, 2008), collaboration with the family is a central feature of TA-C. From the outset, parents/caregivers are enlisted as collaborators in all aspects of the intervention: setting goals, gathering background information, interpreting their child's responses and test performance, discussing scores and hypotheses derived from the testing, and reviewing written reports at the end of the assessment. The clinician's relationship with each family member also becomes a venue for gathering important information about family processes and dynamics (Finn, 2007; Tharinger, et al., 2007).

One distinctive arrangement of TA-C is that parents observe the testing of their child, either in the room, through a one-way mirror, or on a television screen in a separate room via a video link. In some situations (e.g., Tharinger, et al., 2009), two clinicians work with each family, which allows one clinician to dialogue and process the session with the parents as the assessment unfolds. Other studies have shown that a one-clinician adaptation is also effective (e.g., Smith et al., in press). When using one clinician, parents are asked to take notes regarding their impressions, reactions, and questions about test responses for discussion at the end of each session. In the Tharinger et al., (2009) study, the parents reported that the ability to observe and collaboratively discuss their child's testing was one of the most effective components

trusting relationship with the parents, enlisting them as collaborators, and asking them to pose questions they hope the assessment can answer (Finn, 2007). Assessment questions not only guide the therapeutic assessment process and indicate the assessment instruments to be administered; they also allow the clinician to hear the "story" caregivers and family members hold about their child. Clinicians practicing TA gather background information based on the assessment questions, which allows the clinician to gauge the potential impact of later assessment findings. Gauging the family's current beliefs and attending to shifts in their understanding of the child as the therapeutic assessment process progresses allows for more effective discussion of the findings in the summary/discussion phase. The child typically is not involved in the initial session, but in some situations, inclusion is necessary and acceptable within the TA framework.

Test Administration Phase. Depending upon the assessment questions and tests selected, administration of assessment instruments in the comprehensive TA-C model can range from two to six meetings. Test selection is based on a number of factors, including the referral issue and assessment questions, the clinician's training and experience in the use of particular instruments, and the desired outcome of administering the test. With regard to the last factor, a primary goal of traditional assessment is often to obtain scores that can be compared to norms in order to answer

with other common assessment methods, such as school or home observations. For example, the clinician and parents might jointly observe the child in the classroom or the school playground and discuss their observations. In this case, it is often useful to link these real-world data with the findings obtained from self-report measures and observations of the child's behavior in the testing environment. Integrating findings from multiple sources and across contexts assists parents in thinking systemically about the child and his or her problems. Regardless of the instruments or methods used, observation and discussion for each session allow parents to experience the potential conclusions alongside the clinician, in an attempt to more accurately reframe their understanding of their child and reduce their anxiety about discussing the findings.

Intervention Phase. At the intervention point in the therapeutic assessment process, the clinician and parents begin to conceptualize the child's and family's problems in a new way, based on the test findings. Tharinger, Finn, Austin, et al. (2008) have termed this element the "family intervention session," or simply the "family session." In a family session, the clinician designs an activity using established child and family therapy techniques or the modified administration of assessment instruments, intended to bring identified systemic problems into the room. TA clinicians are given significant flexibility in tailoring the intervention session to meet the specific needs of each family. An example of a family session appearing in Smith et al. (under review) involved using a modified administration of the Early Memories Procedure (EMP; Bruhn, 1992) and the Roberts Apperception Test (Roberts & Gruber, 2005). The tests were used to demonstrate to the parents their child's difficulty identifying and understanding emotions, which had previously led to two emergency room visits for psychosomatic symptoms secondary to unidentified stress and anxiety. The parents learned new ways to assist their son in this area and reported renewed confidence in their ability to be an effective source of support when he was feeling overwhelmed.

Family sessions are an opportunity for the clinician to observe the child in the family context and to test systemic hypotheses, while simultaneously allowing the family to better understand how family interactions may help or hinder the family's capacity to deal with the child's problem behaviors (Tharinger, Finn, Austin, et al., 2008). The clinician also tests possible interventions,

which provide the family with a positive experience of family therapy and often result in the family's experiencing a new, positive outcome for a situation they previously felt powerless to manage. Successful family sessions assist the family in developing a more systemic view of the child's problems, which will help the child feel less blamed, and, over time, gain self-esteem (Tharinger, Finn, Austin, et al., 2008).

Summary/Discussion Phase. Discussing the findings of their child's assessment can be very anxiety provoking for parents, and without proper preparation by the clinician, the findings might be easily rejected. The TA-C arrangement of parents observing and discussing findings in each meeting allows for small amounts of feedback to be provided along the way, preparing parents to discuss the findings. However, planning for the summary/discussion session remains a critical component of the intervention (Finn, 2007).

Finn and colleagues (Finn, 2007; Tharinger, Finn, Hersh, et al., 2008) have

Written Communication of Feedback Phase. Written feedback in TA is provided to the parents in the form of a letter consisting of answers to the assessment questions using nontechnical language. The structure and content of this letter closely resemble that of the summary/discussion session. In some cases, such as documenting a diagnosed disability for academic accommodations, a formal report is provided. When indicated by the assessment findings, the letter to parents also contains recommendations for continued care, which might include specific individual or family treatment protocols (e.g., trauma-focused cognitive behavioral therapy, parent training, academic-related interventions, and/or psychopharmacological consultation).

Written feedback to the child in TA-C routinely consists of an individualized story or fable written by the clinician, although other methods of providing the child with feedback are also acceptable within the parameters of TA. These fables present age-appropriate assessment find-

The goal of the fable is to provide the child with a more accurate, compassionate, cohesive, and empathic story about how important events in the child's life have led to his or her current situation.

devised a systematic process for the presentation and discussion of assessment findings based on their concept of "levels" of information. Level-1 feedback is information that is consistent with the parents' currently held views. Level-1 information is readily accepted, raises little anxiety, and validates clients' external reality. Level-2 information is not wholly in disagreement with the parents' existing story, but it may require reformulation of the current view and, thus, might cause some anxiety. Information that is entirely incongruent with the parents' story is termed Level-3. This kind of feedback has the potential to raise the parents' anxiety substantially and, without the proper preparation, might be rejected. The clinician organizes the assessment questions, from Level-1 to Level-3, based on a) the parents' preliminary understanding of the assessment question, b) the congruence of that understanding with the test findings, and c) evidence during the previous sessions that indicate a shift in the parents' understanding of the child (Tharinger, Finn, Hersh, et al., 2008).

ings tailored to the developmental and emotional capacities of the child. The goal of the fable is to provide the child with a more accurate, compassionate, cohesive, and empathic story about how important events in the child's life have led to his or her current situation (Tharinger et al., 2007). Children have been found to feel validated, understood, and more hopeful about their future following a successful feedback session. Tharinger, Finn, Wilkinson, et al. (2008) describe the process of writing fables for children.

Follow-Up Period. Families are typically asked to return for a follow-up session two to three months after the completion of the TA-C. A follow-up allows for the discussion of progress or ongoing challenges and new life situations that may have affected the family. Finn found that families often benefit from a "booster session," in which new or persisting problems are explored within the context of the assessment findings and previous recommendations are modified to meet the current needs of the child and family.

A Review of Current Empirical Evidence

TA With Adults. The potential effectiveness of TA with adults is illustrated in a number of published clinical case studies, including studies by Finn (1996, 2003, 2007), Finn and Kamphuis (2006), Fischer and Finn (2008), Gorske (2008), Peters et al. (2008), and Wygant and Fleming (2008). Controlled research indicates that TA results in greater therapeutic benefits compared to the traditional assessment process (e.g., Ackerman et al., 2000; Finn & Tonsager, 1992; Hilsenroth et al., 2004; Newman & Greenway, 1997). Ackerman and colleagues (2000) also found that clients involved in a TA were more likely to complete the assessment and to follow through with recommendations than were clients receiving traditional assessment. Clients in TA also formed a better therapeutic alliance in subsequent psychotherapy (Hilsenroth et al., 2004). In other adult TA applications, Michel (2002) demonstrated clinical effectiveness with adults and adolescents hospitalized for severe eating disorders and Uhinki (2001) successfully applied the TA model with couples, which is also discussed in Finn (2007).

TA With Adolescents (TA-A). In addition to clinical case material presented in Tharinger et al., (in press), controlled research using TA procedures and techniques with adolescents has demonstrated effectiveness for a range of diagnoses in a variety of settings. As noted, Michel (2002) applied TA with adolescents in an inpatient hospital for eating disorders, reporting that the intervention resulted in greater engagement in treatment from patients and their families. Newman (2004) compared distressed adolescents who either received a very brief (two-hour) TA or five one-hour sessions of individual psychotherapy. Although both groups experienced reduced symptoms of depression, the group that received TA showed significantly fewer symptoms of depression, reported significantly less overall distress, and showed greater self-esteem than the psychotherapy group. Ougrin et al. (2008) compared TA with traditional assessment in a group of 38 adolescents referred to the emergency room because they engaged in self-harming behaviors. Those adolescents receiving TA were more likely to attend their first community follow-up appointment (75% vs. 40%) and were twice as likely to

continue to engage in community services (62% vs. 30%).

TA With Children (TA-C). The body of research with children and families has grown substantially in recent years. Tharinger, Finn, and colleagues have described the techniques and procedures in an operationalizable manner, allowing for replication. Clinicians and researchers practicing TA-C have demonstrated the clinical effectiveness of the approach in case studies conducted in the schools (Tharinger et al., 2007; Tharinger et al., in press), university-based clinics (Hamilton et al., 2009; Smith & Handler, 2009), private practices (Finn, 2007; Handler, 2006), community-based clinics (Guerrero et al., in press; Haydel et al., in press), and a children's hospital (Smith et al., under review).

An aggregate group study (Tharinger et al., 2009) assessed the comprehensive TA-C model with 14 families with preadolescent children referred for emotional and behavioral problems. Children and mothers experienced reduced symptomatology and family conflict and increased communication and family cohesion, and mothers were found to have more positive and fewer negative feelings about their child following the TA-C. Participants were enthusiastically engaged and reported satisfaction with the services, suggesting consumer acceptability.

At the University of Tennessee, Smith, Wolf, Handler, & Nash (2009) employed an experimental single-case time-series design to assess the efficacy of the TA-C model with a 12-year-old boy with aggression and oppositionality. Compared to baseline, the family reported significant decreases in the intensity of his worst anger outburst and oppositional behaviors directed at his mother.

In a second single-case time-series experiment, Smith et al. (under review) demonstrated significant improvements in a depressed 12-year-old boy's self-esteem and social interactions. The father also reported a significant decrease in the family's overall distress as a result of TA-C. These promising findings led to a larger study using a replicated single-case time-series design to assess the treatment efficacy for preadolescent boys with oppositional defiant disorder (Smith et al., in press). The results indicated improvement in overall family distress, reduction in the intensity of the child's worst anger outburst, and case-specific indicators of change, such as the child's self-esteem. Furthermore,

improvements were maintained for at least two months beyond the TA-C without additional intervention.

Conclusion

TA admittedly challenges some of the contemporary notions regarding evidence-based treatment and assessment. Based on new findings, TA researchers are continually refining the way in which the model is understood and applied. Nevertheless, the emerging evidence for TA is promising and suggests that rigorous research is warranted. The group study by Tharinger and colleagues demonstrates the effectiveness and consumer acceptability of TA-C for use with a variety of children's emotional and behavioral problems. And although time-series designs, such as those used in several of the studies mentioned above, are not as rigorous or prevalent as in randomized controlled trials, they are an accepted method for the assessment of treatment efficacy. Methods such as those used by Smith et al. (in press) meet criteria for establishing an intervention as "potentially efficacious" according to current evidence-based treatment guidelines (e.g., Chambless & Ollendick, 2001; Ollendick et al., 2006). However, a need remains for larger sample sizes, control groups, and randomized assignment, in order for TA-C to reach well-supported status. Nonetheless, based on the current body of clinical and empirical research with children and families, TA might be effective in treating a variety of emotional and behavioral disorders. Additional controlled research is necessary to determine specifically for whom TA-C is indicated.

Finally, the evidence suggests that clients experience therapeutic benefits after participating in both the comprehensive TA-C model or one or more of its components. Future research will need to identify potential mechanisms of change in order to better understand these findings. Efforts are currently underway to address these issues and limitations.

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