

Therapeutic Assessment of Families in Healthcare Settings: A Case Presentation of the Model's Application

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In this article, we present a case study of a Therapeutic Assessment (TA) with an 11-year-old boy who had two unexplained behavioral episodes suggesting neurological impairment, which led to two emergency department visits at a children's hospital. TA is a semistructured approach that blends the extensive conceptualizing benefits of psychological assessment with the principles and techniques of evidence-based child and family interventions. We use this case to illustrate how TA is an adaptive and flexible approach to child-centered family assessment that can meet the goals of psychologists working in pediatric and general medical hospitals, primary care clinics, family medicine practices, and other health care settings. With the current case, the clinician was able to use the procedures of TA

to clarify for the family their son's unexplained behaviors, while also providing them with a therapeutic experience. In addition to addressing the family's concerns, the clinician also addressed a number of specific questions provided by the referring neurologist that informed ongoing care of the child. This case illustrates the potential utility and effectiveness of the TA model with children and families referred to a typical psychology service in a health care setting. This case is one of the first applications of the TA model with this population and its success suggests further research in this area is warranted.

Keywords: case study, family assessment, health care psychology, psychological evaluation, Therapeutic Assessment

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HHealth care settings pose a wide array of unique challenges to psychological evaluation and assessment of children and families, which requires both the psychologist and the chosen approach to be pragmatic, flexible, and adaptive (Roberts, Mitchell, & McNeal, 2003; Rozensky, Sweet, & Tovian, 1997). The importance of using a systemic approach that assesses the child within the greater context of the family is undeniable (e.g., Dishion & Stormshak, 2007; Landreth & Bratton,

2006). Recently, some experts in assessment psychology have embraced a systemic emphasis, which has resulted in a paradigm shift in the way child assessments are conducted (Finn, 2007; Handler, 2006; Tharinger, Finn, Austin, et al., 2008). The shift in assessment psychology has coincided with the growing prominence of collaborative care between members of the health care team and mental health professionals (e.g., Connor et al., 2006; McDaniel, 1995; McDaniel & Campbell, 1996; Rozensky et al., 1997; Sweet, Tovian, & Suchy, 2003) and a growing recognition of familial factors in children's medical issues (e.g., Alderfer & Kazak, 2006; Drotar, 2005; McDaniel, 2005; Rozensky et al., 1997). The role of the family encompasses both familial influences on children (e.g., Fiese, 2005) and the effect of the child's medical condition on the family (e.g., Alderfer et al., 2008).

In this article, we present a case study using an innovative, flexible approach to child-centered family assessment: the Therapeutic Assessment (TA) model (e.g., Finn, 2007; Hamilton et al., 2009; Smith & Handler, 2009; Smith, Wolf, Handler, & Nash, 2009; Tharinger, Finn, Wilkinson, & Schaber, 2007). We believe the TA model provides pediatric, health, and primary care psychologists with a flexible approach for addressing commonly encountered referral issues, collaborating with medical professionals, and facilitating familial changes by empowering family members to take active steps in addressing the problem alongside the health care team.

THE FUNCTION OF PSYCHOLOGICAL ASSESSMENT IN HEALTH CARE SETTINGS

Psychological assessments in health care settings often stem from a referral for consultation by the health care team that wishes to better understand the role of psychological factors related to medical concerns, such as disease management and

compliance with a prescribed course of treatment. At other times physicians may be unable to identify a medical cause or explanation for a child's symptoms, which may lead the physician to suspect an etiological role for psychological factors. Psychologists are sometimes asked to assess the family's role in the identified patient's presenting medical or psychological issue. Assessments can also provide an opportunity to identify long-term psychological and interpersonal problems that first appear in medical units independent of a medical condition (e.g., McDaniel & LeRoux, 2007; Rozensky et al., 1997), or are presented as secondary to, or concomitant with, a medical complaint (e.g., Roberts et al., 2003; Sweet et al., 2003). Regardless of the way in which patients reach psychologists for assessment, it seems clear that the complex diagnostic and etiologic presentation of psychological and medical conditions depicted within the biopsychosocial model (Engel, 1977) necessitates an effective multidisciplinary approach (e.g., Bradfield, 2006; Porcelli & McGrath, 2007; Rozensky et al., 1997; Sweet et al., 2003). We believe the core values, structure, and techniques of the TA model can meet psychologists' assessment needs in health care settings, while also addressing systemic aspects of a child's medical difficulties.

THE TA MODEL WITH CHILDREN AND FAMILIES: CORE VALUES, GOALS, AND DEFINING CHARACTERISTICS

Therapeutic Assessment (TA) is a semi-structured form of collaborative psychological assessment, developed by Stephen Finn and his colleagues at the Center for Therapeutic Assessment in Austin, TX (Finn, 2007; Finn & Tonsager, 1997). In traditional psychological assessment, psychological testing is primarily used to aid in diagnosis, case conceptualization, and treatment planning. In TA, psychological testing serves these same traditional purposes, while at the same time forming the centerpiece of a brief psychological inter-

vention. As they undergo a TA, patients are enlisted as collaborators in all aspects of the assessment: setting goals, gathering background information, interpreting their own test performance, discussing scores and hypotheses derived from the testing, and reviewing written reports at the end of the assessment (Finn, 2007). This is in contrast to traditional psychological assessment, where patients are viewed more as passive objects of study (Finn & Tonsager, 1997).

Not only are the techniques, procedures, and goals of TA compatible with pediatric and primary care psychology, but the core values of TA are highly compatible with the collaborative care model (CCM; e.g., McDaniel, 1995; McDaniel & Campbell, 1996) being currently adopted by many psychologists in medical settings. According to Finn (2009) the underlying values of TA, which inform all its procedures, are collaboration, respect, humility, compassion, openness, and curiosity. It is believed that clinicians manifesting these values in interactions with patients create an environment in which healing and growth is greatly facilitated. With children and adolescents, another major therapeutic element of TA is believed to be its ability to help families develop a more coherent, accurate, compassionate, and useful understanding of the nature of a child's difficulties (Finn, 2007). This is accomplished by involving the parents in their child's assessment in several major ways. In health care situations, TA can assist families in understanding the way in which psychological factors are related to the symptom presentation and the ongoing medical care of the child. In contrast to the traditional assessment paradigm, TA is intended to result in therapeutic changes in the family system, beyond simply gaining a comprehensive understanding of the child (Tharinger et al., 2007).

With children and adolescents, TA is best thought of as a family systems intervention that addresses child problems and

family concerns, and attempts to change parents' understanding of and responses to their children's behavioral and emotional problems (e.g., Smith, 2010; Smith, Handler, & Nash, 2010; Tharinger et al., 2009). Finn and his colleagues describe the principles, specific techniques, and procedures that define the TA model and differentiate it from the traditional assessment paradigm and other child-centered family interventions (Tharinger, Finn, Austin, et al., 2008; Tharinger, Finn, Hersh, et al., 2008; Tharinger, Finn, Wilkinson, et al., 2008; Tharinger et al., 2007; Tharinger, Krumholz, Austin, & Matson, in press).

The effectiveness of TA with children and adolescents has been demonstrated by a number of recent empirical studies: Ougrin, Ng, & Low, 2008; Smith et al., 2009; Smith, Handler, & Nash, 2010; Smith, Nicholas, Handler, & Nash, in press; Tharinger et al., 2009. The evidence indicates that after a TA, families often improve their cohesion and communication, while also experiencing decreases in family conflict and the child's and parents' emotional and behavioral symptoms (Smith et al., 2010; Tharinger et al., 2009). In addition to empirical studies, there exists a number of published clinical case studies of successful child and adolescent TA: Michel, 2002; Hamilton et al., 2009; Smith & Handler, 2009; Tharinger et al., 2007; Tharinger, Gentry, & Finn, in press; Tharinger, Krumholz et al., in press; Tharinger, Matson, & Christopher, in press. The study by Ougrin et al. (2008) is notable for our work in that it occurred in a hospital emergency room setting, and studied adolescents who were admitted because of serious self-harm. Compared to adolescents receiving assessment as usual, those participating in a brief TA at the time of their admission showed better compliance with treatment recommendations and an increased chance of being involved with a mental health professional 17 weeks after their self-harm incident. An article by Smith (2010) reviews

the current evidence base of the TA model with children and families.

CASE PRESENTATION

Background Medical Information and Referral

Roughly 10 months prior to the current referral, Georgeⁱ, an 11-year-old Caucasian male was in the dentist's office when he had overheard a root canal procedure being described, at which point he fainted. After fainting, he complained of a headache and feeling sick to his stomach. Shortly after these symptoms arose, George's parents, Mike and Ann, drove him to the Emergency Department (ED) of the local children's hospital for examination. In the ED, George's parents and the physicians described him as acting confused and "goofy," and he displayed immature speech and thought processes, altered gait, and profound memory loss (e.g., he could not remember the alphabet or the sequence of numbers). After a computed tomography (CT) scan was found to be normal, the ED contacted Dr. M, a neurologist, who examined George and ordered magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), and electroencephalography (EEG) scans, results of which were normal. Dr. M diagnosed George with common migraines (ICD-10 Code 346.10; World Health Organization, 1992).ⁱⁱ During the time in which the testing was performed, George's symptoms began to remit. Mike and Ann reported that he returned to normal within 36 hours of fainting. Mike described his son's return to normal like the process of "rebooting a computer – It took a while to get him back up to speed." George had no similar symptoms over the following 10-month period. Then he unexpectedly returned to the ED.

The second episode was similar to the first. However, George's symptoms were more severe and lasted longer. Prior to this visit to the ED, and a second referral to Dr. M, George had complained of a "fuzzy" feel-

ing on the left side of his head that he could feel move across his brain to the right side, at which time his symptoms would begin. He described this sensation as "feeling like water flowing across my brain." George's symptoms included odd, immature behaviors (repetitive, atypical movements) and regressed language skills (slow and pressured speech, mispronunciation of common words). However, no memory loss was reported during this episode. George's symptoms were intermittent for the next 8 days, in which he went "in and out of the episode," as reported by his parents. Continuing the metaphor, George reported that his symptoms would cease when "the dam builders were able to stop the flow of water across my brain." Again, the neurologist's examination yielded no medical explanation. Dr. M reported that he was "at a loss for how to proceed" and he suggested to George's parents that psychological factors might be playing a role in his difficulties. Dr. M described Mike and Ann as reluctant to explore psychological testing until all medical assessment was exhausted. Once Dr. M assured them that he had done all he could, George was referred to the psychology service.

When Dr. M contacted psychology, he reported that he believed George's symptoms might be related to stress and anxiety. He had shared this perspective with the parents prior to the referral and reported that they were initially reluctant to consider psychological explanations. Given the parents' hesitations about a psychological cause, the clinician felt the transparency and collaborative emphasis of the TA model might

ⁱ All names and potentially identifying information has been changed to protect confidentiality.

ⁱⁱ Although George was formally given this diagnosis, the family's insurance was not billed for the TA. The clinician (Justin D. Smith) was a trainee in a psychology doctoral program and conducted the TA during an external practicum. Services rendered by an unlicensed trainee cannot be billed to insurance under Tennessee state law when those services are provided in a medical setting.

facilitate acceptance of any findings that indicated George's symptoms were related to psychological factors. Dr. M's referral also indicated that Mike and Anne might benefit from a brief psychological intervention, further suggesting that the use of the TA model with this family was appropriate.ⁱⁱⁱ The TA model also attempts to include other appropriate key players involved in the child's care, such as the referring physician, other members of the health care team (e.g., nurses, social work, etc.), teachers, and other mental health providers. Thus, Dr. M was asked to provide questions about George and his family that he hoped could be answered by the TA. The process of specifically addressing questions from the referral party serves to show that the referral was completed and also ensures that findings are disseminated to the health care team in order to inform subsequent care of the child. Dr. M's questions were: 1) Is there any evidence of a neurological/neuropsychological problem?; 2) Are there any psychological explanations for George's symptoms and presentation?; and 3) What can I do if I see George and his family again in the future? We present our answers to Dr. M's questions at the end of the case presentation.

Additional Background Information

George was Mike and Ann's first biological child; they also had a daughter, age 9, about whom they expressed no concerns. George was described as having no serious medical, emotional, or behavioral difficulties prior to the recent medical episodes. George was in the 5th grade at a public elementary school, where he was doing well academically and reportedly managed his homework well with little parental assistance. He was active in athletics, participating in baseball, basketball, football and golf. Mike and Ann were both high school teachers and coaches, and Mike had previously coached George in basketball. Mike and Ann reported that they had been hap-

pily married for nearly 15 years and that this was their first marriage.

The Therapeutic Assessment

TA Progression and Session Procedures

George and his parents completed the TA in seven 1–2 hour sessions (11 total hours) over a 28-day period, which included each of the components of the comprehensive TA model (see Smith et al., 2009; Tharinger et al., 2007; Tharinger, Krumholz, et al., in press). TA contains many of the procedures common to any assessment, such as an initial interview, test administration, and feedback to the family. Each of these procedures is guided by TA-specific collaborative techniques, such as the gathering of assessment questions during the initial meeting and the extended exploration of test findings that occurs after administration of test instruments according to their standardized procedures. Unique components are typically included as well, such as family intervention sessions (Tharinger, Finn, Austin, et al., 2008) and a session in which the child is presented with feedback in the form of a personalized story or fable (Tharinger, Finn, Wilkinson, et al., 2008). Each session is conducted in a manner consistent with TA's core values, goals, and defining characteristics, as described previously.

Previous case examples of the child TA model have utilized video link technology, allowing parents to observe the testing of the child in a different room (e.g., Hamilton et al., 2009; Smith et al., 2009). (In contrast, in traditional child assessment, parents typically sit in the waiting room while their children are being assessed.) It is believed that this test observation element of TA allows parents to gain empathy for

ⁱⁱⁱ It is important to note that George's parents were given the option of completing a more traditional assessment prior to beginning the TA. They were also informed that the TA option required a greater commitment from the family in terms of time and resources.

their children and to have more confidence in the eventual findings of the assessment. In the Tharinger et al. (2009) study of child TA, the parents reported that the ability to observe and collaboratively discuss their child's testing was one of the most impactful parts of the TA. The setting in which this case was conducted, like most health care facilities, was not equipped with this technology, so parents observed the testing of the child in the same room, an arrangement which the second author has used in his independent practice setting. Parent observation may not be feasible with all families, but in this case it was viable and seemed appropriate to the clinician. Mike and Ann's presence did not appear to inhibit George or otherwise influence the test results. Inviting parents to observe testing sessions is not always desired though, and clinicians need to judge the advantages and disadvantages of this practice with each family. In this case, the clinician's perception was that observing the testing sessions facilitated the parents' curiosity about George and his problems and seemed to assist them in gradually shifting their understanding as the evidence was presented. At the beginning of most sessions, the clinician met with the parents to prepare them. At the end, the clinician and parents discussed what had occurred. The child played in the waiting area during these miniconsultations. The initial meeting, family intervention (Tharinger, Finn, Austin, et al., 2008), summary/discussion (Tharinger, Finn, Hersh, et al., 2008) and fable sessions (Tharinger, Finn, Wilkinson, et al., 2008), which are described below, included either the entire family or just the parents and clinician.

Initial Contact and Meeting With George and His Parents

The clinician, Justin D. Smith, contacted Ann on the telephone to schedule the initial meeting. Ann seemed eager to get the evaluation underway. She reported that these two incidents with George had

been frightening and stressful, and that she and her husband wanted to understand what was happening to George. Given Ann's curiosity, and desire to identify any psychological factors that might explain George's problems, the clinician felt further convinced that the family might benefit from TA. The clinician described the TA model and emailed an information sheet about TA describing some common questions, such as the goals, timeframe, and level of parental involvement.^{iv} Ann and Mike were instructed to develop questions they hoped the TA might be able to answer.

George,^v Mike, and Ann arrived for the first session with assessment questions in hand, which seemed to reflect some openness to psychological explanations and willingness to participate in the TA. Their questions were: 1. How can a psychological issue translate into a neurological problem? 2. How does our son handle stress, conflict and control issues? 3. Does our son suppress his emotions and have they turned into a psychological issue? 4. Does the fact that his parents are coaches and teachers put extra pressure on him that he can't handle? Do we expect too much of him? 5. Does his competitive nature cause problems handling achievement at different levels other than the top level?

Regarding question 3, Mike and Ann said that George seemed to hold in his emotional reactions to events. Mike believed his son suppressed these feelings, ruminated about them, and then discussed them with his parents only long after the event. Mike reported that he was often surprised when George would report having

^{iv} A sample information sheet about the TA process is available by request from Justin D. Smith.

^v Typically with preadolescents, only the parents meet with the clinician in the initial meeting. In this case, George was invited so that the clinician could better determine if TA was appropriate for this family. George's BASC-2 self-report, along with the parents' reports on this measure were used to guide the subsequent sessions.

been bothered by an earlier experience, as he had given no indication of being upset at the time. Regarding questions 4 and 5, Mike and Ann explained that George's competitiveness and desire to do well in sports and academics sometimes led to his being disappointed in himself when he fell short. Mike and Ann speculated that their positions as teachers and coaches might add to the pressure George felt to succeed. Kazak (1997) suggested framing pediatric referral questions within a contextual, family systems perspective, which this family was able to accomplish from the outset. We felt that questions 4 and 5 were systemic in nature and suggested that Mike and Ann had noticed some ways in which their interactions with their son may be related to his current symptoms. It was also the clinician's impression that Mike and Ann were emotionally invested in their son's achievement and might be subtly communicating to him that they needed him to succeed, suggesting the potential that George indeed felt the pressure and anxiety reflected in this assessment question. Mike and Ann were very curious about their son's recent episodes and seemed eager to find an answer to why they had occurred. They and George shared how frightening the episodes had been for the entire family. George appeared to become increasingly anxious as this topic was discussed, as evidenced by his fidgetiness and averted gaze. Mike and Ann's assessment questions were curious, psychologically minded, and thoughtful. The clinician concluded that this was clearly a high-functioning and predominantly healthy family, which made the recent ED visits even more unexpected.

Results of the Test Administration Sessions

The selection of assessment instruments to be used in a TA is very similar to other psychological testing situations. TA allows clinicians the flexibility to use tests that are indicated by the history of the

presenting problem, behavioral reports and observations during the initial meeting, referral questions from another professional (if applicable), and ongoing test findings. Since extensive knowledge of testing instruments is important to the specific therapeutic techniques of TA, clinicians tend to select tests with which they have sufficient training and experience. Although the use of performance-based measures, formerly known as "projectives", such as the Rorschach (Exner, 2003) and Roberts Apperception Test (Roberts & Gruber, 2005), is commonplace in TA with children, it is by no means mandatory.¹ The goals of TA can certainly be achieved using varied assessment instruments. In this case, we selected some assessment instruments, such as the House-Tree-Person Technique (HTP; Buck, 1966), in order to develop hypotheses to be tested by other valid and reliable measures, provide a playful experience for the child, and provide a stimulus from which the child can tell a story for his observing parents to hear. The use of storytelling and drawing tasks might be selected for this purpose particularly in cases where parents are observing the assessment. It is also within the parameters of TA to rely only on tests with strong evidence of validity and reliability.

¹ We would like to acknowledge the controversy surrounding performance-based (projective) assessment methods, particularly the Rorschach inkblot test: In recent years, experts have provided compelling support for the clinical utility and psychometric properties of the Rorschach (e.g., Rosenthal, Hiller, Bornstein, Berry, & Brunell-Neuleib, 2001; Smith et al., 2005). Conversely, persuasive opposition has also been proffered (e.g., Hunsley & Baily, 1999; Wood & Lilienfeld, 1999). Support for the Rorschach's application in health and pediatric psychology is also mixed, with evidence for (e.g., Sultan, 2010) and against (e.g., Cohen et al., 2008) its use. Other methods (e.g., House-Tree-Person, Roberts Apperception Test) are similarly controversial. Clinicians need to critically evaluate the evidence of a measure's validity when assessing children in healthcare settings and acknowledge its strengths and limitations.

To gain a broad picture of any behavioral or familial problems, George, his parents, and his teacher completed the Behavior Assessment System for Children, Version 2 (BASC-2; Reynolds & Kamphaus, 2004), a set of rating scales about children's behavioral and emotional problems and their adaptive strengths. Mike, Ann, and George also completed the Family Assessment Measure, Version 3 (FAM-III; Skinner, Steinhauer, & Santa-Barbara, 1995), in which family members rate each other on a number of dimensions of family functioning. The results of the BASC-2 were interesting and informative. First, George's teacher rated him as having no significant emotional and behavioral problems and above-average strengths, with the exception of his self-esteem, which she rated as just slightly below average for children his age. Mike's and Ann's ratings of George were largely within normal limits, although there was a tendency for Mike to see George as having more significant problems and less strengths than did Ann. The only elevated scale on Ann's BASC-2 was on Anxiety (T score = 61), while Mike rated George in the borderline clinical range on Anxiety (67 T), Somatization (60 T) Atypicality (63 T), Withdrawal (63 T), and Internalizing Problems (60 T). In fact, the absence of any significant scores on Ann's BASC-2 is noteworthy, and suggested that she had a strong need to see George as having no psychological problems. Similar to Ann, George rated himself as having no significant difficulties and good adaptive strengths, with the exception of a slight elevation on the BASC-2 Attitude to School (63 T) scale. Given the lack of other elevations, this suggested to the assessor that George had noteworthy negative feelings about school. The slight elevations on the Anxiety subscale provided evidence for the clinician to focus on test instruments that might illuminate the processes by which George manages stress and worry. The results of the FAM-III indicated that the family saw themselves as well functioning

across all domains. Again there was one noteworthy exception. George's rating of his father on the Control subscale of the Dyadic Relationship form was elevated (72 T), indicating that he experienced Mike as sometimes being intrusive and overcontrolling.

Although Dr. M reported in his referral that he did not suspect neuropsychological problems, given the referral picture the clinician felt it was necessary to obtain a broad cognitive ability score to understand George's strengths and limitations. He was administered the Wechsler Intelligence Scales for Children, Version 4 (WISC-IV; Wechsler, 2003) and the Bender Visual-Motor Gestalt Test, Second Edition (Brannigan & Decker, 2003). These two measures were used as a gross screening process for possible neuropsychological problems. Other tests certainly could have been used to assess cognitive functioning (e.g., CA Verbal Learning Test for Children) and neuropsychological deficits (e.g., Test of Memory and Learning, Wide Range Assessment of Memory and Learning). These tests were selected because of the breadth and depth of information provided and the clinician's training on these instruments. George's Full Scale IQ was 106, in the average range, and his performance was also average on Perceptual Reasoning (106), and Working Memory (102). His scores on Verbal Comprehension (112) were high average, suggesting that he generally was able to understand and express himself verbally quite well. Although within the average range, George's score of 91 on Processing Speed revealed a personal weakness in his ability to work quickly and efficiently. Sometimes children with deficits in this area feel a great deal of pressure about completing homework and other school assignments in a timely fashion. Results of the Bender were within developmental limits and were not suggestive of a visual-motor integration problem or other neuropsychological deficit. Since neither of these tests suggested any significant defi-

cits in cognition, processing, or visual-motor integration (although admittedly, this did not qualify as a neuropsychological evaluation), further neuropsychological assessment was not sought.

The focus of the assessment then shifted to George's psychological functioning, specifically the management of stress and anxiety. Given the lack of significant findings on the self-report measures, the clinician administered the Rorschach inkblots (Exner, 2003) to better understand the underlying emotional aspects of George's functioning. At this point in the assessment, the clinician felt as though there was insufficient evidence to adequately answer the parents' assessment question regarding the origins of these two episodes and the role stress, anxiety, and pressure might have played. The clinician thought the Rorschach would provide a different lens through which to view this child and his problems. The HTP (Buck, 1966) was selected to develop hypotheses and stimulate expression of George's experiences and emotions to his parents as they observed the administration and listened to stories he told about his drawings. It also provided a more playful exercise, which contrasted with the often-emotionally laden experience of being administered the Rorschach.

The results of George's Rorschach, scored using the 5th Edition of the Comprehensive System and compared to the normative data for 12-year-old respondents (Exner, 2003), indicated a detached style and a preference for clearly defined structure and expectations (Weiner, 2003). There were no signs of severe thought disorder or a psychotic disturbance. However, there was evidence that George was experiencing substantial situational stress and that he was struggling with feelings of powerlessness and anxiety, which he had inadequate resources for managing. In particular, he was neither able to reflect on and "mentalize" about his difficulties, nor very capable of verbalizing his emotional experiences. Furthermore, there was evi-

dence that George tended to "back away" from emotionally arousing situations because he was so easily overwhelmed by them. Despite evidence of a generally positive view of interpersonal relationships and signs of a good early attachment, George did not appear to see significant others as sources of reliable support and comfort and tended to try and manage difficulties on his own, a strategy that was destined to failure given his own limited resources.

Stories George told about his HTP drawings illuminated the potential source of his distress that was evident in the Rorschach results: In describing both his male and female figure drawings, he emphasized achievement. He said the male figure was "... a very good boy. He's very good at comprehension in reading ... he plays football, basketball, baseball, and golf." When describing his female figure, he said, "She doesn't make really good grades. She had an 'F' in Physics on her report card and her teacher doesn't like her." Finally, his description of his tree drawing appeared to dovetail with his Rorschach scores, in suggesting that he did not feel well supported: "Well it lives out in the open with not many trees around it. It doesn't get very much sun or water. It's a dying tree ... it's not a very healthy tree and doesn't have enough water. It lives on dirt and there's no grass."

Overall, George's Rorschach scores suggested he had the potential for disorganization and temporary psychological incapacitation when coping demands exceed his capacities (Weiner, 2003). Even though these findings could not rule out the presence of a medical or organic problem, evidence suggested that these psychological factors could have led to George's odd behaviors that precipitated his two visits to the ED. Therefore, a family intervention session (Tharinger, Finn, Austin, et al., 2008) was designed to further explore these findings and test the emerging hypothesis that George's inability to manage affect and tendency to avoid turning to others for

emotional support contributed to the two episodes. A second hypothesis of the family intervention session was that Mike and Ann played an important role in George's current difficulty managing emotions. The clinician hoped the family intervention task could reveal the way in which this process occurs between George and his parents.

The Family Intervention Session

Two of the main goals of a family intervention session are to test hypotheses derived from the assessment results while providing the family with a transformative experience that might initiate changes in the family system (Tharinger, Finn, Austin, et al., 2008). The clinician's developing conceptualization of George's problems centered on his ineffective coping strategies for managing negative affect and inability to make use of others for emotional support. George seemed to stringently constrict and overcontrol his affective experiences, perhaps because his parents did not know how to help him with them, which led to the two unexplained episodes that were frightening to him and his parents. Secondly, the clinician hoped to elicit the way in which George's parents' approach to his emotions was related to his episodes. As a minor goal, it seemed that the parents' viewing George as strong and somewhat impervious to emotionality was uncomfortable for Mike and Ann, who preferred to downplay his emotional experiences and take a problem-solving approach to his expressed distress.

With consultation from the second author, the clinician planned a family intervention session aimed at evoking the family's strategies for identifying, managing, and discussing feelings. Rolland and Walsh (2006) identified open emotional expression as a key process in family resilience to illness, which we hoped to promote during this session. In TA, clinicians often modify assessment instruments to meet specific goals for a particular family (Finn, 2007;

Tharinger, Finn, Austin, et al., 2008). In this case, the clinician used a modified version of the Early Memories Procedure (Bruhn, 1992) in which the prompts were changed to focus on different emotional experiences. For example, the family was asked to think together about their earliest memory of a time when someone in the family felt sad, angry, and so forth. The clinician intentionally ordered the sequence of prompts to begin with simple emotions (e.g., sad, mad) and then progress to more nuanced affects, such as shame and embarrassment. George was able to recall memories from an early age for the simple emotions but began to have difficulty with those that were more specific. At one point, George confused embarrassment with nervousness and anxiety. Mike pointed out this misconception and explained the differences by providing relatable examples and straightforward definitions. Based on the process of this exercise and the family's responses to the modified early memory stems, it was the impression of the clinician that the family rarely spoke about their emotions and reactions to events. George in particular showed significant difficulty identifying his more complex emotions. Despite the observed difficulty, Mike had shown his ability to discuss emotions with his son, which seemed to instill a sense of mastery for him in the session. Ann also appeared comfortable with this discussion and added some examples based on George's recent experiences in school and athletics.

At the end of this exercise, as the family and clinician discussed what had occurred, Mike asked George about why it had been difficult for him to remember events from his early childhood that corresponded to the emotions named in the task. George's reply was striking to the clinician and his parents. He said, "I don't really connect any feelings to my memories. I can remember stuff, but they don't really have any feeling in them." This statement appeared to illustrate how George attempted to man-

age his emotions. That is, he tended to discount or minimize his feelings because they were either too dangerous, or he was unable to identify what it is he felt, and thus had no way of symbolizing and retaining the affect. Given the evidence thus far, Mike and Ann may have inadvertently reinforced the process of George keeping his emotions to himself and attempting to modulate them without parental assistance. It was not evident to the clinician that they had noticed this process, so a second exercise was employed.

The second task of the family session involved a consensus storytelling exercise using the Roberts Apperception Test, Second Edition (Roberts & Gruber, 2005). The clinician asked the family to coconstruct one story to three emotionally laden pictures. George again had difficulty accurately and effectively identifying and processing the emotional content. While generating a story to the picture depicting a young man with a chair over his head, George was able to identify that the young man likely felt "mad" about something. However, when his father asked what had made the young man mad, George's proposed source of the anger was incongruent with the intensity of the affect being expressed in the picture. Mike and Ann engaged their son in a discussion about this response and assisted George in identifying an event that might precipitate this level of anger. It appeared to the clinician that there was a clear disconnect between events in George's life and the emotional experiences they evoked. This point was picked up on by George's parents as well and discussed in detail in the following session.

Summary/Discussion Session With the Parents

In TA, assessment findings are discussed collaboratively with parents during a "summary/discussion session." Findings are presented in the order of their level of accessibility to the parents (Finn, 2007;

Tharinger, Finn, Hersh, et al., 2008). Tharinger, Finn, Hersh et al. (2008) provide detailed guidelines for this collaborative assessment feedback process. One advantage of conducting a TA with parents observing and being involved throughout the assessment is that they have witnessed and experienced the findings firsthand prior to the often anxiety-provoking "feedback" session. In a successful TA, this session serves to merely organize and clarify what has already been witnessed, discussed and experienced. Since this session is organized around the family's assessment questions, one good strategy is to ask the parents if they can answer their questions themselves, after having been through the TA.

Mike and Ann were able to clearly conceptualize George's problems based on the assessment findings and their observations. For example, Mike and Ann spoke about the process of the family intervention session and how George seemed to have a very basic understanding of emotions and experiences. They had also experienced George's difficulty asking for their assistance in processing and managing this affect. Although this observation was accurate, it was difficult for them to describe what might have led to George's difficulty in this area. The clinician shared findings from the Rorschach that suggested George was easily overwhelmed by his affect, which prompted Mike and Ann to posit that their son might not connect feelings with events because of the potential for becoming more upset than he could handle. The clinician inquired about how the family handled George's problems. Mike and Ann reported that they typically approached George's concerns by attempting to "fix" the problem. The clinician felt this strategy might leave George feeling unsupported about his feelings, even if this approach led to a resolution of the problem. The clinician assisted Mike and Ann in identifying that this approach, although effective in some ways, also provided George with little room to identify and explore

what he was feeling and may have contributed to his feeling unsupported. Mike and Ann reported that it was sometimes difficult or uncomfortable for them to manage George's negative feelings, and it became clear that their positive feelings about themselves and the family were somewhat contingent upon their son's achievement and positive feelings. The clinician helped Mike and Ann practice validating and discussing George's emotional experiences, prior to helping him come to a solution. This session appeared to meet the goal of such meetings (Finn, 2007). George's parents were beginning to think more psychologically and systemically, and also to connect the assessment findings to their real life experiences. Mike and Ann had also been able to acknowledge that they were sometimes uncomfortable with George's expression of emotion, which seemed to be the key to fostering lasting changes in this family.

Fable Session

In TA, feedback to the child is generally provided via an individualized story or fable. These stories are written in a developmentally appropriate manner and describe the seminal findings of the assessment. This form of feedback is much less threatening to a child than direct feedback (Tharinger, Finn, Wilkinson, et al., 2008). The story written for George was about a medieval warrior whom everyone saw as very strong and capable. The warrior could also be fragile though, which the family discovered after he experienced two unexplained episodes of weakness. After consulting a knowledgeable expert, the warrior and his family discovered that he needed to learn about his feelings in order to stay strong and resilient, since this was a major source of his strength. It was also explained that the warrior's parents had learned some secrets about how they could help him learn about feelings. This detail seemed important in instilling a sense of hopefulness for the future for George and the family.

George and his family reported that they liked the story about the warrior and that it was very accurate.

Written Feedback to Parents

In contrast to the typical psychological evaluation, which is often intended for use by other professionals, in TA, parents are provided with a letter that summarizes the findings and answers their assessment questions in everyday language. (For examples of parent letters see Hamilton et al., 2009; Smith & Handler, 2009; Tharinger et al., 2007).

Follow-Up

The follow-up session occurred about 8 weeks after the fable session. The purpose of this meeting is to check in regarding progress and reassess recommendations (Finn, 2007). The clinician asked George and his parents if anything had changed in the family as a result of the TA. They reported that the TA had been a very worthwhile experience: George was becoming aware of feeling overwhelmed and was also showing progress in verbally expressing his emotions. The family reported that they had learned invaluable information about George's functioning, the role of the family in the presenting problems, and also felt that the potential explanation for his episodes had helped ease their anxiety. Results of a second BASC-2 administration showed a few changes on scales that were previously elevated; Mike's rating of George on Atypicality dropped from *T*63 to *T*49 and Ann's report of her son's Anxiety dropped from a score of (*T*61 to *T*54). Although the reported changes may seem small, the short time period between assessments suggests these findings may reflect important substantive changes in George and also the way in which Mike and Ann understand his problems. Perhaps most importantly, George had not experienced any of the symptoms that had led to his ED visits.

The clinician again contacted the family via telephone 6 months after the completion of the TA to monitor their progress. Mike and Ann reported that George had no recurrent symptoms. Perhaps more importantly, they reported that he appeared to be managing his distress more effectively, as evidenced by his willingness and ability to talk with his parents when he felt stressed or upset. Mike and Ann also reported that as a result of what they learned during the TA, they felt confident in their ability to provide their son with the support he needed in these situations, which they felt ill equipped to do prior to the TA.

Dissemination of Findings to the Physician and Health Care Team

Similar to the letter provided to George's parents, Dr. M was provided with a brief, one-page summary answering his referral questions about George in non-technical language. We believe it is important to demonstrate to referral sources that psychology has addressed their concerns and reasons for the referral. Rozensky et al. (1997) and Sweet et al. (2003) emphasized the importance of communication and collaboration between the psychologist and medical professionals. We also feel that communication in useful, digestible language is integral for continued collaboration, particularly in multidisciplinary settings in which professionals from different backgrounds often have varied knowledge of psychological terms and tests. Here is the letter provided to Dr. M:

Dr. M,

I wanted to follow-up with your referral of George to psychology. George and his parents completed a comprehensive child-focused family Therapeutic Assessment, which included a wide array of psychological test instruments. Here is feedback to your questions:

1. Is there any evidence of a neurological/neuropsychological problem?

We found no evidence of impairment in this area at this time using a limited bat-

tery to assess cognitive functioning and visual-motor skills.

2. Are there any psychological explanations for George's symptoms and presentation?

Test results indicate that George's capacity to manage his emotional life is often insufficient to handle periods of amplified stress. I believe it is not a coincidence that the two episodes that led to hospitalization occurred early in the school year. The structure of school and sports provides some containment, but there is an inevitable build-up followed by a breaking point. In times of increased stress, George seems to be able to get by for a while but then he becomes overwhelmed. These two episodes show that he can become incapacitated by emotional stress, leading to disintegration and behavioral regression. There is a familial component to these problems also, in that George's parents have tended to take a more "problem-solving" approach to George's emotions, instead of helping George tolerate and manage stressful feelings.

3. What can I do if I see George and his family again in the future?

Although we cannot completely rule out an organic cause or trigger, our test results suggest that the current episodes were related to George's coping difficulties. If he is to ever return, it may be beneficial to discuss recent stressors in George's life, such as feeling pressure to achieve in sports, academics, and so forth and if he has been able to discuss these feelings with his mother and father. George's parents appear committed in assisting his self-expression and coming to a more mature understanding of his emotions, so this line of questioning would likely not seem inappropriate. However, if his symptoms are different, or of increased severity, we defer to your medical expertise in regards to conducting another thorough neurological examination or referring for a complete neuropsychological evaluation.

Thank you again for your referral and willingness to be involved in the assessment

process. If you have any additional questions or concerns feel free to contact us.

Sincerely,

Justin D. Smith (Nicole Swain, supervisor)

TA and Systemic Change

Although it is impossible to draw firm conclusions from a single case study, it seems useful to reflect on the processes that may have led to improvement in George and his family. Fulmer, Cohen, and Monaco (1985) listed a number of goals of structural family therapy that can be accomplished through a psychological assessment, including altering proximity, detriangulation, and reinforcing hierarchy. In this case, many of the important shifts seemed to occur from the reframing of George's difficulties from medically based to emotionally based. As Mike and Ann witnessed George's deficits in emotional awareness and expression, they appeared to change the way they reacted to him, which seemed to result in his feeling more understood and emotionally supported. This was accompanied by a decrease in his somatic symptomatology. We believe that shifts would have been difficult to achieve without Mike and Ann taking an active role throughout George's assessment. If this is true, this case calls into question the common practice of assessing children and adolescents with minimal involvement of their families. As Tharinger, Finn, Austin, et al. (2008) have noted, in the vast majority of child and adolescent assessments, parents do little more than fill out behavior rating scales, give background information, and comment on feedback at the end of the assessment. We feel strongly that such an approach flies in the face of systemic conceptualizations of children's problems and fails to harness an important therapeutic opportunity.

Limitations and Future Directions

This case presents preliminary evidence of the utility and applicability of the TA

model in health care settings. However, further evidence regarding the efficacy of this approach with various populations is needed in order to determine its suitability for specific diagnoses encountered in health care settings. Previous research findings (e.g., Smith, Handler, & Nash, 2010; Smith et al., 2009; Smith, et al., in press; Tharinger et al., 2009) and published clinical case studies (e.g., Hamilton et al., 2009; Smith & Handler, 2009; Tharinger et al., 2007), suggest that TA is likely to be effective for a broad range of childhood and adolescent psychological problems appearing in health care settings, both independent of, and concomitant with medical concerns. Although the child TA model focuses on shifting the family's understanding of the child, measures of family process, parent-child communication, and systemic functioning were not used to evaluate improvement in this case. Therefore, we can only speculate that familial factors contributed to the observed and reported improvements in the child's symptoms. Future research efforts need to assess improvements in both the child's symptoms and family functioning. We would also like to mention that our clinical experience suggests that TA may not be particularly appropriate for the assessment of involuntary populations, such as forensic evaluations. Perhaps more poignant for families likely to appear in health care settings, we recommend proceeding very cautiously when using the TA model with families who have experienced a recent traumatic event (e.g., domestic violence, child abuse, or neglect), due to the potential of retraumatization to the child or the parents. In general, clinicians will need to carefully consider when and with whom to employ the full TA model, or a modified version of TA, which may also be suitable.

One potential hurdle to the application of TA in health, pediatric, family medicine, and primary care psychology is the time required to conduct a *comprehensive* TA, as

was done in this case. Finn (2007) estimated that a comprehensive TA takes about 20% more time than a traditional psychological assessment. Although, the comprehensive TA model may be valuable when a full child/family assessment and intervention seems warranted, and there is ample time (6–12 hours) to conduct each of the model's components as described. Also, TA may be particularly warranted when other psychological interventions have been tried and have not proved successful. Lastly, since TA has also been found to lead to changes, it may be a desired approach as a brief intervention instead of an assessment and subsequent referral for a separate individual or family treatment.

CONCLUSIONS AND CLINICAL IMPLICATIONS

Psychologists practicing in health care settings are experts on the interface of medical and psychological conditions and they are often called upon to assist medical professionals with thorny and complicated health situations. The case we summarized represents a common referral question encountered by a psychologist in a health care setting, which is to identify possible psychological correlates and points of intervention for a medical issue involving a child and family. We have attempted to illustrate how a relatively new assessment paradigm, TA, can help untangle the web of psychosocial, familial, and intrapsychic issues involved in such referrals, while involving children and parents in a transformative process. George's physical symptoms appear to have been at least in part related to psychological factors, but TA can also be useful in situations in which psychological issues exist alongside a diagnosed medical condition. In both types of referrals, TA works by helping to illuminate children's unvoiced needs and experiences, and then helping parents to understand these needs and respond appropriately. As this case illustrated, when this process works, even a relatively brief intervention can result in

longstanding shifts in the family's approach to, and understanding of, the child. This case also demonstrates how the TA model is able to facilitate collaboration between members of the health care team and psychologists in medical-psychological consultations, such as those in consultation-liaison psychiatry. Dr. M specifically reported that the letter was a useful means of obtaining feedback from psychology. We believe successful cases, such as the one presented here, often result in a strengthening of the working alliance between the health care team and psychologists, and that children's medical care benefits from such collaboration.

Overall, the case presented illustrates the utility and applicability of the TA model in the contemporary role psychology often serves in health care settings. The collaborative and systemic emphases of TA align with the CCM and with pediatric, health, and primary care psychology's current emphasis on the role of familial factors in a child's physical health. The collaborative nature of TA may also engage parents and families who are otherwise not receptive to psychological services or to looking at psychological factors influencing their children's medical conditions. For example, we believe that George's parents were able to make the shifts they did in part because they were allowed to observe and participate in George's assessment. By the time the assessment had ended, Mike and Ann themselves understood some of George's psychological limitations and what he needed from them to overcome such difficulties, with only minor input from the clinician. Again, this illustrates a central feature of the CCM, that when patients understand and are actively engaged in constructing their own case formulations they are more likely to follow through on treatment recommendations. In comparison to the traditional assessment paradigm, TA has been found to lead to longstanding familial changes for a variety of children's psychological problems (e.g., Smith, Handler, & Nash, 2010;

Smith et al., 2009; Tharinger et al., 2009). This evidence suggests TA is an intervention in and of itself, not simply a method for gathering information to aid conceptualization and treatment recommendations.

In sum, we believe that child-centered family TA is a useful tool for psychologists practicing in health care settings, and we recommend that training in this method be made available.^{vi} We also encourage research on the utility and acceptability of TA with children and families coping with puzzling and complex medical conditions.

^{vi} Further information about TA and opportunities for training are listed on the TA website: www.therapeuticassessment.com.

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