THE TA CONNECTION

resources for THERAPEUTIC ASSESSMENT PROFESSIONALS

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IN THIS ISSUE:

Double Take

J.D. Smith, PhD
Northwestern University Feinberg School of Medicine

Warmest of greetings, friends and colleagues. As the title of my introduction hints at, you likely noticed the new look of the TA Connection, the newsletter of the Therapeutic Assessment Institute (TAI). As our membership grows, we felt it time to update the newsletter to reflect the maturation of the Institute and to align with the aesthetics of our new logo and website. A special thank you to David Yupe for creating the newsletter's new layout!

This Issue

This issue contains three exceptional columns, written by Katherine Thomas, Deborah Tharinger, and Jan Henk Kamphuis, as well as exciting announcements about upcoming events that are of interest to the Therapeutic Assessment (TA) community.

Katherine Thomas' column discusses the therapeutic value of conducting within-person repeated measures assessment in the context of TA. This type of assessment allows for a better understanding of change over time and the fluctuations that are obscured when measurement is taken less frequently. Thus, they can help the assessor answer different kinds of assessment questions, such as those that concern variability and relationships between events or experiences and a client's affective reactions to them. This column presents the state-of-the-science in these measurement methods and discusses a number of ways that their application can be fruitful for TA. A brief case example is included that brings the within-person assessment method to life.

Deborah Tharinger's column discusses the value and techniques of the TA model with children (TA-C) in the context of public schools. Using TA-C in the schools requires an integration of a school-focused (teacher's questions and reports of the child in the classroom) and a family-focused perspective (parent's questions and reports of the child at home), but teachers are the primary focus for change. To illustrate, Dr. Tharinger presents the case example of Henry, a 7-year-old Native American student referred for evaluation for special education. Numerous TA techniques are discussed as they were applied in this case, and their application to the school context is highlighted. The outcome of the assessment with Henry was made more accurate and useful by Dr. Tharinger adopting the values and approach of TA-C compared to what likely would have occurred in a traditional assessment. This case is a wonderful example of how TA-C can be used in the schools for the betterment of the child, the school, and the family.

In this issue's final column, Jan Henk Kamhpuis presents the case of Mr. O. and the use of TA in restoring epistemic trust. The column is presented as two assessments, one through the lens of a traditional assessment, and the other through TA. The contrast between the two approaches is clearly evident in the way this man with personality disorder is able to form a level of epistemic trust with the TA assessor in a way that is not possible, or perhaps even made less trusting, by traditional methods. The case includes examples of "mini" assessment interventions during extended inquiry as well as a complete Assessment Intervention Session that was designed to provide Mr. O. with the space to play and explore aspects of himself with the assessor in service of restoring epistemic trust. For more on the concept of epistemic trust and its relationship with TA techniques, check out the recent article by Jan Henk Kamphuis and Stephen Finn (2018) published in the *Journal of Personality Assessment.*

What has TA been up to?

The newsletter is also an opportunity to recap the events of the past half year. Faculty and members of the TAI have been busy spreading the word about TA and conducting trainings. One of the more prominent events for TA each year is the annual meeting of the Society for Personality Assessment (SPA), which took place in New Orleans, LA this past March. TA was well represented among the many exceptional symposia and paper presentations. Among these presentations were 3 symposia solely devoted to TA. These were chaired by Lionel Chudzik, Barbara Mercer, and Diane Engelman. Countless

(well, a lot!) of paper presentations and posters related to TA even if not exclusively devoted to the topic.

As usual, the SPA conference is a great venue for learning about the cutting edge of TA and other areas related to personality and psychological assessment. To highlight, Jan Henk Kamphuis, Hilde De Saeger, and Pamela Schaber also conducted a day-long workshop titled, "Therapeutic Assessment (TA) in Clients with Personality Disorder, with a focus on the Restoration of Epistemic Trust" and Dale Rudin conducted a day-long workshop titled, "Using a Collaborative/Therapeutic Assessment Model in Diagnosing Adults with an Autism Spectrum Disorder." Last, the Collaborative/Therapeutic Assessment Interest Group, co-led by Hale Martin and Filippo Aschieri, was a resounding success with excellent attendance, lively discussion, and of course cameraderie among the attendees.

It is not too early to plan to attend the 2020 SPA annual meeting which will take place in lovely San Diego, CA from March 25–29 at the Westin San Diego Gaslamp Quarter. We expect there to again be TA-related workshops, symposia, and paper presentations, as well as many opportunities to network and catch up with colleagues from around the world.

3rd International Collaborative/Therapeutic Assessment Conference

Another exciting opportunity for the TA community is the 3rd International Collaborative/Therapeutic Assessment Conference that is scheduled for June 19–20, 2020, with preconference workshops on June 18th (see the Save The Date flyer on page 27). Unlike past conferences that were held in Austin, TX, this year we will be on the beautiful campus of the University of Denver. Stay tuned to the TAI website **Events** tab for information on workshops, a call for papers so that you can present, and registration details as they become available over the coming months. Like the last two, we fully expect this event to be stimulating, social, and an all-around good time for attendees. A special thank you to our conference co-sponsors, the University of Denver, the Colorado Assessment Society, and SPA. And it's not a bad idea to plan to arrive a day or two early to acclimatize to the mile-high elevation! I plan to use that as an excuse to do some hiking in the Flatirons near Boulder. Hope to see you all there!

Other Upcoming TA Trainings

As always, visit the TAI website (www.therapeuticassessment.com) for information on upcoming trainings and events. A few to highlight are the Specialization Course in Therapeutic Assessment with Adults and Families with Children presented by Filippo Aschieri, Jan Henk Kamphuis, Hilde De Saeger, and Francesca Fantini to be held in Stockholm, Sweden August 28–30, 2019; an introductory workshop on Working with Shame in Psychotherapy and in Psychological Assessment to be presented by

duction to Therapeutic Assessment: Using Psychological Testing as Brief Psychotherapy presented by Hale Martin in Boulder, CO October 4–5, 2019; and a workshop on Restoring Epistemic Trust through Therapeutic Assessment: Building a Relationship "Superhighway" with Difficult-to-Treat Clients presented by Stephen Finn, Noriko Nakamura, and members of the Asian-Pacific Center for Therapeutic Assessment in Tokyo, Japan November 3¬–4, 2019.

The Leonard Handler Fund

This recently-established fund assists economically disadvantaged clients who would benefit from a TA but are unable to afford one. Leonard Handler (1936–2016) was a brilliant researcher, teacher, and clinician who developed ground-breaking methods used in TA, especially with children and families, such as the Fantasy Animal Drawing and Storytelling Game. Please consider donating to this fund through the TAI website to help make TA available to everyone, regardless of in-come level. Soon we will provide information on how TA-trained assessors can apply for these funds to support underserved clients that otherwise could not afford a TA-informed assessment. Information will be available on the TA website and through the *TA Connection.*

Become a Member of the TAI

Membership in the Therapeutic Assessment Institute (TAI) gets you two issues a year of this lovely newsletter, access to the members-only listserv, discounts on trainings sponsored by the TAI, and discounts on trainings

on the Adult Attachment Projective Picture System. The membership fee is very reasonable at $75 per year for professionals and $40 for students. Please consider joining to receive these benefits and to help support the TAI's mission, and please do also tell your friends and colleagues!

Donate to TA

The TAI is a nonprofit organization with a volunteer Board, and all donations are tax-deductible. Please consider contributing so we will be able to continue to spread TA and provide the best available mental health services to the clients we serve. And please tell your well-to-do contacts about the worthwhile mission of the TAI. We currently use the majority of donations to support scholarships for students and professionals in need of financial assistance to attend trainings, and the Leonard Handler Fund provides financial support to underserved clients. We also are at work on developing training materials for those of you who find it difficult to travel to our workshops. None of this is possible without your generosity. Also consider making the TAI part of your estate plan.

Future Issues of the TA Connection

If you have feedback or suggestions for the newsletter, email me! Many of the topics covered in the newsletter have come from your suggestions, and I hope to continue to provide information that is useful to our readers. If you have conducted an exemplary or interesting TA case, want to write about some aspect of TA, or have a suggestion for a topic you would like to see appear in an upcoming issue, please let me know.
Please email questions, comments, and suggestions to J.D. Smith at *jd.smith@northwestern.edu*

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Within-Person Therapeutic Assessment: Using Repeated Measures to Assess Clients over Time

Katherine M. Thomas, PhD
Center for Therapeutic Assessment, Austin, TX

Introduction to Within-Person Assessment and its Potential Therapeutic Value

Researchers in human sciences have long been interested both in how people behave in general, evaluated using between-person assessment methods, and in how one person behaves over time, evaluated using within-person assessment methods. Assessment approaches that involve measuring people over time are known by numerous names depending on the context and study design. In clinical settings, within-person assessments are often referred to as personalized assessment or precision medicine, and are also commonly referred to by the name of one of their modal designs: daily diary studies. In empirical literature, within-person assessment is often referred to as idiographic research, ambulatory assessment, ecological momentary assessment, and experience sampling methodology. Regardless of the name or measurement scale, within-person assessment approaches produce repeated measures data that are dense with daily or even multiple times daily data points (see Table 1, where I highlight distinctions between assessment approaches).

Table 1. *An Overview of Distinctions in Between-Person and Within-Person Assessment.*

Collecting Data	Between-Persons	Within-Person
Sample size is the	Number of participants	Number of time points
Research using this method is known as	Nomothetic; cross-sectional	Idiographic; repeated measures
People's scores indicate	How they rate themselves compared to others	How they rate themselves over time
We use results to infer	The severity and patterning of constructs that describe a person's functioning compared to others	The severity, frequency, and patterning of constructs that describe a person's functioning over time

Both between-person and within-person assessment methods are foundational to psychological science and clinical practice, and although between-person research is far more prevalent than within-person research, in recent years, there has been a notable boon of clinically relevant research assessing within-person processes. Assessing how people change over time is fueled by the increased ease of assessing certain aspects of daily life with technology (e.g., smartphones) and a growing body of research indicating that assessing within-person processes augments assessment of between-person processes.

Indeed, although clinicians and researchers have long-standing interest in assessing people over time, historically this approach has tended to be tedious. Now, access to many modern electronic devices makes some forms of within-person assessment effortless (e.g., smart devices that track things like sleep-wake patterns, steps taken, heart rate, screen time and usage, etc.). And even more effortful assessment such as nightly self-report ratings of 20+ variables related to emotions, thoughts, and behaviors for two or more weeks can be done in numerous ways (including paper and electronic ratings) and involves answering approximately the same overall number of questions as broadband self-report measures like the Personality Assessment Inventory (PAI; Morey, 1991) and Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF; Ben-Porath & Tellegen, 2008).

There is also now a considerable and compelling body of research identifying how between-person and within-person approaches to assessment ask and answer different types of questions (e.g., Fischer, Medaglia, & Jeronimus, 2018). Thus, having data on both is often clinically useful. For example, scores on a between-person measure like the MMPI-2-RF could indicate a client is highly depressed and antisocial, and often uses substances. Within-person assessment could help answer questions commonly asked in Therapeutic Assessment (TA; Finn, 2007) like: [how] are my anger, sadness, and drinking related? Do certain emotions tend to proceed or follow my drinking? Am I drinking more at certain times [without even realizing it]? We often attempt to answer questions like these in TA and therapy, with or without explicit measures, by observing how our clients behave over time and across contexts. Within-person assessment is a way of quantifying observations about how clients compare to themselves at different times in a way that augments assessments of how clients compare to others (norm-based comparisons).

Clinically Relevant Research using Within -Person Assessment

Research investigating within-person psychological processes has seen a significant rise in the last decade (Wright & Zimmerman, in press), although these methods have also been used for many years to study clinically relevant constructs, particularly processes related to substance use, eating behavior, personality, and mood regulation (e.g., Trull & Ebner-Primer, 2013). A consistently replicated finding is that results obtained from between-person zassessments often notably differ from results obtained from within-person assessments (cf., Fisher et al., 2018). The statistical term for results that are equivalent across between-person and within-person assessments is *ergodic,* and all psychological processes examined to date have been found to be non-ergodic, meaning that between-person results do not necessarily apply to within-person processes (Molenaar & Campbell, 2009). A simple analogy is that, based on between-person research conducted by the Pew Center (2015), the average American woman has 2.4 children, and yet, not a single American woman has 2.4 children!

The literature is becoming ripe with studies that demonstrate the clinical value of within-person assessment. To highlight just some of this research, a recent study by Lewis and Ridenour (2019), which Katie Lewis also presented at the 2019 annual meeting of the Society for Personality Assessment in New Orleans, LA, describes a client in residential treatment at the Austen Riggs Center. She collected multi-method data using a common protocol of self-report, performance-based, and behavioral tests, and also asked the client to rate 10 items related to his interpersonal interaction and emotions, and provide an open-ended description of his primary feeling at the moment, four times daily for two weeks. At the end of each day during this two-week period, he also completed a narrative journal entry that provided useful qualitative data. A notable aspect of this case is that the client reported fairly low levels of anger and aggression on cross-sectional measures; however, in his daily ratings he frequently said "angry" was his primary emotion, and he frequently described himself as feeling angry and behaving with hostility throughout the two-week within-person assessment. In discussing these data, the client initially seemed perplex and noted, "but I'm not an angry guy" (Lewis, 2019). Just as clients' can have discrepancies in their self-report and performance-based data (e.g., someone who has thinking disturbances on the Rorschach Performance Assessment System [RPAS; Meyer, Viglione, Mihura, Erard,

& Erdberg, 2011] but not on the MMPI-2-RF), this client was surprised that the data he provided from day to day was not consistent with his general sense of himself. In this case, the therapist used these data, and the qualitative end-of day descriptions the client provided, to better understand how anger, both expressed and defended against, unfolds in this client's life. Lewis and Ridenour's (2019) study provides a compelling case example of the potential value of incorporating within-person assessment into treatment.

In another study with a client in weekly psychotherapy, Roche and colleagues (2014) used within-person assessment to better understand relationship dynamics between the client and his wife, both of whom completed ratings following each of their interactions for several consecutive days. The researcher and clinician (Mike Roche) found that the client's behaviors toward his wife changed as a function of changes in his self-esteem, anger, and perceptions of his wife's behavior, and discussing these data helped the therapist and client better understand cognitive-affective states associated with his relationship behaviors. This article provides a terrific summary of considerations for using within-person assessment in therapy, and provides a template for evaluating couples' interactions using a simple measurement model.

Aaron Fischer has also championed the use of within-person assessment in clinical contexts in much of his research (e.g., Bosley & Fisher, 2019; Fisher, 2015; Fisher & Boswell, 2016; Fisher, Newman, & Molenaar, 2011; Fisher, Reeves, Lawyer, Medaglia, & Rubel, 2017), and he recently published an open-trial study with a goal of optimizing personalized treatments for mood and anxiety disorders (Fisher et al., 2019).

Incorporating Within-Person Assessment into Collaborative/Therapeutic Assessment

J.D. Smith and others have studied how we can use within-person repeated measures assessment to track the usefulness of our interventions in Therapeutic Assessment (e.g., Aschieri & Smith, 2012; Smith, Eichler, Norman, & Smith, 2015; Smith, Nicholas, Handler, & Nash, 2011; Smith & George, 2012; Smith, Wolf, Handler, & Nash, 2009). Within-person (or within-couple/within-family) assessment also has the potential to be useful when clients ask questions about how processes are related, what might precipitate certain behaviors, if certain feelings/behaviors seem to occur at specific times, how thoughts/feelings/behaviors change across contexts, etc. In this section I briefly discuss some issues involved in considering when and whether within-person assessment might be useful to incorporate with clients.

Typically, in between-person assessments using measures like the MMPI-2-RF, PAI, RPAS, and other measures of cognitive, personality, and psychological functioning, the sample (size) for the comparison group is the (number of) people studied in validating and creating normative data for the measure. In within-person assessments, the sample (size) is the (number of) time points a person responds to the same item. Thus, in many cases it is useful to measure someone more often (e.g., daily or even several times per day) in order to obtain a sufficiently large sample of their behaviors/emotions/etc. However, we also have to consider the trade-off between precision of measurement and response burden, the optimal time scale for capturing fluctuation in the primary construct(s) of interest, and how to validly assess the constructs of interest.

More frequent measurements are more precise but they increase participant burden (aside from instances of passive data collection, like heart rate data collected with a smart watch). Thus, we often make a trade-off between frequent assessments and reasonable schedules of data collection. To provide a simplified illustration, in all of the following scenarios, a client would respond to a total of 400 items; the "sample size" of the number of times the person is assessed decreases in each scenario, but the participant burden also arguably decreases in each scenario:

- 10 items 5 times per day for 8 days = 400 items across 40 time points
- 25 items once per day for 16 days = 400 items across 16 time points
- 100 items once per week for 4 weeks = 400 items across 4 time points

An important consideration when designing a within-person assessment design is to consider the best time scale for capturing the primary construct(s) of interest and answering clients' specific questions. As a general rule of thumb, things that occur and vary more frequently are amenable to more frequent assessments, compared to things that occur less frequently or do not tend to vary. For instance, a couple who is curious about how their emotions, perceptions, and behaviors relate to their difficulties might want to assess these variables after each (meaningful; significantly long lasting; face-to-face; etc.) interaction they have for several consecutive days. This is referred to as event-based or event-contingent assessment, in which

people provide ratings following specified events, like a 5+ minute interaction with their partner, a binge episode, smoking, etc.

A client's specific questions and goals should also influence the assessment design. A person with problems related to drinking might assess drinking behaviors and other variables related to stress, emotions, relationships, etc. on a daily basis, but whether they rate behaviors throughout the day or once daily (usually at the end of the day or the following morning, reflecting on the prior day), will depend on their questions (and their functional ability to provide ratings throughout the day). For instance, a question like "How often am I drinking in an average week, and am I drinking more some days than others?" can be assessed with daily diary ratings. On the other hand, a question like, "is my binge drinking related to certain emotions or experiences?" might be better answered by having the client provide ratings throughout the day to track whether their drinking is commonly proceeded by certain emotional experiences.

In recent years there has been both empirical and applied interest in developing standardized and well-validated tools for within-person assessment, but in general there are far fewer well-validated options available relative to between-person assessments. Both between-person and within-person assessments frequently involve assessing self-report items of emotions, thoughts, behaviors, and interpersonal interactions, and as such, a common approach in assessing within-person processes is to use items from measures validated between-persons and modify the language as is appropriate. This can mean changing questions about psychological traits to read as questions about states (e.g., "I often feel sad or blue" changed to "today I felt sad or blue"). This is frequently done by modifying well-validated measures of personality and emotions (e.g., the Positive and Negative Affect Scale [PANAS]; Watson, Clark, & Tellegen, 1988). Specific tools for assessing within-person psychological processes have also been developed, and I expect such measures are likely to proliferate in the coming years. Measures with empirical support for within-person assessment include the Personality Dynamics Diary (Zimmerman et al., 2019), as well as measures to assess depression (Burchert, Kerber, Zimermann, & Knaevelsrud, 2019), impulsivity (Tomko et al., 2014), emotions (Fisher et al., 2011), and interpersonal behaviors (Moskowitz & Zuroff, 2005; Roche et al., 2014). Although self-reports predominate research and clinical practice, within-person assessment can also involve informant reports (e.g., partner, parent, teacher, coworker) of a person's behaviors.

Analyzing within-person data can be difficult, and the (time-series) statistics commonly used in published research can seem unapproachable for readers without considerable statistical acumen. However, within-person assessment does not need to involve sophisticated statistical analysis to be useful. Simply graphing within-person data is informative and indicative of the frequency, severity, and patterning of a person's experiences from day to day. We can do this using software like Excel and Google Sheets, with the first column indicating the measurement occasion (1, 2, 3…) and subsequent columns with ratings of variables at each occasion. In addition to graphing these data, we can correlate columns of relevant variables to evaluate whether they fluctuate together over time. It is worth noting that correlating within-person data in this way is not the most statistically apt method (because data provided by the same person at consecutive time points violates the model's assumption of independence between data points). However, it is also worth noting that these correlations can nonetheless be informative and can often yield the same results as more appropriate, but often highly technical, statistical analyses (Moleenar, 1985; Thomas & Rieke, 2017). Some of these analyses, like repeated measures ANOVA, auto-correlations (the correlation of a variable with itself over time), and vector autoregression (associations between [multiple] variables over time), are not as intimidating as their names make them sound, and can also be computed using software like Excel/Sheets and a freely-available program for clinical researchers called Simulation Modeling Analysis (Borckardt, 2006) that Smith and colleagues used in their published studies on TA. Still, learning new statistical models is not feasible or practical for many practicing clinicians, and graphing, calculating descriptive data (e.g., frequencies, mean-levels), and computing correlations to see how variables relate over time is a fairly straightforward and clinically useful way to evaluate within-person data.

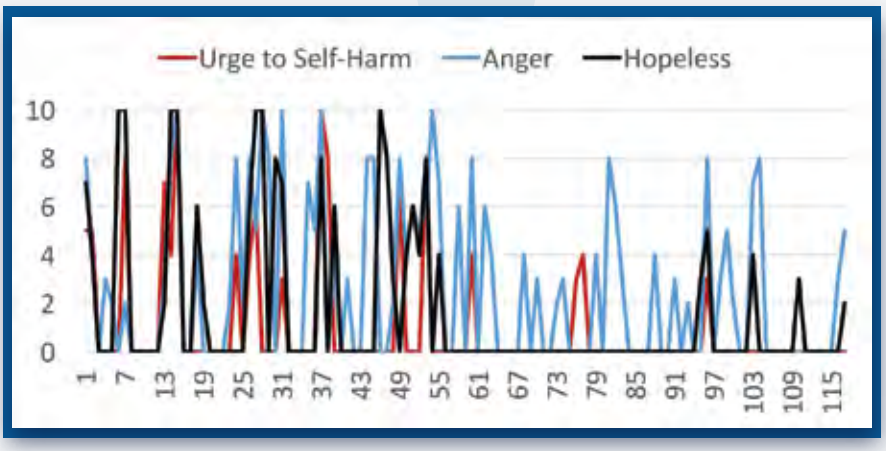
A Case Example of Collaborative Within-Person Assessment

To illustrate, I briefly describe a case example showing how I incorporated within-person assessment into my intervention with a long-term therapy client. For over two years during my graduate training I saw a client, who I'll call "Amy," for weekly, sometimes twice weekly, therapy. Although I did not conduct a formal TA with her, we regularly incorporated TA principles

and methods into our treatment. Amy was in her 20's, single, employed in a clerical position, and sought treatment following a suicide attempt that led to an 8-day hospitalization and some mild but permanent organ damage. On between-person measures (the PAI and the Personality Inventory for DSM-5 [PID-5]; Krueger, Derringer, Markon, Watson, & Skodol, 2012), she reported high levels of suicidality, depression, anger/aggression, and borderline personality features, among other noteworthy results, but I want to focus on our specific and mutual goal of reducing her self-harming behavior (which primarily involved cutting her skin). We were incorporating components of Dialectical Behavior Therapy (DBT) into our treatment when I first saw a daily diary protocol suggested in a DBT skills workbook (McKay, Wood, & Brantley, 2007). Amy and I agreed it might be useful to track some of her behaviors, urges, and emotions from day to day using this protocol, and she even wanted to add additional variables she was interested in tracking (e.g., "time spent with friends" and feelings of "loneliness").

Amy found completing a daily log of her behaviors, urges, and emotions to be incredibly interesting and informative, and our sessions often started with her wanting to discuss some aspect(s) of her recent daily ratings. Because she found these ratings beneficial, she continued to complete them for over 100 consecutive days. (These data were valuable, but briefer data would have also sufficed had she been less engaged in the process). She engaged in self-harm behavior twice during the data collection period. Because this behavior rarely varied (i.e., she self-harmed 2/117 days), it was more informative to examine how daily fluctuations in her urge to self-harm related to fluctuations in various emotions. Across nearly 20 emotions, feelings of anger and hopelessness stood out as the most strongly and positively related to her urges to self-harm. I assessed and discussed these data with her using graphs and correlations, but of note, these two variables also emerged as most predictive of her urge to self-harm using time-series analyses like vector auto-regression. In Figure 1, I present her daily ratings of her urges to self-harm, and feelings of anger and hopelessness (graphed in Excel).

Figure 1. *My Client's Daily Diary Ratings (1-10, Y Axis) for 117 Days (X Axis).*



Discussing these data with Amy proved useful to both of us. At the outset, she guessed that her urges to self-harm would be most related to feelings of sadness; however, her day-to-day sadness was positively but less strongly related to her urges to self-harm compared to her day to day feelings of anger and hopelessness. We reflected on how angry and hopeless she felt just prior to her most severe suicide attempt just before the start of our treatment, and in one session Amy discussed feeling especially hopeless about her future and started to get increasingly angry as the session neared its end. This cued me to ask whether she was feeling an urge to self-harm after our session, and she affirmed that she was. Anticipating this urge based on the data we had collected allowed us to intervene in the moment and plan alternative ways she could cope with her angry and hopeless feelings when our session ended.

▶ *Conclusion: The Potential Value of Using Within-Person Assessment with Clients*

In addition to knowing how clients compare to others, psychologists practicing TA also want to better understand how clients think, feel, and behave day to day, and how they typically change across contexts. Thankfully, researchers are well poised to continue studying human behaviors as they change over time and across contexts. Although I discussed them as distinct throughout this column, it is worth noting that between-person and within-person research designs are not mutually exclusive, and indeed, researchers are increasingly collecting within-person repeated measures data on several subjects across multiple time points to evaluate both normative and individualized psychological profiles (e.g., Wright et al., 2019).

Despite the rise of clinically relevant research on within-person processes, fairly few bridges have been built between this research and clinical practice, and none that are yet widely travelled. One problem is the relative lack of research on accessible and well-validated measures to assess within-person processes, and I hope in the not too distant future we will have more valid and well-studied measures for assessing clinically relevant dynamics that are easy to administer, score, and interpret. In the meantime, we have access to a variety of tools that allow us to tailor repeated assessments to clients in collaborative and therapeutic ways, and when it is feasible and relevant, I hope some of you will consider utilizing this approach. Feel free to email me if you have any thoughts or questions (thomas.kate.m@gmail.com).

References

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

Ben-Porath, Y. S., & Tellegen, A. (2008). *MMPI-2-RF, Minnesota Multiphasic Personality Inventory-2 Restructured Form: Manual for administration, scoring and interpretation.* University of Minnesota Press.

Borckardt, J. J. (2006). *Simulation Modeling Analysis: Time series analysis program for short time series data streams* (Version 8.3.3). Charleston, SC: Medical University of South Carolina. (www.clinicalresearcher.org)

Borkenau, P., & Ostendorf, F. (1998). The Big Five as states: How useful is the five-factor model to describe intraindividual variations over time?. *Journal of Research in Personality, 32*, 202-221.

Bosley, H. G., & Fisher, A. J. (2019, March). *Idiographic Dynamics of Positive Emotion in GAD: Modeling Emotion Regulation at the Person Level.* https://doi.org/10.31234/osf.io/bhn7y

Burchert, S., Kerber, A., Zimmermann, J., & Knaevelsrud, C. (2019, March). 14-day smartphone ambulatory assessment of depression symptoms and mood dynamics in a general population sample: comparison with the PHQ-9 depression screening. *Frontiers in Psychology, 10*, 704.

Finn, S. E. (2007). In our clients' shoes: Theory and techniques of Therapeutic Assessment.New York: Psychology Press.

Fisher, A. J. (2015). Toward a dynamic model of psychological assessment: Implications for personalized care. *Journal of Consulting and Clinical Psychology, 83*, 825–836.

Fisher, A. J., Bosley, H. G., Fernandez, K. C., Reeves, J. W., Soyster, P. D., Diamond, A. E., & Barkin, J. (2019). Open trial of a personalized modular treatment for mood and anxiety. *Behaviour Research and Therapy, 116*, 69-79.

Fisher, A. J., & Boswell, J. F. (2016). Enhancing the personalization of psychotherapy with dynamic assessment and modeling. *Assessment*, *23*, 496–506.

Fisher, A. J., Medaglia, J. D., & Jeronimus, B. F. (2018). Lack of group-to-individual generalizability is a threat to human subjects research. *Proceedings of the National Academy of Sciences*, *115*(27), E6106-E6115.

Fisher, A. J., Newman, M. G., & Molenaar, P. C. M. (2011). A quantitative method for the analysis of nomothetic relationships between idiographic structures: Dynamic patterns create attractor states for sustained posttreatment change. *Journal of Consulting and Clinical Psychology*, *79*, 552–563.

Krueger, R. F., Derringer, J., Markon, K. E., Watson, D., & Skodol, A. E. (2012). Initial construction of a maladaptive personality trait model and inventory for DSM-5. *Psychological Medicine*, *42*, 1879-1890.

Lewis, K. C., & Ridenour, J. M. (2019, January). The integration of EMA and single-occasion multimethod assessment data for a complex psychiatric patient. *Assessment*, doi: 1073191118825313.

McKay, M., Wood, J., & Brantley, J. (2007). *The dialectical behavior therapy skills workbook.* New Harbinger Publications: United States of America.

Meyer, G. J., Erard, R. E., Erdberg, P., Mihura, J. L., & Viglione, D. J. (2011). *Rorschach Performance Assessment System: Administration, coding, interpretation, and technical manual.* Rorschach Performance Assessment Systems LLC.

Molenaar, P. C. (1985). A dynamic factor model for the analysis of multivariate time series. *Psychometrika, 50,* 181-202.

Molenaar, P. C.M., & Campbell, C. G. (2009). The new person-specific paradigm in psychology. *Current Directions in Psychological Science, 18*, 112–117.

Morey, L. C. (1991). *The Personality Assessment Inventory: Professional manual.* Odessa, FL: Psychological Assessment Resources.

Moskowitz, D. S., & Zuroff, D. C. (2005). Assessing interpersonal perceptions using the interpersonal grid. *Psychological assessment*, *17*, 218-230.

Roche, M. J., Pincus, A. L., Rebar, A. L., Conroy, D. E., & Ram, N. (2014). Enriching psychological assessment using a person-specific analysis of interpersonal processes in daily life. *Assessment*, *21*, 515–528.

Smith, J. D., Eichler, W. C., Norman, K. R., & Smith, S. R. (2015). The effectiveness of a therapeutic model of assessment for psychotherapy consultation: A pragmatic replicated single-case study. *Journal of Personality Assessment*, 261–270.

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

Smith, J. D., Nicholas, C. R. N., Handler, L., & Nash, M. R. (2011). Examining the potential effectiveness of a family intervention session in Therapeutic Assessment: A single-case experiment. *Journal of Personality Assessment, 93*, 149–158.

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

Thomas, K.M., & Rieke, C (2017). Measuring individual differences and interpersonal processes in psychopathology. Paper presented at the annual meeting of the *Society for Interpersonal Theory and Research*, Pittsburgh, PA.

Tomko, R. L., Solhan, M. B., Carpenter, R. W., Brown, W. C., Jahng, S., Wood, P. K., & Trull, T. J. (2014). Measuring impulsivity in daily life: the momentary impulsivity scale. *Psychological Assessment*, 26, 339-349.

Trull, T. J., & Ebner-Priemer, U. W. (2013). Ambulatory assessment. *Annual Review of Clinical Psychology*, 9, 151–176.

Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: the PANAS scales. *Journal of personality and social psychology,* 54(6), 1063.

Wright, A. G., Gates, K. M., Arizmendi, C., Lane, S. T., Woods, W. C., & Edershile, E. A. (2019). Focusing personality assessment on the person: Modeling general, shared, and person specific processes in personality and psychopathology. *Psychological Assessment, 31*, 502-515.

Wright, A.G.C., & Zimmerman, J. (in press). Applied ambulatory assessment: Integrating idiographic and nomothetic principles of measurement.

Zimmermann, J., Woods, W. C., Ritter, S., Happel, M., Masuhr, O., Jaeger, U.,... & Wright, A.G.C. (2019). Integrating structure and dynamics in personality assessment: First steps toward the development and validation of a personality dynamics diary. *Psychological Assessment, 31*, 516-531.

Author

Katherine M. Thomas, Ph.D., is a postdoctoral fellow at the Center for Therapeutic Assessment in Austin, TX. She has published extensively on topics related to interpersonal functioning, personality, psychopathology, assessment, and therapy process and outcome. She earned her doctorate in clinical psychology from Michigan State University in 2015 and worked as an assistant professor at Purdue University from 2015-2018. She accepted a position as an assistant professor at Rhodes College to begin in January 2020, where she looks forward to teaching and having a small practice and research program rooted in Therapeutic Assessment.

Please email questions or comments on this column to Kate Thomas at *thomas.kate.m@gmail.com*

Assessing Children in Public Schools Using Therapeutic Assessment Values and Methods

Deborah J. Tharinger, PhD
Center for Therapeutic Assessment, Austin, TX

I welcome the opportunity to discuss and illustrate how the values and selected methods and techniques of Therapeutic Assessment with Children (TA-C) can be implemented to positive effect in psychological assessments/evaluations provided for children in the public schools. I have addressed this topic in pr¬evious publications (Tharinger, Finn, Wilkinson, & Schaber, 2007; Tharinger, Krumholz, Austin, & Matson, 2011) and in my many years teaching Social/Emotional Assessment to graduate students in the School Psychology Program at the University of Texas. In this column, I present a case study of a 7-year-old boy, Henry. Before jumping in to the case, I first provide a brief description of the major goal of school-based assessment and Therapeutic Assessment, and ask if and how the latter can be integrated with the former. Then I review and illustrate the selected therapeutic methods I used in Henry's case that demonstrate the integration. I include the story/fable I wrote for Henry to demonstrate the impact of the child having been seen and heard through a therapeutically driven assessment. I end with a hopeful view of conducting child assessments in public schools that meet the eligibility determination needs of the school and create positive change for the child, both at school and at home, through enhanced teacher and parent understanding and empathy.

School-based Assessment

Psychological assessments are utilized in the schools to identify children for Special Education eligibility, placement and services, usually under the disabilities of Emotionally Disturbed, Other Health Impaired (due typically to ADHD), and Autism. Psychological assessments are also conducted to assess the emotional and behavioral functioning of children qualified for Special Education under other disabilities (e.g., Specific Learning Disabilities, Autism, medical conditions) to determine if psychological services are needed to support their educational attainment. Psychological evaluations conducted in schools are governed by federal and state laws and regulations that must be adhered to. These may seem to restrict the integration of therapeutic approaches to assessment, but that is not necessarily so. I propose that the values of TA and the use of selected TA methods and techniques from TA-C can be infused with the procedures required in school-based evaluations. This integration can greatly enhance the process, outcome, and subsequent impact of psychological assessment in the schools

Therapeutic Assessment with Children/Families.

Finn (2007) describes "Therapeutic Assessment" as an attitude and respect for the relationship with the client, where:

> T]he goal of the assessor is more than collecting information that will be useful in understanding and treating the patient. In Therapeutic Assessment, in addition, assessors hope to make the assessment experience a positive one and to help create positive changes in clients and in those individuals who have a stake in their lives. (p. 4)

This goal can be seen as having universal value and fits the intent of assessment in the schools, which is to positively impact the child, teachers, school staff, and parents and support the child's educational performance. Further, the core values of TA also have the potential to influence the tone and process of assessments in the school. These include: a) actively collaborating with clients; b) respecting clients and their diversity; c) having humility about our expertise and the power of our assessment tools; d) having compassion for clients and their situations; e) having empathy and showing kindness for clients; f) being open and curious about ourselves in relation to our clients and how that might impact the assessment; and g) being open and curious about how each client has developed as a unique individual.

Family Focused vs. School Focused

The model of TA-C was developed primarily for use in outpatient settings with the parents/-caregivers the primary focus for change. In TA-C the aim is to help the parents develop a new, healthier and more empathic understanding of their child and their family and to move toward positive and systemic change. The assessment is guided by the parents' assessment questions and feedback

addresses the assessment questions. The child's teacher typically is much less central. Depending on the assessment questions, the child's teacher may participate, perhaps by completing a short interview and a comprehensive behavior rating form.

In contrast to TA-C, psychological assessments in the schools are guided by the school's questions, that is, does the child meet the criteria for a disability that impairs his or her educational performance or has substantial emotional, behavioral, or social challenges that are secondary to another disability but significantly influence academic achievement? These assessments rely heavily on teachers for their input about the child, willingness to complete interviews and behavior checklists, and enthusiasm to implement and sustain subsequent classroom interventions. Teachers are front-and-center and the primary focus for change. The aim is to help teachers develop a new and healthier understanding of the student in their classroom, resulting in more effective interventions. Parents/caretakers are actively involved in school assessments, and have much to offer in terms of developmental and family history, their current concerns about their child, and follow through with suggested school-home interventions. In some cases, parents/caregivers can also change and develop a new understanding of their child and their family system that positively impacts the child both at home and at school. In my experience, the more the school-based assessor integrates therapeutic methods within the "school" assessment process, feedback and follow-up, the more likely change will permeate both systems, as well as strengthen the relationship between the two systems. This type of integration could help build a model of School-based TA-C.

Case Study

I now present a case study that demonstrates how the goals, values, selected methods and techniques of TA-C can be infused in school-based assessment to produce good outcomes. The case demonstrates how the assessment can result in change for the child, the teacher, and the parent and is a step toward building an integrated model, suggested above.

Two years ago I worked as a School Psychologist at a Native American School on a pueblo in the Southwestern United States, serving K-8 students. All of the students were Native American, as were 85% of the teachers and staff. I am a Caucasian of Scandinavian descent with some formal and informal education about the history and culture of Native Americans in the Southwest, having lived in the area multiple times. My role in the school involved 1) conducting psychological assessments of students referred for social/emotional/behavioral challenges; 2) providing both weekly in-class and pull-out interventions for children so identified; and 3) consulting with teachers to co-implement classroom-based interventions. Thus, my role involved assessment, direct treatment, and indirect treatment, reflective of the model of psychological services that had been adopted in this school. This model was conducive to introducing therapeutic assessment methods into my assessments, as the staff was familiar with my intervention role.

Let me introduce you to Henry. At the time of our work together, he was 7-years-old and in second grade. He lived with his mother, grandparents, sister, baby brother, aunt, and two cousins in a house on the pueblo. His parents had separated two years previously after being together for eight years. It was reported that Henry spent time with his paternal grandparents, but as of late, little time with his father. Henry has attended the Pueblo School since kindergarten and is bilingual (English and native language).

Henry was referred for comprehensive evaluation for special education consideration due to 1) academic underachievement; 2) his tendency to "shut down" when reading and doing writing assignments that he perceived as too difficult, both at school and at home; and 3) concern about his emotional functioning (anxiety and sadness). Some teachers at the school thought Henry's emotional challenges were exacerbated by his academic failure in 1st grade, followed by a short-lived retention in 1st grade the following school year.

Henry's educational needs were reviewed by the Student Assistance Team (SAT) in both the spring of his kindergarten year and mid-first grade. At the end of first grade it was reported that Henry refused to work in class when he perceived the work to be difficult, was inattentive and not interested in school, and had a distant/reluctant relationship with his teacher. His teacher noted that he had difficulty following directions, completing work, organizing tasks, staying in his seat, and being focused during reading and math. His teacher also noted delayed reading, writing, and math skills.

The SAT approved retention in first grade (although his mother confided in me that it was not her choice and she felt pushed by the school to go along with it). Henry began school in the fall of 2016 in first grade, not second grade. From what could be determined from interviews I conducted at the time of the assessment

(I did not work at the school the previous year), he remained in a first grade class for 4 to 6 weeks. He was reported to be extremely distressed during that time. His behavior declined significantly, going from "shut downs" to "melt downs". He was subsequently placed, at his mother's insistence, in 2nd grade and his extremely distressed behavior stopped (although his challenges with independently producing schoolwork and shutting down when frustrated continued). I hypothesized that the retention experience had a very negative and possibly traumatic impact on Henry and his sense of himself as a learner, member of his class, and member of his community. I also had to take into account that this trauma and conflict with the school might impact our ability to build a relationship, to complete a valid assessment, and to establish trust with his mother. I felt that the use of therapeutic methods could go a long way toward repairing the empathic failure Henry (and his mother) had experienced at the beginning of the school year.

Therapeutic Assessment Methods Used in Henry's Case

• **I worked collaboratively with the teacher, mother and Henry.** For example, I supported Henry through his meltdown in the first session with me (discussed below), involved his mother in supporting our work, and checked in with his teacher often about the nature of his meltdowns in the classroom over the course of the assessment.

• **I worked to show respect and attunement to cultural beliefs (in the family and the school).** I was an outsider; in Henry's culture, feelings are private, often even within the family. I felt strongly that his withholding of challenging feelings was getting in his way both at home and at school. He was revealing some of these feeling to me. I supported his expression and with his explicit permission shared his feelings with his mother and teacher during the assessment. I also had to work with myself to not speak up against the "culture of retention" held by many of the senior teachers in the schools, even though I feel it does more harm than good in almost all cases.

• **With compassion, empathy and kindness, I addressed previous hurts and trauma.** For example, I assured Henry when we first met that he would be staying in his second grade class. I let him know that I was interested in how we could support him in second grade. I also acknowledged that not starting the year in second grade had been very hard and sad for him, and he agreed, strengthening our relationship.

• **I worked with Henry, his mom and his teacher to construct Assessment Questions.**

School's Question: Would Henry qualify for a disability that could be shown to be adversely impacting his educational performance?

Teacher's Questions: Why did Henry have such severe and variable melt downs when he was retained? Why does he still look so sad sometimes?

Mother's Question: Why does Henry get mad and shut down when i try to help with his homework?

Henry's question (provided late in the assessment): Why didn't my mother know how upset I was about the changes at home?

• **I experienced the "problem being brought into the room" and used that experience to get into Henry's shoes and grow my compassion for him, as well as enhance my collaboration with his mother and teacher.** For example, during our first session, after I asked Henry the first two questions from the *BASC-3 6/7 Year Old Interview,* he shut down. He would not respond to any of my subsequent questions. He also did not respond to an offer to play with high interest trucks or shoot nerf basketballs. He said he wanted his mother. I let him know that I would be talking with her that afternoon and then would see him again later in the afternoon and we would just play.

At the afternoon session I let Henry know I had talked with his mother and that she said it was good for him to talk with me. He played with the trucks; he was patient, curious, and talked a little; I sports-casted his activities. I said we would meet again for a few times and we could do some questions and some play. He was open to our plan, As a result of this experience, I knew what "shut down" looked like for him, had a common referent to use with him, understood the frustration of his mother and teacher, and understood that Henry was willing to communicate with me, at his own pace.

• **I used process assessment methods (Extended Inquiry) following standardized administration of tests with Henry, specifically on the *BASC-3 6/7, CDI, RCMAS, and Conners'* items.** For example, Henry endorsed two items on the ***BASC-3***: "in trouble at school" (when inquired, he responded "for shutting down") and "sad at home" where he elaborated, when questioned, "that something was not working right at home." Henry did not expand further but suggested I

ask his mother about what was going on at home. Henry later told me that his parents broke up last year and that he was sad.

- **I looked closely at agreement and lack of agreement across the multiple informants and used the inconsistency to highlight how well Henry hid his feelings.** My aim was to enhance empathy and compassion for Henry by revealing his feelings. For example, On the *Conners 3-Child Self-Report Anxiety Screener,* Henry indicated that very often he was nervous or jumpy or worried; had trouble controlling his worries; and often was irritable. In contrast both his mother and teacher indicated very little concern in this area. On the *RCMAS* (which only has a child version), Henry said "Yes" to the following items (all are on the Physiological Anxiety subscale):

Often I feel sick to my stomach.
I have too many headaches.
I get mad easily.
It is hard for me to get to sleep at night.
I am tired a lot.
My hands feel sweaty.
I have bad dreams.
It is hard for me to keep my mind on my schoolwork.

It was apparent when I spoke with Henry's teacher and mother about my findings that they were both unaware of the level of anxiety he was experiencing. A similar experience occurred on the *Conners Depression Screener.* On that measure Henry endorsed that very often he felt worthless, sad, gloomy, irritable and low on energy. In contrast, his mother endorsed no items on this screener, although his teacher endorsed two items, indicating some awareness of Henry's subjective experience. These findings are similar to the results of the *CDI-2*, where Henry rated himself at the Clinically Significant level (T = 71), his teacher rated him at the At Risk level (T = 67), and his mother rated him in the average range (T = 52).

When I shared these findings with Henry's teacher, she was very taken aback. She immediately expressed compassion and empathy for Henry. I subsequently noticed significant changes in her actions toward Henry in the classroom, all positive and supportive.

- **I had multiple sessions and contacts with Henry and his teacher over the course of the assessment.** This allowed for Henry to get comfortable with me and for us to form a working relationship. It also allowed for the teacher and me to strengthen our relationship and collaborate in implementing interventions in the classroom, including a behavior plan. In contrast, it turned out to be difficult to meet often with Henry's mom. She had a new baby to care for and significant other family responsibilities.

- **I considered multiple frameworks in devising a tentative case conceptualization.** I focused on Henry's emotional functioning and strategies he had developed to protect himself from embarrassment and shame. I hypothesized that the combination of his learning disabilities that were not understood or addressed in kindergarten and first grade, the break up of his parents that was not adequately explained or addressed in his family, the trauma of being retained in first grade, and the cultural tendency to not express feelings combined to grow his anxiety and depression and strengthen his protective strategy of shutting down.

- **I provided feedback to the parent and teacher along the way and at the Eligibility and Placement Meeting and the Individual Educational Plan meeting.** Through the comprehensive assessments provided by multiple professionals (he was also assessed by the Diagnostician and the Speech and Language Pathologist), it was agreed that Henry was eligible for special education services with a primary disability of Specific Learning Disability. It was recommended that he receive services from the pull-out resource class to assist him with his academics. It was also evident that he was struggling emotionally and had developed a strategy that was not conducive to his learning (i.e., shutting down). Thus it was decided that he would benefit from individual pull-out psychological services once a week with me, as well as direct services in his classroom from me. I also provided ongoing teacher consultation to support her new-found empathy for Henry and to implement the behavior plan we constructed.

- **I wrote and presented Henry with a story/fable to tell his story,** informed by the findings from the assessment and contextualized through his responses to an idiographic Sentence Completion I constructed for him. In my experience, the story/fable is not only for the child; it is also extremely meaningful and useful to the adults in the child's life. The story/fable usually captures the finding of the assessment in a way that can be easily absorbed and retained.

- **I conducted a follow-up with Henry.** Four months later, at the end of the school year (Henry was assessed in January/February), Henry's teacher reported that he participated more in class, no longer had "shut downs," (The story/fable for Henry begins on page 28.) persisted on classroom tasks, and made significant

academic gains. Henry also showed a significant decrease in levels of anxiety and sadness that went from the clinically significant range to the average range on standardized measures over the four months.

Key Factors in the Positive Change Evidenced by Henry, Emotionally and Academically

- The teacher's increased motivation, empathy and warmth toward Henry enhanced her investment in him and seemed to carry over to his peers responding more positively to him in the classroom. The relationship between Henry and his teacher significantly improved, perhaps helping to heal the non-supportive relationship he experienced with his first grade teacher.

- Henry felt understood by his teacher and his mother in terms of his anxiety, sadness, and frustration.

- The mother's awareness of Henry's continued negative reaction to the parental separation increased, and she was able to talk with him about it.

- The impact of the empathic failure Henry experienced through being retained was starting to heal.

The relationship Henry and I had grew stronger and seemed to generalize to other school staff.

Summary

When Henry was referred for a comprehensive school-based assessment, I gathered information about his school history and hypothesized that, in addition to likely having learning disabilities (formally assessed by the diagnostician and speech and language pathologist), he had suffered from the actions of the school, as depicted in the case. I felt that Henry would be hesitant to participate in a traditional school-based assessment. I decided to integrate TA-C methods and techniques with the hope of gaining his trust, allowing him to open up to me. I also thought the TA-C methods would likely enhance my work with his mother who had been very upset with the school. I also hoped to open the 2nd grade teacher's eyes to view Henry differently and understand what was underneath some of his behavior. I used a collaborative stance with all involved, had multiple sessions with all involved (although less with the mother than I would have liked), provided feedback along the way, and was attuned to cultural features and their variations. I obtained Assessment Questions from Henry's teacher, mother and Henry, while keeping in mind the school's need to determine if a disability resulting in educational need was present.

In the process of the assessment, Henry readily brought his "problem" into the room (shutting down when I asked him to expand on his responses), and only when finding that his mother wanted him to fully participate in the assessment did he let me in. He was responsive to extended inquiries, where he revealed concerns about things at home, and appeared forthcoming on self-report measures. The stark differences across responses given to behavioral rating scales by Henry, his teacher and his mother were central to the case conceptualization and likely impacted by cultural values. The unfolding findings that Henry was highly anxious, was traumatized by his year in first grade and the subsequent retention, and was very unresolved about the separation of his parents significantly changed the perspectives of his teacher and his mother and resulted in changes in the classroom and at home. The story for Henry provided him with a sense that he was heard and understood by the assessor and that others who read it would understand him. And the follow-up check-in demonstrated that positive change had occurred.

Looking back, I see that my assessment of Henry truly integrated TA-C values and methods into a school-based assessment. Without this integration, the diagnostician would still have recommended that Henry qualified for special education services under Specific Learning Disability. The results of my assessment, although indicative of emotional issues, would not have reached the threshold for a secondary disability of Emotional Disturbance, although the findings might have mep-----t the criteria for receiving counseling services due to the emotional concerns.

But what is interesting to me is that without the TA-C methods used, Henry likely would have stayed shut down and not revealed his concerns about the retention and his parents' separation through extended inquires. And without the strong alliance developed between Henry and myself, it is also likely that he would not have endorsed the symptoms of anxiety and depression on the various self-report measures. Thus, in my opinion, Henry would not have been understood through a traditional assessment.

Thus, in closing, I encourage school-based assessors to obtain competencies in TA-C and integrate them in school-based assessments either as a matter of course, or in select cases where they are likely to add significant value. Only with experience will assessors be able to make that distinction, and it will vary by many issues such as openness of the district to therapeutic methods, model of school psychological services in the district, and an array of pragmatic issues. However, in my experience, striving for integration will result in enhanced understanding of children and their systems (school and home) that informs intervention and grows positive change. I had a very good experience in the case I presented, I was curious to understand Henry, the teacher was very available, and the process and outcomes were very favorable. I felt encouraged. I experienced that assessing collaboratively and therapeutically provided the parent and teacher with a new understanding of Henry that resulted in enhanced empathy, motivation, commitment, and positive outcomes. I also saw a repair in the family-school relationship that hopefully will be maintained and nurtured across time.

References

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

Tharinger, D. J., Finn, S. E, Wilkinson, A. D., & Schaber. P. M. (2007). Therapeutic Assessment with a child as a family intervention: A clinical and research case study. *Psychology in the Schools, 44*, 293-309.

Tharinger, D. J., Krumholz, L. Austin, C. & Matson, M. (2011). The development and model of Therapeutic Assessment with children: Application to school-based assessment. In Bray, M. A. & Kehle, T. J. (Eds), *Oxford Press handbook of school psychology,* 224-245. New York, NY: Oxford University Press.

Author

Deborah Tharinger, Ph.D., is a licensed psychologist and a licensed school psychologist. She is a Professor Emeritus in the Department of Educational Psychology at the University of Texas at Austin, where she was an active faculty member for 35 years. She is a faculty member of the Therapeutic Assessment Institute and a member of its Board of Directors. Dr. Tharinger has published over 50 articles and chapters, with the most recent ones focused on Therapeutic Assessment with children and adolescents. Her co-authors have included Dr. Stephen Finn and many of her graduate students. Dr. Tharinger currently resides in Austin, Texas and will start practicing at the Center for Therapeutic Assessment in late summer.

The Two Assessments of Mr. O.: Implications for Epistemic Trust

Jan H. Kamphuis, Ph.D.
University of Amsterdam

Not at all prone to being presumptuous, I named this paper "the two assessments of Mr. O." inspired by the classic paper by Kohut (1979) on the two analyses of Mr. Z. My objective is to show how the principles and procedures of Therapeutic Assessment (TA; Finn, 2007) are optimally geared for restoration of epistemic trust in patients who need that the most: patients with Personality Disorder. And how regular, information gathering assessment may miss the boat, despite best intentions. I intend to illustrate this by borrowing heavily, with permission, from an evergreen case described by my friend and mentor Stephen Finn, called Mr. O. Some may "know" Mr. O. from the set of instructional DVDs (Finn, 2009), in which this case serves to illustrate a (beautiful) Assessment Intervention Session. It will also draw on a paper by Kamphuis & Finn (2018), that was recently published in the *Journal of Personality Assessment.*

Mr. O. decided to visit his general physician because of problems in his job as an accountant. His boss kept pushing him to work faster. Mr. O was outraged about these demand, and felt they were entirely unfair. Yes, he did work a bit slower than others, but then again, he never made mistakes, and had previously more than once saved the company considerable sums of money by getting things "exactly right." Still, this in-his-mind undue emphasis on efficiency was causing him stress, and while he was not "the type to ask for help," his sleepless nights were catching up with him, and he was concerned he might not perform as well as he should at his job, especially because of his difficulty concentrating. After listening carefully to his report, the general physician referred Mr. O. to a psychologist, with the following three questions: *What is the nature of the symptoms and problems of Mr. O.? Does his personality have something to do with it? What can we do about it?*

The psychologist, whom we will call Dr. RA (short for Regular Assessment), took a competent history, and in so doing tried to compile a time line of Mr. O.'s complaints and problems. He asked when Mr. O. had started experiencing problems, what he had tried to counter them, when things were better or worse, etc. From this, the psychologist hypothesized that Mr. O. was holding extreme standards, and perhaps had a rather obsessional personality style. Mr. O. complied with the interview, answering to the best of his ability, assuming as he did, that this Dr. probably knew what he was doing. He did feel a bit uneasy with the apparent implication that HE would have to change.

After the first session, Dr. RA selected some psychological instruments to test his hypotheses. Specifically, he selected the *Brief Symptom Index (BSI;* Derogatis & Melisaratos, 1983) to assess anxiety and depression, the Cluster C personality disorder diagnosis section of a semi-structured diagnostic interview for the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5) disorders (First, 2014) to assess for involvement of personality pathology, a self-report inventory on perfectionism, and the *Schema Questionnaire* (Young, 1998) to tap possible dysfunctional thought processes. Mr. O, meanwhile, was growing increasingly uneasy with how this investigation was taking shape. Why was he asked in so many different ways about excessively high standards? It seemed almost like his boss was interviewing him.

Now consider, in a parallel universe, the doctor referring Mr. O. to Dr. TA (referring to Therapeutic Assessment, as might be expected). Much to Mr. O.'s surprise, Dr. TA asked him right away what he might like to learn from the assessment, and told him that the questions they were going to formulate together would be the focus and frame of Dr. TA's report. What would he like to understand better? What was he curious about?

After some initial trepidation, Mr. O came up with two questions: *Why cannot I work more quickly even though I know that this is what my boss wants?* and *What will be necessary to work more quickly?*

Note how these questions capture "how the rubber of Mr. O.'s personality hits the road," i.e., these questions describe the real-life functional impairment Mr. O wanted help with.

He did not come to change his problematic personality, he was there to save his job. Note that from the outset outside transfer, so-called ultimate outcomes if you will, are the focus of the assessment. Such questions will continue to serve as ostensive cues to both client and assessor: i.e. as signals indicating that one is willing and open to receive meaningful information on these topics. Mr. O. actively seeks outside input to these questions, and it is around these issues he will be maximally responsive to possible new ways of being. Finally, note that this set of questions captures something about Mr. O. He is not a deeply self-curious individual, be he acknowledges he needs help with this specific problem—a bit like the customer who goes to the hardware store to get nails, and nails only.

As a side note, I used to wonder about this aspect of TA. Questions like *Why cannot I work more quickly even though I know that this is what my boss wants?* and *What will be necessary to work more quickly? Or other questions like "am I lazy?" etc. etc.*—are THESE the questions you want to devote such a mega-dose of assessment to? What about severe DSM diagnoses then? I now understand that questions framed in this ego-syntonic way, provide the rays of light people with tightly held self-concepts offer us (or again, the ostensive cues they offer to us), and invite us to make small inroads there, and that these inroads may build into cumulative changes.

Another function that the individualized questions serve, in terms of fostering *epistemic trust*, is that they afford the client control of the frame of the assessment, and in so doing, help decrease his anxiety while increasing the requisite curiosity about the self. Indeed, Mr. O grew calmer and more hopeful as his first session with Dr. TA progressed. Digressing a little, I believe this aspect of providing control to help the client try more risky things reminded me of a brilliant experiment by Sanderson, Rapee, & Barlow (1989). In that study, patients with panic disorder were provided with a dial that they could turn to decrease the amount of CO2 they were inhaling, provided that a light, directly in front of them, was on. However, unbeknownst to them, for ten patients the light was constantly on, and for another ten patients it was never illuminated. In fact, all received the full flow of CO2 mixture, and the dial was ineffective. However, those who believed they could control the CO2 administration, reported fewer panic-attack symptoms, rated the symptoms as less intense, reported lower subjective anxiety, fewer catastrophic cognitions, and were less likely to have a panic attack.

Back to Dr. TA: Dr. TA explained to Mr. O. that he would first like to administer the *MMPI-2* (Graham & Graham, 1990) to try and answer Mr. O.'s question *Why cannot I work more quickly even though I know that this is what my boss wants?* He explained that in this model of assessment, tests provide the client with another way to communicate with the assessor to let him understand their personal experiences. At a later session, they followed up with administration of the *Rorschach Inkblot Method* (Rorschach, 1921/1942).

Assessment findings indeed helped Dr. TA to get into the client's shoes. Elevated scores on MMPI-2 Scale 7 (Pt) the content scales OBS and ANX, alongside Rorschach elevations on OBS, and Dd99 suggested to Dr. TA that Mr. O. held on to some significant anxiety as well as had a detail-oriented, "trying to get it exactly right" personality style.

When contemplating the upcoming Summary and Discussion session, Dr. TA realized that Mr. O. did not see his style as inefficient or even problematic. Straightforward sharing of findings would likely not help Mr. O. make the changes he was looking for. Dr. TA therefore contemplated how he might invite the critical personal dynamic into the session so that together they could observe it, explore it, and discuss it. After considering several options, Dr. TA selected the Bender Gestalt Visual Motor Test (*Brannigan & Decker, 2003*), a neuropsychology test of executive functioning involving copying individual designs onto a sheet of paper.

After explaining to Mr. O. that they would try one more test to help explore his question about *what will be necessary to work more quickly,* Dr. TA introduced the Bender. When Mr. O. asked if he could use a ruler to copy the first design, Dr. TA was internally celebrating that he might have succeeded in bringing the critical behavior into the consulting room. When Mr. O then took 1:43 instead of a few seconds to complete the first design, Dr. TA grew more confident that they would have a golden opportunity to collaboratively explore, in a bottom-up fashion, the nature of Mr. O's problematic style. He enlisted Mr. O. in observing and naming his approach to the task. Mr. O volunteered he completed the copying "carefully and with precision", and confirmed that this was exactly how he approached his tasks at his job as well. Mr. O was surprised to learn how much slower he was than the average person, and shocked to see what responses, according to the manual, would yield a perfect score.

A discussion ensued between Mr. O. and Dr. TA about the pros and cons of speed vs accuracy. Exploring such issues affords some opportunity to do appropriate de-shaming. Dr. TA, for example, offered some measured self-disclosure on how difficult it can be to conform to a boss's values when they went against one's own. After this discussion, Mr. O. said: *I guess, then, do you think we should talk about how we can help me work more quickly?*

As we hypothesize, the safe, validating environment, perhaps along with the de-shaming intervention, allowed Mr. O. to take a risk, and to open himself up for further social communication and learning. Together, he and Dr. TA developed the idea that changing certain self-talk that Mr. O engaged in might work. So, instead of "don't make any mistakes now, you are being evaluated," Mr. O. wrote down in his own words "perfection is not required on this task", and "everybody makes mistakes." Mr. O was not sure if he believed these thoughts, but he was willing to give it a try. This intervention indeed led to speedier drawings, but still slower than average. Dr. TA enquired about what Mr. O. might be feeling in his body. Had he noticed he held the pencil quite tightly, and might that be a sign of some anxiety? Mr. O was not sure, but again he was willing to test its impact by undergoing some progressive muscle relaxation and then copying designs again. After practicing the relaxation, Mr. O's completion time approached the normative range.

What this Assessment Intervention Session (AIS) beautifully illustrates is that the test plane can serve well to try on new personally relevant information (see also Kamphuis & Finn, 2018). Tests, especially in the context of the AIS, can serve as "potential space," Winnicott's (1971) term for a sense of an inviting and safe interpersonal field in which one can be spontaneously playful while at the same time connected to others. In other words, test stimuli can serve as transitional objects; to more safely play with, to infuse with personal meaning, to "try on," before actually internalizing the emerging insights. In AIS, we deliberately use the consulting room and test environment as a safe haven, and encourage clients to embark on a self-relevant, collaborative mentalizing experiment.

Consistently throughout the AIS, Dr. TA enquired what it was like for Mr. O. to approach the task in this new manner. How did he feel about it, did he notice anything going on inside him? This technique serves many different purposes: a) it underscores the collaborative, emotionally attuned enterprise TA strives to be; b) it fosters self-reflection and curiosity; and c) it communicates to the client that he is a mentalizing agent, and that exploring personal dynamics with another, preferred mentalizing agent can be a profitable experience. This of course, ultimately serves the restoration of epistemic trust.

The present AIS also shows how "hot" bottom-up processing—looking at the behavior of interest, exploring, naming and manipulating it —is more likely to produce shifts in patients with rigidly held self-beliefs than "cold," top-down interpretation (Kamphuis & Finn, 2018). A final aspect of this AIS that warrants discussion from an epistemic trust perspective, is the scaffolding Dr. TA offered at the end of the session. Even though Mr. O. was growing optimistic as he was observing his response times drop, he still seemed somewhat preoccupied. So asked, he indicated that, despite himself, it kept going through his mind to "not make any mistakes, not to do anything silly." Dr. TA then asked where he had learned that mistakes were so costly, and should be avoided. Mr O. offered a poignant story of how his father had taught him how to type, hitting him over the head each time when he made a mistake—apparently a strategy recommended in a popular book at the time, called *"cheaper by the dozen."*
Dr. TA gently asked how he felt about this style of teaching.
Mr O. replied he wasn't sure, but thought it was a stressful way to have learned.
Dr. TA agreed, and suggested that his father's teaching was still with him at his job.
Mr O. agreed, and they both sat quietly with this new learning.
The point here is that each and every gentle half step is made, with the assessor going as slowly as possible, just providing the minimal ingredients to have Mr. O. bake his own cake, so to speak. Compare this to the therapist who offers "your father's strict style was abusive, caused you to fear authority, lose spontaneity, and never make mistakes ever again."

Back to Dr. RA, and the feedback ensuing from the assessment. Confident that he got it right, he reported back to the general physician. The report stated that indeed Mr. O had been suffering from anxiety symptoms,

and was at risk for developing a unipolar depression. In terms of personality, he noted that the client had rigid, and overly stringent standards that cause him stress. Dr. RA recommended CBT to restructure the underlying dysfunctional thoughts. The family doctor, when discussing this report with Mr. O. quickly found out that Mr. O. did not agree with this assessment. It was, as he stated, the other people who are sloppy, and he denied the need for individual psychotherapy.

Dr. TA, on the other hand, focused in the Summary and Discussion session on what it might be like to try on the new learnings at Mr. O's job. After all, the new learnings had already occurred and been largely processed in the collaborative AIS. Instead, they discussed several thought experiments about the types of obstacles Mr. O might encounter at his job (i.e. ultimate outcomes), and scheduled a follow-up session to discuss these upcoming experiences.

Concluding Thoughts

Why this presumptuous reference in my title to Kohut's (1979) "The two analyses of Mr Z" Kohut's seminal paper argued that therapeutic abstinence and restraint only served to threaten an already vulnerable Self, and that empathy was a necessary condition for insight and change. In comparing Dr. RA and Dr. TA, as best I can, I am developing a closely related point. Admittedly, Dr. RA was crafted a bit as a strawman, but one would be surprised—or not?—to hear how some assessments are still being conducted.

In any event, the humanistic values of TA, the emotional attunement and holding environment characteristic of TA, operationalized by some of the specific techniques I just described, systematically foster the restoration of epistemic trust. More specifically, these "two cases of Mr. O." illustrate the advantages associated with co-constructing TA questions in yielding ecologically valid, bottom-up supported insights, and subsequent recommendations that are likely to be accepted and followed-up on. In my opinion, the main thrust of TA does not reside in necessarily "deeper," or more profound interpretations. The key difference is that in TA, as opposed to in RA, Mr. O. was stimulated to open up again to examining his own ways; to reconnect to social learning, and to risk a more flexible approach to his life. In sum, we hold that TA, in its principles and procedures, systematically promotes this opening up, this restoration of social communication and learning, or epistemic trust if you will, and that this change is above all crucial in patients with Personality Disorder.

Author Note

This article is an adapted version of a presentation given at the 2018 meeting of the Society for Personality Assessment.

References

Brannigan, G. G., & Decker, S. L. (2003). *Bender Visual-Motor Gestalt Test, Second Edition.* Itasca, IL: Riverside Publishing.

Derogatis, L. R., & Melisaratos, N. (1983). The brief symptom inventory: an introductory report. *Psychological medicine, 13(3),* 595-605.

Finn, S.E. (2009). Assessment intervention sessions in therapeutic Assessment. *Pioneers of Collaborative/ Therapeutic Assessment.* [DVD disc 1]. Falls Church, VA: Society for Personality Assessment

First, M. B. (2014). Structured clinical interview for the DSM (SCID). *The encyclopedia of clinical psychology,* 1-6.

Graham, J. R., & Graham, J. R. (1990). MMPI-2: *Assessing personality and psychopathology*. New York: Oxford University Press.

Kamphuis, J. H, Finn, S. E. (2018). Therapeutic Assessment in Personality Disorders: Toward the restoration of epistemic trust. Journal of Personality Assessment, 1-13. DOI 10.1080/00223891.2018.1476360

Kohut, H. (1979). The two analyses of Mr Z. *The International Journal of Psychoanalysis, 60(*1), 3-27.

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

Sanderson, W. C., Rapee, R. M., & Barlow, D. H. (1989). The influence of an illusion of control on panic attacks induced via inhalation of 5.5% carbon dioxide-enriched air. *Archives of General psychiatry,* 46(2), 157-162

Young, J. E. (1998). *The Young Schema Questionnaire: Short form*. Available in electronic form at http://.home.sprynet.com/sprynet/schema/ysqsl.htm.

Winnicott, D. W. (1971). *Playing and reality.* London: Tavistock.

Author

Jan H. Kamphuis, Ph.D., is a licensed clinical psychologist, and a fellow of the Society for Personality Assessment. He is a Full Professor at the University of Amsterdam (UvA), and formerly served as Chair of the psychology department. He has special interest in (a) personality disorders, and (b) (furthering) the treatment utility of assessment. He also has a small research/ clinical appointment at the Viersprong, a specialized clinic for the assessment and treatment of personality disorders. Dr. Kamphuis has published over 80 international articles, chapters, and books, most of which pertain to innovations in personality assessment and personality disorders. Specific topics include Therapeutic Assessment, MMPI-2-RF, risk assessment, forensic assessment, and treatment selection in personality disorders. He is certified in Therapeutic Assessment with adults.

Photo Album

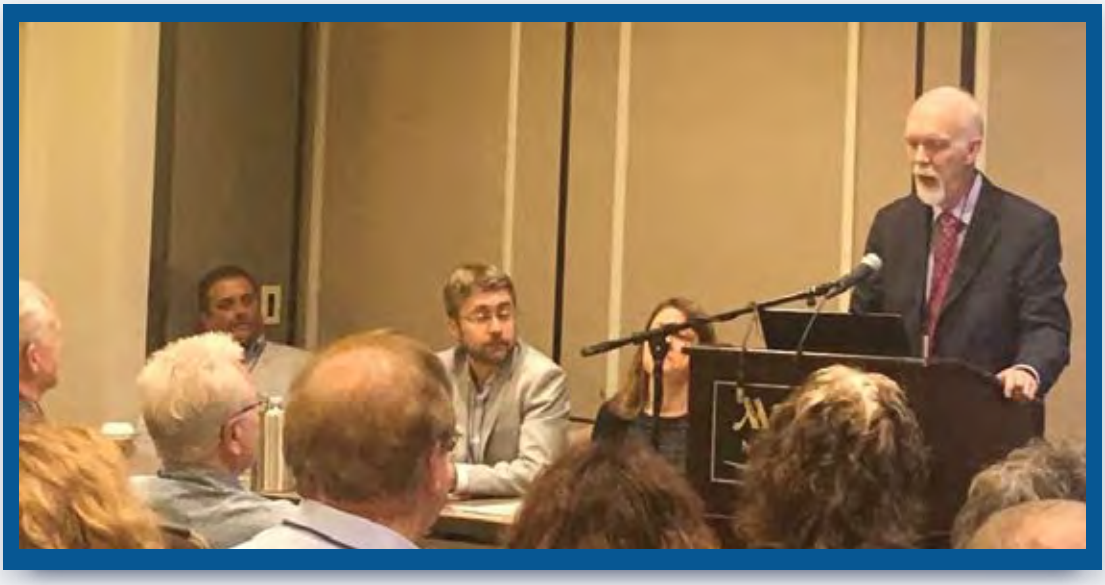
Stephen Finn presenting at the SPA annual meeting in New Orleans as part of a symposium:
"Dealing with the Unknown: When Therapeutic Assessment Uncovers the Unexpected, "
Lionel Chudzik (Chair).

Following the Anchorage, AK workshop on "Working with Shame in Psychological Assessment and in Psychotherapy." From left to right: Laura Jones, Melinda Glass, Stephen Finn, Julie Cradock O'Leary.

Lionel Chudzik presenting at the SPA annual meeting, March 2019, New Orleans

Symposium presented at SPA 2019: "Dealing with the Unknown: When Therapeutic Assessment Uncovers the Unexpected. " From left to right: Stephen Finn, Dale Rudin, Filippo Aschieri, Lionel Chudzik (Chair).

Filippo Aschieri presenting at the SPA annual meeting 2019



Panel at SPA 2019: "Uncovering Shame in Psychological Assessment," (Julie Cradock O'Leary, Chair). From left to right: Raja David, Lionel Chudzik, Stephen Finn

Dale Rudin presenting at the SPA annual meeting 2019.

Recent Publications in Therapeutic/ Collaborative Assessment

Aschieri, F., Durosini, I., & Fantini, F. (2019). Observing couples discussing about "What might this be?". *Rorschachiana, 40*(1), 22–42.

Chudzik, L., Frackowiak, M., & Finn, S. E. (2019). Évaluation Thérapeutique et dépression de l'enfant: faire du bilan psychologique une intervention familiale brève [Therapeutic Assessment and child depression: Using psychological assessment as a brief family intervention]. *Bulletin de Psychologie, 559*(1), 19-27.

Martin, H. (2018). Collaborative/Therapeutic Assessment and diversity: The complexity of being human. In S. R. Smith & Krishnamurthy, R. *Diversity sensitive personality assessment* (pp. 278-293). New York: Rout-ledge.

Owen, J. J. (2018). Psychotherapy integration and borderline personality pathology: An examination of treatment outcomes. *Journal of Psychotherapy Integration.* DOI: 10.1037/int0000124

Sweeney, A., Clement, S., Gribble, K., Jackson, E., Carr, S., Catty, J., & Gillard, S. (2019). A systematic review of qualitative studies of adults' experiences of being assessed for psychological therapies. *Health Expectations.* DOI: 10.1111/hex.12844.

Villemor-Amaral, A. E. D., & Resende, A. C. (2018). *New Framework for Psychological Assessment. Psicologia: Ciência e Profissão, 38*(SPE), 122-132.

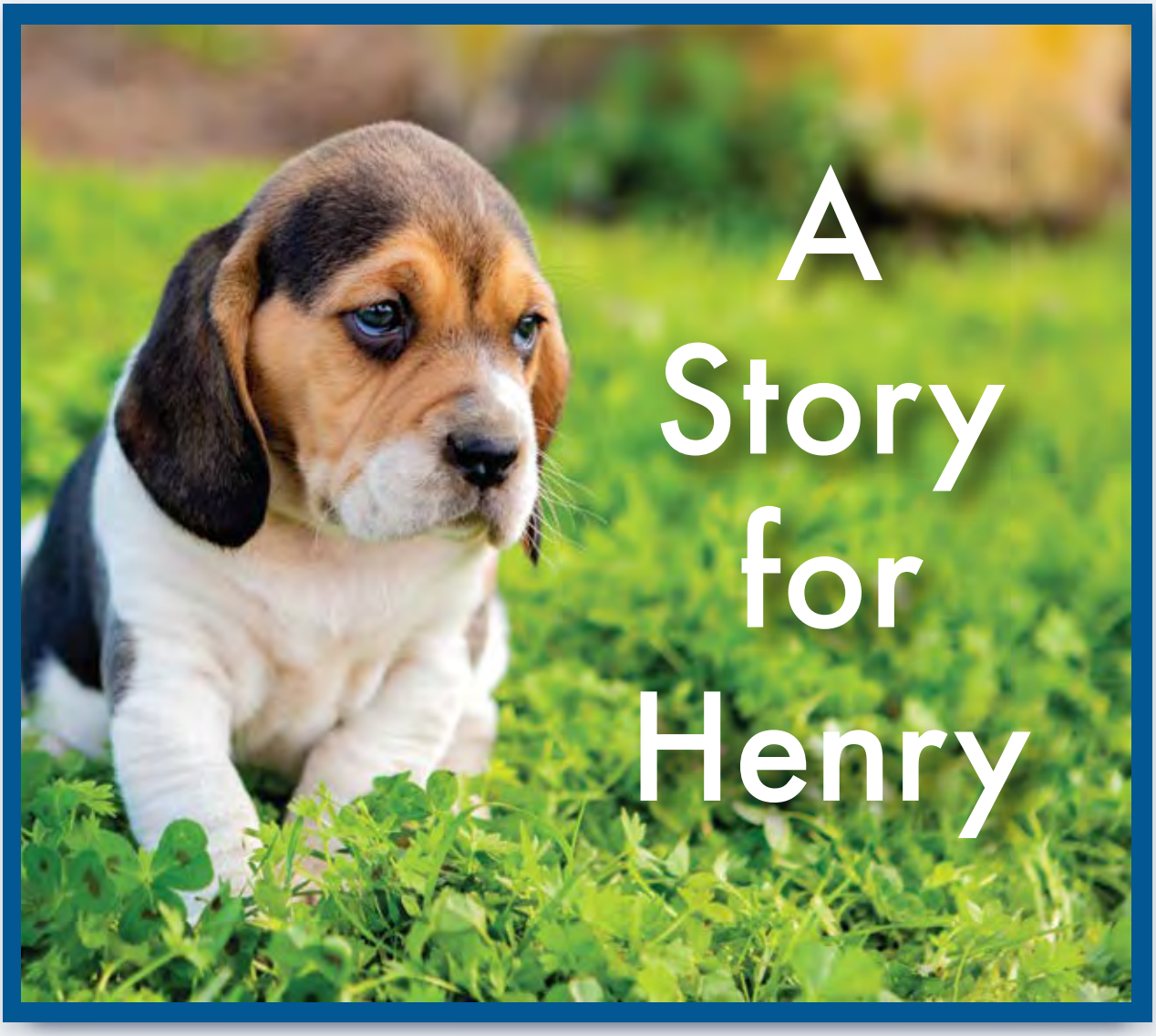
Upcoming Trainings in Therapeutic Assessment

August 28–30, 2019: Stockholm, Sweden
Title: "Specialization Course in Therapeutic Assessment with Adults and Families with Children"
Presenters: Filippo Aschieri, Jan Henk Kamphuis, Hilde De Saeger, Francesca Fantini
Sponsors: Therapeutic Assessment Institute
Language: English
Schedule: 9:00 AM — 5:00 PM each day
Information: wibergpsykologi@gmail.com

September 20–21, 2019: Austin, TX, USA
Title: "Working with Shame in Psychotherapy and Psychological Assessment "
Presenters: Stephen E. Finn
Sponsors: Therapeutic Assessment Institute
Language: English with Italian translation
Schedule: 9:00 AM — 5:30 PM both days
Information: https://www.therapeuticassessment.com/docs/Flyer_copy.pdf

October 4–5, 2019: Boulder, CO, USA
Title: "Introduction to Therapeutic Assessment: Using Psychological Testing as Brief Psychotherapy"
Presenter: Hale Martin
Sponsors: Metis Center for Psychological Services and the Therapeutic Assessment Institute
Languages: English
Schedule: 9:00 AM – 5:00 PM both days
Information: https://230607328.planningpod.com/

November 3–4, 2019: Tokyo, Japan
Title: "Restoring Epistemic Trust through Therapeutic Assessment: Building a Relationship "Superhighway" with Difficult-to-Treat Clients "
Presenters: Stephen E. Finn, Noriko Nakamura, and members of the Asian-Pacific Center for Therapeutic Assessment
Sponsors: Asian-Pacific Center for Therapeutic Assessment and the Therapeutic Assessment Institute
Languages: English and Japanese
Schedule: Nov 3: 10 AM – 6 PM; Nov. 4: 9:30 AM – 4:30 PM
Information: asiancta@gmail.com



I want you to meet Patty the puppy. He is very smart and very strong and very helpful.

And did I mention that he's very cute?

And Patty likes his puppy food—mostly he likes the beans. And for treats he gets puppy bones that look like pretzels. He loves them.

And he likes to watch TV—did you know puppies did that?

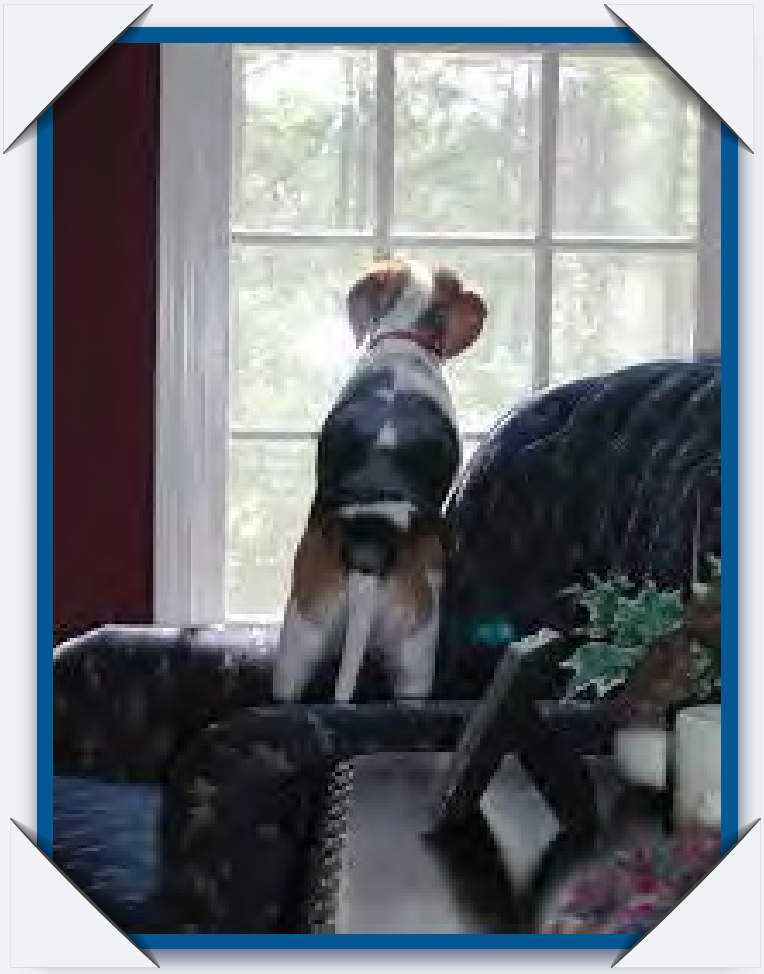
Patty lives in beautiful country with lots of space to run and play. He likes to play.

Patty lives with his mother, aunt, grandparents, cousins and a new baby.

Sometimes he feels like an important puppy in his family and sometimes he doesn't. I wonder why.

Patty used to live with his mom and dad----now his mom and dad live in different houses.

Most people don't know that this makes him quite sad.



Puppies don't always tell grown up dogs that they are sad. And don't show sadness sometimes. But inside it is there.

Besides being sad sometimes, Patty also has tummy aches and headaches. Maybe he ate too many pretzel treats……. or maybe he is worried.

He doesn't bark much about being worried.

I don't know if Patty knows that being worried and sad takes a lot of energy---but I think this happens to Patty sometimes and he feels really tired.

I think he's trying to be brave and doesn't want to worry his mom by barking about his feelings.

But as we will see, we hope that Patty learns that talking about his sadness and worries with an adult dog he trusts can really help.

When you share your feelings with someone you can trust, most puppies don't continue to feel so alone or sad or mad.

Did you know that Patty is very good at putting things together and is curious about how things work? Here he is fixing his house.

Patty goes to puppy school. He liked it at first when he could do things with his paws like putting puzzles together and building stuff.

But then his teachers wanted him to read more and more and write stories and it just seemed too hard and too much.

He gets frustrated and just doesn't want to do it. He shuts down.

Patty even had to start first grade a second time---and this made him and his family very upset. But they fixed that and he went on to second grade---but he still remembers how mad he was.

To try to help Patty with his schoolwork, his teacher asked that he do some tests and activities with some wise dogs to see what ideas they had to help Patty in school.

Here they are. Miss Meg, Miss Rose, Miss Beth, and Miss Deborah. And his teacher and the teacher's helper are there too to help.

They learned a lot about Patty. They learned that he is smart and thinks like an engineer.

And they learned that reading and writing are harder for him—like lots of engineers.

They also learned that he can be sad and worried and that maybe something at home is bothering him. But instead of talking about his sad and worried feelings he gets mad at home.

And they learned when the work is hard or he is asked about his feelings, he often shuts down.

They all understand that shutting down has been a smart way for Patty to protect himself when he can't or doesn't want to do something.

They also want to help Patty learn not to shut down so he can learn more and feel better.

So everyone agreed that Patty should continue to be in his classroom with his teacher. And his teacher understands him better now.

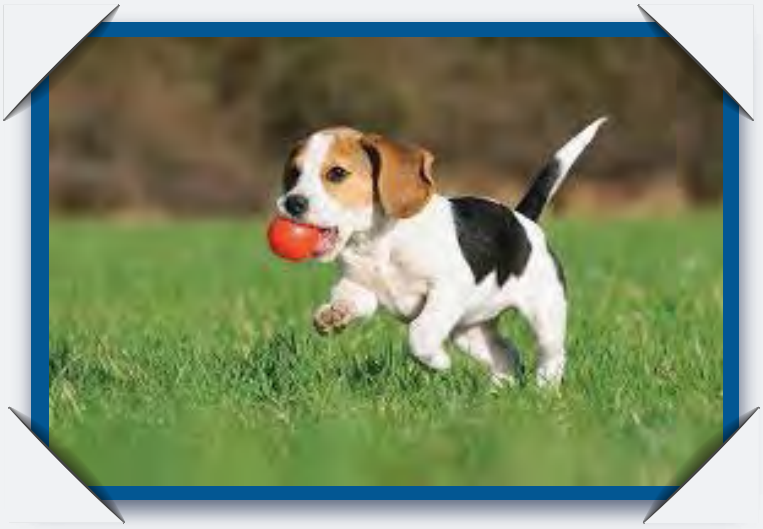
And he should also go to Miss Kim's classroom to get help with his reading and writing.

And he should go to Miss Rose's special room to practice his writing.

And he should go to Miss Meg's special room to practice the way he barks with other puppies and dogs.

And he should go to Miss Deborah's special class to learn to talk about his feelings and learn not to shut down when he gets frustrated.

And Patty has started with all these new teachers and is beginning to feel happier.



We will check back in with Patty in a few weeks to see how things are going.

THE END (for now).