

## THERAPEUTIC ASSESSMENT WITH A CHILD AS A FAMILY INTERVENTION: A CLINICAL AND RESEARCH CASE STUDY

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Psychological assessment has the potential to impact positively both those individuals being assessed and the systems in which they are embedded (e.g., families and schools). Therapeutic Assessment (TA) is a relatively new paradigm that uses collaborative psychological assessment to address consumers' questions of interest and promote positive change. TA with children aims to impact the parents, the child, and their relationship and to date has been used primarily in clinics and independent practices, with some auxiliary involvement of schools. This article draws from the first research project investigating the efficacy of TA with children and families. Clients were referred from the waiting list of a community mental health center, and TA was provided in a university clinic setting. First, excerpts from a TA "report" with a child are presented. Next, the theoretical underpinnings and research on TA are discussed, as well as the protocol for using TA with children and families. Finally, a detailed clinical case study is presented, with outcome measures indicating high acceptability and satisfaction, decreased child symptomatology, improved hope and self-esteem, and enhanced parental efficacy. Yet to be explored is the effectiveness of comprehensive TA in the schools, where the target of intervention could also include teachers, organizational aspects of schools, and parent-school collaboration. Until that time, suggestions are provided for implementing techniques of TA—as currently conceptualized—within schools. © 2007 Wiley Periodicals, Inc.

In this article, we introduce a clinical method, Therapeutic Assessment (TA), which explicitly uses psychological assessment with a child as the cornerstone of a family intervention. We start by sharing the end point of TA with one family through excerpts from a letter written to Mr. and Mrs. Sanchez at the end of our assessment of their 11-year-old granddaughter, an assessment in which they were actively engaged. As will be discussed fully in a later section, a goal of TA is to promote new understanding and empathy in parents about their child that allows them to take steps toward systemic and individual change. Another goal is to provide the child with an assessment experience that directly impacts her in positive ways and enhances her capacity to be responsive to the new parental change. At this point, we encourage you to set aside your experience with formal psychological reports and to read the following excerpts as if you were parents of a child who had problems. How does it affect you? What would you experience receiving this letter?

### LETTER TO MARIA AND EDWARD SANCHEZ

Dear Maria and Edward,

We're writing this letter to give you a written copy of the results from our psychological assessment of your daughter, Christina. This letter summarizes the answers for the questions you posed for the assessment and provides more details about how you can relate to Christina. Before addressing your questions in writing, we want to say again how much we appreciated working with your family. Despite

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everything going on in your lives over the course of the assessment, you managed to make it to the university every Saturday. . . . Maria, you also worked hard watching videos and talking on the phone when your health prevented you from coming. . . . It was clear that you all wanted to be happy as a family and were dedicated to doing whatever would be necessary.

Now, let us turn to your questions.

What exactly is her diagnosis? ADHD? Bipolar? Something else?

As we mentioned in feedback, it does seem that Christina has attention-deficit/hyperactivity disorder (ADHD)—inattentive type. Remember when we were talking about ADHD, we talked about two different types. Some kids who have ADHD just have attention problems; other kids have attention problems and they are hyperactive and impulsive. Kids who are hyperactive and impulsive often cannot sit in their chairs and cannot stop moving. We think that the results from her tests, and the comparison of her behavior with and without medication, indicate that Christina does have ADHD-inattentive type. Her medication does seem to help her focus and pay attention. Next we looked at whether Christina had bipolar disorder or something else. In our feedback we told you that Christina does not seem to have bipolar disorder, but instead may suffer from a mild to moderate form of depression. We think that a lot of your questions can be answered by looking at Christina's behavior as symptoms of depression.

Is she sick, or is she mean?

One thing we know about kids with depression is that their sadness comes out in different ways. Also, depression in children is different from what we see in adults—sometimes it's more difficult to recognize because in addition to feeling sad they may also be irritable and angry, have aggressive outbursts, or be withdrawn. When Christina was here, she seemed more sad and withdrawn. The behavior that you described at home seemed to be more irritable and angry. Even though these two behaviors seem so different, they may both be due to depression.

Remember when we discussed the results from the Rorschach, the inkblot test? Christina's responses to that test are similar to the responses that depressed children give. She scored high on an index that looks at children's problems managing difficult feelings and coping with stress, which means she struggles in that area. Christina also had several other scores indicating that she feels alone, sad, and different. Her self-esteem score was low for her age, indicating she feels badly about herself and might not view herself positively. Another score showed that compared to children her age, she doesn't know how to rely on or turn to other people for emotional comforting or support. (That's why we think it's so hard for her to come to you and talk about her feelings. It's not that she doesn't want to; rather, she doesn't know how.) Remember the story she told right after the inkblots about the man on fire? We think this story is a good example of how Christina feels. She feels scared and helpless, like no one will help her.

Why does she have an attitude? Why is she talking back? Why does she not want to take a bath? And why does Christina have sudden outbursts?

All of these behaviors can be explained by thinking of Christina as depressed. Depression can make children seem irritable, and they may be more likely to talk back and not follow directions. We also talked about why you two are the only ones who see Christina's irritability. We think both of you have done a really good job teaching Christina values and appropriate social behavior. She knows what is expected of her when she is in public and because of this, she seems to work really hard to hold everything together when she is not at home. Then when she comes home, she is like that teapot we talked about. She has been simmering all day and then as soon as she feels comfortable and safe, she boils over. One thing we want to assure you is that her explosions are not because she is an angry or a mean person (and there are scores in psychological testing that would show that—she didn't have them in her protocol) but because she is irritable and doesn't feel good about herself. Remember, she also doesn't know how to turn to people (you) and ask for help managing her feelings.

Why doesn't she share her feelings? Why won't she talk to us about what's wrong?

In Christina's stories and inkblot answers we started to notice something about her. She seems to have a lot of difficulty dealing with emotions. Instead of handling emotions like an 11-year-old, she handles them like a 4-year-old or maybe even a younger child. Remember how we were talking about how she

is like a light switch? When she is off, she looks more depressed (sad and withdrawn), and when she is on, she looks angry and throws tantrums. In all of Christina's stories, we heard how she much she wants to please both of you and how she feels out of control. Just like you two can't understand why she gets so angry, she seems to feel the same way. Remember when we asked if she could have three wishes, what would they be? One of her wishes was that she wouldn't get so mad when you both ask her to do something. It is as if she can't understand why she gets mad either.

How can we help? How should we react when Christina back talks? Is there something we are doing to make her act this way?

In our discussion, we gave you several suggestions about how you can help Christina. Here is a recap of the things we discussed. First, we talked about playing with her. It was so wonderful for us to watch you having fun as a family in the family session. It is clear that there is a lot of love among you all, and Christina really seemed to glow. We also learned last week that your instincts about how to play with her are right on. It seems like you already tend to do things that play therapists do, like letting Christina make the rules and decide what and how to play.

Second, any other positive times that you all have together as a family will help Christina. This might be going somewhere fun together, doing chores together, or just hanging out at the house. We learned that these times are very important to Christina from the memories that she told us about.

Third, Christina needs lots of praise. We learned that Christina really wants to please you and she loves it when you praise her. We know that you have no problem letting her know when she's done something well, and that's great. The more she can hear that, the better. We also know that sometimes you tend to follow up your praise with a "but"—like "you did a good job cleaning, but you missed a spot." It's only natural for parents to want to help their kids learn to do things better. What we think would work best is if you didn't give her those "buts" when you're telling her she did a good job. Give her praise when she's done a good job at something, and then talk about the "buts" later.

Fourth, giving Christina choices and letting her do things her way will make it more likely that she'll do what you want her to do. This will help avoid the fights. Of course, there are times when you have to make her do things that she doesn't want to do. She can't always have a choice or do things the way she wants. At those times, because she has trouble with feelings and she's already irritable, she might start to blow up. There are some things you can do at these times to keep things from getting worse. The first thing is to try to stay calm yourself. You can still be very firm with her, telling her what you need her to do and what the consequences will be. . . . Edward, this is something you've learned can help with your customers when they get angry. We think it can help Christina, too.

Fifth, at those times when Christina is angry, she is not thinking clearly and she's out of control. Her switch is on, she doesn't really understand what's happening, and she doesn't have a good way to get in control of herself. She is like the man on fire in the story she told, scared and wanting help. To help her get control, you can help her label her feelings. Psychologists call this "being a mirror" because you're just reflecting her feelings back to her. This will help her to be less scared, and it will also help her to grow up emotionally. Sixth, there are things you can do to help Christina when she is out of control. For example, you can suggest something that she can do to calm down. We know that she doesn't have a good way to deal with her feelings. . . . You might tell her to take deep breaths, or punch a pillow. Teaching her things like these will help her to learn to control her feelings, so that she'll have more of a dimmer switch.

Seventh, another thing that we think might be important for Christina is to do some more activities with other children her own age. Edward, you've mentioned that you have been a little sad that Christina isn't participating in sports anymore. It sounds like Christina used to be involved in peer activities like softball and basketball. . . . Kids with depression sometimes don't feel like doing fun things or things that they used to like to do. But we think it would be really nice for you to really encourage her to get involved in some things with other kids her age.

Did Christina's biological mother's drug abuse during pregnancy have an impact on the way Christina acts now?

First remember that we think that Christina seems to be doing pretty well, considering the drugs she was exposed to. Many times, children who have been exposed to drugs may have problems with their overall cognitive ability, but we didn't see any big red flags for Christina. Overall, her cognitive ability is average to low average. But, as we've talked about, there are some things that Christina struggles with, and it's possible that these things might have something to do with drugs, but it's hard to know.

In closing, we would like to say how much we enjoyed getting to know your whole family. As you now understand, it will take some special parenting skills to help Christina—skills that aren't intuitive and that you haven't had to use for your other children. We think that you're already doing a great job, and that with a little help from [local mental health clinic] you can have the relationship with Christina that you'd like to have. Please don't hesitate to call us if you have any questions about the assessment or this letter.

Sincerely,

Assessment Team and Supervisors

If you have no previous exposure to Therapeutic Assessment (TA) and have been trained in traditional psychological testing and report writing, the preceding letter may startle you or even make you uneasy. (TA does provide a formal report with appended test results if requested; parents typically use it to communicate with other professionals or schools.) Many assessors are concerned by the very idea of writing directly to parents about test results, especially given that such a procedure is not mentioned in well-known assessment textbooks that were used to train generations of clinicians (e.g., Anastasi, 1988; Sattler, 1988; Tallent, 1992). The content in the letter to the Sanchez family also often generates many questions, for example, Is it really advisable to tell parents their child's diagnosis? Is it realistic to expect parents to understand all this detailed information about their child? In addition, many readers may raise concerns about the tone and style of the letter. Why are the assessors so personal? Doesn't the conversational tone make the report less professional? You may have some ideas about how to answer these questions if you were able to read it as we suggested, as a parent of a child who has problems.

Still, you may be left with other questions about the assessment process reflected in this letter: Could it serve as a useful family intervention and positively impact both the parents and the child? And if so, what factors might mediate the changes? We are interested in informing these questions in the Therapeutic Assessment Project (TAP). In the project we are providing Therapeutic Assessments to children and families in a university clinic and studying their efficacy, and possible moderators and mediators of change. The Sanchez family was one of our participating families. All families are referred to us by a local outpatient community mental health center. Typically the referred families are seeking mental health services for their child and, in lieu of the 3-month waiting list; are informed about our study and assessment/intervention service; and, if they are interested and meet the criteria for inclusion, are invited to participate. After the initial contact, a research session is scheduled with a *two-person* Research Team to obtain consent and assent formally and collect the preassessment research data from both the parent and the child. Variables being measured, using a repeated measures design and both quantitative and qualitative methodologies, include baseline functioning (e.g., child symptomatology; child, parent, and family functioning) and possible moderators (e.g., parental symptomatology, resources, severity of child psychopathology).

The next 8 to 10 meetings, detailed in a later section, consist of the TA sessions. In these sessions, the child and family work with a two-member Assessment Team (AT), advanced school psychology doctoral graduate students, supervised by a licensed psychologist. After each TA session, the parents and child work with the Research Team to complete several measures of hypothesized mediators (e.g., alliance, positive and negative affect, weekly stressors/buffers). Upon

completion of the TA, the family meets again with the Research Team to complete follow-up measures of functioning, several measures of consumer satisfaction and acceptability, and a research interview for parents on their process and attributions. We return later to address the questions about the provision, efficacy, and intervention potential of TA with children. But for now we will orient you to the unique conceptual model underlying TA, as well as to its potential as a powerful intervention.

## THERAPEUTIC ASSESSMENT

### *Background*

TA is a semistructured form of collaborative/individualized assessment developed by Finn and his colleagues (Finn, 1996, 1997, 2003; Finn & Kamphuis, 2006; Finn & Tonsager, 1997, 2002). TA is highly related to the work of Fischer (1985/1994), Handler (2007), and Purves (2002), all of whom developed their models of collaborative assessment independently but subsequently influenced and were influenced by TA. TA also bears strong similarities to Dynamic Assessment (Palinscar, Brown, & Campione, 1994), in which individualized interventions are integrated into psychoeducational assessments to determine the causes of and possible ways to address an individual's learning difficulties. Although TA can be used with all types of psychological assessments—cognitive, learning, neuropsychological, and personality—most of what has been published to date concerns personality assessment with adults. The TAs provided in the TAP, 12 to date, have been comprehensive and addressed two or more of the domains mentioned. A unifying feature across cases has been the integration of findings within the history and current life context of the family, organized according to the questions asked by the parents and child at the beginning of the assessment.

### *Principles and Goals*

Like other forms of collaborative assessment, the principles of TA are rooted in intersubjective, phenomenological, and interpersonal theories of human behavior (Finn, 2002). Interpretation and inference involve an integration of nomothetic and idiographic methods. Data are interpreted in the context of the reason for the assessment and the client's relationship with the assessor. The tests and methods used are an opportunity for the client to communicate with the assessor, and responses reflect the quality of the developing relationship. Assessors use clients' test responses and descriptions of their test experiences to "get in their shoes" and empathically comprehend their experiences and perspectives. In addition, the assessor's experience, affect, and countertransference reactions are essential pieces of information and are understood to illuminate potentially important case dynamics and to contain bias in interpretation and communication about the findings (Fowler, 1998; Handler & Meyer, 1998; Smith, 1998). When TA is implemented in schools, the organizational and systemic features will also be grist for the mill.

TA originally differed from other forms of collaborative assessment in its explicit goal of leaving clients positively changed at the end of an assessment. This goal is achieved through an ongoing focused dialogue between clients and assessors, which can lead to the "coauthoring" of a "new story" about the clients, their strengths, their significant relationships, and their problems in living. By providing an experience of empathic attunement and accurate mirroring, assessors help support clients in grasping and assimilating these new conceptualizations and in trying out next steps in their growth process (Finn & Tonsager, 1997, 2002). And although the techniques used in Therapeutic Assessment are drawn from a number of different interventional approaches, one strong underpinning is *collaborative empiricism* as practiced in cognitive-behavioral therapy. In this approach the clinician and client work together to set up different "experiments" to test

mutually generated theories about why the client has certain problems in living and what will ameliorate them (Beck, 1995). In Therapeutic Assessment, as contrasted with cognitive therapy, these “experiments” often make use of results from psychological tests. This practice is similar to that of the use of dynamic assessment in the schools and may facilitate the entry of TA as intervention into the schools.

#### *Research on Collaborative and Therapeutic Assessment*

To date, controlled research on TA has concerned itself exclusively with adult clients. Studies by Finn and Tonsager (1992) and Newman and Greenway (1997) documented positive treatment effects of TA with adults, including decreased symptomatology and greater self-esteem and hopefulness. Ackerman, Hilsenroth, Baity, and Blagys (2000) found that after TA, adult clients were more likely to complete recommended treatment and felt a stronger alliance with their assessor than clients who received a traditional psychological assessment. Hilsenroth, Peters, and Ackerman (2004) replicated this finding and showed that the positive benefits extended to the alliance clients developed with their therapists in subsequent treatment.

In addition, there are now a number of published case studies illustrating the clinical effectiveness of TA. Finn (1996, 2003) and Finn and Kamphuis (2006, in press) have provided detailed adult case illustrations containing verbatim transcripts from the clinical sessions. DuBose (2002); Fischer (1985/1994); Fulmer, Cohen, and Monaco (1985); Handler (2007); Michel (2002); Mutchnick and Handler (2002); Pollack (1988); Purves (2002); and Quirk, Strosahl, Kreilkamp, and Erdberg (1995) have published clinical case studies of collaborative assessment with children or adolescents. In most of these, parents report gaining a better understanding of their children’s problems and feeling more effective in their parenting and in pursuing of appropriate services, whereas children have shown decreased behavioral problems and improved mood, social functioning, and school adjustment. Our TAP is the first systematic research study we are aware of that examines TA with children and families.

#### *TA With Children and Families.*

TA with preadolescent children is conceived of primarily as a short-term family systems intervention (Finn, 1997), an idea first espoused by Fulmer and associates (1985) and Ziffer (1985). Its primary goal is to help parents and other adult caregivers understand and become more empathic to their children and to guide those adults in shifting their interactions with children in ways that will foster ongoing development in the child and family and successful adaptation. TA’s methods are likely to be appropriate for challenging, multiproblem situations, with children who are especially difficult to understand or families whose own projections or psychological difficulties make them unable to perceive accurately and respond appropriately to their children.

If this assumption is empirically validated, there may be support for utilizing TA in the schools for these types of children/families and for other children when teachers may be struggling to sustain appropriate interventions.

TA with children typically involves 8 to 10 sessions that take place over a 2- to 3-month period. Instruments and methods used include interviews to construct assessment questions and obtain developmental and family history; observations of the child, parents, and family; standardized psychoeducational and neuropsychological measures; behavior rating scales completed by parents and teachers; self-report personality and psychopathology measures; performance-based personality and psychopathology measures, including human figure drawings (Tharinger & Roberts, in press), individually crafted sentence completion tests, stories told to apperception cards, and the Rorschach; extended and creative inquiry to test responses; structured and unstructured play; family sessions; and assessor countertransference reactions to the child, parents, and family.

Specific measures and methods are chosen on the basis of the assessment questions that are being addressed.

School personnel may be involved in the assessment and feedback if a child's problems occur in that context, are raised in the parents' assessment questions, and the parents give their permission. For example, the child may be observed at school, teachers may be interviewed and asked to complete measures of behavioral functioning, and teachers may be provided with feedback at the completion of the TA. If parents have assessment questions that involve the way their own behavior or personality may impact their child, they are invited to take and receive feedback on any of a variety of psychological tests, such as the Minnesota Multiphasic Personality Inventory (MMPI-2). This feedback typically focuses on ways aspects of the parents' personality and parenting style may be contributing to their challenges with their child. Although this practice is less likely to be included in school-based TA, there may be other ways to help parents (and potentially teachers) understand their contributions to their children's struggles.

A unique and controversial feature of TA with children that likely strengthens its intervention potential involves inviting parents to observe all or some of their child's testing sessions. As mentioned earlier, inviting the parents is in the spirit of collaborative empiricism as practiced in cognitive-behavioral therapy (Beck, 1995). In clinical practice, parents often sit in the corner of the office to observe and then discuss their observations and reactions with the assessor after the session. In the TA protocol used in our research project (TAP), detailed later, parents with the child's awareness observe their child's sessions behind a one-way mirror accompanied by a member of the AT who is available to interact with the parents throughout their observations. Typically the parents and both members of the AT meet together to discuss the session at the end. This experience suggests that family psychoeducation and social learning theory are likely strong components of the potential change process of TA. The practice of inviting parents to observe their child's testing sessions may raise concerns for some assessment professions, as test security may be compromised to some extent. However, parents only view the testing materials briefly, and they do not take the tests themselves. Others may be concerned about the willingness of children to disclose with their parents observing. We have found in TAP that most of the preadolescent children not only are willing to disclose, but with the strong alliance with the AT member, use it as an opportunity to communicate to their parents through some of the tests and methods. In addition, many of the parents in TAP have indicated that the observation piece was one of the most central aspects of their gaining a new understanding of their child. However, there are likely children who will not be comfortable or feel safe with this setup. In this case, it may be that TA is not indicated or that the assessor will need to work more intensely with the parents outside the observational context.

#### PROTOCOL FOR TA WITH CHILDREN: WORKING WITH THE SANCHEZ FAMILY

The steps used in the TA clinical protocol used in TAP are described and illustrated with the intervention with the Sanchez family. When appropriate, we share excerpts from the case notes kept by the two AT members.

##### *Step 1: The Initial Phone Contact*

*Description.* TA posits that an assessment begins with the first client contact. In TAP, a member of the AT calls and discusses our procedures with parents who have expressed interest in being referred for an assessment. The assessor addresses any concerns or questions parents may have and asks about the major issues troubling the parents and child. Parents are then mailed detailed written information about the project, the beginning of informed consent. A team member then calls several days later to schedule an initial meeting.

*Case example.* Mr. and Mrs. Sanchez were referred to TAP by a local child guidance center. They sought help in raising their 11-year-old granddaughter, Christina, of whom they had custody since she was an infant. Their daughter, Christina's biological mother, was not able to care for her adequately. Apparently Mr. and Mrs. Sanchez sought services from the local child guidance center as they were struggling with persuading Christina to follow household rules and with her angry outbursts, which at times were quite disruptive. [In referring to Mr. And Mrs. Sanchez, we will use the terms *parents* and *mother and father*, as that is the the child referred to them.] We contacted Mrs. Sanchez by phone, and she indicated an interest in having her family participate. We set up a schedule for the research and TA sessions.

### *Step 2: The Initial Meeting With Parents*

*Description.* In the first meeting with the parents the AT verbally reviews the procedures of assessment and answers questions from parents. The team begins to explore the parents' goals for the assessment and construct individualized assessment questions that capture the concerns, puzzles, and challenges the parents have about their child and family. Background information is obtained to inform the context for each assessment question. Finally, the team coaches the parents on preparing their child for his or her first session.

*Case example.* Case notes from AT member 1: "The Sanchezes started right away telling us about the problems they have with Christina. They were good about forming questions and we have a good start at understanding Christina's developmental history, as well as the family's. [Note: The assessment questions were contained in the earlier letter.] It seemed like Christina is scapegoated but at the end they talked about wanting to know if there was something they were doing to make it worse or if there was something they could do to help. I felt like they love Christina but they're in a stuck place. Christina sounds like she has been a difficult child to parent, and they don't know what to do."

### *Step 3: The Initial Meeting With Child and Parents*

*Description.* This session begins with a brief check-in between the parents and the AT to answer any additional questions and see how the week has gone. The child is then invited in and the parents introduce the child to the AT, who explain the process of the assessment and verify that the child understands the reasons for the assessment and is willing to participate. The parents are asked to share an assessment question or two that they hope the assessment process will be able to answer, and the child is encouraged to come up with his or her own assessment questions, which are then explored. Afterward the parents depart with one of the AT members to observe behind a one-way mirror. The child and other AT member continue their conversation about the assessment process and follow up on any additional thoughts the child has about what he or she would like to learn about self and family through the assessment. The child is invited to engage in a nonthreatening assessment task (typically, human figure drawings) and to engage in free play. Behind the mirror the parents have the opportunity to share observations of their child and the process and to ask further questions. After completion of the session with the child, the parents and both members of the AT meet to share impressions and observations.

*Case example.* Case notes from AT member 1:

During the check-in, the parents took a long time because they seemed to want to tell us several stories about Christina having done something bad. Christina came in next and she didn't talk. The parents did talk about how they wanted to know what they were doing wrong too, but all in reference to her bad behavior. When I was in the room with just Christina I decided to start the drawings right away because I was worried she wouldn't talk much. She seemed to open up and talk more as we went. I found myself



feeling very protective of her. I think it's because of how quiet she is, so I find myself wanting to anticipate her needs. She was thoughtful and careful doing the drawings, and spent a lot of time on them. During free play, she made food out of Play-Doh.

Case notes from AT member 2:

Behind the mirror, the parents watched Christina and paid attention to her drawings. They didn't talk much. Mom mentioned that Christina usually draws stick figures and she thinks Christina draws on about a second grade level. She said that she is always telling Christina to draw real people and tries to show her how, but she never listens. I pointed out how she seemed to be drawing real people now and what did she think was different? She didn't know. Mom was really surprised about how good her drawings were. She said that when Christina shows her pictures, mom usually says good, but then starts slipping in suggestions on how to make it better. She said that Christina acts like she is afraid to show her, but then she shows her. I commented that it really seemed like Christina wanted her approval. Both parents commented that they really liked being behind the mirror and enjoyed watching Christina.

#### *Step 4: Contact With Collateral Sources*

*Description.* Early in the assessment, the AT contacts professionals identified by parents as having information relevant to their questions about the child, and for whom the parents have signed releases of information. Such sources typically include school and medical professionals. Records may be obtained, rating scales may be requested, interviews may be conducted, and a school-based observation may be scheduled.

*Case example.* In Christina's case, there were no assessment questions that involved her learning or behavior at school, and no medical concerns. However, of note was the parents' description of how teachers reported Christina's good behavior at school; the parents had a hard time accepting it as possible.

#### *Step 5: Standardized Testing of Child*

*Description.* At this step the child is given standardized psychological tests that are likely to yield information relevant to the parents' and child's questions for assessment. Four or five sessions are common. After standardized administration, "extended inquiries" and discussion are often used to help illuminate the child's test responses and experience. The parents are invited to observe testing sessions and to offer comments during and after sessions with the AT members. The assessor emotionally supports the parents as they reach new understandings or are confirmed in their existing understandings. Finally, the assessor ascertains parental readiness and resources for change, thus informing the family intervention and feedback plans that will be utilized in subsequent sessions that involve the parents.

*Case example.* In the first testing session Christina participated in the Wechsler Intelligence Scale for Children-IV (WISC-IV) and then a period of free play. In her case notes, AT member 1 noted that Christina was still withdrawn but seemed to be warming up. In the free play, Christina once again made food from Play-Doh, and the team member noted that Christina seemed like a much younger child, and that she felt protective toward Christina. The clinician wondered whether part of her experience was in response to the criticalness of the parents when they were talking about Christina. The parents continued to complain a great deal about her behavior, although they did say that Christina already seemed to be improving as a result of the assessment.

The next three testing sessions were conducted with just Mr. Sanchez observing, as Mrs. Sanchez had experienced a minor stroke and was home recuperating. The AT sent her the videotapes from the missed sessions and one member followed up with her by phone. In these testing sessions Christina repeated several subtests of the WISC-IV off medication, neuropsychological

measures, the Achenbach Child Behavior Checklist (CBCL) Youth Self Report, a case-specific sentence completion task, and the Rorschach, including an extended inquiry. The Early Memories Procedure and selected cards from the Thematic Apperception Test (TAT), Roberts Apperception Test, and Family Apperception Test were administered in the fifth testing session, and Mrs. Sanchez was able to attend and observe. Free play was invited at the end of each of these sessions.

Interpretations of the findings gained through these testing sessions are provided in the letter to the parents that began this article. However, because depression, attachment, and emotion management difficulties were so prominent in our case conceptualization, we provide the following Rorschach scores (Comprehensive System; Exner, 2002) for readers who are familiar with this instrument:  $DEPI = 5$ ,  $CDI = 4$ ,  $FC: CF + C = 2/3$ ,  $Pure C = 1$ ,  $COP = 1$ ,  $Pure H = 1$ ,  $Isolate/R = .43$ . After the standardized administration of the Rorschach, Christina seemed so engaged that an extended inquiry (Handler, 2007) was utilized. Christina provided the following story to her response about an animal blowing fire (Card II response: “an animal blowing fire”).

ASSESSOR: What would he say if he could talk?

CHRISTINA: Help, could somebody come and help put out this fire that’s on me!

A: What kind of help does he need?

C: Somebody to get some water to help put it out.

A: What if I came with some water and put it on him, so his fire went out?

C: He’d say thank you. . . .

A: How does he feel, now that the fire’s out?

C: Happy that somebody was gonna save his life!

A: How did he feel when he was on fire?

C: Hot, and scared, he thought no one could hear him or see him and he was gonna die.

A: Wow, that would be really scary!

In her notes, AT member 1 wrote the following: “I felt like she was telling me how she feels when she has her tantrums (blowing fire), but she really feels scared, like no one will hear her, like she’s going to die. What saddened me the most was that I felt this was pretty clear but it would probably be lost on the parents. The feelings I had toward the parents at that point (angry, helpless, like I wouldn’t be understood), that’s probably just how Christina feels. However, the following week when I read Mrs. Sanchez the extended inquiry to the Rorschach, she seemed to get that Christina was talking about herself.”

#### *Step 6: Parent Ratings of Child (and Standardized Testing of Parents)*

*Description.* At this step, which typically occurs a few weeks into the TA, the parents are asked to complete a comprehensive child behavior checklist, which will be useful for answering the assessment questions and for elucidating differences in parents’ perceptions of their child. In addition, parents may be asked to chart specific child behaviors at home. And finally, parents who have questions about how their own personalities or emotional states are affecting their child are invited to be assessed, for example, by completing a personality test, such as the MMPI-2. In these instances, feedback about parent testing is integrated with feedback about the child’s test results—at the end of the assessment.

*Case example.* Mrs. Sanchez completed the CBCL, in which she indicated clinically significant internalizing and externalizing behavioral difficulties for Christina. The Sanchezes did not complete any testing themselves, as the AT felt that, in light of their strong view of Christina as the problem, the request to complete tests to understand their own contributions to Christina’s behavior would be experienced as disrespectful and they would not be able to incorporate the feedback.

### *Step 7: Discussions With Parents During and After Testing Sessions*

*Description.* At this step, brief meetings are held between the AT and the parents during and after each child testing session to share observations, collect further background information, and begin to discuss initial assessment findings.

*Case example.* As illustrated earlier, the Sanchezes were active observers during Christina's testing sessions, and when Mrs. Sanchez could not attend sessions, an AT member talked to her by phone after she observed sessions on videotape. As the relationship between the family and the AT deepened, Mr. and Mrs. Sanchez also began to reveal information about their own struggles as children and about their own upbringing. Both had experienced extremely difficult lives and had been shamed by family members or faced discrimination because of their ethnic backgrounds. It seemed that each struggled to feel "good" and had guilt about the ways Christina's mother had failed her. This information was key to helping the AT begin to understand why Mr. and Mrs. Sanchez seemed so critical and unempathic toward Christina.

### *Step 8: Tentative Case Formulation and Planning of Final Steps in Intervention*

*Description.* Typically, at this point in TA it is possible to create—on the basis of the observations, testing, and discussions that have already occurred—a tentative understanding of the child and family dynamics, the factors maintaining the child and family problems in living, and what might need to shift for the family to relate to each other more successfully. This formulation guides the final steps in the TA and is tested and revised through those steps.

*Case example.* As detailed in the letter to the parents with which we began, the observations and test results for Christina strongly suggested that she was struggling with multiple developmental and emotional deficits. Her test results and our observations showed signs of insecure attachment and poor emotion management skills, along with depression, anxiety, low self-esteem, and limited coping resources. She also had difficulties paying attention, which seemed possibly related to ADHD but were perhaps compounded by her depression and inner emotional turmoil. Mr. and Mrs. Sanchez had started the assessment with very little empathy for Christina, seeing all her behavioral difficulties as signs of her being "mean" and "disrespectful." Because of their own struggles to maintain self-esteem, they were firmly attached to a view of themselves as "good parents" who "did things right," which led them to respond to Christina in ways that increased her depression, anxiety, and fear of rejection. This view of themselves was so strongly held that the AT experienced great difficulty in attempting to lead them away from seeing Christina as the sole problem and toward a more systemic understanding.

Our goals for the remaining parts of the assessment were (1) to increase the Sanchezes' empathy for Christina and to help them not take her anger and disobedience so personally, while still supporting their view of themselves as "good parents"; (2) to help Mr. and Mrs. Sanchez weave a new "story" about Christina that would lead them to respond more positively and appropriately to her; (3) to give the family some experiences of positive interactions, which would yield hope and increase motivation for different ways of being with each other; and (4) to support all of them emotionally as they "tried out" these new ways of being.

### *Step 9: Family Intervention Session*

*Description.* In TA, a family session often follows the observed child testing sessions and is designed to help the family explore one or more of their questions posed at the beginning of the assessment. Generally the AT structures the family session to help the family "discover" some of the assessment findings that have begun to emerge through the earlier sessions. The goal

is to select a finding that one wants the family to experience that may be challenging or difficult for them.

*Case example.* In this session, the AT first asked the family to play a board game together (“Sorry”); they were surprised and encouraged by how well it went and how much fun the family seemed to have together! Christina lit up as the game progressed and did not want to leave; the parents were lighthearted and teasing and said that they really enjoyed it also. After Christina left the room, the clinicians explained that they had been trying to set up a positive interaction—to help counteract all the recent negative ones between Christina and her parents. They also explained that Christina had reported many positive early memories of the family’s doing things together. The team then praised the parents for things they did instinctively—for example, letting Christina have some control during the game. They explained how this tactic would help prevent power struggles and could help Christina accept other areas of her life in which she needed to accept direction. The parents seemed to understand and left the session promising to play more games with Christina at home.

#### *Step 10: Summary and Discussion Session With Parents*

*Description.* At this step, the AT and parents meet to summarize and discuss results of the assessment and the relevance to the initial questions presented collaboratively. Effective feedback, characterized by empathic understanding, relevance, clarity, and respect, maximizes the probability of beneficial effects and further successful intervention (Pollack, 1988). Parents are asked to confirm, disconfirm, or modify each assessment finding as it is presented, rather than accepting it as “absolute truth.” Research has shown that clients are more impacted by assessment feedback that is presented in an interactive format as opposed to a format in which they are passive listeners (Hanson, Claiborn, & Kerr, 1997).

Thorough preparation for the summary/discussion session is required and involves the integration and interpretation of the assessment findings as applied to the assessment questions. An extensive outline summarizing the findings and reviewing the recommendations is prepared. The outline forms the basis for the letter that subsequently will be sent to the parents. The final step involves drafting a fable for the child that the parents will be asked to review and revise, if they desire, before presenting it to the child. This consideration allows the parents to continue as collaborators and assures that they are on board with family support that may be implied in the fable for the child.

In the feedback/discussion session with the parents, the AT follows the developed plan, yet remains flexible and accepts and responds to parents’ comments, additions, and disagreements, which are subsequently incorporated into the letter for the parents. The parents are encouraged to contact the AT with subsequent questions and reactions and are reminded that they will be sent a summary letter within a few weeks. Plans are discussed for the child feedback session, which usually occurs the following week.

*Case example.* Case notes from the AT: “Hooray! Things went really well! The parents were receptive to everything. They really got the depression piece. I think they were relieved to know that she’s not a bad kid, that she has a good prognosis, and that they can do some things that can help. We learned that their son is schizophrenic, and they were afraid that Christina might be seriously mentally ill. When I read the story to them, they said, ‘It’s us!’ I can’t think of a better compliment!! Mrs. Sanchez even teared up at the end when she talked about how we had helped them. I think they felt that we understood them and had listened to them. I feel hopeful about them and I think they can make some progress because they seemed to understand and be willing to adopt our recommendations.”

### *Step 11: Summary Session With Child*

*Description.* After the summary/discussion session with the parents, the AT meets with the child to answer his or her own assessment questions (if any were generated by the child). The child, with parents present, is then presented with the personalized story or fable written by the AT, often with input from the parents, and chooses who is to read it. Stories have been found to be a nonthreatening way of providing children with meaningful feedback and enhancing gaining of hope and self-esteem (Becker, Yehia, Donatelli, & Santiago, 2002; Mutchnick & Handler, 2002). The child is invited to modify the story and is given a copy of story to take home. Any final questions are addressed, and the child and parents are thanked for participating. Good-byes and appreciative remarks end the session.

*Case example.* The AT constructed a story about a lovely unicorn in an enchanted forest who usually did well, but sometimes and often at home, would breath fire like a dragon—and the parents did not like it or understand it. (The “breathing fire” metaphor was taken from an extended inquiry to one of the Christina’s Rorschach responses—provided earlier—and the unicorn was selected from what animal she would choose to be—“a unicorn because they’re soft and glittery”). In the fable, a wise owl in the forest helped the unicorn and the unicorn’s parents understand that the fire appeared when the unicorn was angry and scared but had no words for her feelings. The owl helped the family learn to help prevent the fire from coming out by strengthening their relationship through supporting each other and doing activities together. The unicorn responded well to the new approach and worked hard to keep her unicorn room clean and allow her parents to help her with her homework. The unicorn’s fire almost entirely went away and the family was much happier together. Christina asked for the AT to read the fable to her, and she listened quite attentively and smiled at key points in the story.

### *Step 12: Written Feedback Is Sent to Parents*

*Description.* Approximately 1 month later, the AT sends a letter to the parents summarizing the results of the TA and addressing the parents’ questions. The parents are urged to call with any questions. Excerpts from the letter sent to the Sanchez family began this article.

#### THE OUTCOME AND PROCESS OF CHANGE: TA AS INTERVENTION

In the personalized fable for Christina, the unicorn’s fire was almost extinguished. Similarly, the research findings showed that Mr. and Mrs. Sanchez reported a significant decrease (over one standard deviation on the Behavior Assessment System for Children-2 [BASC-2]) in Christina’s externalizing symptoms at the end of the TA. They stated that Christina was doing much better (“does not cry for too long anymore, does not scream, does not talk back as much, does not kick the walls,” and “has gone from being good about 20% of the time to being good 85% of the time”). They also described more peace and understanding at home and reported an enhanced sense of their ability to parent well. Furthermore, Mr. and Mrs. Sanchez indicated that they were very pleased with the way their assessment questions were addressed and extremely satisfied with the quality of the service provided and the help they received. Christina indicated that she felt more hopeful and better about herself and also perceived a decrease in family conflict and an increase in family communication. These feelings were evident in Christina’s response to the following question: “Imagine that another boy or girl who is coming to this project asks you what will be different about life because of the assessment, what would you tell them?” Christina said, “I think I can get along easier with my family. We have more fun, we play together, we talk nice to each other and when they ask me to clean my room I don’t get an attitude.” These outcomes, with one exception, held up or even looked better at follow-up assessment, which occurred 4 months later.

The one exception was that the father noted increased symptomatology for the child, although at the same time he noted enhanced hope and family functioning. The AT noted that the father was complaining at follow-up about an incident that had occurred the evening before when Christina wanted to attend a football game and he thought she was lying. It turned out she was not, but the father indicated that he still felt upset. That may have accounted for his endorsement of increased symptoms.

This case study example suggests the potential of TA to be a powerful intervention that is perceived as acceptable and as a positive process, is satisfying for the consumers, helps reduce symptoms of concern, and begins a series of steps toward positive adaptive functioning for the family and the referred child. What happened in this case? What processes and mechanisms may have influenced the significant satisfaction and positive change?

#### *Process Experienced by the Child*

Process was measured using quantitative measures and written comments after each weekly TA session over the 10-week period. Christina indicated experiencing a very positive process across the duration of the TA. She consistently endorsed that the AT was interested in her, liked her, and listened to her, and she indicated that she trusted the team and felt understood. She noted that she enjoyed playing and drawing, and that she liked that she could talk about the way she felt around the house because she could get her feelings out. She also indicated that telling the story about the person with fire coming out and telling her memories were good parts for her. She said that she learned that her parents were fun, loving, and caring, and that she could trust herself. Thus, it appears that the child's positive outcomes likely were mediated by the strong therapeutic relationship; the opportunity to express her emotions; the chance to communicate negative, fearful emotions within a supportive environment; and the opportunity to recall positive experiences with her parents.

#### *Process Experienced by the Parents*

Again, process was measured using quantitative measures and written comments after each weekly TA session over the 10-week period, as well as a postassessment research interview. Findings indicated that both parents were consistently and extremely positive about the process of the TA in their weekly ratings, reporting that they felt accepted, safe, and understood; felt the AT was skillful and tuned into their family; and learned new things each week after the initial session. They commented that the AT was very patient, worked very hard to help them with their child, and helped them feel positive. Before beginning the TA, both parents endorsed moderately positive and negative feelings about their daughter's challenges and future. Over the course of the assessment they significantly increased their positive feelings and even more significantly decreased their negative feelings. The parents attributed their changes to their positive reactions to their child's positive changes, their own enhanced patience, and prayer. In the postassessment research interview, the parents added that they were feeling less guilt, were positively impacted by hearing that Christina loved them and by being able to observe how respectful and appropriate Christina was during the assessment (and thus seeing her as a good child), and felt respected and treated fairly throughout the assessment process.

Thus, it appears that these parents experienced multiple processes that likely enhanced positive change in their family system. They seemed to have been impacted cognitively (learning new things, understanding their daughter better), interpersonally (being respected and treated fairly, experiencing a positive therapeutic alliance), systemically (having positive reactions to child's positive changes, hearing and accepting that their child loves them, being willing to try new ways of interacting), as well as affectively (decreasing their negative affect toward their daughter,

developing patience, and experiencing lessened guilt and shame). A look at the experiences of the AT members provides additional insight into the interpersonal processes at work and suggests a very powerful change mechanism—parallel process.

### *Process Experienced by the Assessment Team*

The AT members reported initial positive feelings toward the parents but subsequently felt weighed down by the consistently negative and critical stance the parents took toward Christina. Although the AT continued to provide a holding environment and absorbed the parents' negativity, they found themselves frustrated and angry with the parents. Through supervision, they were able to maintain a positive and accepting response style toward the parents. Their resulting process is best described by the words of one of the AT members.

I felt that only a little change would be possible for this family. I had grown so fond of the child, but I felt so hopeless. In retrospect, these feelings were likely similar to the feelings that they had toward the child. They had become angry with her because they didn't understand her. Additionally, the parents were afraid that we would find fault with them, and that we would not believe them. Although it was unpleasant, it was necessary for us to listen and validate them. Once they felt believed and respected, their defenses lowered and they began to reveal the compassion underneath. We hoped that a similar process would occur with the child. Once she felt understood and cared for by her parents, she would show more of the loving and eager to please side of herself. This happened during the family session. By the time the feedback sessions occurred, I had come full circle in my feelings toward Mr. and Mrs. Sanchez. I saw them in the way I had seen them at first, as loving and caring but stuck in a bad place. I felt more connected and compassionate toward them, just as they felt more connected and compassionate toward the child. The fact that my own feelings toward them changed so drastically could be a barometer for the change that occurred within the family.

### SUMMARY/DISCUSSION

TA with children is a relatively new form of psychological assessment that serves as a collaborative, short-term family intervention. TA is designed to engage children and their parents in the assessment process collaboratively, address their questions, provide interactive feedback, and facilitate meaningful change. In this article we have described the development of TA, outlined the clinical protocol, presented a clinical case study to demonstrate the application of TA, and demonstrated the efficacy of TA through the research findings on the case study. Our findings support the potential of TA with children as a powerful intervention that is perceived as a positive process, is satisfying for both the child and parents, helps reduce symptoms of concern, changes underlying processes in positive ways, and begins a series of steps toward healthy adaptive functioning for the family and the referred child.

We have touched on the potential to implement TA and study its effectiveness in the schools, and we plan to implement such studies after we have more evidence for the efficacy of TA in the more controlled environment of a university clinic. At this point, we have some suggestions on what TA has to offer school psychologists and others conducting psychological assessments and interventions in the schools. We encourage embracing, as much as possible, a collaborative orientation to assessment, which in itself will enhance the intervention potential of assessment. We also strongly suggest co-constructing and addressing assessment questions from parents, children, and teachers when conducting school-based assessments. We also encourage using multiple methods of assessing personality and health/psychopathology (i.e., self-report and performance-based [projective]), multiple informants, and multitheoretical orientations for integration and interpretation. And finally, we suggest organizing the findings around the assessment questions and tailoring the feedback to parents, child, and teachers in ways that are meaningful to them. One of the

authors (Tharinger) has 10 years of experience instructing and supervising graduate students in school-based assessment practica in being collaborative and using consumers' questions to guide assessment and organize feedback. Finn helped supervise graduate students practicing methods of TA with children, parents, and teachers in a school-based practicum. Almost without exception, the methods have been positively received in the schools and have resulted in positive outcomes and follow-through. Wilkinson has used techniques of TA when conducting assessments within the schools. Although these techniques met with some resistance from administrators (who were unfamiliar with TA and considered the methods to be overly time consuming), the consumers of the assessments (parents, teachers, and students) were incredibly grateful and stated specifically that assessments of this type were more helpful than traditional school-based assessments they experienced in the past. We suspect that the cooperation of administrators could be enlisted by better education and collaboration before assessments even begin.

Careful selection of when TA will have the most payoff (e.g., in terms of parental motivation and follow-through) will be wise, as the combined collaborative assessment/intervention method is time consuming and demands extensive competence from the assessor/intervener. (We estimate that TA takes about 40% more time than traditional school assessments.) Most likely it will be more successful to emphasize the interventional nature of TA when introducing it in schools, rather than presenting it as a substitute for traditional assessment. We would recommend using TA with complex cases in which the systems (teachers and parents) that need to respond to the child in more effective and empathic ways are stuck and in their "stuckness" may be doing harm, or at least obstructing progress. We remain convinced that TA practiced in the schools has the potential to provide parents and teachers with a new understanding of a student that results in enhanced empathy, motivation, commitment, and positive outcomes, as well as enhanced family-school relationships that are more easily maintained across time. We look forward to conducting future implementation and effectiveness studies to support this claim.

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