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Therapeutic Assessment with Adolescents and Their Parents: A Comprehensive Model

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Abstract and Keywords

The comprehensive model of Therapeutic Assessment (TA) as used with adolescents and their parents is introduced. TA is designed to answer specific questions parents and adolescents pose for the assessment, to form working alliances with parents and adolescents, to collaboratively engage adolescents and their parents in the assessment process, and to foster positive development in the adolescent and the family. TA uses a combination of assessment and intervention methods, is theoretically integrative and incorporates the unique tasks of adolescent development into the structure of the assessment itself. The goals and procedures for each step are provided and illustrated with a case study of an adolescent boy and his mother, along with effectiveness data. Finally, the application of TA across cultures, the use of selected steps of TA when the comprehensive model is not feasible, and the adaptation of TA to different settings and presenting problems are addressed.

Keywords: Therapeutic Assessment, adolescents, parents, collaborative

Psychological assessment and psychotherapy have traditionally been viewed as distinct endeavors. However, Therapeutic Assessment (TA) is a relatively new model of psychological assessment that has fused assessment and psychotherapy techniques. TA is a semi-structured form of collaborative assessment developed by Finn and colleagues (Finn, 1996, 2007; Finn & Tonsager, 1997). This model offers many of the benefits of a traditional assessment, while also serving as a short-term therapeutic intervention. Thus, with additional training and supervision, most psychologists could readily add TA to their repertoire by integrating their existing competencies in psychological assessment and clinical interventions.

Our primary goal in this chapter is to introduce TA to assessment psychologists, particularly as it applies to adolescents and their parents, and to encourage clinicians to consider how this model may be useful in their practices. A comprehensive discussion of TA with pre-adolescent children and their parents is available in Tharinger, Krumholz, Austin, and Matson (2011), along with an illustration of its use in school-based assessment practice. TA with pre-adolescent children is also discussed and illustrated in Hamilton et al., 2009; Tharinger, Finn, Austin et al., 2008; Tharinger, Finn, Gentry, et al., 2009; Tharinger, Finn, Wilkinson, and Schaber, 2007; and Tharinger, Matson, and Christopher (2011).

To explicate the TA model with adolescents, we will first briefly discuss the developmental changes of adolescence, as these inform the particular methods used in TA with teenagers and their parents (as compared to those used with children and their parents). Existing models of adolescent assessment have largely overlooked these developmental distinctions. Second, we will comment on the assumptions and goals of traditional models of psychological assessment. We will then introduce TA, and review its (p. 386) development and history, including its philosophical and theoretical underpinnings and core values. We will also summarize research findings on the efficacy of TA. In the latter sections of the chapter, we will turn to pragmatic issues. We discuss how to organize

assessment findings so they are most likely to be therapeutic to clients. Next, we will delineate the comprehensive model of TA as used with adolescents, illustrating each step with the case of a 13-year-old boy and his mother. Finally, we will discuss the importance of evaluating the effectiveness of psychological assessment in both clinical practice and research endeavors.

Developmental Changes in Adolescence

Adolescence is a developmental period that spans, roughly, the ages of 12 to 18, and may extend into the early twenties. This life phase is characterized by intense neurological, biological, cognitive, social, and emotional evolution. Many formulations of adolescent development have focused predominantly on cognitive advances, recognizing that adolescents' budding intellectual capacities exceed those of younger children. For example, Piaget (1972) proposed that individuals transition from concrete operational thought to formal operational thought in early adolescence, with formal operations being characterized by the capacity to manipulate ideas and abstract concepts. Thus, teenagers are able to think in more relative terms and envision possibilities, rather than consider only what is concrete and observable. Further, Elkind (1978) asserted that it is during this developmental period that individuals also become capable of *metacognition*—that is, of thinking about their own thoughts and feelings.

More holistically, in addition to adolescents' burgeoning cognitive capabilities, they simultaneously face the challenges of personal and civic identity development, establishing a self-concept, building self-esteem, seeking autonomy, and cultivating a future orientation (Gibbons, 2000). Adolescence is a time wherein youth begin to explore different adult roles and grapple with developing a sense of self that is separate from their parents' view of them (Dusek, 1977; Holmbeck & Updegrove, 1995; Muus, 1988). More recently, some neuropsychological theories, fueled by an understanding of continued brain development, have framed change in adolescence as occurring within an interpersonal context. Within this context, a fundamental reorganization and individuation of the self occurs, and the neural mechanisms of self-regulation, memory consolidation, and motivation support the capacity for critical thinking that underlies abstract thought (Keating, 2004; Tucker & Moller, 2007).

Adolescence is often portrayed as a developmental period defined by awkwardness, turmoil, discord, and angst. In fact, most teenagers emerge from their adolescence unscathed, and the vast majority actually thrive. Nonetheless, unique vulnerabilities emerge during this period that have significant implications for the well-being of both teenagers and their families. Families with adolescents have been found to experience emotional distancing (Seiffge-Krenke, 1999) and a decline in marital satisfaction that may be precipitated by such separation (Steinberg & Silverberg, 1987). Given the emphasis on independence and autonomy during adolescence for both boys and girls (Seiffge-Krenke), much of this emotional distancing may be developmentally appropriate. However, the reasons for such decreases in family cohesion may also be due to more worrisome emotional changes in adolescence. For example, depressive symptoms have been found to increase markedly during adolescence, with such symptomatology being twice as likely in adolescent girls as in boys (Lau & Eley, 2008). Incidences of anxiety are also higher in adolescence (Kelley, Schochet, & Landry, 2004). Perhaps due to such affective disturbance—but also related to the increase in risk-taking and novelty-seeking behavior—alcohol and drug use and abuse, sexual activity, and eating disorders also increase during adolescence. In sum, multiple vulnerabilities during the developmental stage of adolescence can greatly affect the immediate and long-term health and welfare of teenagers and their families.

Thus, when negative developmental experiences do permeate the lives of adolescents and their families, they probably would benefit from psychological interventions that both honor the adolescent's growing independence and integrate family members into treatment. Fishman (1988) asserted that "the most powerful social therapeutic intervention for working with adolescents is family therapy" because the family is the "pivotal point" in every adolescent's life (p. 4). He further stated that "the very presence of a troubled adolescent in the family creates pressures that require the therapist to pay attention to the other family members. It is only ethical that the therapist address the problems of the context as a whole" (p. 5). Additionally, Fishman highlighted that it is often the family that has the most resources with which to mobilize and sustain change.

A number of other important considerations must also be kept in mind when working with (p. 387) adolescents. Teenagers are actively seeking to increase their autonomy as they work to successfully transition from childhood to adulthood. In an effort to maintain independence and self-consistency during this transition, they tend to resist

people or situations that conflict with their developing self-concept (Meleddu & Guicciardi 1998; Muus, 1988). Thus, teenagers may be sensitive to situations where they feel their sovereignty is not being respected. This can create challenges within the family system as parents attempt to adapt to their child's new, and more autonomous, sense of self. Ideally, parents' relationships with their adolescents will begin to be characterized by cooperation and mutual respect rather than authority (Holmbeck & Updegrove, 1995). In combination with appropriate and consistent limits, new responsibilities and freedoms need to be given to teenagers in order to foster the development of a mature self-concept (Dusek, 1997). The need for a balance between giving adolescents privacy and autonomy, while still providing needed support and limits, can present a similar challenge in the context of psychological assessment. Some adolescents may feel as if seeking help or admitting a problem conflicts with their strivings for autonomy (Oetzel & Scherer, 2003). Thus, teenagers may enter into psychological assessment unwillingly (Fitzpatrick, & Irannejad, 2008; Keating & Cosgrave, 2006). Compounding this, assessment psychologists may initially be viewed as authority figures who might not respect adolescents' newfound autonomy.

Psychological Assessment with Adolescents

While a substantial literature exists on the psychological assessment of "children and adolescents" (e.g., Kamphaus & Frick, 2005; Kaufman & Kaufman, 2001; Knoff, 1986; Ollendick & Hersen, 1993; Smith & Handler, 2007), there is a dearth of information that directly addresses the subtleties of conducting psychological assessments specifically with adolescents. There are a few noteworthy exceptions, however. In his book entitled *Assessing Adolescents in Educational, Counseling, and Other Settings*, Hogue (1999) stated that adolescents "often [exhibit] characteristics and circumstances that set them apart from children and adults … these unique features mean that, in many cases, assessments and interventions appropriate for younger and older age groups may not be indicated" (p. 1). Hogue's book begins with a thorough review of various aspects of adolescent development as they pertain to psychologists' work. He then similarly reviews the basic concepts underlying psychological assessment, ethical issues, and various measures of aptitude and achievement, personality, and behavior. However, outside of highlighting that conducting interviews with adolescents "often presents special challenges for the mental health professional" (p. 157), and identifying specific forms or versions of measures that are tailored for use with teenagers, Hogue does not clearly integrate these two bodies of literature in order to address the unique *process* of psychological assessment with adolescents.

Similarly, in their book entitled *Assessing Adolescents*, Oster, Caro, Eagen, and Lillo (1988) review general developmental considerations for working with adolescents, and present guidelines on how to sensitively approach the initial interview, given that "adolescents rarely refer themselves for treatment" (p. 16). The authors then review a variety of content areas about which it is useful to get information from adolescents in the interview (e.g., bodily concerns, friendships, sexual involvement, school problems). Furthermore, the authors suggest that adolescents have the opportunity to ask any questions that may arise during the interview process, and that assessors seek the adolescent's input surrounding the development of a cogent plan for intervention (Oster et al., 1988). The authors also briefly review the importance, and the process, of the adolescent and his or her family receiving assessment feedback. However, throughout the text, the major emphasis is placed on a review of appropriate psychometric instruments and tests that have been widely used in the assessment of adolescents, whereas the unique processes of assessment with adolescents are addressed only briefly.

In spite of the limitations of their respective books, both Hogue (1999) and Oster et al. (1988) address a notable gap in the literature base on psychological assessment. As is evidenced in the predominant content of these two texts, the literature on adolescent assessment generally focuses on the development and use of adolescent forms of well-known tests or measures specifically designed for adolescents. The value of these contributions must not be underestimated. Measures specifically tailored to adolescents inherently recognize such factors as (1) adolescents' increasing ability to understand more advanced language, (2) their ability to evaluate more complex psychological processes and emotions, (3) the inclusion of more mature content that has increasing pertinence to adolescents (e.g., drug use and sexual experiences), and (4) unique norms that account for the developmental, physical, and emotional differences that permeate the (p. 388) life stage of adolescence. However, as described earlier, there are additional considerations of great salience in conducting psychological assessments with adolescents. We will return to this topic after first reviewing traditional and collaborative models of assessment.

Traditional Psychological Assessment

The psychological assessment literature, education and training models, and the practice of assessment have been dominated by a natural science perspective that advocates "the use of standard techniques and rigid protocols to collect 'sterile' data" (Finn & Martin, 1997, p. 131). Given that "the hallmark of science [is] objectivity" (Fischer, 1985, p. 7), within this traditional perspective, testing is viewed as a tool through which to obtain an "accurate" classification of a client for the purposes of diagnosis, easier communication between professionals, treatment planning, and treatment evaluation (Finn, 2007). Typically, traditional evaluations end, as Fischer (1985) notes, with the client being represented "in terms of scores, bell-shaped curves, traits, psychodynamic forces, or diagnostic labels" (p. v). The assessor is viewed as "a scientist whose task [is] to identify the patient's traits, defenses, symptoms, and diseases through measurement" (Fischer, p. 7). Finn and Tonsager (1997) have called this the "information gathering" model of assessment. Handler and Meyer (1998) refer to this approach when applied to personality assessment as being executed by a "testing technician," rather than an "assessment technician" (p. 4).

In order to achieve the neutrality and accuracy that is the goal in the information-gathering model of assessment, threats to the objectivity of the testing need to be minimized. In this model, it is presumed that the assessor obtains knowledge and information about the client that the client does not have access to otherwise. The traditional paradigm of psychological assessment, then, does not consider testing to be a collaborative venture. It is, instead, an undertaking in which the client is the object of the psychologist's studied expertise (Riddle, Byers, & Grimesey, 2002).

The Development of Collaborative Assessment Models

Over the past several decades, psychologists working within a human science tradition have advocated a more accessible approach to assessment where the client and assessor work together to form a productive understanding of the client's situation (Fischer, 1985/1994). Over time, this model of psychological assessment has come to be called *collaborative assessment* (Fischer, 2000). This move to shift the intent of psychological assessment is somewhat surprising given that many humanistically oriented clinicians initially voiced strong objections to assessment, viewing it as "dehumanizing, reductionistic, artificial, and judgmental … for clients" (Finn & Tonsager, 1997, p. 377). Thus, as a first step, key figures in the development of collaborative assessment, (e.g., Fischer, 1972, 1979, 2000; Handler, 1995, Purves, 2002) simply sought to make the assessment process more humane, respectful, and understandable to clients; they did not initially conceive of psychological assessment itself as a potentially therapeutic intervention. Fischer's (1979) conceptualization of psychological assessment was grounded in phenomenological psychology, with all knowledge being inextricably dependent upon the method of study and the mode of understanding. Because truth is intersubjective, she maintained, "objective" test data are best interpreted consensually with the client, and are fundamentally grounded in "historicity, situatedness, and perspectivity" (Fischer, 1979, p. 118). Each individual person simultaneously shapes, and is shaped by, the world while moving through it, and the goal of an assessment is to take a "snapshot" of this complex process.

Therefore, Fischer (1979, 2000) proposed that life events, rather than test scores, are the primary data within which assessment information should be contextualized. Collaborative assessors are urged to attend to narrative or idiographic information throughout the course of the assessment (including when providing oral feedback and consumer-friendly written reports, Fischer, 1985/1994). A collaborative assessment also requires clinicians to consider the interpersonal context in which an assessment takes place, evaluating the interactions and transactions that occur between client and assessor as a valuable source of additional information (Finn & Tonsager, 1997; Handler & Meyer, 1998). Thus, the more humanistic and phenomenological approaches to assessment sought to shift the assessor's focus from the integration of test scores back to understanding an individual's life. Through such practice, the assessor can ensure that "the mirror they hold up" (Handler & Meyer, 1998, p. 6) to the client is accurate, and avoid the client's feeling misunderstood, stigmatized or disrespected.

Collaborative assessment can be either loosely structured or semi-structured (Finn, 2007). Loosely structured techniques may use standardized testing (p. 389) materials in an unstandardized way, primarily as facilitators or therapeutic tools wherein a "valid" score is not obtained. For example, Fischer (2000) advocates for interrupting standardized testing procedures at "natural breaks" (p. 5) when it seems fruitful to further explore any content or process that was evoked by the testing stimuli. Conversely, Finn (2007) and his colleagues developed TA as a form

of collaborative assessment that is semi-structured. In this model, assessment measures are administered using traditional standardized procedures, with possible idiographic inquiry following the standardized administration. Subsequently, the client and assessor discuss and interpret the testing experience together, which, in and of itself, may act as a therapeutic intervention (Finn & Tonsager, 1997).

Therapeutic Assessment

As in collaborative assessment, TA is based primarily on principles of phenomenological, intersubjective, and interpersonal psychological theories (Finn, 2002). This framework helps redefine aspects of psychological assessment, and delineate the different motivations that drive clients to seek assessments. Various theories of human change provide a lens for understanding three such underlying motivations: self-verification, self-enhancement, and self-efficacy/self-discovery (Finn & Tonsager, 1997). *Self-verification* concerns the well-known fact that people strive to maintain their self-views, and make every effort to discount conflicting information (Swann, 1996, 1997). This phenomenon was extensively discussed by Sullivan (1964), by Kohut (1977), and is recognized in intersubjectivity theory (Atwood & Stolorow, 1984). Accordingly, in psychological assessment, clients prefer to receive information that confirms their self-concept and aids them in maintaining a coherent view of themselves (Finn, 2007). Finn (2007) posits that clients often present, or are presented, for assessment when they are experiencing "disintegration anxiety," which is the uncomfortable (and possibly disorienting) feeling associated with receiving information that conflicts with an existing self-concept.

The second motivation, *self-enhancement*, is discussed within object-relations psychology as the need to feel loved and accepted by others, and to think highly of oneself (Fairbairn, 1952; Winnicott, 1957, 1975). Thus, clients participating in psychological assessments hope to receive praise and acceptance from the assessor and to internalize this experience (Finn & Tonsager, 1997). The third and final motivation, *self-efficacy/discovery*, initially posited by self-efficacy theory and ego psychology, describes the need for humans to increase their knowledge of, and control over, themselves and their world (Freud, 1936; Hartmann, 1958; Hartmann, Kris, & Lowenstein, 1946; & Bandura, 1994). Through psychological assessments, then, clients seek to grow creatively, acquire self-knowledge, and obtain more control over their world.

Core Values of Therapeutic Assessment

TA is guided by a set of core values held by the assessor. These include collaboration, respect, humility, compassion, and openness/curiosity (Finn, 2009). We describe each in turn, as they are foundational to the practice of TA.

Collaboration

Assessors practicing TA believe that assessments are most useful, and the results most accurate, when clients are engaged as full collaborators. Clients are central in establishing the goals for their assessments; assisting in identifying relevant background information; aiding in deriving meaning from the test results, including tying them to real life examples; and providing input into recommendations. Clients also review and comment on any written documents that result from their assessment. Finally, assessors also collaborate with referring professionals and, when appropriate, with other important people in clients' lives, which may include family members, teachers, judges or employers.

Respect

TA seeks to respect clients' dignity; in so doing, assessors should treat clients as they would wish to be treated. Thus, clinicians practicing TA thoroughly explain assessment procedures so that clients may make an informed choice about whether or not to participate. Clients are also encouraged to provide input as the assessment unfolds, and to collaboratively construct recommendations at the end of the assessment. Clients are regarded as "experts on themselves" who work with assessors to better understand life impasses or dilemmas. TA is also suited to clients of different cultures in that assessment procedures are adapted to specific cultural contexts; clients are asked to help assessors understand how assessment findings relate to their unique cultural identities.

Humility

Assessors practicing TA are acutely aware that they bring their own perspectives and biases into (p. 390) their work. They acknowledge that they can never fully understand another person's inner world. Assessors are also knowledgeable about the limitations of psychological tests, and do not view them as providing infallible "Truths" about clients. Test scores and interpretations are seen as starting points for discussions about clients' lives, and as tools for generating hypotheses that may assist clients in discovering new "self stories." Assessors trained in TA work to "find their own versions" of the struggles experienced by clients. They are humbled by how their clients' struggles mirror their own and are also acutely aware that all of us are growing, struggling human beings, generally doing the best we can given our respective backgrounds and resources.

Compassion

In TA, assessors integrate empathy and psychological testing to "feel into" their clients' lives, seeking to understand puzzles, behaviors, and patterns that are incomprehensible to others. This often results in clients' feeling more compassion for themselves, and receiving more acceptance and support from others in their lives. Often, as compassion increases and shame decreases, clients find that they are able to make needed changes that formerly eluded them.

Openness/Curiosity

Assessors practicing TA aspire to conduct each assessment with openness to learning about themselves, the world, and the amazing resourcefulness of human beings to adapt and respond to challenging circumstances. They are genuinely curious about each person who presents for an assessment, and find that their curiosity often inspires clients to step back and view themselves and their life circumstances in new ways.

Research Findings

TA has been utilized with adults, couples, adolescents, and children and has shown great promise clinically. In controlled research with outpatient adults, TA has been shown to lead to decreases in symptomatology (Finn & Tonsager, 1992; Newman & Greenway, 1997), increases in self-esteem (Finn & Tonsager; Newman & Greenway; Allen, Montgomery, Tubman, & Escovar, 2003), and increases in hope (Finn & Tonsager). Compared to traditional information-gathering assessment, collaborative assessment has also been shown to lead to better compliance with treatment recommendations (Ackerman, Hilsenroth, Baity, & Blagys, 2000), and better alliance in subsequent psychotherapy (Hilsenroth, Peters, & Ackerman, 2004). With inpatient adults, a very brief (four-hour) TA resulted in better alliance, cooperation, and satisfaction with treatment; lower distress; and an increased sense of well being, as compared with a manualized, structured, supportive therapy or standard psychiatric treatment and milieu therapy (Little & Smith, 2008). A recent study with children under 13 and their families showed decreased symptomatology in children and mothers, decreased family conflict, and increased communication and cohesion following an eight-session TA. In addition, mothers had more positive and fewer negative feelings about their children after the assessment (Tharinger, Finn, Gentry, Hamilton, Fowler, & Matson, 2009).

Regarding adolescents, we are aware of two comparison studies. Newman (2004) compared distressed adolescents who received a brief (two-hour) TA ($N = 18$) to those receiving five hours of psychotherapy ($N = 18$). The group who received the TA showed significantly less symptomology and depression, and increased self-esteem, compared to the group receiving therapy. Ougrin, Ng, and Low (2008) compared TA with traditional, non-collaborative assessment in a group of 38 adolescents referred because they engaged in self-harm. Those receiving TA were much more likely to attend the first community follow-up appointment (75% vs. 40%) and to become engaged with services (62% vs. 30%); both factors have been associated with better psychosocial outcomes in this population of adolescents. In addition to controlled research, a number of case studies have been published on TA with adults (Finn, 1996a, 1996b, 2003, 2007; Finn & Martin, 1997; Finn & Kamphuis, 2006; Fischer, 1978; Fischer & Finn, 2008; Gorske, 2008; Peters, Handler, White, & Winkel, 2008; Wygant & Fleming, 2008); with children (Guerrero, Lipkind, & Rosenburg, 2011; Handler, 2006; Hamilton, et al., 2009, Haydel, Mercer, & Rosenblatt, 2011; Smith & Handler, 2009, Tharinger, Finn, Wilkinson, & Schaber, 2007; Tharinger & Roberts, in press); with couples (Finn, 2007); and with adolescents (Michel, 2002).

Principles for the Organization of Assessment Findings

In TA, assessors share aspects of their insights and interpretations with clients throughout the assessment process rather than waiting to share all their impressions at a closing feedback meeting (Riddle et al., 2002). In fact, Finn (2007) has (p. 391) re-conceptualized "feedback sessions," in which the assessor reports "data" obtained about the client, as "summary/discussion sessions," in which clients are invited to provide input as the assessment findings are interpreted. In these closing sessions of a TA, the assessor pays close attention to the order in which assessment findings are presented to ensure that clients are best able to internalize, and make use of, the assessment information (Finn & Tonsager, 2002).

Attending to the order of feedback is informed by the research on Swann and Read's (1981) *self-verification theory*. Their research indicates that individuals tend to accept feedback more readily when it is consistent with their self-views than when it is discrepant; this tendency persists whether people view themselves positively or negatively (e.g., Collins & Stukas, 2006; Finn, 2007; Giesler, Josephs, & Swann, 1996). Thus, Finn (1996a) recommended that the assessment findings that are congruent with how clients view themselves be discussed first (Level 1 findings). When working with adolescents and their families, it must also be considered whether assessment results are consistent with how parents view their son or daughter, as well as how parents view themselves in relation their child. Presenting the most self-verifying information first serves to put adolescents and parents at ease, and supports their expectation that the assessment findings will be valid and useful.

Level 2 findings are those that reframe or amplify clients' typical ways of thinking about themselves or their families, and should be presented next. Although clients may be somewhat surprised by Level 2 feedback, and may not immediately accept it without question, it is expected that they will be able to integrate this new information into their self-views fairly easily. Ideally, the majority of the findings presented during the summary/discussion session should be Level 2 information (Tharinger, Finn, Hersh, et al., 2008); this is the information that is most likely to facilitate change in parents and adolescents.

Lastly, if the previous information is relatively well received, the assessor may go on to introduce Level 3 findings, which fundamentally conflict in some way with clients' self-views or the understandings of their family (Finn, 2007). Adolescents and parents are likely to become anxious upon hearing Level 3 information, and may initially challenge or reject these findings. Although parents or teenagers may be threatened by this higher-level feedback, within the context of a collaborative and supportive environment, and with the passage of time (e.g., weeks or months after the assessment is completed), they may come to understand and integrate these findings into the way they see themselves and their family. In addition, when their needs for self-verification and self-discovery are met through Level 1 and Level 2 feedback, many clients are quite open to receiving and integrating Level 3 feedback in the summary/discussion session.

The assessors' goal in the summary/discussion session is to help adolescents and parents accept and assimilate as many of the assessment results as possible. However, presenting too much new information may be overwhelming. Furthermore, some Level 3 feedback may be so threatening that it would not benefit clients to hear it for the first time in the summary/discussion session. For example, hearing that their adolescent suffers from significant depression may overwhelm parents if they have not been previously prepared for such a "bombshell." Furthermore, if the assessors know that clients are especially fearful of the word "depression," it is prudent to use phrases such as "lots of sadness" or "feeling really down" instead. If parents have, in some way, been exposed to Level 3 findings earlier in the assessment, and if the sequencing of information has been well executed and language mindfully used, clients are more likely to absorb and incorporate this higher level feedback into their existing views of themselves or their family. This then allows them to address their problems in living more effectively.

It is important to note that all of the assessment sessions should be executed with the intent of transforming Level 3 information into Level 2. When adolescents and parents have had the consistent experience of viewing themselves or their adolescent in a new way, hearing corresponding information from the assessor in the summary/discussion session is likely to be much easier. The practice of organizing feedback around clients' assessment questions also increases the likelihood that Level 3 findings will be accepted. If the information can be framed as an answer to a confounding question or an explanation for something that clients have long wondered about, they may be more motivated to process and consider the information rather than defensively reject it (Finn, 2007).

General Steps of Therapeutic Assessment

Finn (1996, 2007) has outlined a semi-structured, six-step, general model for TA. There is variation in the steps as applied to children, adolescents, adults, and couples. Each of the steps of TA, according to Finn, is important in its own right; additionally, (p. 392) however, in our experience, the whole is greater than the sum of the parts. The steps in the general model include: (1) the assessment question–gathering phase, (2) the standardized testing phase, (3) the intervention phase, (4) the summary/discussion phase, (5) the written communication phase, and (6) a follow-up phase. Finn acknowledges the reality that specifics of the client, setting, assessor, and resources available may preclude assessors' adoption of all six steps, and encourages assessors to adapt the model to their particular needs and circumstances.

The Model of Comprehensive TA with Adolescents

Figures 17.1 and 17.2 depict the comprehensive TA model as used with (1) children and their parents and (2) adolescents and their parents, respectively. The general steps of TA, as described above, are evident in both. As can be seen when comparing Figures 17.1 and 17.2, the major distinctions between TA with adolescents and TA with children is (1) the privacy and confidentiality afforded adolescents as compared to children, and (2) the direct work with adolescents in exploring and processing their own testing findings, in contrast to the direct work with parents in exploring and processing the test findings of younger children. These distinctions are intended to reflect the differing developmental needs of children and adolescents discussed earlier. However, particularly in the age range of 11 to 13, a hybrid of the adolescent and child models may be used to fit the needs of individual children and families. As mentioned earlier, a comprehensive chapter on using TA with children and their parents also is available (Tharinger, Krumholz, Hall, & Matson, in press).

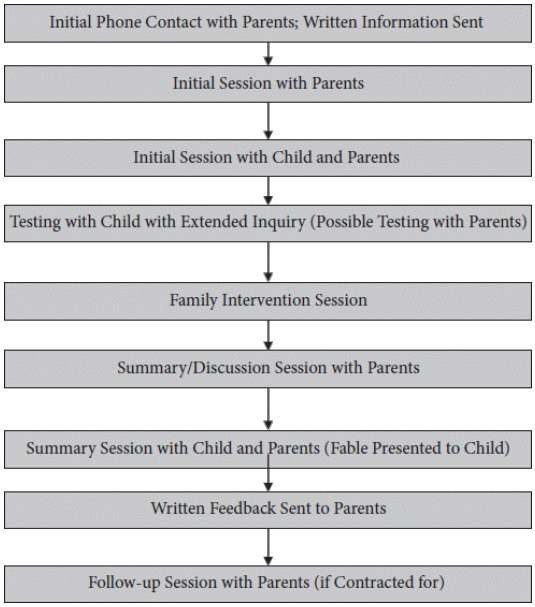

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Figure 17.1 TA with Children and Their Parents.

To grant adolescents some privacy and confidentiality, and with their parents' agreement, adolescents are allowed and encouraged to pose both shared and confidential assessment questions. In contrast, with pre-adolescent children, all their questions are disclosed to their parents. In addition, adolescents' testing sessions are not observed and processed by their parents, as they are in TA with children. Furthermore, adolescents often participate in an individual intervention session with the assessor, whereas children typically participate only in an intervention session in which their parents also (p. 393) participate. Also, adolescents are provided with oral feedback addressing their private assessment questions prior to their parents' receiving oral feedback, which is not the case in the child model. Adolescents are also given a preview of the feedback their parents will receive, after which they may be given the option of attending their parents' feedback session, whereas children are not. In addition, adolescents receive a separate (and private) letter summarizing their specific feedback, while children's

written feedback (usually in the form of a story or fable) is given to children and parents in a joint meeting. Thus, multiple steps in TA provide adolescents with privacy and confidentiality.

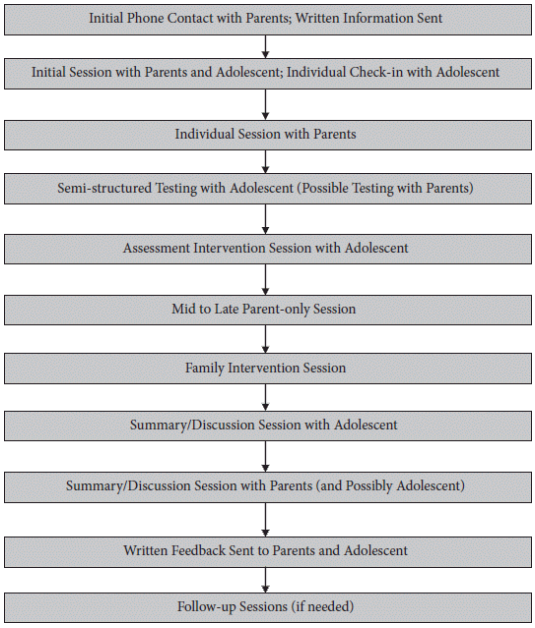

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Figure 17.2 TA with Adolescents and Their Parents.

There is also a major distinction between adolescent and child TA with respect to the primary focus of clinician attention and intervention. In TA with children, the assessor works with the parents as they observe and process their child's test responses. The intent is to shift parents' "story" about the child, so that it is more coherent, accurate, compassionate, and useful (Tharinger et al., 2007). This is the main focus of attention because children respond readily to shifts in their environment, and their self-stories are not as "fixed" as are those of older clients. In contrast, in TA with adolescents, assessors work with the youth directly to further their insight into themselves. The extensive social and cognitive shifts that occur in this developmental stage allow adolescents to comprehend information derived from their cognitive and personality tests; they are able to scrutinize previously unexamined beliefs, behaviors, and values, and to observe themselves as the objects of their own thought (Elkind, 1978; Piaget, 1972). Thus, by affording privacy, confidentiality, and active processing of findings in the moment, the assessor invites adolescent clients to actively participate in their assessments as equal partners, which, in turn, allows them to feel that they are respected as valuable contributors throughout the intervention. (p. 394) While this work with the adolescent is occurring, assessors also work with parents in a series of separate sessions, to facilitate and coordinate shifts in how they view their children, themselves, and their family.

We now describe and illustrate the goals and procedures for each step in the comprehensive TA model with adolescents and their parents. The majority of this material is abstracted from training materials designed by Finn and presented nationally and internationally over the past decade. We will illustrate each step with a recent case. The assessment presented herein was conducted as part of the Therapeutic Assessment Project (TAP) at the University of Texas. The assessment team consisted of the second author, Lauren Gentry, and Jamie Kuhlman, both doctoral students. The TA was supervised by Deborah Tharinger, licensed psychologist; and Pamela Schaber, licensed psychologist. Consultation was provided by Stephen Finn, licensed psychologist.

In TAP, we are studying the processes and outcomes of TA with children and adolescents. Variables of interest for potential change have included child symptomatology, family functioning, affective attitudes, and satisfaction with the assessment experience. Participants are recruited from the waiting list of a local outpatient community mental health clinic for children. If they meet entrance criteria, clients are offered a comprehensive TA, and, upon its completion, are placed at the beginning of the waiting list at the clinic, should they want additional services. The TAs are free of charge and take place at the university. Each assessment is conducted by an assessment team of two advanced graduate students in a doctoral-level professional psychology program, and supervised by licensed psychologists experienced in TA. In the TA model used in TAP, one assessment team member works primarily with

the adolescent and the other with the parent(s). The assessment team comes together for all joint meetings with the family. The family members also work with independent research assistants to complete extensive pre- and post-assessment research measures and interviews, as well as brief interviews after each assessment session. Informed consent and assent is obtained from all family members prior to the start of the assessment. For the case illustrated in this chapter, both the mother and the adolescent boy gave their additional consent for us to write about them and their assessment experience in a published book.

TA with adolescents and their parents typically consists of 8 to 10 weekly sessions that take place over a two- to three-month period (although these sessions can be condensed into a shorter period if necessary). Meetings of an hour and a half are usually sufficient. We have found that weekly sessions allow time between sessions for adolescents and parents to process what they are learning, and to begin to construct a new story about themselves. This schedule similarly allows assessors time to absorb findings and thoroughly plan for the next session. This pacing, then, more closely resembles that of therapy or counseling than that of a traditional assessment.

Initial Phone Contact with Parents to Discuss Referral and Provide Information on TA

In the initial conversation with parents to explore the family's engaging in a TA, the assessor explicitly states that the assessment is intended to be a collaborative process, and stresses that parents' input is essential to the success of the TA. This assertion is then put into practice by asking parents to begin thinking about what questions they wish to address through the assessment, including those concerning their child, themselves, and their family. This invitation demonstrates from the beginning that parents will help to determine the course of the assessment. After the initial phone contact, more extensive information about the TA process is mailed to the parents, as is a separate information form designed specifically for adolescents. The intent of this separate information sheet is to support adolescents' individuation from the beginning, as well as to highlight the importance of their collaboration in the assessment process. The form for adolescents asks the following questions: "What is a Therapeutic Assessment?" "Why me, and what will this be like?" "What will I get out of this?" "What's the downside of this?" "Will you really tell me what you figure out?" "Who else will get the results of the assessment?" "Suppose I don't want to do the assessment?" and "What if I say yes, and then later I want to stop?"

For example, the information sheet answers "Why me and what will this be like?" as follows:

> Your parents have agreed that a psychological assessment with you could be useful to help them understand you better and help you understand yourself. Your parents will be invited to pose questions for the assessment that we will attempt to answer. In (p. 395) our experience, parents ask questions such as, "Why is our son so angry all the time?" "Why is our daughter suddenly failing in school?" or "Why do we all fight all the time?" We will let you know the questions that your parents ask. We hope that you will work with us to figure out the answers to your parents' questions. We will also ask you, when we meet with you and your parents together, and when we meet with you privately, what questions you have about yourself and your life that you would like to ask. We will then work together to answer your questions as well. You can share your questions with your parents or you may keep them private. You might want to start thinking about questions you want the assessment to try to answer. Usually we can handle up to 4 or 5 different questions. Examples of questions teenagers have asked include, "Why don't my parents trust me like they should?" "Why do I get overwhelmed so easily?" "Why can't I get along with my parents any longer" "Why is school so hard for me now?" and "How come I'm having such problems with my friends?" After we settle on your and your parents' questions, we will be asking you to come for about 10 or so appointments. We will talk with you about your life, ask you to fill out some questionnaires, and ask you to do some psychological tests and talk with us about your experience. At the end of the assessment, we will meet with you privately to talk about the results of the assessment and answer your questions. Afterwards, we will meet with your parents to answer their questions. And at the end, we will write you a letter that tells you what we all figured out."

Initial Session with Parents and Adolescent

This first session is guided by multiple goals and procedures. The assessment team typically begins by meeting with the adolescent and parents together. This conjoint meeting may constitute one-half to two-thirds of the

session, and is followed by a check-in with the adolescent alone. The session then closes with the parents rejoining the adolescent. In this initial meeting, the assessment team works hard to make connections with the multiple individuals involved, who often have long-standing conflicts or "feel stuck," which has led them to seek the assessment. For example, conflict between the parental subsystem and the adolescent is commonplace, as is disagreement within the parental subsystem. These conflicts are often exacerbated by the developmental tasks of adolescence discussed earlier. The competencies required of assessors in this first session are much like those used in therapy with adolescents and families: for example, listening, balancing, validating, summarizing, and exploring. We now discuss the goals and procedures of the first session, and illustrate by continuing our case example.

Establishing Relationships and Alliances

Case material:

Matt is a 13-year-old Caucasian male nearing completion of the eighth grade. He was referred for mental health services by his mother, Lisa, who reports that Matt is bright and mature beyond his years, but that he has recently been experimenting with an assortment of illicit and prescription drugs. Although Matt has yet to run into trouble with legal or school authorities, his mother is extremely concerned about his experimentation at this young age, as well as the influence that several of his friends have on his behavior. Lisa is a single mother who became pregnant with Matt when she was 16 years old and ended the relationship with Matt's father prior to his birth. Lisa describes her relationship with Matt as being close and open, but recently as more distant. Matt's contact with his biological father is sporadic at best, which has been upsetting for Matt throughout his life. Matt has a close relationship with Lisa's longtime boyfriend, Peter. Matt was diagnosed with Type 1 Diabetes at the age of seven and, although he is fairly responsible about managing his blood sugar, his health is an ongoing concern for Lisa. For example on one recent occasion, Matt had an overnight hospital stay after recreationally drinking a bottle of cough syrup. From the initial phone contact, we hypothesized that Lisa was probably struggling with letting her son individuate, as she described them as "best friends." We also felt that she genuinely had no understanding of why Matt was choosing to experiment with drugs.

Case material:

In establishing relationships and alliances with Lisa and Matt, it was important for the assessment team to validate the concerns and experiences of each as they began to discuss their recent challenges. For example, the assessors normalized for Matt that it is developmentally appropriate for adolescents to distance from their parents as they work on their own identity formation, while they simultaneously validated how difficult this separation must be for Lisa. In further building rapport with Matt, it was invaluable for the assessor to engage him in a conversation about the things he liked, including music, sports, and leisure-time activities, rather than focusing exclusively on his recent problem behaviors. Both Matt and Lisa were highly personable, appeared to have a positive relationship with one another, and were willing participants in the assessment; as such, relational foundations were established with ease in this initial session.

The first goal of the initial session is for assessors to begin establishing relationships and alliances with the adolescent and the parents. This includes helping the family to feel welcome, safe, accepted, and that they are truly valued as collaborators in the (p. 396) assessment process, thus establishing a foundation of trust that will be further developed throughout the assessment. We have found the following steps to be especially useful:

(1) Warmly welcome everyone and explain the goals of the session;
(2) Introduce the session from a collaborative perspective;
(3) Ask if the adolescent or parents have any questions about the assessment at this point;
(4) Listen attentively, with interest and concern;
(5) Restate what you learned from talking to the parent over the phone and ask for clarification;
(6) Ask for any reactions to the information sheets that were sent home;
(7) Listen carefully and ask questions of each person present; give each family member the opportunity to state how he or she views the situation and, if there is disagreement, how each person feels about that.

It is also important to give the adolescent and parents permission to ask questions about you, the assessor, and any aspect of the assessment, as well as to discuss the limits of confidentiality. Additionally, in our experience, it is also very useful in this first session to ask about previous assessment experiences that the adolescent or the parents have had, and to listen for past hurts or disappointments, to accept and empathize with these, and to then offer an assessment contract that addresses the previous negative experience. Assessors should also encourage the family to alert them if they feel upset or poorly treated during any part of the TA. Finally, it is imperative that the assessor be attuned to interactions between family members during this session and throughout the assessment, gaining first hand experience of the family members' relationships and readiness for change.

Negotiating Some Privacy for the Adolescent

A second goal of the initial session is for the assessors to suggest and negotiate appropriate autonomy and privacy for the adolescent throughout the assessment. Typically, this involves securing the parents' permission for the adolescent to ask private assessment questions and to receive confidential feedback that addresses those questions. As most adolescents being assessed will be under the age of 18 and, thus, not *legally* entitled to confidentiality from their parents in relation to health and mental health care, this request is not made lightly and is understood not to be legally binding. The intention of seeking such privacy for adolescent clients is therapeutic. It acknowledges that most adolescents are beginning to individuate from their parents, and that, in our society, this is typically developmentally appropriate. Most adolescents appreciate this recognition, and thus are more likely to engage in the assessment. The request also encourages parents to accept this age-appropriate shift in their child, and to tolerate some expression of their son or daughter's autonomy. In many families, this request (and the subsequent negotiations) are, in and of themselves, an intervention, wherein boundaries are challenged and developmentally appropriate privacy needs explored. Such a request can also provide an opportunity to educate parents about the appropriate developmental needs of adolescents.

Case material.

Having normalized Matt's separation and individuation from his mother led relatively seamlessly into discussing Lisa's willingness for Matt to pose private questions for the assessment. Lisa readily agreed to honor such privacy for her son. However, the assessment team assured her (and informed Matt) that if Matt were to disclose any information in the course of the assessment that indicated a threat to his safety (particularly given that Matt's drug experimentation had previously resulted in a hospital stay), Lisa would be informed immediately. As is sometimes the case, in spite of Lisa's affording Matt the opportunity to pose confidential assessment questions, Matt chose to be continually open with his mother about his experience of the assessment.

In our experience, most parents are very open to the request that their teenagers be able to pose private questions and receive individual feedback. Generally, parents appreciate their children's developmental changes and hope that their adolescents will confide in the assessor, obtaining needed help that they no longer seek from the parents. We have also found that some parents are not able to tolerate this request, or that one parent can but the other (p. 397) cannot. When this is the case, more time is often needed to discuss the issue, and slowing the assessment process down until the matter can be satisfactorily resolved is generally good for everyone. We have also found that, by the end of the assessment, adolescents often choose to share their private questions and feedback with their parents, perhaps as a reflection of the paradox of trust.

Obtaining Assessment Questions from Parents and Adolescent Jointly

The third goal of the initial session is to gather and co-construct assessment questions from the parents and the adolescent together, with the adolescent knowing that, if they are so negotiated, he or she will still have the opportunity to privately pose additional questions later. In our experience, most adolescents pose some questions with their parents present and some questions privately. In helping parents and adolescents frame questions to be explored through the assessment, it is important to use the clients' own words if possible, and to refine questions that are too broad or too narrow. It is also helpful to continually engage clients' curiosity, as this tends to suspend their emotional reactions, instead putting them in a role wherein they are more objectively exploring themselves. It can also be very useful for assessors to suggest implicit questions that they have heard with their "third ear" (i.e., queries that have been alluded to or implied, but not explicitly articulated), thus assisting the client in making the question explicit. If a client is struggling with posing questions, or insists that he or she has no questions, it may be

useful to return to discussing the aims of collaborative assessment and the importance of its being guided by clients' curiosities about themselves or their families. In cases like these, it is possible that the relationship and trust are not adequately established and the process may need to be slowed down. In other cases, it may be that one of the participants, perhaps one of the parents, is not fully on board with the assessment. In these cases, it is useful to comment on this and ask about the person's reservations so that the assessor may work to address these concerns.

In our experience, assessment questions are a crucial component of the collaborative assessment process. They serve to lower clients' anxiety by defining the contract for the assessment and, from the start, engage clients as active participants in the assessment process. Constructing questions also tends to engage clients' curiosity about themselves or their children, and very importantly, provide "open doors" to discuss difficult or awkward information. For the assessor, the constructed questions provide information about clients' current self-schemas/stories and indicate where those self-structures may be open to change. Finally, collecting assessment questions from clients sets the stage for them to "mentalize" (Allen, Fonagy, & Bateman, 2008) about their problems, which in itself can be therapeutic. Many clients report that they experience relief just from framing their persistent problems in the form of questions.

Case material.

With minimal guidance, Lisa and Matt readily developed questions for the assessment. Lisa's questions were: (1) Why is Matt experimenting with drugs? (2) "Am I communicating with him in the right way?" and (3) "Why is Matt not motivated to reach his potential in school?" The question that Matt posed in his mother's presence was: "Why does my mind go blank in tests for algebra?" He subsequently alluded to the fact that he sometimes has difficulty putting his thoughts into words, but did not develop an additional question about this. While discussing Matt's recent history of drug experimentation (which had also included taking prescription stimulant medications and smoking marijuana), Lisa made a comment about how she was unable to relate to Matt's behavior because she had never experimented with drugs in her youth. Although it seemed somewhat uncomfortable for Matt to hear his mother talk with two relative strangers about his experimentation with drugs, he did not become defensive or withdrawn at any time. In fact, he only contradicted his mother on one occasion, saying that his experimentation with drugs had nothing to do with "peer pressure," and he remained engaged throughout the session.

After the questions are formed, the assessor typically collects relevant background information to flesh out the history and context underlying each question. In collecting background information about each question, we have found queries such as the following to be very helpful: "What does the problem look like in daily life?" "If this problem were resolved today, what would be different about your life?" "If you had to answer the assessment question today, what would you say?" and "What would be the most difficult thing to hear at the end of the assessment?" In posing such follow-up questions, however, it is essential to respect the client's right to privacy at all times. Information-gathering questions should be connected to the client's agenda for the assessment in a face-valid way, which is exemplified by the client's assessment questions. If the assessor wishes to ask a follow-up question that does not appear to be related to the client's concerns, it (p. 398) is important that the assessor ask permission and explain why the question is relevant. In addition, it is important to allow clients to declare certain topics "off limits," even though the absence of the information may constrict the ability to fully address a particular assessment question.

In wrapping up the information gathering portion of the session, the assessor summarizes the assessment questions that have been agreed upon, invites both the parents and the adolescent to develop additional questions as the assessment unfolds, and reminds everyone that there will be ample opportunity to further discuss the questions as the TA progresses.

Obtaining Private Assessment Questions from the Adolescent

The next goal of the initial session is to gauge how the adolescent is experiencing the process, and to invite him or her to meet individually to pose private questions. If so negotiated, the parents are asked to leave the room, and the assessor solicits reactions from the adolescent in response to the session so far. The assessor attempts to align with the adolescent, conveying genuine understanding of the difficulties that come with adolescence, including that relationships with parents can be challenging. The assessor continually encourages questions and

reactions from the teen, seeks his or her explicit agreement to take part in the assessment, and highlights that the process will only be useful if the adolescent is on board and curious. If the teen is hesitant or unsure, the assessor may suggest that he or she take more time to think about it, and will support the adolescent in doing so. If, at any time, the adolescent decides not to participate, the assessor must respect this decision and agree to represent to the parents that this is not the right time for a TA. If the teen agrees to participate collaboratively, the assessor then invites private assessment questions and again reviews the legal limits of confidentiality. The process of constructing questions and exploring their context is very similar to that described earlier for the joint session with the adolescent and the parents.

However, it should be mentioned that sometimes it is difficult to get adolescents to formulate individual questions to be answered through the assessment. This can happen for a number of reasons, including an underlying reluctance to participate in the assessment, distrust of the assessor, limited intellectual abilities, or, in some cases, an inability to "step back" and become curious about oneself. If an adolescent says he or she has no questions, but seems very willing to participate, it is best to proceed, keeping in mind that assessment questions may emerge in subsequent sessions. If the lack of questions seems to be a reflection of marginal motivation to participate (perhaps accompanied by a desire to mollify parents), the assessor should once again reassure the adolescent that it is not necessary to do the assessment, and that the assessor will back up the adolescent with his or her parents. Again, some adolescents will insist on proceeding and may generate questions once they develop more trust with the assessor.

Reuniting and Completing the Assessment Contract

Case material.

In his individual check-in, Matt was open to discussing his recent struggles, including his experimentation with drugs; he readily came up with private assessment questions. These included: (1) "Why do I feel distant from my friends sometimes even when I'm hanging out with them for hours on end?" (2) "Why did I take Adderall the second time without weighing the pros and the cons?" and (3) "Why do I smoke pot when I don't remember anything the next day?" When the assessor asked Matt what his best guess was about the answer to his final question, he said that, when he smokes marijuana, "it's an hour or two that I don't have to contain myself. It feels like nothing can, kinda, tear me down at all." The assessor then reiterated that smoking marijuana allows him to "let go," and asked if he felt like he had to "contain himself" during other times in his life. He said: "At school, I feel like I can't be myself. I can't wear what I want to wear. I have to be careful about jokes I make because I might offend someone." Matt also talked at length about all of the research he had done on the drugs he had used, including that he did not have the experience he was "supposed" to have when he drank the bottle of cough syrup. In fact, Matt was very forthright about his embarrassment at having ended up in the hospital following that incident. During this conversation, Matt also asserted that there are many drugs he would "never" try, including drugs like "meth, coke, PCP, and heroin."

The fourth goal involves reuniting the adolescent and parents to summarize what has happened in the first session, as well as discuss what is to come. We have found that meta-processing can be useful at this point. Questions such as: "What was it like to talk about these things today?" or "How are you feeling as you leave today?" may help (p. 399) solidify the experience and unite the family in their commitment to the assessment. The desired outcome at the end of the first session is for the family to leave feeling less shame, and more calm, understood, curious, and hopeful. Before ending the session, any additional details of completing the contract for the assessment are discussed, such as the projected number of sessions, ending date, procedures, and if any formal written feedback will be needed (although some details may be handled privately with the parents, such as cost, insurance, etc.). Releases to contact collateral professionals are also obtained from parents, and even though it is not legally necessary, we generally also ask for adolescents' permission to contact previous therapists, teachers, etc. Finally, the next session is scheduled, which typically involves a meeting with the parents to obtain family and developmental history. As addressed shortly, it is important for the assessor to explain to the adolescent the reasons for the upcoming meeting with the parents alone "e.g., we want to ask your parents questions about when you were little and we think it might be boring for you to sit there", and to address any questions or concerns he or she may have about such a plan.

Reflecting on the Session and Initial Impressions/Hypotheses

The final goal of the initial session involves the assessor taking time to consolidate initial impressions and hypotheses, and to sort through any emotional reactions and anxieties that may be surfacing in relation to the clients. Such reflection underscores that the assessor and his or her reactions to, and relationships with, family members are a valuable source of information throughout the assessment process.

Session with Parents Only

Case material.

Upon coming back together, neither Lisa nor Matt expressed any lingering hesitations about participating in the assessment, and, in fact, both were very upbeat about their willingness to take part. Matt asked some brief questions about the kinds of assessment activities he would be doing in the ensuing weeks, but he had no concerns about the assessment team meeting with his mom individually the following week. Additionally, both Lisa and Matt appeared somewhat reenergized by the end of the first session.

Case material.

Upon reflection, the assessment team noted that both Lisa and Matt were immediately likable. They were personable and seemed bright and open. They were both engaged and present throughout the session. In spite of the challenges their family was facing, they appeared to have a close and positive relationship with one another. The assessment team felt they had made a good connection and that the case would proceed well.

The primary goal of this session is to further explore the parents' assessment questions by asking about relevant developmental and family history. This private session also allows the parents to share information that they might not have felt comfortable discussing in front of their child, or that would not have been appropriate for the teenager to hear (e.g., marital conflict, details about financial stress, (p. 400) information about an absent parent, etc.). Parents may also have additional assessment questions that they were not comfortable posing in front of their adolescent. If this is so, the assessor works with the parents to formulate these additional assessment questions so they may be shared comfortably with the teen. For, while the adolescent may be allowed private assessment questions, all of the parents' questions for the assessment are shared with the adolescent—except in very rare instances. This session is also an opportunity for the assessor to strengthen the collaborative relationship with the parents, and to empathize with aspects of their lives, especially the difficulties of parenting and frustration with their adolescent. Additionally, it allows the assessor the opportunity to discern parents' readiness for change. In our experience, some parents need much of the session to complain about their adolescent in a scapegoating manner before they can begin to develop or resurrect empathy for their child. Other parents need time to express guilt for the challenges their child has had to endure, and to seek some "absolution" from the assessor before being able to move on. The assessor needs to be flexible and able to adjust to parents' specific needs, gathering information and offering support in ways that will facilitate the family's moving toward positive change.

It is also in the first parent-only session that the assessor typically introduces the idea of parents undergoing some psychological testing as well. This possibility is usually raised seamlessly if the parents have posed an assessment question that addresses their parenting style or how their personality fits with their adolescent. For example, a parent may have asked, "Are there ways that my reactions to Sam's behavior contribute to his withdrawal and secrecy?" or, "My guess is that my personality really clashes with Ellen's sometimes, resulting in a real firestorm between us. How can I get that under control?" If parents have provided such an opening, the assessor offers to do some testing with them with private feedback focused on the interface of their personality and parenting style and how these factors impact their adolescent. This parental assessment feedback remains within the bounds of the goals established for the assessment. In the TAP project, if parents agree to be tested, we typically use the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) with them, but depending on the parents' questions about themselves, any of a number of tests may be appropriate. Sometimes, adolescents are aware that their parents are engaging in testing of their own, and this can help them feel less scapegoated. Regardless, typically they are not privy to their parents' test results, unless their parents offer this information.

Testing Sessions with the Adolescent

Case material.

Lisa needed no time to vent or disclose guilt. Rather, she began by discussing Matt's development chronologically, including willingly disclosing many of the details surrounding her teenage pregnancy. In so doing, Lisa matter-of-factly detailed her remarkable efforts to keep her life on track after finding out about her pregnancy. While continuing to attend high school, she also took night classes in order to complete her graduation requirements prior to giving birth. Lisa then spent the summer at her parents' home. That fall, when Matt was about four months old, Lisa began college, finishing her degree four years later. In discussing Matt's early life, Lisa also talked about the trauma and overwhelming feelings associated with Matt's diabetes diagnosis. It appeared that she had sought out positive ways for Matt to manage his illness. She arranged for him to give presentations to his classmates, involve his peers in his treatment, and attend a summer camp for diabetic children and their siblings annually. Nonetheless, Lisa did report feeling that Matt's diabetes had impacted him emotionally. Lisa also described Matt's relationship with his biological father as being characterized by unmet promises and infrequent contact, and highlighted how hurt and disappointed Matt continued to be by his father's failure to maintain a relationship with him. She also relayed how painful and angering this was for her. In spite of his father's absence, Lisa noted that Matt had positive relationships with her many close male friends, and that Matt also was extremely connected to her longtime boyfriend, who had been actively engaged in Matt's life since he was six.

In discussing developmental history, Lisa stated that Matt had been an easy child, notwithstanding his recent drug use, and that he was respectful and obedient. While Lisa emphasized her closeness with Matt, she also highlighted the importance of acting as a mother and not as a friend with her son when he needed to adhere to structure and limits. She also indicated that, although he had many friends, Matt appeared less confident with his age mates than with adults, and often allowed himself be "taken advantage of" by his peers. She suggested that many of his problem behaviors (like drug use) were due to his succumbing to peer pressure. When asked what she would be most afraid to learn through the assessment, Lisa stated that the worst thing she could find out would be that Matt wanted to commit suicide, and that he could be that depressed without her being aware of it.

Finally, while Lisa was obviously very concerned about Matt's drug use, she also recognized, and was troubled by, a shift in their relationship towards less open communication. Given the systemic nature of her question about whether she was communicating with Matt in the "right way," it seemed very appropriate for the assessors to explore her willingness to engage in testing of her own. Lisa readily agreed, stating that she was willing to do anything necessary to help her son.

Typically the standardized testing begins in the third session of a TA with an adolescent. Although the number of testing sessions varies by case, four or five is average. As Finn (2007) has recommended, it is of utmost importance to begin with assessment measures that clearly reflect the clients' central concerns. Commencing with tests that are tied in their face validity to the adolescents' and parents' goals communicates to clients that: (1) they are being taken seriously; (2) their concerns are the first priority; and (3) their questions will be addressed collaboratively from the start. The tests administered vary based on clients' presenting problems and assessment questions. Nonetheless, assessments often consist of: (1) cognitive testing, (2) academic achievement testing, (3) basic neuropsychological measures, (4) socio-emotional testing, which may include behavior rating scales like the Behavior Assessment System for Children, Second Edition (BASC-2), the Child Behavior Checklist (CBCL), (5) a self-report inventory, such as the Minnesota Multiphasic Personality Inventory for Adolescents (MMPI-A), and (6) performance-based personality measures such as the Rorschach, sentence completions, projective drawings, apperception tests. Again, depending on the issues to be explored, there are a number of other psychological assessment tools that may be useful in informing the assessment questions. Beginning with the first assessment measure and continuing for all remaining testing (p. 401) activities, the assessor explains to adolescents, in an accessible way, how each test will address their (or their parents') agenda for the assessment. Following standardized administration of each task, the assessor then asks teenagers to expand, reflect upon, and discuss noteworthy responses or experiences as they completed the activity.

This exploration of the testing experience and particular responses may take the form of *extended inquiry* or *testing the limits*. In extended inquiry, the assessor seeks to further engage clients as collaborators by inviting

them onto "an observation deck" where they can think about their own test responses more objectively (Finn, 2007; Handler, 2006). From this viewpoint, clients are encouraged to connect their test responses to their lives outside of the assessment room, as well as to access any painful affect that is revealed through the assessment experience. Through such conjoint observation, clients can begin to collaboratively "weave a new story" about themselves that often relates to their assessment questions.

So, after completing a particular standardized test, the assessor simply inquires about clients experiences of the task ("What was that like for you?" or "What did you think of that?"). The assessor then asks follow-up questions on any observations that clients' have made, and encourages them to make connections to their outside lives, as well as to their assessment questions. After seeking clients' input, the assessor is then free to share relevant observations or thoughts; however, the assessor must do this tentatively, inviting clients' feedback and honoring their reactions to the assessor's suggestions or ideas.

Case material.

When taken together, Matt's assessment data suggested that he was quite bright; he performed in the high average range of cognitive functioning, exhibiting a significantly stronger performance in tasks that were verbal as opposed to visual-spatial in nature. In his academic achievement testing, Matt's scores ranged from the low average range to the superior range. While he exhibited some difficulty with academic fluency, spelling, and reading novel words, his profile was not indicative of the presence of a learning disability in any area of academic functioning.

When Matt was completing the Woodcock-Johnson Tests of Cognitive Abilities, after he exhibited substantially more difficulty on the performance IQ tasks as compared to the verbal IQ activities, the assessor asked "Matt, if you had a choice between working on a puzzle or doing something that had to do with language or vocabulary, which would you choose?" Matt, not surprisingly, explained that he would prefer a language-based task. Similarly, when Matt completed the Woodcock-Johnson Tests of Achievement, the assessor inquired about his experience of the timed versus the untimed math tasks, and how these activities might have related to his tendency to "go blank" in algebra class. Matt's social-emotional-personality assessment results indicated that he was experiencing a great deal of negative emotionality, including depression and anxiety. Further, Matt appeared to engage in over-introspection and excessive rumination, and to be vulnerable to chronic feelings of insecurity, inadequacy, and sensitivity to criticism. Socially, Matt exhibited a tendency to withdraw and be passive in relationships, a propensity that led to his needs for interpersonal closeness not being met. Further, he indicated often feeling misunderstood by others, distant, lonely, and plagued with social anxiety.

Related to these feelings, we noted that Matt failed to give any full human responses during the standardized Rorschach administration. The assessor subsequently gained more information about Matt's ability to perceive humans and human connection through testing the limits with Matt in this activity. In so doing, the assessor chose the two Rorschach cards in which the human form is most readily recognizable (III and VII) and said, "A lot of people see humans in this card. Do you see where the people might be?" When Matt immediately said that he recognized the human figures, the assessor had him identify each part of the human form he saw in the inkblot in order to ensure that he was, in fact, seeing the popular response. In the event that Matt had been unable to accurately identify the human figures in these blots, the assessor would have used a scaffolding technique to help him recognize these more common percepts. For example, saying: "Most people see this as a face. Can you show me the different parts of that face?" Matt's success in seeing humans on the extended inquiry suggested that his initial failure to report such percepts was not due to some serious deficit in interpersonal perception. Instead, Matt seemed to "leave out" these percepts to focus on non-human content. To us, this suggested that Matt's feelings of social isolation were very real and may have been triggering a tendency to exercise poor judgement in decision-making; additionally, his risk-taking activities (like drug use) were possibly an attempt to cope with his loneliness.

Extended inquiry can take different forms, depending on the assessment tool with which it (p. 402) is being used, as well as the nature of the parents' or adolescent's questions for the assessment. For example, it may be useful for the assessor to inquire about a client's experience of the performance IQ tasks as compared to the verbal IQ activities, or to ask about their feelings about the timed versus untimed academic tasks. With the MMPI-A, it is often helpful to look at the critical items and follow-up with the adolescent on any items that were endorsed. Typically, there are at least a few surprising responses. It is important to remember that adolescents can have a multitude of

reasons for endorsing a particular item, some of which may be more benign than they seem. These endorsements could be affecting elevations in the profile and it is important to fully understand the reasons underlying such responses. With the Rorschach, it can be useful to pose such queries as: "Does this response remind you of anything we've been talking about?" "Could you tell me a story about…?" or "If this monster could talk, what would he say?" (Handler, 2006). The assessor can also ask clients to review their own responses and identify those that have personal significance. When engaging in extended inquiry, it is important for the assessor to assure clients that the only intent is to understand why they endorsed certain items, or gave particular responses.

(p. 403) In garnering more information about clients' assessment data, the assessor can also "test the limits," which is a process that seeks to establish if clients can give a better performance, or more common test response when provided with additional resources (time, encouragement, help, etc.). While widely utilized in traditional assessment, "testing the limits" in TA is practiced with the intent of collaborating with, "scaffolding," or emotionally supporting clients in such a way that they more capably perform the task at hand. So, for example, a client who has significant test anxiety in her math class may, following standardized administration, be given unlimited time on an alternate form of some math subtests to see if that testing context ameliorates her stress response. Such exercises can give the assessor a sense of which contextual variables are related to clients' problematic behaviors, and which variables could be changed to help them improve their performance. It is important to note that the additional information that is gleaned through extended inquiry and testing the limits in no way alters the standardized scoring of the assessment measures; however, this additional data can be used to more comprehensively interpret and derive meaning from the assessment results.

Adolescent Intervention Session

In addition to what the adolescent may learn through the testing and exploration through extended inquiry methods, an important component of TA with adolescents is an individual intervention session that provides an opportunity for the adolescent and assessor to experientially work together to provoke a salient problem and enact a more adaptive solution. This *in vivo* experience can shed light upon the reasons for teenagers' problems in living and provide them with an alternate experience that is, in some way, corrective or healing. Although increases in self-knowledge and understanding are valuable, they are not synonymous with behavior change. Thus, facilitating such experiential learning increases the likelihood that the TA will have an enduring impact on clients' lives. Intervention sessions are highly complex, and, as such, are conducted with an eye to a multitude of smaller goals. The assessor is seeking to engage clients in:

(1) exploring hypotheses derived from the testing,
(2) understanding aspects of the assessment findings,
(3) heightening awareness of findings that would otherwise probably be rejected,
(4) experiencing a "living example" of an assessment finding,
(5) independently discovering assessment findings,
(6) testing out possible interventions for managing clients' problems in living and experiencing more adaptive solutions, and
(7) preparing for the summary/discussion sessions.

See Finn (2007) for a more complete explanation of the goals and techniques of individual assessment intervention sessions.

Given these ambitious goals, extensive planning is needed. First, the assessor needs a clear understanding of the adolescent's problem behaviors and how he or she names, understands, and experiences them. The assessor must also be capable of aiding clients in drawing connections to experiences outside of the assessment room; that is, conjointly extrapolating how these problematic behaviors present themselves in clients' daily lives. Furthermore, the assessor needs a hypothesis regarding the factors that are necessary and sufficient to produce the problem behaviors, and must be prepared to engage clients in an exploration of the context of their problems in living. Such contextual understanding is imperative to enlisting clients in imagining (and experiencing) solutions to their challenges. The assessor must also have some idea as to how contexts might be altered in order to elicit more adaptive strategies from clients. It is these collaboratively generated possible solutions, then, that are tested *in vivo*. It is the hope that as this exploration unfolds, the client will have a more positive experience and will exhibit more adaptive behavior. If not, the assessor must continually revise the possible solutions until clients experience

some success. Thus, adolescent intervention sessions can take a wide variety of forms, and are an opportunity for the assessor to be creative.

Case material.

The intervention session was introduced to Matt as an "experiment" during which he and the assessor would try to address some of his assessment questions in a more experiential way. As usual, the assessor assured Matt that his experience of the session would be discussed at the end, including how well the "experiment" had worked for him. As reviewed above, Matt had reported a tendency for his mind to "go blank" in various situations. Although this tendency may have been exacerbated in part by his diabetes, it was hypothesized on the basis of the standardized test findings that his "bottled up" emotions were "leaking out" at times, overwhelming his capacity to cope, and also contributing to this "blankness."

Thus, Matt's intervention session was planned as follows: he would begin the session by rating his "blankness" on a scale of 0 to 10, (with 0 being "totally blank/unable to express himself" and 10 being "completely clear/able to express himself perfectly"). Matt would then complete a memory-for-words task, followed by telling stories drawn from two to four thematic apperception test (TAT) cards. The first card was to be relatively benign in order to introduce him to the task, followed by progressively more emotionally evocative cards, with the intention of getting him emotionally aroused or "stirred up." In the event that his stories failed to be emotionally evocative, the assessor was going to prompt him to: "… tell a story that is emotional, sad, or worrisome in some way…." Following this exercise, Matt would again be asked to rate his "blankness" and would then be administered an alternate memory-for-words list. It was hypothesized that his performance would worsen (due to his emotional arousal), at which point the assessor would provide him with various emotional regulation strategies, such as mindfulness techniques and/or muscle tensing and relaxing exercises in order to ameliorate his "blankness." After working through these coping strategies, Matt would then be given a third form of memory-for-words, at which point, it was hoped, his performance would improve. Lastly, he would be asked one final time for a rating of his "blankness," after which he and the assessor would discuss the experience.

In spite of the careful attention that went into the design of this session, as sometimes happens with assessment interventions, it did not unfold as planned. In fact, Matt did only negligibly worse on the second administration of the memory-for-words list, indicating that either: (1) the TAT stories did not sufficiently emotionally arouse him, or (2) it was not his emotional arousal that was precipitating his "blankness." So, after some impromptu consultation with the other assessor and a supervisor, the primary assessor abandoned the plan for the session and instead transparently talked with Matt about what the hypothesis had been for the session, what his thoughts were about that hypothesis, and about his general experience of the session. The assessor also began to "trickle in" some feedback from the assessment data to see how accepting Matt would be of it.

Although Matt had previously informed the assessor that he tended to "bottle up" his negative emotions for fear that they would threaten his interpersonal relationships, he had a very strong reaction to the assessor's suggestion that he was experiencing any negative affect at all. This fit with Lisa's presentation, for whom, the assessment team slowly learned, it was important to tirelessly present herself as a positive and strong person. Matt similarly insisted that he was "basically a happy person" and worked very hard to keep his negative feelings to himself. The assessor validated Matt's "content" self-presentation, and recognized his work to keep his negative emotions "in check." However, the assessor also sought to normalize, accept, and help Matt acknowledge and "sit with" his painful affect. Subsequently, Matt relayed that he had just told his mother during the past week that he tended to not express any of his negative feelings, but, instead, bottled them up and held them inside. The assessor was then able to tie this disclosure back to what Matt had said in his first session about being able to "let go" when he smoked marijuana. He acknowledged that smoking "weed" was the only time his bottled-up feelings went away. By the end of the intervention session, Matt was able to "name" his negative feelings as "sadness, anger, and frustration." The assessor was then able to validate Matt's feelings and compliment him on his insightfulness, given that much of the assessment data indicated that he was experiencing just those kinds of feelings. Thus, this case illustrates that, even when adolescent intervention sessions do not go as planned, they may still serve to offer clients a corrective emotional experience and a more integrated view of themselves.

In Matt's next meeting with the assessor, before the start of the family intervention session, he shared that he was still struggling with some of the assessment findings that had been discussed the week before. He said that he had

thought a great deal about it, and he continued to believe that he did not exhibit any negative emotionality. In fact, he had talked with some friends about whether or not he came across as sad or angry, and they had confirmed that he did not. In response, the assessor validated that, in casual interaction, Matt did not come across as sad or angry. In that moment, Matt shared a realization that the activities he had completed throughout the assessment were not intended to get at the image he wanted to project, but at how he was really feeling. Compellingly, Matt was then able to recognize that he had "let out a little bit" of how he was really feeling in these activities. The assessor emphasized how much she appreciated and valued Matt's having shared himself with her. Matt was then able to disclose that he had told some of his friends about his negative emotions. The assessor then asked Matt if he had been satisfied with how his friends had responded to his inquiry about if he came across as sad or angry. He said that, while it felt good to be reassured that he did not come across as feeling mad or depressed, he had also wanted some of his friends to recognize his negative emotions, and was disappointed when they failed to do so. The assessor then talked with Matt about what it would be like for him to tell his friends that he sometimes wanted them to recognize and talk with him about his negative feelings. Matt seemed curious and open to undertaking this next step with his friends.

Once the adolescent has a new or more successful experience in the intervention session, the assessor then engages him or her in a discussion about how to implement and generalize the experienced solutions to life outside of the assessment room. In these discussions, it is also important for the assessor to consider and address the challenges that may be faced as adolescents attempt to broadly implement these new behaviors in their lives, as well as how these difficulties might be managed. The assessor then asks clients to report back at the following assessment session after they have reflected on the intervention experience, and have had the opportunity to try to apply it to contexts outside of the assessment. (p. 404)

(p. 405) Mid to Late Parent-Only Session

Following the completion of the adolescent testing and intervention sessions, another parent-only meeting typically is scheduled. The goals of this session are as follows:

(1) Continuing to build and develop the relationship with the parents,
(2) Collecting additional background information that may shed light on some of what is being gleaned from the adolescent,
(3) Assessing how the parents and family have been functioning since the start of the assessment, and
(4) Beginning to tentatively provide and discuss some of the initial assessment findings, including feedback from the parents' own assessment (e.g., the MMPI-2).

In preparing for this session, several considerations are useful in guiding decision making. First, the assessor needs to evaluate whether the adolescent can tolerate the assessor meeting individually with his or her parents at this late point in the assessment. As the adolescent and assessor have met privately for the past many sessions, it is understandable that he or she could have concerns about what might be shared with the parents at this point, as well as how the parents may respond to any information that is divulged. It is important to let the adolescent know the plan and goals for the parent meeting, as well as to review and discuss any concerns the adolescent may have. It is likely that the strong alliance and collaborative relationship that the assessor has developed with the adolescent, wherein respect for the teen's autonomy has been repeatedly demonstrated, will serve to allay any apprehension. If not, persistent concerns may be very useful in informing the remainder of the assessment.

Another question that is important to consider is, "Can the parents contain information without 'spilling it' to the adolescent?" This session usually involves "sprinkling in" some of the findings and assessing the parents' reactions in an effort to begin preparing them for the summary/discussion session. Therefore, if the assessor's experiences with the parents to date suggest that the parents would be highly reactive to a particular assessment finding, and would subsequently rush home and interrogate their child about his or her experience of this finding, the assessor would probably want to broach the topic conservatively at first. For example, the assessor might say: "I'm still bringing together and making meaning out of all of the assessment information, but one thing I wanted to do today is just get a little bit more information from you about the way you see John at home. Does it ever seem to you that he might feel a little sad or worried?" as opposed to, "The assessment information is indicating that John is severely depressed and anxious." If, however, the assessor judges that there are clear parental boundaries, and

that the parents are more prepared for a given assessment finding, the assessor may feel safe being (p. 406) less tentative. For example, the assessor may say: "Many of the assessment results suggest that John is struggling with some pretty significant feelings of sadness and worry right now. Does this fit for you? How have you seen this come across at home?"

Similarly, it is useful to explicitly consider the question, "What findings might be most difficult for the parents to accept?" As reviewed previously, such information can be conceptualized as "Level 3 feedback"—assessment findings that are highly incongruent with how parents see themselves, their family, or their adolescent. Often, parents are unwilling or unable to readily accept such information, due to fear, shame, or a conflicting worldview. It may be the case that testing supports parents' worst fears about their child or their family. Often, parents may recognize on some level that their worst fears are well within the realm of possibility. As such, they actually may be more ready to accept the information than the parents who do not articulate such a possibility. Regardless, considering this question allows the assessor to "test the waters" by beginning to share pieces of findings that are expected to be difficult for parents to integrate, in order to see how they are received.

Giving parents feedback at this time allows the assessor to see how readily the parents can absorb personal feedback, as well as if they express curiosity about how their personalities and parenting styles are affecting their adolescent. Again, parents' openness is likely to be an accurate gauge of how they will approach final feedback, and is indicative of their openness to recommendations that may be more systemic in nature (e.g., a referral for family therapy). The assessor should be alert to the possibility of resistance or negativity, as some parents may be recognizing the complementarity that exists between their parenting style and their adolescent's challenges for the first time. Some parents may be relieved to have this insight, while others may be overwhelmed, initially dismissing the information, or responding with feelings of guilt and shame. In our experience, within the context of a strong collaborative relationship, the assessor can accept the parent's reaction and work with it in ways that offer potential for change.

Case material.

The assessment team began the session by checking in with Lisa about her week and asking if she had noticed any changes in Matt since the beginning of the assessment. She said that he had been more motivated to complete his schoolwork and had not, to her knowledge, used any illegal substances. She also reported a recent fight that she had had with her son wherein Matt had yelled at her, which he had never done before. Interestingly, Matt had just shared with the assessor that he was fearful of exhibiting any negative affect due to his belief that such expression would estrange his friends and family. The assessment team then inquired about how much Matt had shared with Lisa so far about his testing experiences. She said that typically they discussed the assessment only minimally, but that, in the last week, he had brought up his intervention session twice. As he did with some friends, Matt also told Lisa that he had been surprised to hear that the testing indicated that he was experiencing some sadness and worry. Lisa reported that she, similarly to Matt's friends, had assured Matt that she did not view him as being sad or worried. As Lisa relayed this story, it did not seem that she had entertained the possibility that Matt might have been checking in with her about this emotionally laden feedback to see if she could "handle" his being depressed or anxious. If only subtly, it appeared that Lisa had communicated that, in fact, she could not accept it.

The assessment team then reviewed Lisa's MMPI-2 feedback with her, sharing that her profile suggested that she was resilient, strong, optimistic, and a "superwoman." Lisa readily agreed with this feedback and related it to her life experiences. She said that, rather than viewing the trials and tribulations of life as hard, they were "just what life gave her." She further said that she has no need to "wallow"; problems just need to be fixed. She frequently referred to the metaphor that "sometimes you bite off more than you can chew, but you just have to chew faster." While she ultimately acknowledged that "everybody crawls into bed and cries for a half hour sometimes," she said that Peter, her long-term boyfriend, was the only person in her life who had seen her "break down." Lisa then said that, when she is upset, the best way for her to feel better was to help others, and that, in facing obstacles, thought and action are better than emotion. Lisa was able to discuss some of the negative aspects of her personality style as well. She acknowledged that she tried to avoid confrontation "at all costs." Similarly to Matt, Lisa said that she feared that, if she confronted others, they would get angry and leave her.

When the assessment team asked Lisa if she viewed Matt as having this same coping style, she readily recognized that he did not, at which point the assessment team validated this, but also emphasized that it often seemed that

Matt tried to be this way. Lisa was then able to acknowledge that he may have learned this coping style from her. At this point, the assessment team began to "trickle in" the sadness and worry evidenced in Matt's testing responses. Lisa was able to appreciate that Matt's outside presentation might be different from his internal experiences. The assessment team then addressed Lisa's worst fear, assuring her that nowhere in Matt's testing was there any indication of suicidal ideation. Upon hearing this, Lisa was visibly relieved and said, "If he's sad, we can fix it." She then wanted to know what, specifically, was triggering Matt's negative emotional experiences. While the assessment team acknowledged that there was no way of knowing definitively, these feelings appeared to be long-standing and may have been related to issues like Matt's feelings of loss related to his relationship with his biological father, as well as to his chronic struggle with diabetes.

Lisa then began to talk about how Matt often said that he did not have friends, or had a hard time making friends. In response, Lisa reported that she told him that he did have friends and that he did make friends well. Similarly, Lisa brought up how Matt had only recently shared with her that he had been struggling with some long-standing sleep disturbance. In response, Lisa relayed that she promptly tried to "fix it" by bringing several sleep CDs home the following day. When the assessment team inquired about Matt's response to Lisa's problem-solving and "wondered aloud" if this was always what he needed, Lisa was able to recognize that Matt might not always want her to immediately try to fix things, but may just want her to empathize or to try to understand how he is feeling. The assessment team ended on a positive note, praising Lisa for her insights and telling her of Matt's many strengths, as well as what a pleasure it had been to work with him. Nonetheless, it became clear in this session that it would be important to integrate Lisa's tendency to gloss over Matt's emotionality by entering "problem-solving mode" into the family intervention session: Matt needed to have the corrective emotional experience of having his mother "sitting with him" in his sad and worried feelings in order to learn that such emotionality was acceptable and not shameful. Also, unless he could get this kind of support from his mother and others, he was destined to find other ways (e.g., drugs) to manage his negative emotions.

Lastly, it is important for the assessor to be thinking about what can be learned in this session that would help in planning the family intervention session, which is coming up next. For example, if it is expected that parents are going to be highly resistant to a major finding of the assessment, it may be extremely useful to design the upcoming family intervention session around that finding (and the related assessment question), given that parents are likely to be more open to receiving unsettling feedback if they have recently experienced it *in vivo* with the emotional support of the assessor.

(p. 407) Family Intervention Session

Just as is the case in adolescent intervention sessions, the overarching goal of family intervention sessions is for the assessor to create an *in vivo* experience that allows the clients to grasp a systemic formulation of the youth's presenting problems (Tharinger et al., 2008). In family intervention sessions, the assessor has the opportunity to meet with the adolescent and family together, and, in so doing, can gain rich information about these interpersonal relationships. The family context is vastly influential to teenagers' development; as such, the assessor may gain some insight into the ways in which family dynamics contribute to adolescents' struggles, as well as any distortions adolescent clients may have about other family members. Working within the family context, the assessor is able to form and test systemic hypotheses. Simultaneously, the assessor encourages parents to develop more systemic views of their child's challenges, and experiment with potential solutions. Just as in adolescent intervention sessions, in family intervention sessions, the assessor seeks to give the family a positive, healing, and successful experience of managing family challenges. The development of a systemic perspective on adolescents' problems helps both teenagers and parents feel less blamed and more hopeful about managing (p. 408) problems conjointly, thus fostering more positive family relationships.

Common Techniques Used in Family Intervention Sessions

There is a wide array of possible activities to consider when designing family intervention sessions (see Tharinger et al., 2008). We have found the Consensus TAT or the Consensus Rorschach to be especially useful in family sessions with adolescents. Family members are asked to work together to develop a story or a response to each stimulus card about which they all agree. They are to talk through the development of these responses aloud. These techniques, then, involve using projective assessment materials in a non-standardized way to help the

family observe their own processes and interactions when completing a novel task (rather than obtaining responses that can be scored).

Questions to Consider in Planning the Family Intervention Session

Planning family intervention sessions can be quite complex. We have developed questions that are useful in the planning process. First, *Whom should I invite to attend?* Generally, it is desirable for all family members who reside in the adolescents' household to participate in this session. It may also be useful for family members who play a significant role in adolescents' lives, but do not live with the teenager, to participate as well. Sometimes, when parents are separated or divorced, it is necessary to have separate intervention sessions for each parent, including the adolescent in each. Also, if one wishes to target particular aspects of the family's functioning, one may restrict the session to only certain family members. Second, *What do I most want the parents to learn?* Ideally, in family intervention sessions, parents become aware of how they contribute to their child's problems through experiencing the way in which *their own behavior change* (in the area that is problematic for the teenager) ameliorates their child's challenges. Third, *What do I most want the adolescent to learn?* It is hoped that through participating in the family intervention session, teenagers will come to recognize that their parents are willing and able to help them with their difficulties, and that they do not have to "go it alone" in managing their problems in living. Also, teenagers may come to see how their own behavior elicits certain responses in their parents, and consider the possibility of acting differently. Fourth, *What are the most important assessment questions?* Often the answer to this question readily comes to light throughout the course of the assessment. It may be that the most central assessment questions are those related to the issues that are creating the most distress in the adolescents' lives, those that are most systemically rooted, or those that are most amenable to change.

Another important question is, *How does the system work to create and maintain the adolescent/family problems?* Again, the answer to this question may become clear during the course of the assessment. If not, it is likely to become apparent as the family intervention session unfolds. It is often the case that a youth's problem behavior is symptomatic of a larger, systemic issue. For example, the adolescent's difficulties may be masking marital conflict, or the adolescent's depression might be distracting from a parent's own mental health challenges. Therefore, the moment the parents begin to fight, or a father's depressive symptoms begin to be unearthed, the adolescent's motivation to maintain his or her problematic behavior is powerfully renewed. The assessor must be very sensitive to these possibilities throughout the course of the assessment, as well as in planning for, and facilitating, the family intervention session. Another important question is, *What are more adaptive solutions?* It is hoped that through participating in the assessment and experiencing the family intervention session, adolescents learn that they are not responsible for shielding their parents from their own, "adult" problems in living; that, in fact, parents are capable of managing their own challenges *and* helping their children with theirs. Assessors further seek to ensure that families have a different, and more positive, experience in the family intervention session than they typically enact at home, allowing them to recognize that they can create this more adaptive solution conjointly.

It is also important to consider, *How much intensity can the family handle?* Family intervention sessions can be very intense (see Tharinger et al., 2008). Family patterns are often quite resistant to change; therefore, the experience of altering ingrained systemic patterns can be quite powerful. When adolescents' challenges are symptomatic of a larger, systemic issue, illuminating the "real" problem (such as the parents' marital conflict or a father's depression) can be highly threatening because the family is being stripped of the coping mechanism they were using to manage those difficulties, which are now exposed and vulnerable. (p. 409) As such, assessors must carefully monitor the way family intervention sessions unfold, assessing each family member's response to it and tolerance for the experience. In the event that one or more family member appears "flooded," the assessor may pull back from the plan for the session and/or enlist an appropriate family member to support the distressed loved one. Seeing this interaction, then, can provide the assessor, and the family, with additional information from which to derive understanding and meaning. Most importantly, the assessor must provide the family with an alternate and more adaptive way in which to manage their problems.

It is always a good idea when planning this session to ask, *What could go wrong?* Just as in adolescent intervention sessions, family intervention sessions sometimes do not go as planned. For example, one or more family members may become overwhelmed; parents may demonstrate an unwillingness to alter their behavior in any way in order to better support their child; and the adolescent could be resistant to accepting a parent's new behavior, thus

discouraging the parent from pursuing the more adaptive solution. Alternatively, family members may create an experience that is different from the one the assessor was planning, but one that is beneficial nonetheless. Such challenges and detours often cannot be anticipated fully. So the assessor must be adaptable, spontaneous, creative, and attuned to the family's experience and needs as the session unfolds.

Summary/Discussion Session with Adolescent

Case material.

In the family intervention session with Matt and Lisa, the assessment team presented this mother and son with two thematic apperception test cards and one adolescent apperception test card, in turn. The pair was instructed to conjointly develop a story to each card, which they subsequently shared with the assessors. The assessment team introduced this consensus story telling task as being directly related to Lisa's assessment question concerning whether or not she was communicating with her son in the "right way." In planning for the session, it was hypothesized that Matt would contribute sad content to the stories, and that Lisa would cheerily transform these themes into happy endings.

Prior to the start of the session, while checking in one-on-one with the parent assessment team member, Lisa indicated that she had thought a great deal about the feedback provided to her in the previous sessions, and shared her fear that her positive, optimistic coping style was making it difficult for her son to share any sad feelings he was experiencing with her. She relayed that, because Matt continually saw her engaging in active and positively framed problem solving, he might feel that he, too, had to be this way. She wondered if this personality difference was precipitating some of their communication problems. Matt similarly shared with the adolescent assessment team member while meeting one-on-one that, when he was feeling down, another's extreme happiness and positivity made him feel not understood, and ultimately worse, while having someone "sit with him" in his negative emotion led to his feeling more understood and, ultimately, better.

While executing the intervention task, Matt and his mother generally worked well together; they were receptive to one another's ideas, and Lisa asked for Matt's opinion frequently as they developed their conjoint stories. As was anticipated, however, Lisa did attempt to positively reframe any negativity Matt brought into their stories. When she was able to preserve themes of negative emotionality, she consistently attributed these bad feelings to a neutral source ("They're just mad because it's raining"), or gave the option of a neutral feeling rather than a negative emotion ("Do you think he's lonely, or just hungry?"). In response to the most emotionally evocative card in the intervention activity (which came third), Lisa took the lead in telling a very humorous story that kept her and Matt laughing. Interestingly, Lisa was aware of the fact that Matt had created a very sad story in response to this same card in his individual intervention session. Both she and Matt commented on the fact that her story was much less emotional than his had been. The assessment team then asked what kind of story Matt and Lisa thought most people told in response to this particular card. Matt acknowledged that most people probably told a sad story. The assessment team then asked Matt and Lisa to tell a story that was more similar to what they thought most people would tell. Again, Lisa appeared to shy away from negative emotionality through making jokes or attributing any negativity to neutral sources like having to "work in the fields." The assessment team then made the observation that it seemed much easier for Matt and Lisa to talk about the details of chores, for example, than a story character's feelings of loneliness. The assessment team went on to ask Matt and Lisa if the dynamics of this interaction related to their lives at all (with respect to it being more difficult for them to discuss negative emotions).

Ultimately, Matt was able to state that he thought "normal" people are supposed to be happy all the time, and that this was the way his mom acted. In response, the assessment team validated that Matt felt like an outsider when he had feelings that were not happy, and that it was really hard work for him to keep all of his negative emotions "bottled up." Lisa was then able to share with Matt that she did, in fact, get sad. She powerfully stated that, often, when she took a bubble bath in the evenings, it was because she had had a difficult day and she needed to cry. Matt said that he was surprised to hear this, but promptly shared with his mom that his equivalent is going to his room, turning off the lights, and listening to music. Lisa then explained that, while she wanted to protect Matt from her negative emotional experiences, she wanted him to feel free to share any negative feelings he had with her.

However, even after these powerful exchanges, there continued to be occasions throughout the remainder of the session wherein Lisa would try to put a positive spin on Matt's emotions and/or where she would enter "problem-

solving mode," glossing over Matt's negative feelings. These occasions presented opportunities for the assessment team to model acknowledging and validating Matt's feelings, and to explain to Lisa that, while her inclination to comfort or problem solve for her son was very natural, it was not what he needed in order to feel heard and understood. In an effort to emphasize this point, the assessment team then asked Matt if he preferred it when his mom entered "problem-solving mode," or when she just listened and tried to understand his feelings. He said that, while it was "okay" when his mom tried to help him solve his problems, it felt better when she just listened and tried to understand how he was feeling. The resolution of the session was for Matt and Lisa to work together to "catch" Lisa when she entered problem-solving mode, and for Matt to tell her when he just needed her to listen. This family intervention session was central to creating a breakthrough experience for this mother and son. While they were both beginning to recognize their personality differences and how these dissimilarities affected their relationship, openly discussing and experiencing these differences in a concrete way opened the door to positive change for this family system.

TAs with adolescents culminate in summary/discussion sessions; the assessor first has a session with the adolescent alone, and subsequently a session with the adolescent's parents, preferably that same day or a day or two after. Sometimes adolescents are invited to this latter meeting, and sometimes, even if invited, the adolescent declines to (p. 410) participate. It usually is fairly clear from the topics to be discussed with the parents whether it is appropriate for the adolescent to attend the parental feedback. The goals of the adolescent summary/discussion session are:

(1) to answer adolescents' assessment questions and increase their self-knowledge;
(2) to present a more accurate/compassionate story through which to understand the adolescents' problems in living—for example, that they are depressed rather than being "lazy and unmotivated";
(3) to provide adolescents with the experience of being understood in an emotionally supportive environment;
(4) to promote systemic and contextual thinking rather than focusing on the adolescents in isolation; and
(5) to promote abstract thinking, which is developmentally appropriate, given adolescents' burgeoning cognitive capacities.

Lastly, it is important to note that adolescents are typically given individual feedback prior to their parents in an effort to promote individuation, which is also developmentally appropriate.

Ideally, by the time the assessor reaches this stage of a TA, all of the most poignant assessment findings have already been discussed with, or experienced by, the client. Nonetheless, this may not always be the case; it is also quite possible that even when (p. 411) the assessor has "trickled" certain findings into clients' sessions, they have been resisted in some way. Finally, even when each finding has been discussed in isolation, it is often a different experience for the client when the assessor "puts the pieces together" to form a whole picture, so summary/discussion sessions must be carefully planned.

First, the adolescent's questions must be considered. Reviewing teenagers' assessment questions often sheds light on what they are ready to hear. However, this consideration must also be attended to with all of the major assessment findings. Furthermore, it is important to note that what adolescents are open to hearing does not always map onto what their parents are prepared to hear. Therefore, the information that is shared with teenagers must, at times, be tailored according to what their parents are judged to be capable of taking in. In considering this, it is helpful to bear in mind how differentiated the adolescent seems to be from his or her parents. Regardless, it is important that assessors not put adolescents in the position of harboring "secret information" from their parents.

Similarly, the assessor must carefully consider what the adolescent's worst fears are and how much information the teenager can handle without becoming overwhelmed, as well as how the adolescent tends to behave when he or she is overwhelmed. In preparing for this session, the assessor also needs to carefully consider what language is accessible to the adolescent and how the various assessment findings can be presented in a way that is meaningful for the teenager. Finally, it is imperative that the assessor be mindful of incorporating knowledge of the adolescent's strengths into the feedback in addition to data related to their areas of difficulty. In so doing, however, the assessor must prepare for the fact that such strengths-based information must be sensitively delivered if it conflicts with the teenager's self-perception. For example, an adolescent who views herself as being "stupid" may be rejecting of feedback from the assessor that her cognitive abilities are higher than those of 87 percent of her

peers; such information is likely to be Level 3 information and must be prepared accordingly.

Conducting the Summary/Discussion Session with the Adolescent

Case material.

Matt was highly receptive to all of the assessment information. Following his experience in his individual intervention session, as well as in the family intervention session with his mother, all of the assessment findings going into the summary/discussion session were conceptualized as being Level 1 or Level 2 information. Given that his questions were congruent with the assessment results in many ways, the assessor began Matt's feedback session with a discussion of his assessment questions. In fact, while reviewing Matt's assessment questions, the assessor was able to cover nearly all of the assessment findings, and was also able to integrate a discussion of what would be shared with Lisa given her assessment questions (which also fit very well with the findings and with Matt's questions for the assessment). Matt was consistently able to expand on the assessor's presentation of the assessment results by discussing how they related to his experience in the assessment, as well as to his broader life experiences.

In beginning summary/discussion sessions with adolescents, it is often useful to review the purpose of the session. The assessor may then want to check in with teenagers about anything they feel anxious or worried about in beginning the session, or if there is any particular information they would prefer to review first. The assessor can then choose to begin with a discussion of assessment results as they relate to teenagers' assessment questions, or to summarize the assessment information first, followed by a review of "answers" to adolescents' assessment questions. The former format is typically preferable when the assessment information maps well onto the assessment questions; the latter approach may be better when the teenagers' questions differ significantly from the findings of the assessment. Regardless of the order in which the assessor presents the assessment results, it is crucial that teenagers' are continually asked for confirmation, examples, and any disagreements they have as findings are reviewed. Additionally, throughout the session, the assessor needs to stay carefully attuned to the teen's reactions to the assessment information. If the adolescent appears overwhelmed at any time, the assessor needs to "back off" and provide emotional support. Once all of the feedback is reviewed, it is nice for the assessor to end with something he or she appreciates about, or has learned from the adolescent. (p. 412) Prior to ending the session, it is also quite useful to review with teenagers what will be said to their parents at their upcoming summary/discussion session, and address if the adolescent will be invited to attend. Once this has been decided, the assessor should specify if there will be future contacts, such as a follow-up session in several months.

Summary/Discussion Session with Parents

This is the final session of the TA process, with the exception of a follow-up that may be scheduled several months later. This meeting follows shortly after the summary/discussion session with the adolescent only. As mentioned earlier, often parents attend without the adolescent, but in some cases the decision is made to include the teenager. Although this is the culminating session of the TA (and in traditional assessment would be where parents are first informed about the findings), paradoxically, if all has gone well in earlier sessions, much of the information in the parents' summary/discussion sessions has already been shared. This meeting, then, can be viewed as "icing on the cake," tying together all of the pieces of the assessment experience, and looking forward to next steps. This is not to underestimate the potential impact of these sessions, however. For, even if all the pieces have been shared previously, it often is very powerful for parents to hear them put together into a coherent story.

The major goal of this session is to answer the questions the parents have posed for the assessment. Adhering to the collaborative underpinnings of the TA method, the assessor seeks parents' continued input throughout the session and strives to provide them with continued emotional support and an experience of being understood. This alliance, which has been developed throughout the course of the assessment, provides the framework that allows parents to continue to absorb the findings from the assessment, and to consider their role in resolving their adolescent's challenges. Just as is the case with adolescents, it is imperative that the assessor conceptualize and organize feedback to the parents according to the "Level" system described previously.

As the assessor addresses the parents' questions in this thoughtful manner, he or she is offering a more accurate and compassionate story about the teen that serves to reframe the parents' thinking and adjust their earlier

misunderstandings or distortions without overwhelming or "flooding" them. In most cases, the new story is systemically framed, serving to help the parents view their adolescent within the context of the family, its history, and how that has impacted their son's or daughter's development. An implicit aim is to encourage systemic rather than individual change (i.e., it is the family's obligation to work together to develop and enact solutions rather than it being the adolescent's job to change in isolation). Lastly, this session is geared towards promoting differentiation within the family, supporting the growing autonomy of the adolescent, and empowering him or her within the connectivity of the family unit; this is, in many ways, the heart of the adolescent TA model.

We have found that in-depth planning is essential for an effective summary/discussion session with parents. While reviewing the parents' questions in light of the assessment findings, the assessor is well served by considering what the parents seem ready to hear, what their worst fears are, and how much information they can handle at this time. These considerations about parents' readiness for various findings very much shape the plan for this session. The success of the mid to late parent-only session, where initial, tentative feedback was provided (in some cases from both from the adolescent's and the parents' test findings) is probably a useful gauge in anticipating the pace and depth of the summary/discussion session. It is also useful to review how the parents have responded in the past when they become psychologically overwhelmed, and to build this knowledge into planning for this session. Assessors also need to review what was told to the adolescent in his or her feedback session, how enmeshed or triangulated the parents are with their child, and whether it would be beneficial for the teenager to attend this session. As discussed below, adjustments are made to the session if the adolescent participates.

Conducting the Summary/Discussion Session with the Parents

We recommend that the assessor begin the session by acknowledging that feedback meetings can be anxiety-producing, and checking in with the parents about their emotional state prior to starting the session. It is then a good idea to review the plan for the session, including explaining what will happen, and encouraging questions and collaboration. Before beginning the discussion of findings, we suggest that the assessor thank the parents for participating in the assessment, and in particular acknowledge any factors that may have been especially difficult for the parents. It can be very helpful at this point to show some empathy for the parents' struggles with or confusion (p. 413) about their child, perhaps by acknowledging that the assessor also struggled in putting all the pieces together, as their child is complex, and a thorough assessment was needed for understanding to be reached. The assessor then moves into answering the parents' assessment questions. In some cases (as is the case with giving adolescents feedback), it may be useful to provide an overview of the findings before moving into addressing the parents' questions. Regardless, because the assessor cannot accurately predict all of the parents' reactions to the feedback, parents' responses must be carefully monitored as the session unfolds. If parents appear to be experiencing overwhelming emotions, the assessor must modify the plan for the session and stop to provide emotional support whenever necessary.

In the event that parents disagree with the assessor about any assessment findings, it is imperative that the he or she avoid arguing with parents, and instead encourage them to share their own perspective. If necessary, the assessor can "agree to disagree" with the parents. Although recommendations may have been offered throughout the session, all recommendations are summarized at the end of the session. The parents are encouraged to discuss how feasible the recommendations may be, and whether they have any questions or concerns about how to implement them. The assessor then thanks the parents again, and shares genuine sentiments about what he or she appreciated about being involved with the family. Finally, just as was done with the adolescent, the assessor clarifies if there will be future contacts, such as a follow-up session within a few months.

There are some variations to this summary/discussion session if the adolescent does or does not attend, and advantages to each. If the adolescent does *not* attend, one additional step early in the session is to summarize the feedback session with the adolescent, being careful to respect the confidentiality afforded the adolescent. The assessor may ask the parents if their child shared anything with them from the earlier summary/discussion session, and what they took away from that discussion. In addition, if the adolescent does not attend, it is important that the assessor discuss with the parents what to say to their adolescent after their summary/discussion session. It is often beneficial for the parents to talk more fully and openly with their child about integrating and making meaning out of the assessment findings; if this is the case, the assessor should encourage and scaffold such a discussion. If it appears that the parents are uncomfortable with the idea of independently broaching this topic, the assessor can offer a family session to help with the integration of the assessment findings and recommendations.

Case material.

Matt was invited to, and did attend, Lisa's summary/discussion session. This decision seemed appropriate, given that much of Lisa's feedback overlapped significantly with Matt's, and that a goal was to enhance their communication with each other. We noted that Matt seemed quieter and less active in this session than he had been in his individual session. Lisa seemed very well prepared to hear and take in all of the findings, as they had been shared with her in her second parent-only session and reviewed both verbally and experientially in the family intervention session. Thus, the session went very smoothly. Lisa readily related the assessment findings to their lives, and demonstrated great openness to reflecting on how her personality and coping style had contributed to Matt's challenges; she exhibited notable readiness for change.

If the adolescent *does* attend the session, it is often useful to empower the teenager to summarize his or her understanding of the test findings; if they so choose, they may also share information that relates to their private assessment questions at this time. Subsequently, as the assessor reviews the findings in relation to the parents' questions, probably in more depth, everyone in attendance has the opportunity to work collaboratively with their own understandings of the assessment findings, and to express their respective views of how to proceed. Thus, when the adolescent is in attendance at this final session, it becomes an amalgamation of feedback and family therapy, wherein healthy family interactions are facilitated. With some families, this model will prove to be very effective; in others, it is overly ambitious, asking the family to take too many steps at once. Thus it is important to carefully weigh the potential costs and benefits of including the adolescent. It is also useful to note that the adolescent himself or herself may have insight into (p. 414) the appropriateness of attending (the teen may adamantly refuse to join the session, or, alternatively, may push to be present); the adolescent's wishes should carefully be considered.

Written Feedback for Adolescents and Parents

Case material.

Here is an excerpt from our letter to Matt:

"'Why did I take Adderall the second time without weighing the pros and the cons?' First of all, it's normal in adolescence to experiment with lots of different kinds of new things, and sometimes drugs are a part of that experimentation. But, with you, it seems like the way you have used drugs has been a little bit different—the testing we did together showed that you're feeling quite a bit of stress right now that's overwhelming your coping resources (this makes a lot of sense given everything you're dealing with—school feels harder this year, your diabetes, your dad, not being at the same school as your closest friends … each one of those things is a lot, Matt—let alone all of them together).

"I know we talked a lot about how your mind goes blank sometimes—this 'blankness' is sometimes called 'dissociation' and may be related to being overwhelmed by feelings. This seems to happen to you more than it does to other people your age. When people feel overwhelmed like this, they sometimes don't have as much self-control, or are more impulsive in their decisions and behaviors (they don't carefully weigh pros and cons). It seems like trying different kinds of drugs is kind of an escape for you—it's a way to let go of all of the hard feelings you're trying to keep bottled-up inside. This fits with an item you marked on [the MMPI-A] when you responded 'false' to 'talking over problems and worries with someone is often more helpful than taking drugs or medicines.' It seems like escaping your bad feelings might be more important than facing the consequences for experimenting with drugs. It might be that the more you are able to talk about and express the negative feelings you're bottling up, the less overwhelmed you'll feel and the less you'll need to escape them with drugs like Adderall."

And here is an excerpt from Lisa's letter:

"'Am I communicating to him in the right way?' We could really see how important open communication has been for you and that you have always felt close to Matt. A part of adolescence is trying to find some independence and autonomy. As a result, teenagers often distance themselves more from their parents and start to become closer to their peers. We think that some of this shift in communication is a natural part of growing up. However, there may also be some other reasons why your communication has slowed down.

"It is really evident how much you care about Matt, are concerned about him, and want him to be happy. One of the ways in which parents tend to show this to their kids is to try to reassure them that 'everything will be ok.' Just like we talked about, this is a completely natural reaction to when children seem worried or upset, and it is important to show them that they are safe. However, sometimes teenagers need to know that adults understand how they are feeling. We think that some of Matt's behaviors, like the drug use, may be his way of trying to let people know what is going on with him. It's really important for teenagers that other people see how they are feeling, acknowledge it, and let them know that it isn't wrong to feel that way.

"Like we discussed in the family session, sometimes adolescents need to feel 'mirrored' and understood in their emotions. This helps them know that people understand them and see when they are in distress. It also lets them know that they are not 'bad' for having certain feelings. When adults communicate to teenagers that they see how they are feeling, and accept it, teenagers feel safer, more hopeful, and more protected. Just like you described that everyone sometimes need to cry and express negative emotions, Matt sometimes needs your help in doing this. Sometimes he may just need for you to let him be upset and talk about these emotions instead of having you try to 'fix it' right away. You did a great job doing this during the family session. It was really nice to see you listen to Matt as he admitted that sometimes he feels sad, and to open up to him about the feelings of sadness you experience sometimes. I think it was really important for him to learn that it is normal not to be happy all of the time. As we saw, this really made Matt feel better. Sometimes, all it takes to work through hard feelings is to have someone you love really listen to you.

"We know that this is very different from how you tend to approach problems. Like we discussed, your testing results showed that you are a very resilient, strong, and optimistic person. While you do allow yourself to be emotional at times, you tend to approach problems as things to overcome. However, you noted that Matt doesn't seem to have this same approach. You were really perceptive to notice that there may be aspects of your way of communicating and your coping style that might be preventing Matt from being open with you. As he shared, you being more open and willing to 'sit' with his painful emotions makes him want to communicate more with you."

It is customary in TA with adolescents to compose a letter for the teenager that closely follows the presentation of their summary/discussion session, usually organized around his or her assessment questions. The letter is written in the first person with colloquial language and active voice, and incorporates comments, examples, or even disagreements that the adolescent offered during the summary/discussion session. The written feedback to parents typically follows a similar framework; that is, a letter is written rather than a traditionally organized psychological report (Finn, 2007). However, a formal report may also be provided if it is needed for other purposes, such as documenting a diagnosis or a disability for school accommodations. As the format of the letters is typically very similar to the organization of oral feedback, the preparation time put into the oral feedback pays off greatly when it comes to producing the letter. The letters are typically mailed, and the adolescent receives a copy of both his or her letter and the parent letter, while the parents receive only their letter. As is often the case with teenagers' private feedback, in our experience, many adolescents also end up sharing their letter with their parents.

(p. 415) Follow-up Session

Case material.

Matt and his mom returned for a follow-up session approximately 10 weeks after the final summary/discussion session, which coincided with the end of Matt's summer vacation. Matt's summer had been divided into spending a few weeks with his grandparents, a few weeks at camp, and a few weeks at home with his mother. Matt indicated feeling that the assessment had facilitated some changes for him and his mom. He said that he was talking about his difficult feelings more with a friend. He also acknowledged that, although his mother still almost always acted happy, it continued to be comforting to him to know that, underneath, she, too, struggled with some hard feelings. Matt also relayed that he better understood his academic and cognitive strengths and weaknesses as a result of the assessment, which was helpful given that he was about to enter high school. He also revealed more about his drug use that occurred prior to the assessment, and proudly described how he had recently resisted the opportunity to use various drugs. Matt also said he was using new coping methods to manage his negative emotionality, including writing and planning a community volunteer project. Lisa shared that she felt as though Matt had seemed more confident and more mature over the summer, and that Matt had commented on feeling more

mature as well. Lisa also shared that she had made an effort to approach their interactions differently, and provided an example that supported her assertion.

If possible, it is highly recommended that a follow-up session occur one to three months after the TA has been completed with the adolescent and his or her parents. The assessor typically meets with the parents and the adolescent to discuss any progress the teen and family have made, as well as any difficulties they have encountered. Thus, the assessor has the opportunity to explore with the family any factors that may be promoting or hindering their progress, as well as to answer any questions that have arisen for the parents and/or the adolescent since the conclusion of the assessment. In the event that the family is experiencing some ongoing challenges, the assessor can assist the family in problem solving any difficulties that may be interfering with the implementation of recommendations. New events in the family's life, both positive and negative, may also be (p. 416) explored as to their impact on the adolescent and the family. In our experience, it is often most useful to divide the session into three parts: individual check-ins with the parents and adolescent, followed by a joint meeting with everyone.

Evaluating the Effectiveness of TA in Clinical Practice and Research

We recommend that assessors using TA in their practices systematically and efficiently collect information to help gauge the effectiveness of TA as an assessment process and as an intervention. The process can be as simple as asking the parents and adolescent to complete a short, open-ended satisfaction measure at the conclusion of the assessment, accompanied by some standard items that can be rated on a numerical scale. For example, clients can be asked to describe how the process was for them and then rate how well their assessment questions were addressed. This information can aid the clinician in becoming more effective at TA, and can help the clients know that their input—their collaboration in the process—is honored through to the end.

Case material.

We were very pleased to see the research findings on this case. At pre-testing on the BASC-2, Matt had rated various clinical scales in the clinical range (Anxiety, Depression, Sense of Inadequacy, Internalizing Problems, and Emotional Symptoms Index). None of these scales was in the clinical range at post-testing, and the decrease across the previously elevated scales averaged a full standard deviation (e.g., Depression, 75 to 59; Anxiety, 73 to 62; Sense of Inadequacy, 79 to 69). Matt also evidenced much improvement on the adaptive scales of the BASC-2. His score on the Self-Esteem scale improved over one standard deviation (21 to 37); similarly, his score on the Interpersonal Relations scale increased almost one standard deviation (43 to 51). His overall Personal Adjustment score went from 34 to 43. On another measure developed for TAP, Matt reported a large decrease in his negative affect related to his future. Matt also indicated that his assessment questions had been addressed well.

Lisa's data told a bit of a different story, yet they fit well with her process throughout the TA. At pre-testing on the BASC-2, all of her ratings of Matt on both the clinical and adaptive scales were in the "normal" range. At post-testing, she rated Matt in the "at risk" range on the Anxiety scale (from 57 to 65), and noted improvement on Functional Communication scale (from 43 to 50). All other scales were in the normal range at post-testing. On another measure developed for TAP, Lisa also noted a substantial decrease in her negative feelings about Matt's future, as well as an increase in her positive feelings. Lisa reported feeling that her assessment questions had been extremely well addressed. On the PEAS, Lisa averaged a 4.5 out of 5.0 across the six scales, indicating a very high sense of satisfaction with the process and outcome of the TA. More specifically, Lisa indicated a 4.8 on the Collaboration subscale, a 4.9 on the Relationship between Assessor and Parent subscale, a 4.8 on the Relationship between Assessor and Child subscale, a 4.4 on the Learned New Things subscale, a 5.0 on the Feelings subscale, and a 3.8 on the Family Involvement subscale. Finally, on a measure of family functioning, both Matt and Lisa reported an increase in family cohesion.

In summary, both Matt and Lisa indicated high satisfaction with the TA and an enhanced sense of hope for the future. Matt perceived his internalizing symptoms as having decreased significantly, and his self-esteem and relationships with others as having improved greatly over the course of the TA. Lisa demonstrated a change in her "story" about her child that is illustrative of one of the primary goals of TAs conducted with youth and their families. Instead of minimizing or denying her son's distress (as she did before the TA began), at the end she was able to

acknowledge his anxiety. She also perceived an enhanced parent–child relationship, which fit our observations. We certainly felt that our goals had been met in helping this family.

In addition, TAP is in the process of developing measures that can be utilized to assess the process of and satisfaction with psychological assessment. At this point, the Parents' Experience of Assessment Survey (PEAS; Finn, Tharinger, & Austin, 2008) has been developed, and is undergoing further study to address its length and psychometric properties. The PEAS has six subscales: Collaboration, Learning, Feelings about the Assessment, Assessor–Child Relationship, Assessor–Parent Relationship, and Family Involvement, and is filled out by parents at the end of their children's psychological assessments. (p. 417) Similar instruments for children and for adolescents are also in development.

In TAP, as mentioned earlier, we are researching the processes and outcomes of TA with children and adolescents. We have focused on pre- and post-change in child symptomatology, family functioning, and parental affective attitudes, as well as satisfaction with the assessment experience, using the PEAS. The measures are well described in Tharinger, Finn, Gentry et al. (2009). We also have conducted brief interviews after each session with both the parents and the children. We briefly describe the findings of the case we have been following.

Conclusion

Our intention in this chapter has been to introduce TA and its use with adolescents and their parents to current and future assessment psychologists and, in turn, to encourage psychologists to consider how this model may be useful in their clinical work. We believe we have made three major contributions. The first is the explicit acknowledgement that adolescents (and families with adolescents) are unique clients with distinctive clinical needs. Current assessment models have only begun to address these needs, and primarily through the development of measures and norms specific to adolescents. The TA model we presented and illustrated herein demonstrates the importance of integrating the unique tasks of adolescent development into the structure of assessment itself.

The second contribution is the TA model itself. TA is a unique integration of theoretical frameworks, as well as a combination of assessment *and* intervention methods and techniques. The TA model can be used with a variety of clients across all ages and many concerns, and may be particularly suited to adolescents in that it attends to such fundamental issues such as teenagers' simultaneous need for autonomy and their continued reliance on their parents. As such, we described and illustrated the goals and procedures for each step in the comprehensive TA model as used with adolescents and their parents, and illustrated each step with a case study. It is hoped that this approach provided the reader with concurrently conceptual and clinical lenses through which to view the workings of TA with adolescents and their parents.

The third contribution of the present chapter is that it encourages practitioners to evaluate the process and outcomes of psychological assessment in both clinical practice and research endeavors. Assessment practice has been challenged in the past decade to demonstrate its usefulness. By providing clinical and research data that support its efficacy and effectiveness (thus building an evidence base), the practice of psychological assessment is more likely to be valued, advanced, and sought out by consumers and sites where psychological services are offered.

Future Directions

We close by raising issues about the ongoing development of therapeutic assessment with adolescents and their parents. These include TA's application across cultures, the use of selected steps of TA when the comprehensive model is not feasible, adapting TA in different settings and with different presenting problems, and education and training opportunities to establish competence in TA.

It is imperative to consider cultural differences in the practice and research on TA. In the case we followed in this chapter, Matt and Lisa were Caucasian. Lisa was a single mother who had given birth to Matt when she was a teenager. How did these cultural factors impact their respective experiences of the assessment? How would their experience of the TA been different if, for example, they were Hispanic and had presented as an "intact" family? If

they were African American? Asian? Native American? Wealthy? Living in poverty? A single-father–headed household? Factors of cultural variability in TA are yet to be formally explored. Questions such as: "Are there differential effects or experiences of TA based on culture differences?" are essential given the ever-increasing multicultural nature of our clients.

Further, are there particular components of the assessment intervention described herein that are more or less effective in precipitating therapeutic changes in various clients? Thus, future research should include inquiries into: (1) the differential experiences of participants from various cultural groups, and (2) the acceptability and efficacy of individual components of the intervention across cultural groups, particularly cultures with differing norms and values about adolescent development (e.g., differential impact of seeking assessment questions from participants; collaborative approaches to test administration, interpretation, and application to real life experiences of the participant; and implementation of intervention sessions and summary/discussion sessions). TAs are complex and multifaceted and must be retrofitted to the individual client and his or her family and cultural system. Inquiry in this area would increase our understanding not only of how to adapt TA to different cultural groups, but (p. 418) also of the effective components of TA and how those interface with different contexts.

As briefly mentioned earlier, certain practitioners will find that it is not feasible to apply the comprehensive model of TA because of constraints (typically time and money) in their particular settings. Thus, a challenge for future research is to determine the relative effectiveness of components of TA. Tharinger and Finn have written elsewhere (Tharinger, et al., 2007) about the bare bones of TA that are required to deem that TA is being practiced and researched. In addition to adopting the core values described earlier, essential ingredients include:

(1) Embracing a collaborative orientation to assessment, which in itself will enhance the intervention potential of assessment;
(2) Co-constructing and addressing assessment questions from parents and children/adolescents;
(3) Organizing the findings around the assessment questions and tailoring feedback to parents, children/adolescents in ways that are meaningful to them;
(4) Adopting multi-theoretical orientations for integration and interpretation of assessment findings.

Questions remain about the added value of other steps. That is, what is the added benefit of intervention sessions? Follow-up sessions? Adolescent summary/discussion sessions? Data informing these questions could guide the psychologist in deciding which steps are essential and which are add-ons, but do not necessarily result in better outcomes. Anecdotally, the authors have noticed in TAs with *children* and their parents that some of the families appeared to benefit most from observing and subsequently processing the testing of the child; others, from the impact of the family intervention session; and still others, from the summary/discussion session. Thus, although future research should attempt to determine the moderators that might impact the efficacy of each step of TA, practitioners will need to thoroughly plan and flexibly adjust to meet the needs of individual clients—utilizing both clinical experience and research findings.

It is also important that TA with adolescents and their parents be conducted and studied across a wide range of settings, including psychiatric hospitals, pediatric hospitals, residential treatment centers, community mental health clinics, independent practices, and schools. Our research has been conducted at a university-based clinic, and our practice has been conducted primarily in independent practice settings. We also have implemented components of TA with adolescents in the schools and have several other such projects underway. Others are using TA with children and adolescents in a community-based clinic that primarily serves economically disadvantaged children and their families (Mercer, 2011; Guerrero, Lipkind, & Rosenburg, 2011; Haydel, Mercer, & Rosenblatt, 2011). This work has shown that TA can be applied and is effective in such settings, but assessors must be acutely aware of the cultural context.

It is also our experience that careful determination of when TA will have the most payoff (e.g., in terms of adolescent and parental motivation and follow-through) will be wise, as the comprehensive TA model can be time-consuming and demands extensive competence from the psychologist. We recommend using TA with complex cases in which the adolescent and parents are stuck, and in their "stuckness," may be doing psychological harm to themselves or each other, or at least obstructing progress. Also TA may be particularly applicable to adolescents and families where previous treatment efforts have repeatedly failed. These points underscore one more constraint on the practice and research on TA at this time—the competence of the practicing psychologist or

supervised students in training. As we mentioned in the introduction, it is our experience that psychologists with expertise in assessment and several schools of psychotherapy can add TA to their repertories by obtaining additional education, training, and supervised experience. Such opportunities are available and growing (cf. www.therapeuticassessment.com for a list of training workshops), and Finn and colleagues are currently exploring setting up a certification program in therapeutic assessment. In addition, it is important for faculty in professional psychology graduate programs to introduce and teach the basics of TA to their students to encourage their consideration of additional training. It is our experience that graduate students are extremely excited about learning and practicing TA, and some see it as the pinnacle integrative experience of their graduate training.

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