

Therapeutic Assessment with Brief Therapy: A Single Case Study of an Elementary Student's School Refusal

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Abstract: Psychological assessments, such as intelligence testing, have two aspects: gathering information for treatment and therapeutic assessment, which directly link psychological assessment to patient assistance. This study examined a therapeutic assessment session using brief therapy questioning techniques, focusing on interaction and circular causality. In one particular case, this method was applied in the pediatrics department to a girl who was not attending school and her parents. The results indicated that the child's problem system changed significantly after one assessment session and one feedback session, followed by two follow-up sessions in which the chief complaint was resolved. This study examined a particular case, and although there are limitations to this study due to the absence of a control group and its focus on a single case, it remains important and worthwhile to examine the implementation of therapeutic intelligence testing for children using brief therapy perspectives.

Key Words: therapeutic assessment, brief therapy, school refusal, pediatrics

Introduction

Brief therapy has a background in communication theory (Watzlawick et al., 1967) and systems theory (Bertalanffy, 1969), where problems are not specifically attributed to individuals. Instead, a therapist intervenes by identifying interpersonal interactions as vicious cycles that occur in the system in which the problem is maintained (De Shazer, 1985; Wakashima, 2019). Therefore, it is possible to resolve problems such as school refusal, even in the absence of the individual, through interventions with parents and the school, and its effectiveness has been reported in a variety of cases (e.g., Hasegawa, 1987; Hasegawa, 2005; Wakashima, 2010; Wakashima, 2019).

Brief therapy takes the position of not being concerned with determining the cause of the problem and is incompatible with psychological testing, which has a background of linear causality and is often viewed as separate from therapy when psychological testing is conducted. Hasegawa

(1987) divided the brief therapy interview procedure into four steps: 1) listening to the problem, 2) determining attempted solutions and exceptions, 3) defining specific treatment goals to be achieved, and 4) intervention. and stated that steps 1-3 are conducted as a whole, moving back and forth during the interview.

The therapist uses multiple questioning techniques with patients and their families to facilitate therapeutic conversations and construct solutions. How you define a problem in an interview is important (Wakashima, 2019). For example, questions to start are asked early in the interview to understand the problem and the patients' vision of the solution and to capture the direction of the interview goal (Wakashima, 2010).

Regarding feedback from psychological tests, Itakura (2009) discussed the possibility of new reality construction through feedback based on the theory of social constructivism and the narrative model perspective. In other words, feedback from psychological testing has the potential to constitute a new reality using the test results as a resource, as the interaction between the tester and the patient unfolds. By highlighting the positive aspects of the patient and what has already been done through the feedback process, it contributes to a new reality configuration. It also highlights the importance of paying attention to

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the “how” in communicating results; it is the aspect of the relationship, not the content.

During pediatric psychological consultations in Japan, there is an increased need for developmental assessment and intelligence testing is often performed as an adjunct to diagnosis. For example, a consultation where the chief complaint is school refusal involves the evaluation of physical symptoms and follow-up for treatment but may also call for intelligence and psychological testing to scrutinize the presence of background illness (Japanese Society of Psychosomatic Pediatrics, 2015).

Intelligence testing is not only a diagnostic aid for developmental disabilities but is also conducted to understand the child’s abilities and characteristics and to develop treatment and support plans. While some studies (Fujiwara, 2009; Kataoka et al., 2012) argue that the intelligence test results are fed back to families and schools, and that positive changes are obtained for children, such as “the school’s response has improved,” there are also cases where tests are used only for diagnosis and understanding of characteristics, and are not effectively used to address the patient’s chief complaints.

In addition, although regional differences in Japan exist, demand for psychological evaluations is high relative to supply, and medical institutions are facing prolonged waiting periods for psychological consultation (Goto et al., 2018). This limits the number and amount of time that can be realistically spent on psychological assessment and treatment. This study examines the possibility of assessment sessions that use a brief therapy perspective.

There are two paradigms of psychological assessment: informational and therapeutic assessment (Finn & Tonsager, 1997).

Information assessment is treated as gathering information for treatment and is often distinguished from subsequent psychotherapy. In other words, a therapist conducts tests primarily for diagnosis, treatment and treatment planning, evaluation of treatment effects, and deeper understanding (Finn, 2007), and psychotherapy is conducted afterward. A common comment of parents of children who have been tested for developmental counseling is that they were only tested and not given counseling, which is likely because assessment and subsequent treatment are often differentiated.

In contrast, therapeutic assessment involves linking psychological assessment directly to patient assistance. Finn (2007) described therapeutic assessment as primarily an attitude toward psychological assessment, stating that the goal of assessment is to help create positive change in the patient and those around the patient, and that it is not tied to any particular procedure, technique, or philosophy and can be practiced in a variety of ways. Three examples of this practice are presented below.

Therapeutic Assessment (Finn, 2007)

The Therapeutic Assessment Center in Austin, Texas, has created a semi-structured collaborative assessment approach called Therapeutic Assessment (TA). The TA model consisted of the following six steps: 1) first session, 2) conduct standardized testing, 3) assessment intervention session, 4) summarizing and discussion session, 5) provide written feedback, and 6) follow-up. In the first session, the patient’s assessment questions, that is, patient problems and questions they wished to clarify during the examination, were asked, and the assessment was conducted around these questions. During the feedback session, the therapist and the patient discussed and confirmed the results. Feedback is provided in writing in addition to verbal explanations. Follow-up sessions are conducted, as required.

Therapeutic Assessment with Children (Tharinger et al., 2009)

Tharinger et al. (2009) proposed therapeutic assessment with children (TA-C) as a way to intervene with the whole family as a client for problems presented by children. The TA-C reported a reduction in symptoms, an increase in a positive family environment and positive emotions, and a decrease in negative emotions for both parents and children as a result of the five steps and nine sessions.

The five steps of the TA-C consist of: 1) forming the assessment questions, 2) testing the child while parents observe, 3) family interview session, 4) summation/discussion session with the parent, and 5) feedback to the child.

Step 1 usually involves meeting with parents only. During this step, the therapist collaboratively structures the issues, questions, and conflicts that the parents have about their children, their relationship with their children, and what they would like the assessment to address. It also gathers background information on parental questions and establishes a safe relationship between parents and therapists.

In Step 2, the necessary tests are performed, scored, and interpreted according to the manual, and aspects of collaboration with parents are reinforced by using one-way mirrors and other means to allow parents to observe their children during the tests.

Step 3 involves a family session to test possible interventions to help parents develop a more systemic view of their child’s problems in terms of case overview.

Step 4 involves sharing the test results with the parents to develop a new understanding of the child’s issues and questions and to support any emotional reactions generated by the results.

In Step 5, the test results are communicated as an allegory or metaphor appropriate to the child’s developmental age.

Collaborative WISC-IV Feedback with Parents (CFP) (Kumamoto, 2020)

In Japan, Kumamoto (2020) proposed Collaborative

WISC-IV Feedback with Parents (CFP), which consists of two sessions, considering that few sites can implement the standard six steps of TA. CFP includes the essence of TA: working with the patient and discussing the test results with the patient. The CFP will interview the parents, develop assessment questions, and conduct testing with the child in Session 1. In Session 2, individual results are presented in writing to the parents, and ideas for coping are discussed in collaboration with the parents.

In Kumamoto's study (2020), 17 children with developmental disabilities and their parents participated in the CFP and were tested in the first session, followed by a second session of feedback, approximately one week later. Three months later, a questionnaire was administered to the parents. While there were no changes in the children's behavior during this period, the parents' mental health problems were reduced, as were their inefficient child-rearing behaviors toward their children. It was noted that there was no improvement in the child's problematic behavior and that many parents asked for further advice and ongoing support sessions as a result.

Based on the above previous studies, to conduct intelligence testing as a TA, it is important to construct assessment questions with the parents during the initial interview and to communicate the results in feedback sessions, emphasizing interaction rather than a one-way explanation of results from the therapist. In addition, it may be useful to consider assessments and interventions that view the family and school as a system that constitutes the child's problems, since it is often not the children themselves but their parents who report the chief complaints.

This study reports a case in which the child's problem system changed significantly after one assessment session and one feedback session, followed by two follow-up sessions in which the chief complaint was resolved and discusses the implementation of therapeutic intelligence testing for children.

Ethical Considerations

Verbal and written consent were obtained from the parents and patients for the publication of this case. The Ethics Review Committee of the Nursing Department of Kushiro City General Hospital approved this study.

Case Description

Case: X (3rd grade elementary school girl)

Chief complaint: She could not go to school alone because she was afraid of being seen by others.

Visitor to a hospital: Father, Mother, X

Developmental history and current medical history: She lived with her parents and an older brother. No specific problems were observed during early childhood. At the beginning of elementary school, she had difficulty separating from her mother when going to school. In the

2nd grade of elementary school, the school closed because of COVID-19. Since then, she has been unwilling to attend school for an increasing number of days, triggered by events such as "forgetting something" or "the teacher getting angry with the whole class." After moving to 3rd grade, she was unable to sit in the same classroom as her peers due to psychological issues, and her absences increased even more. The situation did not improve, and she and her parents visited the pediatrician at Hospital Y. The pediatrician ordered a psychological assessment for selective mutism, separation anxiety disorder, and school refusal by the therapist. The therapist works in the pediatric department of Hospital Y.

Session 1 (120 minutes)

Visitor: Parents, X.

Assessment Interview

When the therapist asked about the current problems, the parents mentioned that X was not able to sit in the classroom and continued to attend school in a separate room.

X said she was inclined to study with classmates, but when she arrived at school, she was not able to enter the classroom. When asked about the problem in more detail, X said that she went to school every morning with her mother and met Teacher Z at the school's entrance, but whenever there was a class or assembly that she did not like, she froze up on the spot. X was able to calmly enter the schoolbuilding if she was told she could take a break from her weak subjects.

X did not participate in the subjects or assemblies she disliked. The therapist praised X's ability to participate in school, even partially, and confirmed her goals for this psychological consultation. Her mother expressed hope that X's anxiety would go away, and she would be able to confidently attend classes in the classroom. X said, she wanted to go to class and play with her friends. When the therapist identified the current problems, X mentioned that the classroom was noisy, that she had anxiety entering the classroom, and that she was fine when leaving the house but suddenly became more anxious when entering the school building.

An exception was that she could attend morning meetings in her classroom with Teacher Z. When Teacher Z was not present, she did not enter the classroom but stayed alone in a separate room.

The following assessments were performed: WISC-IV (Japanese version of the Wechsler Intelligence Scale for Children, Fourth Edition), Picture Vocabulary Test-Revised (PVT-R), Parent-interview ASD Rating Scale-Text Revision (PARS-TR), Social Maturity Scale Third Edition, and Japanese version of the ADHD Rating Scale-IV home version (ADHD-RS IV).

After the examination, the therapist repeatedly praised

X's ability to continue attending school in a separate room, while relying on her teacher. The therapist also told the mother that X needed to challenge her anxiety to meet her goals and consider where she could start. In response, the mother expressed her cautious attitude, saying, "I don't have to force X too much, do I?" The therapist asked her to observe X's condition from this perspective.

The Test Results

WISC-IV; FSIQ83, VCI62, PRI78, WMI118, PSI102. PVT-R, evaluation point 4 (delayed). PARS-TR: Peak in early childhood 16, Childhood Present 26, ADHD-RS IV; Inattentive 6, Hyperactive-Impulsive 5. Social Maturity Scale Third Edition, Social Life Quotient 77.

The pediatrician diagnosed her with autism spectrum disorder (ASD) and notified her parents. No medication was administered.

Session 2 (two weeks later)

Feedback Session (30 minutes)

Visitor: X's parents

The therapist asked how the past two weeks had been going. X's mother shared Session 1 feedback with Teacher Z. Later, X would go to the classroom with Teacher Z to submit a handout. Until then, Teacher Z had delivered X's handouts to the classroom. Teacher Z asked X to participate in the evacuation drill, but X was able to participate. The therapist praised X for trying new things.

Feedback on Inspection Results

The therapist informed the parents about X's intellectual level, and strengths and weaknesses in her cognitive abilities. The parents' understanding of ASD was confirmed, and a supplemental explanation was provided. As an assessment of the problem it was determined that X's verbal comprehension index and perceptual reasoning index were at a mildly delayed to borderline level, suggesting that there are situations in which she has difficulty in understanding situations and reasoning. In addition, it is thought that the characteristics of ASD include difficulty in responding to new situations, perfectionism, and other obsessive-compulsive traits, and that anxiety and a desire not to fail due to these traits are strong obstacles to challenging behaviors with which they have difficulty. The therapist informed the parents that she may be too cautious, and as a result, have fewer opportunities to try new things, which may make it difficult for her to gain self-confidence.

The following three concrete measures were proposed: 1) to alleviate X's anxiety, explain in a way that allows her to visualize. Owing to weakness in language understanding, it may be more difficult to understand than people around you think, 2) encourage her to participate in a few of the activities she does not want to do by devising ways to participate, and 3) incorporate vocabulary and communication training in the time spent in separate classrooms. Both parents were

convinced of the results and anticipated sharing the strategy with the school; however, they still wanted to continue with follow-ups.

The therapist and parents discussed and scheduled a follow-up session seven weeks later.

Session 3 (after seven weeks)

Follow-up Session 1 (40 minutes)

Visitor: Parents, X.

First, there was an interview with the mother for 30 minutes, and then a 10-minute interview with all participants. The mother talked about a significant improvement with X's problem. X now spends more time in a separate classroom next to the main classroom where she can still hear the lesson. The classroom teacher was able to easily move between the classroom and the adjoining classroom, and had more time to interact with X. The number of teachers involved with X increased and X was given opportunities to engage with other children. X was resistant at first, but gradually became accustomed to the idea of spending time together in the separate room.

The therapist praised the mother's involvement with the school and X's efforts, and asked about current problems. The mother expressed her concern that the pace of the next step was too fast. Asking the mother for details of her concern, she said that she was worried that since X is the type of person who cannot say no, she would say "I can do it" even if she is forced to do so by Teacher Z's suggestion. She was concerned that if X pushed herself too hard, she would not be able to return to school again.

The therapist normalized the mother's anxiety by telling her that not rushing is important, because she will practice these things repeatedly. The therapist told the mother to continue with the challenge, after sharing her concerns with the school. The mother agreed to consult Teacher Z. A second follow-up interview was scheduled one month later.

Four Weeks after Session 3

The appointment was postponed because X prioritized school events.

Session 4 (seven weeks after Session 3)

2nd Follow-up Session (30 minutes)

Visitor: Mother, X

In the first week of the new semester, X spent all day in the classroom, but in the following week, she was absent as a reaction. After that, she took classes in the classroom every morning.

The therapist complimented X on the challenge of exploring the right pace and the increase in what she was able to do as a result. Once again, upon reviewing the current problem, the mother said that X seems to have trouble communicating what she wanted to say to the teacher. Asking for details, X had prepared a notebook so that she could write down what she wanted to say and show it, but she had

difficulty choosing the right time to show it to the teacher. The therapist advised them to communicate this problem with the teacher. Additionally, referring to the test results, it was identified that X had weaknesses in vocabulary and communication skills.

The therapist suggested that communicating requires practice and that they should make intention cards for common matters, and both the mother and child agreed. The mother said that follow-up interviews would not be necessary for a while because of X's current good condition, and the psychological consultation was paused.

Discussion

In this study, we assessed and provided feedback on the problems presented by the perspective of the child's interaction with the family and school, while administering an intelligence test to a case of continued school refusal because of strong symptoms of anxiety. The problem was resolved. The following is a discussion on the implementation of TA using intelligence testing, mainly for children.

Test Results as One of the Components of a Circular Causal

TA begins with a session with the patient and their family to discuss the problem and expectations for the inspection, followed by an inspection using standardized methods. During TA-C (Tharinger et al., 2009), only the parents come in for the initial visit and collaborate with the therapist to discuss issues, questions, and conflicts that the parents have about their child, their relationship with their child, and what they would like to see during the assessment. The therapist then gathers background information about the parents' questions. Time is spent on this part of the program to build a safe relationship between the parents and therapists (Aschieri et al., 2012). In addition, tests are performed once or twice a week for 1 to 1.5 hours each time (Finn, 2007). Thus, previous therapeutic assessments involved repeated testing as necessary to search for answers to the assessment questions. However, in Japan, institutions that conduct multiple psychological testing sessions are limited. In addition, the psychological tests to be conducted in Japanese medical institutions are ordered by doctors, and the test battery is often determined prior to the therapist's interview with the parent or client. Therefore, assessment questions are usually limited to what can be measured by the tests already available. That is, it is necessary to construct a therapeutic assessment based on a predetermined examination in a limited amount of time.

In general, intelligence and developmental testing gathers information about the cognitive aspects of the individual client for diagnosis and understanding of the condition from which measures are derived, but the information obtained from test results is a limited aspect of the client in the testing room. Mitani (2014) proposed that developmental

disabilities are a product of characteristics and social barriers, indicating the need to understand the adjustment of children with developmental disabilities to society. In this case study, the results of the psychological test were considered one of the components of the problem maintained by the interaction between the client's characteristics and the environment. This made the test a resource not only for gathering information for diagnosis and understanding the pathophysiology but also for considering direct and indirect interventions for assessment questions.

Creating Assessment Questions Using Brief Therapy Questioning Techniques

Tharinger et al. (2009) set up a parent-only interview day to develop assessment questions, carefully discussing issues that parents have about their children and their own conflicts with them, and organizing what they would like the assessment to address. Kumamoto (2020), however, interviewed parents, created assessment questions, and conducted the inspection in the first session. In this case, as in Kumamoto (2020), the interview, development of assessment questions, and testing were conducted in the first session; however, the difference was that the mother and child were interviewed in the same room. We would also like to emphasize that, in creating the Assessment Questions, we used a questioning technique that focused on aspects of the current problem and its interaction with the environment.

To develop the assessment questions, a brief therapy interview technique of starting questions is used (Wakashima & Hasegawa, 2018), searching for solution efforts and exceptions to problems, compliments to client resources, and what has already been achieved. When asked the starting question, both parents and X hoped that X would participate in the classroom. They wanted to explore how they could do this. A vicious cycle was observed, in which the mother and teachers dealt with X's anxiety and distress by removing anxiety so as not to make X anxious, which strengthened X's tendency to avoid anxiety. However, we found exceptions, such as situations in which the prospect was clear or she was with her mother or Teacher Z X was able to participate in the group. In the first session, the mother and child shared the question of what to do about wanting to enter the classroom but feeling too anxious to do so, after which the inspection could be conducted.

In many cases in Japan, when conducting assessments centered on intelligence testing, the time allotted for the session is the time to conduct individual testing of the child and interview the parents. To create assessment questions in a situation where time is limited, it was considered that the brief therapy approach was effective in identifying the current problem and then exploring the vicious cycle that maintains the problem and its exceptions.

Follow-up Sessions

The sixth element of TA is a follow-up session held 1-2 months after written feedback to assess progression. Kumamoto (2020) conducted a mailed questionnaire survey three months after the two sessions, with no follow-up interviews. As a result, parents reported the following benefits: they learned about their children's cognitive characteristics, were able to devise supportive measures, became aware of ways to support their children, and their own anxiety and feelings toward their children changed. However, the children's problematic behavior did not decrease, and requests for more advice and ongoing sessions were made.

In this case study, the analysis and interpretation of the test numerically revealed the areas in which X needed support, which could be shared with her parents. Understanding that X had ASD was also helpful in gaining support from others. These results are similar to those of previous studies (Kumamoto, 2020, Fujiwara, 2009, Kataoka et al., 2012.), where the analysis and interpretation of the test results have a certain therapeutic effect. However, prior cases did not mention follow-up sessions. After the feedback session, although the problem was already showing improvement and the future direction was shared with the parents, they strongly desired continued follow-up. Therefore, the timing of the follow-up was discussed in collaboration with the parents and was set at two months.

At the first follow-up session, we kept a solution-focused approach in mind and identified improvement and good circulation since the feedback session. The parents requested further follow-ups, but the appointment was extended. Seven weeks after the first follow-up session, good circulation was maintained.

In the second follow-up session, X's communication issues were discussed and the session reaffirmed the feedback report. In many cases, clients do not fully understand the results of intelligence tests at one point, but in this case, the client had the opportunity to review the results again four months after the feedback.

The follow-up interviews were considered effective in terms of supporting the change to a good circulation system and reaffirming the findings and measures communicated in the feedback sessions.

Limitations and Conclusion

In addition to the session process, in this case, the patient and parents' high motivation for treatment, parents' consultation with the school, and the school's cooperation, as well as many resources, contributed to a swift improvement. In cases with fewer resources and greater difficulties, it may be necessary to follow up with counseling as a treatment after feedback, or to connect the patient to support resources such as social welfare. In addition, because of the single case report, there are limitations in demonstrating the

effectiveness for other cases.

Nevertheless, this study revealed that intelligence testing sessions, often conducted for informational purposes, can be therapeutic for patients and their families. It was also suggested that focusing on the current problem and its interactions and viewing the individual test results as an element of the system that maintains the problem, may be effective for conducting therapeutic assessments within a short time period. In addition, although individual factors are not emphasized in brief therapies, the objective presentation of these factors through standardized tests is thought to be a resource that can promote behavioral change in clients and their families. Many cases require therapeutic assessment and ongoing treatment. However, having a therapeutic approach to the examination sessions may help meet the needs of clients seeking psychological support, improve the effectiveness of treatment, and shorten the duration of treatment.

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