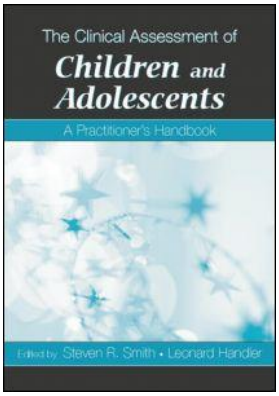

The Clinical Assessment of Children and Adolescents: A Practitioner's Handbook

Steven R. Smith, Leonard Handler

The Use of Therapeutic Assessment with Children and Adolescents

Publication details
https://www.routledgehandbooks.com/doi/10.4324/9781315827308.ch4
Leonard Handler
Published online on: 11 Aug 2006

CHAPTER

4

THE USE OF THERAPEUTIC ASSESSMENT WITH CHILDREN AND ADOLESCENTS

Leonard Handler
University of Tennessee

WHAT IS THERAPEUTIC ASSESSMENT?

Therapeutic assessment is an approach to assessment in which the assessment process itself is considered to be a potential therapeutic intervention (Finn, 1996; Finn & Tonsager, 1992, 1997; Finn & Martin, 1996). The goal of therapeutic assessment is not just the collection of information *about* a patient/client, but rather, the assessment procedure itself is designed to be transformative. The term "Therapeutic Assessment" (TA) refers to a set of specific techniques developed by Finn and his associates. However, there have been a number of related assessment approaches developed by others that differ somewhat in procedure, but not in the goal of providing a transformational experience for the patient/client. These approaches are designated as "therapeutic assessment" (ta), preserving Finn's specific approach as "Therapeutic Assessment." In this chapter I describe the differences between Therapeutic Assessment (TA) and therapeutic assessment (ta) on the one hand, compared with traditional assessment. This is followed by a description and discussion of several therapeutic assessment approaches for children and adolescents, and a case study employing one such approach.

HOW DOES THERAPEUTIC ASSESSMENT DIFFER FROM TRADITIONAL ASSESSMENT?

Finn and Tonsager (1997) refer to traditional psychological assessment as the "information-gathering model," typically used to facilitate communication among professionals, to help make decisions about a patient (e.g., medication decisions, treatment decisions) or diagnostic decisions. In sharp contrast to the information-gathering approach, TA and ta models are designed to provide the client/patient[1] with a view of himself or herself that becomes truly transformative, leading to an awareness of personal problems or issues and, eventually, to their resolution. A more detailed discussion of the differences between TA (ta) and collabo-

rative assessment, on the one hand, and the traditional assessment approach appears in Finn and Tonsager (1997), Fischer (1985/1994), and Handler (in preparation).

I became disenchanted with the traditional model rather quickly in graduate school when I realized that the assessments I labored over had little impact on patients' lives. Typically, they were used only to diagnose the patient. When I gave feedback to patients I recognized how little they took away from my efforts to explain their problems. I became aware that patients were having a variety of experiences during the "data collection" phase of the assessment that were vitally important in understanding them, and so I began to collaborate with them during the assessment process. We discussed important thoughts and feelings that were stimulated by the various tests I administered, and I found that this approach resulted in a dramatic change in what the patient took away from the assessment process. Many clients also developed an understanding of themselves that sharply illuminated their life issues, thereby giving them important self-knowledge. I compared this collaborative approach with the traditional (information-gathering) approach and realized that the latter approach offered little benefit to the patient/client, whereas the former approach seemed to motivate patients/clients to deal with their identified life issues.

Connie Fischer (1985/1994) developed a collaborative approach to therapeutic assessment, based on human science psychology and grounded in the European existential-phenomenological philosophy of science. She responds to the client with interventions, either during the assessment process itself or shortly thereafter. These interventions are constructive, illuminating for the client some important aspect of his or her functioning. Furthermore, these interventions provide for the client an awareness of areas of possible growth and development. Fischer states, "These interventions into the client's ways of moving through situations are intended both to evaluate the client's current possibilities and to try out different ones. Psychologists too often have acted as though individualized understanding and intervention should be reserved totally for a separate enterprise, that of therapy" (p. 47).

The following example is from Fischer's book, *Individualizing Psychological Assessment* (1985/1994); it illustrates how she actually collaborates with clients in the assessment process, relating performance (behavior) on psychological tests with the patient's important life issues and possibilities.

The client is a 6-year-old girl, referred for "gifted student" evaluation:

Assessor:	I'm going to tell you two things you said, and you tell me what's different about them: (1) "I don't know. There's some. Is it five pennies?" and "It's when there's snow. It's a season." What's different about you in those two answers?
Client:	I was smart about winter.
Assessor:	And what about the number of pennies in a nickel?
Client:	I was ignorant about pennies.
Assessor:	Ignorant? Who says "ignorant"?
Client (giggling):	Eddie, he's my brother. He's in fifth grade.
Assessor:	But you knew the right answer; five is correct. What's ignorant about that?
Client:	I didn't know if I was sure. I didn't know ahead of time if it was right.
Assessor:	If I hadn't kept at you, do you think you would have guessed by yourself?
Client:	Nope, I mighta made a mistake.

Assessor:	Here's a new test [Stanford-Binet]. This time the rules are that you're supposed to guess, even if you might be wrong. Okay? [Assessor continues with the S-B, documenting that [the] client in fact has been earning misleadingly low scores because of her fear of looking ignorant.] Marie, you know what? I think you were "smart" when you guessed. I'm going to suggest to your mother and father that they tell Eddie that sometimes it's "ignorant" not to guess. What do you think about that?
Client:	Eddie says you're not allowed to guess at school or kids'll make fun of you.
Assessor:	Maybe they do sometimes, especially if you're being silly. Let's practice some more guessing, and see if you can tell when it's silly and when it's not (p. 97).

ADVANTAGES OF THERAPEUTIC ASSESSMENT WITH CHILDREN AND ADOLESCENTS

The advantages of Therapeutic Assessment (and therapeutic assessment) are that both approaches accomplish the following:

1. They can be used to build rapport quickly with children and adolescents. Patients/clients view the TA (ta) process more as a game and less like a test.
2. Patients' problems and life issues become obvious very quickly, allowing the clinician to evaluate and treat a child or adolescent in the same session, or soon thereafter. Many of the approaches described later in this chapter can be completed in one session or less.
3. When used periodically in the treatment of a child or adolescent, the assessments can allow the clinician to track a patient's/client's progress, measuring his or her acceptance of various aspects of the treatment process.
4. TA (ta) approaches save time and money; because the techniques bridge the gap between assessment and therapy, the child or adolescent benefits from the assessment and treatment processes without an arduous period spent waiting for the assessor to administer and score the tests. Because rapport has been established, and the assessor has provided therapeutic feedback to the child, it is often appropriate for the assessor to continue treating the child after the initial assessment session, making the transition from assessment to treatment smoothly and efficiently.
5. TA (and ta) procedures provide important information to parents or other caretakers, so that they obtain a first-hand appreciation of their child's or adolescent's problems. When they observe the TA (ta) process or review the assessment results the clinician shares with them, parents develop a new understanding about their child's problem(s). They come to view the(se) problem(s) from a very different perspective. Parents can be enlisted more directly in cooperative efforts in problem resolution, because they, like the child or adolescent, can understand the problem better.
6. Integrating assessment with therapy into an ongoing treatment approach can yield specific information to insurance companies and managed care organizations, to demonstrate improvement and provide focused efforts toward future treatment goals.

THE PROBLEM WITH TRADITIONAL ASSESSMENT PROCEDURES FOR CHILDREN AND ADOLESCENTS

Traditional psychological assessment has often been described as quite stressful, often leaving the patient feeling anxious, angry, or confused (Barber, 1996; Beutler & Berren, 1996; Schafer, 1954, 1956). Psychological testing can be especially stressful for children and adolescents, because the testing sessions are often perceived by children to be much like classroom exams. Although examiners often make heroic efforts to build rapport and to support and encourage the child or adolescent, the examiner must nevertheless administer the tests in a standardized manner, with a minimum of guidance or explanation. The results, according to Schafer, often engender feelings of frustration or abandonment, along with a great deal of apprehension and stress.

Children referred for assessment are often more at risk of developing negative emotions surrounding their experience with assessors who adhere to the traditional testing model because they have typically been referred for emotional problems. In my own experience with the traditional approach, support and rapport-building were typically not enough to prevent the appearance of negative emotions, often causing interference in how the child or adolescent dealt with the test, and therefore resulting in damaged test results. Conversely, TA and ta approaches are quite enjoyable for children and adolescents. They are typically quite engaged in the process and do not feel pressured or anxious. With the use of collaborative assessment procedures, the clinician can investigate reasons for a child's or adolescent's poor performance, can determine, by judicious discussion with the patient, why he or she was not successful and can demonstrate how the child can be successful. Examples of this approach can be seen in the work of Fischer (1985/1994) and Handler (1988, 1998).

Failure experiences are actually built into some assessment instruments, such as the various Wechsler intelligence tests and various achievement tests. The examiner is to stop testing only after a prescribed number of failures. Because many of the children and adolescents we typically test have some type of emotional problem, failures, especially if they are repeated, can be extremely distressing and demoralizing for them, with negative effects that interfere with performance throughout the assessment process (Handler, 1998).

Similarly, whereas the Free Association phase of the Rorschach is often enjoyable for children, the Inquiry can easily engender feelings of failure, especially if the child finds it difficult to tell the examiner why it looked like his or her percept. Asking the examiner for guidance or additional information does not result in much reassurance to allay these feelings or to find direction in a (sometimes) confusing Inquiry question, because the examiner is not allowed to provide the guidance and direction the child seeks.

During my graduate school training, as I tested more and more children and adolescents, I became aware of their discomfort with the standardized testing approach. Nevertheless, I recognized the importance of adhering to standardized procedures in relation to the use of available norms. Gradually, I developed an expanded Testing of the Limits phase (Handler, 1998, 2005a), based on the work of Klopfer (Klopfer, Ainsworth, Klopfer, & Holt, 1945), employed *after* the test was administered in the standardized manner. I went back over the items the patient missed, modifying them in various ways, in order to facilitate the child's or adolescent's success with each item. This approach gave the child/adolescent more confidence, and it helped me understand why he or she failed the item and what experiences or information he or she needed in order to perform better. These discussions were included in the report, and they allowed me to be more specific in crafting focused recommendations for remediation.

If, in the testing session, the child or adolescent became frustrated or despondent over a difficult item, I typically said to him or her, "Do you remember that you got upset when I asked you_____? Well, now that the test is over, let's see if you can be more relaxed and let me ask you that question again." For example, on the Vocabulary subtest of the WISC, I might ask if he or she had ever heard that word before, and if so, I might ask, in what way they had heard it. I might ask what the word reminded him or her of. If these hints were not enough, I might offer additional clues, until the correct answer was elicited, whereupon we might "celebrate" his or her success, or, at the very least, the child/adolescent would be praised. "See," I might say, "look how you figured out the right answer; you really do know your stuff." Actually, I have found that such efforts help the child/adolescent build a search process that he or she then learns to employ in the future.

The children, adolescents, and adults I tested in this way seemed much more open and willing to collaborate, following this approach to their assessment; I found that the transition from assessment to the actual therapy, with me or with someone else, was quite smooth. Although many clinicians frown upon taking patients for therapy whom they have previously assessed, I found the procedure to be quite productive. Therapy proceeded more rapidly and with fewer problems.

Gradually, I became more and more troubled about the formal structure of the traditional assessment procedure, which required a great deal of time and effort, and which delayed actual treatment for weeks or months. I wondered what the children who were tested in this manner thought when they came to see "the doctor" about their problems and were then required to wait so long to actually begin treatment to deal with their ever-present problems. These children probably initially thought they were already *in* therapy, only to have the "doctor" merely ask them a bunch of puzzling, irrelevant questions, and then weeks or months passed with no other contact.

When I discovered D. W. Winnicott's book, *Therapeutic Consultations in Child Psychiatry* (1971), I began to recognize the possibility of using some more collaborative assessment procedures that could be therapeutic as well. In this way the assessment and the treatment could be integrated into the same session. Such an approach would be much more meaningful to the child or adolescent because it would provide him or her with at least initial information and perhaps a solution to their painful problems. Later on I recognized that my approach to assessment with patients/clients was in many ways similar to what Finn and Fischer were doing and writing about. I began searching for more flexible assessment methods for children and adolescents, and now I employ a therapeutic assessment approach with most of the children and adolescents I see in therapy. This approach is especially useful with children and adolescents who at least appear to be unaware of their problem(s) or are unaware of the roots of their problem(s). Therapeutic assessment approaches can be used as a one-time intervention, or such approaches can be used intermittently, to track the progress of the patient in therapy. In this chapter I describe therapeutic assessment methods that can be used either in a one-time consultation or in an ongoing assessment and treatment procedure.

THEORETICAL SUPPORT FOR THERAPEUTIC ASSESSMENT

Narrative therapy (McAdams, Josselson, & Lieblich, 2001; McAdams, 1985, 1993; McLeod, 2001) concepts fit the therapeutic assessment paradigm quite well, especially the Fantasy Animal Drawing Game and Gardner's Mutual Storytelling Game, to be described later. A central theme of narrative therapy is that of enabling a person to reauthor his or her life

story (Lieblich, McAdams, & Josselson, 2004). These narratives are formed by the child's dominant culture and family members. Mutual storytelling approaches offer an opportunity for the child or adolescent to tell his or her narrative to the clinician, and, then, the therapist's story offers the child a chance to reauthor the narrative and/or to see himself or herself in a different (more positive) manner. McLeod (cited in Lieblich, McAdams, & Josselson, 2004) describes the theory and process of narrative therapy as follows:

> The person seeking help is a narrator and actually tells and reauthors stories [about him or herself and others] that enable him or her to convey a sense of identity and to make sense of problematic experiences by integrating them into a coherent and complex story. The idea of the narrative therefore includes within it a personal dimension in terms of the unique life stories that make up the teller's autobiography. Narrative also implies an interpersonal process. Telling a story is a performance, shaped by the responses of the audience. (p. 15)

Of course this definition, written with adults in mind, is only partially descriptive of the employment of narratives with children and adolescents, because most of them will not yet have formed a coherent sense of identity. The troubled children and adolescents tell stories that present their problems, but they typically do so in metaphor. It is very probable that narratives of children and adolescents that are fraught with pain and strife eventually become the building blocks of the narratives of the adult self, unless intervention takes place to alter the developing narrative. As indicated above, this process can take place in two ways: by responding therapeutically to the painful narrative, and/or by alerting and informing the parents or caretakers and helping them assist in reauthoring the child's or adolescent's narrative. This would best be done by helping parents or caretakers change the way they view the child/adolescent and his or her problem(s).

Another theory that is consistent with therapeutic assessment approaches is the intersubjective psychoanalytic approach developed by Stolorow and his associates (Mitchell & Aron, 1999; Orange, Atwood, & Stolorow, 1997; Stolorow, Brandchaft, & Atwood, 1987). This approach emphasizes the interactive vision of the patient-therapist relationship and its powerful reciprocal nature. Stolorow (2001) states, "In this view, psychoanalytic therapy is no longer an archeological excavation of deeper layers of an isolated unconscious mind. Instead, it is a dialogical exploration of the patient's experiential world, conducted with an awareness of the unavertable contributions of the therapist's experiential world to the ongoing exploration" (p. xi). This quote fits quite well the interactive approach to assessment I describe as therapeutic assessment (Finn, 2002; Handler, 2004, 2005a,b).

A CAVEAT

To successfully employ TA (ta) approaches to assessment, the clinician must set aside some of his or her traditional training and instead focus on being more playful and imaginative. In one respect, success in TA (ta) with children is facilitated if the assessor allows himself/herself to engage playfully in the assessment process with the children. This was brought home to me in my first attempt to use Winnicott's Squiggle Game as a therapeutic assessment procedure. In this attempt I used the Squiggle Game as I might have used a standardized "test"; the result was that it was of no use in helping to understand a child. In my second attempt, many years later, I used the Squiggle Game as a real game, playing back and forth with a child, without censoring my responses. This time the squiggle results were quite helpful in understanding the child and in providing symbolic feedback.

SOME THERAPEUTIC ASSESSMENT APPROACHES

In the following section I describe some TA (ta) approaches I employ in working with children and adolescents. Although space considerations prevent me from discussing all of the different ta approaches I have devised or have been devised by others, I describe some selected approaches and games I use with children and adolescents. Almost any board game, any test, and most play activities can be used in therapeutic assessment with children and adolescents.

The Squiggle Game

This "game" was often used by D. W. Winnicott, the British psychoanalyst, in his clinical work with children and adolescents. Although the Squiggle Game has typically been identified as an approach Winnicott used with children, I discovered a number of cases where he used the game with adolescents as well (Winnicott, 1971, 1972, 1989).

Winnicott viewed the game as a way of communicating ("getting into contact") with children/adolescents. In the process of squiggling with the patient, he was able to free up the child and help him or her symbolically express problems. He would say to a child or adolescent he was seeing, usually for the first time, something like "I have a game I'd like us to play. Here's how we play it. I close my eyes and I make a mark [on the paper], and you turn it into something. Then you close your eyes and make a mark and I turn it into something" (Winnicott, 1971, p. 3). This interactive process continues, many times, with patient and therapist squiggling, back and forth. Winnicott states, "What happens in the game . . . depends on the use made of the child's experience, including the material that presents itself" (1971, p. 3). The effective squiggle game resembles a play scene, with the child/adolescent and Winnicott commenting on each other's productions and on their own productions. Sometimes Winnicott arranged all the squiggles on the floor, so that he and/or the child could discern a pattern. Based on the content of the squiggles, the child's/adolescent's comments, and an estimation of whether the child/adolescent could handle the insight, Winnicott would sometimes make a direct interpretation concerning what he believed was troubling the patient. At other times the interpretations were made metaphorically. An example of Winnicott's direct interpretation comes from the case of Robin, a five-year-old boy from a farm community, who was showing signs of school refusal. The following quote comes from the middle of a session with Winnicott and the boy. Winnicott states:

> We had all the drawings spread out on the floor in a line beside the table where we were playing or working together so that we could see them all at once, and we found that we had a farm—the snakes, the spider, the earth, the duck and the goose and a fish for the pond and a pig—and we began to wonder whether [squiggle] No 9 was something lying around on the ground. He suggested it was a bit of wire. He added: "And we have got a farmer" referring to my drawing 6. I said: "Would you like to be a farmer?" and he said: "Well yes, but the trouble is there is a lot of work to be done on a farm." It will be remembered that he had come from a farm to the consultation. . . . In my mind was the question of making some kind of interpretation such as: "You wonder whether to go out in the world and be a farmer and work or be where you can get back to mother's lap and curl up like the snake, and touch her when you feel like it, for pleasure." He accepted this idea without any apparent difficulty. (p. 36)

Winnicott's goal with the Squiggle Game was to help the child or adolescent communicate with him through play. Typically, at first, the child's or adolescent's squiggles are rather

specific and concrete. Eventually, as the game continues, the child's/adolescent's squiggles become less concrete and more imbued with fantasy. From this point Winnicott would often ask the child or adolescent about his or her dreams, because he felt the dreams were more focused fantasies. He states, "I have a definite intention in these interviews to get to the real dream material; that is to say, to dreams dreamed and remembered. Dream contrasts with fantasying, which is unproductive, shapeless, and to some extent, manipulated" (1971, p. 32). The child's or adolescent's problem is further illuminated by his or her dream material. Winnicott's casebook, *Therapeutic Consultations in Child Psychiatry"* (1971), is filled with many remarkable cases, presented in detail and with the squiggles reproduced as well.

The Fantasy Animal Game

I devised the Fantasy Animal Game (Handler & Hilsenroth, 1994) one day about 25 years ago when I found myself face to face with a frightened five-year-old girl who stood inside my office, at the door, frozen and silent. She would not respond to the efforts I made to communicate with her. Her mother had been hospitalized for over a year, when the child was two or three, because of severe depression. After she returned to her family she attempted to make up for the time she was away by very actively involving herself in the child's life. I had been experimenting with Winnicott's Squiggle Game (Winnicott, 1971), with little success. I also experimented with various drawing activities, including drawing animals, as methods to involve children in enjoyable assessment approaches. I marveled at how Winnicott could facilitate the child's or adolescent's use of fantasy using the Squiggle Game, but, as I described above, I was disappointed when I found his approach and the drawing tests I devised were of little use to me or the patient in assessment or therapy.

Watching my young client standing far from me, close to the office door, I asked her if she liked to draw. To my surprise, she nodded "Yes." "Well," I said, "would you like to draw?" Again she nodded in the affirmative. I invited her to sit next to me at my desk and asked her to "draw a make-believe animal, one that no one has ever seen or heard of before." Asking for a fantasy or make-believe animal was my latest attempt to have the child become involved in fantasy, a method, Winnicott emphasized, to access unconscious processes in a symbolic manner.

To my surprise, she literally attacked the paper, scribbling over the entire sheet. In one of the scribbled loops she placed a small dot. Surprised by this explosive reaction from this formerly frozen child, I recognized that a transformation had occurred. I took a chance that she would now be more open and asked her to tell me a story about her make-believe animal. She replied with the following narrative: "This little fishie [pointing to the dot inside one of her scribbled loops] is stuck inside the momma fishie and she can't breathe and she's drowning." One need not be a rocket scientist to be able to interpret the story she told. She was telling me how she was experiencing her mother's attempts to reconnect with her daughter.

I felt she needed a response from me, but I doubted I could address the child directly. Rather, I felt, a metaphorical response was necessary, using the child's own metaphor. I asked her if I could tell her a story about the fishies and she again nodded, "Yes." Here is the story I told her: "This little baby fishie [pointing to the dot] is stuck inside the momma fishie and she can't breathe; she's dying. But along comes a big helper fishie and he makes an opening in the momma fishie and the baby swims out, and she's free." Suddenly, the child brightened. "Can I sit in your lap?" she asked. As I picked her up, she asked if I could tell her the

story again, and so I did. This change in the child's attitude and her responsiveness indicated to me that some important change had occurred in this child. Her continued drawing and storytelling in later sessions affirmed my opinion. In the following sessions the child was more active and spontaneous, as we dealt with her problem. In addition, I shared the child's drawing and story with her mother and collaborated with her to modify her "smothering" behavior. Additional case material concerning the Fantasy Animal game can be found in a paper by Mutchnick and Handler (2002), and in a forthcoming book, *Therapeutic Assessment with Children and Adolescents* (Handler, in preparation).

The idea behind such an unusual request to draw a make-believe animal is to help the child or adolescent use fantasy in drawing and storytelling, thereby allowing him or her more access to and expression of unconscious processes. In addition, the use of storytelling allows the clinician to assess the child's/adolescent's self-narrative and allows the therapist to collaborate with the child (and the family) to co-create a healthier, more adaptive narrative. Sharing the child's or adolescent's drawing and story with parents is important in effecting change in their view of the child and changing their narrative of their child/adolescent to a more positive and constructive story. This aspect of TA (ta) is very important because it coincides with and amplifies the clinician's work with the child or adolescent Thus, for example, parents often view their child or adolescent and describe him or her negatively, using some very pejorative terms (e.g., "sneaky," "spiteful," "bad," "lazy," "selfish," "provocative"). When parents are made aware of the child's or adolescent's problem, they typically begin to see him or her in a new light, and they change these negative labels.

The clinician who uses one or another type of mutual storytelling must be able to interpret the metaphors used by the child or adolescent to describe his or her problems, so that the clinician can respond with a story, metaphorically presented, that offers the child or adolescent a reauthored version of the problem. Gradually, over time, but occasionally quite rapidly, the clinician's reauthored stories begin to develop more meaning for the patient, until the altered, more positive narrative becomes internalized.

Developing a Helpful Narrative

It is typically useful to begin the story told to the child or adolescent in the same manner as the story was told to you, using the same setting and the same characters. The therapeutic assessment clinician then continues to construct a story that helps to provide some antidote to the child's or adolescent's emotional pain. Lacking that for some reason, typically because there might be no real solution to offer, the story is constructed so that it expresses the clinician's recognition of the child's/adolescent's discomfort or pain. Sometimes, in these difficult situations, the therapeutic assessor gives voice, metaphorically of course, to the client's pain by expressing it in the story. In one such situation, a child could not get her schizoid and depressed mother to respond emotionally to her. She told a story about a similar situation with an imaginary animal. I told a story in response, about the animal who shouted at her mother "and gave her mother hell" for not showing such interest. The immediate effect was that the child felt more at ease and became more cheerful; the long-range effect was that she turned instead to her father, who was much more emotionally available.

Some clinicians use the Fantasy Animal Game during the first session, as I did with the first client, described above. Ordinarily, during the first session, I ask the child or adolescent if he or she is interested in playing a "make-believe animal game," in which they would invent a make-believe animal, "one that no one else had ever seen or heard of before." If the

child or adolescent is not interested in the game, we go on to do something else, which may or may not be a therapeutic assessment activity. Sometimes the child/adolescent wants to draw but does not want to engage in the fantasy that is required to play the game effectively. I, of course, allow him or her to draw, and sometimes the child produces a fantasy animal. At other times the child draws interesting animals or people and we discuss these drawings. If a child/adolescent seems anxious and/or resistant during the first session, I wait a session or two, or as many sessions as are necessary before suggesting the Fantasy Animal game. I use a trial-and-error approach, allowing the child to make the choices. Sometimes a child/adolescent is interested in making a Fantasy Animal drawing but is reluctant to tell a story and, therefore, I offer several different types of assistance. First, I might say, "I'll help you get started: Once upon a time, a long, long time ago. . . ." Then I motion to the patient to continue. If this does not help, I suggest we tell the story together. I ask the child/adolescent to begin, and when he or she wants me to pick up the story, I suggest that he or she point or gesture to me, or say, "your turn." Thus, a symbolic dialogue is established. Sometimes the patient asks me to take over when he or she wants to avoid some aspect of the story. When this occurs I suggest the child continue for a while.

In this back-and-forth approach, the clinician is able to respond quickly to a portion of the child's/adolescent's story in an attempt to see what kinds of interventions are effective in facilitating problem resolution. For example, a very arrogant six-year-old boy who ignored the authority figures in his life told Fantasy Animal stories about his (benevolent) domination of animals in a variety of jungle settings. He pointed to me with an air of authority and insisted I take over and continue the story he was telling, which involved his control of all the jungle animals. I quickly introduced the lion, who I identified as the king of the jungle, and I gave the lion the authority to be in charge of the jungle setting. The child was surprised, but after several additional story exchanges with similar themes, in other sessions, he no longer challenged the authority of the lion. This was soon followed by his ability at home to begin responding more appropriately to his parents' directions.

While the Fantasy Animal Game is an excellent instrument for use with latency-age children, many adolescents enjoy participating as well. I have even used the approach with young adults, with excellent results. Many adolescents enjoy the playful aspects of the game, and they enjoy listening to the created stories of the clinician as much as do children.

Gardner's Mutual Storytelling Approach

No one has done more clinical work with storytelling techniques than Richard Gardner (1971, 1975, 1986, 1993). He has used the approach by itself and has incorporated it into several board games (described later in this chapter). Gardner uses the Mutual Storytelling approach separately, as a diagnostic tool, and later, after a "diagnosis" is made, he uses the approach therapeutically. He does not advocate the use of his approach in therapeutic assessment and warns against using it therapeutically before the diagnostic phase, because he feels it interferes with the free flow of unconscious material, which "contaminates" the child's unconscious message. My view is quite the opposite, and I have used storytelling approaches in therapeutic assessment with excellent results, often in the very first session. Although Gardner recommends using this approach primarily with latency-age children, in some cases immature adolescents will benefit from its use.

Gardner also recommends asking the child to produce a moral derived from the child's story or from the assessor's story. Although this approach is helpful to children who need superego messages, I believe it is counterproductive for use with a child with whom uncov-

ering work is necessary. Focusing on a moral makes the entire storytelling process much more conscious, which interferes with the symbolic or metaphorical expression, which is much more unconscious. Except for my disagreement about these two issues, I recommend Gardner's publications describing the mutual storytelling approach. He reports that this approach is especially useful with resistant children, which has also been my experience.

Gardner has a very novel way of introducing the approach, which I find works quite well with most children. Using a tape recorder, he makes believe he is a radio show host, or, with a video camera, a TV host. He introduces the child as a guest and tells the audience the child will be telling a story. Although a few children might be frightened by the idea of being on the radio or TV, most of the children with whom I have used this approach were enthralled by having this "opportunity." They engage enthusiastically and often insist on hearing themselves during playback time. New information often comes up during the playback time.

Engleman and Allyn (2005, July) devised a very unusual storytelling approach as a therapeutic assessment intervention. Engelman uses one or several of a child's Rorschach responses and, together with a creative writer, develops an elaborate and quite detailed story for the child or adolescent that is metaphorically relevant and which becomes part of the treatment. The story incorporates important life history data about the patient and basic mental health messages that are important to communicate, metaphorically, to the patient. The story is shared with the child, who has input in revising it. The story is actively employed in the treatment process itself.

Projective Tests

Almost any projective test can be adapted for use in therapeutic assessment, including the Rorschach (Exner, 2003), the TAT (Morgan and Murray, 1935), and other narrative tests (e.g., the Children's Apperception Test [CAT; Bellak & Bellak, 1949], the Roberts Test [McArthur & Roberts, 1982], the Tasks of Emotional Development [TED; Pollack, Cohen, & Weil, 1982]), the Tell Me a Story Test (Costantino, Malgady, & Rogler, 1988), the Draw-A-Person Test (DAP; Machover, 1949), and other drawing tests, such as the Kinetic Family Drawing test (K-F-D), the Hand Test (Young & Wagner, 1999), and many others. All that is necessary is that the examiner ask the child or adolescent to tell a story to the stimulus, and for the examiner/therapist to respond with his or her own therapeutic story. In the case of the Rorschach, the child or adolescent is asked to make up a story about one or more of his or her percepts (Handler, 1996, 2002, 2004, 2005a). Ordinarily it is helpful to choose those percepts that are unusual or idiosyncratic. The clinician would then respond with a relevant therapeutic story. Sometimes a child's story has little or no meaning to the clinician. When this occurs I usually ask the patient to tell me another story about the same response. Very often the second story does have important meaning. If the second story has no symbolic meaning for the clinician, he or she should move on to another response.

For the Hand Test (Young & Wagner, 1999; also see the chapter by Clemence in this volume for a description of the test) the examiner/therapist first administers the test by presenting each card, which contains a picture of a hand in position, and asks, "What is this hand doing?" After finishing the administration of the 10 cards I ask the patient to make up a story about his or her response to one or more of the stimulus cards. The clinician might then respond by making up his or her own story, one that is helpful in responding to the child's metaphorically expressed problem.

One additional way to use the Hand Test is to consider the child's or adolescent's responses as interpersonal responses to the clinician. In this approach, the patient first gives

his or her response to each card, and the therapist then gives his or her response, in an attempt to respond to the implicit or symbolic message the child/adolescent is offering. It is sometimes also interesting to reverse the process, where the therapist first gives his or her response, and then the patient gives his or her response.

When using tests such as the TAT, or other related tests, the examiner might respond with his or her own story immediately after the patient tells a story to each card. Although this approach may skew findings for the later cards, it is also possible that each story the patient tells is a symbolic response to the previous story by the clinician. Therefore, what may be developed here is a series of card-by-card communications from the patient to clinician, and from the clinician to the patient. It is perfectly appropriate, however, for the clinician to first obtain the patient's responses to all the cards before he or she begins responding to the child's or adolescent's stories.

Usually, when I use the TAT or related tests I listen carefully for themes that represent difficulties or problems in each story as the child or adolescent tells it and as I write it. Typically I wait to respond until the test is completed. However, sometimes, with younger children, I respond with my story as soon as I identify a problem theme. I also ask the child or adolescent what he or she thought of my story and ask the child to identify his or her favorite part. Sometimes, in order to determine how my story affected the child or adolescent, after I tell my story I ask him or her to tell another story to the card. The changes in the story often reflect the effects of my communication. For example, if the child's or adolescent's story concerns anger at a parent and my story deals with resolution of that problem, the patient's story might include a section about his or her affection for the parent.

Board Games

Gardner devised a number of interesting board games that are based on his mutual storytelling approach, such as the Pick and Tell game, in which the child/adolescent and assessor/therapist move a pawn around the board, using the traditional method of throwing the dice. When the patient lands on a specific space, he or she, without looking, must pick an item out of one of four different bags—the bag of faces, the bag of toys, the bag of words, or the bag of acts—and must then tell a story about the item chosen. The exception is the bag of acts, where the child must perform the act indicated on the card. The client is rewarded with chips if he or she tells a story, and with fewer chips if the story is less well developed. The game may be played by the patient alone, in an assessment phase, or the child/adolescent and the therapist can play together, each telling a story about the object they chose from the bag. A clinician using this game for therapeutic assessment should feel free to modify the approach, such as, for example, having the clinician tell a story in response to the child's/adolescent's story rather than having the clinician tell a story to his or her own selected card.

Another game designed by Gardner is the Thinking, Feeling, Doing Game, in which the client and assessor/therapist move around the board, using a throw of the dice, landing on different colored spaces. Depending on the color of the square on which the mover lands, the player selects a talking card, a feeling card, or a doing card. The child/adolescent or the therapist must read the card and respond to it. For example, one card reads, "Everyone in the class was laughing at a boy. What had happened?" When a child expresses a feeling or thought the therapist thinks is important to discuss, he or she helps the child express these thoughts and feelings. I tried using this game with children and young adolescents. However, I didn't feel we made any therapeutic progress, but other therapists sing its praises.

Another game devised by Gardner is the Storytelling Card Game, which is a cleverly disguised version of the Make a Picture Story Test (MAPS), a test devised by Shneidman (1952), but which is no longer published or available. In the MAPS, as in the Storytelling Card Game, there are a variety of typical scenes or backdrops, with no people or animals in them, and a variety of human and animal figures available to place in the scenes. The client is asked to make up a story using one of the backdrops and several people and/or animals. Recently, I found an old copy of the MAPS test in a storage closet at the university and realized that the backgrounds and people looked quite dated. Gardner's cards are much more up to date. According to Gardner, the clinician can respond to the child's story by making up his or her own story. The patient's story can also be used for exploration. Doing the latter would not be a therapeutic assessment approach, but doing the former would certainly be consistent with the therapeutic assessment paradigm.

There are a number of board games produced and marketed by a wide variety of sources, many available online, that purport to provide behavioral or emotional change. For example, Peacetown purports to teach children and adolescents how to resolve conflict; Exploring My Anger, Angry Animals, Furious Fred, Breaking the Chains of Anger, the Conduct Management Game, and From Rage to Reason are purported to help a child or adolescent learn to control anger; and the Social Conflict Game is designed to be used with children and adolescents who experience frequent conflict with peers. There are games for dealing with sexual abuse and domestic violence (The Peace Path); for helping a child or adolescent deal with personal loss (The Good Mourning Game); games to stimulate the child or adolescent's creativity and problem solving (Imagine, the Ungame, the Nurturing Game); and even games to help a child or adolescent give up self-defeating behaviors (the Use, Abuse, and Recovery Game). In sum, there is almost no limit to the games available that purport to deal with children's and adolescents' emotional problems and life and living problems. Most of these games could be used in a therapeutic assessment paradigm. They are available from such online sources as, for example, childtherapytoys.com, selfhelpwarehouse.com, feelingcompany.com, childwork.com, and creativetherapystore.com. Although I do not endorse these websites, they seemed to have available a wide variety of the games mentioned above, along with many others.

The Use of Photography in Therapeutic Assessment

Wolf (1976) indicates that the use of various photographic techniques stimulates significant progress in psychotherapy with resistant patients. He used a Polaroid camera, an early "instant" film version of the digital camera, to help children and adolescents take a closer look at themselves and focus on aspects of their personality that had previously been too anxiety-provoking to discuss openly. He states, "We have found that the photo itself often serves to initiate those important discussions which ultimately elicit significant material. This brings new energy and interest into our therapeutic sessions" (p. 198). Such use of photographs can also be incorporated at the beginning of therapy.

In this approach the clinician introduces a Polaroid, digital, or traditional film camera and asks the adolescent to take a picture of himself/herself, either pretending to do something, making a silly face, or giving his or her feelings a bodily or facial expression. He asks the client to cut the picture away from its background and then invites him or her to "play" with the photos by drawing whatever they wish to add, cut out whatever they wish to eliminate, and elaborate upon the photo in any way they choose. The therapist then collaborates with the client in exploring underlying content.

Stephen Finn (personal communication, November 20, 2004) describes an alternative way of using photography in therapeutic assessment. He cites the case of an eight-year-old boy in the third grade. He was acting up a great deal, both in school and at home. This behavior problem began about a year before his parents brought him for an evaluation. When asked about anything that had happened in the family or at school at about that time, the parents could not think of anything that would have produced this acting-out behavior.

The boy was given some standard assessment instruments, but nothing remarkable came through, except that he showed some depression on the Rorschach. As part of the assessment the boy was given a disposable camera that was capable of taking 12 pictures and was asked to take it home to take pictures of the 12 most important people and things in his life. After he brought the camera back, Finn had two identical sets of pictures made, one for him and one for the boy.

At the next session the boy was asked to tell what each picture was and why it was important to him. Finn then asked him to take the pictures and put them on the table and arrange them from the most important to least important. The boy arranged the 12 pictures as follows: his cat, his dog, his mom, his dad, and *eight* pictures of a photograph of his mother's brother, who had died a year before, of AIDS.

The family was a Christian family and the parents were very embarrassed that the uncle had been gay and had died of AIDS. The boy was very close to his uncle and had spent a great deal of time with him. The boy was not allowed to see him as he was dying, or even to go to the funeral. The family had not talked about the uncle's death at all.

The parents watched from a separate room, over a video link, as Finn and the boy discussed the loss of his uncle. They were shocked when they heard their son tell Finn about his loss and sorrow. Finn later told the parents he did not think the boy had had a chance to grieve over the loss of his uncle, and the parents admitted that they did not know what to say to the boy or what to do when the uncle died. He planned with the parents a way to talk to the boy about his uncle's death.

At the next session, Finn planned a ceremony with the entire family, to say goodbye to the uncle. During the ceremony the mother cried uncontrollably about her brother's death. Follow-up sessions revealed that the boy's acting out had stopped, both at home and at school.

This case vignette illustrates the importance of using the information acquired in the assessment session to inform the parents about the source of the child's problem and to plan with them a way to repair the problem. Of course the child must also be made aware, either directly or indirectly (e.g., metaphorically), of the source of the problem and of the solution. However, it is important that both the child and the parents be made aware of the source of the problem and the solution planned.

Yet another way of using photographs is to ask the patient to bring in unposed (candid) family pictures, without sorting them first. We examine the pictures together and compare our impressions of them and then discuss what they might signify about the relationship of the people in the pictures. For example, a 17-year-old boy who enjoyed a close, positive relationship with his father felt his father had stopped loving him because he had increasingly become remote and distant from the boy. The boy blamed himself for the damaged relationship, and he believed the father preferred a younger brother, or his baby sister. The early photographs seemed to confirm the boy's impression that he and his father had a close, positive connection. For example, in many of the pictures the father had his arm around the boy's shoulder and in one picture the father was proudly displaying his son to a large group of friends and family.

As we continued to look at later pictures, I noted fewer of them showed this loving pattern. Instead, the father, who seemed to have aged dramatically in a very short time, showed up in group pictures detached from everyone, and now standing in the back of the group rather than in the forefront. Now the boy was standing alone, detached from the group. I asked the boy what was happening in the family in that picture. To my surprise he said, "I think that was about the time my father started getting sick." I was surprised at his comment, because he had not mentioned his father's illness before this interaction. "What do you think was going on at the time this picture was taken?" I asked. The boy began to cry, realizing, for the first time, that his father had withdrawn from everyone, including him, after the initial diagnosis of his serious illness. The family had placed a premium on keeping things as they were before the illness, and everyone in the family was in denial of the seriousness of the father's illness. It was at this point the boy began to actually mourn his father's death, some two years after his father had died.

CHOOSING SUITABLE THERAPEUTIC ASSESSMENT APPROACHES

The decision concerning which ta approach to use should not be determined by age alone. In fact, I believe the decision concerning which approach to use should instead be made on the basis of the child's or adolescent's level of emotional development. Any of the ta approaches described in this chapter can be used with both children and adolescents, but some are more appropriate than others if the child's age and developmental levels are congruent. The lower the adolescent's developmental level, the more he or she will be happy with those approaches that are less challenging and less complex. For example, a very immature 14-year-old boy chose to play Chutes and Ladders, or Candyland, two games based on chance alone. He also loved to draw fantasy animals and tell stories about them.

Although it is true that any of the approaches described in this chapter are appropriate for children and adolescents, it is important to recognize that some children and adolescents are very threatened or even traumatized by the possibility of losing a game based on skill alone. However, they are typically not so disturbed by losing a game based on chance alone. Therefore, modifications must be made in each of the approaches described herein, to match the developmental level of the child or adolescent. Most adolescents whose developmental level is age-appropriate would prefer to play checkers, chess, or some other game of skill, such as Stratego, whereas latency-age children prefer games based on chance alone. Some older latency-age children are often comfortable playing games based on both chance and skill, such as Monopoly. The game Monopoly for Juniors has been modified so that the skill component has been reduced; it is primarily now a game of chance.

The Fantasy animal approach is typically appropriate for children, but, as indicated above, many adolescents enjoy it. The same may be said of the Squiggle Game. I have used it with adolescents who do not think it is stupid to play in this manner. Winnicott (1971, 1972, 1989) cites a number of case studies in which he and the adolescent patient squiggled.

Various approaches to Drama therapy, Gestalt therapy, and Psychodrama are more useful with adolescents, but children enjoy them as well (e.g., Brooks, 2002). The same is true for the use of various photographic techniques discussed in this chapter. Art techniques are useful with children and adolescents because the approaches can be modified to suit the developmental level of the child or adolescent. All the projective tests and photography methods can be used effectively with children and adolescents

Case Study

Lisa is a blond, blue-eyed, eight-year-old girl whose parents came from Kansas to work in Knoxville's tourist industry. Lisa's mother died after a long illness, about six months before Lisa came for therapy; her father has custody of her, but the mother's parents also want custody of Lisa and her five-year-old brother. Lisa's father does not recognize her feelings of abandonment and extreme vulnerability. She clings to her father and has announced to everyone that she wants to live with him, rather than with her grandparents, who live nearby. Lisa's father said she had not shown any sadness concerning the loss of her mother and felt this was a good thing because it meant she was getting over the loss. Even though I explained this was not a good sign because she was not expressing her loss and was containing it, he nonetheless still felt it was a sign of progress.

During the first three sessions the child appeared distant and irritable. She was moody and did not relate to me very much. She spent most of her time playing alone, with one toy or game, or another, but spent only a few minutes with each one. She was arrogant and demanding, refusing to discuss anything with me, and certainly not her mother's death. Instead, she assumed an air of pseudo-independence and criticalness, expressed mainly through her negative evaluation of the toys. Lisa's hyperactivity seemed to me to be part of the way she dealt with the loss, literally hurling herself into action and moving rapidly from activity to activity. She soon began to settle down, spending most of the sessions drawing. She rarely responded to my questions about what she was drawing, and when she did, it was with much irritation.

Lisa soon became more responsive, and so I asked her, during one session, if she would "draw a make-believe animal, one that no one has ever seen before." She turned away from me and drew a picture of a boy, next to a fox, shouting "Help, help!" Lisa said someone was saying, "Booga-booga-boo," as if to frighten the fox away. She told the following story: "There once was a fox with a tail that is short and it had no whiskers. The fox lived in the woods. His mom died. One day *I* was in the forest. I saw it. It was big, but friendly. It had a sister and a brother. His dad, he went to get food one day and a hyena came and killed him. The kids were sad but they knew they loved him, so they went to a cave and they lived happily ever after."

The story appeared to be autobiographical, especially because Lisa personally entered the story. She showed obvious concern about her father and the feeling that she would lose him as well, and then denied the loss, as she had been doing previously (i.e., "they went in a cave and they lived happily ever after").

I then began to tell my story, in response to her story: "Once upon a time there was a fox in the woods and his mom died and the dad was with them. The kids were all sad, and they were scared, too. 'What will happen if you die, too?', they asked the dad. 'Oh children,' he said, '*I* am strong and healthy and I will be alive for many, many years, and I will always be with you and take care of you.' The children started to smile and then they laughed, and they climbed on their dad and kissed and hugged them." At this point Lisa corrected me, "hugged and kissed," she said. This correction indicated that she was paying close attention to my story. I continued, "and they all laughed together and then the dad made dinner for everyone to eat."

At this point Lisa interrupted again, and said, "You forgot to say, 'Don't worry, I will always be with you.' Then she got sick and had to die." Lisa was obviously referring to a conversation she had had with her mother when her mother became ill. But then she quickly returned to the story again, saying, "She died because of the hyena—no, a mountain lion."

Somewhat startled, and with sadness in my heart, I constructed the remainder of my

story, modified by Lisa's input: "Then the children said to the dad, 'Mama promised us she would always be with us, but then she died. She promised but she couldn't keep her promise, because the hyena-the mountain lion killed her.' 'Well', said the dad, 'I can beat up any mountain lion or any other animal in the woods or the jungle. No animal can hurt me or kill me, so I can, can, can promise you I will be there whenever you need me. If you close your eyes and see a picture of your mother, she can always be with you in your mind. So the kids all closed their eyes and got pictures of their mama in their minds, and they said, 'Hi mom, I'm so, so, so, so, glad to see you.' And they were happy."

As I told my story, Lisa became better connected with me, more cooperative, and quite a bit friendlier. She asked me to repeat the stories. I soon felt her hard shell softening, which I felt was definitely due to my story and her ability to begin telling me how hurt she was that her mother promised she would always be with Lisa, and then had disappointed her. She was also able to tell me, in her narrative, that she felt she would lose her father as well, and would retreat from interpersonal relationships from then on. As we were about to end the session, she spoke to me directly for the first time. In a soft voice I had not heard before she said, "My momma died and I live with my daddy. He takes good care of me; I love him."

The reader might notice how Lisa personalized the story about an animal, both in content and in the personalization, when she used the word "I" in placing herself in the forest. I believe the child was relieved that she could begin talking about her mother's death, and about the possibility she could also lose her father as well. I inadvertently said, in my story, what Lisa's mother had told her, in an effort to protect and soothe the child. I had not been aware that Lisa's mother told her daughter she would not die, even though she was very ill, or that the child believed her. Imagine the shock and the anger she felt at her mother for telling her something that was not true. When I shared Lisa's story with her grandparents, they indicated that their daughter had indeed told Lisa she would not die.

In the two sessions after the interaction reported above, Lisa was much less hyperactive. She and I were able to complete an entire game, and she was now much more verbal. Her grandmother indicated she was still quite bossy, even arrogant, with family members. I decided to address the issue metaphorically, by telling her a story. I told her a story about Roger, the dog, who needed to learn how to get along with his family. Therefore, the owner took Roger to dog school, where the teacher told Roger she would help him get along by using treats and not punishment. So the teacher said "sit" to Roger, and when he sat down, she gave him a delicious doggie treat.

Suddenly, Lisa got down on all fours, saying she wanted to be Roger. She made believe she was eating the doggie treat. Then I described another scene where Roger was given a doggie treat when he would lie down. Again Lisa gobbled up the imaginary doggie treat and wagged her behind. I ended the story by saying, "Roger, you are a wonderful doggie," and Lisa "trotted" over to me to be petted. I then asked Lisa if she would tell a story about Roger. She told the following story:

"Roger came to a neighbor and said, 'My owner—she's a little three-year-old girl with pigtails—was kidnapped.' So the neighbor and Roger went to find her. So they went into the woods and they saw her lying on the ground, with her eyes closed, and they thought she was dead. But she wasn't; she was just sleeping." I felt this was Lisa's denial again of her mother's death. I felt she could now handle a more reality-based intervention, so I said, "So sometimes people who are sleeping look like they're dead and sometimes people who are dead look like they're just sleeping." Lisa immediately said, "Yes!" and added, "I wish my momma was sleeping and not dead. I think about it all the time. I wish she was really just sleeping." I asked, "Do you dream about your momma?" "Yes!" she replied, "I get scared

sometimes. I dream about her being dead and being here. Sometimes I dream I die and I go to Heaven and see Jesus and her in Heaven. I dreamed I got hurt and she took care of me. I miss her. I dream about Swiper, the evil fox [from a TV show, she says, called Dora the Explorer], took my momma and I never saw her again. When she was sick I said, 'I'm afraid you'll die.'" I asked Lisa what her mother answered. Lisa replied, "She said, 'that will never happen. Think of happy things.'" I then told Lisa that her momma wanted to stay with her, but she got sick, really sick. "It's very sad that she died," I said, "but she can be there for you in your memories and in your thoughts and in your dreams. She was a good momma and she took good care of you. Now your grandparents want to take care of you and your daddy wants to take care of you, too."

In this second story Lisa was continuing to work out her feelings about the loss of her mother, dealing with the sadness, but not yet approaching the underlying anger related to her mother's breaking her promise not to die. The second story allowed me to evaluate the progress we had made in therapy and the direction of future goals.

SUMMARY

This chapter describes a paradigm shift in the clinical use of assessment, called therapeutic assessment, which is more consistent with an intersubjective psychoanalytic approach and narrative therapy approach, compared with the traditional psychoanalytic and psychometric assessment traditions. The approach highlights a more collaborative method of clinical application, in which assessment and treatment are combined. The combination of assessment and therapy, often in a single session, has been effective in facilitating significant therapeutic change in the patient/client. Several methods of adapting traditional assessment techniques for use in this paradigm were described, as were nontraditional approaches. Finally, a case study was included to illustrate the application of one storytelling approach.

ACKNOWLEDGMENTS

I thank Stephen Finn for reading and commenting on an earlier draft of this chapter.

NOTE

1. Many clinicians who do therapeutic assessments use the term "client" rather than the term "patient." They make good arguments for using "client," as do those who use "patient." Therefore, I have decided to use the two terms interchangeably in this chapter.

REFERENCES

Barber, R. (1996). The experience of being psychologically evaluated: A phenomenological inquiry (Doctoral dissertation, University of Tennessee, Knoxville).

Bellak, L., & Bellak, S. (1949). *The Children's Apperception Test.* Larchmont, NY: C.P.S.

Beutler, L., & Berren, M. (Eds.). (1996). *Integrative assessment of adult personality.* New York: Guilford Press.

Brooks, R. (2002). Creative characters. In C. Schaefer & D. Canglosi (Eds.), *Play therapy Techniques* (2nd Ed.) (pp. 269–282). Lanham, MD: Jason Aronson.

Costantino, G., Malgady, R., & Rogler, L. (1988). *TEMAS (Tell-Me-A-Story) manual.* Los Angeles: Western Psychological Services.

Engelman, D., & Allyn, J. (2005, July). *Use of a Rorschach percept to construct a therapeutic story.* Paper presented at the XVIII International Congress of Rorschach and other Projective Methods, Barcelona, Spain.

Exner, J. (2003). *The Rorschach: A comprehensive system* (4th Ed.). Hoboken, NJ: John Wiley.

Finn, S. (1996). *Manual for using the MMPI–2 as a therapeutic intervention.* Minneapolis, MN: University of Minnesota Press.

Finn, S. (2002, March). *Challenges and lessons of intersubjectivity theory for psychological assessment.* Paper presented at the Annual Meeting, Society for Personality Assessment, San Antonio, TX.

Finn, S., & Martin, H. (1996). *Therapeutic assessment with the MMPI–2 in managed healthcare.* In J. Butcher (Ed.), Personality assessment in managed healthcare: Using the MMPI–2 in treatment planning (pp. 131–152). New York: Oxford University Press.

Finn, S., & Tonsager, M. (1992). Therapeutic effects of providing MMPI-2 test feedback to college students awaiting therapy. *Psychological Assessment, 4,* 278–287.

Finn, S., & Tonsager, M. (1997). Information-gathering and therapeutic models of assessment: Complementary paradigms. *Psychological Assessment, 9,* 374–385.

Fischer, C. (1985/1994). *Individualizing psychological assessment.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Gardner, R. (1971). *Therapeutic communication with children: The mutual storytelling technique.* New York: Jason Aronson.

Gardner, R. (1975). *Therapeutic approaches to the resistant child.* New York: Jason Aronson.

Gardner, R. (1986). *The psychotherapeutic techniques of Richard Gardner.* Creskill, NJ: Creative Therapeutics.

Gardner, R. (1993). *Storytelling in psychotherapy with children.* Northville, NJ: Jason Aronson.

Handler, L. (1988, March). *The use of Inquiry and Testing of the Limits in WISC and WAIS Interpretation.* Paper presented at the Annual Meeting, Society for Personality Assessment, New York.

Handler, L. (1996, March). *Single projective test responses which illuminate therapeutic issues.* Paper presented at the Annual Meeting, Society for Personality Assessment, Denver, CO.

Handler, L. (1998). The clinical interpretation of the Wechsler Intelligence Tests as personality instruments. In L. Handler & M. Hilsenroth (Eds.), *Teaching and learning personality assessment.* (pp. 245–324). Mahwah, NJ: Lawrence Erlbaum Associates.

Handler, L. (1999). The assessment of playfulness: Herman Rorschach meets D. W. Winnicott. Invited Special Series, The Assessment of Psychological Health. *Journal of Personality Assessment, 72,* 208–217.

Handler, L. (2002, July). *Non-traditional approaches to the administration and interpretation of projective techniques.* Paper presented at the XVII International Congress of Rorschach and Other Projective Methods, Rome, Italy.

Handler, L. (2004, August). *A changing paradigm in personality assessment.* Annual Meeting, European Rorschach Society, Stockholm, Sweden.

Handler, L. (2005, July-a). *A Rorschach assessment amplified, using play in Testing of the Limits.* Paper presented at the XVIII International Congress of Rorschach and Other Projective Methods, Barcelona, Spain.

Handler, L. (2005, July-b). *The administration and interpretation of the Rorschach in light of changes in psychoanalytic theory.* Paper presented at the XVIII International Congress of Rorschach and Other Projective Methods, Barcelona, Spain.

Handler, L. (in preparation). *Therapeutic assessment with children and adolescents.* Mahwah, NJ: Lawrence Erlbaum Associates.

Handler, L., & Hilsenroth, M. (1994, April). *The use of a fantasy animal drawing and storytelling technique in assessment and psychotherapy.* Paper presented at the Annual Meeting, Society for Personality Assessment, Chicago.

Klopfer, B., Ainsworth, M., Klopfer, W., & Holt, R. (1945). *Developments in the Rorschach technique* (Vol. 1). Oxford, England: World Book.

Lieblich, A., McAdams, D., & Josselson, R. (Eds.) (2004). *Healing plots: The narrative basis of psychotherapy.* Washington, DC: American Psychological Association.

Machover, K. (1949). *Personality projection in the drawing of the human figure.* Springfield, IL: Charles Thomas.

McAdams, D. (1985). *Power, intimacy, and the life story: Personological inquiries into identity.* New York: Guilford Press.

McAdams, D. (1993). *The stories we live by: Personal myths and the making of the self.* New York: William Morrow.

McAdams, D., Josselson, R., & Leiblich, A. (Eds.) (2001). *Turns in the road: Narrative studies of lives in transition.* Washington, DC: American Psychological Association.

McArthur, D., & Roberts, G. (1982). *Roberts Apperception Test for Children manual.* Los Angeles: Western Psychological Services.

McLeod, J. (1997). *Narrative and psychotherapy.* London: Sage.

Mitchell, S., & Aron, L. (1999). *Relational psychoanalysis: The emergence of a tradition.* Hillsdale, NJ: Analytic Press.

Morgan, C., & Murray, H. (1935). A method for investigating fantasies: The Thematic Apperception Test. *Archives of Neurology and Psychiatry, 34,* 289–306.

Mutchnick, M., & Handler, L. (2002). Once upon a time . . . : Therapeutic interactive stories. *Humanistic Psychologist, 20,* 75–84.

Orange, D., Atwood, G., & Stolorow R. (1997). *Working intersubjectively: Contextualism in psychoanalytic practice.* Hillsdale, NJ: Analytic Press.

Pollack, J., Cohen, H., & Weil, G. (1982). The Tasks of Emotional Development test: A survey of research applications. *Psychology—A Journal of Human Behavior, 18*(4), 2–11.

Schafer, R. (1954). Some applications of contemporary psychoanalytic theory to projective testing. *Journal of Projective techniques, 18,* 441–447.

Schafer, R. (1956). Transference in the patient's reaction to the tester. *Journal of Projective Techniques, 20,* 26–32.

Schneidman, E. (1953). Manual for the Make A Picture Story Test. *Projective Techniques Monographs, No. 2.*

Stolorow, (2001). Foreword to Buirski, P., & Haglund, P. *Making sense together.* Northville, NJ: Jason Aronson.

Stolorow, R., Brandchaft, B., & Atwood, G. (1987). *Psychoanalytic treatment: An intersubjective approach.* Hillsdale, NJ: Analytic Press.

Winnicott, D. (1971). *Therapeutic consultations in child psychiatry.* New York: Basic Books.

Winnicott, D. (1972). Basis for self and body. *International Journal of Child Psychotherapy, 1,* 7–16.

Winnicott, D. (1989). Two further clinical examples. In C. Winnicott, R. Shepherd, & M. Davis (Eds.), *Psychoanalytic explorations* (pp. 272–283). Cambridge, MA: Harvard University Press

Wolf, R. (1976). The Polaroid technique: Spontaneous dialogues from the unconscious. *Art Psychotherapy, 3,* 197–214.

Young, G., & Wagner, E. (Eds.). (1999). *The Hand Test: Advances in application and research.* Malabar, FL: Kreiger.