

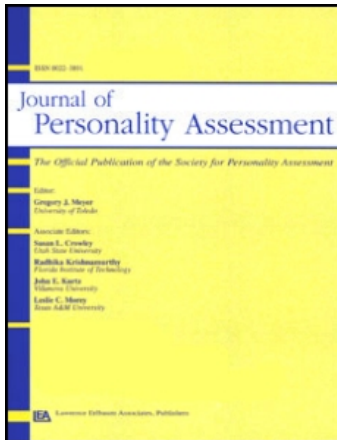
This article was downloaded by: [rholigrocki]

On: 13 August 2009

Access details: Access Details: [subscription number 913850348]

Publisher Routledge

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



Journal of Personality Assessment

Publication details, including instructions for authors and subscription information:

<http://www.informaworld.com/smpp/title-content=t775653663>

Interventional Use of the Parent-Child Interaction Assessment-II Enactments: Modifying an Abused Mother's Attributions to Her Son

Richard Holigrocki ^a; Robbi Crain ^b; Yvonne Bohr ^c; Kelly Young ^b; Heather Bensman ^d

^a School of Psychological Sciences, University of Indianapolis, ^b Julian Center, Indianapolis, Indiana ^c Department of Psychology, York University, Toronto, Canada ^d Children's Medical Center, Dallas, Texas

Online Publication Date: 01 September 2009

To cite this Article Holigrocki, Richard, Crain, Robbi, Bohr, Yvonne, Young, Kelly and Bensman, Heather(2009)'Interventional Use of the Parent-Child Interaction Assessment-II Enactments: Modifying an Abused Mother's Attributions to Her Son',*Journal of Personality Assessment*,91:5,397 — 408

To link to this Article: DOI: 10.1080/00223890903087430

URL: <http://dx.doi.org/10.1080/00223890903087430>

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: <http://www.informaworld.com/terms-and-conditions-of-access.pdf>

This article may be used for research, teaching and private study purposes. Any substantial or systematic reproduction, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

CLINICAL CASE APPLICATIONS

Interventional Use of the Parent–Child Interaction Assessment–II Enactments: Modifying an Abused Mother’s Attributions to Her Son

RICHARD HOLIGROCKI,¹ ROBBIE CRAIN,² YVONNE BOHR,³ KELLY YOUNG,² AND HEATHER BENSMAN⁴

¹*School of Psychological Sciences, University of Indianapolis*

²*Julian Center, Indianapolis, Indiana*

³*Department of Psychology, York University, Toronto, Canada*

⁴*Children’s Medical Center, Dallas, Texas*

We describe the assessment and treatment of a mother who was a victim of domestic violence and of her 10-year-old son, both of whom were living in a domestic violence shelter. The Parent–Child Interaction Assessment–II Modifying Attributions of Parents intervention (PCIA–II/MAP; Bohr, 2005; Bohr et al., 2008; Bohr & Holigrocki, 2005) is a structured brief treatment using video recordings from a parent’s play with his or her child. The play involves using toy people and animals to complete story stems related to a trip to the zoo (see Holigrocki, Kaminski, & Frieswyk, 1999, 2002). The therapist shows the parent video excerpts of the interaction, invites reflection and commentary, and collaborates with the parent to change how she makes sense of her child’s behaviors. The pretreatment assessment revealed a depressed, fearful, highly stressed mother with a harsh parenting style. Her son experienced significant distress; had behavior problems; and viewed adults as harsh, fragile, irresponsible, and unavailable. Posttreatment gains were evident in the parent’s reduced depression and greater parenting sensitivity; however, parenting stress and child behavior problems remained elevated. We emphasize the utility and application of a multimodal assessment that integrates rating scales, free response, and video-recorded interactions.

Due to the efforts of clinicians such as Connie Fischer and Stephen Finn, there has been increasing attention paid to the value of assessment and feedback models that elicit the assistance of the individual who is being assessed. Fischer (1985/1994, 2000) has described collaborative assessment as an activity in which the client and the assessor coconstruct an understanding of the client’s life world and try out alternative approaches to problematic situations. Finn and Tonsager’s (1997; see also Finn, 2007) assessment model also elicits a collaborative discussion of assessment findings, which includes a dialogue about the client’s ways of responding to problems. The aim is for clients to gain new ways of understanding that help them to change their behaviors, thoughts, and feelings so that they may better address their difficulties. Tests are used idiographically and nomothetically; and data may draw on the client’s subjective experience, the therapist’s subjective experience, and the dynamic interplay between the two. The assessor is fully embedded along with the client in the assessment process; and an assessment is considered successful when the client feels understood, learns new ways of being, is changed, and is able to sustain the change.

The removal of some barriers between assessor and client, or encouraging the client’s active role in the assessment pro-

cess, is clearly part of humanistic and cognitive constructivist traditions. Elements of collaborative initiatives appear in the psychodynamic assessment literature as well. Many examples of this collaborative approach can be found in publications by the psychologists who were trained in the Menninger School of Assessment (see Allen, 1981; Berg, 1985; Schlesinger, 1973; Sugarman, 1981).

Whether construed from a humanistic, psychodynamic, or other theoretical framework, such constructivist methods of psychological assessment and treatment have often sought to draw on the expertise of the person who is being assessed. The assessor develops a coconstructed and experience-near picture of the client by using the client’s questions during the assessment and the client’s interpretations of her or his own responses. Accompanying the greater insight and understanding garnered from the process of assessment comes the opportunity for the client to generate more choices, have more influence in her or his change process, and experiment with alternative behaviors. The effective effort on the part of the assessor to develop such enhanced client capabilities yields an assessment that seamlessly merges into treatment.

In contrast to the therapeutic approach of assessment, traditional information-gathering models of assessment strive for accurate description to assist with communication between professionals to enhance decision making and the prediction of client behaviors (see Finn & Tonsager, 1997). Assessors strive to be objective observers who utilize measures for nomothetic comparisons. The primary source of data is test scores, and

Received October 23, 2006; Revised January 25, 2009.
Address correspondence to Richard J. Holigrocki, School of Psychological Sciences, University of Indianapolis, 1400 E. Hanna Avenue, Indianapolis, IN 46227; Email: rholigrocki@uindy.edu

clients participate as producers, not interpreters, of data. Assessment is successful when the data collected are reliable and valid, recommendations are heeded, and correct decisions are made.

Therapeutic assessment compared to traditional assessment not only involves an increase in the client's active participation but also a systems focus. Tharinger et al. (2008), for example, commented on the disjunction between the widespread acknowledgement of the importance of family systems in influencing child functioning and the limited ways systems perspectives are incorporated into the psychological assessment of children. Traditionally, parents contribute to assessments by completing rating scales about themselves or their children. Therapeutic assessment, on the other hand, supplements traditional assessment by discussing with parents the child's assessment as it is observed and often assesses parents as they take part with their children in a structured family intervention (see also Tharinger et al., 2009). Tharinger et al.'s (2008, 2009) work shares with our own a movement from an individual-centered assessment model to a model that expands to include systemic or relational assessment.

We describe a model of parent-child assessment and treatment that is based in collaborative and therapeutic assessment while employing aspects of traditional information-gathering assessment. We invite feedback from parents on video-recorded interactions with their children. Our efforts involve focusing these feedback sessions on changing parental attributions, a critical variable in parent-child relationship quality (Bugental, Johnston, New, & Silvester, 1998; Schechter et al., 2006). Following a traditional model, we use several rating scales and a free-response measure to inform the upcoming treatment process, develop a pretreatment baseline, assess posttreatment change, and measure treatment effects at follow-up.

PCIA-II ASSESSMENT

The Parent-Child Interaction Assessment-II (PCIA-II; Holigrocki, Kaminski, & Frieswyk, 1999, 2002) is a constructivist method of assessing parents and children. As part of this assessment, we film parent-child dyads as they play with toy people and animals during an imaginary trip to a zoo. Like other story stem measures, data are elicited about the parent and child across multiple contexts. A total of 15 scenarios are enacted such as when the child is lost at the zoo or the parent and child encounter a stranger. We refer to these PCIA-II scenarios as coconstruction tasks, as they involve constructive processes activated by both the parent and child.

During the standard PCIA-II inquiry procedure, the parent and child are individually shown excerpts from their video recording and asked questions pertaining to the mentalizing functions of each person (see Holigrocki & Hudson-Crain, 2004; Holigrocki & Kaminski, 2002; Holigrocki & Raches, 2006). For example, the child is shown a segment of the video and is asked to reflect on what he or she and the parent were thinking, feeling, and wanting. The parent completes a similar inquiry. What is of most interest to us is not the accuracy of what they are recalling, which is an objectivist concern; rather, inquiry data are viewed as the product of their current construction of the recently undertaken activities.

For clinical purposes, PCIA-II videos are usually coded using content analysis methods; however, specific observational

codes have been developed by the authors for use in research (see Holigrocki, 2009). Coding systems, such as the Atypical Maternal Behavior Instrument for Assessment and Classification (AMBIANCE; Bronfman, Parsons, & Lyons-Ruth, 2004; Lyons-Ruth, 2000) that was developed for classifying mother-infant interaction, is adequately conceptually robust to describe essential features of PCIA-II interaction with parents and school-age children.

INTERVENTION

Attributions

Hollon and Kriss (1984) organized cognitive factors into the mutually influencing domains of structures, processes, and products. Knowledge structures, such as schemata, consist of specific information, rules, and prototypes that serve to organize old and new information. Cognitive processes, such as assimilation and accommodation, describe how the cognitive structures are modified, maintained, and activated. Cognitive products are the output of the cognitive structures; hence, they are signs that stand for both the structures and the processing activity. Attributions are cognitive products, or interpretations, that refer to the ways in which we explain, evaluate, and predict the behavior of others and ourselves.

Attributions as mediators or moderators of behavior have been subject to much study and the generation of several implicit models. They have been conceptualized as stimulus-dependent appraisal events, reliant on information from the immediate context, but also as memory-dependent, or influenced by the interpreter's history (Bugental et al., 1998). Much research has been based on the early work on attributional bias, starting with Ross's (1977) seminal research on observer effects or the "fundamental attribution error." This theory stipulates that individuals from Western cultures have a tendency to attribute others' actions to internal factors (e.g., character) more than to context and circumstances, whereas the converse is true when those same individuals explain their own actions. Another type of attributional bias received attention in investigations of the information processing of aggressive youths. Hostile attribution bias, an unwarranted attribution of hostile intent to others, was seen to originate in schemata based on the observer's background and to lead to unwarranted aggression (Dodge & Crick, 1990; Epps & Kendall, 1995). It is this type of bias, and aggression, which is of particular concern in maltreating parents.

Parental attributions are cognitions directed toward making sense of a child's behavior. Research suggests that these attributions have an impact on the parent's immediate affective and behavioral responses to the child as well as the long-term quality of the parent-child relationship (Bugental & Goodnow, 1998; Miller, 1995). Attributions vary across many dimensions such as their positive and negative valence and accuracy. However, in saying this, we are aware of the epistemological morass of attempting to determine whether an attribution is justified or accurate in any given situation. Nevertheless, if we allow consensus to be our guide, there are clearly some parental attributions that fall far from the mark, whereas other attributions tend to be shared or easily understood by skilled observers. This line of reasoning may bring to mind considerations of minus versus ordinary form quality on a Rorschach test, whereby consensus allows one to sidestep an objectivist conception of reality without sacrificing clinical utility.

Research has linked parental attributional bias to problematic parenting practices. Abusive or physically coercive parents are more likely to attribute defiant intentions to their children, view themselves as lacking power, and be highly controlling. Further, blame-oriented or hostile attributions may precede and foster ineffective, overreactive, or harsh disciplinary practices as well as child conduct problems (see Bradley & Peters, 1991; Bugental and Johnston, 2000; Nix et al., 1999; Smith & O'Leary, 1998; Snyder, Cramer, Afrank, & Patterson, 2005). Most relevant to our work is the empirical research by McGuigan, Vuchinich, and Pratt (2000), which demonstrated that the relationship between domestic violence and a family's risk of child abuse was mediated by a parent's negative views of the child. Efforts directed at modifying the parental attributions of victims of violence are expected to improve parental functioning. The modification of attributions in psychotherapy is nothing new, as it is a variant of the classic cognitive psychotherapy introduced by Beck (1976) in which clients are encouraged to examine dysfunctional interpretations of interpersonal events and replace them with more constructive cognitions about their relationships.

PCIA-II/MAP

Clinicians can draw inferences about parental attributions from the data gathered during the parents' dialogue about the PCIA-II video-recorded interactions. Bohr (2005) and her clinical team in Toronto, Canada have been employing the PCIA-II in a treatment program for high-risk parents for the past 4 years. As part of this initiative, they expanded the PCIA-II inquiry and developed the PCIA-II Modifying Attributions of Parents intervention (PCIA-II/MAP; Bohr, 2005; Bohr et al., 2008; Bohr & Holigrocki, 2005), which is a structured intervention that integrates a cognitive-behavioral therapy brief-treatment model with direct observation and video-recall methods of assessment. The PCIA-II/MAP elicits parents' interpretations of their children's behaviors and provides a pathway for modifying parental attributions.

The assessment and treatment involve approximately 10 hours of time with the client (i.e., 2–3 hours for each pretreatment and posttreatment assessment, four 50-minute biweekly intervention sessions, and a mailed follow-up questionnaire). The assessor/therapist begins by using a traditional information-gathering model of assessment. The PCIA-II and a selection of rating scale and free response measures tailored to the clinician's practice provide a pretreatment baseline that can be used for comparison to posttreatment and follow-up levels of functioning. The therapist or clinical team views the video recording and chooses critical problem moments and identified strengths that highlight areas of child or parent behavior problems and parent strengths.

After the standardized data are collected, nonstandardized techniques are used in the assessment intervention sessions. During the intervention sessions, the parent is shown the scenarios that include the critical problem moments and identified strengths. After watching a scenario in its entirety, the video is cued to an identified strength moment. The parent's sensitivity and/or positive behavior toward the child is pointed out, with attention paid to the child's response. Next, the parent is shown a specific critical moment and is asked a series of questions designed to identify parental attributions for the behaviors evident in the problem moment (see Table 1). The attributions are noted; and if they are deemed inappropriate, negative, or dys-

TABLE 1.—Identifying and modifying attributions questions.

Type of Question
Identifying attributions
What do you notice here? What was happening here? What were you thinking here? What were you feeling? What is [child's name] intention here? or Where is [he or she] coming from? What was [he or she] thinking here? What was [he or she] feeling? Was there anything [he or she] was wanting or needing from you here? If so, what was [he or she] wanting or needing?
Modifying attributions
What else might [his or her] intention have been? Could it be that [he or she] intended this? What might [he or she] have intended instead? Let's pretend for a moment that [he or she] did not mean this. What else might [he or she] have meant to do? What might [he or she] have needed from you? Is this behavior typical? Is this how you would ordinarily interpret, think, and feel about [his or her] behavior?

functional, the parent is asked a second set of questions. The latter are designed to assist the parent in generating alternative, more constructive attributions. If the parent is unable to do so, the therapist presents the parent with several options (e.g., "Is it possible that Rhonda was wanting your approval right there?"). The parent's responses to these questions are recorded. During the final session, the PCIA-II and the other outcome measures are readministered to the dyad.

In Indianapolis, Indiana, we have started to empirically assess the efficacy of the PCIA-II/MAP intervention with women victims of violence who are residing in the Julian Center. We are conducting a randomized controlled trial with treatment and wait-list groups utilizing a pretreatment–posttreatment follow-up experimental design. Mothers and their school-age children are being filmed as they complete the PCIA-II/MAP (four session intervention model: pretreatment assessment, four intervention sessions, and posttreatment assessment). In addition, mothers complete a series of free response and rating scale assessments measuring key parent variables pertaining to attributions, stress, psychopathology, and life circumstances as well as child variables pertaining to personality, psychopathology, and intelligence. Women taking part in the study continue with their regular course of treatment and receive the PCIA-II/MAP intervention as an adjunctive treatment option.

We chose to implement the intervention with the domestic violence population because we expected that the mothers' histories of intimate partner violence would leave them prone to inaccurate or negative attributions when attempting to understand their children's behavior. For example, dysfunctional attributions are frequently linked to a parent's misperception of the power balance in the relationship with his or her child. Women who have experienced themselves as helpless in a spousal relationship involving destructive power can be more vulnerable to cognitive distortions of this type. We were also responding to the widespread nature of intimate partner violence. The prevalence rate of severe partner violence in America is estimated at 8.64% of couples; and of these couples, 62.57% have children living in the household (approximately 7 million children; McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006).

Last, mothers who have been victims of domestic violence experience a variety of associated psychological concerns. Among these difficulties are increased levels of depression, posttraumatic stress disorder, the development of learned helplessness, overall psychological distress and disturbance, as

well as lowered self-esteem (e.g., Cascardi & O’Leary, 1992; Walker, 2000). In addition, parenting stress has been shown to be elevated, which may lead to a host of parenting difficulties. Among these parenting difficulties are decreased warmth and control, harsh and inconsistent discipline practices, and difficulties with overall parenting effectiveness (e.g., Levendosky & Graham-Bermann, 1998). It was hoped that an intervention such as the PCIA–II/MAP might provide the abused mother with increased awareness, insight, problem-solving skills, and the ability to reclaim a realistic understanding of her influence in her child’s life and of the power balance within their relationship. Additionally, based on the research that has shown that the effect of domestic violence on child abuse risk is mediated by a parent’s negative view of children (see McGuigan et al., 2000), interventions directed at modifying attributions may minimize the likelihood of child maltreatment.

CASE DESCRIPTION: MS. A. AND ROBERT

Ms. A., a resident in an agency providing housing for female victims of domestic violence and their children, volunteered for the PCIA–II/MAP intervention. She had been experiencing many difficulties as a parent and wanted to improve her relationship with her child. She is a 28-year-old African American woman with three children. She has a 12th-grade education and is employed full-time as a waitress. She is separated from her

husband, who was physically abusive, and she has had several other abusive partners in her past. She carries a diagnosis of major depressive disorder and is in individual, family, and group therapy.

Robert, her oldest child, is 10 years old, in the 4th grade, of above average height, and moderately obese. He has two younger school-aged sisters. There is no reported history of physical abuse toward Robert, although he was frequently a witness to his father’s and stepfather’s violence toward his mother. Robert has been diagnosed by a psychologist as having an adjustment disorder with depressed features; in the past, he was diagnosed with attention deficit hyperactivity disorder and oppositional defiant disorder. He is in individual and family therapy.

Ms. A.’s Pretreatment Assessment Findings

Ms. A. was administered a battery of self-report, free-response, and observational measures that assess adverse life experiences, personality, and parenting. The rating scale data are presented in Table 2. We describe the test findings followed by their implications for treatment.

Adverse life experiences. On the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998), Ms. A. reported that as a child she was a victim of significant emotional and physical abuse (e.g., feeling hated, insulted, often hit with a hard object).

TABLE 2.—Pretreatment parent and child rating scale findings.

Test	Score Type	Scales, Subscales, and Scores					
Ms. A.							
Adverse Life							
CTS–2	T	Psych Aggression	110**	Sexual Coerc	99**		
CTQ	Percentile	Emotional Abuse	95**	Emot Neglect	80*		
		Physical Abuse	80*	Phys Neglect	80*		
		Sexual Abuse	70				
Personality							
MCCI–III	Base rate	Schizoid	64	Schizotypal	85**	Thought Dis 68	
		Avoidant	82*	Borderline	61	Major Dep 48	
		Depressive	100**	Paranoid	104**	Delusional Dis 91**	
		Dependent	72				
		Histrionic	30	Anxiety	71	Disclosure 82*	
		Narcissistic	57	Somatiform	62	Desirability 47	
		Antisocial	61	Bipolar: Manic	62	Debasement 72	
		Sadistic	58	Dysthymia	71		
		Compulsive	60	Alcohol Depen	59		
		Negativistic	72	Drug Depen	59		
		Masochistic	88**	Post-Traumat	62		
BDI–II	Raw	Total Score	26**				
Parenting							
CAP	T	Abuse	75**				
AAPI–2	Percentile	Phys Punish ^a	98**	Low Empathy ^a	84*		
PSI	Percentile	Total Stress	99**				
Robert							
KBIT–2	Standard	Verbal	111	Nonverbal	105	IQ Composite 97	
CBCL	T	Internalizing	74**	Anxious/Dep	72**	Affective 70**	
		Externalizing	76**	Withdrwn/Dep	73**	Anxiety 68*	
		Total Prob	75**	Somatic	68*	Somatic 70**	
				Social	78**	Attention 66*	
				Thought	54	Oppositional 80**	
				Attention	67*	Conduct 76**	
				Rule Breaking	71**		
				Aggressive	84**		

Note. CTS–2 = Conflict Tactics Scale–2; CTQ = Childhood Trauma Questionnaire; MCCI–III = Millon Clinical Multiaxial Inventory–III; BDI–II = Beck Depression Inventory–II; CAP = Child Abuse Potential Inventory; AAPI–2 = Adult-Adolescent Parenting Inventory–2; PSI = Parenting Stress Index; KBIT–2 = Kaufman Brief Intelligence Test–2; CBCL = Child Behavior Checklist. Data were collected in Session 1. ^aUsually reverse scored, transformed for ease of comparison with other measures. Asterisks highlight scale elevations whereby * = borderline or marginal significance and ** = clinical or prominent significance based upon cutoffs established in test manuals.

Downloaded By: [rhologrocki] At: 13:35 13 August 2009

Additionally, she reported that she was neglected emotionally and physically (e.g., unsupportive family, sometimes not having enough to eat). Her Conflict Tactics Scales-2 (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) results suggest that she has recently been the victim of significant maltreatment by a partner involving both psychological aggression (e.g., destruction of her possessions) and sexual coercion.

Parenting. Ms. A. is likely highly reactive to parent-child stressors. On the parenting inventories, Ms. A. scored above the conservative cutoff on the Abuse scale of the Child Abuse Potential Inventory (Milner, 1986), indicating that her parenting attitudes and behaviors are similar to individuals known to physically abuse their children. Her Adult Adolescent Parenting Inventory-2 (AAPI-2; Bavolek & Keene, 2001) indicated she has a strong belief in corporal punishment and has difficulties empathizing with her children. The parent-child role reversal score was not elevated, which would indicate appropriate family roles, although this was not in keeping with the videorecorded interactions described below. On the Parenting Stress Inventory (PSI; Abidin, 1995), she demonstrated signs of experiencing high levels of parenting stress.

Personality. Based on Ms. A.'s valid Millon Clinical Multi-axial Inventory-III (MCMI-III; Millon, Davis, & Millon, 1997) profile, she is often anxious and expects others to harm her, even in situations in which most would feel safe. To protect herself, she may withdraw, perhaps choosing the sadness and loneliness that accompanies her isolation to the fears that she experiences when with others. When she does enter relationships, she may expect deception and rejection and behave in a self-effacing and self-sabotaging manner. By presenting herself as weak, she appears to pose no threat and may stave off anticipated aggression from those around her. Occasionally, she may have angry outbursts and demean those she sees as critical of her, but such outbursts likely leave her feeling remorseful and sad and eventuate in further withdrawal. Her emotional world is erratic, often vacillating between intense anger and sadness. Her Beck Depression Inventory-II (BDI-2; Beck, Steer, & Brown, 2001) also indicates severe depressive symptoms.

Ms. A. was administered Thematic Apperception Test (TAT; Murray, 1943) Cards 1, 7GF, 6BM, 3BM, and 17BM. We include five of these stories in the Appendix, with one story omitted due to its limited content.

The first 2 cards illustrate the detachment from and limited connection to others that Ms. A. experiences. The first card has a depressive cast, a tired little boy sitting in a dark corner trying to fix his violin. His parents are not available, which is a theme that is echoed in Card 7GF where the mother and daughter sit together without interacting. This theme of sad detachment converges with the self-report test findings and bring one closer to feeling her isolation. In response to the next card, Ms. A. tells a story about a victim of violence who has been assaulted and feels helpless. Through the story, she vividly communicates her lived experience of the adversity indicated by the CTQ and CTS-2. Her last story adds an element that our selection of self-report tests could not approach. In her telling of a story about a determined trapeze artist trying to do the impossible with the environment working against him, she conveys her struggle to improve.

From her TAT responses, we find that her method of coping involves the defensive withdrawal from others, whereas her defensive style includes the frequent use of denial and projection as indicated by Cramer's (2002) *Defense Mechanism Manual* scoring system. Themes of denial occur throughout these TAT stories, involving a fall that is "not deadly," a violin that is not necessarily broken, and unexpected happy endings; projection also occurs in the themes of violence and danger.

Taken together, we see that she is very depressed and is struggling to make changes but essentially feels helpless to do so. She is afraid of being harmed and has withdrawn from others, protectively isolating herself and imagining better situations.

Parent-child interaction observations (PCIA-II). On the pretreatment PCIA-II involving Ms. A.'s video-recorded play with her son at the toy zoo, Ms. A. demonstrated harsh parenting techniques. Although she sometimes set appropriate limits, she just as often attempted to change her child's behavior through the use of inappropriate punishments involving abandonment. For example, when Robert indicated that he was hurt in one scenario, she threatened to leave him at the zoo. She displayed a range of affect that was usually appropriate, although she sometimes exhibited laughter following Robert's misbehaviors. She was frequently misattuned to his distress and his efforts to obtain positive responses from her. Her anger peaked during what she perceived to be role reversals such as when he attempted to demonstrate autonomy. The AMBIANCE was used to code the videorecordings. The coding revealed problematic behavior in her affective communication, role/boundary confusion, and intrusiveness/negativity. For example, in the "Hurt Arm" scenario we present following, affective communication errors (contradictory signaling type) were apparent in Ms. A.'s sad, serious, and firm voice tone mixed with anxious laughter. Notably, Robert commented that her toy figure was smiling while Ms. A. was expressing concern to him, a perception on his part that her concern was insincere. Role/boundary confusion was noted in Robert's attempt to take care of himself by telling his mother to get the first aid kit, and some intrusiveness was evident during the last portion of the scenario when Ms. A. made her figure chase Robert's figure.

Treatment implications. Assessment findings suggested that Ms. A. has a significant trauma history and that her level of mistrust may make her particularly sensitive to feeling criticized by the therapist. The therapy sessions needed to be supportive, rather than confrontational, with attention paid to strengths and competencies to allow the therapist's reflections on her attributions to be heard. Her parenting behaviors suggested that she needed assistance in attuning to Robert's needs for care and autonomy. Results also suggested that she might require assistance in identifying her tendencies to withdraw from him when she is distressed and express anxiety through laughter, which he interprets as mocking.

Robert's Pretreatment Assessment Findings

Robert was administered a free-response test and an intelligence test, and his mother completed a checklist evaluating his behaviors. We present the data from the Kaufman Brief Intelligence Test-2 (KBIT-2; Kaufman & Kaufman, 2004) and the Child Behavior Checklist (CBCL; Achenbach & Rescorla,

2001) in Table 2. A summary of the self-report, free response, and observational findings, along with treatment implications, are described below.

Intelligence and personality. Robert's verbal and nonverbal intellectual functioning is in the average range as measured by the KBIT-2. His CBCL suggests that his behaviors are very aggressive and defiant. He is also experiencing a high level of anxiety and depression along with somatic discomfort. His social problems are notable, mostly involving peer rejection, and he has attentional problems.

Robert was administered TAT Cards 1, 3BM, 4, 13MF, 15, and 2. Of the stories he told, two stories are reproduced in the Appendix because of their relevance to the parent's treatment.

What is notable about Robert's first story is the role of the child and parent. The child refuses to meet the expectations placed on him, but he is not offered assistance. There is an absence of parents or helpful adults who step in to guide, mentor, or understand the boy. Rather, his behavior is brought into line through punishment. This story of a child all alone is the other piece of the puzzle, complementing Ms. A.'s experience of detachment and difficulty providing attunement. In Robert's next TAT story, he tells of an Olympian mother who is stressed by her children. The combination of stress, stroke, coma, and head injury prevent her from competing, and the coach feels guilty for having pushed her so far. In both stories, the protagonists refuse to complete their tasks: the first only doing so when punished and the second avoiding due to somatic complaints. Robert's stories illustrate the defiance apparent in his CBCL but also reveal his experience of being with his mother. His narratives to two TAT cards richly condense all that was illustrated by Ms. A.'s own TAT stories, self-report inventories, and the observed play; that is, Robert's stories reveal his experience of her as overtaxed, fragile, retreating, and unavailable.

Overall, we see that Robert is a boy of average intelligence who is experiencing significant psychological distress coupled with behavior problems and peer rejection. Although he seems to have the intellectual capacity to achieve, much is likely to interfere with his development. Not only is he taxed by psychological distress, but he may also view the adults who occupy his world as harsh, fragile, and irresponsible.

Child-parent interaction behaviors (PCIA-II). On the PCIA-II, Robert often made his toy figure engage in risky, self-injurious behaviors that seemed to be attempts to elicit nurturance from his mother. He was frequently defiant and rule breaking, complying partially, but rarely fully, with what his mother asked of him. He proudly described himself as a "daredevil," and his reckless behavior was minimally curbed by his mother.

Treatment implications. Although Robert is only involved in the pretreatment and posttreatment assessments, not the treatment itself, we recognize that he has severe behavioral problems, and his aggression and defiance would challenge and stress most parents. Hence, it was important to acknowledge to Ms. A. the reality of the stresses involved in raising a child with such behavioral difficulties. Ms. A. may also need assistance in attuning to his depression and anxiety, recognizing how Robert may communicate distress by somatic means. She may also require

guidance to understand that he may not trust in her ability to effectively parent him.

From his mother's TAT and MCMI-III data, we can infer that she may not be available to him during the times she feels stressed. During such moments, she may attempt to protect herself by withdrawing. Robert's TAT story about the Olympic athlete suggests this as well. Unless the dyadic pattern is recognized and broken, a cycle of further negative defiant and escapist behaviors on the part of Robert and detachment and cue-ignoring from Ms. A. can be expected.

Assessment Intervention Sessions

Following the pretreatment session, we watched Ms. A. and Robert's PCIA-II video to choose critical problem moments. The video included their play in response to the 15 PCIA-II scenarios, 4 of which are considered in the treatment model to be attachment system activating (ASA) scenarios (i.e., Race, Lost, Hurt Arm, and Tunnel). These scenarios activate attachment based on Bowlby's (1969/1982) description of the following set of conditions: distance and time away from the mother, a child's condition (e.g., ill health), a mother's location and behavior (e.g., absent), and other environmental conditions (e.g., alarming events). The *Race* scenario offers a competitive game of distance and proximity, *Lost* involves the absent parent, *Hurt Arm* begins with an injured child, and *Tunnel* sets up a potentially frightening event. As per the PCIA-II/MAP manual, we reviewed the ASA scenarios several times (i.e., viewing them first in their entirety and then with attention to child behavior problems, parent behavior problems, and parent strengths). Next, we reviewed the remaining 11 PCIA-II scenarios.

We identified strengths and critical problem moments that were explored in R. Crain's intervention sessions with the parent in the absence of the child. Each critical moment video excerpt was shown to the parent, after which she was asked a series of questions pertaining to her attributions. Later in the session, the therapist collaborated with the client to develop alternate attributions for the child's behaviors (See Table 1 for list of identifying and modifying attributions questions).

In what follows, we describe excerpts from two of the four assessment intervention sessions. Statements in italics indicate behavioral observations, and square brackets are used to insert editorial comments. Ellipses indicate pauses and dashes are inserted at the point of interruptions.

PCIA-II Race scenario. In the first intervention session, the therapist played the video of the Race scenario that Ms. A. and her child had completed a few days before. The scenario was as follows:

Examiner: (*Examiner places two figures together on the zoo board beside a block*). There is a contest to see who can run the fastest. This is the starting block and the two of you are to run to the tree and back. Play out what happens together.

Child: Okay, are you ready?

Parent: Uh huh.

Child: Set.

Parent: Go.

Child: Go. (*Parent and child both begin to move their figures toward the tree and back*)

Parent: Oh, Robert.

- Child: I win (*smiling*)
 Parent: Please slow down (*laughing*)
 Child: So you wanted me to be the first one?
 Parent: I'm old.
 Child: You wanna try it again?
 Parent: *Sighs*.
 Child: Ready, set, go.
 Parent: Yeah.
 Child: Go.
 Parent: On your marks get set go.
 Child: (*Child does not move figure*) You can have a –
 Parent: You're not moving.
 Child: You can have a head start (*Smiling at parent*).
 Parent: I don't want a head start. Go. (*Parent and child begin racing to the tree*). Okay, okay, I can't do that no more.
 Child: I'm getting tired.
 Parent: You won. Oh well, what's your prize?
 Child: Uh, I get to go wander off all by myself. (*Child begins to move figure away from parent to the other end of the zoo board*)
 Parent: No, that's not a prize.
 Child: Whee! I'm lost.
 Parent: Robert, get back here. [*sternly*]
 Child: I'm lost. (*Child moves figure back to parent.*)
 Parent: That's not a prize. You can't wander off like that.
 Child: Okay.
 Parent: Maybe we can get some ice cream or something.
 Child: Okay, ice cream. (*Child moves figure away from parent*)
 Parent: I still didn't say go. I'm standing here. Where are you going? (*Robert moves his figure back to parent smiling and looking at the examiner*)
 Child: To ask you.
 Parent: No, we go together.
 Child: Okay.
 Parent: Who's going to pay for it when you get there if I'm still here?
 Child: Uh, my allowance.
 Parent: Okay where is your allowance?
 Child: In, it's in my pocket.
 Parent: No it's not.
 Child: Yes it is.
 Parent: Why would I give you money at the zoo to keep in your pocket?
 Child: So the giraffes could eat it.

In this scenario, the parent's presentation is that of sad detachment. She moves slowly, mentions she is old, does not praise Robert when he wins, and shows little concern when he says he is lost. At first, Robert tries to positively draw her in and engage her by giving her a head start; then his attempts to engage her become more negative when he wanders off as a prize for winning and pretends to be lost. Also, some role reversal/confusion was evident in Robert's giving Ms. A. a head start and his paying for his own ice cream. The therapist and Ms. A. reviewed several of these critical problem moments during the first intervention session.

The critical problem moment chosen for discussion is Robert's choice of wandering off by himself as a prize. This critical problem moment video excerpt was replayed for Ms.

A., and she was asked a selection of the identifying attributions questions. Of note is that Ms. A. explained Robert's behavior as due to his wanting "attention." What was unclear to her was to what Robert wanted her to attend and why he wanted her to attend to him at this time. She also mentioned that his wandering was due to his being free spirited, wanting his own space, and feeling that there were no boundaries because he had achieved something. Ms. A. had not considered that Robert might have wanted her to engage in parenting and nurturing activities, and she did not recognize that he approximated these roles himself by offering her a head start in the race and paying for his own reward of ice cream.

Later in the session, the therapist asked Ms. A. to develop alternate attributions for the reasons for Robert's choosing to wander off at the zoo. Although Ms. A.'s initial attributions involved Robert wanting attention, she developed several alternative explanations. She mentioned that his wandering off may be because he (a) wants to be the leader and have her follow him, (b) wishes for his own space away from his family difficulties, (c) is upset or angry at her and blaming her for leaving his father, (d) tries to take on a parenting role and is stressed by doing so, or (e) wants to be in control. By focusing specifically on this situation and allowing the parent the time to reflect on what was happening, it is apparent that there are multiple ways to interpret her initial attribution that he wanted attention. With assistance from the therapist, Ms. A. expanded her description to articulate how Robert was having conflicting needs for autonomy and caretaking and is a child who is very affected by the difficult family circumstances. It was good to see Ms. A. show some cognitive flexibility by entertaining alternative attributions. However, Ms. A. did not mention the possibility that Robert may have wanted her to follow him, reach out to him, and provide nurturing by preventing him from wandering off, all of which are typical parental behaviors.

PCIA-II Hurt Arm scenario. In the second intervention session, the therapist played the video from the Hurt Arm scenario. This scenario involved the following interaction:

- Examiner: Robert has fallen and hurt his arm. Play out what happens together.
 Parent: Are you okay?
 Child: Mom, it hurts.
 Parent: You okay? Can you get up?
 Child: I think.
 Parent: Come on. Let me help you up. Let me see, let me see.
 Child: What are you smiling for? [*Child is referring to the smile on the parent's figure.*]
 Parent: (*laughs*) I'm not smiling. I'm trying to see about you. It's bleeding a little, that's scraped real good. You okay though?
 Child: Well, get the first aid kit.
 Parent: We'll get one. I'm looking in my purse.
 Child: *Child knocks his figure onto the ground.* I fell again.
 Parent: Robert. (*Parent laughs.*)
 Child: *Returns figure to upright position.*
 Parent: You okay?
 Child: Yeah.
 Parent: You wanna sit down for a minute?

- Child: Yeah (*Child moves figure to sit down and parent follows.*)
- Parent: Okay, we'll sit down for a minute. Let me see this. Your face looks okay. You're okay. (*Parent leans figure into child's figure and makes kissing noises.*)
- Child: *Child climbs up on the high rock.*
- Parent: Now why you wanna get up there for?
- Child: *Child makes figure jump off rock, into the sky, arching above the table.*
- Parent: Isn't that how you fell the first time?
- Child: Yup.
- Child: *Child has his figure land on parent's head then drops his figure the remaining way to the ground.*
- Parent: So you trying to fall again?
- Child: Ow, I fell again.
- Parent: (*laughs*) Now you doin' that on purpose now. You still want that ice cream? You still want that ice cream? Okay, you better watch it. (*Repeatedly the parent moves her figure close to child and the child moves his figure away, this chase continues for about 15 s while she is talking.*)

Several of the activities in the Hurt Arm scenario were identified as critical problem moments. Some of these were the affective communication errors of Ms. A.'s laughter and Robert's asking Ms. A. why her character was smiling. Other problem moments were Robert's attempts to elicit care from Ms. A. by asking her to get the first aid kit and his escalation of self-harm by repeatedly falling. There were also instances of identified strengths. For example, Ms. A. asked him several times if he was okay, helped him up, and asked him if he wanted to sit down. In the second intervention session, the identified strengths were highlighted and several of the critical moments were explored.

For this article, we include one identified strength and one critical problem moment example from Hurt Arm. After showing Ms. A. the excerpt where she asked Robert if he wanted to sit down, the therapist said the following:

Therapist: That was excellent, the way that you attended to him when he fell again. You were very nurturing, [asking Robert,] "Do you want to go sit down for a while? Are you ok?" That was excellent, very, very good. It seems like he got that need for you to look at him, and kind of attend to him, that was definitely met, right there, and he was very compliant with you [as seen by him] coming over to sit down.

The parent agreed and was next shown the part of the video when Robert asked Ms. A. to get the first aid kit to help him with his hurt arm. In response to the identifying attributions questions, she explained that Robert was giving her advice and trying to act like an adult. She recognized that he was "feeling pretty needy emotionally." The therapist explored these attributions, working with Ms. A. to help her generate alternate or deeper understandings of Robert's behavior. Her modified attributions of Robert's behavior with the first aid kit were that he (a) wanted to reiterate that he was really hurt, (b) wanted to find the first aid kit because he was adventurous and saw this as a chance to explore the zoo, and (c) was concerned that she would not understand or meet his needs.

Treatment Outcome

As we discuss gains made in treatment, we remind the reader that both the mother and son completed the PCIA-II/MAP as a

conjoint treatment with other therapies. In this case study, the extent and nature of changes that were specifically caused by participation in the PCIA-II/MAP treatment could not be determined. Based on these constraints, we are limited to illustrating the treatment method with the knowledge that a sound test of the treatment's efficacy calls for a randomized clinical trial.

We readministered the BDI-2, PSI, CBCL, and TAT to the parent during the final meeting and the rating scale measures were completed by her during a 5.5 month follow-up. Some improvement following the four treatment sessions was evident, mostly in Ms. A.'s reduced depression. Ms. A.'s BDI-2 scores showed a change from a pretreatment total score of 26 (severely depressed range) to moderate range scores of 18 at posttreatment and 14 at follow-up (equivalent to a clinically significant T score reduction of $T = 64$ to $T = 51$). On the TAT, her pretreatment Card 7GF story about the mother and child showed some improvement. Initially, she told a story about a self-focused mother who was reading the bible alongside a physically distant daughter. The posttreatment story was as follows:

Card 7GF. Looks like a mother reading to her daughter. She's lookin' out the window daydreaming. Maybe she's daydreaming about what the story is about. It seems like she is not really sittin' down. Maybe her mother just told her to come over. She may be thinking about something else. Something else is on her mind but her mother stays with her. Maybe she looks at the kids outside and she feels like she doesn't belong. Maybe the mother is trying to downplay it—read her a story to make her feel better.

Although the characters in the posttreatment TAT story are not talking to each other, and efforts at comforting seem minimal, there are signs of shared activity, sensitivity to the daughter, and maternal attempts to be helpful. All of these story elements are positive changes that were not apparent during the pretreatment TAT. In the posttreatment PCIA-II compared to the pretreatment observation, the parent's play showed brighter affect, greater playfulness, some improved responsiveness, and no intrusiveness.

There were several areas that the four-session intervention did not directly impact. Ms. A.'s posttreatment TAT stories continued to show themes of helplessness, victimization, and the fear of failure. Her parenting stress remained elevated on the PSI. The brevity of the intervention and its focus on modifying parental attributions did not decrease Mrs. A.'s significant parental distress, nor did it lessen her fears associated with her maltreatment. Also, Robert's CBCL scores were stable, and themes in his posttreatment play suggested he still expected that Ms. A. would not attend to his needs or appreciate his distress. This brief parent-focused intervention was not expected to lead to immediate effects in the child, so we had not expected signs of an immediate reduction of Robert's symptoms. We remain open to the possibility that change may have occurred in the child, but our assessment measures were not sensitive enough to discern child improvement. Adjunct treatments directed at Robert's behavioral problems will be necessary, as will be continued treatment of Ms. A. beyond the brief parent-focused cognitive-behavioral therapy treatment described here.

Of note, during the 5.5-month follow-up, we invited the parent to comment on her experience of the intervention. In response to the question of whether she found the intervention helpful, she wrote the following:

Yes, I really enjoyed the feedback that I was given. I'm still applying things I remembered learning from the program, now. The feedback, the "virtual" interaction was helpful also, rather than talking out a scenario. The zoo "trip" was surprisingly very effective.

In her second sentence, Ms. A. contrasts "virtual" with "talking out a scenario." She may be referring to something she gained from the posttest PCIA-II assessment. Perhaps completing the zoo task again with her child, after having received the verbal feedback during the assessment intervention sessions, added a consolidating element to her learning experience.

DISCUSSION

Our assessment paradigm involves the integration of self-report, free response, and direct observation methods. The trained researcher or clinician can employ each of these three modalities toward a conceptualization encompassing symptoms, organizing structures, and evolving interpersonal dynamics. Self-report scales such as the BDI-2 or CBCL effectively describe symptoms, whereas the MCMI-III reveals patterns that help to explain observed behavior. One drawback to rating scale results is that psychologists may be left with the feeling that they know enough to diagnose but do not know the person they are diagnosing. The TAT stories deepen and extend psychologists' empathy for clients and enrich psychologists' understanding of their experiences. In addition to developing such a feel for the participants, the TAT can be used to develop structural hypotheses that assist in understanding verbal, behavioral, and affective content. Through the PCIA-II, psychologists can witness the dyadic dynamic system as a whole, as each member of the dyad is affected by and affects the other.

Ms. A. depressed and withdrawn on self-report scales, reveals fears of attachment on the TAT and detaches herself from play when with Robert. Robert, with severe symptoms on the CBCL, tells TAT stories of maternal fragility and retreat, and he tries to parent himself throughout the PCIA-II. Together, the rating scale, free response, and play assessments resolve into a portrait of a mother and child, both afraid and trying to get needs for safety met in the limited ways they have available to them. Although most assessment measures converged across modalities, the AAPI-2 parent-child role reversal score was not elevated and indicated appropriate family roles. However, role reversals were present on the video recording as Robert attempted to fill the void left from Ms. A.'s depressive withdrawal and difficulty nurturing. Ms. A. was usually angered by these role reversals, which may have led her to downplay them on the self-report measure. Also worth considering is that some researchers have expressed concerns about the factor structure of the AAPI-2 Role Reversal scale, although thorough validity tests have been hampered by the lack of a theoretically related comparison measure (see Connors, Whiteside-Mansell, Deere, Ledet, & Edwards, 2006).

The PCIA-II/MAP offers a structured way of identifying parent strengths and problem areas and working to alter how the mother is making sense of her child's behaviors. The interventions occur after an in-depth, multimodal assessment, which brings to the treatment team a profile of the parent and child's functioning across multiple domains. At this time, only a portion of the assessment, the videorecorded PCIA-II, is shared with the parent. However, future extensions of this model could invite

dialog with the parent and child about the full range of assessment data, which would bring this intervention more in keeping with the work recently detailed by Finn (2007). The recordings also provide an opportunity to involve the child in a similar reflective and reconstructive process, but this is a pathway for future exploration.

Of note, Tharinger et al. (2009), in a recent empirical pilot study of the use of therapeutic assessment with families, reported that postinterview data revealed that attributional shifts occurred on the part of many of their parents. Parents prior to the intervention judged many of the children to be "bad" and individually responsible for their problems. Following the assessment, the children were viewed as "hurt" or "troubled" or "sad," and the parents could discuss their own contributions to the children's difficulties. Although our methods differ from the TA approach employed by Tharinger et al. (2009), Ms. A. showed a similar change in attributions. For example, Ms. A. initially attributed Robert's behavior to his desire for attention or to being needy. Therapy led to a more complex understanding, which allowed her to entertain the idea that his behavior may have been related to his being angry at her, blaming her for leaving his father, and taking on a parenting role because of unmet needs.

The PCIA-II/MAP intervention model helps parents to recognize the power they hold, see the positive behaviors they demonstrate with their children, and develop alternative attributions when theirs have been too negative. When parents are able to find new, more constructive and sensitive ways of construing the meaning of their child's behaviors, their relationship with their child has a chance to improve. Psychodynamically oriented clinicians may view operative aspects of this intervention as increasing the mentalizing capacity of clients (e.g., Allen, 2003; Fonagy & Target, 1997) whereby parents develop enhanced sensitivity to their children's thoughts, feelings, and needs and increase their capacity to try alternate understandings. From a constructivist perspective, the activity is one of developing a new manner of construing and cocreating the play context, which re-presents in a microcosm key transactions that occur outside of the realm of play.

For the clinician, the intervention provides a manner of organizing what is learned from an assessment and offers a structured method for providing clients with feedback regarding some of what was seen. Similar to what has been described by Finn (2007) and Fischer (1984/1994), the intervention deeply involves the client in thinking about the information that was and is being gathered. In all implementations of collaborative assessment models, the client is not a passive recipient of a psychological assessment but, as we have seen with Ms. A., is invited to reflect on the data and become an active participant.

This article is limited to a demonstration of how the assessment and collaborative feedback model is employed in our current practice and clinical research. We hope that this report might add to ongoing work in the integration of assessment and intervention and the conjoint employment of traditional and interventional methods of assessment. Additionally, we provide in this article an example of how to implement the PCIA-II/MAP intervention, and the case itself will be of interest to those studying the relationship between domestic violence, cognition, and parenting.

In our qualitative analysis of high-risk family PCIA-II/MAP clinical outcomes in Toronto, Ontario, Canada; Indianapolis,

Indiana; and Rome, Italy, depression, child abuse potential, and parenting stress are positively affected by the treatment, and parents demonstrate increased sensitivity, attunement, and improved quality of attributions (Bohr & Holigrocki, 2007). Ms. A.'s gains, however, were primarily limited to reduced depression and some improved sensitivity. Her parenting stress was not altered and, unfortunately, her child abuse potential was not reassessed posttreatment, which is now part of our standard procedure. The reader is reminded that we are implementing a four-session treatment model with highly stressed and often depressed mothers who are recent victims of domestic violence and living in a shelter with their children. Although additional sessions may have helped to consolidate and extend gains for Ms. A., shelter residents have life circumstances that can make lengthier treatments nearly impossible. We are not making assertions as to the efficacy of the PCIA-II/MAP intervention based on this case; the treatment outcome research will be the basis of any such claims.

On a final note, we have found that the use of video recordings in collaborative assessment provides a number of clinical advantages. Video allows the therapist and client to slow down a situation to facilitate careful collaborative reflection and discussion. In our work, the reduced pace can assist a parent in developing new ways of construing a past event and can help to sensitize a parent to aspects of her child's affect, thoughts, and behavior of which she may have been unaware. It can further facilitate the parent's examination of her own thoughts and feelings in the targeted situation, a process that can be impeded when it is necessary to rely on memory. Preliminary qualitative findings suggest that this type of assessment/intervention is promising and may improve parents' sensitivity and attunement as well as their own well-being.

ACKNOWLEDGMENTS

We thank the Julian Center, Indianapolis, Indiana, and its staff for their cooperation. The treatment research of which this case study is a part was supported by the InQuery Collaborative Grant, University of Indianapolis. Selections from this article were presented at the March 2006 symposium *Collaborative Feedback* at the Society of Personality Assessment Annual Meeting in San Diego.

REFERENCES

- Abidin, R. (1995). *Parenting Stress Index professional manual* (3rd ed.). Lutz, FL: Psychological Assessment Resources.
- Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA School-Age Forms and Profiles*. Burlington: University of Vermont, Research Center for Children, Youth, and Families.
- Allen, J. G. (1981). The clinical psychologist as a diagnostic consultant. *Bulletin of the Menninger Clinic*, 45, 247-253.
- Allen, J. G. (2003). Mentalizing. *Bulletin of the Menninger Clinic*, 67, 91-112.
- Bavolek, S. J., & Keene, R. G. (2001). *Adult-Adolescent Parenting Inventory AAPI-2: Administration and development handbook*. Eau Claire, WI: Family Development Resources, Inc.
- Beck, A. T. (1976). *Cognitive therapy and emotional disorders*. New York: International Universities Press.
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory* (2nd ed.). San Antonio, TX: The Psychological Corporation.
- Berg, M. (1985). The feedback process in diagnostic psychological testing. *Bulletin of the Menninger Clinic*, 49, 52-69.
- Bernstein D., & Fink, L. (1998). *Childhood Trauma Questionnaire manual*. San Antonio, TX: Psychological Corporation.
- Bohr, Y. (2005). Infant mental health programs: Experimenting with innovative models. *Infant Mental Health Journal*, 26, 407-422.
- Bohr, Y., Dhayanandhan, B., Armour, L., Sockett DiMarco, N., Holigrocki, R., & Baumgartner, E. (2008). Mapping parent-infant interactions: A brief cognitive approach to the prevention of relationship ruptures and infant maltreatment (the MAP method). *Infant Mental Health Promotion: IMPrint*, 51, 2-7.
- Bohr, Y., & Holigrocki, R. J. (2005). *PCIA-II/MAP treatment manual: Modifying attributions of parents intervention*. Unpublished manuscript, York University and the University of Indianapolis, Indianapolis, IN.
- Bohr, Y., & Holigrocki, R. (2007, July). *Modifying risky parental attributions: A brief cognitive approach to the prevention of relationship ruptures and child maltreatment*. Workshop presented at the World Congress of Behavioral and Cognitive Therapies (WCBCT), Barcelona, Spain.
- Bowlby, J. (1969/1982). *Attachment and loss: Attachment* (Vol. 1, 2nd ed.). New York: Basic Books.
- Bradley, E. J., & Peters, R. (1991). Physically abusive and nonabusive mothers' perceptions of parenting and child behavior. *American Journal of Orthopsychiatry*, 61, 455-460.
- Bronfman, E. T., Parsons, E., & Lyons-Ruth, K. (2004). *Atypical Maternal Behavior Instrument for Assessment and Classification (AMBIANCE): Manual for coding disrupted affective communication*. Unpublished manuscript, Harvard Medical School, Cambridge, MA.
- Bugental, D., & Goodnow, J. (1998). Socialization processes. In N. Eisenberg (Ed.), *Handbook of child psychology* (Vol. 3, pp. 389-462). New York: Wiley.
- Bugental, D. B., & Johnston, C. (2000). Parental and child cognitions in the context of the family. *Annual Review of Psychology*, 51, 315-344.
- Bugental, D., Johnston, C., New, M., & Silvester, J. (1998). Measuring parental attributions: Conceptual and methodological issues. *Journal of Family Psychology*, 12, 459-480.
- Cascardi, M., & O'Leary, K. (1992). Depressive symptomology, self-esteem, and self-blame in battered women. *Journal of Family Violence*, 7, 249-259.
- Conners, N. A., Whiteside-Mansell, L., Deere, D., Ledet, T., & Edwards, M. C. (2006). Measuring the potential for child maltreatment: The reliability and validity of the Adult Adolescent Parenting Inventory-2. *Child Abuse & Neglect*, 30, 39-53.
- Cramer, P. (2002). *Defense Mechanism Manual* [revised June 2002]. Unpublished manuscript, Williams College, Williamstown, MA. (Available from Dr. Phebe Cramer, Bronfman Science Center, Williams College, Williamstown, MA 01267)
- Dodge, K. A., & Crick, N. R. (1990). Social information-processing bases of aggressive behavior in children. *Personality and Social Psychology Bulletin*, 16, 8-22.
- Epps, J., & Kendall, P. C. (1995). Hostile attribution bias in adults. *Cognitive Therapy and Research*, 19, 159-178.
- Finn, S. E. (2007). *In our clients' shoes: Theory and techniques of therapeutic assessment*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Finn, S. E., & Tonsager, M. E. (1997). Information-gathering and therapeutic models of assessment: Complementary paradigms. *Psychological Assessment*, 9, 374-385.
- Fischer, C. T. (1994). *Individualizing psychological assessment*. Hillsdale, NJ: Lawrence Erlbaum Associates. (Original work published 1985)
- Fischer, C. T. (2000). Collaborative, individualized assessment. *Journal of Personality Assessment*, 74, 2-14.
- Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology*, 9, 679-700.
- Holigrocki, R. (2009). *Parent-Child Interaction Assessment-II (PCIA-II): Psychometric properties and the application of coding systems*. Manuscript submitted for publication.
- Holigrocki, R. J., & Hudson-Crain, R. (2004). Victim-victimizer relational dynamics as maintained by representational, defensive, and neurobiological functioning. *Bulletin of the Menninger Clinic*, 68, 197-212.
- Holigrocki, R. J., & Kaminski, P. L. (2002). A structural and microanalytic exploration of parent-child relational psychopathology. *Constructivism in the Human Sciences*, 7, 111-123.
- Holigrocki, R. J., Kaminski, P. L., & Frieswyk, S. H. (1999). Introduction to the Parent-Child Interaction Assessment. *Bulletin of the Menninger Clinic*, 63, 413-428.

- Holigrocki, R. J., Kaminski, P. L. & Frieswyk S. H. (2002). *PCIA-II: Parent-Child Interaction Assessment Version II*. Unpublished manuscript, University of Indianapolis. (Available from Richard J. Holigrocki, School of Psychological Sciences, University of Indianapolis, 1400 E. Hanna Avenue, Indianapolis, IN 46227)
- Holigrocki, R. J., & Raches, C. M. (2006). Sequelae of child sexual abuse: A child and parent assessment. *Journal of Personality Assessment*, *86*, 131–141.
- Hollon, S. D., & Kriss, M. R. (1984). Cognitive factors in clinical research and practice. *Clinical Psychology Review*, *4*, 35–76.
- Kaufman, A. S., & Kaufman, N. L. (2004). *KBIT-2: Kaufman Brief Intelligence Test manual* (2nd ed.). Circle Pines, MN: American Guidance Service.
- Levendosky, A., & Graham-Bermann, S. (1998). The moderating effects of parenting stress on children's adjustment in woman-abusing families. *Journal of Interpersonal Violence*, *13*, 383–397.
- Lyons-Ruth, K. (2000). *Atypical Maternal Behavior Instrument for Assessment and Classification—AMBIANCE. The AMBIANCE assessment measure for disorganized attachment*. Unpublished manuscript, Harvard Medical School, Cambridge Hospital, Cambridge, MA.
- McDonald, R., Jouriles, E., Ramisetty-Mikler, S., Caetano, R., & Green, C. (2006). Estimating the number of American children living in partner-violent families. *Journal of Family Psychology*, *20*, 137–142.
- McGuigan, W. M., Vuchinich, S., & Pratt, C. (2000). Domestic violence, parents' view of their infant, and risk for child abuse. *Journal of Family Psychology*, *14*, 613–624.
- Miller, S. (1995). Parents' attributions for their children's behavior. *Child Development*, *66*, 1557–1584.
- Millon, T., Davis, R., & Millon, C. (1997). *MCMI-III manual* (2nd ed.). Minneapolis, MN: National Computer Systems.
- Milner, J. S. (1986). *The Child Abuse Potential Inventory: Manual* (2nd ed.). Webster, NC: Psytec.
- Murray, H. A. (1943). *Thematic Apperception Test manual*. Cambridge, MA: Harvard University Press.
- Nix, R., Pinderhughes, E. E., Dodge, K. A., Bates, J. E., Pettit, G. S., & McFadyen-Ketchum, S. A. (1999). The relation between mothers' hostile attribution tendencies and children's externalizing behavior problems: The mediating role of mothers' harsh discipline practices. *Child Development*, *70*, 896–909.
- Ross, L. (1977). The intuitive psychologist and his shortcomings: Distortions in the attribution process. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (pp. 173–220). New York: Academic Press.
- Schechter, D. S., Myers, M. M., Brunelli, S. A., Coates, S. W., Zeanah, C. H., Davies, M., et al. (2006). Traumatized mothers can change their minds about their toddlers: Understanding how a novel use of video feedback supports positive change of maternal attributions. *Infant Mental Health Journal*, *27*, 429–447.
- Schlesinger, H. (1973). Interaction of dynamic and reality features in the diagnostic testing interview. *Bulletin of the Menninger Clinic*, *37*, 405–517.
- Smith, A. M., & O'Leary, S. G. (1998). The effects of maternal attributions on parenting: An experimental analysis. *Journal of Family Psychology*, *12*, 234–243.
- Snyder, J., Cramer, A., Frank, J., & Patterson, G. R. (2005). The contributions of ineffective discipline and parental hostile attributions of child misbehavior to the development of conduct problems at home and school. *Developmental Psychology*, *41*, 30–41.
- Straus, M., Hamby, S., Boney-McCoy, S., & Sugarman, D. (1996). The revised Conflict Tactics Scales (CTS2): Development & Preliminary Psychometric Data. *Journal of Family Issues*, *17*, 283–316.
- Sugarman, A. (1981). The diagnostic use of countertransference reactions in psychological testing. *Bulletin of the Menninger Clinic*, *45*, 479–490.
- Tharinger, D. J., Finn, S. E., Austin, C. A., Gentry, L. B., Bailey, K. E., Parton, V. T., et al. (2008). Family sessions as part of child psychological assessment: Goals, techniques, clinical utility, and therapeutic value. *Journal of Personality Assessment*, *90*, 547–558.
- Tharinger, D. J., Finn, S. E., Gentry, L., Hamilton, A., Fowler, J., Matson, M., et al. (2009). Therapeutic assessment with children: A pilot study of treatment acceptability and outcome. *Journal of Personality Assessment*, *91*, 238–244.
- Walker, L. (2000). *The battered woman syndrome* (2nd ed.). New York: Springer.

APPENDIX

Parent and Child's Pretreatment Thematic Apperception Test (TAT) Stories

Parent

Card 1 (Boy and a violin). Looks like a little boy sittin' in a dark corner tryin' to fix his violin. Looks like he might be in the kitchen or dining room in the corner by hisself. He looks tired. (What is he thinking?) Looks like he's thinking . . . it's not necessarily broken. He just doesn't know what he wants to do with it. Looks like he might pick it up and put it in position to play it. It looks like someone else comes into the room and helps him play it—maybe a sibling or older person. It doesn't seem like his parents are around. (How does it end?) Well, it ends happy. It's not dark. He finally plays the song he's wanted to play. He and that other person have a good time. He's outdoors now playing.

Card 7GF (Woman on a sofa beside a girl holding a doll). Looks like a mother and daughter. The daughter is holding a baby doll but she's distracted. The mother is reading the bible. Maybe the girl is being disciplined. She seems distant. Maybe something else is bothering her. The mother seems focused. Maybe more focused on herself than her daughter's expression. (What is the daughter feeling?) She's feeling like something else is on her mind and she's withdrawn. Even though they are close physically there is distance. The daughter feels that distance. It seems like she puts the baby doll down and walks to the window and looks outdoors. The mother just keeps reading.

Card 3BM (Boy huddled against a couch beside a revolver). Hmm . . . Looks like a woman that has a set of car keys on the floor. Maybe she tried to leave but didn't make it. Maybe she wasn't prepared. She's ashamed and fed up with things. Maybe she got pushed around or hit and collapsed. She's just tired and fed up with things. She feels hopeless. She just threw the keys on the floor and quit trying. She knows it's just not gonna do her any good right now.

Card 17BM (Naked man clinging to a rope). Looks like a trapeze artist. Looks like he's doing something impossible—looks like gravity is not there. The rope looks real slack and he's not using his feet. He's trying to do something that's not possible. But he's determined. It looks like the rope is gonna snap. He still looks determined. Looks like he's gonna fall. Looks like he's gonna fall. But not a deadly fall just a little bruised up and his hands are gonna be burnt. Looks like he's lookin up at the rope like, "I don't know how to climb up this vertical wall with this rope." He's dustin' hisself off but he's really sore and debating if he's gonna do it again. He's lookin' at that rope trying to figure out if there's another method—another way to get up to the top. He's trying.

Child

Card 1. What is this a picture of? (Robert shows the examiner the card.) Um, . . . once upon a time there was a little boy named Charles and he didn't want to do his school work. So he sat there and didn't do anything, um . . . and then his teachers came over and asked what is wrong and he says, "I don't want to do my school work." And then his teachers take him to the principal's office for not doing his school work and then he gets in trouble by his parents and his parents punish him and then he can go back to school but he has to complete his make-up work. . . . In the end the little boy learns his lesson so now he does his homework and his school work and he never gets in trouble. The end. (What is he feeling?) Kind of frustrated and sad.

(What is he thinking?) He's thinking he should do his school work. (How did they punish him?) They took away his privileges.

3BM. One day there was a lady named . . . Roseanne. She was a very athletic person, but it was very stressful because she had children and, like, she was training to be in the Olympics, but it was too much stress on her mind. Uh, so she, um, called her coach, if she could be taken out of the Olympics and her coach said, "No, you have come a long way and you have to be in the Olympics for Russia." So she says, "I'm on my way." So she goes in the room and puts on her athletic gear. So she goes to the car and makes her way to the Olympic Stadium. Before she could get in her car or walk out the door she fell down to her knees and dropped her car keys and she had a stroke. The coach was trying to call her and there wasn't much time left before the Olympics would start. So her coach went to her house and found her laying by the couch. He tried to wake her up and she did not wake up. So he rushed her to the Emergency Room and he called and then he called the Olympian that was the head coach of the whole Olympics and told him that the Russia's track stars are out of the Olympics and then they go to the emergency room. They found out that she had had a stroke. And she was in a coma for three days. While because, while she was going to the emergency room she bumped her head against the wall and after those three days were up and Roseanne woke up, she thanked the coach. The end. (What was Roseanne feeling?) She was feeling very stressed. (What was Roseanne thinking?) She was just thinking I should just quit the Olympics because I am too stressed. (What was the coach feeling?) Her coach was feeling angry before he got to her house. (What was the coach thinking?) I should not have pushed her so far when she called and told me she was stressed.

Note. In each of the TAT stories, the Card's name is followed by a summary of Murray's (1943, pp. 19–20) description. The assessor's questions are abbreviated and included within parentheses.