Projective Techniques and Psychological Assessment in Disadvantaged Communities

ROBERT STOREY, MARK GAPEN AND JAMES S. SACCO

ABSTRACT

This paper outlines the use of psychological testing in a community clinic. The emphasis is on the use of projective techniques in designing treatment plans for youth in disadvantaged communities. These assessments fall into three categories of testing referrals: determining mental impairment for disability, learning disability assessments, and diagnostic clarifications and treatment recommendations for therapists. The demands of psychological testing often require that the psychological evaluation play a role in how the client progresses in a system of care. Placement and risk decisions are often made in the psychological report. Projective techniques are stressed as a means to answer the most common questions asked from community referral agents such as schools, child protective case workers, courts, and human services agencies involved with residential programs. The relative strength of projective testing is compared with the value of empirical approaches stressed in modern psychology. Copyright © 2014 John Wiley & Sons, Ltd.

Key words: psychological testing, projective testing, poverty, disadvantaged communities, risk assessment, placement decisions

Psychological testing is a key component in providing the supportive services necessary to intervene over long periods of time to families who are experiencing chronic crisis and involvement in child welfare, juvenile justice, special education, and corrections/legal involvement. Psychological testing has two clear camps: the “empiricists” defined by the value placed on mathematical calculations as a predictor of human behavior, and the “clinicians” defined by clinical judgment and “feel” for the client. The empiricists have worked diligently to attempt to bring a level of discipline to interpretations made based on psychological tests. Empirical standards are applied to psychological testing and have resulted in many advances in the accuracy of interpretations made from psychological testing.

A prime example of the application of empiricism to psychological testing is the evolution of scoring systems for the Rorschach Inkblot Test. Beginning from its
inception with Herman Rorschach and following it through its many evolutions to its current modern form known as the Comprehensive System (Exner, 2001), known colloquially as the “Exner System.” The American Psychological Association (APA) has strongly favored this approach. The Exner system adheres to a strict fidelity of scoring, mathematical calculation, and specific statements supported by mathematical correlation using large samples of human behavior. These advances are intended to increase the test–retest reliability, validity and predictive value of the technique. There is clear value in this approach.

Psychological reports are frequently used in large systems of care to make decisions about how children or families can exist within the community. These reports often drive how families survive on a basic level, children with disabilities exist in school, and how involved an individual can become in the criminal justice system. High-risk families exist within this complicated system and psychotherapy is supported using psychological testing to navigate the system and complicated courses of treatment. This “outpost mentality” (where mental health services represent an oasis or triage center in a high-risk neighborhood or community) translates into the world of psychological testing by shifting the emphasis away from strict objective testing towards the projective interpretations of psychological data presented for individuals involved with complicated legal, psychological, child protective, and domestic violence situations. Psychological tests are most valuable in assisting in facilitating ongoing treatment strategies that seek to document treatment themes and point to styles and approaches to problems based on the test interpretation.

COMMON REFERRAL QUESTIONS

The delivery of long-term treatment to a high-risk population frequently requires psychological testing to perform very specific functions that are attached to the delivery of service within a systems care servicing these families. The principle use of the psychological testing is as follows:

(2) Disability or other entitlement assessment.
(3) Special education evaluation of learning disabilities and achievement difficulty. Clinic-based testing often provides an important adjunct to school-based testing because the testing performed in schools is strictly educationally focused and not clinically focused. Data from psychologically-oriented evaluations are often included in a school’s individualized education program (IEP) process or in some cases the evaluation is a second opinion to an assessment performed at school.

Psychological testing assists therapists in understanding their client’s behavior, problems, and accurately assesses their personality during long-term psychotherapy for very high-risk families struggling to live in the community.
Frequently during this course of treatment, it is necessary to assist the family member in documenting disability and connecting through the welfare system as quickly as possible. This reduces the strain on families and begins to open the door to introducing problem solving at a different level of life other than what Maslow (1943, 1962) would consider the basic survival level of functioning.

When working on the front lines of disadvantaged communities, a variety of assessment techniques are necessary in determining what useful and helpful answers to referral questions are asked of psychologists. These answers often have very high impact for families in legal decisions, placement, education services, custody and dangerousness. Psychological testing is useful as an adjunct to psychotherapy because it informs the clinician concerning the possible deeper mechanics of why problems exist and how they manifest into the behaviors that impact society. Referral agents are frequently asking psychologists to assist them in calculating the risk of working in one direction versus another direction. One example of this is in child custody where state agencies involved with child welfare decisions of keeping custody with the family or removing custody with the family and placing the child in foster care. This is followed by either separation of the child, maintaining the child in a known high-risk home, or some variation thereof. Psychological testing can be of great assistance to the treating clinician as well as the case manager in identifying high risk possibilities and personality strengths and weaknesses that can contribute to a more solid treatment plan with specific intervention strategies.

The demands on the psychological testing therefore fall in three broad areas. The first is defining the presence or absence of a mental impairment that is measured against existing disability criteria. This can be accomplished most efficiently using empirical measures, well validated surveys, and other assessment measures, which detect the presence or absence of clinically significant symptoms. When they are combined into a diagnosis that meets the criteria within disability (as defined under the following statutes: Sections 216(i), 223 (a), 223(d), 1614(a) and 1621 of the Social Security Act, as amended; Regulations No. 4, Subpart P, sections 404.1505, 404.1509, 404.1577, 404.1581, and 404.1582; and Regulations No. 16, Subpart I, sections 416.905, 416.906, 416.907, 416.909, 416.981 and 416.982), then the psychologist can say that a mental impairment exists. The Social Security Administration has a very clear definition of disability, which is the same for both children and adults: “The law defines disability as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months”. This is an area in which objective tests are useful in that they produce a numerical score with ranges of morbidity. Projectives can be used but in this area, an objective test is generally of more value.

The second typical referral question and use of testing involves the assessment of residual functioning capacity. This is also a second step in the
documentation of disability. If individuals’ mental impairment interferes with their capacity to work in a competitive work place, then this must be detailed in a narrative addressing the impact of this impairment on daily work functioning. In most cases individuals are part of family systems which suffer from serious Posttraumatic Stress Disorder (PTSD), attention deficit hyperactivity disorder (ADHD), explosive disorders, and other mental impairments that frequently chop-up not only individuals’ vocational history but the functioning of the family system as a whole. Adults frequently do not have a consistent work history, or if they do it is interrupted by a vague or traumatic accident.

The third area of typical referrals consist of a therapist who is involved in a plan involving one (or more) of the following components: psychiatric medication, educational consultation, and other system issues and having psychological data is a useful way to promote a larger decision about a child or a family’s service delivery over time. The psychological test report then works towards helping the service provider understand why the child or family behave in a certain fashion. Projective testing then becomes more instructive to the therapist as a way of trying to capture the impact of a symbolic trauma induced by environmental factors. This population is primarily disabled due to long-term exposure to a toxic mix of developmental trauma (including emotional, physical and sexual abuse, and various forms of neglect), interpersonal violence (including participation in or exposure to domestic violence), neighborhood violence (including gang involvement), and injustices within service delivery systems (e.g. real or perceived insults from the Department of Children and Families). The diagnosis of PTSD was developed to capture the symptoms of veterans returning from foreign conflicts. Some major differences between that type of trauma exposure and those elucidated above are where the trauma occurs (in a foreign country versus at home), when the trauma occurs (adulthood versus childhood and adolescence), and who perpetrates the trauma (soldiers versus family members, attachment figures and intimate partners).

As a result, a new conceptualization was needed to broaden our understanding of the sequelae to chronic and complex exposures such as those mentioned earlier. The concept of complex trauma was introduced as a way to explain the traumatic impact of a child living in a world that both attacks and fails to protect it (Cook et al., 2005). Developmental psychologists commonly make use of the concepts of equifinality and multifinality in describing the developmental pathways leading to psychopathology (Cicchetti & Rogosch, 1996). The concept of equifinality acknowledges that there are multiple pathways which may lead to similar behavioral manifestations, while the concept of multifinality acknowledges that the same set of factors may lead to different outcomes in different individuals. These constructs are imperative for understanding developmental trauma as there is no one clear path that leads all children to a defined symptom profile such as PTSD. As the child develops without direction, then disruptive and aggressive behavior disorders flourish. Psychological testing may be the best way to capture as many of the developmental pathways that have led to a particular clinical
manifestation. Psychological tests are meant to elucidate the contextual factors, inter- and intra-psychic processes, and history in order to capture this reality early and provide a way to redirect children away from destructive patterns whose earliest symptoms come through the fantasies of children exposed to trauma.

**PROJECTIVE TECHNIQUES**

The use of projective techniques must be taken in the context of the experience of the person making the interpretation or supervising the interpretations. A glib application of a recipe linkage of certain signs and symbols is a dangerous route to follow. Projective testing is best used as a source of constructing hypotheses to explain barriers in treatment and personality attributes that continue to interfere with the progress of long-term psychotherapy. Projective techniques can outline the guidelines to assist in the planning of the therapy so that the maximum application in community interventions such as mentoring, case management, or other action techniques that are a part of therapy and can be useful.

The very first projective indication in the psychological test battery is exactly how the client is presented for evaluation. In a public setting, this frequently involves a parent, substitute parent, case manager, or relative who presents the client for therapy. Psychologists with a projective mind-set will immediately begin to take note of how the case is presented and the way in which the child disconnects from who brought them to therapy. This is an instant observation of a rich source of information for the psychologist. This will begin to inform a diagnostic hypothesis concerning the attachment quality that this child or adolescent exhibits as part of the question being asked in the psychological tests.

Children can be brought for testing by an over involved parent, or dumped off in the waiting room by an overwhelmed case manager. This is a clear piece of diagnostic information which needs to be placed in the hypothesis course that will constantly chime into answering the projective question of “why this, and not that?” The explanation of why a child of an individual chooses to represent a standard set of stimuli in a particular way is a way of understanding how this person became the person they are. The way a child is brought or an adult presents for testing will reveal how they live their life and can be a rich source of projective information.

The psychologist will then evaluate who sent the person for the assessment and what their motivations are. Frequently, the referral is designed to facilitate an ongoing entitlement process. This needs to be addressed quickly and definitely and is the most straightforward psychological task. This can be done with strictly empirical methods and is a very straightforward question. When the question delves deeper into the nature of personality and how it affects how a person is functioning in the community, a more detailed understanding of the “centra phema” of the person is necessary. The centra phema or basic engine is a psychoanalytic concept of understanding the deeper unconscious meanings of any particular behavior or personality structure.
The psychologist must evaluate what questions are being asked and to what level of certainty they can give a response that is helpful. The point of the psychological test is to be helpful and the referral begins the process of trying to understand what is the most helpful role that a psychologist can play during the evaluation process? Simply gathering data and giving a hundred percent accurate result is not the type of psychological evaluation that is helpful in an action oriented, front line community clinic.

In training, psychologists use this approach in trauma situations, and it has become clear that it is necessary for the psychologist to feel comfortable with the idea that it is their mind, training and experiences that make a difference between a calculation and a psychological interpretation. The psychological interpretation takes the data available and mixes it together with experiences and creates a product that is useful and helpful to the person who is suffering in the street and their helper.

The Rorschach

The Rorschach is one of the more controversial of projective techniques. Psychologists have been consumed in arguing the details of how the best way of coding, interpreting, and recording of this instrument is accomplished. In the community setting, the Rorschach is useful to answer several of the following questions.

1. Is there a mood disturbance or are observed behaviors impulse driven.
2. Cognitive level in the presence and absence of information processing deficits.
3. The existence of thought pathology and the difference between dissociation and hallucinations.
4. The level of risk of exposing a person with a particular personality through a certain social context as part of a planning process.

The projective interpretation of the Rorschach can provide a way of assessing whether the person’s responses during the Rorschach indicate the presence of any other difficulties outlined earlier. When the Rorschach protocol is overwhelmed by darkness and anxiety, then that question is answered. When this is compared with a self report inventory, the answer is more strongly confirmed. This is how the projective and the empirical can work together in a simple fashion to identify something critical. This will have implications for disability, treatment, and psychopharmacology.

Certainly, the Rorschach can contribute a wealth of information to the therapist about the nature of drives and defenses. The Rorschach was developed at a time when affect regulation was the main idea behind the psychoanalytic techniques. There have been many derivatives and variations since; however, there is a unique understanding in all schools about the connectedness of the
unconscious and the conscious and the many wrinkles that may take and result in the difficulties. The Rorschach is a way to unscramble symbols used in the unconscious to master traumatic experiences in childhood.

The IQ test

The use of the IQ is the primary responsibility of the psychologist. The psychologist is charged with evaluating a person’s cognitive levels and indicating the variations within them as a way of understanding how the person thinks. Wesccher tests are highly empirical instruments which should be reported as scored in accordance and with the strictest of fidelity. There is also an element of the IQ scatter that has been the essential idea of an interpretive hypothesis (Rappaport, 1945). This process involved using a projective analysis of why the various subtests were as scattered as they were. The principle idea in this projective technique involve the impact of trauma on the thinking process. The various subtests being seen as elements of the cognitive functioning, the projective analysis of the scatter revealed the way in which trauma had left the imprint on the way a person thinks and is capable therefore of achieving within certain highly defined areas such as visual motor functioning, language acquisition, and social relationships capacity.

In dealing with children who live in chaotic home environments, it is frequent that they do not do well in school. Many of them do have an unrecognized learning difficulty that may not be a full dyslexia but is in fact a neurodevelopmental sequelae of trauma involving partial interference with the information processing of learning. This results in a difficult to diagnose but often highly disruptive disorder that can interrupt the educational experiences of many in a public setting. Many times these disruptions of learning are the result of strong aggressive impulses that are not identified or treated and therefore result in inhibited learning as well as disruptive behavior in social situations. Psychological testing is a way of understanding how a child’s mind is impacted by whatever trauma can be deduced from their history. The psychologist is then challenged to provide a way to understand how all of these various elements intersect and result in the problem motivating the referral.

The Human Figure Drawing

There are very few techniques in the projective handbag as useful and as widely useable as the Human Figure Drawing (or in some fashion any symbolic writing by a child at any age). Regardless of whether they are a child or an adult, there are aspects of personality that will be revealed immediately by examining the Human Figure Drawing or other symbolic drawings such as the House Tree Person technique (Koppitz, 1966, 1984).

The principle element of the Human Figure Drawing or the projective technique in general is to unravel the symbol. The symbol is a representation,
an abstract way of communicating about what a person thinks, how they store the electrical energy involved in an over-stimulated traumatic experience that may have occurred in a variety of ways. Children are affected by either the absence of protection or the over-stimulation that resulted from various types of abuse. This will create a defensive strategy that is born in childhood and generally stays with the person into adulthood unless there is strong intervention during the life cycle. Many of these conditions result in criminal actions due to the tendency of society to criminalize the weakness of people with this type of psychological commission.

The drive regulation ideas of pushing and pulling are essential to understanding the projective data that can be summarized in the Human Figure Drawing. The first technique in understanding the Human Figure Drawing is to have a free association about what the image looks like. There are many elements of drawing that become noticeable after observing thousands of them over time. The most common aspects of the Human Figure Drawing to draw one’s projective attention to include the following:

1. Size of the drawing and its developmental quality.
2. The amount of darkness or erasures indicating the amount of tension attributed to various parts of body.
3. The presence of piercing long phallic like images.
4. The presence of nurturance in the form of breasts or other rounded sources of support.
5. Placement on the paper and the size of the drawing.
6. The stance.

The psychologists are urged to put themselves in the position portrayed on the paper. Often, this is a highly inhibited or an explosive wide-eyed expression. The ideal of interpreting projective material is to try to answer the question, why did they do it this way, rather than any way? Many hypotheses can be generated using this approach due to projective drawings.

**THERAPEUTIC ART**

Regardless of the type of approach in scoring and analyzing the data, the psychologist is charged with communicating the results in such a way to be maximally beneficial to the child. While it is vitally important not to hew too far from the data, accuracy is not sufficient for providing helpfulness. For this reason, moving beyond simply accurately reporting the quantitative findings is imperative. The value of the psychologist is to gather data in such a way as to contribute to the understanding of a problem. No “objective” measure exists to discern the meaning of projective data in relation to cognitive, self-report, and neuropsychological data; the interpretation is the firm purview of the psychologist conducting the testing. The formulation process
frequently will involve the construction of a variety of hypotheses that could differentiate alternatives in the treatment program. There are several areas in which this is specifically true. First, for younger clients maximizing their educational attainment should be a clear goal. In fact, a recent report issued by Georgetown University found median difference of 33% in lifetime earnings between those with a high school diploma and those with less than that (Carnevale, Rose & Cheah, 2013). Understanding learning difficulties and redirecting them at any time in their lifecycle, the earlier the better, is a useful element in long term treatment of this population. This can create the way for someone to obtain a GED (General Educational Development) assessment, begin community college, or in some way use the academic experience as a way to balance out what might be a chaotic home and community existence.

Second, the formulation which takes into account both inter- and intra-psychic processes is helpful for a prescriber who is working with the therapist to try to adjust the medication of the identified patient in such a way as to improve not only the individual’s functioning but also the family’s functioning whether it is an adult, caretaker, or a child or adolescent. Frequently, there is a question of whether the child or adolescent’s behavioral presentation is a manifestation of anxiety or whether it is a manifestation of ADHD. In our population traumatic exposures are virtually ubiquitous, and behavioral adaptations tend to be marked by dysfunctions of arousal regulation. While some of our clients present as predominately hyper- or hypo-aroused, many present with a combination of both as a result of unstable or disordered arousal. Regardless of the underlying arousal pattern, the presenting behavior is disruptive and difficult to manage, and this results in an exacerbation of ongoing home and community life. Since attention problems result from either hyper- or hypo-arousal, children are often prescribed stimulants when they are anxious, or they are given a serotonin-specific reuptake inhibitor (SSRI) when in fact they are predominately hypo-aroused. Additionally, dissociation is a fairly common response to chronic childhood trauma. Dissociation tends to be associated with hypo-arousal, and it is important to differentiate from an organic psychotic process. This is a very common question that prescribers are faced with when trying to manage a complicated childhood psychopharmacology, which may include atypical anti-psychotics, stimulus, SSRIs, and benzodiazepines. The integration of cognitive and projective data is the clearest, most reliable method to make distinctions that have direct ramifications for psychiatrist’s medication decisions.

Children and adolescents have limited defensive strategies at their disposal when faced with trauma within the caregiving system. Given that children are simultaneously dependent on their abuser for their very survival, there is a strong psychological pull towards denying the abuse. This leads to a common presentation of numbing, dissociation, and emotional avoidance. These clients will often deny every symptom on symptom inventories. In contrast, these children’s internal experience is often expressed through their responses to projective techniques. For this reason, the projective techniques can be particularly helpful in assessing the level of mood involvement in chronically abused children. This can
begin with the Rorschach and the assessment of the achromatic responses and extend into the CAT (Children’s Apperception Test) or TAT (Thematic Apperception Test) with examination of the themes that pervade the stories. Similarly, projective tests with impulsive individuals frequently have more color and a variety of other externalizing images. Victims will portray images that have hard crusts such as crabs, spiders, and other types of images.

While projective data are imperative for generating hypotheses about individuals’ psychological organization, it is important that the hypotheses be tested against the more objective data from collateral sources, rating scales, and cognitive and neuropsychological assessment measures. Projective data provide the scaffolding in which to fit the rest of the data to form an overall picture of the dynamic developmental pathways that have resulted in a child’s behavioral presentation. An over-reliance on empiricism and quantitative data results in a risk that psychologists will become enamored with correctness and miss the forest for the trees. The principle role of psychologists in formulating psychological testing is to apply their critical understanding to the variety of data and experiences offered as part of the assessment to form a dynamic psychological formulation that includes both inter- and intra-psychic processes. This is not a feat that can be accomplished by applying a formula or algorithm to a dataset. Our brains are heavily biased to detect patterns amongst complex stimuli, and the psychologist who interacts with the client in the testing environment has gleaned far more data from unconscious interpersonal processing than are available when relying on standardized measurement data alone. Overall, the proper role of the evaluating psychologist is to use this critical thinking to try to understand the experience individual while simultaneously using the test as a way to contribute to that understanding. Until we reach a day when we devise a formula that captures the entirety of the human experience, psychological testing will not be able to rely solely on actuarial predictions. In the meantime, it is important for the psychologist to keep the balance of the individual as a calculation and a mathematic formula as well as a living, breathing human being whose nature will change with the social context in a way that mathematics will never capture.

The process of constructing a dynamic formulation allows the psychologist to be able to assist the psychotherapist in assessing the origin of the problematic behavior. The first question a psychologist should ask is where the problem behaviors occur. For example, does the problem behavior occur at home, in the school, or in both contexts? This simple question can disentangle whether the etiology of the problem is more organic and neurodevelopmental or more environmentally produced by signals that are altered by psychological malfunctioning in family systems. This can be instructive in helping the therapist adjust who is involved with the therapy, how the therapy is progressing, and ways of identifying goals that can promote progress and a steady movement away from dysfunctional living.

In the community setting, the role of the psychological evaluator should not end simply with reporting the findings. Instead, frequently there are opportunities
to work with caregiving systems in achieving their children’s educational goals. The identification of special needs process within the school systems is one that favors the parent; however, they often are not aware of the process of their rights and need assistance in asserting those rights without creating further difficulties for the school. The psychologist is in a position to assess whether the difficulties are generated context demands (e.g. a mismatch in expectations between school and home settings) or whether a neurodevelopment or organic process is the primary etiology (being exacerbated by the environment). The psychologist then is in a position to be able to assist the treatment planning process by advocating for change at the appropriate level (e.g. medication changes, parenting behavior changes, or classroom accommodation changes).

Beyond advocating for educational accommodations, the psychological evaluation must be tasked with providing treatment and other psychological recommendations. Understanding the way a child spends his or her time is critical in creating a useful psychological recommendation. Children generally spend nine months of their life from early morning until after school in structured adult-monitored activities. In contrast, the bulk of the remaining time may be spent in unpredictable, often chaotic, struggling, exposed, unsteady, and often toxic home environments. In these contexts, a recommendation is useless if there is no mechanism in place to act on it. To affect genuine change in developmental trajectories, it is imperative for psychotherapy to have the option to engage young people who are locked into their own homes, on the internet, alienated from friends, overweight and a target of bullying, or in other ways socially inept to engage in existing community resources. Every community has a Boy’s and Girl’s Club, YMCA, and other established social recreational activities. Many of the children and adults in this population do not take advantage of these resources for a variety of reasons that must be addressed in the recommendations of the psychological evaluation. In sum, a well done psychological evaluation will provide the “blueprint” upon which to design services. These services may include a Student Support Team and school psychologist within the school setting, intensive case coordinator, outreach psychotherapist, psychiatrist, primary care physician, and therapeutic mentor within community settings.

The psychological evaluation thus serves as the “golden thread,” which ties together and provides a roadmap connecting other mental health services. Our experience in this area suggests that when long-term outreach psychotherapy is combined with other home-based services including therapeutic mentoring, behavior disorders can be “held” in the community without an escalation in level of care or use of emergency services. The combination of comprehensive and medically-driven psychotherapy and therapeutic mentoring creates a way for young people from Head Start to early community college to generate a passion and create positive alternatives in their free time. The projective tests often offer a wide range of hints as to resilience factors for positive developmental trajectories as they can reveal the person’s interests and strengths. The content in the Rorschach, the stories in that TAT, the portrayals
in the Human Figure Drawing, and the general understanding where the person has been and where they are likely to go, can create ways to offer suggestions for social recreational activities after school. This need exists throughout the life cycle and has different forms. Many of the individuals Aichorn (1935) would describe as “neurotic” delinquents can be influenced by this type of psychotherapy if it is sustained over a period of time with an active involved caregiver (most likely the mother). This combination of psychotherapy and an active mother can be woven into successfully altering developmental trajectories from the school to prison pipeline into other outlets including vocations and higher education. This is where the concept of developmental trajectories becomes especially important. Despite many of the same stresses including poor schools, active gang recruitment, and neighborhood disorder, the concept of multifinality stipulates that the outcome can be more positive if some factor alters the developmental trajectory. Psychological evaluations provide the “road map” to targeted interventions which have the best chance of improving outcomes for vulnerable youth. Without some form of intervention young people, often inner city urban youth, are condemned from early educational experiences to a life that often leads down very self-destructive paths. The alternative can be created using psychological evaluations to inform psychotherapy and mentoring so that the youth becomes engaged in positive aspects of social recreational activities in the community. Psychological testing can outline the use and can point to what a child’s interest might be so that an active therapist and mentor can explore them in a way of igniting a more positive sense of self, in children and adults struggling in this family.

Beyond recommendations for community engagement, psychological evaluations also assist therapists in adjusting their therapeutic style to the personality style elucidated by the psychological testing. For example, when clients exhibit low language affinity and limited cognitive capacity, highly abstract, insight-oriented, and expressionistic types of therapy are less likely to be useful in everyday life. In contrast, a more simple goal that is designed for symptom control (e.g. straightforward cognitive behavioral techniques and coping exercises) might be more useful in affecting genuine improvement to quality of life. These types of interventions can be accomplished in groups with less emphasis on the individual therapy, or in many cases must be reinforced in individual therapy over time. As is often the case in our population, the psychological evaluation is oriented around elucidating children’s adaptations to attachment disruptions and other types of trauma exposure. For many of these children, a group-based or behavior management approach to treatment is contra-indicated. Instead it is easier to manage one psychotherapy relationship than deal with the complicated issues of accessing or maintaining presence in a group (regardless of the quality of the group). Additionally, trauma exposure must be considered when planning behavioral interventions. For example, time out from positive reinforcement is the most widely utilized behavioral technique with children. For most children the removal of positive reinforcement acts to
calm the nervous system; however, for children with histories of neglect, the removal of relational engagement acts as a trigger and dysregulates them further. For many complexly traumatized children, play therapy and attachment-based techniques are the most appropriate types of interventions. A follower of Anna Freud, Selma Fraiberg coined the concept of “Ghosts in the nursery,” which deals with children’s own relationships with their caregiving systems (Fraiberg, Adelson & Shapiro, 1975). These “ghosts” will be manifested in the therapeutic space through symbolic play. Unraveling the symbolism is a task that the projective approach in psychological evaluations takes as its primary journey. In essence, the projective theorist is attempting to construct the “centra phema” around which a predictable understanding of the person can be gained with an eye towards developing helpful interventions that could shift the course of their life. Without a road map, too many families maintain their current courses of life and head towards high expense, unproductive, largely criminal, substance-involved, and domestically violent lives. It is of primary importance for the testing psychologist to be aware of this phenomenon and be active in offering helpful alternatives to therapists in unraveling a child’s ghosts. These ghosts generate dysfunctional behavior when mismanaged by social context that are of marginal ability to protect, direct, and contain. The therapy offers a place to contain irrational emotions and develop ways of understanding symbols and ways that can offer children to do something different with the energy generated from the over stimulation and trauma.

There is much debate in our field currently about the status of pediatric Bipolar Disorder. This controversy is at least partly fueled by the fact that emotional dysregulation (a hallmark of Bipolar Disorder) is a common factor to many childhood psychological difficulties, most specifically as one sequela of chronic trauma exposure (Parry & Levin, 2012). The astute clinician will take a careful history of the child’s caregiving environment with an eye towards differentiating a true Bipolar process from emotional dysregulation secondary to trauma. The biggest differentiator is whether the dysregulation is stemming from an internal source (i.e. organicity as in Bipolar) or an external source (i.e. adaptations to trauma exposure). Psychological evaluations are a critical link in providing the data to best answer this question. If the etiology of a behavior is “signal based” (as in complex trauma), the probability that an interational type of therapy is most appropriate increases dramatically. The more the problem appears to be rooted in the dyad and triads of the family, the more likely that a home-based family therapy intervention should be tried. Often, this has been tried with limited success and varying members sabotaging the process over time. This is the opportunity for a psychologist to reinforce the need for this type of connect family processing of events that could assist in improving the quality of life, decreasing school problems, increasing positive community activity. In contrast, the psychological evaluation may point to a more organic etiology of problem behavior. In this instance, interventions including medication and case management might be more appropriate.

The psychologist is often asked to assess risk or threat. A full exploration of threat assessment is beyond the purview of this paper. Suffice it to say,
psychological risk assessment typically involves answering questions as to whether a parent is fit to care for a child in the community, what is the risk of aggression in various placement settings, and what is the risk of self-destructive behaviors (and the level of supervision to contain them). These questions are frequently asked by state agency case managers who are classifying disruptive behaviors in such a way to try to minimize the disruptions to the child in terms of level of care while simultaneously protecting the community. The psychologist is thus charged with identifying the nature of the problems, the etiology, the triggers, and the level of risk engendered by the interaction of the child’s vulnerabilities with triggers in the world. Systems of care including case managers, residential treatment facilities, Department of Children and Families (DCF), and individual therapists frequently rely on psychological evaluations to provide information to their decision-making process. To this end, the projective techniques can be helpful in establishing some of the more common risk indicators. The following are some of the ways in the evaluation provides helpful information:

(1) predatory or exploitative behavior exhibited by a combination of history, control tactics on the projectives, and possible psychopathy check lists or other indicators of antisocial or jealous controlling behavior as seen in domestic violence.

(2) Cognitive level and whether any placement or current academic plan is creating frustration that could lead to violence. School disruption frequently results from improper educational placement which causes frustration, shame, and ultimately violence.

(3) Fitness to parent is frequently a question asked of the psychologist. This is often a combination of psychological tests to screen for the presence or absence of serious emotional disturbances. The history of how the parent behaves during the case management plan is the other source of data in order to come up with a predictive statement about fitness to parent.

Finally, the ability to parent is impacted by active and passive risks. The active risks generally stem from highly exploited and explosive disorders that hurt children by their proximity to these psychic explosions. Passive risks include the threat from a sustained predator, in which case it is much more difficult to identify the signs of psychological struggle. The parent’s attendance and behavior during the psychological evaluation is a critical part of the assessment. Evaluating psychologists must combine their psychological test data with observational data of an interactional style. A great deal can be understood about the parent–child relationship by simply observing how a parent and child interact. The central question of a psychologist is how much focus does the parent place on the child and does the history bear this out. Parenting is not a highly complex process but it is one that takes focus, heart and soul, and motivation. When these elements are there and not disrupted by high-risk activities, even parents with serious limitations can be supported in such a
way as to maintain the family system within the community. In contrast, the evaluating psychologist must be keenly aware of certain risk factors which stem primarily from unstable housing, domestic violence dependencies, substance abuse and criminal involvement of families through necessity. These situations often expose children to high risk environments and frequently are a place where children and families live and are invaded by exploitive forces beyond their control. The primary risk a psychologist must search for is whether there is active exploitation. This is not the result of any psychological test instrument, but stems from a fellow interview and record review to establish whether there is any history and possibility that the child is currently at active risk. Once this is ruled out, then the formula of risk and protective factors can be calculated using a variety of psychological testing instruments as well as projective, data and observational and record review.

Overall, the psychological evaluation serves as the “golden thread” tying together the roadmap for disparate agencies to coordinate care for children. Given the multitude of stressors impacting children as well as the multitude of systems often involved, something is needed to elucidate the developmental factors at play as well as the interactions amongst inter- and intra-psychic processes and contextual factors. This roadmap is one that requires both empirically rigorous testing methods and the clinical expertise of the evaluator. There is no amount of empirical data that can highlight the complex interactions of children’s developing nervous systems with their systems of care. The most important role that psychological evaluations can play in a community setting is to shine a light on the risk and protective factors and developmental trajectories that may lead either to a life of misery, continued abuse, systems involvement, and ultimately early death or a healthy productive life.

REFERENCES


Robert Storey, EdD
Community Services Institute, Inc.,
1695 Main St, Ste 400,
Springfield, MA, 01103, USA
robert.storey@communityserv.com

Mark Gapen, PhD
Community Services Institute, Inc.,
1695 Main St, Ste 400,
Springfield, MA, 01103, USA
mark.gapen@communityserv.com

James S. Sacco
Community Services Institute, Boston and Springfield,
77 Reed Street, Agawam, MA, 01001, USA
fcsacco11@gmail.com