

THE TA CONNECTION

resources for THERAPEUTIC ASSESSMENT PROFESSIONALS

Editor's Introduction

*By Justin (J.D.) Smith, Ph.D.
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Welcome!

Friends and colleagues: It is with great excitement that I introduce you to *The TA Connection*, a newsletter for the practitioners, teachers, researchers, trainees, and followers of Therapeutic Assessment (TA). I am honored to be serving as the founding Editor and am joined by my dear friends and Associate Editors, Stephen Finn, Hale Martin, and Deborah Tharinger. The impetus for this newsletter is to foster an exchange of ideas and communication of breaking news on TA and related areas that are likely to be of interest to our community. For the time being, we will publish two issues each

year, one in the Winter/Spring prior to the Annual Meeting of the Society for Personality Assessment, and the second in the Summer/Fall shortly after the beginning of the academic year. We intend to expand the newsletter's frequency as the TA community grows and prospers.

We intend to provide readers with a range of topics relevant to TA in each issue. In each issue you will find three standing columns:

(1) The Researchers' Corner, which will provide a review and commentary of recently published research to keep us all abreast of the empirical basis of TA and its therapeutic techniques. In this issue, I summarize what we have gleaned from the handful of published studies

using single-case time-series designs to assess the effectiveness and processes of TA.

(2) The Instructors' Corner, which will describe and discuss issues and practices relevant to the teaching and supervision of practitioners of TA from graduate student trainees to seasoned professionals. In this issue, Hale Martin describes the successes and challenges of his approach to teaching a graduate-level course devoted to TA.

(3) The Clinicians' Corner, which will cover a host of clinical techniques, strategies, and useful tips for using TA with our clients. In this issue, Deborah Tharinger presents a case example to illustrate the use of the Adult Attachment Projective Picture System (AAP) to assess

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the adolescent and parent(s) in the TA adolescent model.

There will also be recurring and one-time columns on specific topics and subspecialties, such as the use of TA in forensic situations and neuro-psychological evaluations. In this issue, Barton Evans discusses the way in which TA can be used in court related assessment opportunities, such as custody and parental fitness evaluations. We also aim to include highlights of recent trainings and activities of TA practitioners and researchers. In this issue, Stephen Finn describes the 2012 Advanced Training that took place in Austin, TX this past October. Two teams of participants, supervised by Marita Frackowiak and Pamela Schaber, completed TAs with an adult and an adolescent and her family in a one-week intensive training. Last, you will find references to

recently published articles on TA and collaborative assessment and announcements of upcoming TA workshops and trainings.

We welcome your feedback and suggestions for the newsletter as it takes shape. I'd also like to invite anyone who is interested in submitting a column for consideration to email me at jsmith6@uoregon.edu. These are exciting times for TA with robust research supporting the model's effectiveness and many of the therapeutic techniques we use in TA with our clients. I hope *The TA Connection* serves to bring our community together and offers a venue to advance our knowledge of TA, share ideas, and learn from one another for years to come.

Please email questions or comments on this column to J.D. Smith at jsmith6@uoregon.edu

The Anatomy of Change in Therapeutic Assessment A Review of Recent Single-Case Time-Series Studies

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In 2010, Poston and Hanson published a meta-analysis of the therapeutic benefits of providing clients with individualized feedback following a psychological assessment. Meta-analyses look at multiple studies of a similar type and summarize the overall significance of those studies. Despite the varying

quality of the studies Poston and Hanson examined and the different outcome variables and ways that feedback was approached, the resulting effect size (a statistical measure of how much positive impact clients derived from an assessment) was noteworthy (.42). This figure clearly indicates that clients experience benefits from receiving feedback on their assessments. The findings of the Poston and Hanson study are germane to Therapeutic

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Assessment (TA; Finn, 2007), because individualized feedback is one of the foundations of the model. Even though these findings are robust and statistically sound, group studies comparing mean-level differences between groups of clients obscure the anatomy of change, as B. F. Skinner (1938) so aptly noted. That is, they reveal very little about how change unfolds during the intervention under investigation. Single-case experiments—in which client outcomes are repeatedly examined throughout the intervention—are an alternative to the group design and have the ability to tell us whether the client improved as a result of receiving the intervention while also giving information about how and when the change occurred.

I recently published a review of studies between 2000 and 2010 and found that single-case experiments are commonly used in a number of social science disciplines, particularly in clinical, school, educational, rehabilitation, and sport psychology (Smith, 2012). Multiple studies have been conducted in recent years applying the single-case experimental design and a sophisticated variation called “time-series analysis” to the study of TA with children and families and adult clients. In a single-case experiment, the subject serves as his or her own “control”, usually by comparing outcome variables to measurements taken during a so-called “baseline phase”, because the intervention began after this period. These baseline measurements are then compared to those taken during and after the intervention using statistical

***These findings are
in line with the
experience of
many clinicians
practicing
Therapeutic
Assessment with
children—that is,
different families
seem to benefit
most from
different parts of
the model.***

methods that account for the repeated measurements of the design. One or more dependent variables can be measured at any point, but are generally assessed either daily or weekly in intervention research. In this column I review the major findings of these studies and evaluate what these repeated measurement studies reveal about the change processes initiated by the TA model.

TA with Children and Families

The child and family version was the first of the TA models to be tested with the single-case time-series design. Various colleagues and I conducted a series of experiments, and we began by examining a single family before moving on to studying multiple families at once. Our first study examined the effectiveness of TA for a family with a 9-year-old boy presenting with disruptive behaviors and anger outbursts that occurred only in the home (Smith, Wolf, Handler, & Nash,

2009). In the middle of the TA (just after standardized assessment had been completed), the parents brought in a homemade videotape of their son's aggressive behavior at home the previous week to make sure the assessors understood how severe the boy's behavior was. We asked the parents to make daily ratings of family distress and of their son's behaviors before, during, and after the TA intervention. Our analysis revealed a significant decrease in the *intensity of the boy's worst anger outburst* when comparing baseline levels to those reported during the TA. The effectiveness of participating in TA appeared to have continued to grow during a relatively brief (40-day) follow-up period, as shown by significant reductions in the *intensity of his worst anger outburst* and in the *degree of his hateful behavior directed at his mother*. In contrast to other studies I will review, this family did not report a statistically significant decrease in family distress during the study period. However, all the dependent variables showed significant improvements when comparing baseline scores to those reported after the TA was completed. The videotape brought in by the parents was used to help each family member develop an observing ego by examining their respective contributions. One interesting result was that major improvements appeared to occur around the time of the family intervention session. This intrigued us and led us to conduct and publish a second study that explicitly looked at this phenomenon.

In this next study (Smith, Nicholas, Handler, & Nash,

2011) we presented the case of a 12-year-old boy whose parents were concerned about his self-esteem and academic achievement. Although the comprehensive family TA model was used in this case, the boy's father was the only parent able to be involved. As the assessment went on, it became clear that the father was a major factor in the boy's difficulties, suggesting that a family session focusing on the father-son dynamic could be instrumental to lasting change. When we analyzed the daily outcome measures, we found no statistically significant change during the TA in comparison to baseline. However, there were highly significant changes during the 60-day follow-up period, as shown by a notable Pearson's r effect size of .708. Furthermore, we were able to exploit the strengths of the single-subject design, and examine the point during the assessment that change occurred. Because our previous study had suggested that the family session is instrumental to change, we compared scores taken before and after this point of the assessment, and found that it was an important turning point. While the boy's behavior had been steadily worsening before the family session, afterwards it steadily improved. These results suggest that the family intervention session plays a vital role in the change process in child TA, perhaps especially in those families in which the child's difficulties are largely systemic in nature.

In order to strengthen the methodology of the single-

subject design and have greater confidence that the changes we had observed were indeed due to the TA model and not other factors, my colleagues and I (Smith, Handler, & Nash, 2010) next conducted a series of TA interventions with families and their preadolescent boys who met diagnostic criteria for oppositional defiant disorder. By studying three relatively homogenous families at once, we not only increased the validity of our findings, but also revealed that the process of change differed for each family. Analyses revealed that by the end

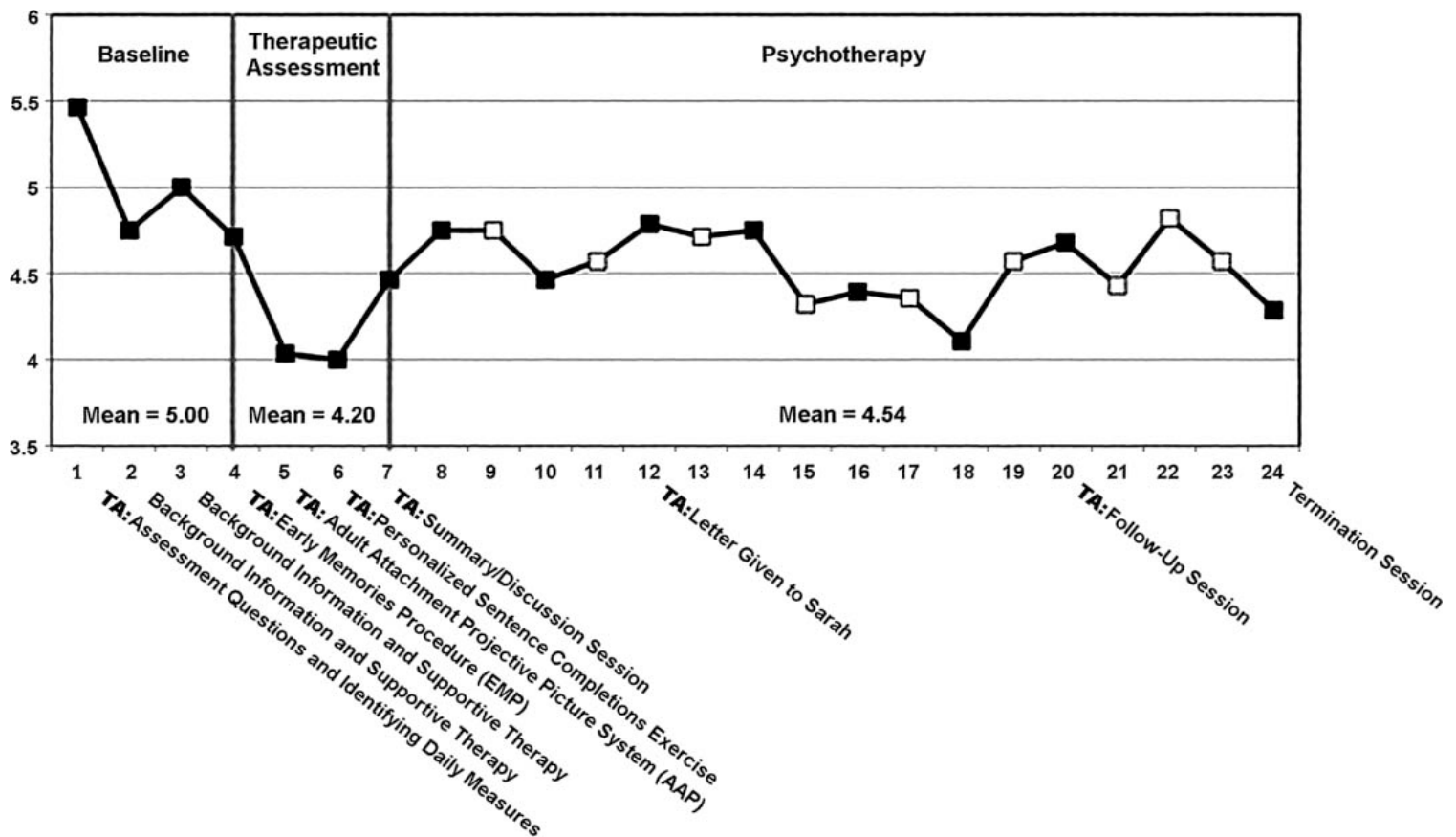
The single-case time-series designs research to clinical experience and illuminates the process of change clients experience as they participate in a Therapeutic Assessment

of the study period, which included a pretreatment baseline, the TA, and a two-month follow up, each of the families reported statistically significant change on a composite measure of *family distress* and *child symptomatology*. However, one family appeared to have improved very early in the TA, a second family experienced change later in the TA, and the third family realized improvements in the two months that followed the completion of the intervention. The results of the daily measures were corroborated by broad and sweeping improvements on nearly all domains assessed using the Behavior Assessment System

for Children, Second Edition (BASC-2; Reynolds & Kamphaus, 2004) between pre-treatment and follow up. These findings are in line with the experience of many clinicians practicing TA with children—that is, different families seem to benefit most from different parts of the assessment, and at least at this point, it is difficult to predict what part of the TA will have the greatest impact.

TA with Adult Clients

Three adult TA case studies have been or will be published using a single-case time-series design. Aschieri and Smith (2012) examined the effectiveness of TA for a woman with a history of trauma who was experiencing academic, self-esteem, and interpersonal problems as an emerging adult. Time-series analyses revealed significant improvements coinciding with the onset of TA in a composite measure of functioning, which included daily ratings of *anxiety*, *loneliness*, *recognition of love for herself*, *recognition of love for others*, and the degree that she was *hard on herself*. Further, an analysis of the slope of her symptomatology revealed a significant trajectory of improvement that began with the first session of the TA. These results were evident during the TA itself; unfortunately, follow-up was not available.



A second study (Tarocchi, Aschieri, Fantini, & Smith, in press) revealed similar findings and involved an adult woman with a history of repeated interpersonal trauma who had sought treatment for a constellation of symptoms consistent with *complex posttraumatic stress disorder*. The results indicated that the client's self-reported *loneliness* and *despair* were significantly reduced during the TA in comparison to baseline. Reductions in *anxiety* approached significant improvement. The results also indicated that the effects were maintained during a 2-month follow-up period, which was followed by psychotherapy with the assessor. Results of the time-series analysis were consistent with weekly scores on the Outcome Ratings Scale (Miller, Duncan, Brown, Sparks, & Claud, 2003).

Carol George and I (Smith & George, 2012) described and evaluated the process of participating in TA and continuing with psychotherapy with the same clinician. The client was a middle-aged woman who was experiencing troublesome anxiety and depressive symptoms following a successful treatment for metastatic cancer. The Adult Attachment Projective Picture System (AAP, George & West, 2012) revealed a dysregulated attachment status, which is common to trauma survivors, and this woman had not only survived the trauma of a terminal cancer diagnosis but also familial trauma in childhood. Our analysis showed that the client had a significant reduction in her symptoms immediately after she began the TA, and that they rose toward the end of the TA, although not significantly. The

significant improvements the woman experienced during the assessment were maintained during the subsequent 4-months of biweekly psychotherapy but did not continue to improve during this period (see Figure above). Although change occurred early in this case, it is impossible to know whether the client would have relapsed without the rest of the assessment or the subsequent psychotherapy.

Conclusions

The single-case time-series design is an excellent complement to the group design; both in terms of tying research to clinical experience and in illuminating the process of change clients experience as they participate in a TA. In all, the six publications I have reviewed entailed eight single-subject experiments. In each case, the client or family improved on

more than one salient domain. However, the anatomy of change differed somewhat in each case. Not surprisingly, as many of you who do TA may have yourselves experienced, some clients demonstrated fairly rapid improvement, almost as soon as the assessment began. This proves the feedback about assessment findings is not the only mechanism of change! In other cases, it took time for noticeable gains in clients' problems to become apparent. This finding may simply indicate the way in which psychological interventions unfold in general, as shown in research on such topics as the phase model of change (e.g., Howard, Lueger, Maling, & Martinovich, 1993). However, this finding may also reflect something particular about TA. For example, successful TA hinges upon the development of a trusting therapeutic relationship in the early phases. When this occurs there is likely to be some relief of distress and early overall improvement in similar domains (e.g., anxiety, hopelessness). In some cases, this initial relief may drive improvement throughout TA, but in other cases, additional TA interventions may be necessary to reach clients in a new and profound way. TA practitioners intervene in each session through specific components of the model, such as the extended inquiry, assessment or family intervention session(s), summary/ discussion of findings, and the written feedback letter. Through these intervention strategies in each phase of the TA, the assessor's goal is to initiate change in the client's self-view by instilling self-compassion, demonstrating empathy, identifying dilemmas of change, and teaching more

effective means of coping with their struggles. This provides a common thread connecting each session and building upon previous sessions – almost akin to receiving additional doses of the active ingredients of change. It is the progression of the steps of the TA model that gently ushers clients toward change. The TA model is effective and powerful because of this progression and the use of different techniques to achieve a common goal, rendering the model as a whole a robust intervention approach. To apply a cliché, the whole of TA is greater than the sum of its parts.

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Justin (J.D.) Smith, Ph.D. is a postdoctoral fellow in the Development and Psychopathology Research Training Program at the Child and Family Center at the University of Oregon. He has published more than 20 peer-reviewed journal articles and book chapters concerning

assessment-driven interventions for adults, children, and families, single-case research designs, and time-series methodology.

Please email questions or comments on this column to J.D. Smith at jsmith6@uoregon.edu

Teaching Therapeutic Assessment

*By Hale Martin, Ph.D.
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Since 2008 I have had the honor of teaching an entire quarter long course in Therapeutic Assessment to our doctoral clinical graduate students! It has been quite a pleasure. The course was intended to be offered as an elective every other year, alternating with other elective assessment courses. But after the second course, the student demand led to my offering it every year. Thirty students took the course this past year, proving it to be one of the more popular elective courses in our graduate program. I notice that students in training today find TA compelling and typically wonder why anyone would do assessment any other way. I would like to take a few moments to write about the development of the course, including how it has evolved, key aspects of the course I would recommend, and responses from the students.

Development and Evolution

Initially developing a ten-week course, two hours per week on Therapeutic Assessment (TA) seemed a big undertaking, so of course I consulted with our esteemed leader, Stephen Finn. His wisdom has always been reliable. I also hoped to emulate his workshops by integrating the parts that I have found most useful into the course. As always, Steve was

helpful and supportive. He affirmed my ideas about readings and suggested a few I had not considered. The two main techniques I borrowed from Steve's workshops were showing video and staging role-plays.

Video examples. Watching video of actual TA sessions has been a mainstay throughout the four times I have taught the course and is a favorite learning avenue for

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my students, as it is for me in Steve's workshops. Actually seeing the work is invaluable. I have tried various ways to do this and have found that the students particularly appreciate viewing the work of fellow trainees. I think it makes TA feel doable. Adding student video is not difficult because I supervise TA in our in-house clinic where client sessions are always recorded. As with most of us, it takes some courage for students to show their work;

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but, they have invariably felt affirmed and exhilarated afterward. I think showing multiple assessors has added to the richness of the course. I select videos that demonstrate each of the major components of TA: initial interviews, extended inquiries, assessment intervention sessions, and summary/discussion sessions.

The dreaded role-plays. I have found students are rarely initially excited about role-plays--maybe none of us are. It requires us to put ourselves on the line in a semi-imaginary performance. Maybe it is because it feels infantilizing or because it threatens our self-soothing imagined competence, or simply because it feels like hard work. However, some course evaluations always include this as a major positive aspect of the course. My technique here has changed each time, and I am still not settled on the best way to do role plays. I started by having students discuss the selected client in small groups of five, anticipating what might emerge. Then I had one group volunteer to role-play in front of the class, with one assessor and the other group members as a lifeline they could call out to consult with at any moment. I had students switch who role played the assessor from time to time so several in the group got a chance to be on the line. I played the client. This was very well received the first year, but not as well the second year, as several students pointed out how intimidating it was for the assessor. They suggested I be the assessor, so I tried that the following year. I selected a volunteer student with some acting experience to play the client. I trained the student about the client as best as I could in limited time. I stopped the action frequently to get consultation from the entire class. This approach seemed to work okay but left some of the class uninvolved. I then experimented with having small groups of three students (assessor, client, and observer) role-play with each other the case I provided. I tried to have the students rotate but ran into time constraints. (The class is only two hours long.) I now believe that the best way to structure the role-plays depends on the unique class; however, it does seem to be an effective and integral part of the course. I will see this coming year if I can anticipate how best to structure the role-plays from the student roster going into the course.

Other Essential Components

Beyond viewing video and doing role-plays, there are other components that seem to contribute to a successful outcome in this course.

Readings. Another pillar of the course is the readings. The first thing I wanted to accomplish is to imbue the students with an appreciation of the underlying philosophy of TA that continues to guide its development. Accordingly, I start with Connie Fischer—I love her writings! We read her 1978 chapter "Collaborative Psychological Assessment," her article "Collaborative, Individualized Assessment" (2000), and chapter 4 "Assessing Process" from her 1985 book *Individualizing Psychological Assessment*.

Of course we also read a lot of Steve Finn. In a previous course, the students have already read the seminal research of Steve and Mary Tonsager (1992). To gain a deeper appreciation of the empirical foundations of the TA approach, we read one of Bill Swann's articles on self-verification (1997), and some of Deborah Tharinger's studies. I also discuss at length the Poston and Hanson meta-analysis (2010). Beyond that it is a smorgasbord and it is difficult not to assign too many readings. I include below the reading list for the last version of the course (see Appendix). I try to cover research, a diversity of case presentations, child and adolescent TA, and conveying results in written form, including writing stories for children and adults. Students particularly like Steve's (1996) manual chapter on the initial interview, a thorough thinking through of the first session with a client, and the Tharinger et al. article on writing individualized fables for children. One of my personal favorites is the article by Len Handler titled "The Case of Bud" that is a unique application of collaborative technique.

Presenting one case in great detail. Another aspect of the course that I think is useful for my students is walking through one complete case in great detail session-by-session. The case also provides the material for most of the role-plays we do. It takes parts of about five weeks of class, but it gives students the opportunity to see what an actual TA case looks and feels like. It also allows the opportunity to study

the data (history, picture drawings, sentence completion, MMPI-2, Rorschach, TAT, etc.) as a review and application of what the students have learned in previous classes. The case is fairly complicated, but provides colorful and engaging material that fits together well, demonstrating the value of multimethod assessment. I give some test results, such as the Rorschach, at the end of one class to be discussed at the beginning of the next class. This challenges students to see what they can determine about the results in the intervening week. The ensuing discussion is generally lively as we try to figure out

Teaching this course is a highlight of my academic year. I am gratified that students are consistently excited and inspired by Therapeutic Assessment.

answers to the client's questions, how we might structure an assessment intervention session, and ultimately how we might convey these answers.

Assignments: Letters/stories/reports. There are two written assignments for the course. The first is to write a fable for a child. I first read several stories that have been written as examples of what is possible. I have tried two ways to provide data for the fables. First I have discussed a child assessment I have done and provided the raw data. Second, I have asked students to think of a child they have assessed, or more likely worked with in therapy. Their assignment is to write a fable that would be therapeutic for the child they have in mind. I have found the second option the best. They have more energy and direction for a child they know than for one that is an abstraction. I have had some students ask if they could write a story for an adult à la Diane Engelman and J. B. Allyn. With few exceptions, the stories they write are amazing. I am shocked at how easily it seems for students to write truly excellent stories. Many choose to illustrate the story. One student two years ago wrote a clever and engaging long poem called "Collin the Kangaroo and His Power Pouch." I never have enjoyed grading papers so much!

The second assignment is to write an explanation to an adult client that would be part of a feedback letter. This gives me the chance in preparation to read some

of the metaphors I have come to use with clients, such as the emotional container and saucer I learned from Steve. Again, I challenge them to think of an adult client they have worked who was struggling with a difficult issue. How could you creatively and effectively explain this to the client? The result has been as interesting as the fables! Explanations have ranged from dealing with grief, which included:

"...With the encouragement of our culture's standard view of grieving, it was as if you packed up these losses one by one into a suitcase. You placed each death of a loved one into this suitcase so that you were still able to carry it around and function, but they would be unseen by you or anyone else...."

to working in couples therapy, which included:

"...I like to think of it like a figure skating team. I think we can all agree that professional figure skating requires a great amount of skill but, even more so, a good team to pull it off. When a pair is competing, they will be judged on how well they work together and how well they perform individually. The best teams are not necessarily the ones who make the fewest mistakes, but rather are those who recover from their mistakes the most gracefully. When I watch the male partner throw the female partner spinning into the air, I think of all the times they must have tried that move before and how many times they must have failed at it."

One note on writing letters/reports: I try from the beginning to impress upon the students the need to develop strategies to write reports immediately. Finishing reports is too often the bane of assessment. Having an overdue report hanging over our head--like I have now--is an albatross.

Food. Finally, I have to acknowledge that no successful graduate school course would be complete without food, so we attempt to continue our tradition of fun food. Fortunately, the course is during the spring quarter, so ice cream has been a salient feature. It seems to go well with TA.

Student Reaction is the Proof of the Pudding

Students have consistently rated the class highly. On a Likert scale from 1 (strongly disagree) to 6 (strongly agree), the statement "this was an excellent course" gets ratings between 5.6 to 5.8 over the years. I have learned in teaching to expect that something some students like most, others will like least; and as I mentioned above, some aspect of a course that works one year may not work the next.

However, it is clear that the biggest strength of the course over the years is the written assignments. Students express that it is a fun exercise that gives them the chance to be creative and opens new channels to communicate with clients. One student said "Great assignments that fit like hand in glove with the content of the class and relevant materials." Another student commented "the assignments creatively promoted growth." The course readings are also consistently highly rated. One student confided "All of the readings were good--this is very unusual!" Another student claimed the best part of the course was "...going through the readings to learn new ways to think. I also appreciated getting the saucer metaphor and the like." Other consistent winning components of the course include watching videos of various sessions (including other students doing TA) and walking through the case in-depth.

Weaknesses vary—I hope that means I am responsive to feedback! The clearest negative response came the second year when I attempted to repeat the role-plays that were successful the year before. Somehow this second year I made them feel anxious about it. I also sometimes get comments about students being distracted and even annoyed by too much discussion--however there are positive comments from the same class about that too. I guess this all suggests that along with individualizing assessment we could profitably individualize teaching.

Conclusions

Teaching this course on TA is a highlight of my academic year. I am gratified that students are consistently excited and inspired by TA. One of my disappointments is seeing only a few of my students go on to practice TA after graduation--in spite of their

fascination with it, their love of the training, and for some their considerable expertise! I understand this in terms of the relative sparse familiarity with TA in the broader psychological community and in clients, as well as the current managed care attitudes about assessment in general. I also understand it is easier to make money to pay off student loans doing therapy than TA (with the added bonus of not having to write those darn reports!). However, I firmly believe those students who say that the course has made them better clinicians in general. For the time being I have to be satisfied to work to train an army in TA, as Steve and I have conspired.

Assigned Readings

WEEK 1—Overview, Review

WEEK 2—Collaborative/Therapeutic Assessment

Fischer, C. T. (1978). Collaborative psychological assessment. In C. T. Fischer & S. L. Brodsky (Eds.). *Client participation in human services* (pp. 41-61). New Brunswick, NJ: Transaction Books.

Finn, S. E. (2007). *In our client's shoes*. Chapter 1: What is Therapeutic Assessment?

Finn, S. E., Fischer, C. T. & Handler, L. (2012). Collaborative/Therapeutic Assessment: Basic Concepts, History, and Research (pp. 1-24). In S. E. Finn, C. T. Fischer, & L. Handler (Eds.), *Collaborative/Therapeutic Assessment: A casebook and guide*. Hoboken, NJ: John Wiley & Sons, Inc.

WEEK 3—Initial Interview

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

Finn, S. E. (1996). *Manual for using the MMPI-2 as a therapeutic intervention*. University of Minnesota Press, Minneapolis, MN. Step 1. The initial interview.

WEEK 4—Assessment Interventions

Fischer, C. T. (2000). Collaborative, individualized assessment. *Journal of Personality Assessment*, 74, 2-14.

Fischer, C. T. (1985). *Individualizing psychological assessment*. Brooks/Cole Publishing Company, Monterey, California. Chapter 4: Assessing process.

Finn, S. E. (2007). *In our client's shoes*. Chapter 8: Assessment Intervention Sessions: Using “softer” tests to demonstrate “harder” test findings with clients.

WEEK 5—Summary/Discussion

Swann, W. B., Jr. (1997). The trouble with change: Self-verification and allegiance to the self. *Psychological Science*, 8, 177-180.

Finn, S. E. (2007). *In our client's shoes*. Chapter 10: Therapeutic Assessment of a man with “ADHD.”

Armstrong, J. (2012). Therapeutic Assessment of a dissociating client: Learning internal navigation. (pp. 27-46). In S. E. Finn, C. T. Fischer, & L. Handler (Eds.), *Collaborative/Therapeutic Assessment: A casebook and guide*. Hoboken, NJ: John Wiley & Sons.

WEEK 6—Child and Family

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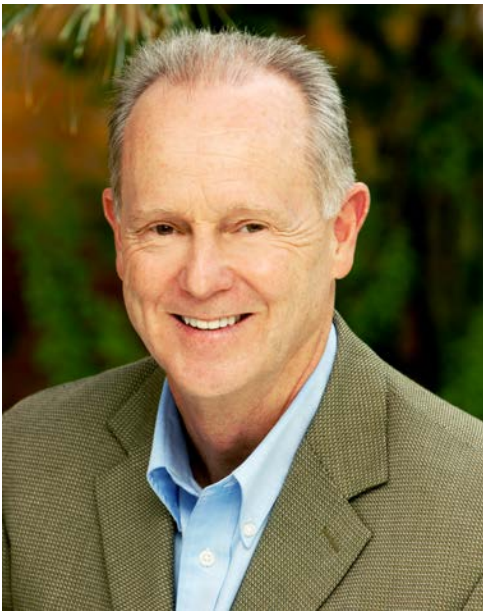
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Using the Adult Attachment Projective Picture System (AAP) with Adolescents *and* their Parents in Therapeutic Assessment *Contributions and Cautions*

By Deborah J. Tharinger, Ph.D.
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At the Therapeutic Assessment Project (TAP) at the University of Texas at Austin, we have been studying Therapeutic Assessment (TA) with adolescents (TA-Adol) for the past several years. Many of us who practice TA with adolescents consider it the most challenging model of TA, as it entails extensive collaboration and processing with the

adolescent client *and* his or her parents. The goals include helping to reframe or reconstruct the current stories that the adolescent has about self and family and that the parents have of their adolescent and their role as parents in this phase of their family's development. A core feature of TA-Adol is structuring the model to address the developmental tasks of individuation *and* connectedness for the adolescent and parents.

For more information, see our recent chapter on TA-Adol (Tharinger, Gentry, & Finn, in press) and case study article (Austin, Krumholz, & Tharinger, 2012).

Early on we noticed that a number of the assessment questions adolescents and parents came up with for their TAs had to do with their parent-child relationship. We were curious whether we could help families answer these questions

by inviting them to look at their situations through the lens of attachment. There is an impressive 50-plus year history of attachment theory and research in developmental psychology (Cassidy & Shaver, 2008), and many experts believe that attachment concepts help make sense of various emotional and relational experiences. Recently, clinicians have started to use attachment theory to guide interventions in individual psychotherapy (Slade, 2008) and family therapy (Johnson, 2008). All of this made us think that attachment measures could be a useful addition to TA-Adol.

We were aware of the Adult Attachment Interview (AAI) (Gerge, Kaplan & Main, 1984/1985/1986) and the Adult Attachment Projective Picture System (AAP) (George & West, 2012). The AAP is a relatively new measure of mental representation of attachment classification based on the analysis of stories told to a set of projective picture cards designed to systematically activate the attachment system. The AAP has also been demonstrated to be appropriate and valid to use with older adolescents (Webster & Joubert, 2011). Using the AAP was uniquely attractive to us, given its ease and efficiency in administration and coding (25 minutes to administer, 45 minutes to score by an experienced coder).

We were also drawn to including the AAP as it is a performance measure that stimulates right brain activity, and thus is likely to reveal information that is less conscious and less defended, which could be useful in exploring parent-child relationships beyond what is

available in self report measures or interviews. However, we were also well aware that the AAP could yield “Level 3” information, i.e., that was not yet in adolescents’ or parents’ awareness. We also knew it can be challenging for people to learn that they do not have a Secure Attachment classification, and that mothers can feel blamed if we give them such information about their child or about themselves. However, we also felt that such obtained information, if used carefully, could inform intervention sessions, help the information move experientially from Level 3 to Level 2, and thus be central to the immediate and longer-term process of change. In that light, TA may be the ideal assessment model in which to use the findings from such tools as the AAP.

Inviting parents to participate in their own testing is not new to TA. In TA with children (TA-C) and TA-Adol, it has been customary in the comprehensive model to invite parents to be tested as part of their child’s assessment if they pose any kind of assessment question concerning their role in their child’s problems, their relationship with their child, or what they need to change to be helpful. In our work we typically have offered parents the opportunity to take the MMPI-2 and receive feedback focused on the impact of their personality on their parenting.

In our recent TA-Adol cases, if applicable to the posed assessment questions, we invited the parents to complete the

MMPI-2 and the AAP. Three cases posed central assessment questions about the parent-adolescent relationship. We invited the parents in all three cases to complete the AAP, in addition to the MMPI-2, and all agreed. In addition, all of the adolescent clients also completed the AAP and the MMPI-A (along with additional measures specific to the case and the posed assessment questions). We used the two-assessor model and the Assessment Team consisted of myself, and an advanced doctoral student, Judy Wan. Melissa Lehmann, Ph.D., a reliable AAP coder, scored all of the AAPs, blind to any case or assessment material.

In all three cases, we incorporated the AAP findings with the other testing results to

Fairly explicit findings from the AAPs were presented to the parents, including a brief overview of each of the attachment classifications and more in-depth information about their own patterns as per the AAP.

inform case formulations, guide intervention sessions, address assessment questions in feedback and make recommendations. Fairly explicit findings from the AAPs were presented to the parents, including a brief overview of each of the attachment classifications and more in-depth information about their own patterns as per the AAP. We discussed what parents

thought fit for them and what did not. The adolescents were given more general information about their attachment status as it fit with that of their parents and possible implications for current parent-child relationships. The segments of the feedback letters provided to the parents and the adolescent in Case 3 presented below reflect our general approach. It is important to note here that how to present and discuss the findings from the AAP must be very idiographic to the particular family and take into account all of the assessment findings as well as readiness of the family to absorb and make use of such information. We now describe the three cases.

Case 1 involved an adopted foster male child, age 17, who had a history of severe abuse and neglect and ongoing serious emotional and behavioral challenges. He was adopted in his early teens by a heterosexual married couple with two of their own biological children and his younger biological half sister, whom they also had adopted. The question that led us to invite the AAP into the TA was: *How can we help our son with trust and bonding so he can have better relationships in the future?*

The AAP results were useful. The boy's AAP was coded as Unresolved, which did not surprise us given his tumultuous history and continued emotional and behavioral problems. His secondary classification was Preoccupied, which was somewhat surprising given his tendency to appear distant and resistant to connecting, but made sense when we considered the description of his biological mother as being enmeshed with him emotionally when he was a young child and then

disappearing for days at a time. His adoptive mother's AAP was coded as Dismissing, as was his adoptive father's, although the father's AAP contained several noteworthy secure features. The mother had told us about having experienced an abusive childhood and the father had provided a fairly healthy developmental history. The father seemed open to the AAP feedback given to him and his wife supported that the qualities associated with Secure and Dismissing attachment status fit her experience of being his partner and observing his relationship with their son and other children. Our experience of being with the father throughout the TA process fit his AAP findings as well, in that he seemed both available and responsive and also needing to escape at times to regroup from a chaotic system.

The mother in this case was a bit resistant at first to seeing herself as having characteristics of a Dismissing attachment status. As many people (and many mothers) she seemed to have assumed she was securely attached (she was very familiar with the literature on Reactive Attachment Disorder), but was open to thinking about the findings. In the week following, she spent time discussing her early childhood with her mother and seemed more in touch with the scarcity of emotional resources available to her at that time. She also was more forthcoming about her own struggles with depression and treatment. She also began to integrate that her "dismissing" qualities had served her well (and continued to). Her dismissing pattern may have been adaptive to keeping some of her own

experiences at bay. The mother became interested in how the combination of her dismissing pattern and her son's preoccupied pattern might have added to their relational challenges.

Case 2 involved an adopted female child, age 16, who had been in kinship placement until her late childhood; she had a history of witnessing abuse domestic violence and likely was the recipient of abuse. She was adopted at age 12 by a childless heterosexual married couple. The adoptive mother acknowledged her own difficult childhood and adolescence, as well as the adaptive ways she had used mental health and spiritual interventions. The adoptive father was more circumspect and somewhat cautious about the whole TA process. The question that led us to invite the AAP into the TA was: *How can (daughter) and (adoptive mother) find a balance of disclosure and privacy that fits well for each of them and promotes trust between them?*

Again, the AAP results were very useful and added insights not revealed by the other methods of assessment. The adolescent's AAP was coded as Unresolved and Dismissing in terms of attachment status, as were both of her adoptive parents. Both parents seemed open to discussing how their daughter was dismissing and how her childhood survival skills reflected the usefulness of this pattern. In addition, as mentioned, the mother in this case had shared details of her abusive childhood and she seemed to easily accept the description shared with her about the dismissing pattern; she could see the strengths that came from the dismissing characteristics, but also seemed

somewhat sad to hear (or validate her experience) that emotional experience was threatening to her. She pondered the meaning of the match between her and her daughter's attachment pattern, and seemed to gain insight into their difficulties they had trusting each other and sharing their emotional experiences. Also by the end of the assessment the mother seemed more able to differentiate her own experiences in adolescence from what her daughter was going through (i.e., she stopped merging the two of them). The father maintained his distant stance from the feedback about his own pattern, although he did key into some marital issues that might be impacted by he and his wife's matching but compromised attachment patterns.

Before continuing to the third case, it is useful to reflect on the possible impact of adoption, especially in late childhood/early adolescence, on parents' ability to integrate attachment status information about their children. In both of the cases presented above, as well as a case study by Frackowiak (2011) using the AAP with an adolescent in a TA-Adol, the adoptions occurred during early adolescence, after the children had challenging and abusive childhoods in their families of origin and out-of-family placements. When a child is adopted in early adolescence, the adoptive parents may feel great empathy and understanding of their child's difficult history and may not be surprised to hear, if it is the case, that the child's attachment status is insecure and perhaps even unresolved.

Case 3 provides an example of using attachment status findings to address assessment questions in TA-Adol with parents and their biological adolescent in an intact families. This case involved the biological female child, a twin, age 15, of two older parents, a married heterosexual couple. The girl had a history of early pediatric pain that went undiagnosed and not understood through her childhood and early

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adolescence. Both parents had multiple chronic medical conditions, strong family histories of mood disorders, and had obtained treatment for their depression. The questions that led us to invite the AAP into the TA were: (From mother)--*How can we help our daughter develop self-soothing and self-control when she is feeling anxious, so she can rely more on herself?* (From adolescent) *How can my mom and I better listen to each other and respect each other when we communicate? She keeps calling me manipulative – makes me sound evil.*

Again, the AAP results were very useful and added insights not revealed by the other measures. The adolescent's AAP was coded as Preoccupied; the mother as Dismissing; and the father as Preoccupied. No one was coded

as Unresolved. The findings corresponded well to our experience of the family members. We focused in on mother-daughter relationship due to the assessment questions, specifically the combination of a dismissing mother and a preoccupied daughter. I came to think about the nature of their relationship with the phrase: *Don't Dismiss My Preoccupations; Don't Be Preoccupied With My Dismissals.* The parents quite easily assimilated the provided descriptions of their respective current attachment statuses and felt that the classifications fit each of them well. The mother connected the findings with her role in her family of origin of becoming the caregiver to her siblings after a parental divorce that required her mother to go to work full time.

Both parents were also able to readily see their daughter as Preoccupied. We also discussed the development of attachment status starting in infancy and it was here that the mother was very hesitant to consider that she (and her husband and family) had provided less than sensitive and available emotional care to her daughter. The mother emphasized her daughter's difficult temperament from birth, and we wondered about the contribution of the early presenting and yet undiagnosed muscle pain. We were able to support the mother's perspective by empathizing how hard it would have been to be responsive under those conditions and that she had certainly done her best. We mention this aspect of the

case as other assessors/clinicians working with attachment findings clinically may find a similar resistance. However, the resistance need not take away from how the findings on the current state of mind about attachment can be very useful to understand and guide present relational concerns.

In this case, the attachment findings were central in planning the family intervention session and informing the attachment-related assessment questions. To illustrate our work, I provide our written responses to the “attachment” related assessment questions for this case. I have named the adolescent Mary, the mother Susan, and the father, Bob. I first present a section of the letter to the parents and then a section from the letter to the adolescent.

Assessment Q: How can we help (Mary) develop self-soothing and self-control when she is feeling anxious so she can rely more on herself?

Susan, you posed this question and it is such a good one. From the results of the AAP, we can see that Mary has not developed what we call an “internalized secure base” that she can rely on. Why not? The “why” is always complex. Our best answer is that Mary was born with a very sensitive temperament. As you have said Susan, she “just came out that way”. Her temperament combined with her medical issues and undiagnosed pain since early childhood likely added to her sense of not being understood or getting the relief she needed.

As a result of all of these influences and perhaps a strong biological vulnerability for depression, Mary’s response to the stresses in her life all rolled into a kind of grumpiness and helplessness, as well as a resulting

interpersonal style that is a bit less than endearing and thus contributes to her not getting what she needs. The good news is that Mary can work to develop the ability to self-soothe and have self-control when she is feeling anxious. It will take time and patience, but through changes in the way you all interact and through her individual therapy we believe Mary can develop the internalized secure model that she needs. We often call this “earned” secure attachment. In the Family Session we practiced some ways for you to respond to Mary so she would feel heard and emphasized with. She responded well, and Mary, you were a quick study. And in the Summary/Discussion session, Susan, you let us know that you were trying to respond to Mary in this way and that she seemed to be easier to be with subsequently.

Assessment Question: How can my mom and I better listen to each other and respect each other when we communicate? She keeps calling me manipulative – makes me sound evil.

I know there is tension between you and your family, Mary, especially between you and your mom. It seems that when you are overwhelmed and stirred up, it is more difficult for you to process your thoughts, make good decisions, and to make yourself feel better. So, you usually turn to your mom for comfort, help, and attention. Unfortunately, many times your mom is unable to respond to you in a way that makes you feel like your feelings are heard, which makes you even more upset than you were to begin with. The two of you have developed this negative pattern of communicating (i.e., yelling, screaming, and crying) that isn’t helpful for either of you.

Instead, we suggest that everyone in the family practice different ways of responding to each other. Mary, I know it is difficult for you to help

yourself feel better when you are overwhelmed right now and what makes you feel better is for your parents to really hear what you’re feeling and make you feel safe and heard. So-- we encourage both your parents to try to respond and react to you in a new way that acknowledges your feelings and what you are saying first before they try to help you solve your problems by telling you to do something. It seems like you and your parents have already taken in some of these suggestions and have already begun applying them in your lives. In the Summary/Discussion session you let me know that you noticed your mom has been trying to listen to your feelings more and that when you are also trying harder not to talk to your mom in a negative tone of voice. You also told me that when you caught yourself talking to your mom in a negative tone of voice, you apologized. I think this is change in the positive direction. Mary, as you feel more comforted by your parents when you are stirred up, you can also learn about ways you can comfort yourself. It is important to remember you all may have to try these new ways of communicating many times and for a while before a permanent change happens.

Conclusions

I have shared with you our initial experiences of using the findings from the AAPs of the parents and the adolescent in TA-Adol to inform awareness and changes in adolescent-parent relationships. We note the possible differential experience of adoptive and biological parents, possibly particular to early formation of attachment status. This difference fits well within the TA model, in that a adolescent’s having insecure attachment is probably Level 1 information for adoptive parents of children with previous histories of abuse and neglect and Level 2 or 3

information for parents vis a vis their own biological children or children adopted as infants. Our experience encourages us to continue to explore the use of findings on attachment status from the AAP and incorporate them into addressing relationship questions that are often very central in TA-Adol. We are also reminded of being cautious, as this information can be sensitive and challenging to integrate.

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The Forensic Corner

By Barton Evans, Ph.D.

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We all know that Therapeutic Assessment (TA; Finn, 2007) is powerfully validating and life-affirming and life-changing assessment-based treatment, which provides “experience-near” help with clients’ problems in living. Generally speaking, TA has rarely been considered in the context of issues normally reserved for forensic psychology. Indeed many forensic psychologists believe that clinical assessment approaches such as TA run counter to forensic psychological assessment (see Greenberg & Shuman, 1997). What is not well known is how TA can be used in legal or quasi-legal settings to develop effective ways to resolve disputes and provide rehabilitative treatments for court involved individuals. The purpose of this column introduces TA practitioners to applications of TA to court related assessment opportunities. I will share some ways in which a modified TA model has already been used, discuss some of the dilemmas of its applications, and hopefully begin a dialogue with the TA community about this topic.

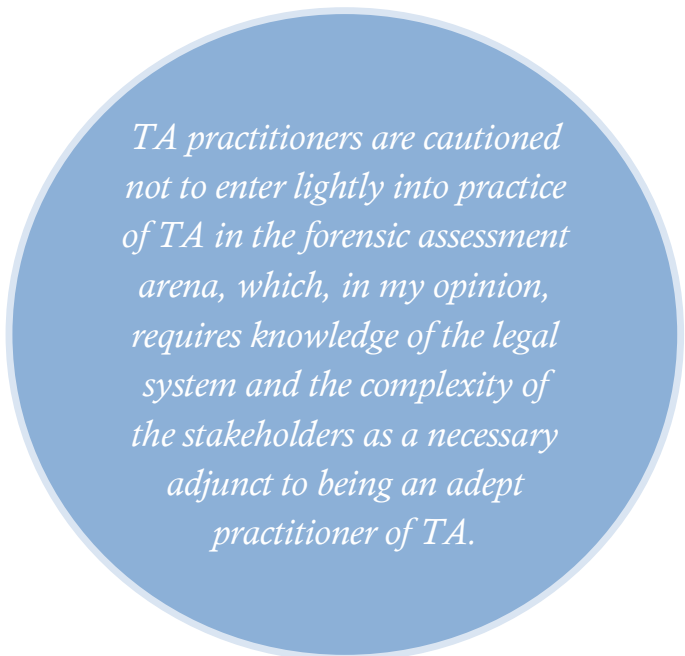
In terms of the history of the application of TA to forensic settings, the earliest effort of which I am aware is the cutting edge work of Dr. Connie Fischer (1985/1994) on collaborative assessment in which she reports on court referred cases such as custody evaluations. Next, I am most familiar with the successful (and unfortunately unpublished) court project in Austin, TX through the Center for Therapeutic Assessment (Finn, personal communication). Steve Finn and Terry Parsons Smith were referred high conflict, divorcing parents who were locked in their inability to resolve conflicts over parenting plans for their children. The next step in these highly litigious cases was protracted litigation leading to a court trial with a judge determining the court-ordered parenting plan. Such parenting plans are frequently resented by either one or both parents and compliance with the final custody plan outlined in the final court order is usually very low. Expensive

child custody/parenting plan evaluations (CC/PPE) may occasionally be more helpful, but are hardly a substitute for productive ongoing, parental communication necessary for problem resolution on behalf of their children.

As noted by Garrity & Baris (1997), unrelenting conflict over parenting between divorcing spouses is emotionally destructive to children and predicts negative long-term mental health outcomes for children. Conflicts over parenting plans (also called custody arrangements) between two high conflict parents often escalates into anger, blame, and projection. Even minor behavior by one partner can be misperceived as threatening or shaming by the other partner and this interaction becomes self-perpetuating cycle of blame and recrimination. Strong feelings of anger and fear are aroused, which interfere with the parents calmly resolving their disagreement about the best interests of their children. These conflicts can take on a life of their own and the parents move further and further from cooperative, thoughtful decisions about their children. Overt power manipulations, threats, coercion, and deception become the mode of communication between high conflict divorcing or divorced couples and the goal becomes to achieve power and control over the other parent or family members rather than to function as caring parents. Interestingly, other research indicates that children have the best long-term outcomes with high conflict divorced parents, who are also highly cooperative in parenting their children (i.e. they really don’t like each other, but can set their disagreements aside to cooperate on behalf of their children). So, by reversing this destructive high-conflict parental pattern, children will likely benefit greatly.

Quite successful in their outcomes, Finn and Smith demonstrated the utility of TA as an alternative to CC/PPE. Their focus was to use TA to help deactivate destructive couples communication, block projections, and resolve contentious legal situations by empowering the parents themselves to come up

with plans that best met their children's needs. Having been involved in CC/PPE for many years, I was personally intrigued with the approach and outcomes described by Steve Finn and have elaborated on placing TA more squarely in its legal context, including active involvement with attorneys (Evans, 2012; 2009). I believe this hybrid approach is especially effective when a mastery of TA is blended



TA practitioners are cautioned not to enter lightly into practice of TA in the forensic assessment arena, which, in my opinion, requires knowledge of the legal system and the complexity of the stakeholders as a necessary adjunct to being an adept practitioner of TA.

with an understanding of legal principles, as well as forensic neutrality, which incorporates both compassion and skepticism as dual lenses of observation (see Evans, 2005).

In a related area, the court ordered assessment of parenting capacity found in termination of parental rights (TPR) cases and assessment of children in foster care settings also offer rich opportunities for modified TA intervention. Caroline Purves (2002, 2012) is the pioneer in this application of collaborative/therapeutic assessment to this highly vulnerable population of children and parents. Such evaluations are nearly always court ordered and participation of clients is involuntary. She emphasized the essential importance of collaborative interventions that “build on the notion that testing is a two-person process that has an impact on the client. This method helps the client feel his or her agency in working within the mental health and social services system” (2002, p. 164).

In Evans 2009, I offered a specific model for working with the courts in termination of parental rights cases, where the court decides whether or not the parent is “unfit” to meets the needs of her/his children. As one can imagine, stakes are extremely high in these cases and even the least capable parent will fight tirelessly to keep their child. Further the legal bar for termination of parental rights is quite high, usually requiring Department of Social Services (DSS) to prove parental unfitness with clear and convincing evidence – 75% certainty in most jurisdictions. By the time the TA assessor gets the referral from either DSS or directly from the judge, there is already a long contentious history between the parent (and her or his attorney) on one side and DSS (and the County or State attorney) on the other. My model is what I call the hybrid TPR model, where the evaluator will render an opinion on the questions posed by DSS and the judge, while at the same time inviting the parent in the TPR to pose his or her own questions. I explain to DSS and the judge that feedback to the parent will be given and that the court report will come as a letter addressed to both the parent being evaluated and the judge. I have found that judges, DSS social workers and often even the parent undergoing the evaluation have embraced this model, which attempts to approach the evaluation as a collaborative exploration of a very contentious and deeply felt problem rooted in determining what is best for the young child.

Another area where TA has been used in the forensic arena is the work of Dr. Lionel Chudzik in France (2012, 2011) and J.D. Smith (2011). Chudzik and Smith have worked as psychotherapists providing TA and psychotherapy with criminals including violent and pedophilic offenders. Chudzik and Dr. Filippo Aschieri (Chudzik & Aschieri, manuscript in preparation) have described the powerful forces, such as the punitive legal system, vindication for and protection of the victim, and over-identification with the offender, that interfere with a straightforward approach to assessment and treatment. Chudzik has especially been successful in using TA to see the person underneath “the offender”, opening the possibility of a highly nuanced treatment where he must attend to both the suffering of the offending client and the requirements for risk assessment and

reporting of risk to authorities when re-offending becomes a strong possibility.

TA practitioners are cautioned not to enter lightly into practice of TA as an alternative to CC/PPE or other applications in the forensic assessment arena, which, in my opinion, requires knowledge of the legal system and the complexity of the stakeholders as a necessary adjunct to being an adept practitioner of TA. An understanding of the legal system is essential to navigate the tricky waters around such interventions without which therapeutic endeavors can come to naught. I recall vividly hearing from my dear friend and master forensic psychologist, Dr. Ben Schutz, how parents would come together during his feedback session in CC/PPE and how quickly this mutual understanding would come undone after they met with their attorneys. I have even gone as far as including the attorneys in the initial interview and feedback sessions with the parents, which I strongly believe is an important aspect of TA as an alternative to custody evaluation. In this approach, parents and their attorneys develop a parenting plan together with the assistance to the TA assessor. If the TA assessor is not aware of legal issues, she or he will be limited in the ability to assist this complex group of clients. Similarly, if the TA assessor is unaware of risk factors and reporting requirements in treating violent and child abusing clients, important opportunities for boundary setting and containment will be missed.

It is important to note that many forensic psychologists will find the use of TA in forensic areas counter to their prevailing beliefs. The leading reference recommending the separation of forensic and clinical practice is Greenberg and Shuman's (1997) article called "Irreconcilable conflict between therapeutic and forensic roles." They point out how a lack of clarity between the role of psychologist (as therapist or neutral evaluator) and the role of the client (as patient or litigant) can seriously interfere with both tasks and they provide 10 reasons why the lack of a clear boundary will be problematic. Evans (2005) challenged the prevailing forensic notion of neutrality and indicated that TA intervention may be useful or even necessary with individuals undergoing torture evaluations. With this said, TA practitioners should have a solid knowledge of Greenberg and

Shuman's work and the pitfalls that await the TA practitioner who ventures into TA forensic practice without solid grounding in both areas.

In closing, I hope that the TA Connection can become a forum for conversation and debate on the application and modification of TA in forensic settings. I am of the opinion that there are many creative approaches yet to discover in TA and hope that TA practitioners will offer their questions, thoughts and brief articles on this challenging subject.

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Author



Barton Evans, Ph.D. is a clinical and forensic psychologist at the Asheville VAMC and Clinical Professor of Psychiatry, George Washington University. He is author of *Harry Stack Sullivan: Interpersonal Theory and Psychotherapy* and co-editor of *Handbook of Forensic Rorschach Assessment*. Dr. Evans has also published extensively on the assessment and treatment of psychological trauma, including victims of torture.

Please email questions or comments on this column to Barton Evans at fbevans3@gmail.com

The 2012 Therapeutic Assessment Advanced Training

By Stephen E. Finn, Ph.D.
*Center for Therapeutic Assessment,
Austin, TX*

The week of October 15-20, 2012 five brave psychologists came to Austin, Texas for the Therapeutic Assessment Advanced Training. This workshop is a Level-3 training open to people who have either attended the TA Immersion Course or who have participated in both Level 1

(introductory) and Level 2 (observed live assessment) workshops. Participants work in small groups under close supervision assessing actual clients referred to the Center for Therapeutic Assessment. This year Mariam King and Thomas Rosén worked with Marita Frackowiak on the TA of an adult woman. Gay Deitrich-MacLean, Larry Friedberg, and

Judith Glasser completed a TA supervised by Pamela Schaber of a 17-year-old girl and her two parents. I supported both groups, shared recent insights on TA techniques, and led the large group meetings at the beginning and end of each day. Both cases were very moving, and as we watched video excerpts as a group each afternoon we could see changes in the clients

unfolding over the course of the assessments.

An Overachiever Learns to Take It Easy

The adult client was a woman in her 40's, referred by her individual psychotherapist who had been seeing her since she "burned out" at a very demanding job several years earlier. The client had been hospitalized at that time for severe depression with suicidal ideation, and was still on disability and not working at the time of the assessment. Her collapse had been completely uncharacteristic, as this was a hard driving, over-responsible woman who had worked hard her whole life to achieve and please others. One of the major questions for the assessment was whether the woman should start working again, and both client

and therapist felt pressured by her insurance company, who were challenging whether she still qualified for disability.

Although there were many touching and interesting aspects to the assessment, two that stood out for me were the extended inquiry of the Rorschach and the Assessment Intervention Session. When administering the Rorschach, Miriam, Thomas, and Marita noticed that almost all the client's responses were Whole Responses. This approach to the test seemed very representative of the client's approach to life in general—of always trying to achieve a great deal and never taking the "easier way out." After the administration, the team talked about this result with the client, and she agreed that she always aspired to do the "most possible," or she felt that she wasn't really trying. The

team then assured her that D responses (using only part of the card) were "just fine" and asked her to look at several cards and "try on" what it was like to give such responses. The client very tentatively offered several popular D responses and looked to the team, who assured her that they were good responses. She then began to smile and gave several more D responses. As it began to sink in that these too were acceptable, she sighed, looked incredibly relieved, and said, "This is *so* much easier." The team then had a long discussion with the client of how she might "overdo" what was needed and how she had developed a hard driving approach to life in her family growing up.

Similar themes were explored in the Assessment Intervention Session. There were many split-off affect states evident in the client's testing, and at first the team considered various interventions that would elicit those affects and bring them into the client's awareness. There was an interesting parallel process where the team came to question their initial ideas and to wonder if they were being "over-achievers!" Eventually, they decided to build on themes that emerged from the Rorschach extended inquiry, and to support the client in "practicing" relaxation and enjoyment and seeing what she learned. Drawing on several early memories about times the client had been happy and relaxed, the team brought in art materials, magazines, and peanut

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Celebration dinner at the end of the TA Advanced Training, October 20, 2012, at Fonda San Miguel, Austin, TX. *From left:* Pamela Schaber, Judith Glasser, Thomas Rosén, Larry Friedberg, Gay Deitrich-MacLean, Steve Finn, Marita Frackowiak, and Mariam King.

butter and jelly so the client could teach them to make her favorite “double-decker” sandwiches from childhood! They and the client clipped photos and text from magazines, while the client put them together in a collage book entitled, “A Balanced Life.” She grew more and more relaxed, even a bit silly, as the team supported her in having fun, and when we reviewed the videos later we could see stress lines relaxing in her face. The team later reported that the activity was therapeutic for them also, as they had learned that they didn’t always have to “mine” for difficult material in an intervention session to have a major impact. Also, this activity set the stage for the Summary/Discussion Session, where the team suggested that client was not yet ready to return to work, but was making steady progress. Both the client and the therapist reported feeling relieved.

Two Parents Come to Hear Their Daughter’s Pain

The Adolescent-TA group worked with a 17-year-old girl and her parents referred by the girl’s individual therapist. This was quite a complex case, which the team handled masterfully. The girl looked quite competent, but had been sending out increasingly more intense signals that she was in serious trouble (e.g., leaving vague notes about being suicidal, starting to cut herself, running away in the middle of the night). At the beginning of the assessment, the

parents were upset about her erratic behavior. The mother tended to be very emotional and although she could show empathy for the girl, she would quickly get angry and intrusive.

“Hour for hour, the Advanced Training was the best training in which I have ever been involved!”
– Gay Deitrich-MacLean

The father was a “sturdy survivor” who tended to keep his head down and plow through difficulties. When his daughter spoke about being upset, he generally tried to “fix” things or gave her little lectures rather than just listening and trying to understand.

In my mind, the key to this case was the way the team managed the dual alliances with both the teen and the parents. After the initial sessions, the team divided up for the middle parts of the assessment. Pamela and Larry met with the parents most days, while Judith and Gay worked with the teen. The girl developed enough trust to let the team know how much emotional pain she was in. And the team’s steady gentle confrontation of the parents shifted them so they were more prepared to hear their daughter’s distress. For the family Assessment Intervention, the team asked the girl to read selected MMPI-A items aloud that she had endorsed. The team then helped the parents respond

in a way that was emotionally attuned and supportive. In the Summary/Discussion sessions, it became clear that even the girl’s therapist hadn’t been fully aware of how much she was struggling because the girl had not felt safe disclosing how much pain she was in.

Feedback from Workshop Participants

We all ended the week feeling good about work we had done, and the workshop participants all expressed satisfaction with the assessments and the training. Many said it was helpful not only to work on one case but also to see another case unfold. I recently wrote and asked the participants for comments to share with you all, and they provided me with a few quotes: Judith Glasser wrote, “For me, the Advanced Training was a confirmation of the efficacy of TA. I was able to experience the transformation of a family narrative first hand.” Gay Deitrich-MacLean said, “Hour for hour, the Advanced Training was the best training in which I have ever been involved!” Mariam King commented, “A great deal of learning about . . . TA . . . was accomplished in an atmosphere marked by openness and with a spirit of playfulness that was unusual to in a newly formed group. The professional caliber of the trainees and the teachers was astounding.”

The Next Advanced Training

The next TA Advanced Training will take place in Austin, September 16-21, 2013. Detailed information and application materials can be downloaded from the TA Website at www.therapeuticassessment.com/training3.html. The number of spots is extremely limited. If you have any questions about whether the training would meet your needs, please do not hesitate to contact me.

Author



Stephen E. Finn, Ph.D. founded the Center for Therapeutic Assessment in Austin, TX in 1993. These days he practices, supervises, and teaches Therapeutic Assessment around the world.

Please email questions or comments on this column to Stephen Finn at sefinn@mail.utexas.edu

Recent Publications in Therapeutic/Collaborative Assessment

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Upcoming Trainings in Therapeutic Assessment

March 20, 2013, San Diego, CA, 8:30 AM – 4:30 PM

Title: "Introduction to Therapeutic Assessment: Using Psychological Testing as Brief Therapy"

Presenters: Pamela Schaber, Filippo Aschieri, and Jennifer Imming

Sponsor: Society for Personality Assessment

Information: www.personality.org

April 11-14, 2013, Stockholm, Sweden, 9:00 AM – 4:30 PM

Title: "Working with Shame in Psychotherapy and Psychological Assessment"

Presenter: Stephen E. Finn

Sponsor: Therapeutic Assessment Institute

Information: [Download workshop information](#)

May 17-18, 2013, Monterrey, Mexico, 9:00 AM – 5:00 PM

Title: "Introducción a la Evaluación Terapéutica: Utilizando las Pruebas Psicológicas como una Intervención Psicoterapéutica Breve"

Presenter: Stephen E. Finn

Sponsor: Centro de Tratamiento e Investigación de la Ansiedad and Sociedad Mexicana de Rorschach y Métodos Psicodiagnósticos

Information: [Download workshop information](#)

May 27-31, 2013, Austin, TX, 9:00 AM – 5:00 PM

Title: "Therapeutic Assessment Immersion Course"

Presenter: Stephen E. Finn and members of the Therapeutic Assessment Institute

Sponsor: Therapeutic Assessment Institute

Information: [Download workshop information](#)