Volume 2 Number 1 | **Winter/Spring 2014**

THE TA CONNECTION

resources for THERAPEUTIC ASSESSMENT PROFESSIONALS

Entering the Next Era

By Justin (J.D.) Smith, Ph.D.
Baylor University

As I assemble this issue of the *TA Connection*, I am melting in the summer heat of Arizona. This is my last week in Phoenix before beginning a new post as an Assistant Professor in the Department of Psychology and Neuroscience at Baylor University. I am sure many of you are also entering into new and exciting (although sometimes anxiety-provoking and uncertain) phases of life as well. I am reminded of a quote attributed to Heraclitus, a Greek philosopher who lived in the 6th century BC: "The only constant in life is change." The TA community is of course evolving as well. This year welcomes two significant firsts for TA: the inaugural Collaborative/Therapeutic Assessment Conference (CTAC), to be held in September in Austin, TX, and an Immersion Course outside the USA, conducted in May in Massa, on the Tuscan coast of Northern Italy. In addition to these exciting firsts for TA, this issue of the *TA Connection* features columns on the research, training, and clinical practice of TA written by Hilde De Saeger, Mark Hume, and Steve Finn, respectively.

This Issue

In this issue's column on TA research, Hilde De Saeger discusses the findings of a randomized trial of TA as a pretreatment intervention for patients with severe personality pathology awaiting treatment at the Viersprong Clinic in the Netherlands. The TA model outperformed a brief, manualized goal-focused pretreatment intervention model on all treatment readiness outcomes. The implications of this study are numerous and a patient-centered research study is underway to better understand how TA produced positive results in the trial. In the teaching and training column, Mark Hume describes how he was able to develop a successful TA clinic within a clinical psychology training program, including securing referral sources, increasing its financial viability, and getting students and administration to "buy in." I suspect his experiences will be useful to professionals wishing to emulate Mark's success in a training context and for those assessors developing private practices or trying to implement TA into their current practice setting. In

In this issue:

the clinician's corner, Steve Finn discusses using the Wartegg Drawing Completion Test in the context of TA. As we have to come to expect from Steve, he is well-versed in the research base of this test, has received training and consultation from the world's leading authority, Dr. Alessandro Crisi, and of course uses it with great care and success in TA. For those of you who were unable to attend the symposium on the Wartegg at SPA in March, a similar presentation will occur at the CTAC in September.

Inaugural CTA Conference

Speaking of the CTAC, I am pleased to announce that the program is largely set and is included at the end of this newsletter. Thanks to all of you who submitted to present your work. I sincerely hope to see all readers of the *TA Connection* at this exciting event.

The inaugural CTAC will take place September 11-13, 2014 at the AT&T Conference Center in Austin, TX. As is evident in the attached program, the conference consists of full- and half-day workshops on Thursday and a scientific program on Friday and Saturday composed of a variety of topics and formats including plenaries, symposia, a roundtable discussion, paper sessions, and a poster session. The range of topics is impressive and with 3 concurrent running for most of the scientific sessions there is sure to be something of interest for everyone. If you are like me, it will be excruciating to choose what to attend!

The CTAC will take place at the beautiful new AT&T Executive Education and Conference Center in Austin, which is near the University of Texas campus and close to downtown. We have a block of rooms reserved at the very reasonable rate of $169 per night for double occupancy. Click here for the conference center's room reservation page. Reservations must be made by August 11 to guarantee this rate.

Also remember to register for the conference and for the Thursday workshops. The registration page can be found through the TA website or by clicking here. Early bird rates end July 28. Also, there are a limited number of discounted spots reserved for students and postdocs to attend the conference – so register now! For licensed psychologists who would like continuing education credits, there will be a $15 one-time fee for which you will receive credits for each day that you attend the conference. All three days will total about 20 credits. We will collect this money onsite so please have cash or a check when you register.

Immersion Course in Italy

For the first time in the five years since we began this format, this year's Immersion Course was held outside of Austin. In fact, it was even outside of the United States. With the logistical difficulties and costs associated with international travel, the Therapeutic Assessment Institute felt it would serve the international TA community to hold the course in Europe. The European Center for Therapeutic Assessment at Catholic University Milan organized the course, which was held on the stunning west coast of Italy (Massa Carrara) the last week of May. The course focused on TA with adults and had a different format from years past: Lectures and role play groups occurred in the

mornings while the afternoons were devoted to touring the beautiful landscape and cities near Massa, including Cinque Terre, Pisa, the famous marble caves in the mountains above Massa, and, for some, Florence. There was no shortage of food, wine, and beautiful vistas. A few pictures sure to provoke envy are featured on pages 17–18 in this issue. Oh, and it wasn't all about beautiful Italy – the training went well too!

Other Trainings

The 6-day Advanced TA Training will again be held in the fall in Austin; November 10-15, 2014. Other confirmed opportunities for training in TA and related topics are scheduled for Istanbul, Turkey, Tokyo, Japan, Holland, and Milan, Italy. A complete listing is provided on page 20.

Future Issues of the TA Connection

As always, I would love to hear your feedback and suggestions for the newsletter. If there is a topic you would like to see appear in an upcoming issue, please let me know. There is also a standing invitation to anyone who is interested in submitting a column for consideration. Email me at jd_smith@baylor.edu with your ideas. A warm thank you to the contributor's in this issue: Hilde De Saeger, Mark Hume, and Steve Finn.

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

Therapeutic Assessment as Pretreatment Intervention for Patients with Severe Personality Pathology

By Hilde De Saeger
The Viersprong Clinic, Holland

There is a remarkable scarcity of research documenting the extent to which clinical assessment improves treatment outcome (Hunsley & Mash, 2007). Similarly, some clinicians perceive that psychological assessment does not provide them with essential information for treatment planning, which has led some to advocate for a (drastic) reduction of its use in clinical practice. Much of the displeasure with the utility of assessment likely originates in the traditional information-gathering approach to psychological assessment. Based on the medical model, an information-gathering assessor views the client as a subject of observation. In this paradigm, it is not expected that the presence of the assessor and the administration of tests would affect the client's results, let alone help relieve the client's symptoms. It's not surprising that an assessment done with these assumptions may leave the assessor wanting.

A notable exception to the general paucity of research into the treatment and clinical utility of psychological assessment are the findings from collaborative and Therapeutic Assessment (TA). TA has undergone a significant evolution since it was developed in the mid 1990's (Finn, 2007; Finn & Kamphuis, 2006; Finn & Martin, 1997; Finn and Tonsager, 1997, 2002; Finn, Fischer, & Handler, 2012). Recently, Finn and colleagues suggested that TA can perhaps best be understood as a brief therapeutic intervention grounded in psychological assessment. The primary objective in TA is to help clients to gain new information about themselves and the world in order to create important changes in their lives (Finn, 2007). Trials of the TA model, and the less structured collaborative assessment procedure, have demonstrated significant therapeutic effects for adults, adolescents, and school-aged children and their parents. The findings include increased hope (e.g., Finn & Tonsager, 1992; Holm-Demona, et al, 2008; Newman & Greenway, 1997), decreased depression, hopelessness, suicidality, psychological pain, and self hate (e.g., Aschieri & Smith, 2012; Ellis at al, 2012; Smith & George, 2012; Tarrochi, Aschieri, Fantini & Smith, 2013), better compliance with treatment recommendations and a better therapeutic alliance with subsequent treating professionals (e.g., Hilsenroth et al., 2004; Ougrin, Ng, & Low, 2008),

and improved family functioning as well as symptom improvement in children (Smith, Handler & Nash, 2010; Smith, Nicolas, Handler & Nash, 2011, Smith, Wolf, Handler & Nash, 2009; Tharinger et al., 2009; Tharinger, Finn, Wilkinson, & Schaber, 2007).

Despite a promising record of clinical effectiveness, existing research had not tested the comprehensive TA model for adults, which has only taken shape in the last decade. Also TA had not yet been rigorously tested in a controlled trial with adults suffering from severe personality disorders; yet, the TA model is arguably ideally suited to address the issues distinctive of this population. For example, high psychiatric comorbidity, high drop-out rates, ambivalence toward change, motivation and commitment issues, and limited introspection are characteristic of patients with severe personality pathology. The problems such clients deal with are diffuse and their cognitions about themselves and the world are rigid (Emmelkamp & Kamphuis, 2007). Patients with severe personality disorders are noted to be extremely sensitive to the sustained empathy of many therapeutic approaches, such as humanistic and interpersonal psychotherapy. Emphasis on emotional containment, empathic connection, close collaboration, and recognition of dilemmas of change are all key aspects of the TA approach, both in spirit and procedure. For these reasons, my colleagues and I decided to conduct a pretreatment randomized controlled trial among patients with severe personality pathology awaiting treatment at the Viersprong Clinic, which is the National Center for personality pathology in the Netherlands. This clinic is the highest level of treatment for adult clients with severe personality pathology who have failed to improve in other treatment modalities. The institute offers several evidence-based psychotherapy programs in outpatient, day-treatment, and inpatient formats. The waiting list for the clinic can be quite long – up to a year – and clients often enter treatment with negative experiences of psychological and psychopharmacological intervention, little motivation, and significant problems in various domains of functioning. Needless to say, these clients are in need of a pretreatment intervention to address some of these barriers to effective treatment. We posited that TA would fit the bill. I will now provide an overview of the randomized trial that was recently published this month in *Psychological Assessment* (De Saeger et al., 2014).

Study Overview

From September 2010 until March 2012 all patients awaiting therapy at the Viersprong were invited to participate in our randomized trial where they would either be assigned to a group that would TA or an evidence-based goal-focused pretreatment intervention (GFPTI). Both arms of the study consisted of 4 face-to-face sessions with the therapist. The inclusion criteria were having personality pathology and being at least 18 years old. Patients who at intake had severe, disabling psychiatric symptoms that would interfere with psychological treatment, including a severe substance use disorder or active psychosis, or who had an estimated IQ of less than 80 or evidence of language difficulties, were excluded from

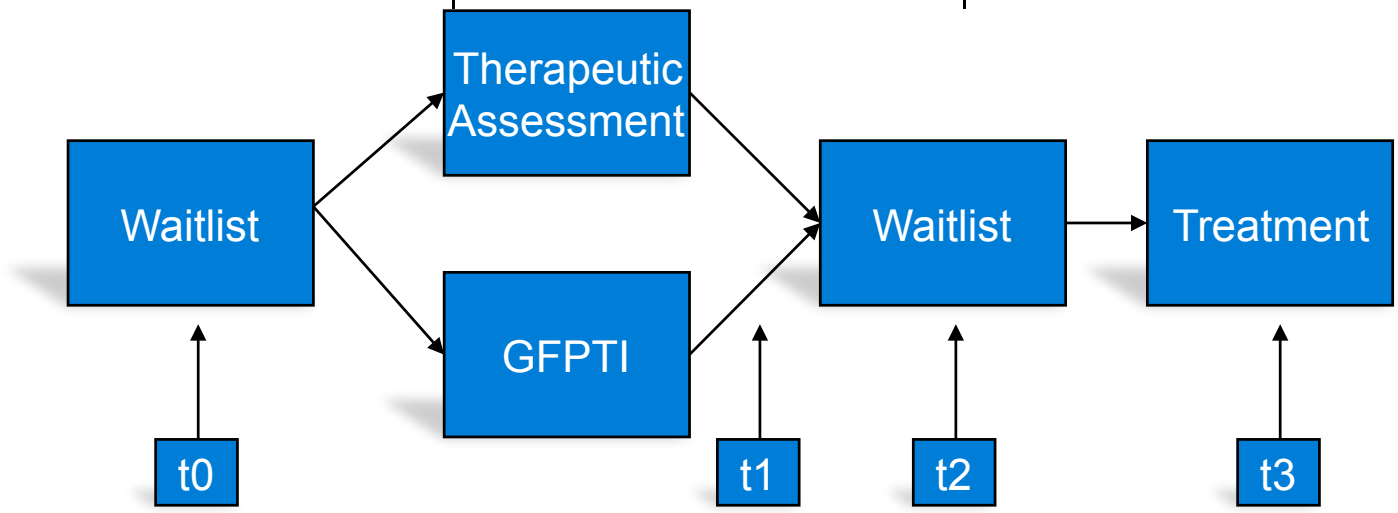

Figure 1. *Study Design*

participating. The final sample consisted of 74. The sample was 60.8% female, had an average age of 39 years, and was all White.

The study design (see Figure 1) began with a typical intake assessment (non-TA) that included the Structured Clinical Interview for DSM IV Axis I and II disorders (SCID–I: First, Spitzer, Gibbon, & Williams, 1997, translated version by van Groenestijn, Akkerhuis, Kupka, Schneider, & Nolen, 1999; SCID–II: First, Spitzer, Gibbon, Williams, & Benjamin, 1996, translated version by Weertman, Arntz, & Kerkhofs, 1996). The participant then received TA or GFPTI. All of this occurred while the client was on the waiting list. 43 clients who agree to participate in the study, out of 117, began treatment in the clinic before completing the TA or GFPTI and were removed from the final analysis.

The 'full package' of TA was used. This consisted of (a) collecting the clients' questions for the assessment, (b) administration of self-report (the MMPI-2) and performance-based tests (the Rorshcach), (c) an assessment intervention session, and (d) individualized, collaborative feedback is another element of the TA procedure.

GFPTI was a fully structured method, including homework assignments. In the first session demoralization and hope issues were key elements. The second session was aimed at the main problem or issue on which the subsequent treatment would focus. The third session explored the client's dilemma of change. The last session focused on reframing the problems and setting goals for the period prior to beginning treatment (i.e., while on the waitlist).

We assessed clients' treatment readiness as well as psychological symptoms and satisfaction with the intervention they received. The same measures were included in the pre- and post-intervention assessments (t0 and t1 in Figure 1). At post-intervention only, we added specific measures on the evaluation of the interventions itself (i.e., experience of therapeutic alliance, perception of preparation for treatment).

"Desirable treatment outcomes may also be located in harder to measure gains in insight, acceptance, and meaning, derived in the context of a supportive holding environment."

Results

Here is a summary of the key findings of the study. More information is available in the article (De Saeger et al., 2014). In short, the results largely met our expectations. Group comparison tests indicated that the clients receiving TA:

- Had higher outcome expectations for their treatment (a large, significant effect)
- Were more on track concerning their focus for treatment (a medium, marginally significant effect)
- Reported a stronger alliance to the therapist (a medium, marginally significant effect)
- Had greater self-awareness (a small to medium, marginally significant effect)
- Felt more understood by the therapist (a small, marginally significant effect)
- Were more satisfied with the intervention (a large, significant effect)
- Showed less demoralization (a small, non-significant effect)

The one aspect of the results that was somewhat surprising is that there were no significant differences by group in patients' self-reported symptoms. Both groups showed little decrease in symptomatology during the intervention.

Conclusions

The results of this study are a step toward alleviating the debate surrounding the utility of psychological assessment. In the context of assessment, treatment utility is often defined as improving the outcomes of treatment – typically concerned with the reduction of psychiatric symptoms. By this measure, TA did not outperform GFPTI. However, from a more inclusive view of treatment utility, TA was better able to prepare, motivate, and inspire the clients for the tasks of therapy, and to clarify the goals for therapy.
Considering clients with treatment-resistant personality pathology, such effects are likely to be of major value. In their meta-analysis of the therapeutic effects of collaborative, individualized feedback, Poston and

Hansen remarked, "… if tests are used collaboratively and if they are accompanied by personalized, highly involving feedback then clients and treatment appear to benefit greatly. Specifically, how and why it is beneficial remains largely unknown…" (p. 210).

Our findings may serve as a reminder of the complexity of what is referred to as treatment utility in terms of treatment outcome. Treatment outcome may be operationalized as re-moralization, symptomatic improvement, or adaptive functioning; frequently outcome research defines it rather narrowly as a decrease in acute symptoms. However, desirable treatment outcomes may also be located in harder to measure gains in insight, acceptance, and meaning, derived in the context of a supportive holding environment. As mentioned, clients with personality path-ology often have motivational and commitment issues. Their capacity for introspection tends to be limited and their cognitions, about themselves and the world are oftentimes quite rigid.

Future Directions

Our study, like most randomized controlled trials, was not optimally designed to clarify how and why patients receiving a TA reported higher satisfaction, greater expectancy that they would benefit from subsequent treatment, and a greater sense of alliance. Nor are we able to determine the precise way these processes transferred to subsequent treatment in the clinic. Quinn (1996) noted that "most of what is written and discussed about clients' experiences is generated out of the perceptions and impressions of practitioners, researchers and theoreticians" (p. 72). So, rather than proffer a hypothesis ourselves, we tried something quite radical to answer this question: We asked the client! Given the fact that clients in TA are seen as collaborators in the assessment process, it only seemed logical to invite them to take an active part in the research process on TA. To this end, we embarked on a qualitative follow-up study to the randomized trial to see what the clients remember about their TA experience and to what extent TA offered them a "new experience." If so, what did they feel was different from before. We also asked these same questions of the GFPTA group to determine if the experiences of the TA group were specific or shared. The results of this qualitative study are nearly ready and we expect to be able to share them in the fall of 2014.

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Please email questions or comments on this column to Hilde De Saeger at hilde.de.saeger@deviersprong.nl

Building and Growing a Therapeutic Assessment Clinic

The Promise, the Process, and Some Realities

By Mark Hume, Ph.D.
Argosy University Orange County

Over the past 9 years, I have experienced the unique pleasure of developing, refining, building, and supervising a Therapeutic Assessment (TA) focused graduate clinical training and community service clinic. Inspired by the work of Steve Finn and the collaborative/therapeutic assessment community, our training program has resulted in the remarkable clinical growth of our graduate students and some truly inspiring clinical encounters with our clientele. It is my hope that by sharing the experience of developing and growing our Therapeutic Assessment clinic, others hoping to build training clinics or private practice with a focus on collaborative/ therapeutic assessment may find useful advice, direction, and perhaps some inspiration.

Wisdom from Some Masters "for the Journey"

I can't underestimate the importance of beginning a clinic or practice on a guiding foundation of central clinical and ethical principles, not to mention a true passion for this work. I imagine that all of us who have a love of psychological assessment can look back fondly to an early mentor who inspired them to pursue this passion. For me, it was my first year assessment professor at the California School of Professional Psychology–Los Angeles, Ken Lott, Ph.D. He espoused a model of assessment he likened to investigative detective work – seeking to really understand the client and what made him or her tick (you might say "In Our Clients' Heads"). Dr. Lott also taught us that the key to developing a career and referral base was to "always do your best work." This simple statement has guided my career, my teaching, and my supervision.

At the annual meeting of the Society for Personality Assessment (SPA) 2 years ago, Radhika Krishnamurthy provided a beautiful and inspiring deeper illustration of this ethic in her presentation titled, "The Dharma of Good Personality Assessment." Among the central ideas presented was that Dharma is the natural law encouraging ethics such as "doing that which is right because it is right." Another key idea consistent with Dr. Lott and TA is to be of service, to do what we can to improve lives and the world.

Clearly, central among by mentors and sources of inspiration is Steve Finn. I can recall as if it were yesterday the first time I heard Steve speak and present a case at a meeting of SPA 8 or 9 years ago. The concept that assessment, which I already loved, could be used as a brief therapeutic intervention with impactful results sent my mind, and eventually my practice and teaching, on fire. Again, as some reflection of the cryptic but important advice of Dr. Lott, Steve, when asked for advice on building a TA practice, suggested contacting local clinicians for referrals for their most challenging cases and then providing pro bono assessments doing your very best work.

The last piece of wisdom guiding my practice and behavior that I'll mention here is perhaps mildly humorous, but it has indeed certainly served me well in achieving goals and aspirations within various institutions including universities, state hospitals, and prisons. This piece of wisdom is, "it is better to ask for forgiveness than permission." A Google search attributes this wisdom to Admiral Grace Hopper. The essential point of this wisdom for me is that it is often difficult to verbally convince the "powers that be" of the benefits of some new procedure or process. On the other hand, doing excellent clinical work from a new paradigm and then allowing the natural process

of client benefit, student growth, and positive or enthusiastic reactions from clinical referral sources to actually change hearts and minds.

The Origins of the Argosy University Therapeutic Assessment & Psychotherapy Service (AUTAPS): Necessity is the Mother of Invention

Not unlike many phenomena that ultimately influence or define the characteristics and logistics of clinical and academic programs, the AUTAPS was initially born out of necessity rather than a strategic plan. Argosy's clinical training program structures a psychodiagnostic assessment practicum as a required first-year placement. Back in 2006, the program was experiencing a shortage of diagnostic placement sites. At that time, Argosy shared a campus with the Art Institute, and with a small cohort of 4 Argosy students, we conceived the plan to provide learning dis-ability assessment to the Art Institute students.

With my passion for personality assessment, I was willing but not particularly excited about a psychoeducational focused practicum site. Once the assessments began, we all discovered an interesting and important truth. College students, particularly nontraditional college students, have experienced a wide variety of challenges, insults and traumas, self-esteem and shame issues, personality problems, and difficulties with effective coping. It was not an uncommon experience for a client to present with questions about possible ADHD only to have us discover significant personality issues, including such diagnostic considerations as Borderline Personality Disorder. Helping the graduate students learn how to write therapeutically and empathically, including when appropriate the use of metaphor, resulted in remarkably positive effects for these challenging and interesting cases. Our collection of integrated test protocols and case demographics has also enabled some interesting research.

"When we talk about getting "in our client shoes", we are setting a standard of the goal and ethic to respect and engage the client in collaboration and this also demands us to step out of our comfort zone and get into the experience of a client."

So how did this tiny clinic across the hall from classrooms with one referral source grow and develop into a large and dynamic training facility? I believe it is the realization and illustration of the wisdom of Drs. Lott, Krishnamurthy, and Finn. Somehow, the director of the University of California Irvine Disabilities Center heard about our service, made a few referrals and was pleased with the results. She shared her experiences with other disability center directors at the local Universities in the Cal State system, and word spread from. By 2009, we were receiving referrals from a dozen local universities. Argosy moved to a new campus facility with a clinic built to our specifications, including 7 offices, a conference room and a reception desk. The graduate student staff had also doubled to 8 students.

How and why did this rapid growth happen? In hindsight, it is very clear that low cost psychoeducational and/or psychological assessment are significantly needed on university campuses. There are many college students who are struggling and suffering and don't understand why. This is a niche of service, which is likely to exist in many communities. Other communities may have different underserved needs, which may serve as a starting foundation. I also cannot underestimate the attractive nature of our low cost service. For the first 3 years of the clinic, when we were still largely serving the Art Institute, our services were free of charge. We then moved to a very low-cost sliding scale fee of $50–$250 for a comprehensive assessment. Our current structure is $200–$500. We are always willing to go below the sliding scale fee structure, or even offer pro bono services, for particularly high need cases. For those considering beginning a clinic, there may be some financial realities, which limit your fee structure, but if flexibility at the beginning is feasible it does have a powerful effect on building word of mouth referrals.

The Pleasures, Benefits, and Challenges of a Training Core Focus

An absolute necessity in building a TA based clinic is a highly motivated and passionate clinical staff fully versed in the principles and attitudes of the model. No one is more excited about TA than graduate students in their first practicum. It builds their most valuable clinical skills. As their professor and supervisor, it is like working with a motivated and resistance-free therapy client. It helps dramatically that I am the head of the assessment track within the academic program and all assisting faculty and supervisors are my former students and supervisees. In a different approach than that described by Hale Martin in a previous issue of this journal, TA is taught throughout the assessment sequence at Argosy. Students learn a collaborative style for the assessment background and clinical interview; forming questions with their "volunteer" assessment subjects. They learn to write empathically and therapeutically about cognitive assessment results. They explore more deeply the clients "stories" in personality assessment and focus on answering questions and retelling stories via letters and metaphors with the information obtained from the assessment pointing towards potential new life chapters. The process of selecting, training, and supervising clinicians who were not taught or trained by the clinic director – my experience is currently within a practicum site located in a prison – is more challenging at the outset, but just as rewarding at the culmination of training. When logistically and financially feasible, a powerfully inspiring and effective means to a skilled and impassioned clinical staff is the TA Immersion Course.

As the graduate students complete their training year at AUTAPS, they are almost universally highly motivated and enthusiastic to learn how to practice TA. Almost without exception, the clinical skills developed and written work product, in the form of both therapeutically written assessment reports for referral sources and therapeutic letters and reports for the client, are truly impressive, especially by the end of the training year. As research and anecdotal clinical experience has previously shown, clients are deeply moved (often to tears) by the experience of being truly understood, sometimes for the very first time. We have found them highly motivated to pursue recommendations for therapy and other suggestions. In fact, the high numbers of potential therapy candidates, and the limited low cost resources in our area, led us to add psychotherapy services to the clinic 4 years ago with very positive results for both the graduate students in training and the local underserved community. Again, our best work inherently advertises our service, "like a craftsman door" (Acklin, 2012).

Growing Pains: The Joys and Stresses of Becoming Bigger and Better Known

As noted above, AUTAPS started in 2006 with four students in two tiny little rooms across the hall from classrooms. Today the clinic is housed in a custom-built, 7-office space with 10–12 assessment students, eight therapy students, and one trainee on predoctoral internship. It has also grown from one referral source (the Art Institute) to over 24, including eight four-year universities, six community colleges, a law school, a university hospital, a local health plan HMO, a religious mental health service, a community hospital, a disabilities attorney, and several local therapists and psychiatrists. AUTAPS has never advertised beyond one-to-one communication with a few universities and we have yet to be listed in a local community resource directory. Essentially, all of our referrals come via word of mouth. We could, and possibly should, consider listing the clinic in a community resource directory. However, at this point there is an ideal match between the number of referrals and the capacity of our students to complete these assessments. AUTAPS is listed on the websites of four local universities as a resource for learning disability assessment.

What is the take home message here? Basically, we go back to where we began. First and foremost, we wanted to build a practice or a clinic in which to conduct excellent work and to do what is right because it is right for the service of the community. This speaks to an attitude, which is central to what TA is all about. When we talk about getting "in our client shoes," we are setting a standard of the goal and ethic to respect and engage the client in collaboration and this also demands us to step out of our comfort zone and get into the experience of a client, which may not be attractive or easy. Yet, by taking the step to willingly stretching ourselves, we provide a unique, effective, and hopeful experience

for our clients. For students in and supervisors this is also a unique growth process, which both enables and demands the best in us and from us.

Final Reflections

What are the most important lessons I've been taught through my experience of founding in building a TA-focused training clinic? What can my experience teach those of you who are hoping to build a clinic or practice based on TA?

As stated above, I believe it is essential to start such an endeavor with some guiding principles and ethics consistent with the attitudes at the core of TA. Among these are the commitment to always do our best work, to be of service to our local community, and to meet the needs of our clients with empathy, respect, and a willingness to stretch ourselves. In building a community-oriented clinic, one must begin with a commitment to these values and a passion for and full endorsement of the TA model, and have a clinical team who is just as dedicated. This latter phenomenon is clearly much easier when the clinic is connected to a graduate training program, which is also dedicated to training the TA model. Finding a niche of underserved community assessment needs serves a dual benefit of not only providing a path toward word of mouth referrals but also serving the value of doing what is right because it is right in service of humanity. The wisdom of Admiral Hopper regarding asking for forgiveness rather than permission comes in quite handy when contending with institutional administrations. An added dose of patient persistence goes a long way. Ultimately, it is the superior value and impact of the TA model that will win over even the toughest critics. As students repeatedly comment, why would you do assessment any other way?

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Author

Mark Hume, Ph.D. is designated as Associated Program Faculty (equivalent to Assistant Professor) at The American School of Professional Psychology at Argosy University Southern California, is the Founder of the Argosy University Therapeutic Assessment & Psychotherapy Service (AUTAPS), and is a Senior Psychologist Specialist at the California Institution for Men prison. His passion and focus is in the training of future assessment psychologists. To that end, Dr. Hume developed and supervises Therapeutic Assessment-oriented practicum and internship programs at both institutions. His teaching passion is psychological assessment, which he infuses with the values, techniques, and model of Therapeutic Assessment.

Please email questions or comments on this column to Mark Hume at mhume@argosy.edu

Using the Crisi Wartegg System in Therapeutic Assessment

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

Although I had a passing acquaintance with the Wartegg Drawing Completion Test (WDCT) from several consultations I had done with psychologists in Sweden, it was not until I met Alessandro Crisi at the European Rorschach Association meeting in Prague in 2009 that I became interested in the test. My previous contacts with the Wartegg had left me skeptical of the far-reaching interpretations I heard colleagues make of the eight drawings; for these "conclusions" seemed to be based on very little hard data. When Dr. Crisi explained that he had collected normative data and done a number of validity studies with the Wartegg, I became intrigued, and when he invited me to administer the test to one of my clients and send him the protocol to interpret, I jumped at the chance.

I still remember the look on my colleagues' faces at the Center for Therapeutic Assessment when I read Dr. Crisi's report on a disturbed young man I was assessing. Not only did Dr. Crisi's interpretation fit perfectly with the results of the MMPI-2, Rorschach, and Adult Attachment Projective (AAP) I had already collected, Dr. Crisi also made a number of intriguing hypotheses about issues I was struggling to understand. For example, Dr. Crisi asked me if the client's father had been abusive, and I said I didn't think so, because the father seemed so constricted and distant. But when I explored the topic of how the family handled anger in a subsequent session, I learned that for much of the client's early childhood, the father had been severely alcoholic and had frequently gone into violent rages. Neither of the parents had thought to mention this before, even though one of their central assessment questions concerned why their son was so irritable and quick to anger.

Not long after this, Dr. Crisi sent me his book on the Crisi Wartegg System (CWS; Crisi, 2007), and fortunately I was just getting to the point where I could read Italian. For those of you who are not at all familiar with the Wartegg or Dr. Crisi's system, let me orient you briefly.

The Basics of the Wartegg

The WDCT is a graphic projective test, invented by Ehric Wartegg, an East German psychologist, in 1926 – just five years after Hermann Rorschach published his inkblot test. The test consists of eight boxes, each of which contains an ambiguous mark (Figure 1). The client is asked to make a drawing in each box "that means something," avoiding abstract drawings. While these instructions are somewhat vague, most clients grasp the task immediately, and for those who do not, the assessor can give more instruction. There is no time limit to the test, and the client is told this and that he or she can complete the boxes in any order. After the drawings are completed, the assessor asks the client to describe each drawing, and to say which drawings he or she likes best and least, and which marks are preferred and least preferred. The WDCT can be used with children as young as 5

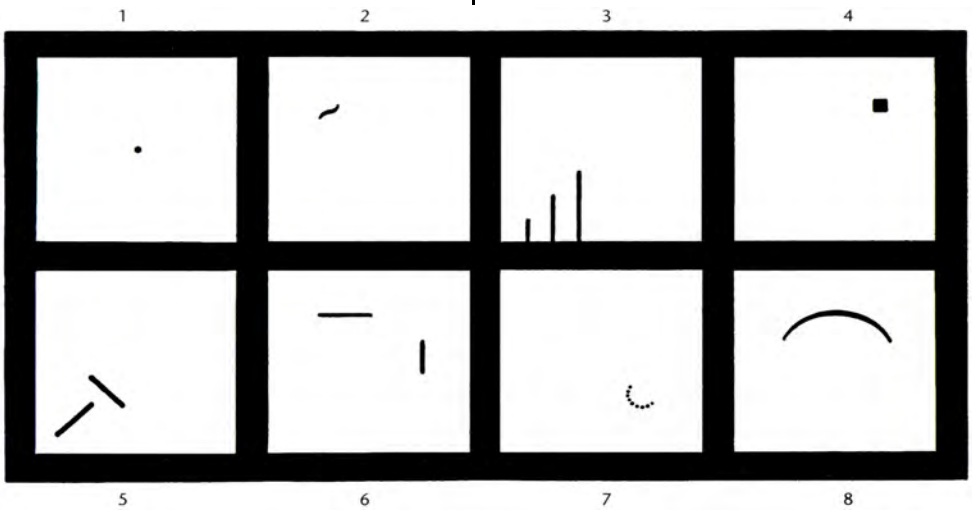


Figure 1. The Wartegg Drawing Completion Test Response Form

or 6, and is generally pretty easy for people to do. Some clients have anxiety about their drawing ability and will say, "But I can't draw well." They are told that drawing quality is not important and to just do the best they can. The average time to complete the WDCT is 15–20 minutes.

The WDCT is used widely in Scandinavia, South America, and to some extent in Asia, but typically without rigorous scoring and with interpretation based on content and verbal lore passed down from teacher to student. Wartegg himself did develop a scoring system, but it was incredibly complicated and also was not supported by any controlled research. For these and other reasons, the Wartegg has almost been completely unknown in the United States until recently.

While it may seem rather far-fetched that certain ambiguous marks would be related to particular conflict areas, Dr. Crisi's interpretations are based on extensive research, not on armchair speculation.

The Crisi Wartegg System

What I learned from Alessandro Crisi's book is that he brought a similar kind of rigor to the WDCT that John Exner brought to the Rorschach. Dr. Crisi: 1) chose one of the many variations on the WDCT stimuli, 2) developed a standardized method of administration, 3) put together a clear scoring system that has demonstrated reliability, 4) collected a large sample of normative subjects in Italy and computed normative data, 5) undertook a series of studies to investigate and document the convergent, discriminant and construct validity of CWS scores, and 6) developed a computer program for computing the CWS structural summary and interpreting it.

Many of the codes in Dr. Crisi's system are similar to those generally used with the Rorschach: The assessor scores Form Quality, Populars, Contents, human and inanimate movement, morbids, perseverations, and special scores related to thought disturbance. Dr. Crisi also developed a number of novel codes, including some based on his data about which order the boxes are typically drawn in, and another that reflects the extent to which the respondent's drawings fit with the typical "content pull" of each box. For example, Dr. Crisi found that drawings in Box 1 relate to how the person views him- or herself, and drawings in Box 2 and 4 often reflect some aspect of the respon-dent's relationship with mother and father, respectively. For example, Dr. Crisi has shown that children who are orphaned often have a great deal of difficulty with Boxes 2 and 4, and are more likely than other children to leave those boxes blank.

Again, while it may seem rather far-fetched that certain ambiguous marks would be related to particular conflict areas, Dr. Crisi's interpretations are based on extensive research, not on armchair speculation. Dr. Crisi has also investigated correlations between CWS codes and indices, and scores from the MMPI-2, Rorschach Comprehensive System, and Adult Attachment Projective Picture System. As we would hope, convergent validity is not perfect (or else why include the Wartegg?) but there are many intriguing significant correlations.

Validity. At this point, there is no comprehensive summary of the many CWS validity studies outside of Dr. Crisi's manual. (An English translation will be available this year.) But in 2012, Grønnerød and Grønnerød published a meta-analysis of 37 Wartegg validity studies from around the world that used a variety of scoring systems. (Only one of the studies included in their analysis used the CWS because most of the CWS studies are published in Italian.) The Grønnerøds concluded that there was evidence for the validity of the WDCT (median validity coefficient = .33) but that it was impossible to draw firm conclusions about the test in general because of the large variance in the test stimuli, administration, coding, and interpretation systems. For those of you who are not familiar with meta-analyses of other psychological tests, a median validity of .33 is in the same ballpark as those that have been found for the MMPI-2, Rorschach, and WAIS (cf.

Meyer & Archer, 2001; Meyer et al., 2001).

Incremental Validity of the CWS. More exciting for me is what I have come to understand about the incremental validity of the CWS. Many of the clients we see at our Center for Therapeutic Assessment in Austin have severe emotion regulation problems, and the Rorschach—while undeniably valuable—is a kind of psychological "stress test" for these clients. Child clients, especially, often seem completely overwhelmed by the Rorschach, and even many adults give "constricted," somewhat barren protocols. The optimized administration procedure used in R-PAS has helped to some extent, but even so, we often have to "peek through the blinds" of high Form % (high Lambda) to make sense of our protocols. This is one situation in which the Wartegg helps immensely. Its simple, non-threatening format is not very emotionally arousing for most clients, yet it yields much of the same information that one can get from a valid Rorschach protocol.

The CWS and Therapeutic Assessment. Several years ago, 16 American psychologists participated in the first complete course on the CWS conducted in the United States, organized by the Center for Therapeutic Assessment in Austin. This group completed all 3 levels of training, and did a final case interpretation seminar in Rome, Italy in April 2013. Recently, this group also collected an initial American normative group on the CWS and assisted with the English translation of the CWS. The fact that I and other members of this training group made time in our complicated lives and busy schedules to learn a new test will tell you something about how passionate we have become about the CWS.

A Brief Case Example

Adam was a good-looking, athletic 11-year-old boy brought to me by his parents for a Therapeutic Assessment because of "lying" and "refusal to do his schoolwork." Adam's lies were generally about homework (i.e., saying that he had none when he did, claiming that he had turned in assignments when he had not, telling the teachers various tall tales about why he didn't have his work completed). Adam's parents had divorced four years earlier and still barely talked to each other, even though Adam went back and forth between their houses every week. But they were in complete agreement that Adam should be doing better in the private school that he attended and that they knew he was "a bright boy" who simply was "lazy" and "stubborn." To make matters worse for Adam, his older sister attended the same school and was an academic star. His parents were also very high achieving.

Adam quickly engaged with me during the assessment, and seemed quite comfortable with either of his parents watching (on alternate weeks) from the corner of my office as we did the testing. He was not, however, an easy child to test. He hated the intellectual and achievement testing, and only kept trying because of the good relationship I had with him and because of the frequent play breaks I gave him. Often Adam completely shut down when tasks got difficult, appearing listless and unable to continue; we jointly developed a rating scale about how "dead" he was feeling, and we interrupted tasks before he got above a "5" on a 10-point scale. Gradually, Adam's parents came to see that he was in fact trying, but that he easily got demoralized and flooded by overwhelming feelings of inadequacy. Furthermore, the testing showed that Adam had a solidly normal IQ, with a relative strength in verbal expression, some difficulties with higher-level executive functioning, and no significant learning disabilities or ADHD. But I also knew that most of the students in Adam's private school had much higher IQs and that his high average verbal expressive abilities could easily lead teachers and others to overestimate his general cognitive abilities.

Personality testing was also not easy. On multiple self-report tests like the Children's Depression Inventory, the Revised Children's Manifest Anxiety Scale, and the Behavioral Assessment for Children–2, Adam endorsed few problematic items, basically saying, "I'm doing just fine, thanks." This did not surprise me, as Adam had talked at the beginning of the assessment

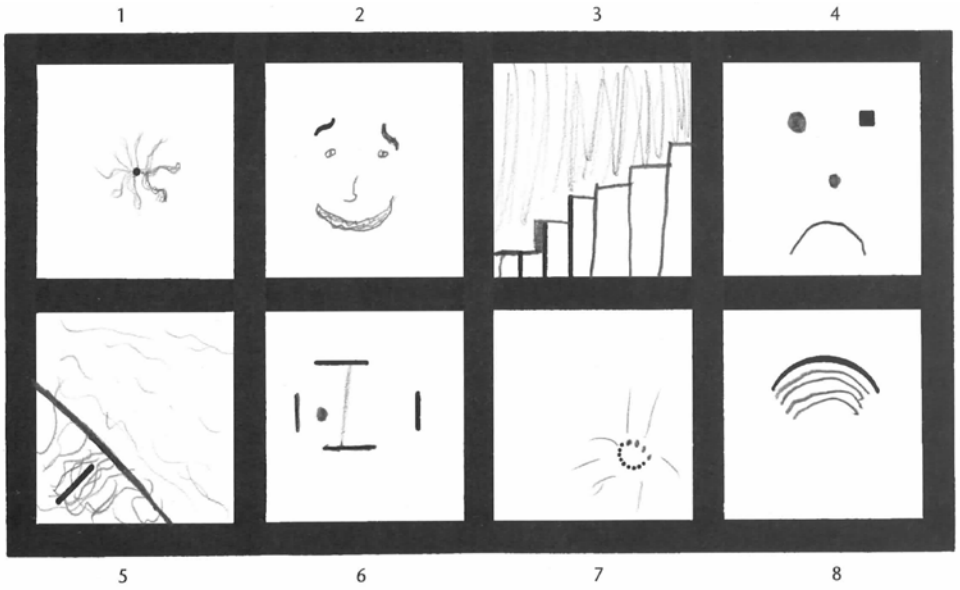
about being upset that his parents thought he needed "psychological help." His Rorschach was also very constricted, with an R-PAS complexity score of 44 and a Lambda of 2.00. I was more and more aware from my observations in sessions of how Adam's parents' high expectations and ongoing relationship conflict were affecting him negatively, but I desperately wanted "hard data" I could use in making my case to them.

Luckily, Adam was completely comfortable taking the WDCT and the resulting protocol was valid, rich, and informative. Figure 2 shows Adam's drawings and his verbal descriptions of them. When asked which drawing he liked the most, Adam said number 8, because "it's happy." His least favorite drawing was number 4 because, "I don't like it when people fight." I don't have space to explain the CWS scoring and structural summary in this brief article, but I want to summarize the main findings.

As you can pick up from the content of Boxes 4 and 6, Adam's CWS scores showed a significant level of depression and suggested that depression was greatly interfering with his intellectual performance. In fact, on the CWS Suicide Index, Adam's score was quite high for his age, even though it was not above the threshold that suggests overt suicidality. Adam also was struggling with a crippling amount of anxiety, and all of this was made worse by the fact that he was a highly emotional boy, who had difficulty modulating his emotions. In fact, in many ways, Adam's emotional development resembled that of children age 5–7. He tended to block his anger and aggression and to turn it against himself, which further intensified his depression. The WDCT also suggested that Adam was very insecure and felt badly about himself, but that he was good at masking this. He appeared to have a strong positive relationship with his mother, and to identify with her, but to have a highly conflictual relationship with his father. There were suggestions in the WDCT that Adam expected to be humiliated by male authority figures and that he shut down in part to avoid being judged by them.

The WDCT results helped me in my case conceptualization and fit with many of the impressions and hypotheses I had been coming to on my own. They also got me to take a more careful look at Adam's relationship with his father. Soon after the WDCT I asked each parent to work with Adam on a piece of homework in my office while I observed. Adam's mother was pretty supportive; although she kept wanting Adam to do more on his own than I thought he was ready for. His father, however, was easily frustrated, critical, and shaming of Adam. I found a way to give the father feedback about this after the session, and I

Figure 2. *Adam's Completed WDCT*



Note. Adam's descriptions of his drawings were: Box 1 = *a plant with a dot in the middle and tentacles coming out;* Box 2 = *it's supposed to look like me, I don't know if it does;* Box 3 = *the stairs leading up to the bedroom in Mom's house;* Box 4 = *this is what I feel like when people are fighting…sad;* Box 5 = *a dam with water rushing on one side and calm on the other;* Box 6 = *Dad's mom told me about a game she used to play. Two people have a controller, there are bars, and a ball bounces between. She said she'd play with me, but she never did;* Box 7 = *the sun;* Box 8 = *a rainbow.*

learned he himself had struggled in middle school and had to repeat a grade. His parents had been horrified and narcissistically wounded by this, and he "reformed" and went on to do well in high school and get an advanced degree. Unconsciously, he seemed to think that if Adam really wanted to, that he too could succeed. The WDCT also gave me a way to talk about all these things with Adam's parents in a less threatening way. As is typical in Therapeutic Assessment, I explained that the WDCT scores suggested various hypotheses and that I would need their help in knowing whether these were true for Adam. In fact, Adam's parents agreed with every finding from the WDCT (in part because of my careful work with them beforehand) and we were able to use these findings to come up with a detailed set of next steps, including hiring a therapeutic tutor to work with Adam on school work rather than his parents. They also agreed to work with a therapist on their co-parenting relationship. Interestingly, in the written feedback to me after the assessment, both parents mentioned the WDCT as having been very useful in understanding their son.

Final Thoughts

In summary, I highly recommend the Crisi Wartegg System and the WDCT to any of you who wish to learn an empirically validated performance-based personality test. The CWS is not difficult to learn, is easy and quick to give, can be used with adults and with children, and should only become more useful in the USA as we finish collecting American norms. Dr. Crisi is committed to offering training workshops to American psychologists, and is a frequent presenter at the annual meeting of the Society for Personality Assessment. If you wish to invite Dr. Crisi to teach in your local area, email him at alessandro.crisi@uniroma1.it. There will also be a symposium on "Therapeutic Assessment with the Crisi Wartegg System" at the CTAC in September.

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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.

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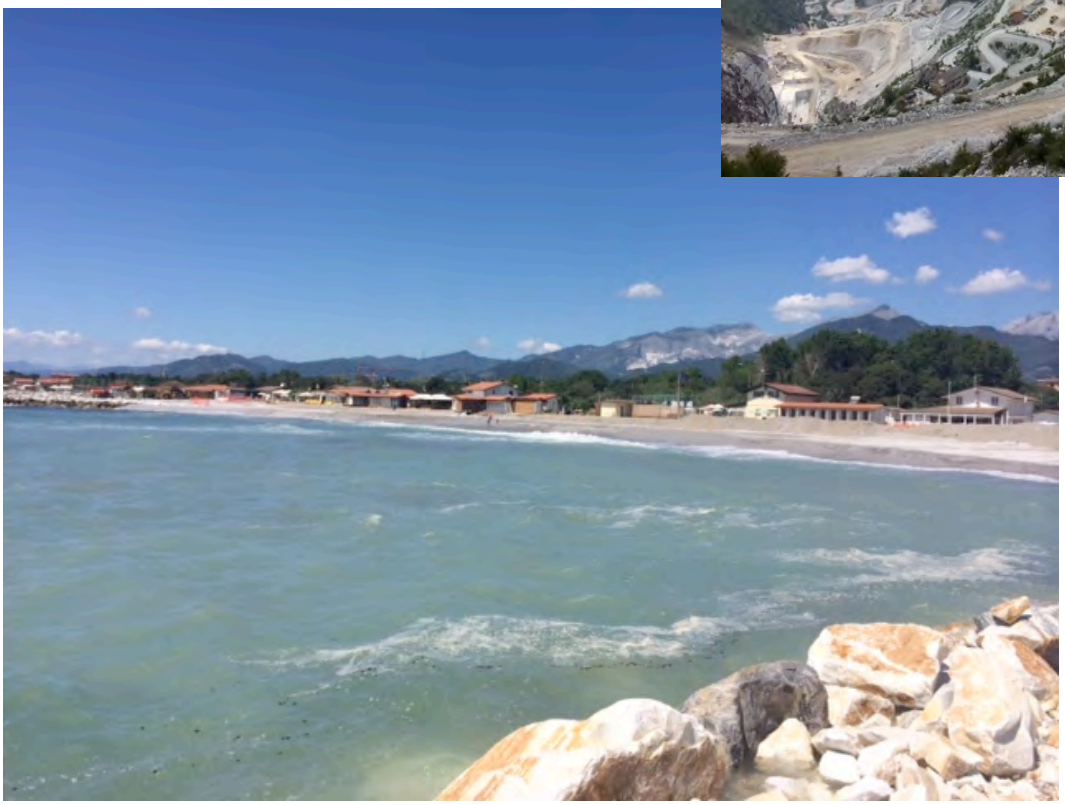
2014 Therapeutic Assessment Immersion Course in Italy and Presentations at SPA

Symposium at the 2014 SPA meeting entitled, "*Using the Crisi Wartegg System in Therapeutic Assessment*" conducted by (left to right) J.B. Allyn, Alessandro Crisi, Diane Engelman, Stephen Finn (Chair), Tracy Zemansky, and Pamela Schaber.

Participants of the 2014 TA Immersion Course in front of Casa di Ferie Sacro Cuore, in Massa, Italy. Photo courtesy of Ronald Vilé.

Representing “TA” at the marble caves near Massa, Italy. Artists (left to right) Filippo Aschieri, Linda O'Dell, Laura Guli, and Erica Dell'Acqua.

Clockwise from right: The marble mines; the Torre pendente di Pisa (the Leaning Tower of Pisa); the beautiful beach at Massa.



Recent Publications in Therapeutic/Collaborative Assessment

Andreasson, K., Krogh, J., Rosenbaum, B., Gluud, C., Jobes, D. A., & Nordentoft, M. (2014). The DiaS trial: dialectical behavior therapy versus collaborative assessment and management of suicidality on self-harm in patients with a recent suicide attempt and borderline personality disorder traits-study protocol for a randomized controlled trial. *Trials, 15*(1), 194.

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Upcoming Trainings in Therapeutic Assessment

July 15–19, 2014, Istanbul, Turkey
Title: "Therapeutic Assessment of Psychological Trauma" workshop at the XXI International Congress of the Rorschach and Projective Methods
Presenters: Stephen E. Finn and Barton Evans
Information: www.rorschach2014.org

September 11–13, 2014, Austin, TX, USA
Title: "Inaugural Collaborative/Therapeutic Assessment Conference"
Chair: J.D. Smith
Sponsor: Therapeutic Assessment Institute
Information: www.therapeuticassessment.com

October 17, 2014, Milan, Italy
Title: "Therapeutic Assessment of Psychological Trauma"
Presenters: Stephen E. Finn and members of European Center for Therapeutic Assessment
Sponsor: European Center for Therapeutic Assessment
Information: www.therapeuticassessment.com

November 10–15, 2014, Austin, TX, USA
Title: "Therapeutic Assessment Advanced Training"
Presenters: Stephen E. Finn and members of the Therapeutic Assessment Institute
Sponsor: Therapeutic Assessment Institute
Information: www.therapeuticassessment.com

November 30, 2014, Tokyo, Japan
Title: Introduction to Therapeutic Assessment
Presenter: Stephen E. Finn
Sponsor: Asian Center for Therapeutic Assessment
Information: www.therapeuticassessment.com

Collaborative/Therapeutic Assessment Conference

September 11–13, 2014
AT&T Conference Center, Austin, TX

Schedule

Preconference Workshops

Thursday, September 11, 2014

FULL DAY: 8:30 AM – 5:00 PM

PDR1. *Introduction to Therapeutic Assessment: Research, Basic Concepts, and Classic Videos*
Stephen E. Finn, Center for Therapeutic Assessment, Austin, TX

HALF DAY: 8:30 AM – 12:00 PM

PDR2. *Embracing Therapeutic Assessment and Neuropsychology: Concerns, Challenges, and Commonalities*
Diane Engelman, Center for Collaborative Psychology, Psychiatry, and Medicine, CA
Lena Lillieroth, Center for Dependency Disorders, Stockholm, Sweden
Dale Rudin, Center for Therapeutic Assessment, Austin, TX

PRD3. *Essential Skills in Gathering and Using Assessment Questions in Collaborative and Therapeutic Assessment*
Justin D. Smith, Baylor University, Waco, TX
Filippo Aschieri, Catholic University of Milan, Italy

HALF DAY: 1:30 PM – 5:00 PM

PDR2. *Planning and Conducting Assessment Intervention Sessions*
Pamela Schaber, Center for Therapeutic Assessment, Austin, TX
Marita Frackowiak, Center for Therapeutic Assessment, Austin, TX
Lena Lillieroth, Center for Dependency Disorders, Stockholm, Sweden

PDR3. *Integrating Attachment in Therapeutic Assessment*
Carol George, Mills College, Oakland, CA
Melissa Lehmann, Center for Therapeutic Assessment, Austin, TX
Julie Wargo-Aikins, Wayne State University, Detroit, MI

Conference Registration and Hotel Reservations

Click here to register for the conference. Early bird rates end July 28, 2014.

Click here to make room reservations online or call 1-512-404-1900. Availability is limited.

Conference Program

Friday, September 12, 2014

7:30 Registration Opens

8:30 – 10:00 Plenary 1

105 *Welcome and Opening Remarks*
J.D. Smith, Baylor University, Waco, TX
Stephen E. Finn, Center for Therapeutic Assessment, Austin, TX

We can only know through our relationship with the world: Constance T. Fischer and collaborative psychological assessment
Stephen E. Finn, Center for Therapeutic Assessment, Austin, TX
Caroline Purves, private practice, Berkeley, CA
Leora Bernstein, Integrated Assessment Services, Cambridge, MA

10:00 – 10:20 Break

10:20 – 12:00 Session #1

105. SYMPOSIUM: *Violence, relapse, and personality pathology: Therapeutic Assessment with complex and challenging clients*
Lena Lillieroth, Center for Dependency Disorders, Stockholm, Sweden
Hilde de Saeger, The Viersprong Clinic, Holland
J.D. Smith, Baylor University, Waco, TX

PDR1. SYMPOSIUM: *Using the Crisi Wartegg System in Therapeutic Assessment*
Diane Engelman, Center for Collaborative Psychology, Psychiatry, and Medicine, CA
Janet Allyn, Center for Collaborative Psychology, Psychiatry, and Medicine, CA
Pamela M. Schaber, Center for Therapeutic Assessment, Austin, TX
Tracy R. Zemansky, Courage to Change, Inc.
Discussant: Alessandro Crisi, Italian Institute of Wartegg, Rome, Italy

PDR2. SYMPOSIUM: *Teaching and learning Therapeutic Assessment: Getting in our students' shoes*
Hale Martin, University of Denver
Raja M. David, Minnesota School of Professional Psychology at Argosy University
Erin Jacklin, University of Denver
Mitra Lebastchi, University of Denver
Jason Turret, University of Denver
Vanessa Zimmerman, University of Denver

12:00 – 1:20 Lunch

1:20 – 3:00 Session #2

105. SYMPOSIUM: *Forensic applications of Therapeutic Assessment*
Lionel Chudzik, Center for Treatment and Studies of Externalizing Disorders, France
F. Barton Evans, Charles George VAMC, Asheville, NC and George Washington University
Mark Hume, Argosy University Southern California

PDR1. PAPER SESSION: Cutting edge Collaborative/Therapeutic Assessment research

Trainee and client experiences of Therapeutic Assessment in a required graduate course: A qualitative analysis
J.D. Smith, Baylor University, Waco, TX

Kaitlyn Egan, Baylor University, Waco, TX

Changes in parental stress following collaborative psychological evaluation of children and adolescents
Alison Wilkinson-Smith, Children's Medical Center Dallas

Development of a new measure of curiosity about self: The Self Curiosity Attitude-Interest Scale
Filippo Aschieri, Catholic University of the Sacred Heart, Milan, Italy
Valentina Saleri, Catholic University of the Sacred Heart, Milan, Italy
Ilaria Durosini, Catholic University of the Sacred Heart, Milan, Italy

Caregiver engagement during collaborative assessment feedback: Correlates and predictive validity of an observational rating
J.D. Smith, Baylor University, Waco, TX
Thomas J. Dishion, Arizona State University, Tempe, AZ
Daniel S. Shaw, University of Pittsburgh, PA
Melvin N. Wilson, University of Virginia, Charlottesville, VA

PDR2. SYMPOSIUM: *Why write a therapeutic story? How stories communicate assessment findings with children, adolescents, and adults*
Diane H. Engelman, Center for Collaborative Psychology, Psychiatry, and Medicine, CA
Marita Frackowiak, Center for Therapeutic Assessment, Austin, TX
Deborah J. Tharinger, University of Texas at Austin
Janet Allyn, Center for Collaborative Psychology, Psychiatry, and Medicine, CA

3:00 – 3:20 Break

3:20 – 5:00 Session #3

105. SYMPOSIUM: *Assessment of pathological mourning with the Adult Attachment Projective Picture System: Implications for Therapeutic Assessment*
Carol George, Mills College, Oakland, CA
Melissa Lehman, Center for Therapeutic Assessment, Austin, TX
Julie Wargo-Aikens, Wayne State University, Detroit, MI
Dale Rudin, Center for Therapeutic Assessment, Austin, TX

PDR1. PAPER SESSION: Collaborative/Therapeutic Assessment Around the World

Confronting the Shadow of Western Cultures Via Collaborative/Therapeutic Assessment
Lionel Chudzik, Center for Treatment and Studies of Externalizing Disorders, France

Assessment that promotes psychological changes
Noriko Nakamura, Nakamura Psychotherapy Institute, Tokyo, Japan

Perspectives of Therapeutic Assessment in Brazil
Anna Elisa Villemor-Amaral, Universidade São Francisco, Brazil

Back to anonymity
Alessandro Crisi, Italian Institute of Wartegg, Rome, Italy

PDR2. SYMPOSIUM: *Therapeutic Assessment in a counseling service for university students: Working on dependence and separation issues with young adults*
Francesca Fantini, Catholic University of the Sacred Heart, Milan, Italy
Vittorio Cigoli, Catholic University of the Sacred Heart, Milan, Italy
Camillo Caputo, Catholic University of the Sacred Heart, Milan, Italy
Filippo Aschieri, Catholic University of Milan, Italy

Saturday, September 13, 2014

8:30 – 10:00 Plenary 2

105. *Billing health insurance for Therapeutic Assessment*
Raja M. David, Minnesota School of Professional Psychology at Argosy University

It's time for your check-up!: The potential of brief collaborative assessments
J.D. Smith, Baylor University, Waco, TX

Quantitative and qualitative results of a randomized trial of TA: A wonderful collaboration
Hilde de Saeger, The Viersprong Clinic, Holland

The road ahead
Stephen E. Finn, Center for Therapeutic Assessment, Austin, TX

10:00 – 10:20 Break

10:20 – 12:00 Session #4

105. ROUNDTABLE: *Working with referring professionals: Common questions and concerns*
Jennifer Imming, private practice, Austin, TX
Pamela M. Schaber, Center for Therapeutic Assessment, Austin, TX
Filippo Aschieri, Catholic University of the Sacred Heart, Milan, Italy
Judith Reyes, private practice, Austin, TX

PDR1. SYMPOSIUM: *The last hope with difficult clients: Referrals for a Therapeutic Assessment at the European Center for Therapeutic Assessment of the Catholic University of Milan*
Filippo Aschieri, Catholic University of the Sacred Heart, Milan, Italy
Patrizia Bevilacqua, Catholic University of the Sacred Heart, Milan, Italy
Camillo Caputo, Catholic University of the Sacred Heart, Milan, Italy
Francesca Fantini, Catholic University of the Sacred Heart, Milan, Italy

PDR2. PAPER SESSION: Applications of C/TA

Would I lie to you? The use of power and deception during an assessment intervention session
Raja M. David, Minnesota School of Professional Psychology at Argosy University

Use of the Rey-Osterrieth Complex Figure as a tool for Therapeutic Assessment intervention
Anna Sapozhnikovah, University of California Berkeley
Bruce L. Smith, University of California Berkeley

Therapeutic Assessment of suicide risk in a VA setting: Lessons learned and case presentations
Beeta Homaifar, VA Eastern Colorado Health Care System, Denver, CO
Bridget Matarazzo, VA Eastern Colorado Health Care System, Denver, CO

Therapeutic Assessment-Child model for an ordinary Japanese family: Does our son have "ADHD?"
Tadayuki Hashimoto, Sapporo Gakuin University, Hokkaido, Japan

12:00 – 1:20 Lunch

1:20 – 2:40 Session #5

105. PAPER SESSION: Child and Adolescent issues in Collaborative/Therapeutic Assessment

A developmental perspective on generating Therapeutic Assessment questions
Mike Troy, Children's Hospitals and Clinics of Minnesota
Julie Robinson, Children's Hospitals and Clinics of Minnesota

Adolescent collaborative assessment: It's like quantum superposition
Mike Troy, Children's Hospitals and Clinics of Minnesota

Seeing double, or are we? Therapeutic Assessment of twins
Alison Wilkinson-Smith, Children's Medical Center Dallas
Alexis Clyde, Children's Medical Center Dallas

PDR1. SYMPOSIUM: *Breaking Solomon's sword: Therapeutic Assessment in family court*
Barton Evans, Charles George VAMC, Asheville, NC and George Washington University
Caroline Purves, private practice, Berkely, CA

PDR2. SYMPOSIUM: *A tale of two theories: Infant mental health assessment meets Therapeutic Assessment*
Natalie Gart, Children's Hospital Los Angeles
Marian E. Williams, Children's Hospital Los Angeles
Irina Zamora, Children's Hospital Los Angeles

2:40 – 3:00 Break

3:00 – 4:20 Session #6

105. SYMPOSIUM: *A collaborative approach to the assessment of adults who may or may not have an autism spectrum disorder*
Dale Rudin, Center for Therapeutic Assessment, Austin, TX
Stephen E. Finn, Center for Therapeutic Assessment, Austin, TX
Marita Frackowiak, Center for Therapeutic Assessment, Austin, TX
Pamela Schaber, Center for Therapeutic Assessment, Austin, TX

PDR1. SYMPOSIUM: *From community to hospital: Translating Collaborative/Therapeutic Assessment for use in inpatient and residential treatment settings*
Gay Deitrich-MacLean, private practice, Laramie, WY
Sandy Soenning, Menninger Clinic, Houston, TX
Hilde de Saeger, The Viersprong Clinic, Holland

PDR2. POSTER SYMPOSIUM

Methods for evaluating the effectiveness of single-case time-series experiments: Analysis of data from a study of collaborative assessment for psychotherapy consultation
Kaitlyn Egan, Baylor University, Waco, TX
J.D. Smith, Baylor University, Waco, TX
Wendy Eichler, University of California Santa Barbara
Steven R. Smith, University of California Santa Barbara

The rock and the lightning rod: MMPI-2 and Rorschach correlates of couple's unconscious functionality emerging through collaborative assessment
Livio Provenzi, Catholic University of the Sacred Heart & Italian Society of Relational Psychoanalysis, Milan, Italy
Romina Coin, Italian Society of Relational Psychoanalysis, Milan, Italy

Collaborative feedback of the Japanese version of WAIS-III: What brings changes to clients?
Michiru Kumamoto, Hyogo University of Teacher Education, Kato, Japan

4:30 – 5:00 Concluding remarks, large group wrap up, and farewell (105)